South West Yorkshire Partnership NHS Foundation Trust

Trust Board (performance and monitoring)
Tuesday 3 October 2017 at 12.30pm
Rooms 5 & 6, Laura Mitchell, Halifax

AGENDA

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

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

3. **Minutes and matters arising from previous Trust Board meeting held 25 July 2017** (attached)

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

5. **Performance reports month 5 2017/18**

   5.1. Integrated performance report month 5 2017/18 including finance (attached)

6. **Exception reporting**

   6.1. Serious incident report quarter 1 2017/18 (attached)

   6.2. Safer staffing (attached)

7. **Strategies and policies**

   7.1. Information Management & Technology Strategy update (attached)

   7.2. Mortality review - learning from healthcare deaths policy (attached)

8. **Annual reports**

   8.1. Health and safety annual report 2016/17 (attached)

   8.2. Sustainability annual report 2016/17 (attached)

9. Governance matters

9.1. Receipt of public minutes of partnership boards (attached)

10. Assurance from Trust Board Committees (attached)

- Clinical Governance and Clinical Safety Committee 19 September 2017
- Mental Health Act Committee 1 August 2017
- Remuneration & Terms of Service Committee 5 September 2017

11. Use of Trust seal (attached)

12. Trust Board Work Programme (attached)

13. Date of next meeting

The next meeting of Trust Board will be held on Tuesday 31 October 2017, Rooms 49/50, Folly Hall, Huddersfield.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 3 October 2017
Agenda item 2

Title:	**Trust Board declaration of interests, including fit and proper persons declaration**
Paper prepared by:	Company Secretary
Purpose:	To ensure the Trust continues to meet the NHS rules of Corporate Governance, the Combined Code on Corporate Governance, Monitor's (now NHS Improvement) Code of Governance and the Trust's own Constitution in relation to openness and transparency.
Mission/values:	The values of the Trust reflect the need for the Trust to be open, honest & transparent. 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:	**Declaration of interests** The Trust's Constitution and the NHS rules on corporate governance, the Combined Code of Corporate Governance, and Monitor (now NHS Improvement) 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 to company secretary so that the Register can be amended and such amendments reported to the Trust Board. The Trust Board receives assurance that there is appropriate management of any potential 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, the Trust Board considers any potential risk or conflict of interests. If any should arise, they are managed through the conduct of the meeting, for example through the exclusion of any director with a conflict, and recorded in the minutes of the meeting. The Company Secretary is responsible for administering the process on behalf of the Chief Executive of the Trust. There are no legal implications arising from the paper. However, Board members should note that the requirement for the Chair and Directors of the Trust to declare interests is part of the Trust's Constitution. 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.

	The attached declarations are in addition to the annual exercise received by Trust Board in March 2017. Note, there is a separate annual exercise for the Members' Council and staff. **Non-Executive Director declaration of independence** Monitor's (now NHS Improvement) 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. *In addition to the annual exercise that took place in March 2017, declarations have been received from Angela Monaghan and Kate Quail prior to their commencement on 1 August 2017.* **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. *In addition to the annual exercise that took place in March 2017, declarations have been received from Angela Monaghan and Kate Quail prior to their commencement on 1 August 2017.* **Risk appetite** The key risk is ensuring that individuals manage any potential conflicts of interest. Adhering to the requirements of the guidance will reduce this risk and this is currently being managed within the risk appetite of the Trust.
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
3 October 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 (now NHS Improvement) 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 since the annual update on 28 March 2017.

Name	Declaration
NON-EXECUTIVE DIRECTORS	
Angela Monaghan	➢ Self, Former CE of Martin House Children's Hospice ➢ Spouse, Strategic Director at Bradford Metropolitan District Council ➢ Spouse, Director of the National Association for Neighbourhood Management
Kate Quail	➢ Self, Director of The Lunniagh Partnership Ltd, Health and Care Consultancy ➢ Self, Trustee of Sheffield Parent Carer Forum ➢ Self, Sheffield Flourish ➢ Self, Darnwell Wellbeing, Sheffield
OTHER DIRECTORS	
Salma Yasmeen	➢ Spouse, owner of Insonova Ltd, provides Quality and Risk Management consultancy services to the NHS and private companies

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Trust Board meeting held on 25 July 2017

Present:	Ian Black	Chair
	Julie Fox	Deputy Chair
	Laurence Campbell	Non-Executive Director
	Rachel Court	Non-Executive Director
	Charlotte Dyson	Non-Executive Director
	Chris Jones	Non-Executive Director
	Tim Breedon	Director of Nursing and Quality
	Alan Davis	Director of HR, OD and Estates (Accounting Officer)
Apologies:	Dr Adrian Berry	Medical Director / Deputy Chief Executive
	Mark Brooks	Director of Finance and Resources
	Rob Webster	Chief Executive
In attendance:	Rob Adamson	Deputy Director of Finance
	Dawn Stephenson	Director of Corporate Development (Company Secretary)
	Karen Taylor	Director of Delivery
	Dr Subha Thiyagesh	Deputy Medical Director
	Salma Yasmeen	Director of Strategy
	Emma Jones	Integrated Governance Manager (author)

TB/17/57 Welcome, introduction and apologies (agenda item 1)

The Chair Ian Black (IB) welcomed everyone to the meeting. Apologies were received as above.

TB/17/58 Declaration of interests (agenda item 2)

There were no declarations over and above those made in the annual return in March 2017 or subsequently.

TB/17/59 Minutes and matters arising from previous Trust Board meeting held on 27 June 2017 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 27 June 2017 as a true and accurate record. There were no matters arising discussed.

TB/17/60 Chair and Chief Executive's remarks (agenda item 4)

IB highlighted the following:

- The next Members' Council meeting was scheduled for 26 July 2017 and included recommendations for approval from the Nominations Committee for the appointment of new Non-Executive Directors; Deputy Chair / Senior Independent Director; and Lead Governor.
- This was the last Board meeting for both Julie Fox, Deputy Chair and Dawn Stephenson, Director of Corporate Development. Julie had served two three year terms and the Trust owed a significant debt of gratitude. Dawn had been with the Trust almost since Foundation Trust status and the Board have relied on her diligence and application.

- With these changes there would also be changes to committee Chairs and members from 1 August 2017, for further review in November 2017:
  - Audit Committee - IB would be a time limited member until 30 November 2017.
  - Clinical Governance & Clinical Safety Committee - Charlotte Dyson (CD) to be chair and Rachel Court (RC) a member.
  - Mental Health Act Committee - Laurence Campbell (LC) member.
  - Equality & Inclusion Forum - CD member.

Alan Davis (AGD) as Accounting Officer in the Chief Executives absence highlighted the following:

- Sustainability & Transformation Plans (STP) progress dashboard was published last week showing a baseline of the progress made to date. South Yorkshire & Bassetlaw STP was rated as outstanding and the Memorandum of Understanding included under agenda item 9.1. West Yorkshire & Harrogate STP was rated as making process with leadership established. The publication also reflected some of the significant challenges in the acute sector.
- The Care Quality Commission (CQC) published its comprehensive assessment of the state of mental health services in the NHS. This was a helpful summary of all of the improvement that has happened, including in the Trust, in the last three years. It also included a fair description of the challenges ahead. There was a strong correlation with the work of the STPs in mental health. Some areas were recognised as key by the Board such as increase in the demand and how do we use the resources in the best possible way linked with the Trust's Workforce and Estates strategies.

Julie Fox (JF) commented that within the CQC publication it highlighted that children should be involved in the planning of their care which may be an area to focus on. TB commented that within the CQC report there were a number of things familiar to the Trust, particularly in relation to Child and Adolescent Mental Health Services (CAMHS). The Trust had seen an improvement and it was recognised as a system wide issue with commissioners and within the national health sector. RC commented that the visit to the CAMHS service had been helpful and it was important how the information and lessons learned were brought together.

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

TB/17/61 Risk and assurance (agenda item 5)

TB/17/61a Assurance framework and risk register (agenda item 5.1)

DS reported that she had met with each of the Directors to review the principle risks, controls in place, and sources of assurance. The assurance framework had been discussed in detail by the Executive Management Team (EMT) with the overall current assurance level of amber/green. The paper details the rationale and links any gaps in control back to the organisatonal risk register, internal audit reports, results of the Care Quality Commission (CQC) re-inspection, Integrated Performance Report and priority programmes. The Corporate/Organisational risk register also includes those that are below 15+ that were not meeting the risk appetite. Risks have been aligned to committees for review and assurance. It was noted that some targets may be more aspirational than achievable and they would continue to be reviewed by the EMT. An internal audit has commenced a review of the assurance framework and risk register with examples of best practice in relation to risk appetite requested.

LC commented that the alignment of risks to committees was a positive step forward as it allowed for deeper discussion and consideration. It was important that risk appetite continued to be embedded across the Trust down to ward level and enable emerging risks to be identified. TB commented that a lot of work had been done in relation to the clinical risk scan and incident processes and a reporting culture needed to continue to be encouraged.
CD commented that it was important that risks within services were clear and that they be linked to innovation. TB commented that areas of innovation were discussed as part of the transformation board.

Chris Jones (CJ) asked what actions were taking place around the workforce strategic risk under the improving care objective. AGD commented that a lot of initiatives were in place including actions from the wellbeing survey and Workforce Strategy. Due to the work taking place the RAG rating was considered amber/green, however it was still identified as an area of concern on the risk register.

JF asked if there were any further actions that could be done in relation to the risk around changes to national funding arrangements. Rob Adamson (RA) commented that it was important to continue conversations with partners in the system and collective conversations as part of the Sustainability and Transformation Plans may assist this.

It was RESOLVED to:

- **NOTE the controls and assurances against the Trust's strategic objectives for Quarter 1 2017/18; and**
- **NOTE the key risks for the organisation subject to any changes/additions arising from papers discussed at the Board meeting around performance, compliance and governance.**

TB/17/61b Exception report - fire safety (agenda item 5.2)
AGD reported that a verbal update was given at the Trust Board meeting in June 2017 and the exception report provided formal assurance to ensure the Board was full sighted on all of the issues. He highlighted the following:

- The Trust's overall position is good, however we need to continue to be vigilant.
- Although the Trust was already compliant a number of areas were retested with sites on more than one floor revisited which showed the assessments were still appropriate.
- Work was taking place around the application of the smoking ban and banned items list through the Acute Care Forum.
- Mandatory fire training would be increased to 95% adherence for inpatient areas.
- New builds and any major refurbishment included sprinkler systems as a standard, looking at potential of retrofitting sprinkler systems in inpatient areas.

TB commented in relation to sprinkler systems, any potential retrofit would go through a ligature risk assessment process which was a shared approach across the North East and Humber and the Trust received a positive response from the CQC in terms of the application of the process. In relation to banned items, we need to ensure people understand what they can and can't bring in our services and continue to review our approach to searching. Work was taking place across the system in relation to smoking bans and there may be learnings to be shared from other areas.

It was RESOLVED to NOTE the contents of this report.

TB/17/62 Strategies (agenda item 6)

TB/17/62a Equality strategy (agenda item 6.1)

DS reported that the strategy was consistent with legislation in order to deliver our equality duties. It was important that staff live the Trust's values and there were some good examples around dementia facilities and services for children. The strategy had been coproduced with staff, carers, Equality and Inclusion Forum members and the British. Black, Asian, and minority ethnic (BAME) staff network and identified links with other strategies including Communication, Engagement and Involvement and Workforce. It included high level objectives with TB would take the strategy forward as lead Director and supported by AGD around the workforce elements.

It was RESOLVED to APPROVE the updated Equality Strategy.

TB/17/63 Performance reports (agenda item 7)

TB/17/63a Integrated performance report month 3 2017/18 including finance (agenda item 7.1)

TB highlighted the following in relation to quality:

- Medicines omissions data from national system shows progress for early part of the quarter however indicates an increase in June 2017 which is being investigated.
- Complaints to be discussed under agenda item 7.2
- Prone restraint met the target in June 2017 which is a target set by the Trust to reduce the amount of time people are in restraint.
- Falls reduction on track
- Un-outcomed appointments data will be available for the next report.
- Safety first work on mortality reporting continues, review work meeting with Mazars and other Trusts to ensure policy was fit for purpose across. Good conversations with acute colleagues in terms of managing the process.
- Increase in Serious Incidents however within normal range, one specific incident will require a review.
- Fire safety, is an important issue for us as discussed under agenda item 5.2.
- Safer staffing remains pressured and may need targeted support to maintain full rates with plans in place.
- NICE guidance had a positive response to our work from commissioners and the CQC.
- CQUINs have been set with the exception of minor points and enhanced monitoring was in place.

Karen Taylor (KT) highlighted in relation to the NHS Improvement national metric around data completeness, that guidance was awaited from NHS England about requirements. The Trust was confident around the data collected for ethnicity with issues around the collection of accommodation and employment data understood.

KT highlighted the following in relation to locality:

- Out of Area Beds showing some spikes with a lot of continued working taking place to ensure those numbers are as small as possible. Children and young people in adult beds can also impact out of area placements.
- Improving Access to Psychological Therapies (IAPT) on target for quarter one after a lot of hard work.
- New perinatal service fully functional from September 2017.

IB asked about what actions were taking place to address children and young people on adult wards. TB commented that when it occurs it is assessed and agreed as the least worst option that that time. It is considered a serious issue by the Trust as it means the right service was not available and it may also not help that individual with their recovery. The matter has been raised with NHS England and was being discussed across the local system.

Salma Yasmeen (SY) highlighted in relation to transformation and priority programmes:

- Acute & Community Mental Health - Final report to the Executive Management Team with a significant section on lessons learned.
- Work was taking place in relation to benefits realisation and post implementation reviews to increase visibility.
- Older Peoples Mental Health - early stages of the design phase with strong community development.
- Rehab and recovery - A community service model is agreed in principle with local CCGs and has been implemented in Wakefield. Implementation in Calderdale is expected in 2017/18.
- Priority programmes section under development and proposed that the transformation programmes are picked up as part of priority programmes and the section be merged.

RA highlighted the following in relation to finance:

- Month 3 results were better than planned with a small surplus which followed trends in months 1 and 2.
- Improvements in Out of Area Beds and Agency spend
- Small risks around CQUIN and STF.
- NHS Improvement rating was 1, last year the Trust was rated as 3 largely due to agency spend.
- Cash lower than planned, partly due to late STF receipt for 2016/17.
- Capital plans continuing to progress schemes
- CIPs year to date performance was ok however some risks and important to focus on driving additional savings.

AGD commented that the management and focus on out of area beds and agency spend has delivered significant benefits in managing the cost with a lot of work taking place through the Operational Management Group. It was also important to recognise areas of pressure that may have an impact and recognised that they made need some additional expenditure which could mean we are above the agency cap.

AGD highlighted the following in relation to workforce:

- Sickness absence was above 0.5% reduction on last years, with schemes in place and reduction part of all managers objectives and performance better than average compared to others.
- Appraisal target is 95% of band 6, current performance is 75.6%, KT commented that work is taking place with each of the BDUs on a trajectory for completion.
- MHA/MCA training - MCA now at 81% hard work of everyone to get to that target, 74% on MHA training.

It was RESOLVED to NOTE the Integrated Performance Report and AGREED that the transformation section of the report be amalgamated with the priority programmes section for future reports.

TB/17/63b Customer services report quarter 1 2017/18 (agenda item 7.2)
DS reported that in quarter 1 there were 106 formal complaints, 72 compliments, 393 general enquiries and staff contacts were responded to and there were 78 requests to access information under the Freedom of Information Act. Most complaints contained a number of issues; the most frequently raised issues were access to treatment / medication, values and behaviours, patient care, communication, admission and discharge and clinical treatment. There has been a good improvement in the Friends and Family Test and positive feedback received around the compassion of staff and commitment to the services they provide.

It was RESOLVED to NOTE the feedback received through Customer Services in Quarter 1 of financial year 2017/18.

TB/17/64 Governance items (agenda item 8)

TB/17/64a South Yorkshire and Bassetlaw (SYB) Health and Care Working Together Partnership - Memorandum of Understanding "Agreement" (agenda item 8.1)
SY reported that the paper provided an update on the role of the Trust within the South Yorkshire & Bassetlaw Sustainability & Transformation Plan (SYBSTP). The Memorandum of Understanding (MOU) had been confirmed and agreed with NHS England and NHS Improvement. In response to the Trusts request to be changed from a partner to a core member, the lead for the SYBSTP has written formally to confirm that we would remain a partner and acknowledged our continued commitment. Arrangements would be reviewed in March 2018.

The Board discussed what further work could be done between now and March 2018 to further assist the review of the Trusts role and that it was hoped there would be further clarity around risk and reward share in relation to control totals prior to this date.

It was RESOLVED to NOTE the final version of the South Yorkshire and Bassetlaw Accountable Care System MOU (the 'Agreement') and SUPPORT conversations to continue on the partnership status currently allocated to the Trust.

TB/17/64b Scheme of delegation update (agenda item 8.2)
DS reported that as part of the review and approval of the Trust's Constitution and Scheme of Delegation in January 2017, the Executive Management Team requested that a further review of the Scheme of Delegation take place. The further amendments include areas of delegated authority that are in place have been stated, documents cross referenced and updated to reflect current guidance, and duplications removed to make it easier to read. The proposed amendments have been considered by the Executive Management Team and Audit Committee who support their approval.

It was RESOLVED to APPROVE the update to Scheme of Delegation and SUPPORT its approval by the Members' Council on 26 July 2017.

TB/17/64c Equality annual report 2016/17 (agenda item 8.3)
DS reported that the annual report provides an overview of Trust activity in 2016/17. It highlights work to ensure an approach that is about culture not compliance, promoting an agenda of inclusivity and respect and valuing the diversity of the communities we serve and of the staff we employ. As part of the Equality Strategy, TB would take the strategy forward as lead Director and supported by AGD around the workforce elements.

CJ asked if there were gaps in quality data and the actions in place to address them. AGD commented that a detailed report was on the Trust's website and Annual Report and Accounts in relation to a number of key equality areas. DS commented that detailed reports were received by the Equality & Inclusion Forum.

It was RESOLVED to RECEIVE the Equality Report 2016/17.

TB/17/64d Medical appraisal/revalidation annual report 2016/17 (agenda item 8.4)
SThi reported that the paper included an update on the progress in achieving satisfactory medical appraisal and revalidation and assurance to support the signing of the Statement of Compliance as required by NHS England. SThi highlighted the following:

- 141 doctors had a prescribed connection with the Trust as at 31 March 2017.
  - 89% successfully completed the appraisal process during 2016/17.
  - 10.5 % had an agreed postponement in line with the medical appraisal policy.
- 6 revalidation recommendations were required from 1 April 2016 to 31 March 2017.
  - 5 doctors had positive recommendations made.
  - 1 doctor had a recommendation of deferral.
  - All recommendations made were upheld by the General Medical Council (GMC).
  - Item 1.3 in the paper was in error, no issue in 2016/17.
- The Trust continues to strengthen its appraisal and revalidation processes. A key risk identified was the voluntary status of the appraisers and if under pressure from other areas of work, doctors could withdraw from this role, thus threatening the appraisal process.

The Board discussed strands to continue to strengthen the process including 360 degrees feedback, staff wellbeing survey to identify any hotspots working with clinical leads in trios to address any concerns, and medical leaders advisory group raising any professional concerns and hotspots.

It was RESOLVED to ACCEPT the report and APPROVE the statement of compliance confirming that the organisation is a designated body as in compliance with the regulations.

TB/17/65 Receipt of minutes of partnership boards (agenda item 9)

A list of agenda items discussed and Minutes where available were provided for the following meetings:

- Barnsley Health and Wellbeing Board (next meeting scheduled for 8 August 2017).
- Calderdale Health and Wellbeing Board (next meeting scheduled for 17 August 2017).
- Kirklees Health and Wellbeing Board (next meeting scheduled for 28 September 2017) - SY advised the Wellbeing Plan was on the agenda under item 9.1, with Kirklees working towards a single commissioning agenda around integration and out of hospital care.
- Wakefield Health and Wellbeing Board 20 July 2017 - KT advised that a positive discussion was being had around the autistic spectrum which was a system wide issue.

It was RESOLVED to NOTE the updates provided.

TB/17/65a Kirklees Health & Wellbeing Plan (agenda item 9.1)
SY reported that the Kirklees Health & Wellbeing Board had approved their local place based plan which would contribute to Sustainability & Transformation STP and sets out their vision for health and social care.

The Board discussed areas of noting for the Trust with the Plans 'triple aim' in line with the Trust's objectives, including Child & Adolescent Mental Health Services (CAMHS) and Improving Access to Psychological Therapies (IAPT) around pregnancy with the implementation of the Trusts perinatal service in September 2017. The Board requested that a letter to the Health & Wellbeing Board included clarification of resources to support their plan.

Action: Salma Yasmeen

It was RESOLVED to NOTE the Kirklees Health and Wellbeing Plan 2017–2020 and REQUEST that the Trust writes to the Kirklees Health and Wellbeing Board to confirm our organisational commitment to the Plan.

TB/17/66 Assurance from Trust Board committees (agenda item 10)

Audit Committee 18 July 2017
LC highlighted the following:

- Charitable funds annual report and accounts 2016/17.
- Scheme of delegation update.
- Future Focussed Finance (FFF) accreditation process to support financial skills and integration with other areas of the organisation.
- Internal audit - Data Quality – Clinical Record Keeping - TB commented that since the audit work had taken place by the Operational Management Group and a report would go to the Clinical Governance & Clinical Safety Committee and Audit Committee to summarise the actions that had taken place.
- Internal audit - Programme management office (integrated change team) understanding that the processes were changing and proposed to do a further review next year.
- Corporate/organisational risk register.

Nominations Committee 11 July 2017
IB highlighted that recommendations made by the committee would be discussed by the Members' Council on 26 July 2017 in relation to the appointment of Non-Executive Directors and Deputy Chair / Senior Independent Director.

Remuneration & Terms of Service Committee 11 July 2017
RC highlighted the following:

- Workforce strategy action plan with ongoing reports to be received by the committee.
- Sickness absence and agency spend positions.
- Wellbeing survey.
- Clinical excellence awards process.
- Progress on workforce risk register.
- Confidential items for assurance would be updated to the Trust Board via email.

TB/17/67 Trust Board work programme 2017/18 (agenda item 11)

It was RESOLVED to NOTE the work programme.

TB/17/68 Date of next meeting (agenda item 12)

The next meeting of Trust Board will be held on Tuesday 3 October 2017, Rooms 5 & 6, Laura Mitchell House, Halifax.

Signed …… Date ……

South West Yorkshire Partnership NHS Foundation Trust

TRUST BOARD 25 JULY 2017 – ACTION POINTS ARISING FROM THE MEETING

Actions from 25 July 2017

Min reference	Action	Lead	Timescale	Progress
TB/17/65a Kirklees Health & Wellbeing Plan	The Board requested that a letter to the Health & Wellbeing Board included clarification of resources to support their plan.	SY		

Outstanding actions from 27 June 2017

Min reference	Action	Lead	Timescale	Progress
TB/17/55c Mental Health Act Committee 16 May 2017	The Board discussed the collection of ethnicity data in relation to 'not known' and 'not provided'. Regular reports are provided to each BDU to ensure actions are taken forward around sharing best practice and supporting staff to ask those questions. CJ advised that the Mental Health Act Committee would continue to receive reports and if a substantial improvement was not seen after two quarter it would be escalated.	ABe / TB	October 2017	

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 3 October 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:	Changes to the timing of the board for September mean that the timing of *The Brief* for all staff is concurrent with the production of Board papers. The latest edition of *The Brief* is attached **[Annex 1]** and provides details of the national and local strategic context, performance, staffing and other issues. From a Board perspective it is worth emphasising the following: ➢ The process for appointment of a new Chair is progressing well and a proposed shortlist has been developed for approval at the Nominations Committee which meet on 9 October 2017. ➢ We are progressing the development of more formal arrangements with mental health providers in West Yorkshire. There is a paper in the private Trust Board meeting with a proposition of Committees in Common. This builds further on work being progressed through the West Yorkshire and Harrogate Sustainability and Transformation Plan (STP). ➢ There have been changes to the senior leadership at Locala with Robert Flack the Chief Executive retiring. The Chair and I will be meeting with the new Chair and interim Chief Exec in the next fortnight. ➢ Winter planning is a major focus for the national and regional teams of the ALB. ➢ STPs are expected to focus on supporting winter planning alongside some clear emerging priorities to government which are A&E, cancer and the four national clinical priorities. ➢ The Care Quality Commission (CQC) have published details of how engaged leadership is seen as a driver of high performance as evidenced in their inspections. This comes at a time when we have been awarded the organisation of the year award at the Kate Granger Awards, and continue to focus on engagement and the wellbeing of staff. ➢ Finance and performance remain tight. ➢ Decommissioning, tendering and budget reductions continue to

	cause stress and pressure in Barnsley. We are working closely with staff and partners to minimise this. **Risk Appetite** The Executive Management Team (EMT) have been reviewing the Board Assurance Framework and Risk Register. This has informed the statements in all papers that form the Trust Board meeting.
Recommendation:	**Trust Board is asked to NOTE the Chief Executive's report.**
Private session:	Not applicable.

28 September 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 know that families and carers matter
- We're respectful and honest, open and transparent, to build trust and act with integrity
- We constantly improve and aim to be outstanding so that we're relevant today, and ready for tomorrow.

What's happening externally?

National and local news

- NHS England chief executive Simon Stevens warned at the Health and Care Innovation Expo conference on 12 Sept of a challenging winter ahead, with the Southern hemisphere coming out of a particularly bad flu season
- Accident and Emergency remains a hotspot in the NHS and local performance is being extensively scrutinised – leaders from 60 trusts deemed to have the worst record were summoned to a meeting with Secretary of State Jeremy Hunt on 18 Sept
- Two acute trust chief executives resigned in Sept, from East Kent Hospitals University NHS Foundation Trust and North Middlesex University Hospital Trust – they were under pressure from ministers over consistently poor A&E performance
- NHS England updated its Mental Health Dashboard with data from Q4 of 2016/17 – this led to analysis by the Royal College of Psychiatrists which showed the difference in spend on child and adolescent mental health services across the country
- NHS mental health providers are working together across West Yorkshire to improve care across the region – this includes tackling out of area placements and meeting the demand for gender-specific psychiatric intensive care unit beds.

What's happening internally?

Safety and quality

We had 1,057 incidents in August, the vast majority of which were low or no harm:

- Green no harm - 649
- Green - 285
- Yellow - 92
- Amber - 24
- Red - 7

We had two serious incidents reported in August, and no never events. We've also:

- Developed a new policy on learning from deaths, working with Mazars. It is going to Board for approval on 3 Oct and will be published on our website.
- Developed safeguarding training for West Yorkshire Safeguarding Week, 9-15 Oct
- Won a Kate Granger Compassionate Care Award for 'best organisation' – thank you for all your hard work to make this possible
- Agreed to be a case study in a CQC report looking at improvements in mental health.

With **all of us** in mind.

28 September 2017

South West Yorkshire Partnership NHS Foundation Trust

Performance (Aug)

- **109%** safer staffing fill rate across our inpatient areas
- **91%** average fill rate of registered nurses, **86%** on day shifts, **102%** on nights
- **99%** of people recommend our community services in the Friends and Family Test, and **79%** our mental health services
- **53%** of people completing IAPT treatment and moving to recovery – our target for this is 50% and IAPT performance remains a challenge across the Trust
- **370** out of area bed days were used, an increase from July
- **89%** of staff are up to date with data security training – our target is 95%

We have three key organisations risks that we need to manage:

1. Workforce – e.g. care could suffer if we don't have the staff we need
2. Finances – e.g. losing income could impact our sustainability
3. Pressures in the system – e.g. funding cuts could impact services

Question for discussion in teams: What are the top three risks within your service?

Staffing

Wellbeing at work matters to all of us. We have many ways to help staff stay well at work including our wellbeing roadshow. Staff can also get a fast-track appointment to see our occupational health team for work-related stress or physiotherapy.

The national NHS Staff Survey will be sent out from 3 Oct – please share your views so that we can continue to improve and make progress in areas that matter to you.

The shortlist for our Excellence awards has been announced – congratulations to our finalists and good luck at our ceremony on 7 Nov. Thanks to everyone who submitted an entry – the standard was very high.

Please make sure you've had your appraisal - 89% of bands 6 and above and 46% of bands 5 and below have already.

Month 5 finances (Aug)

- In Aug we made a surplus of £22k, which is less than we were expecting - there's significant risk due to reduced income for community services
- We spent £446k on agency, giving a year to date total of £2.3m – our cap for the full year is £5.7m
- We've saved £2.9m so far this year, £122k less than planned – we need to save £8.3m in total, £0.8m of which has not yet been identified
- We have an NHS Improvement financial risk rating of 1 - the highest score possible out of 4

With **all of us** in mind.

South West Yorkshire Partnership NHS Foundation Trust

Infrastructure
In estates developments, our intermediate care wards have moved to Barnsley Hospital, and we're aiming to relocate the remaining services and functions at Mount Vernon by December. Stanley and Walton wards are now up and running in the Unity Centre at Fieldhead.

We working on our programme to implement our new mental health clinical system, SystmOne. Staff can see it in action at a demonstration session.

Are you cyber safe? Staff are asked to complete a survey and answer seven questions to find out and remember to be cautious with:

- Suspicious emails
- Attachments
- Links

Service change

- A quality impact assessment of the new model of Barnsley intermediate care is underway and procurement of care home beds is ongoing.
- Barnsley diabetes and musculoskeletal services are being tendered by the CCG.
- Yorkshire Smokefree is moving to a new model in Sheffield from 1 October, and we're awaiting the outcome of Doncaster and Rotherham bids.
- Our Barnsley IAPT service has received a contract performance notice from Barnsley. We're also in discussions with commissioners about our Kirklees service.
- Our new perinatal service is now accepting referrals, and we're holding launch events for our partners.
- Partners across West Yorkshire are setting up an adult eating disorder service, with information events being held in October.

Quality improvement and innovation

- Our funding bid for research posts has been approved by the National Institute for Health Research.
- Our quality improvement strategy is being finalised – keep an eye out for more details.
- A new digital challenge has been launched on i-hub – share your ideas and suggestions.
- Save the date: We're holding a quality improvement event.

Focus on: Fighting flu

Last year, 3 out of 4 of us had the jab. This meant we could keep services running and keep £384k of funding, the equivalent of 15 band 5 nurses.

The jab protects you, your family and service users. All of us have a professional duty and it's better to be protected than not.

Staff can get their jab from one of our peer to peer vaccinators – just get in touch with them. You can also call into one of our clinic dates or drop by occupational health at Fieldhead.

#allofus
our wellbeing at work

With **all of us** in mind.

28 September 2017

South West Yorkshire Partnership NHS Foundation Trust

Take home messages

1. Be proud that we've made good improvements and are providing compassionate care
2. At the same time, we're also keeping on top of our finances and performance e.g. agency spend
3. Our key risks are around workforce, finances and pressures in the system
4. Thank you for your hard work and resilience in continuing to deal with challenges
5. Your wellbeing matters - there's support available including flu jabs, staff physio and counselling
6. All staff are being sent the NHS Staff Survey this year – please share your views when you get yours.

With **all of us** in mind.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 3 October 2017
Agenda item 5.1

Title:	**Integrated performance report Month 5 2017/18**
Paper prepared by:	Director of Finance and Director of Quality & Nursing
Purpose:	To provide the Board with the Integrated Performance Report (IPR) for August, 2017
Mission/values/objectives	All Trust objectives
Any background papers/ previously considered by:	IPR is reviewed at Executive Management Team Meeting on a monthly basis. IPR is reviewed at Trust Board each month.
Executive summary:	**Quality** ➢ Safer staffing levels maintained, but pressure remains ins some areas ➢ Increase in under 18 admissions to acute adult wards remains a concern ➢ Safety huddles starting to produce positive results ➢ Complaints response time subject to improvement plan ➢ Quarter 1 CQUIN outturn in line with expectations **NHSI Indicators** ➢ The Trust is typically performing well against the vast majority of national metrics ➢ Improving Access to Psychological Therapies (IAPT) - proportion of people completing treatment who move to recovery – remains slightly above threshold. ➢ Data Completeness Priority metrics for mental health remains below threshold and is linked to the recording of employment and accommodation for all service users. Focus has previously been on collecting this information for patients on the care programme approach in line with the public sector agreement indicator (PSA) –the collection for all service users is now an area of focus **Finance** ➢ Pre STF surplus of £22k in August (below plan). Cumulative surplus is now £226k. ➢ Out of area beds £726k overspent year-to-date. Reduction in overspend expected when the re-provided Unity ward opens in September ➢ Agency staffing costs improved to £446k in-month which is broadly in line with our cap and remains favourable to prior year

	➢ Use of resources risk rating remains at 1 ➢ CIP delivery is £2.3m, which is £0.1m below plan ➢ Cash balance of £19.7m is over £3m behind plan **Workforce** ➢ Mental Health Act / Mental Capacity Act training have both surpassed the 80% target. ➢ Sickness absence levels is 4.9% cumulatively and deteriorated to 5.2% for the month of August. ➢ Appraisal completion for B6 and above is at 89%, just short of the 95% target **Locality** ➢ There have been a number of medical staffing resignations; the consequences are being actively managed ➢ Lower level occupancy in forensics services than expected ➢ New male and Psychiatric Intensive Care (PICU) wards at Fieldhead now open **Priority Programmes** ➢ Establishment of SROs and linked change managers is almost finalised ➢ Determination of the governance bodies that will oversee delivery of each priority programmes is complete ➢ Allocation to appoint operational leads and clinical leads is complete ➢ The scope of each programme has been defined and some have more detailed plans developed
Recommendation:	**Trust Board is asked to NOTE the Integrated Performance Report and comment accordingly.**
Private session:	Not applicable.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report

Strategic Overview

August 2017

With **all of us** in mind.

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Introduction

Please find the Trust's Integrated Performance Report for August 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. An executive summary of performance against key measures is included in the report which identify how well the Trust is performing in achieving its objectives. As outlined in last months report, the transformation and priority programme sections are now being reported as a combined section. This report includes matching each metric against the updated Trust objectives.
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:
• Improving health
• Improving care
• Improving 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
• National metrics (NHS Improvement, Mental Health Five Year Forward View, NHS Standard Contract National Quality Standards)
• Locality
• Transformation
• Priority Programmes
• 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-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Year End Forecast
Single Oversight Framework metric		2	2	2	2	2	2								1
CQC Quality Regulations (compliance breach)		Green	Green	Green	Green	Green	Green								Green
Improve people's health and reduce inequalities		**Target**	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Year End Forecast**
Total number of children & young people in adult inpatient wards [5]		0	0	1	1	2	3								1
% service users followed up within 7 days of discharge		95%	98.3%	97.5%	97.3%	93.3%	97.2%								1
% clients in settled accommodation		*60%*	82.2%	82.5%	82.2%	81.8%	81.7%								1
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks [1]		*TBA*	60.6%			Q2 data due Oct 17									
Out of area beds [2]		<=100 Green, 101 -199 Amber, >=200 Red	282	346	253	347	370								3
IAPT –proportion of people completing treatment and moving to recovery		50%	45.6%	49.4%	56.4%	52.4%	53.0%								
Improve the quality and experience of care		**Target**	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Year End Forecast**
Friends and Family Test - Mental Health		85%	85%	82%	86%	89%	79%								85%
Friends and Family Test - Community		98%	97%	99%	98%	95%	99%								98%
Patient safety incidents involving moderate or severe harm or death			4	6	5	9	8								
Safer staff fill rates		90%	110%	111%	103%	112.6%	109%								100%
Number of records with up-to-date risk assessment (MH) [3]			KPI under development												
IG confidentiality breaches		<=8 Green, 9 -10 Amber,	9	12	12	6	9								
% people dying in a place of their choosing [4]			KPI under development												
Improve the use of resources		**Target**	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Year End Forecast**
CQUIN achievement		£4.2m	£346k	£664k	£842k	£869k	£856k								£4.2m
Surplus vs Control Total		In line with Plan	£26k	£53k	£95k	£204k	£226k								£1020k
Agency spend		In line with Plan	£501k	£426k	£500k	£457k	£446k								£7m
CIP delivery		£1074k	£472k	£1024k	£1643k	£2306k	£2950k								£8.3m
Sickness absence		4.5%	4.8%	4.7%	4.7%	4.8%	4.9%								4.50%
Mental Health Act training		>=80%	51.2%	56.9%	70.5%	75.0%	80.3%								80%
Mental Capacity Act Training		>=80%	64.9%	69.6%	78.0%	82.5%	86.1%								80%

NHSI Ratings Key:
1 – Maximum Autonomy, 2 – Targeted Support, 3 – Support, 4 – Special Measures

Notes:
1 - Please note: this is a proxy definition as a measure of clients receiving timely assessment / service delivery by having two face-to-face contacts. It is per referral. This is a new KPI and is still under discussion with commissioner so may see further developments to this in future months.
2 - Out of area beds - this identifies the number of out of area bed days during the reporting month - the national definition for out of area bed is: is a patient that is admitted to a unit that does not form part of the usual local network of services. This is for Adult Acute and PICU Mental Health Services only. Whilst there has been improvements the number of days used remains above plan.
3 - data for this indicator is currently being identified and will be reviewed internally before being included in this report. It is anticipated we will be able to flow this data from September data which will be included in the October report.
4 - the report parameters are being validated, data will then be pulled and verified and it is anticipated this will be available in next months report.
5 - further detail regarding this indicator can be seen in the National Metrics section of this report.

Lead Director:

• This section has been developed to demonstrate progress being made against Trust objectives using a range of key metrics.
• A number of targets and metrics are currently being developed and some reported quarterly.
• Opportunities for benchmarking are being assessed and will be reported back in due course.
• More detail on areas of underperformance are included in the relevant section of the IPR.

The performance information above shows the performance rating metrics for 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 were relates to our 16/17 agency expenditure performance and our financial risk.

Areas to Note:

Finance

• Pre STF surplus of £22k in August. Cumulative surplus is now £226k.
• Out of are beds £726k overspent year-to-date. Reduction in overspend expected when the re-provided Unity ward opens in September
• Agency staffing costs improved to £446k in-month which is broadly in line with our cap and remains favourable to prior year
• Use of resources risk rating remains at 1
• CIP delivery is £2.3m, which is £0.1m below plan
• Cash balance of £19.7m is over £3m behind plan due to timing of two block payments (now received), an outstanding debt with Locala, and earlier receipt and payment of supplier invoices than assumed in the plan

Quality

• Safer staffing levels maintained but pressure remains in some areas
• Under 18 admissions increase remain a concern
• Safety huddles start to produce positive results
• Complaints response times subject to improvement plan
• Q1 CQUIN outturn is in line with expectations

NHSI Indicators

The Trust is performing well against the vast majority of NHSI metrics.
• Data Completeness Priority metrics for mental health remains below threshold and is linked to recording of employment and accommodation for all service users. Focus has previously been on collecting this information for patients on the care programme approach in line with the public sector agreement indicator - the collection for all service users is now an area of focus.

Locality

• The Ministry of Justice has recently relocated its main office. We are led to believe that this has caused some recruitment issues. In real terms there is a significant impact on Section 17 leave which will effect service user experience and progress. In addition to this the service has noted a direct impact on admissions and in the medium to long term would anticipate an impact on discharges and length of stay. This issue is in common with other secure services and has been escalated to NHSE.
• The Calderdale and Kirklees BDU clinical leads are working to resolve a medical staffing pressure for junior and training grades. We have had a number of Consultant grade vacancies due to retirements and moves to other Trust posts, however recruitment is underway.
• The move to the new Male Acute and PICU Wards at Fieldhead has taken place. Staff across the service worked together to ensure a smooth transition for service users. Feedback from service users about the new ward environment has been very positive.
• Positive feedback received related to the Neighbourhood Nursing Service performance dashboard which has been recognised by the Queens Nursing Institute and feeds into the alliance contract reporting in Barnsley.

Priority Programmes

• Establishment of SROs and linked change managers is almost finalised
• Determination of the governance bodies that will oversee delivery of each priority programmes is complete
• Allocation to appoint operational leads and clinical leads is complete
• The scope of each programme has been defined and some have more detailed plans developed, others require further development
• Next month we will move to the next phase of the IPR, with a defined number of transformation programmes being reported on and other programmes including summary highlights

Workforce

• Mental Health Act and Mental Capacity training have now both achieved 80% compliance.
• Sickness absence increased to 5.2% in August (4.9% year to date).
• Appraisal compliance for Band 6 and above is at 89%, just short of the 95% target.
• Appraisals completed for Band 5 and below is 46% as at the end of August 2017. The target is 95% by the end of September 2017.

Quality Headlines

Work has been undertaken to identify additional quality metrics, some of these are under development and are likely to be in place by the end of quarter 1. For the new indicators where historic data is available, this has been included. These indicators can be used to measure progress against some of the Trusts quality priorities for 2017-18.

Section	KPI	Objective	CQC Domain	Owner	Target	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Q1 17/18	Year End Forecast Position *
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	Improving Care	Safe	TB	6	0	0	1	2	1	0	0	0	0	1	4
C-Diff	C Diff avoidable cases	Improving Care	Safe	TB	0	0	0	0	0	0	0	0	0	0	0	4
Complaints	% of feedback with staff attitude as an issue	Improving Health	Caring	AD	< 20%	14% 23/168	7% 12/162	18% 28/158	12% 23/195	20% 13/63	14% 11/77	24% 19/77	24% 18/73	16% 9/58	19.8% 43/217	4
Service User Experience	Friends and Family Test - Mental Health	Improving Health	Caring	TB	85%	72%	71%	71%		85%	82%	86%	89%	79%	84%	2
	Friends and Family Test - Community	Improving Health	Caring	TB	98%	98%	98%	98%	99%	97%	99%	98%	95%	99%	98%	4
Quality	Total number of reported incidents	Improving Care	Safety Domain	TB	N/A	3509	3405	3293	2946	846	1018	976	1076	1057	2830	N/A
	Total number of patient safety incidents resulting in severe harm and death	Improving Care	Safety Domain	TB	N/A	10	19	19	20	4	6	5	9	8	16	N/A
	Total number of patient safety incidents resulting in moderate or severe harm and death	Improving Care	Safety Domain	TB	N/A	73	79	73	84	20	23	31	34	31	75	N/A
	MH Safety thermometer - Medicine Omissions	Improving Care	Safety Domain	TB	17.7%	16.8%	17.7%	Data not avai	18.70%	15.8%	13.0%	25.7%	24.2%	23.3%	N/A	3
	Safer staff fill rates	Improving Care	Safety Domain	TB	90%					110%	111%	103%	112.6%	109%	109%	4
	Safer Staffing % Fill Rate Registered Nurses	Improving Care	Safety Domain	TB	80%					109.7%	109.7%	100%	96.5%	91.2%	107%	4
	Number of pressure ulcers (attributable) 1	Improving Care	Safety Domain	TB	N/A	98	95	78	86	27	25	30	32	31	82	N/A
	Number of pressure ulcers (avoidable) 2	Improving Care	Safety Domain	TB	0	1	4	3	2	0	1	1	0	0	2	3
	Complaints closed within 40 days	Improving Health	Responsive	TB	80%				28% 11/39	10% 2/20	24% 6/25	0% 0/18	10% 2/20	11% 2/18	12.7% 8/63	1
	Referral to treatment times	Improving Health	Responsive	KT/SR/CH	TBC	KPI under development										
	Un-outcomed appointments 6	Improving Health	Effective	KT/SR/CH	TBC		2.2%	2.9%	2.6%	5.0%	4.6%	4.3%	3.8%	3.5%	4.3%	
	Data completeness	Improving Health	Effective	KT/SR/CH	TBC	KPI under development										
	Number of unvalidated records	Improving Care	Effective	KT/SR/CH	<10%	KPI under development										
	Number of Information Governance breaches 3	Improving Health	Effective	MB	<=8	36	25	29	36	9	12	12	6	9	33	
	Staff FFT survey - % staff recommending the Trust as a place to receive care and treatment	Improving Health	Caring	AD	80%	N/A	79.26%	N/A	80%	N/A					74%	N/A
	Staff FFT survey - % staff recommending the Trust as a place to work	Improving Health	Caring	AD	N/A	N/A	65.19%	N/A	66%	N/A					60%	N/A
	Number of compliments received	Improving Health	Caring	TB	N/A	Data not avail until Oct 16.		141	81	19	44	18	33	45	81	N/A
	Eliminating Mixed Sex Accommodation Breaches	Improving Care	Safety Domain	TB	0	0	0	0	0	0	0	0	0	0	0	4
	Number of Duty of Candour applicable incidents 4	Improving Health	Caring	TB	N/A	73	86	83	86	108					79	N/A
	Duty of Candour - Number of Stage One exceptions 4	Improving Health	Caring	TB	N/A	Reporting established from Oct 16		0	2	3				Data avail Oct 17	1	N/A
	Duty of Candour - Number of Stage One breaches 4	Improving Health	Caring	TB	0	Reporting established from Oct 16		0	1	1					0	3
	% Service users on CPA given or offered a copy of their care plan	Improving Care	Caring	KT/SR/CH	80%	85.6%	85.0%	83.0%	85.2%	85.2%	85.0%	85.5%	85.0%	85.3%	85.2%	4
	% of prone restraint with duration of 3 minutes or less	Improving Care	Safety Domain	KT/SR/CH	80%	Reporting Established from July 16	79.7%	75.6%	66.3%	68.40%	75.70%	80%	75.8%	86.2%	75%	4
	Delayed Transfers of Care	Improving Care	Effective	KT/SR/CH	7.5%	2.2%	2.6%	3.1%	2.7%	1.9%	1.7%	1.1%	1.7%	2.8%	1.6%	4
	Number of records with up to date risk assessment	Improving Care	Effective	KT/SR/CH	TBC				KPI under development							
	No of staff receiving supervision within policy guidance 7	Improving Care	Well Led	KT/SR/CH	TBC				48.11%							
	Number of Falls (inpatients)	Improving Care	Safety Domain	TB	TBC	162	158	136	95	39	52	49	41	54	139	
	Number of restraint incidents	Improving Care	Safety Domain	TB	TBC	Data not avail				104	140	101	144	159	345	

** 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. The number of breaches in August is correct as at 27th September. This number may change next month following further review of the incidents but this will be identified in next months report.

4 - These incidents are those where Duty of Candour is applicable. A review has been undertaken of the data and some issues identified with completeness and timeliness. To mitigate this, the data will now be reported a month in arrears. We have therefore provided a refreshed April – July position in this report. August data will be available in the next report. However some may be subject to confirmation. Data correct at 13/9/17.

6 - This is the year to date position for mental health direct unoutcomed appointments which is a snap shot position at a given point in time. The increase in unoutcomed appointments in April 17 is due to the report only including at 1 months worth of data.

7- This shows the clinical staff who were employed during Q1 and of these, how many have received supervision in the last 12 months. Please note that services only been fully using the system since December 2016.

Quality Headlines

During 2016/17, the Trust undertook some work to develop the key quality measures. 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 will relate to CAMHS. 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.

As part of the Trust's ongoing review of quality, additional metrics have been identified for reporting in 2017/18 relating to:
• Number of unvalidated records – this metric will allow the Trust to track improvement required within the data quality plan. It is proposed that the threshold will be less than 10%. This is under review since the decision to move to SystmOne in mental health services.
• Number of records with up to date risk assessment - the data for this is being identified using Sainsbury's level 1 risk assessment. This metric will also allow the Trust to track improvement required within data quality plan. It is anticipated reporting will commence from Oct 17.
• Complaints closed within 40 days - Eighty-eight per cent of complaints (16) closed in the period took longer than 40 days to respond; 40 days being the internal target. Work is underway to improve this position. This includes improving time to investigate, time to draft response and time to progress through director sign off process prior to review by the Chief Executive. A 'paper-light' process will be introduced in the near future to mitigate delay as far as possible at director sign-off.
Fortnightly reporting to BDUs enables increased scrutiny of issues and themes, complaints investigation, response timeframes and action planning, to ensure service improvement in response to feedback.
• Number of restraint incidents - August has seen an increase in the number of reported incidents compared to previous months which is attributed to a small number of individuals across Barnsley, Calderdale and specialist service BDUs that were admitted in a very acute state and the treatment area changed as appropriate to meet service user needs.
• % of prone restraint with duration of 3 minutes or less - Training is provided giving alternatives to the use of prone restraint and why they are preferable.
If prone restraint is used, staff must clearly identify why alternatives could not be used. This allows for staff reflection on the potential use of alternatives and provides information for supervision. Length of time in prone restraint can be accurately measured in Datix against the target of less than 3 minutes duration.
• NHS Safety Thermometer - Medicines Omissions – This only relates to Inpatient areas in Calderdale, Kirklees and Wakefield. The overall in-patient medicines omissions has fallen from 25.7% in June to 24.2% in July and then to 23.3% for August. However the average for Q4 last year was 18.7% under the CQUIN. Work from last year has focussed on improving the medication omissions particularly "patient refusals" on Older Persons Services (OPS) wards. Last year OPS areas could have between 20 & 30% meds omissions. Their omissions have now reduced to below that of the Working Age Adults (WAA) wards:
Ward 19 & Beechdale = 15.4%
Ashdale, Elmdale & Ward 18 = 29.4%
Chantry & Poplars = 13.6%
Trinity & Priory= 23.3%
Learning disabilities with only the odd exception returns 0% medication omissions.
OPS wards are now around the national average for medication omissions which is an improvement. WAA have increased in their omissions since the CQUIN has ceased whereas LD ward remains at zero medication omissions, demonstrating excellent clinical practices
• Falls reduction - In 2014, the Trust joined the national Sign up to Safety campaign, and made five pledges to improve patient safety. The pledges are being addressed through the Patient Safety Strategy implementation plan. The Trust committed to reduce avoidable harm by 2018 in five main areas, including falls. The targets for falls are to 1) reduce the frequency of falls by inpatients by 15% by 2018, and 2) reduce the frequency of inpatient falls resulting in moderate/severe harm or death by 10% by 2018.
The total number of inpatient falls fell from 823 in 2014 to 623 in 2016 with a reduction in falls causing moderate or severe harm from 19 in 2014 to 18 by 2016 with a forecast for a further reduction in 2017. The Trust remains on track to achieve the sign up to safety targets for falls by 2018. The target is currently being reviewed to ensure it takes account of some inpatient changes. For the month of August, there has been an increase in the number of falls reported. On review of the data, this appears to be linked to Calderdale BDU whereby a number of fall incidents linked to 3 complex cases - all cases have relevant packages of care in place and daily safety huddles are in place to assist with the prevention and reduction of fall incidents.

Safety First

Summary of incidents during Q1 17/18, August 2017

Summary of Incidents	Q1 17/18	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017
Green no harm	1753	534	618	601	655	649
Green	778	227	285	266	319	285
Yellow	230	67	88	75	75	92
Amber	57	14	18	25	18	24
Red (should not be compared with SIs)	22	4	9	9	9	7
Total	**2840**	846	1018	976	1076	1057

• All serious incidents are investigated using Root Cause and Systems Analysis techniques. Further analysis of trends and themes are available in the quarterly and annual incident reports, available on the patient safety support team intranet pages. The report for 2016/17 has recently been added.
• Incident reporting levels remain within the normal range.
• Risk panel remains in operation and scans for themes that require further investigation. Operational Management Group receive a monthly report.
• No never events reported in August 2017.
• Mortality Update – Improvements to data collection for deaths reported on Datix were implemented from 1/4/17. Some amendments have been made to improve data quality. Managers must review the 'Death of a service user' section on Datix within 48 hours if possible to ensure timely processing of mortality data. Monthly meetings are in place to review mortality.

	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017
Suicide (incl apparent) - community team care - current episode	1	1	2	5	1
Self harm (actual harm)	0	1	1	0	0
Death - confirmed related to substance misuse (drug and/or alcohol)	1	0	0	0	0
Fire / Fire alarm related incidents	0	0	1	1	0
Illegal Acts	1	0	0	0	0
Information disclosed in error	0	1	0	0	0
Vehicle Incident	0	0	1	0	0
Homicide by patient	0	0	1	0	0
Physical violence (contact made) against other by patient	0	0	1	0	0
Pressure Ulcer - grade 3	0	0	1	1	0
Physical/sexual violence by other	0	0	1	0	0
Administration/supply of medication from a clinical area	0	0	0	1	0
Self harm (actual harm) with suicidal intent	0	0	0	0	1
Suicide (incl apparent) - community team care - discharged	0	0	0	1	0
Total	**3**	**3**	**9**	**9**	**2**

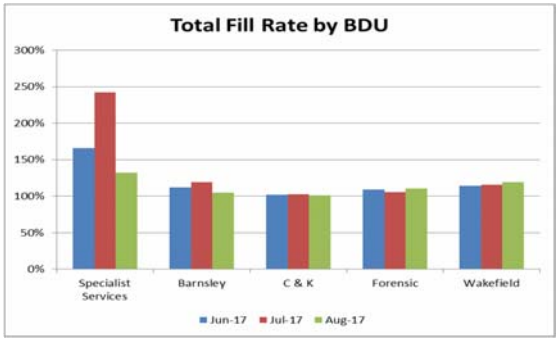
Quality Headlines

Safer Staffing

Overall Fill Rates: 108.9%
Registered fill rate: (day + night) 91.2%
Non Registered fill rate: (day + night) 124.7%

Overall fill rates for the majority of Trust inpatient areas remain above 90% for both registered and non-registered staff.

Fill rate	Month		
BDU	Jun-17	Jul-17	Aug-17
Specialist Services	166%	242%	133%
Barnsley	112%	119%	105%
C & K	102%	103%	102%
Forensic	109%	106%	111%
Wakefield	115%	115%	119%
Grand Total	**110%**	**113%**	**109%**



Overall

For the first time in three months two wards dropped below a 90% overall fill rate. These were wards 4 and 5 at Mount Vernon Hospital where ward 4 dropped to 78.4% and ward 5 dropped to 87.0%. This is because the number of inpatients on the wards was reduced substantially to facilitate smooth transfer to new premises in Barnsley Hospital as part of the 'lift & shift' transition of intermediate beds. A memorandum of understanding agreed with Barnsley Hospital to ensure services available to our patients. Of the 32 inpatient areas 26 (81.25%) achieved greater than 100%.

Registered On Days (Trust Total 85.6%)

The number of wards which are achieving 100% and above fill rate has decreased from 9 in July to 5 in August. There has been an increase in the number of wards that have failed to achieve 80%, 11 wards in all (34%). These remain mainly focused in the Forensic BDU (Medium Secure Unit)

Registered On Nights (Trust Total 101.9%)

The number of wards which are achieving 100% and above fill rate on nights remains consistently around 60%. Only Thornhill and Sandal continue to fall below the 80%.

Safer Staffing average Fill across all BDUs for RN days was 85.6%% (- 7.6%), RN nights 101.9% (+2.1%) NRN days 125.1% NRN nights 124.1%. Overall average fill rate was 108.9% (- 3.7%)

Average Fill Rates for Barnsley BDU were 107%, a decrease of 11%. , Calderdale and Kirklees BDU 101%, with a decrease of 2%, Forensic BDU had a slight increase to 110% , Wakefield BDU was 119% with an increase of 4%, Specialist services average fill rates for August were 133%.

It has been identified that on occasion on both days and nights, the Forensic BDU have dropped below the specified registered nurse requirement. The reasons behind this are the service currently has a substantial number of empty beds and on occasion have made a clinical judgement that registered nurse cover can be reduced. Secondly, on occasion, registered nurse cover from bank or agency to cover short term sickness has not been possible - this is more of an issue and is monitored by the management team. Thirdly, the service have taken on 22 new registered staff week commencing 25th September to fill vacancies so anticipate future registered nurse cover will be improved in future. Safe staffing levels have been maintained using the professional guidance tool.

Infection Prevention & Control Incidents

Surveillance
0- MRSA Bacteraemia and 0 MSSA Bacteraemia
2 cases of C diff to date (Barnsley BDU), 1 been to PIR (post infection review) and deemed unavoidable and the other case is yet to go to panel, (presently trajectory of 6 for BBDU).
3 ecoli bacteraemia - SWYFT are dedicated to the reduction of ecoli bacteraemia and have committed the CCGs Health and Social Care economy reduction plans (lead by the CCGs).

Annual Infection Prevention and Control (IPC) Action Plan and Annual Audit Plan- progressing well, no areas at risk of non-completion.

The team progressed with a Policy for Annual Influenza Vaccination Programme for inpatients. This is tracking through the internal procedures. There are a few issues that are being worked on. It is envisaged that these issues will be resolved, so that the implementation of the policy can commence as soon as possible, being mindful that we are approaching flu season.

Quality Headlines

Infection Prevention & Control Incidents cont…

IPC Training is maintained at above 80% and all BDU are rating as green.

The team has been working on a procedure / protocol for non-clinical staff to deal with blood and body fluids. This is following a recent incident at Kendray Hospital.

Review of alcohol gel dispensers, in response to an incident in another acute trust, where a patient drank alcohol gel and consequently died. There hasn't been any communication from HSE with regards to this incident as yet.

IPC week is 16th October 2017 - this is a national event and this time the Trust will be focusing on Hydration. The phrase being used is 'Make Germs Hydrate, Lets Hydrate.' This will not only be a preventative measure for Urinary Tract Infections (UTIs), but has beneficial effects from a well-being perspective.

The team have been supporting the 'lift and shift' at Mount Vernon Hospital (MVH).

Information Governance

The number of IG confidentiality breaches was 9 in August. 1 incident has been reported to the Information Commissioners Office (ICO) and we are responding to ICO questions on this.

CQC Publication

The CQC is producing a publication featuring mental health trusts that have improved. This publication, by means of about six case studies, will explore how leadership can drive improvement, and what the improvement journey means in practice for staff and people who use services. The case studies will be of NHS mental health trusts that have improved ratings significantly between inspections. It will be based on interviews with staff and representatives of public groups. They have asked us to feature in the publication and will be coming to interview staff on 28 and 29 September.

Care Quality Commission and NHS Improvement use of resources framework

Following consultation feedback, NHS Improvement and the Care Quality Commission (CQC) published their new use of resources assessment framework. This rating is expected to be combined with CQC ratings from 2018.

Commissioning for Quality and Innovation (CQUIN)

The Trust submitted its quarter 4 returns at the end of April. Validation of the final quarter 4 position has been undertaken and the final overall achievement for the Trust from the schemes was 88%.
The shortfall against target for 16/17 was slightly better than expected with improvements in mental health clustering and increase in the results of the national audit looking at the physical health for people with severe mental illness.

For 2017/18 the CQUIN schemes are part of a national two year scheme. 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 are:
• Preventing ill health by risky behaviours – alcohol and tobacco
• 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 has been identified, work continues to review the indicators in conjunction with the commissioner and work streams have been established with representation from commissioner and acute trust partner organisations where indicators span across providers requiring joint working. Progress on this is being monitored via the Trust CQUINS leads group.

Risks in performance currently relate to:
• Improvement of health and wellbeing of NHS Staff and are linked to the requirement to achieve a 5% increase in specific questions in the staff Health & Wellbeing survey, the baseline is currently very high and to achieve this would mean that SWYPFT would be one of the best in the country.

0.5% of CQUIN monies for 17/18 are currently set aside as part of an STP risk reserve
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.

The Trust is currently forecasting a year end position of £856k shortfall, of which £720k relates to the STP indicator. NHSI have written to all trusts confirming further information will follow in relation to this Indicator, the Trust continues to rate this element of the scheme Red until further guidance is issued from NHSI.

Safeguarding Children

Perinatal mental health case – A member of the Safeguarding Children's Team demonstrated the values of the Trust by putting the patient first and in the centre of the care which was delivered. An unwell mum presented for an outpatients appointment with her baby and during the appointment there was evidence that the mum and her baby needed support. The safeguarding team member and the perinatal mental health team manager worked together to ensure that the wellbeing of mum and baby were maintained throughout the intervention and stayed with them until the out of hours ambulance arrived to take them to a mother and baby unit. The members of staff provided emotional support to mum, assisted her to care for her baby and bought items (baby food, nappies, wipes etc.) to ensure that the baby was well cared for. Their intervention and commitment demonstrated the 'think family' approach and ensured the safety of mum and baby.

Quality Headlines

Safeguarding Adults

There has been continued support offered from the Safeguarding Adult's Team to the learning disability team, especially through the complex case of the service user where there is an extensive history of abuse. The current concerns require sensitive multi agency management and the safeguarding team are working with the clinicians and Practice Governance Coach to ensure that all decisions are considered from a legal perspective and that the service users' needs and desired outcomes remain central to the process. The team are ensuring that the processes, documentation and support for the service user is proportionate and able to be evidenced if required for potential Court of Protection. The safeguarding adult's team are to further support through attendance at a vulnerable adults risk matrix meeting, planned for the 21/9/2017.

Safeguarding

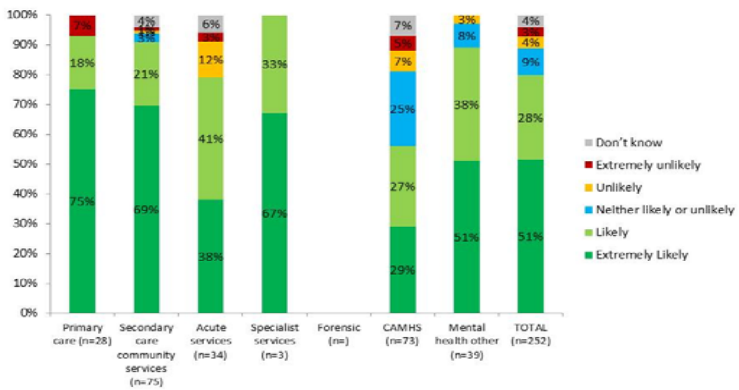
The Safeguarding Team have developed a number of new training programmes which will be delivered during the West Yorkshire Safeguarding Week. This demonstrates a commitment to multi-agency working and a continuous drive to raise the safeguarding agenda.

Patient Experience

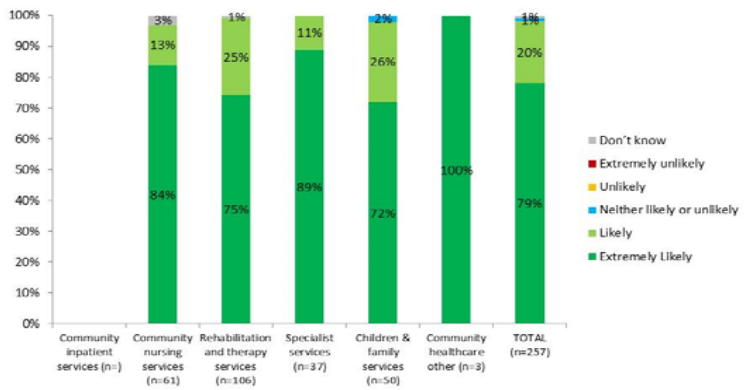
Friends and family test shows

- Community Services – 99% would recommend community services.
- All service lines achieved 72% or above for patients/carer's stating they were extremely likely to recommend the Trust's services.
- Mental Health Services – 79% would recommend mental health services. This is based on 248 responses.
- Significant variance across the services in the numbers extremely likely to recommend the Trust– between 29% (CAMH services) and 75% (primary care mental health services)
- Small numbers stating they were extremely unlikely to recommend.
- Data for August relates to 252 responses

Mental Health Services



Community Services



- Complaints with staff attitude 16% - 9 out of 58 complaints related to staff attitude.

Success

We've been chosen as the winner of the organisation category at the 2017 Kate Granger awards for compassionate care.
Judges commended our recent successes such as our police liaison scheme, the work of Kate Markham, and great feedback from service users. We were also recognised for our ambitious and innovative way of delivering care which makes a long-term, measurable difference to patients' lives.
We were presented with the award at the Health and Care Innovation Expo in Manchester on 12 September.

Mortality Update

Improvements to data collection for deaths reported on Datix were implemented from 1/4/17. Some amendments have been made to improve data quality. Managers must review the 'Death of a service user' section on Datix within 48 hours if possible to ensure timely processing of mortality data. Monthly meetings are in place to review mortality. An internal action plan is in place in response to national guidance on learning from deaths issued in March 2017.

A new Trust policy on Learning from Deaths has been submitted to the September Trust Board for approval. This was developed in collaboration with Mazars and eight other mental health trusts as part of the northern alliance. This is submitted as an interim policy to be reviewed in April 2018.

Safety Huddles

Safety Huddles are daily 5-10 minute discussions where team members gather to focus on patients and reducing harms specific to their team, for example one team may choose falls, another violence and aggression or AWOL incidents. In Spring 2017, Chantry Ward and Stroke Unit began to pilot this approach, where all staff on the ward attend the Safety Huddle, whether clinicians or support staff - everyone has a voice. The Huddle helps the team focus on keeping patients safe from harm today, and tomorrow in line with the Measurement and Monitoring of Safety Framework (Health Foundation). We now have a further 5 teams beginning their Safety Huddles journey, which starts with establishing a baseline of the team's safety culture. It is important to monitor this at different stages of implementing Safety Huddles to evidence change and improvement in culture. Although early days, the initial teams are delivering outcomes in reducing harm and improving care. Huddles' success is based upon the approach or harms not being imposed on teams or being performance driven, and it has huge potential for impact across the Trust. Plans are being developed for scale up.

This section of the report outlines the Trusts performance against a number of national metrics. These have been categorised into metrics relating to:
• NHS Improvement Single Oversight Framework - NHS providers must strive to meet key national access standards, including those in the NHS Constitution. During 16/17, NHS Improvement introduced a new framework for monitoring provider's performance. One element of the framework relates to operational performance and this will be measured using a range of existing nationally collected and evaluated datasets, where possible. The below table lists the metrics that will be monitored and identifies baseline data where available and identifies performance against threshold.
• Mental Health Five Year Forward View programme – a number of metrics were identified by the Mental Health Taskforce to assist in the monitoring of the achievement of the recommendations of the national strategy. The following table outlines the Trust's performance against these metrics that are not already included elsewhere in the report.
• NHS Standard Contract against which the Trust is monitored by its commissioners. Metrics from these categories may already exist in other sections of the report.
The frequency of the monitoring against these KPIs will be monthly and quarterly depending on the measure. The Trust will continue to monitor performance against all KPIs on a monthly basis where possible and will flag up any areas of risk to the board.

NHS Improvement - Single Oversight Metrics

KPI	Objective	CQC Domain	Owner	Target	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Q1 17/18	Year End Forecast Position *	Trend
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Improving Care	Responsive	SR	92%	98.2%	97.0%	97.5%	98.7%	98.9%	97.8%	98.20%	98.8%	96.0%	98.3%	4	
Maximum 6-week wait for diagnostic procedures	Improving Care	Responsive	SR	99%	99.6%	100%	100%	100%	99%	100%	100.0%	100.0%	100.0%	99.7%	4	
% Admissions Gate kept by CRS Teams	Improving Care	Responsive	SR/CH	95%	96.9%	99.3%	99.2%		95.6%	98.3%	100.0%	97.8%	96.9%	98.5%	4	
% SU on CPA Followed up Within 7 Days of Discharge	Improving Care	Safe	SR/CH	95%	96.7%	97.8%	97.3%	97.5%	98.3%	97.5%	97.3%	93.3%	97.2%	97.6%	4	
Data completeness: Identifiers (mental health)	Improving Health	Responsive	SR/CH	95%	98.1%	99.7%	99.8%	99.7%	Data Not avail [3]	99.7%	99.8%	99.8%	99.8%	99.8%	4	
Data completeness: Priority Metrics (mental health)	Improving Health	Responsive	SR/CH	85% *(by end March 17)*	Reporting developed from Oct 16		42.3%	61.1%	58.9%	60.4%	59.6%	59.8%	60.0%	59.6%	2 *	
IAPT - proportion of people completing treatment who move to recovery [1]	Improving Health	Responsive	SR/CH	50%	50.1%	52.5%	48.0%	50.5%	45.6%	49.4%	56.4%	52.4%	53.0%	50.1%	3	
IAPT - Treatment within 6 Weeks of referral [1]	Improving Health	Responsive	SR/CH	75%	76.1%	83.6%	88.9%	86.0%	80.3%	84.2%	81.2%	79.4%	79.5%	81.9%	4	
IAPT - Treatment within 18 weeks of referral [1]	Improving Health	Responsive	SR/CH	95%	98.9%	99.3%	97.9%	99.9%	99.6%	99.4%	99.6%	99.6%	99.2%	99.5%	4	
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Improving Care	Responsive	SR/CH	50%	77.5%	82.0%	82.2%	73.6%	86.1%	88.9%	89.2%	76.3%	96.1%	89.2%	4	
% clients in settled accommodation	Improving Health	Responsive	SR/CH	*60%*	Reporting developed from Sept 16		82.7%	82.9%	82.2%	82.5%	82.2%	81.8%	81.7%	82.2%	4	
% clients in employment	Improving Health	Responsive	SR/CH	*10%*	Reporting developed from Sept 16		8.3%	8.8%	9.3%	8.8%	9.0%	9.3%	9.3%	9.0%	1	
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) inpatient wards / b) early intervention in psychosis services / c) community mental health services (people on Care Programme Approach)	Improving Care	Responsive	SR/CH						Due Q4					Due Q4	2	

Mental Health Five Year Forward View	Objective	CQC Domain	Owner	Target	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Q1 17/18	Year End Forecast Position *	Trend
Total bed days of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	SR/CH	*TBC*	14	2	60	86	0	1	3	42	45	4	N/A	
Total number of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	SR/CH	*TBC*	4	1	4	3	0	1	1	2	3	2	N/A	
Number of detentions under the Mental Health Act	Improving Care	Safe	SR/CH	*TBC*	167	174	156	168	212			Due Sept 17		212	N/A	
Proportion of people detained under the MHA who are BME [2]	Improving Care	Safe	SR/CH	*TBC*	15.0%	10.3%	10.9%	19.6%	10.8%			Due Sept 17		10.8%	N/A	

NHS Standard Contract	Objective	CQC Domain	Owner	Target	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Q1 17/18	Year End Forecast Position *	Trend
Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users, as defined in Contract Technical Guidance [1]	Improving Health	Responsive	SR/CH	90%	97.8%	97.9%	97.8%	98.0%	95.9%	97.0%	98.7%	98.0%	Due end Sep	98.7%	4	
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	Improving Health	Responsive	SR/CH	99%	99.5%	99.6%	99.7%	99.7%	Data Not avail [3]	99.7%	99.7%	99.7%	99.7%	99.7%	4	
Completion of Mental Health Services Data Set ethnicity coding for all Service Users, as defined in Contract Technical Guidance	Improving Health	Responsive	SR/CH	90%	89.6%	91.1%	94.0%	90.2%	Data Not avail [3]	89.8%	89.3%	89.4%	90.0%	89.3%	4	

** See key included in glossary.*
1 - In order to provide the board with timely data, data from the IAPT dataset primary submission is used to give an indication of performance and then refreshed the following month using the refreshed dataset data.
2 - BME includes mixed, Asian/Asian British, black, black British, other
3 - There was no April Primary submission this month due to the transition to MHSDS v2. Data to flow monthly from May 17 onwards.

Areas of concern/to note:

The Trust is typically performing well against national metrics.

% SU on CPA Followed up Within 7 Days of Discharge - Performance dropped below threshold in July due to 8 clients out of the 121 discharged not being followed up within the timeframe. Of the 6 clients from Wakefield CCG, Calderdale CCG and Kirklees CCGs who were not followed up - in each case efforts were made to try and make contact with the clients within the seven day period and appointments were booked, however no contact was able to be made. One client from Barnsley CCG took their own discharge and moved out of area and so contact was not able to be made. One forensic client who was not followed up was discharged back to prison however contact was not made with the prison in reach team and so this breached the 7 days. Threshold has been achieved in August.

IAPT - proportion of people completing treatment who move to recovery – further slight increase in performance from last month and remains above threshold at Trust level.
Within both Barnsley and Kirklees IAPT services some local performance issues have been identified. In Barnsley, a piece of work undertaken with the national IAPT intensive support team (IST), the full report from this is awaited from the national team . In the interim the service have developed an action plan which has been shared with commissioner. Additional issues from the work with the IST will be picked up and added to the action plan as appropriate. The service do see a seasonal dip in the numbers of referrals received - this has been consistent in Aug and Dec and around Easter for the past few years. However in December last year the service saw significant spike which contributed to the breach of 6 week access threshold due to demand. A number of groups and workshops are undertaken every month so they don't tend to impact on into treatment as there is a steady flow – though we have noticed that every other month when stresspac finishes then it does have a positive effect on moving to recovery.
In July, the Senior IAPT leads for Kirklees met with the CCG to discuss concerns regarding elements of the IAPT services performance. As a result of this Kirklees IAPT and the Kirklees CCGs have agreed to develop an action / recovery plan to ensure Kirklees IAPT meets nationally agreed KPIs and locally agreed areas for improvement over the next three months of 2017. The agreed areas for improvement are access, DNA and Attrition rates as well as improving access for older people. Kirklees IAPT currently achieves KPIs for both recovery and waiting times. The action plan covered a wide range of actions including those for the Long Term Conditions pilot but in particular focussed on those areas where concerns had been expressed.

Max time of 18 weeks from point of referral to treatment - incomplete pathway - no performance issues to flag for August 17 however, from 1st June the implementation of the Diabetes SPA in Barnsley, which is hosted by SWYPFT, has meant that additional data now flows into this line as the service aligns to the RTT reporting definition. Some risk in achievement has been identified, however this is based on the SWYPFT only element of data and it has been acknowledged there are a number of data quality issues impacting. A number of mitigating actions have been put in place as part of the SPA implementation which will assist with the position going forward. Data is being monitored on a weekly basis, however it is unlikely we will see the impact of this until late September/early October.

Data Completeness Priority metrics for mental health remains below threshold and is linked to the recording of employment and accommodation for all service users. Focus has previously been on collecting this information for patients on the care programme approach in line with the public sector agreement indicator - the collection for all service users is now an area of focus.

Total bed days of Children and Younger People aged under 18 in adult inpatient wards has increased to 45 days during the month of August. This is linked to the admissions of 3 patients - 2 aged 17 and 1 aged 16 of which one was admitted in August and discharged in August; one was admitted at the end of July and continues to be an inpatient; one was initially admitted in June and discharged in August but re-admitted shortly after discharge following a breakdown in their mental health and their carer support. The Trust has robust governance arrangements in place to safeguard young people when they are admitted to our adult wards; this includes guidance for staff on legal, safeguarding and care and treatment reviews. Admissions are due to the national unavailability of a bed for young people to meet their specific needs. Work is taking place as part of the new models of care programme to address this issue. The Trust have 2 beds that can be made available (1 male, 1 female) in the event of national unavailability. We routinely notify the CQC of these admissions and discuss the detail in our liaison meetings, actioning any points that the CQC request.

MHSDS - Ethnicity coding - the August primary figure indicates an increase in performance to above the threshold. This should only be taken as indicative however we would hope to maintain or improve on this performance in the refresh submission.

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:

• The formal report from IST on our IAPT service is still awaited. A support visit from IST has been arranged for 3rd October where they will suggest tools and techniques the team could use to address some of the issues identified pending the final report. It is expected that this will supplement the interim action plan that the IAPT team have put in place based on the verbal feedback they have received
• 3 medical staff in the Community Mental Health Services have handed in their resignation in the last month. The Clinical Leads are working on plans to ensure continuity of care in the affected teams. Exit interviews will be conducted to inform strategies for recruitment and retention across the Trust
• Ward Management capacity in the Acute Service Line has been significantly affected due to 2 Ward Managers on long term sickness absence and 2 Ward Managers being successful in their applications for Practice Governance posts in the Trust. Contingency plans are being formulated to ensure Ward staff have access to timely and knowledgeable management support.
• Positive feedback received related to the Neighbourhood Nursing Service performance dashboard which has been recognised by the Queens Nursing Institute and feeds into the alliance contract reporting in Barnsley.

Calderdale & Kirklees BDU:

• Young person admissions to adult beds continue with an additional admission in August. These only occur following detailed risk assessment of all options.
• Average length of stay for Older Adults is above expected performance due to discharge of some longer term individuals,
• Sickness absence is above expected performance in the Rehab service largely due to long term absence due to serious ill health.
• Perinatal Mental health service is now operational. The workforce is nearly complete and the implementation team have now agreed to appoint a peer support worker/s to develop community outreach in each district.
• IAPT Kirklees is undertaking a weekly review of performance based on an agreed action plan with commissioners concerning access targets to treatment. The target is 15% per annum calculated on a varying monthly basis. The service focus this year has meant month on month improvement and achievement.
• The Adult Eating Disorders new community model is being developed across an STP footprint.
o SWYPT are actively engaged in developing the vision and Hub and Spoke model.
o A number of engagement and information events have been arranged for staff to participate in and to contribute to the plans. The Trust has raised concerns about staff engagement and the potential effects on current job roles and are involved in discussing an approach to engagement and communication.
• The BDU clinical leads are working to resolve a medical staffing pressure for junior and training grades. We have had a number of Consultant grade vacancies due to retirements and moves to other Trust posts, however recruitment is underway.

Forensics BDU:

• Service Review – this work is continuing nationally. Our service has been asked to develop a proposal for an LD Community Team across West Yorkshire. Tentative links have been made with Leeds and York Partnership and Bradford District Care Trust.
• The Forensic Child and Adolescent Mental Health service (FCAMHs) is working hard to develop the partnership agreements with other providers and supply an implementation plan to NHSE. Service due to commence November 2017.
• Significant improvements have been made in the delivery of 25 hours meaningful activity.
• Appraisal figures and Cardio Pulmonary Resuscitation training are key hotspots for the BDU. Plans in place to address.
• Occupancy – further slight drop to 85%. The service continues to monitor this and ensure referral processes are timely and efficient.
• The Ministry of Justice has recently relocated its main office. We are led to believe that this has caused some recruitment issues. In real terms there is a significant impact on Section 17 leave which will affect service user experience and progress. In addition to this the service has noted a direct impact on admissions and in the medium to long term would anticipate an impact on discharges and length of stay. This issue is in common with other secure services and has been escalated to NHSE.

Specialist BDU:

• Year to date (YTD) sickness rates are within target levels with the exception of Calderdale/Kirklees CAMHS and Horizon Unit. These exceptions are largely attributable to a small number of staff on long term sickness with all being proactively managed in accordance with sickness procedures.
• All services are below target for appraisals (Band 6 and above) but detailed plans are in place to ensure the required levels are achieved by end September.

CAMHS
• Ongoing difficulties are being experienced in accessing Tier 4 beds, leading to use of beds on generic adult mental health wards (over 16 years only). Though a crucial option at the point of crisis this is clearly not the most appropriate way of meeting the needs of young people and creates additional pressure on staffing levels etc. on adult wards.
• The business case progressed as part of the West Yorkshire STP has been approved subject to agreement of robust governance and risk sharing arrangements. Implementation will reduce the requirement for Tier 4 admissions through strengthening the capacity of crisis and intensive home based treatment teams.
• A September 2017 to March 2018 waiting list initiative is being implemented– as approved by EMT. Additional generic mental health practitioner and psychologist capacity has been secured through agency staffing but difficulties are being experienced in achieving the planned staffing establishment. This will require revision of the initial target (400 children/young people to receive an intervention earlier and be removed from CAMHS waiting lists) with work underway to agree a new trajectory.

Learning Disability
• Robust reporting and charging arrangements are now in place with regard to the 2 spot purchase in-patient beds. A marketing plan is being developed to ensure high occupancy levels are maintained. The occupancy rate to date is 66%.
• An individual Care Treatment Review has identified concerns with regard to care planning processes on Horizon Unit. To a large extent these were attributable to gaps in records/documentation. The necessary remedial work has now been completed.

Wakefield BDU:

• The move to the new Male Acute and PICU Wards at Fieldhead has taken place. Staff across the service worked together to ensure a smooth transition for service users. Feedback from service users about the new ward environment has been very positive. The move will see the bed complement return to commissioned levels following a reduction in bed numbers given the fire on Trinity 2 last year.
• Sickness absence in the Acute Service Line continues to be above expected levels. Managers are being encouraged to attend refresher sessions provided by HR to ensure that they are fully aware of their responsibilities in the management of absences and that they are offering the correct levels of support to staff who are beginning to experience difficulties as well as to those who are off sick.
• Appointments have been made to additional Band 7 posts in the Psychiatric Liaison Team based at Pinderfields Hospital and covering Dewsbury and Pontefract hospital sites. The new skill mix will move the team closer to compliance with the Core 24 standards for PLTs and will provide more focussed input for older people on in patient wards and those with difficulties with Substance Misuse

This section of the IPR reports the Trust's progress against the identified Trust priorities for 2017/2018.

The framework below continues reporting on progress with Trust priorities showing the necessary components each programme needs to have in place to get started in the disciplines of Governance and scope.
In respect of the priority programmes across the board we can report that:
• Determination of the governance bodies to oversee delivery of each priority programmes is complete
• Allocation to appoint operational leads and clinical leads is complete
• Scoping for some priorities is clarified and for some there is still work to complete. Work by the integrated change team continues with SRO's and the wider change network team to complete this scoping stage
• Establishment of SRO's and linked change managers is nearing completion
• This update includes the Community Forensic Community CAMHS priority that was added as a priority in the last IPR.
Given that the arrangements for governance and scope are nearing finalisation future IPR updates will be reporting on progress against plan and summaries of risk status for priorities.

	Governance										Scoping Phase							Update
	SRO Identified		Governance Route Agreed		Clinical lead Identified		Operational lead Identified		Change Manager Identified	RAG	Scope Agreed		1st Draft PID		Governance Body Approval		RAG	
IMPROVING HEALTH																		
Strategic Priority One: People First																		
1.1 Enhancing Liaison Services	✓	Sean Rayner	✓	OMG	✓	Abdul Nusair	✓	James Waplington/ Alison Gibbons/Sandra Keen	✓	Sharon Carter		✓	21/07/2017	–	01/09/2017	–	01/09/2017		This priority is primarily focussed on the transition to a new framework and benefit realisation for enhancing liaison services. In Wakefield, recruitment to clinical posts is underway and the new service is on target to commence from September 2017. In conjunction with Mid Yorkshire, Wakefield and North Kirklees CCGs, work is underway to establish a benefits realisation framework to support the 3 year evaluation of the project. Kirklees and Calderdale have produced a plan to support service readiness for April 2018. Barnsley, Wakefield, Kirklees and Calderdale have completed the Liaison MH assessment tool 2017, updating the Trusts position against key elements relating to Liaison MH and Core 24.
1.2 Improving People's Experience and Equalities	✓	Tim Breedon	✓	EMT	–	31/7/17	✓	Karen Batty	✓	Paula Rylatt		–	26/07/17	–	26/07/17	–	26/07/17		• Governance arrangements are developing and progress has commenced for the integrated change team to document scope. Scope agreed with SRO and leads. • Initial conversations held with patient experience manager Liam Redican. Outline scope agreed with SRO on 26/07/17 and further detailed planning meeting with Liam Redican, Karen Batty and Bronwyn Gill scheduled for 8/8/17 to develop specific scope and action plan for 17/18 deliverables. • Date not yet known for governance body (EMT) approval however anticipated to be October 17 along with other priority updates. • Timescales agreed and core change team identified. Detailed change project planning underway.
1.3 Recovery based approaches	✓	Salma Yasmeen	✓	Transformation Board	N/A		✓	Matt Ellis	✓	Sue Barton		✓	07/08/2017	N/A	N/A	–	08/08/17		• SRO, governance and integrated change team role agreed. • Creativity and sustainability workshop held - this will inform the overall plan which is currently under development and will be co-produced.
1.4 Physical /Mental Health	✓	Adrian Berry	✓	Transformation Board	✓	–	✓	–	✓	Ryan Hunter		✓		✓	–	✓	–		• Scope of this priority is limited to the rollout of effective physical health monitoring for people accessing our mental health services. • SRO is in place but there is considerable alignment with physical health CQUIN so consideration to be given to whether governance route needs to be aligned to CQUIN. • A bid made to the Health Foundation was unsuccessful but work is occurring across the Trust and this will be reviewed and finalised by the SRO • Clinical lead needs review due to capacity issues and operational leads yet to be confirmed hence the current yellow RAG
Strategic Priority Two: Joining up Care																		
2.1 Supporting place-based plans	✓	Salma Yasmeen	✓	EMT	N/A		✓	Sean Rayner Carol Harris	✓	Sharon Carter		N/A		N/A		–	01/09/17		• This priority is focussed on place based plans, part of the Trust Strategy to go to Trust Board in October. We will continue to develop this as a strategic priority in partnership with external stakeholders • Integrated Change Team are supporting the SRO in scoping the governance for Wakefield and Barnsley and alignment to Trust Strategy and working of services in BDUs. • Work is still required to scope actions in Calderdale and Kirklees. • EMT discussions planned to discuss place based plans and agree by October/November
2.2 Accountable Care in Barnsley and Wakefield	✓	Sean Rayner	✓	EMT	N/A		✓	Sean Rayner Andrea Wilson	✓	Sharon Carter		N/A		N/A		–	01/09/17		• Priority is focussed on planning and influencing SWYPFT role in each ACO • Following on from initial scoping discussions this has been identified as ongoing strategic development that is emergent rather than a defined change project work. • Barnsley ACO is in progress and Wakefield new models of care (NMoC) are in place • Work is ongoing to identify specifically scope and alignment to the Trust Strategy.
2.3.1 New Models of Care	✓	Sean Rayner	✓	EMT	✓	As per individual project	✓	As per individual project	✓	Sharon Carter		✓	01/04/17	✓	01/04/17	✓	12/07/17		• This priority is for New Models of Care (NMoC) in the Barnsley alliance contract related to place based plans. NMoC currently includes Intermediate Care, Diabetes, Respiratory, Neighbourhood Nursing (NNS) and Right Care. • Governance structures are in place and project plans for the projects that are in progress for respiratory service and intermediate care. • Priority will respond to partner timescales, e.g. in diabetes services
2.3.2 Vanguards	✓	Salma Yasmeen	✓	EMT	✓	As per individual project	✓	As per individual project	✓	Sharon Carter		✓	01/04/17	✓	01/04/17	✓	12/07/17		• Vanguards being rolled out for NMoC and for Portrait of a Life (POAL) • Wakefield connecting care Vanguard: Work is being undertaken to identify Wakefield governance structure and alignment of SWYPFT involvement.

IMPROVING CARE																		
Strategic Priority Three: Quality Counts, Safety First																		
3.1 Patient Safety	Please see the Quality section of this report for an update on progress with this priority. NOTE: We have a patient safety scope agreed with the SRO and clinical lead for this priority and have identified change projects and initial timescales. Detailed project and change planning is underway.																	
3.2 Older People's MH transformation	✓	Salma Yasmeen	✓	Transformation Board	✓	Subha Thiyagesh	✓	John Keaveny	✓	Ryan Hunter		–	March 2016	–	March 2016	–	March 2016	• Work is progressing well towards a business case for an in-patient model. Work is now progressing on inpatient staffing models and a meeting is scheduled with commissioners for 20 October to discuss inpatient options. • Workforce data analysis has now been undertaken and further series of workshops are arranged. • Two draft Standard Operating Procedures (SOPs) are in place and a third due completion shortly. Review and revisions of these SOPs will then be undertaken. • Revised plan is in place with regards to project resources • A new clinical model will be agreed and approved with partners. This will extend the provision of community services closer to peoples homes together with new c • Benefits are targeted in 2018/2019, with a new clinical model, the provision of new community models closer to peoples homes that will seek to prevent admissions. Focussing on new ways of working should mean that in future we have clinically appropriate lengths of stay, only people who need to be in a bed are in a beds.
3.3 Improving Autism and ADHD	✓	Carol Harris	✓	OMG	✓	Marios Adamou	✓	Marios Adamou	✓	Richard Norman		–	04/09/17	–	04/09/17	–	04/09/17	Scope of this priority is focussed on reducing waiting times for autism and ADHD pathways. Governance route has been agreed through the OMG and governance roles have been finalised. Work continues to firm up the scoping phase of this priority
3.4 Perinatal Mental Health	✓	Carol Harris	✓	Transformation Board	✓	Stephen McGowan	✓	Stephen McGowan	✓	Ryan Hunter		✓	–	✓	–	✓	–	Priority concentrates on the development of a new perinatal service and the transition to a new framework and documentation is at pace with launch scheduled for 1st September 2017.
3.5.1 West Yorkshire work – Tier 4 CAMHS	✓	Carol Harris	✓	Transformation Board	✓	Dave Ramsay	✓	Dave Ramsay	✓	Richard Norman		✓	–	✓	–	✓	–	• Work concentrates on the provision of Tier 4 CAMHS beds and improved access times led by Leeds Community Healthcare with SWYPFT as one of the providers as part of the West Yorkshire Sustainability and Transformation Plan (STP) • Initial draft business case to NHSE was produced on 4 August 2017 and work continues on a final business case scheduled for submission by 30 September 2017 with the new model of service commencing 1 October • Funding has been secured though STP NMoC work stream • Work continues in scoping the extent and role of Trust
3.5.2 West Yorkshire work – Secure Adult MH	✓	Carol Harris	✓	Transformation Board	✓	–	✓	Sue Threadgold	✓	Richard Norman		–	04/09/17	–	04/09/17	–	04/09/17	• A bid was submitted through the West Yorkshire STP for NMoC was unsuccessful, however the Trust is continuing in defining a review of forensics services through specialist community work • Integrated change team are supporting the forensic service in developing the scope and extent of this work
3.5.3 West Yorkshire work – Suicide prevention	✓	Tim Breedon	✓	EMT	✓	Mike Doyle	✓	Mike Doyle	✓	Paula Rylatt		✓	26/07/17	✓	26/07/17	✓	26/07/17	• Governance arrangements are developing and documentation of the scope of this priority by the integrated change team has commenced. • West Yorkshire Suicide prevention draft strategy and action plan with deliverables to 31/3/18 developed and the first West Yorkshire network held on 31/7/17. • Plan to launch and disseminate the strategy widely by 30/9/17. • Dedicated project worker to be recruited and project and change support also required from the integrated change team. • This work reports to both SWYPFT EMT and the West Yorkshire STP. • A decision for funding to employ a project manager is due in September. Detailed scoping regarding the local application of the West Yorkshire strategy and action plan will then commence.
3.5.4 West Yorkshire work - Eating Disorders	✓	Carol Harris	✓	Transformation Board	✓	Arasu Kuppuswamy	✓	Stephen McGowan	✓	Richard Norman		✓	04/08/17	✓	04/08/17	–	09/08/17	• Work is focussed on provision of community treatment services for eating disorders across West Yorkshire led by Leeds and York Partnership NHS Foundation Trust with SWYPFT as a partner as part of the West Yorkshire STP • Funding has been secured though STP NMoC work stream • Work near completion on scope and the role of SWYPFT in the service • Governance arrangements now complete
3.6 Quality priorities	✓	Tim Breedon	✓	EMT	N/A		✓	Karen Batty	✓	Sue Barton		–	04/08/17	N/A	N/A	✓	–	• Quality priorities agreed in Quality account • Scoping phase is ongoing to develop an action plan for improvement initiatives • Governance arrangements are developing and progress commenced for integrated change team to document scope. These will form part of the revised Quality Strategy currently in development
3.7 Community Forensic CAMHS	✓	Carol Harris	✓	Transformation Board	✓	Dr Abdullah Kraam	✓	Sue Threadgold	✓	Richard Norman		✓	21/07/17	✓	04/08/17	✓	09/08/17	• This work was agreed to be added as a Trust Priority by executive management team (EMT) in August 2017 • It is the result of a successful bid by SWYPFT, as lead provider, to provide forensic CAMHS services across Yorkshire and Humberside in partnership with: Sheffield Childrens Hospital; Tees, Esk and Wear Valleys FT and; Humber FT. • Partnership governance, agreement of the service model and the implementation plan has commenced. • Scheduled commencement to the new model of service is from November 2017 • Integrated Change Team are supporting the forensic CAMHS service in this priority
Strategic Priority Four: Compassionate Leadership																		
4.1 Leadership development	✓	Alan Davis	✓	EMT	N/A		✓	Andrew Cribbis	✓	Paula Rylatt		–	04/09/17	–	01/09/17	–	01/09/17	• The Scope for this priority is agreed with SRO and completed • Includes the revised framework for leadership development and development of integrated change network being agreed following approval at EMT • Scoping paper to be presented to EMT • Meeting to prepare PID are arranged. • Timescales and milestones agreed. Plan is currently being developed - some actions and day to work/delivery i.e. not a change project.
4.2 Change and quality improvement - Strategic Approach	✓	Salma Yasmeen / Tim Breedon	✓	EMT	N/A		✓	Karen Batty	✓	Sue Barton		N/A		✓	Ongoing	✓	01/06/17	• Quality Strategy, which includes the integrated change framework, to be presented to Trust Board in Sept/Oct • Links being made to leadership development programme, currently being scoped • Network plans approved by EMT
4.3 Membership	✓	Kate Henry	✓	EMT	N/A		–	04/08/17	✓	Richard Norman		–	–	–	–	–	–	Scope to be delivered within the new structural arrangements and work continues to inform this scope

IMPROVING USE OF RESOURCES

Strategic Priority Five: Operational Excellence

5.1 Flow and out of area beds	✓	Karen Taylor	✓	OMG	✓	Dr Nusair	✓	Roland Miller	✓	Ryan Hunter / Sarah Foreman		✓	04/08/17	✓	04/08/17	✓	04/08/17		• Out of Area (OOA) summit conducted 7th August and event well attended by staff. • Meeting held with NHS Improvement on 8th August to review the output from the OOA summit. • Internal action planning from the output of the event is to be picked up in September. • Patient flow event with YHASN is scheduled for 7th Sept.
5.2 Workforce – sickness, rostering, skill mix and agency	✓	Karen Taylor	✓	OMG	N/A		✓	Various	✓	Sarah Foreman		✓	15/06/17	✓	15/06/17	✓	15/06/17		• Separate task and finish groups are established for each of the work steams in this priority: e-rostering; sickness absence; recruitment. These groups continue to meet regularly to check on progress and agree actions • E-rostering: Training for ward managers and deputies is scheduled for September to ensure consistent understanding across localities of using the system in particular around annual leave and creation of additional duties. Review of the rostering policy is to be undertaken to check that it is still fit for purpose and any recommendations for update/amendment put forward • Sickness absence: Review of each area is to be undertaken to ensure trigger points are being used effectively and consistency is established across the Trust, commencing with Forensics and Wakefield BDUs and then to be rolled out Trust wide. Communication around missed Occupational Health (OH) appointments to be issued to individual staff as required. • Recruitment: Guidance document has been produced for those who retire from the Trust and wish to return to work. A survey is in development that aims to collect information from those who are about to retire, or have recently retired, about ways in which the Trust could encourage people to stay working for the Trust. Trust wide admin bank issues to be addressed.
5.3 Effective use of supplies and resources	✓	Mark Brookes	✓	OMG	N/A		✓	Rob Adamson	✓	Sarah Foreman		✓	16/06/17	✓	16/06/17	✓	16/06/17		• Patient Transport: Estimated benefits arising from a review of patient transport are £146k per annum. • Pathology and radiology: We are in the process of identifying a clinical lead for a project to review pathology and radiology provision and cost. • Translation and Interpreting: The introduction of a new provider for translation and interpreting services has commenced. • We are assessing the best approach to tender for out of area bed providers. Other areas of focus include training, conferences and supervision as well at IT contracts and a review of lease cars.
5.4 CQUIN	Please see the Quality section of this report for an update on progress with this priority.																		
5.5 Financial sustainability and CIP	Please see the Finance section of this report for an update on progress with this priority.																		

Strategic Priority Six: Digital by Default

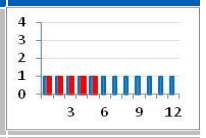
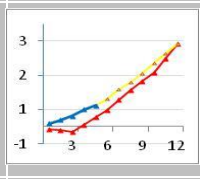
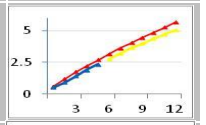
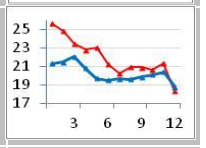
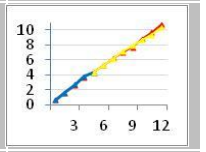
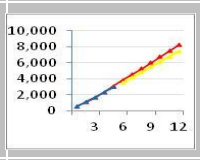
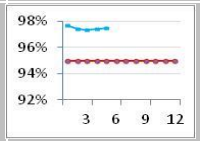
6.1 Clinical record system	✓	Salma Yasmeen	✓	Transformation Board	✓	Adrian Berry / Tim Breedon	✓	Ed Reid	–	Sharon Carter		✓	16/06/17	✓	16/06/17	✓	16/06/17		• Scope and governance agreed, programme manager in place and recruitment to project team continuing. • Procurement process ongoing, announcement made to staff via intranet and cascade briefing • Change Manager now agreed • High level plan developed which will be discussed and developed with key stakeholders • A series of demonstrations of the proposed system are planned, commencing September 2017
6.2 Digital health	✓	Kate Henry	✓	Transformation Board	✓	Jacob Agoro	✓	Jacob Agoro	✓	Paula Rylatt		–	31/07/17	–	31/07/17	–	31/07/17		• Digital strategy is defined and action plan developed. Scope still being developed for actual projects within this priority • Not all actions are clinical, however the clinical work on the action plan has an agreed clinical/operational lead from CAMHS and a pilot with ORCHA has been scoped to launch from August. • The draft action plan and scope presented to the implementation group (progression of the steering group) on the 15th August and then to EMT on 24th August for approval. • The ORCHA pilot is scheduled to begin in September subject to approval. • The digital health priority (which is part of but does not represent the entire digital strategy) is scoped and a digital health programme plan is in place and agreed with the SRO- this includes a number of different projects and actions, including a digital challenge on i-hub which has been launched.
6.3 Data driven improvements and innovation	✓	Mark Brooks	✓	EMT	N/A		✓	Nikki Cooper	✓	Sharon Carter		✓	04/08/17	✓	16/06/17	✓	16/06/17		• This change project has agreed governance through EMT and EMT approval has been gained. • Work is ongoing to determine the scale of integrated change team involvement • Scope is defined and considered to be day to day work, i.e. not a change project • Work is related to data warehousing and development and use of business intelligence processes

RAG Ratings	
	On Target to deliver within agreed timescales/project tolerances
	On Trajectory but concerns on ability/confident to deliver actions within agreed timescales/project tolerances
	Off Trajectory and concerns on ability/capacity to deliver actions within agreed timescales/project tolerances
	Actions will not be delivered within agreed timescales/project tolerances
	Action Complete

Key	
✓	Complete
–	In progress and date for delivery if known

Overall Financial Performance 2017 / 2018

Executive Summary / Key Performance Indicators

	Performance Indicator	Year to Date	Forecast	Narrative	Trend
1	NHS Improvement Risk Rating	1	1	The NHS Improvement financial risk rating is maintained at 1 for the 5 months to the end of August 2017. The individual I & E margin rating remains at 2 with an additional surplus of £300k required to achieve a rating of 1.	
2	Normalised Surplus (inc STF)	£0.6m	£2.4m	August 2017 finance performance excluding STF is a surplus of £22k. Including STF this is a surplus of £115k. This is less than the monthly plan primarily driven by reduced income. The forecast delivery of the planned surplus remains challenging with mitigation of income risks and control of expenditure pressures key.	
3	Agency Cap	£2.3m	£5m	Agency expenditure in August 2017 is broadly in line with previous months at £446k. This remains under the agency cap set for 2017 / 2018. Staffing pressures do continue in a number of areas which may result in agency use to support activity and access.	
4	Cash	£19.7m	£18.8m	Cash is £3.3m lower than planned (14%) due to a timing issue with two August block contract payments (now paid). Creditors are also lower than plan due to the timing of when some invoices are received.	
5	Capital	£4.4m	£10.4m	Capital expenditure is marginally below plan for the year to date. The majority of spend relates to the Fieldhead redevelopment.	
6	Delivery of CIP	£2.9m	£7.5m	Year to date CIP delivery is £122k behind plan. Overall the forecast position is £0.8m below plan. Task and Finish groups are progressing cost reduction opportunities through effective rostering, sickness absence reduction and non pay review.	
7	Better Payment	97%		This performance is based upon a combined NHS / Non NHS value.	

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

Plan
Actual
Forecast

Contracting

Contracting Issues - General

The meeting with North Kirklees and Greater Huddersfield CCGs regarding Mental Health Five Year Forward View will take place in October. Work continues on the mobilisation of the new model of service delivery for Smoke Free Services in Sheffield to meet the new contract commencement on 1 October 2017. The outcomes of the procurement for Integrated Health and Wellbeing Services in Rotherham and Smoke Free Services in Doncaster are expected mid-September/early October. Following a successful bid SWYPFT has been awarded the contract for lead provider of a regional community forensic CAMHs services and is working towards the mobilisation of the service for early November 2017. Work continues with the transition of the new model of service delivery for Intermediate Care Services in Barnsley planned to commence from 1 October 2017. Formal notice was received from Barnsley CCG, decommissioning the Care Navigation Service from 31st January 2018. Contracts for Musculoskeletal (MSK) and diabetes services in Barnsley are being competitively re-procured for new services to commence 1 April 2018. A bid to NHSE to support the implementation of secure stairs within the forensics secure estate has been confirmed as successful.

CQUIN

CQUIN for Quarter 1 was achieved across all main contracts.

Contracting Issues – Barnsley

Key strategic work areas in Barnsley continue across intermediate care, MSK and diabetes services. Future contracts for community MSK and diabetes services will be competitively re-procured with new services/contracts commencing from 1 April 2018. Formal notice was received from Barnsley CCG decommissioning care navigation services in Barnsley from 31st January 2018.

Contracting Issues – Calderdale

Key priorities relate to a sustainable 24/7 crisis resolution service, pressures within psychology services and the provision of specialist autistic spectrum disorder services for adults. Key ongoing workstreams include the mobilisation and implementation of the expansion of improving psychological therapy services to long term conditions and full implementation of the perinatal service across Barnsley, Wakefield, Calderdale and Kirklees. Development of the THRIVE model of delivery for CAMHs services in Calderdale continues between commissioners and providers.

Contracting Issues – Kirklees

The meeting with North Kirklees and Greater Huddersfield CCGs regarding Mental Health Five Year Forward View will take place in October. The current priority areas of work related to Kirklees CCG's contracts include IAPT services and expansion to Long Term Conditions and the reconfiguration of adult mental health rehabilitation services. Commissioning of sustainable specialist ASD Services for Adults remains a priority.

Contracting Issues- Wakefield

A key ongoing work stream includes the full implementation of the perinatal service across Barnsley, Wakefield, Calderdale and Kirklees. Transformation of CAMHs services remains a key priority and work stream with commissioners.

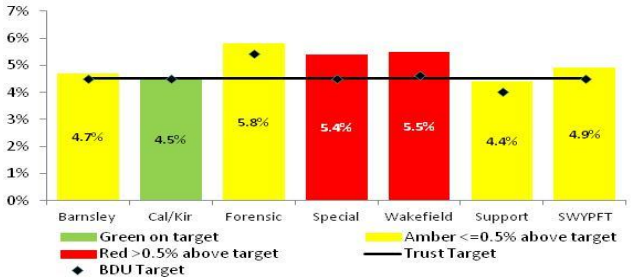
Contracting Issues - Forensics

The key area of monitoring continues to relate to the occupancy target. The sub contract for advocacy services has been awarded to Cloverleaf commencing 1st September 2017. SWYPFT has been successfully awarded the Lead Provider role for the Yorkshire & Humber delivery of Community Forensic CAMHs services. A bid to NHSE to support the implementation of Secure Stairs within the Forensics Secure Estate has been confirmed as successful.

Contracting Issues – Other

Work continues on the mobilisation of the new model of service delivery for Smoke Free Services in Sheffield to meet the new contract commencement on 1 October 2017. The procurement processes for ITT submissions for Doncaster Smoke Free services closed on 9 August 2017. The procurement process for ITT submissions for an integrated Health & Wellbeing Service for Rotherham including Smoke Free services closed on the 4 August 2017. The outcome of the procurement processes are due Sept/October 2017.

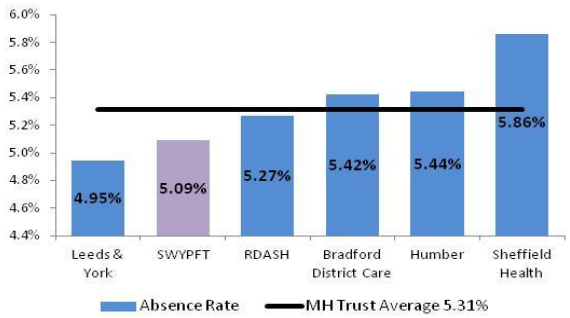
Sickness Absence



Current Absence Position - August 2017

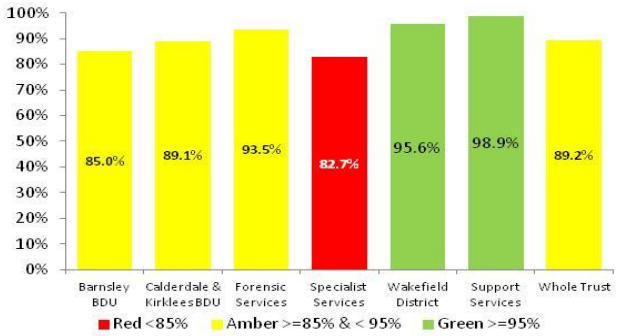
	Barn	Cal/Kir	Fore	Spec	Wake	Supp	SWYPFT
Rate	5.2%	5.1%	6.0%	5.1%	5.5%	4.4%	5.2%
Trend	↑	↓	↑	↑	↑	↓	↑

The Trust YTD absence levels in August 2017 (chart above) were above the overall 4.5% target at 4.9%.
The YTD cost of sickness absence is £2,436,880, if the Trust had met its target this would have been £2,247,123, saving £189,757.



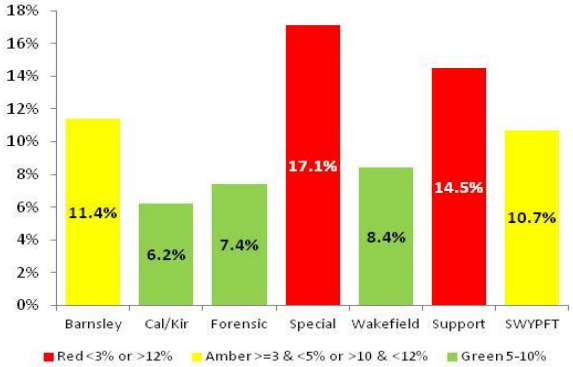
The above chart shows the YTD absence levels in MH/LD Trusts in our region for 12 months from March 2016 to April 2017.
During this time the Trust's absence rate was 5.09% which is below the regional average of 5.31%.

Appraisal Data - Band 6 and Above



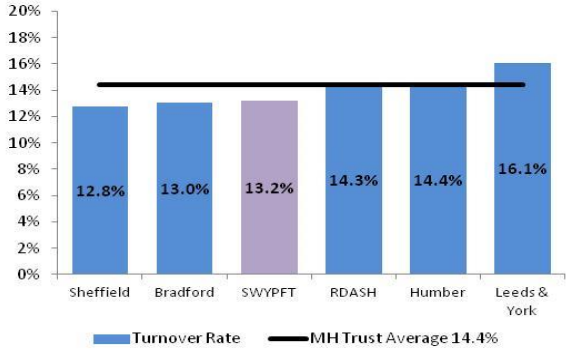
The above chart shows the appraisal rates for staff at Band 6 and above to the end of August 2017.
The appraisal target is 95% and over. For staff at Band 6 and above, all appraisals should be completed by the end of June in each financial year. Plans in place within Specialist Services to have completed band 6 appraisals by end of September.

Turnover and Stability Rate Benchmark



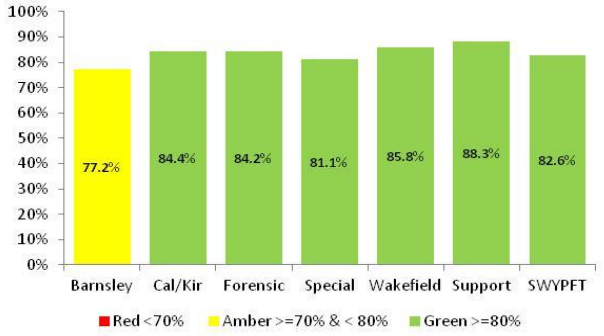
This chart shows the YTD turnover levels up to the end of August 2017.
Turnover figures may look out of line with the average across the Trust but this is because of the small amount of data; the figures will level out over the new reporting year.

A number of staff from the supported living service have been TUPEd out of the organisation and also a high number of age retirements have occurred in specialist services and within support services the higher level of turnover is a result of half of them being as a result of age and ill health retirement and redundancy. Support services have also seen a higher level of turnover this month as a result of age and ill health retirement and redundancy.



This chart shows turnover rates in MH Trusts in the region for the 12 months ending in March 2017. The turnover rate shows the percentage of staff leaving the organisation during the period.
This is calculated as: leavers/average headcount.
SWYPFT figures exclude decommissioned service changes.

Fire Training Attendance



The chart shows the YTD fire lecture figures to the end of August 2017.
The Trust continues to achieve its 80% target for fire lecture training and only one area has dropped below the 80% target in August.

Workforce - Performance Wall

Trust Performance Wall

Month	Objective	CQC Domain	Owner	Threshold	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Sickness (YTD)	Improving Resources	Well Led	AD	<=4.4%	4.7%	4.8%	4.9%	5.0%	5.1%	5.1%	4.8%	4.7%	4.7%	4.8%	4.9%
Sickness (Monthly)	Improving Resources	Well Led	AD	<=4.4%	4.6%	5.2%	5.8%	6.1%	5.8%	5.3%	4.8%	4.6%	4.8%	5.0%	5.2%
Appraisals (Band 6 and above)	Improving Resources	Well Led	AD	>=95%	84.8%	89.8%	93.2%	93.7%	94.4%	94.9%	5.2%	17.6%	61.3%	80.9%	89.0%
Appraisals (Band 5 and below)	Improving Resources	Well Led	AD	>=95%	76.8%	84.9%	89.0%	91.4%	92.8%	93.6%	1.9%	5.3%	18.4%	31.1%	46.2%
Aggression Management	Improving Care	Well Led	AD	>=80%	80.0%	78.8%	78.4%	77.6%	77.2%	76.6%	76.4%	75.6%	78.1%	76.6%	77.0%
Cardiopulmonary Resuscitation	Improving Care	Well Led	AD	>=80% by 31/3/17	65.0%	66.9%	69.7%	72.8%	73.8%	73.9%	75.2%	75.3%	74.7%	73.1%	71.9%
Clinical Risk	Improving Care	Well Led	AD	>=80% by 31/3/17	39.9%	45.1%	53.5%	55.3%	60.4%	62.2%	64.8%	65.3%	69.1%		77.3%
Equality and Diversity	Improving Health	Well Led	AD	>=80%	90.3%	89.4%	90.1%	89.0%	89.4%	88.2%	87.3%	86.6%	86.0%	86.6%	87.1%
Fire Safety	Improving Care	Well Led	AD	>=80%	83.7%	82.9%	85.5%	84.0%	82.9%	82.7%	81.5%	82.0%	81.5%	81.8%	82.6%
Food Safety	Improving Care	Well Led	AD	>=80%	82.6%	82.9%	83.9%	82.9%	82.6%	82.1%	82.6%	81.2%	80.3%	79.1%	79.2%
Infection Control and Hand Hygiene	Improving Care	Well Led	AD	>=80%	81.3%	81.9%	83.8%	83.6%	83.6%	83.4%	83.0%	83.5%	84.0%	83.7%	83.6%
Information Governance	Improving Care	Well Led	AD	>=95%	86.5%	85.9%	86.5%	91.9%	95.2%	96.1%	92.0%	91.7%	91.3%	90.4%	89.1%
Moving and Handling	Improving Resources	Well Led	AD	>=80%	77.0%	78.1%	78.8%	80.5%	81.9%	81.7%	81.1%	77.3%	78.8%	79.3%	79.3%
Mental Capacity Act/DOLS	Improving Care	Well Led	AD	>=80% by 31/3/17		12.9%	46.0%	48.2%	53.1%	64.1%	64.9%	69.6%	78.0%	82.5%	86.1%
Mental Health Act	Improving Care	Well Led	AD	>=80% by 31/3/17		11.0%	20.9%	23.2%	30.5%	47.9%	51.2%	56.9%	70.5%	75.0%	80.3%
No of staff receiving supervision within policy guidance	Quality & Experience	Well Led		*TBC*						39.5%					
Safeguarding Adults	Improving Care	Well Led	AD	>=80%	89.0%	88.6%	89.5%	89.7%	89.4%	89.1%	88.5%	88.0%	86.7%	86.2%	86.0%
Safeguarding Children	Improving Care	Well Led	AD	>=80%	86.7%	87.0%	87.8%	87.6%	87.0%	85.6%	85.5%	84.8%	83.6%	84.3%	84.7%
Sainsbury's clinical risk assessment tool	Improving Care	Well Led	AD	>=80%	93.2%	93.8%	94.8%	95.1%	94.7%	93.7%	93.3%	91.2%	91.7%	93.2%	94.2%
Bank Cost	Improving Resources	Well Led	AD	-	£486k	£458k	£477k	£505k	£493k	£722k	£398k	£457k	£579k	£576k	£518k
Agency Cost	Improving Resources	Effective	AD	-	£833k	£753k	£885k	£662k	£729k	£833k	£501k	£426k	£500k	£457k	£446k
Overtime Costs	Improving Resources	Effective	AD	-	£16k	£14k	£26k	£19k	£15k	£12k	£16k	£13k	£9k	£9k	£12k
Additional Hours Costs	Improving Resources	Effective	AD	-	£40k	£41k	£47k	£41k	£48k	£53k	£56k	£36k	£48k	£44k	£38k
Sickness Cost (Monthly)	Improving Resources	Effective	AD	-	£447k	£511k	£565k	£592k	£527k	£561k	£476k	£504k	£487k	£511k	£527k
Business Miles	Improving Resources	Effective	AD	-	328k	330k	316k	284k	287k	273k	289k	245k	285k	£299k	267k

Workforce - Performance Wall cont…

Notes:

Mandatory Training
Green Compliance Status:
• Mental Health Act (80%) and Mental Capacity Act (86%) training have both met the Trust target. An e-learner refresher course is being developed.
• Training compliance for Equality and Diversity, Fire Safety, Infection Control and Hand Hygiene, Safeguarding Adults, Safeguarding Children and Sainsbury's Too is are above our target.

Amber Compliance Status:
• Food Safety - 79% slight increase on last month
• Clinical Risk - 77.4% a further 3% increase on last month and continues on an upward monthly trajectory. As well as the elearning provision, bespoke face to face training has been facilitated for a number of services, giving the opportunity for a collective learning experience through sharing knowledge and exploring scenarios
• Data Security Awareness Level 1 (formally IG) - 89.1% a 1% decline from last month.
• Aggression Management - 77% a slight increase from last month. The MAV team continue to put on extra training sessions to the ones already scheduled to meet demand. The Aggression Management/Physical Interventions (for in-patient services) has 86.4% compliance
• Mandatory resuscitation training compliance of 71.9% given a number of new staff in post.
In the period June to September resuscitation training had 170 spare Basic Life Support places. Flexible start times are being introduced. Training will continue to be provided in Barnsley, Halifax, Wakefield and Dewsbury. The Team are working with OMG and managers to try and train teams rather than individuals. They are also working with colleagues in the Managing Aggression and Violence (MAV) Team to combine training, so lessening the number of times that employees are required to leave their clinical areas to attend training.

Sickness
• The Trusts year to date position is 4.9%, which continues to be above the Trusts threshold and has increased slightly from last month which was 4.8% year to date.
• All BDUs with the exception of Specialist and Support Services saw an increase in the monthly sickness position during August 17. Wakefield reported the highest level of sickness during the month (6.5%), which increases their year to date position to 5.5%. Forensic (5.8%), Specialist Services (5.6%) BDUs continue to report the highest year to date sickness levels.
• Hotspots can be seen in Wakefield acute and specialist services. All episodes are in a process of review.
• BDUs continue to focus on long term sickness and the recent staffing summit identified some further potential areas which are being explored that may assist with reducing sickness absence.
• Inpatient areas sickness rates are an area for focus and a Health and Wellbeing Trainer has been appointed to focus on supporting staff in these areas.
• A system of immediate referral into Occupational Health using ERostering has been developed for absence due to MSK and Stress.
• A coordinated system for reasonable adjustments or redeployment for staff is being finalised to support people to remain at work
• Further training support is being rolled for managers on wellbeing and effective absence management.
• The Trust has introduced a fast track facility for episodes of sickness related to musculoskeletal and stress management.
• Pilots are taking place in Wakefield and Forensic BDUs to deep dive into the absences.
• Workshops have been established for managers to assist with the management and sickness review process with a focus on wellbeing and attendance.

Publication Summary

This section of the report identifies any national guidance that may be applicable to the Trust.

Department of Health (DH)

Accountable care organisations consultation

The development of the accountable care organisations (ACOs) contract has identified some necessary changes to regulation. This is largely to ensure that current rules continue to apply to the new contract, and the organisations using it. It also increases flexibility in some cases, for example for GPs who wish to enter into ACO arrangements without terminating their existing contracts. This consultation seeks views on the proposed changes to the regulations on the running of an NHS standard contract. The consultation closes on 2 November 2017.
Click here for link to consultation

This section of the report identifies any reports or publications that may be of interest to the Trust or its members.

Statistics on NHS Stop Smoking Services, England: April 2016 to March 2017

Mixed sex accommodation breaches: July 2017

Direct access audiology waiting times: June 2017

Diagnostic imaging dataset: April 2017

NHS sickness absence rates: April 2017

Out of area placements in mental health services: June 2017

Out of area placements in mental health services: July 2017

Bed availability and occupancy: Q1 2017-18

Psychological therapies: reports on the use of IAPT services, including reports on the integrated services pilot: May 2017

NHS outcomes framework indicators: August 2017

Hospital activity data: Q1 2017 – 2018

Learning disability services monthly statistics, England commissioner census (Assuring Transformation) provisional statistics: July 2017

NHS Improvement update: August 2017

NHS Improvement provider bulletin: 20 August 2017
NHS Improvement provider bulletin: 16 August 2017
NHS Improvement provider bulletin: 6 September 2017
NHS Improvement provider bulletin: 13 September 2017

Items to note specifically from these bulletins relate to
- New charging regulations for overseas visitors
- Consultation taking place re oversight of NHS providers
- Purchase Price Index and Benchmarking tool to be charged for and now open to mental health and community providers

Provisional monthly hospital episode statistics for admitted patient care, outpatients and A&E data: April 2017 to June 2017

Provisional monthly hospital episode statistics for admitted patient care, outpatient and A&E data: July 2017

Children and young people's health services monthly statistics, England, experimental statistics: May 2017

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

Referral to treatment waiting times statistics for consultant-led elective care for July 2017

Monthly hospital activity data for July 2017

Delayed transfers of care for July 2017

Mental health services monthly statistics: final May, provisional June 2017

Mental health services monthly statistics: final June 2017, provisional July 2017

South West Yorkshire Partnership NHS Foundation Trust

Finance Report

Month 5 (2017/2018)

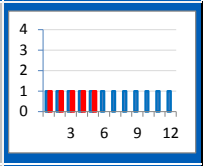
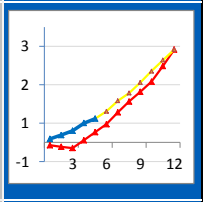
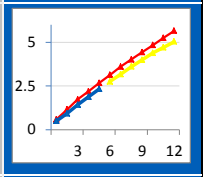
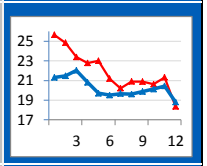
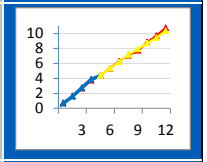
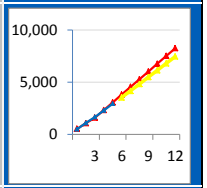
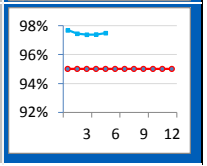
Appendix 1

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	Trend
1	NHS Improvement Finance Rating	1	1	The NHS Improvement financial risk rating is maintained at 1 for the 5 months to the end of August 2017. The individual I & E margin rating remains at 2 with an additional surplus of £300k required to achieve a rating of 1.	
2	Normalised Surplus (inc STF)	£0.6m	£2.4m	August 2017 finance performance excluding STF is a surplus of £22k. Including STF this is a surplus of £115k. This is less than the monthly plan primarily driven by reduced income. The forecast delivery of the planned surplus remains challenging with mitigation of income risks and control of expenditure pressures key.	
3	Agency Cap	£2.3m	£5m	Agency expenditure in August 2017 is broadly in line with previous months at £446k. This remains under the agency cap set for 2017 / 2018. Staffing pressures do continue in a number of areas which may result in agency use to support activity and access.	
4	Cash	£19.7m	£18.8m	Cash is £3.3m lower than planned (14%) due to a timing issue with two August block contract payments (now paid). Creditors are also lower than plan due to the timing of when some invoices are received.	
5	Capital	£4.4m	£10.4m	Capital expenditure is marginally below plan for the year to date. The majority of spend relates to the Fieldhead redevelopment.	
6	Delivery of CIP	£2.9m	£7.5m	Year to date CIP delivery is £122k behind plan. Overall the forecast position is £0.8m below plan. Task and Finish groups are progressing cost reduction opportunities through effective rostering, sickness absense reduction and non pay review.	
7	Better Payment	97%		This performance is based upon a combined NHS / Non NHS value.	

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

1.1 NHS Improvement Finance Rating

The Trust is regulated under the Single Oversight Framework and the financial metric is based on the Use of Resources calculation as outlined below. The Single Oversight Framework is designed to help NHS providers attain, and maintain, Care Quality Commission ratings of 'Good' or 'Outstanding'. The Framework doesn't give a performance assessment in its own right.

NHS Improvement are currently consulting on the Single Oversight Framework for 2017 / 2018 and beyond. It is proposed that the metrics on Use of Resources will be expanded to include metrics such as staff retention, sickness absence, Finance cost when compared against turnover and Estates cost per square metre.

			Actual Performance		Plan - Month 5	
Area	Weight	Metric	Score	Risk Rating	Score	Risk Rating
Financial Sustainability	20%	Capital Service Capacity	3.2	1	3.0	1
	20%	Liquidity (Days)	17.3	1	13.6	1
Financial Efficiency	20%	I & E Margin	0.7%	2	0.3%	2
Financial Controls	20%	Distance from Financial Plan	0.4%	1	0.0%	1
	20%	Agency Spend	-12.4%	1	-13.9%	1
Weighted Average - Financial Sustainability Risk Rating				1		1

Impact

The current risk rating is rated as 1 which is the highest possible score. All metrics are currently at 1 with the exception of I & E margin. This needs to be greater than 1% to achieve a rating of 1.

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.

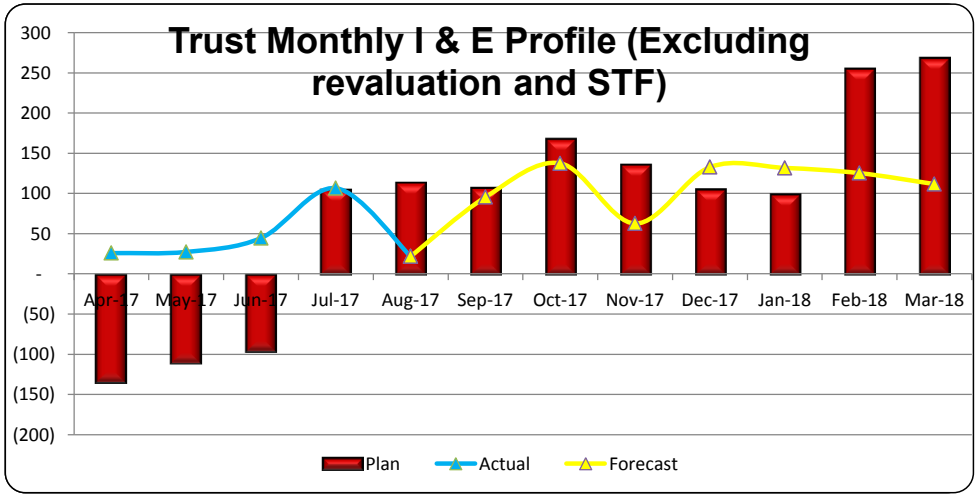
I & E Margin - the degree to which the organisation is operating at a surplus/deficit

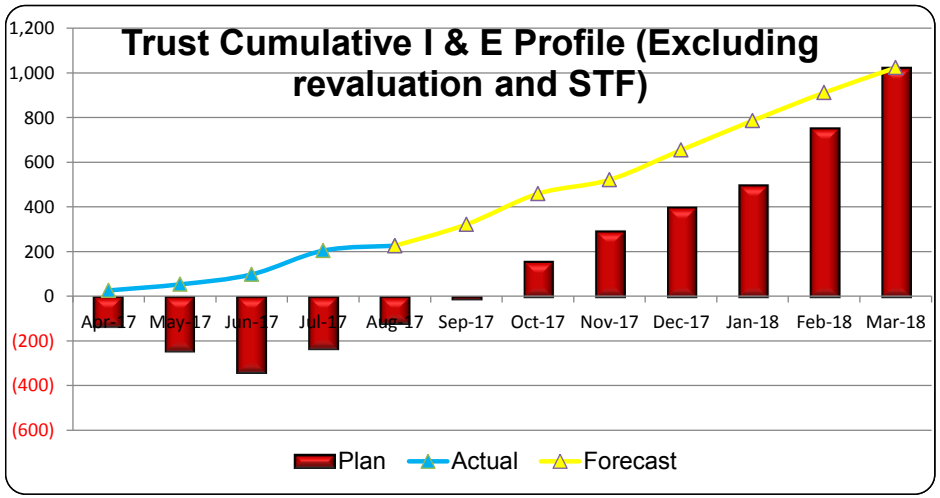
Distance from plan - variance between a foundation Trust's planned I & E margin and actual I & E margin within the year.

Agency Cap - A cap of £5.6m has been set for the Trust in 2017 / 2018. This metric compares performance against this cap.

2.0 Income & Expenditure Position 2017 / 2018

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**
				17,117	16,953	(164)	Clinical Revenue	86,241	85,862	(380)	206,411	202,767	(3,644)
				17,117	**16,953**	**(164)**	**Total Clinical Revenue**	**86,241**	**85,862**	**(380)**	**206,411**	**202,767**	**(3,644)**
				1,033	1,115	82	Other Operating Revenue	5,672	5,709	37	13,193	13,165	(28)
				18,149	**18,068**	**(82)**	**Total Revenue**	**91,913**	**91,571**	**(342)**	**219,605**	**215,932**	**(3,673)**
4,266	4,115	(151)	3.5%	(14,239)	(13,854)	385	Pay Costs	(71,343)	(69,563)	1,780	(170,513)	(167,813)	2,700
				(3,232)	(3,529)	(297)	Non Pay Costs	(16,854)	(17,548)	(693)	(40,362)	(42,446)	(2,084)
				205	137	(68)	Provisions	14	(258)	(272)	1,145	4,457	3,311
4,266	**4,115**	**(151)**	**3.5%**	**(17,266)**	**(17,246)**	**20**	**Total Operating Expenses**	**(88,184)**	**(87,368)**	**815**	**(209,730)**	**(205,802)**	**3,927**
4,266	**4,115**	**(151)**	**3.5%**	**883**	**821**	**(62)**	**EBITDA**	**3,729**	**4,203**	**473**	**9,875**	**10,130**	**255**
				(489)	(517)	(27)	Depreciation	(2,452)	(2,568)	(116)	(5,500)	(5,717)	(217)
				(283)	(286)	(3)	PDC Paid	(1,415)	(1,424)	(9)	(3,397)	(3,426)	(29)
				4	3	(1)	Interest Received	19	16	(3)	45	37	(8)
4,266	**4,115**	**(151)**	**3.5%**	**114**	**22**	**(93)**	**Normalised Surplus / (Deficit) Excl.STF**	**(119)**	**226**	**345**	**1,023**	**1,023**	**0**
				93	93	0	STF	395	395	0	1,394	1,394	0
4,266	**4,115**	**(151)**	**3.5%**	**207**	**115**	**(93)**	**Normalised Surplus / (Deficit) Incl SFT**	**276**	**621**	**345**	**2,417**	**2,417**	**0**
				0	0	0	Revaluation of Assets	0	0	0	0	0	0
4,266	**4,115**	**(151)**	**3.5%**	**207**	**115**	**(93)**	**Surplus / (Deficit)**	**276**	**621**	**345**	**2,417**	**2,417**	**0**





Income & Expenditure Position 2017 / 2018

Although a small surplus of £22k pre STF has been recorded in month this is the first month where surplus has been lower than plan. The main factor is reduced income relating to Intermediate Care whilst the Trust continued to incur full costs prior to service transfer.

Month 5

The normalised year to date position is a surplus of £226k excluding STF and £621k including STF funding. This is £345k ahead of plan, the key headlines are below:

In month financial performance has seen the continuation of previous trends with underspends in pay offset by non pay overspends (such as continued out of area expenditure). However the reduced income, as noted below, reduces the overall in month surplus position. STF has still been achieved however as the year to date position remains higher than plan.

Income

Provision continues to be made for under achievement of CQUIN targets of £300k. A reduction in income in relation to intermediate care has been reflected in month 5 however the Trust is still incurring full costs in August 2017.

Pay Expenditure

The Trust continues to run with a number of vacancies and utilises temporary (both internal bank and external agency) staff to meet clinical and service requirements. The most significant pay savings year to date are within Nursing, Medical and Psychology. Agency expenditure continues at a broadly consistent average spend of £466k a month. Expenditure maintained at this level would ensure that the Trust remains within the NHS Improvement cap. YTD agency spend is 46% lower than last year, however work continues to reduce this as far as possible and to be assured the improvement is sustainable.

Non Pay Expenditure

Continued non pay expenditure relating to clinical needs. Out of area expenditure to provide the required level of bed capacity is overspent by £726k YTD, drugs expenditure and clinical supplies such as dressings also remain pressures. These are currently being offset by non clinical spend areas such as travel or stationery.

Forecast

Full year forecast currently remains in line with plan, but there are a number of risks identified. These include out of area bed usage, CIP delivery, impact of tenders and CQUIN delivery. Mitigations are constantly considered and assessed. A full review of the Trust year-end forecast will take place at the end of the second quarter.

Currently the financial impact of changes within Intermediate Care are showing as reduced income, assumed reductions within the BDU, Corporate Services and capital charges. This does however require further expenditure reductions shown within provisions to achieve the Trust control total. Work is ongoing to ensure that costs relating to this service are removed at the earliest possible opportunity. The value of dual running and stranded costs is yet to be finalised.

Income Information

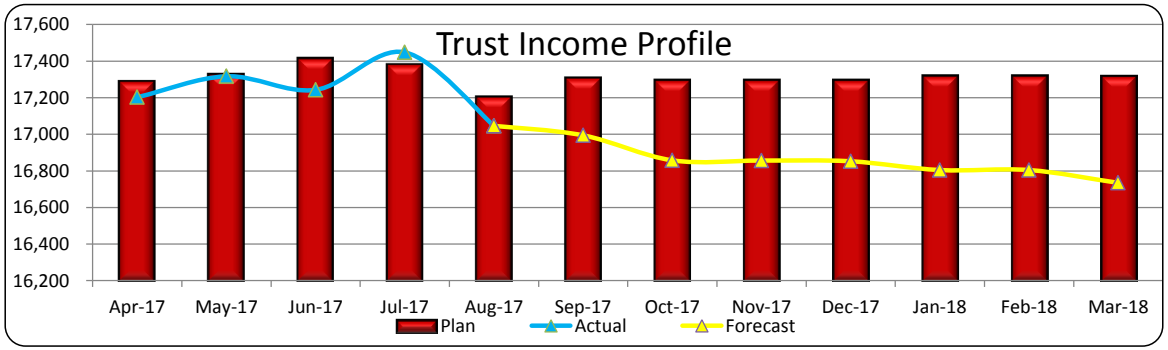
The table below summarises the year to date and forecast income by commissioner group. This is identified as clinical revenue within the Trust income and expenditure position. (page 5)

The majority of Trust income is secured through block contract arrangements and therefore there is traditionally little variation to plan. The budget values are reconciled against signed and agreed contracts with any movement highlighted (none in month). The headlines for these are outlined below with CQUIN highlighted as the biggest risk. CQUIN is reviewed internally within the Trust and agreed with commissioners on a quarterly basis. 0.5% of the 2.5% CQUIN income relates to STP metrics. As previously stated this element of income is not currently recognised within the Trust financial position. All other quarter 1 CQUIN targets were achieved.

Movements in sources of funding are broken down below including the movement from traditional CCG contracts into Alliance agreements.

	Year to Date			Variance Headlines		
Commissioner	Budget	Actual	Variance	CQUIN / LIS	Other	Total
	£k	£k	£k	£k	£k	£k
CCG	64,206	63,823	(382)	(300)	(82)	(382)
Specialist Commissioner	9,722	9,722	(0)	0	(0)	(0)
Alliance	4,393	4,211	(182)	0	(182)	(182)
Local Authority	2,306	2,306	0		0	0
Partnership	2,879	2,879	0	0	0	0
Other	2,736	2,921	185	0	185	185
Total	**86,241**	**85,862**	**(380)**	**0**	**(300)**	**(79)**	**(380)**

	Forecast			Variance Headlines		
Budget	Actual	Variance	CQUIN / LIS	Other	Total	
£k	£k	£k	£k	£k	£k	
150,869	149,875	(994)	(869)	(124)	(994)	
23,333	23,333	(0)	0	(0)	(0)	
13,608	10,636	(2,972)	0	(2,972)	(2,972)	
5,535	5,535	0		0	0	
6,909	6,904	(5)	0	(5)	(5)	
6,158	6,485	327	0	327	327	
206,411	**202,767**	**(3,644)**	**(869)**	**(2,775)**	**(3,644)**



CQUIN Risk		
	YTD	Forecast
Wellbeing Improvement	0	136
Primary Care Collab	0	13
STP Reserve	300	720
Total	**300**	**869**

The income position is based upon currently known facts and a number of key assumptions. These include:

Trusts have been asked to confirm that the CQUIN relating to STPs and reserves remains uncommitted until further guidance is provided. This is the case here which does create a pressure within the overall income forecast.

The Income forecast has been updated to reflect changes in funding allocations in respect of the new model of care for Intermediate Care in Barnsley.

Income Opportunities - It has been confirmed that the Trust, again in partnership, has been successful in a number of new opportunities to support New Models of Care. This includes CAMHS and Adult Eating Disorder services which are due to commence later in the year. The income and expenditure forecast will be updated accordingly.

2.1 Pay Information

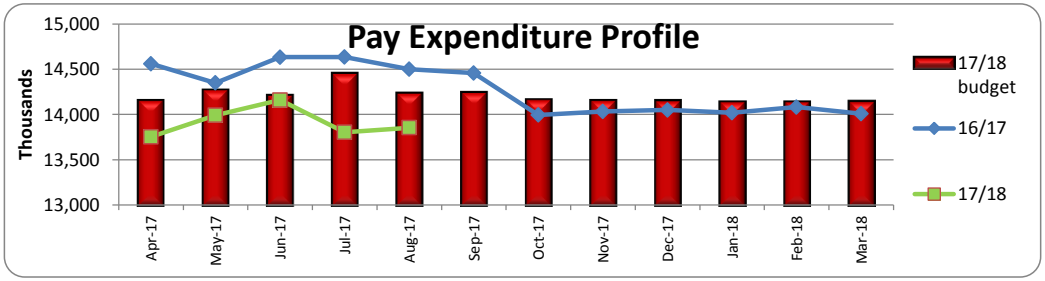
Our workforce is our greatest asset and one in which we continue to invest in ensuring that we have the right workforce in place to deliver safe and quality services. In total workforce spend accounts for circa 75% of total Trust expenditure.

The Trust workforce strategy continues to be developed but current expenditure patterns highlight the usage of temporary staff (through either internal sources such as Trust bank or through external agencies). Actions are focussed on providing the most cost effective workforce solution to meet the service needs.

	Apr-17 £k	May-17 £k	Jun-17 £k	Jul-17 £k	Aug-17 £k	Sep-17 £k	Oct-17 £k	Nov-17 £k	Dec-17 £k	Jan-18 £k	Feb-18 £k	Mar-18 £k	Total £k
Substantive	12,841	13,094	13,040	12,842	12,850								**64,667**
Bank & Locum	411	472	620	505	558								**2,566**
Agency	501	426	500	457	446								**2,330**
Total	**13,752**	**13,992**	**14,161**	**13,804**	**13,854**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**69,563**
16/17	14,559	14,350	14,633	14,634	14,502	14,456	13,994	14,034	14,050	14,020	14,081	14,008	**171,321**
Bank as %	3.0%	3.4%	4.4%	3.7%	4.0%								3.7%
Agency as %	3.6%	3.0%	3.5%	3.3%	3.2%								3.3%

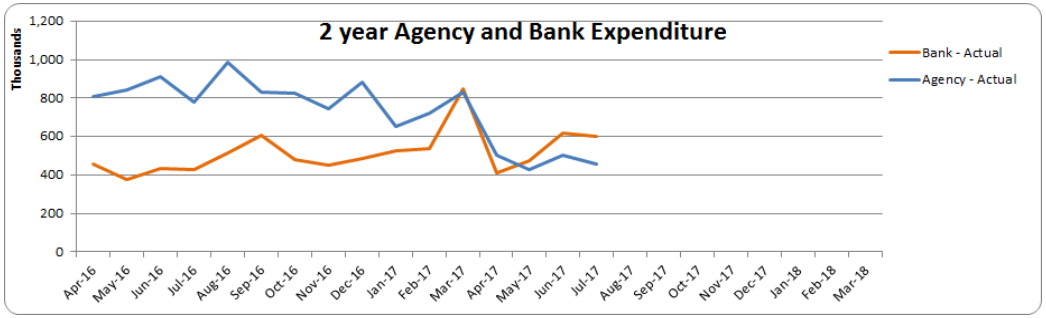
Year to Date expenditure - by staff group

	Substantive £k	Temp £k	Agency £k	Total £k
Medical	7,443	139	1,092	8,674
Nursing Registered	22,533	893	234	23,660
Nursing Unregistered	7,473	1,096	509	9,077
Other	16,409	160	462	17,031
Admin	10,809	278	33	11,121
Total	**64,667**	**2,566**	**2,330**	**69,563**



Aug WTE Analysis

	Budgeted	Contracted	Bank	Agency	Variance
Medical	212	175	2	17	(18)
Qualified Nursing	1,446	1,275	53	9	(108)
Unqualified Nursing	678	653	90	32	97
Other Clinical	845	774	6	8	(58)
A & C	849	771	27	0	(50)
Other	353	322	6	2	(23)
Staff Vacancy Factor	(116)	0	0	0	116
Total	**4,266**	**3,969**	**185**	**68**	**(45)**



Key Messages

Both 2016/17 and 2017/18 have seen a focus on reducing agency staffing, the graph above shows the actual downward trend in the use of Agency staffing by month. Some agency staff have moved to Bank posts and a more moderate increase in month on month bank usage can be seen. Agency use is forecast to continue to decline at a slower pace and bank usage to marginally increase. The WTE Analysis table above presents the budgeted WTE across staffing categories and demonstrates that whilst overall agency and bank usage are covering gaps in services the actual staffing profile is currently altered from plan with the use of temporary staff.

2.1 Agency Expenditure Focus

Agency Spend is currently within the NHS Improvement agency cap.

Spend in August is £24k lower than cap

Agency costs continue to remain a focus for the NHS nationally and for the Trust. As such separate analysis of agency trends is presented below.

The financial implications, alongside clinical and other considerations, continues to be a high priority area 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 had experienced increased levels of agency spend rising from £3.6.m in 2013 / 2014 to £9.8m in 2016 / 2017. This increase was across all staffing groups.

These trends were being experienced nationally within the NHS and as a result NHS Improvement introduced a number of metrics and guidance designed to support Trusts reducing their reliance and spend on agency staff. One of these measures was the introduction of a maximum agency cap (as monitored within the Trusts risk rating). The Trust cap for 2016 / 2017 was £5.1m and was breached by 93%.

The realisation of a number of actions from work streams established in 2016 / 2017 has resulted in reduced agency spend in the current year. These can be allocated to 2 main themes :

* Reduction in the number of agency staff used - this is evident within the Admin & Clerical category where the Trust currently has none. Overall medical staff numbers remain broadly the same although there has been a number of starters and leavers.

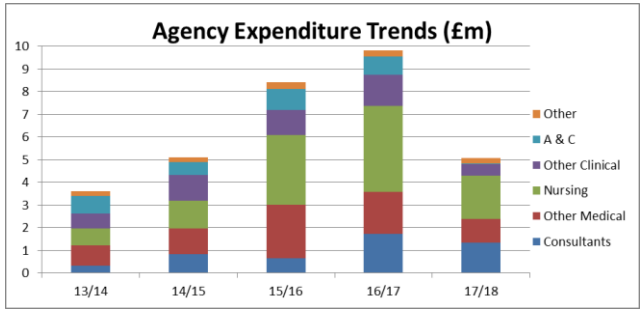
* Reduction in the hourly rate paid. In particular qualified nursing staff who are now all paid within the NHS Improvement capped rates. 12 out of 17 medical locums continue to be paid higher than the NHSI caps. These have been individually approved by the Trust Medical Director and are reported weekly to NHSI.

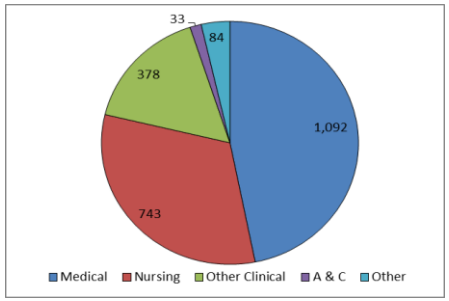
The Trust's work streams and actions have had a significant impact on the usage of Agency and Bank.

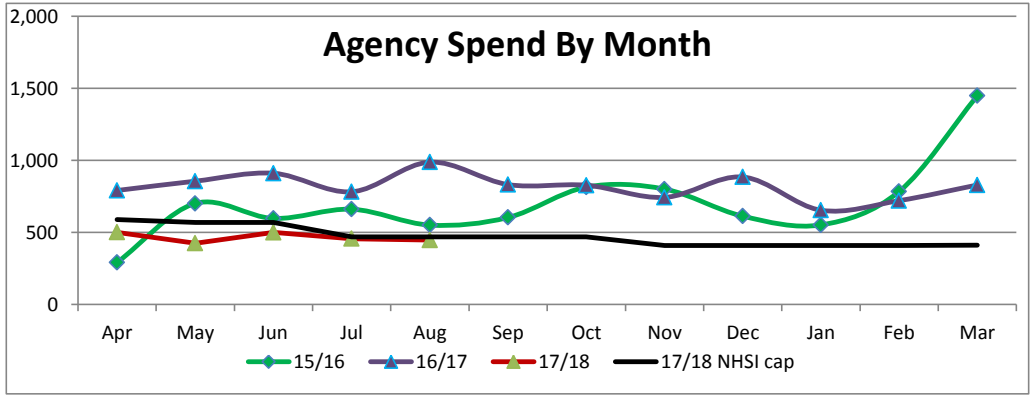
Across all agency categories spend has reduced on 2016 / 2017. YTD has reduced by £2m (46%).

The zero reliance on Admin & Clerical agency usage continues to be achieved.

In August spend remained below the month NHSI cap, YTD the spend remains 13% below the cap. Significant recruitment of newly registered nurses in September and substantive recruitment to medical posts is expected to drive a further reduction in agency costs.







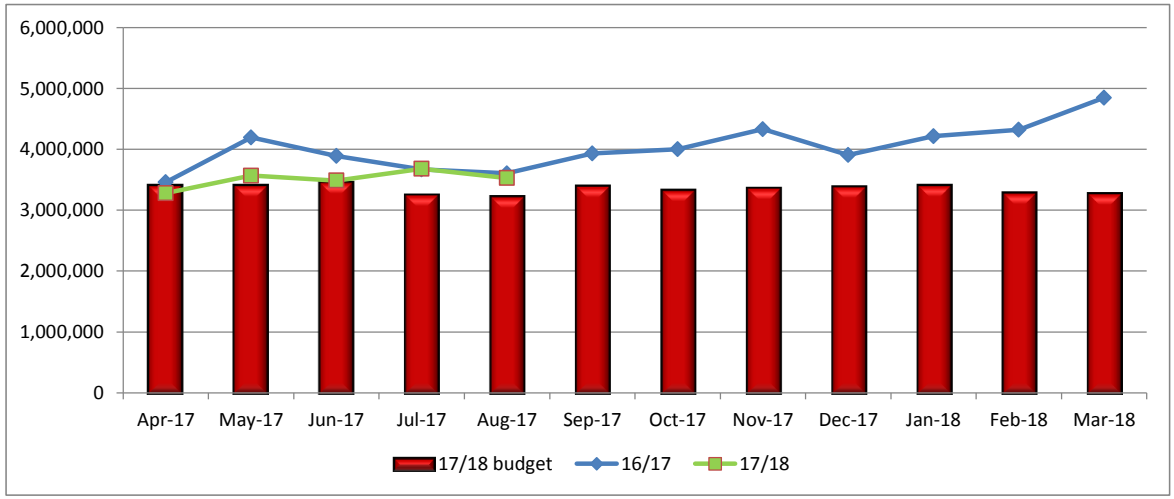
2.1 Non Pay Expenditure

Whilst pay expenditure represents approximately 75% of all Trust spend non pay expenditure presents a number of key financial challenges. This analysis focusses on non pay expenditure within the BDUs and Corporate Services and therefore excludes provisions and capital charges (depreciation and PDC).

The Trust is forecasting to spend considerably less on non pay compared to last year. For the year to date this is £1.3m less than the same period in 2016 / 2017. This is driven by a number of key areas which are highlighted below.

	Apr-17 £k	May-17 £k	Jun-17 £k	Jul-17 £k	Aug-17 £k	Sep-17 £k	Oct-17 £k	Nov-17 £k	Dec-17 £k	Jan-18 £k	Feb-18 £k	Mar-18 £k	Total £k
2017 / 2018	3,281	3,568	3,488	3,681	3,529								**17,548**
2016 / 2017	3,459	4,193	3,890	3,671	3,604	3,931	4,002	4,331	3,909	4,217	4,322	4,849	**48,379**

Non Pay Category	Budget £k	Actual £k	Variance £k
Clinical Supplies	1,263	1,433	(170)
Drugs	1,251	1,778	(527)
Healthcare subcontracting	1,466	2,126	(660)
Hotel Services	874	726	149
Office Supplies	1,738	1,598	139
Other Costs	1,936	1,696	239
Property Costs	2,522	2,535	(13)
Service Level Agreements	2,532	2,518	15
Training & Education	305	311	(5)
Travel & Subsistence	1,843	1,649	194
Utilities	483	469	14
Vehicle Costs	640	709	(68)
Total	**16,854**	**17,548**	**(693)**
Total Excl OOA and Drugs	**14,138**	**13,644**	**494**



Key Messages

Healthcare subcontracting relates to the purchase of all additional bed capacity. As such this includes commissioner commissioned activity which is provided through this method. The Out of Area focus provides further details on this.

Drugs continue to present a financial pressure. The Trust has recently changed pharmacy system and it is expected that this will help drive through future cost reductions and

Cost reductions and savings are being made where ever possible and have focussed on non-clinical areas such as travel and office supplies.

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 varied 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 excluded activity relating to Locked Rehab in Barnsley.

Out of Area Expenditure Trend (£)

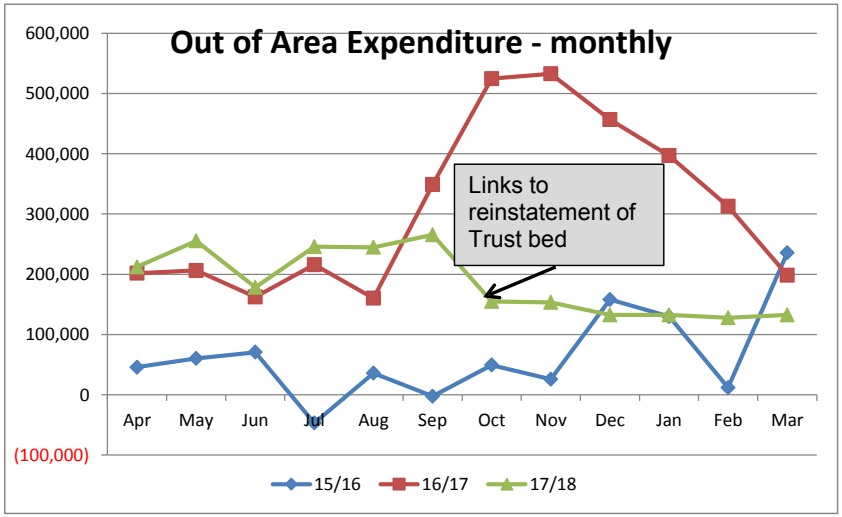
	Apr £000	May £000	Jun £000	Jul £000	Aug £000	Sep £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	Mar £000	Total £000
15/16	46	60	71	(47)	36	(3)	49	25	158	130	12	236	**772**
16/17	202	206	162	216	160	349	525	533	457	397	313	198	**3,718**
17/18	212	255	178	246	245								**1,137**

Bed Day Trend Information

	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	624	416	364	**5,494**
17/18	282	348	254	351	391								**1,626**

Bed Day Information 2017 / 2018 (by category)

PICU	198	176	168	169	213								**924**
Acute	84	170	85	178	148								**665**
Gender	0	0	0	0	30								**30**



Expenditure on Out of Area placements increased significantly during 2016 / 2017 but through continued action usage reduced throughout Quarter 3 and 4. This trend continued in Quarter 1 2017 / 2018 but has increased in Quarter 2. High demand is being observed across the Trust and also nationally.

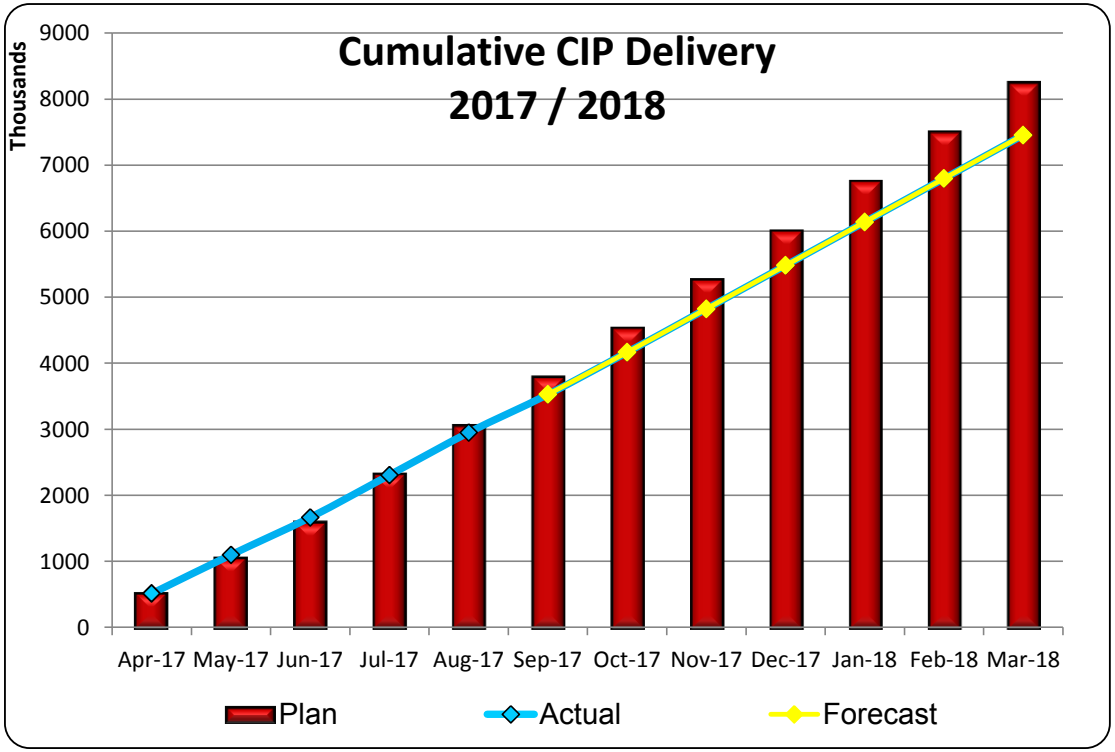
Demand, and expenditure, has increased in August 2017 and is the highest month for the year to date. Work continues through the Project Board to ensure that this is minimised. Future costs are forecast to reduced from Quarter 3 as the Trust bed capacity is reinstated with the opening of the first unit in the Unity Centre, Fieldhead.

YTD overspend is £726k.

This replaces capacity reduced as a result of the fire in November 2016. To date an interim payment of £500k has been received against the insurance claim. A further payment is currently being pursued. These payments help to offset the cost pressure associated with additional out of area bed usage. Overall costs incurred will exceed the insurance payment leaving a cost pressure with the Trust.

2.1 Cost Improvement Programme 2017 / 2018

	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 - Cumulative	537	1,074	1,610	2,341	3,072	3,809	4,546	5,283	6,021	6,768	7,515	8,262	3,072	8,262
Delivery as originally planned	405	850	1,315	1,857	2,360	2,876	3,402	3,927	4,452	4,978	5,503	6,029	2,360	6,029
Mitigations - Recurrent & Non-Recurrent	106	247	349	449	590	651	763	896	1,029	1,161	1,294	1,427	590	1,427
Total Delivery	**511**	**1,097**	**1,664**	**2,306**	**2,950**	**3,527**	**4,165**	**4,823**	**5,481**	**6,139**	**6,797**	**7,456**	**2,950**	**7,456**
Variance	(26)	24	54	(35)	(122)	(283)	(382)	(460)	(539)	(628)	(717)	(806)	(122)	(806)



The Trust identified a CIP programme for 2017 / 2018 which totals £8.3m. This included £1.6m of unidentified savings for which specific schemes need to be defined and

Savings identified against the Cost Improvement Programme total £3.0m to date. This is £122k behind plan. The majority (80%) has been delivered in line with original savings plans.

The forecast variance has reduced from £1.4m to £0.8m primarily due to non-recurrent pay savings as posts are now forecast not to be filled in the current financial year. Additional non pay efficiency savings have been identified. A number of schemes which are being progressed, including effective rostering and reduction of sickness absence, are yet to have a cost reduction value attributed against them but are likely to be already contributing to the Trust overall financial position.

Task and Finish groups, including non pay review, continue and as new savings are identified they will be captured here.

3.0 Balance Sheet 2017 / 2018

	2016 / 2017 £k	Plan (YTD) £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	111,199	113,780	114,599	1
Current Assets				
Inventories & Work in Progress	166	215	166	
NHS Trade Receivables (Debtors	2,138	1,999	4,248	2
Other Receivables (Debtors)	8,289	7,290	8,691	3
Cash and Cash Equivalents	26,373	23,010	19,702	4
Total Current Assets	**36,966**	**32,514**	**32,807**	
Current Liabilities				
Trade Payables (Creditors)	(7,213)	(6,434)	(5,413)	5
Capital Payables (Creditors)	(1,157)	(752)	(333)	5
Accruals	(9,912)	(12,072)	(11,484)	6
Deferred Income	(754)	(950)	(772)	
Total Current Liabilities	**(19,036)**	**(20,208)**	**(18,003)**	
Net Current Assets/Liabilities	**17,929**	**12,306**	**14,804**	
Total Assets less Current Liabilities	**129,128**	**126,086**	**129,403**	
Provisions for Liabilities	(7,550)	(6,763)	(7,204)	
Total Net Assets/(Liabilities)	**121,578**	**119,323**	**122,199**	
Taxpayers' Equity				
Public Dividend Capital	43,665	43,665	43,665	
Revaluation Reserve	18,766	18,413	18,766	
Other Reserves	5,220	5,220	5,220	
Income & Expenditure Reserve	53,928	52,025	54,549	7
Total Taxpayers' Equity	**121,578**	**119,323**	**122,199**	

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. Capital expenditure is detailed on page 14. The value of fixed assets is the broughtforward value of assets adjusted for the value of additions, disposals and depreciation charges.

2. Timing delay in receipt of two August block contract payments (now received).

3. Other debtors remain higher than planned, including £1.6m from Locala, £100k from PSS, these continue to be chased by the team.

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 16.

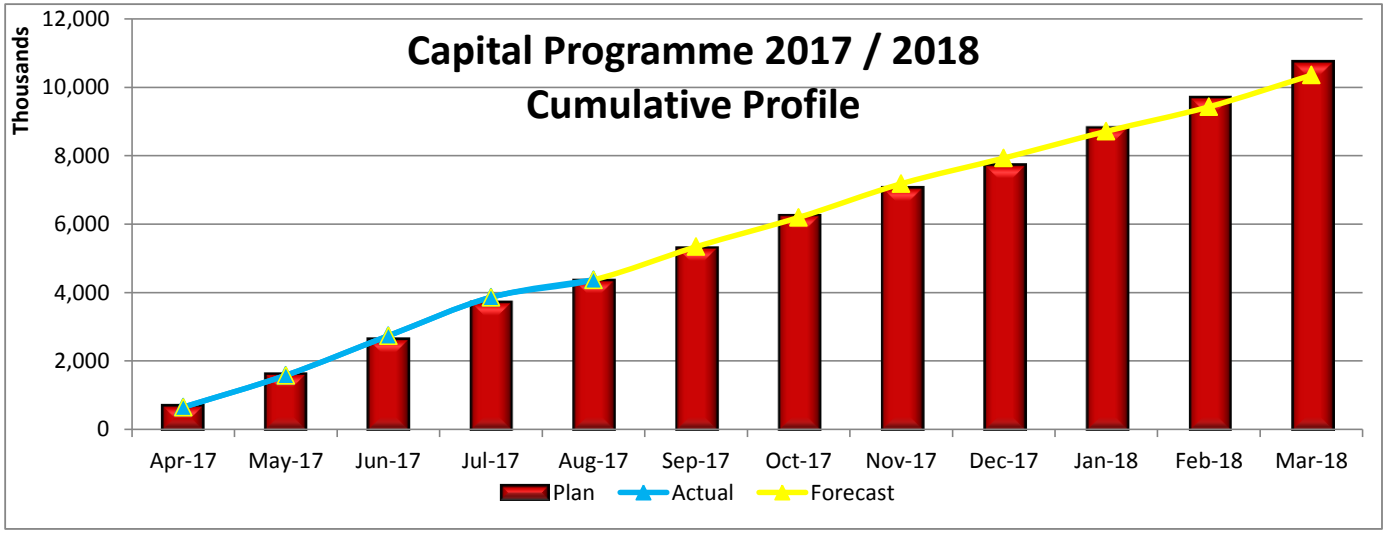
5. Creditors continue to be paid in a timely manner as demonstrated by the Better Payment Practice Code performance.

6. Accruals are lower than planned.

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

3.1 Capital Programme 2017 / 2018

	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	1,558	574	271	(303)	1,605	47	3
Equipment Replacement	44	44	34	(10)	44	(1)	
IM&T	2,121	596	158	(438)	1,988	(133)	4
Major Capital Schemes							
Fieldhead Non Secure	7,030	3,169	3,944	775	6,757	(273)	5
VAT Refunds	0	0	(37)	(37)	(37)	(37)	
TOTALS	**10,753**	**4,383**	**4,370**	**(13)**	**10,356**	**(397)**	2



Capital Expenditure 2017 / 2018

1. The Trust capital programme for 2017 / 2018 is £10.8m and schemes are guided by the current Trust Estates Strategy.

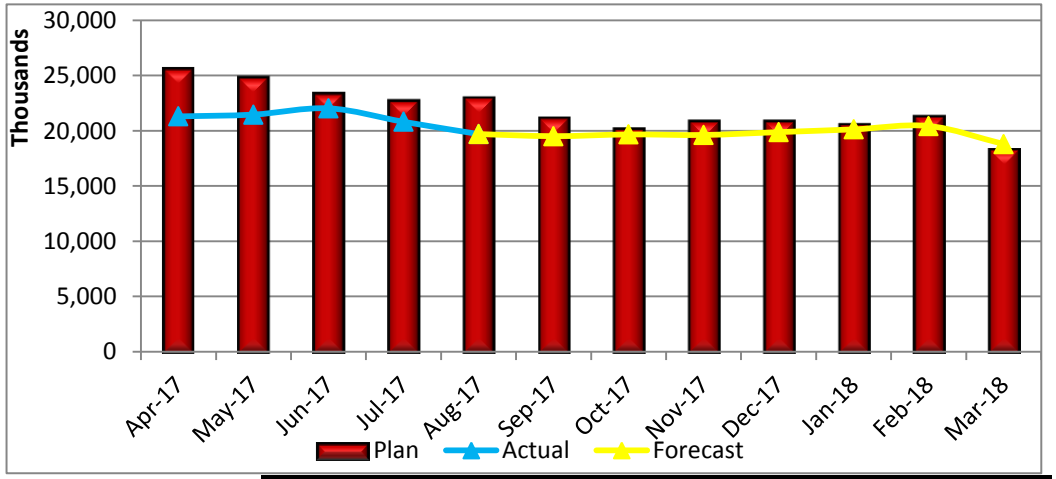
2. The year to date position is £13k behind plan (0%). Excluding the benefit from arising from successful VAT recovery agreed with HMRC this is £51k behind plan.

3. The minor capital programme has been reviewed and revised to ensure the overall outturn remains within Trust approved board plan.

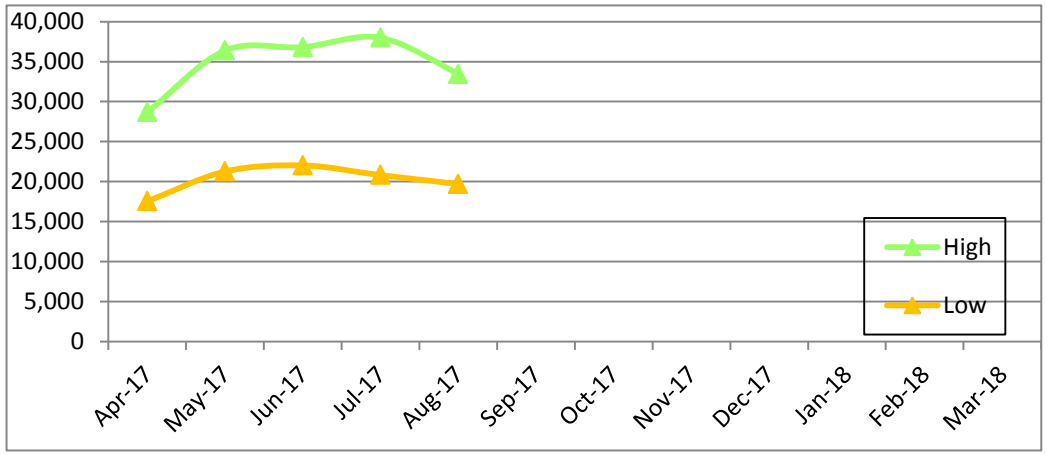
4. Requirements for the implementation of the mental health clinical record system are currently being generated. The results will be included in an updated forecast.

5. Expenditure valuations received on the Fieldhead Non secure scheme are currently under review.

3.2 Cash Flow & Cash Flow Forecast 2017 / 2018



	Plan £k	Actual £k	Variance £k
Opening Balance	25,495	26,373	
Closing Balance	23,010	19,702	(3,308)



Cash is behind plan for the year to date. A detailed cash management plan is being developed to maximise cash.

Cash management actions will include a full review and chase of all overdue debtors, review of capital expenditure timing with our P21+ partner, review of creditor arrangements.

A detailed reconciliation of working capital compared to plan is presented on page 16.

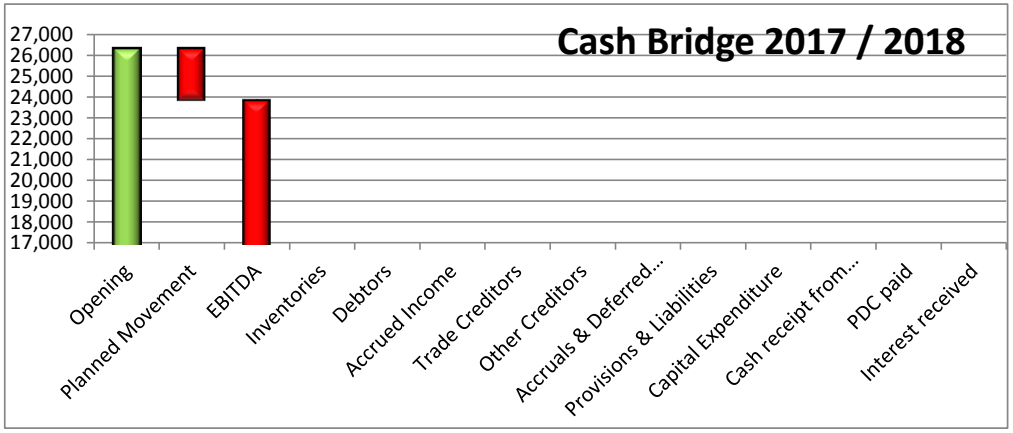
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is:	£33.5m
The lowest balance is:	£19.7m

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	**25,495**	**26,373**	878	1
Surplus (Exc. non-cash items & revaluation)	4,213	4,534	321	2
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	(200)	(2,783)	(2,583)	5
Accrued Income / Prepayments	(835)	(1,498)	(662)	6
Trade Payables (Creditors)	0	(3,224)	(3,224)	7
Other Payables (Creditors)	0	0	0	
Accruals & Deferred income	(300)	1,591	1,891	3
Provisions & Liabilities	(1,000)	(346)	654	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(4,383)	(5,194)	(811)	
Cash receipts from asset sales	0	233	233	4
PDC Dividends paid	0	0	0	
PDC Dividends received			0	
Interest (paid)/ received	20	16	(4)	
Closing Balances	**23,010**	**19,702**	**(3,308)**	



The plan value reflects the March 2017 submission to NHS Improvement.

Factors which increase the cash positon against plan:

1. Brought forward cash position was higher than planned.

2. Surplus position, and that specifically related to cash, is higher than planned.

3. Accruals are being reviewed with key suppliers chased for invoices. This helps provide assurance over the year to date position.

4. Trust assets (South Kirby and Darfield Health Centres) have been sold in June and August 2017 which were originally planned to be sold in Quarter 4 2017 / 2018. These disposals form part of the overall Trust Estates Strategy.

Factors which decrease the cash position against plan:

5. Debtors are higher than plan. In August 2017 this relates largely to 2 block invoice payment from a commissioner which has not yet been received.

6. Accrued income continues to be higher than plan. This is forecast to reduce further once Qtr 1 CQUIN performance is agreed with commissioners and Qtr 1 STF payment is received.

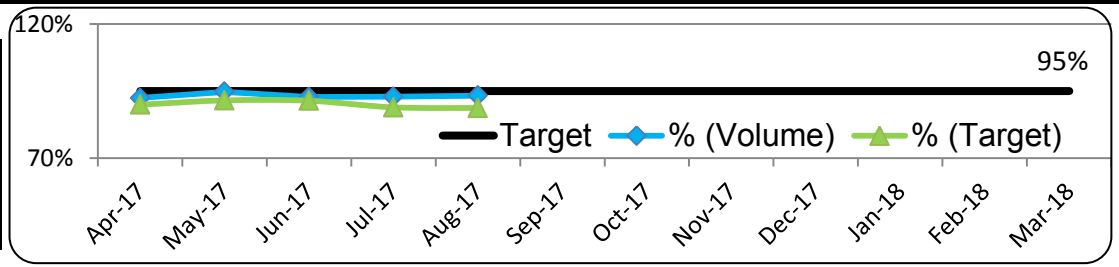
7. Creditors are lower than planned. Invoices are paid in line with the Trust Better Payment Practice Code.

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

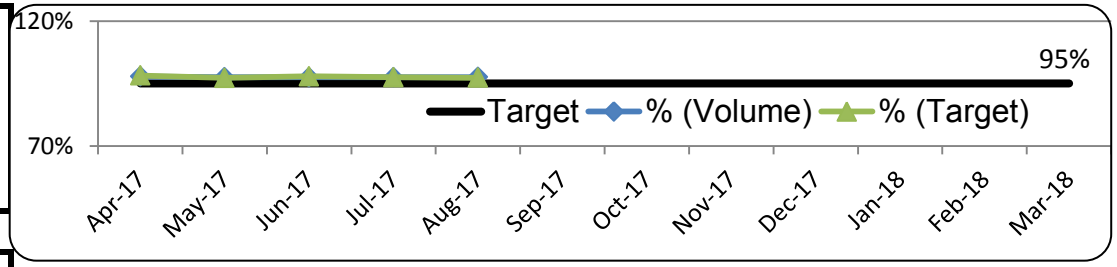
4.0 Better Payment Practice Code

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

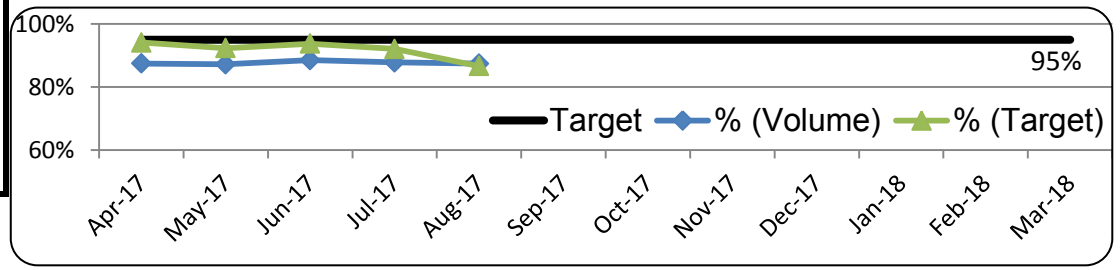
NHS	Number %	Value %
Year to July 2017	93%	89%
Year to August 2017	93%	89%



Non NHS	Number %	Value %
Year to July 2017	97%	97%
Year to August 2017	98%	97%



Local Suppliers (10 days)	Number %	Value %
Year to July 2017	88%	92%
Year to August 2017	87%	87%



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 (£)
21-Aug-17	Property Rental	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	3044696	212,218
25-Jul-17	Drugs FP10´s	Trustwide	Bradford Teaching Hospitals NHS FT	3042227	96,053
10-Jul-17	Drugs FP10´s	Trustwide	Lloyds Pharmacy Ltd	3040834	77,308
06-Jul-17	Staff Recharge	Wakefield	Wakefield MDC	3040438	67,888
13-Jul-17	Property Rental	Barnsley	Barnsley Metropolitan Borough Council	3042585	65,744
07-Jun-17	Property Rental	Kirklees	Mid Yorkshire Hospitals NHS Trust	3037242	62,020
12-Jun-17	Drugs FP10´s	Trustwide	Lloyds Pharmacy Ltd	3037685	56,153
11-Aug-17	Drugs FP10´s	Trustwide	Lloyds Pharmacy Ltd	3043925	49,122
14-Aug-17	CNST contributions	Trustwide	NHS Litigation Authority	3044206	47,581
07-Jun-17	Domestic SLA	Kirklees	Mid Yorkshire Hospitals NHS Trust	3037242	45,391
12-Jun-17	Drugs FP10´s	Trustwide	Lloyds Pharmacy Ltd	3037685	45,008
10-Jul-17	Drugs FP10´s	Trustwide	Lloyds Pharmacy Ltd	3040834	35,787
11-Aug-17	Drugs FP10´s	Trustwide	Lloyds Pharmacy Ltd	3043925	35,374
04-Jul-17	Property Rental	Kirklees	Mid Yorkshire Hospitals NHS Trust	3040038	31,010
03-Aug-17	Property Rental	Kirklees	Mid Yorkshire Hospitals NHS Trust	3043200	31,010

4.2 Glossary

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

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

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

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

* 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	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.90%	4.30%	4.40%	4.50%	4.60%	4.70%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	5.20%	4.30%	4.50%	4.60%	5.00%	5.20%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	96.60%	7.00%	24.00%	70.30%	82.70%	84.60%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	96.00%	3.20%	8.20%	25.00%	39.90%	50.30%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	76.20%	77.50%	71.90%	81.70%	78.40%	80.00%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	81.30%	81.90%	79.10%	78.20%	78.00%	74.70%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	77.90%	76.00%	74.70%	79.10%	82.70%	84.30%
Equality and Diversity	Resources	Well Led	AD	>=80%	89.00%	88.20%	88.50%	89.00%	89.70%	89.70%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	81.50%	78.80%	80.80%	79.80%	78.30%	77.20%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	79.60%	77.50%	76.10%	73.30%	69.30%	67.10%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	86.70%	86.40%	87.10%	87.10%	85.50%	84.50%
Information Governance	Resources	Well Led	AD	>=95%	95.40%	91.30%	89.80%	89.60%	88.00%	85.40%
Moving and Handling	Resources	Well Led	AD	>=80%	82.80%	83.10%	81.90%	82.30%	82.70%	82.60%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	89.90%	89.50%	89.30%	86.50%	86.90%	85.60%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	88.20%	88.00%	86.50%	86.50%	86.10%	85.80%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	95.70%	94.70%	94.60%	93.90%	94.90%	96.00%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	55.90%	54.60%	56.90%	64.30%	73.60%	76.50%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	42.90%	44.60%	41.20%	55.60%	64.10%	68.00%
Agency Cost	Resources	Effective	AD		£115k	£92k	£109k	£118k	£109k	£84k
Overtime Costs	Resources	Effective	AD		£4k	£7k	£3k	£4k	£2k	£3k
Additional Hours Costs	Resources	Effective	AD		£25k	£32k	£20k	£21k	£22k	£21k
Sickness Cost (Monthly)	Resources	Effective	AD		£167k	£124k	£136k	£136k	£159k	£164k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		131.92	111.33	108	113.58	111.16	110.21
Business Miles	Resources	Effective	AD		102k	108k	91k	97k	104k	96k

Calderdale and Kirklees District

Month	Objective	CQC Domain	Owner	Threshold	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	5.00%	4.20%	4.20%	4.30%	4.40%	4.50%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	4.90%	4.20%	4.20%	4.50%	4.50%	5.10%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	98.50%	3.00%	14.90%	52.80%	81.20%	89.10%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	96.50%	0.80%	2.50%	8.60%	21.70%	40.50%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	75.80%	74.30%	72.30%	73.90%	74.20%	75.90%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	72.80%	75.20%	75.40%	77.30%	72.80%	70.10%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	69.40%	72.40%	71.30%	73.10%	79.20%	80.60%
Equality and Diversity	Resources	Well Led	AD	>=80%	86.50%	86.20%	84.50%	82.00%	82.50%	83.00%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	80.90%	81.10%	80.50%	79.40%	82.70%	84.40%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	78.70%	79.60%	78.30%	79.20%	77.70%	80.90%
Infection Control and Hand Hygiene	Quality & Experience	Well Led		>=80%	78.90%	78.00%	78.80%	80.20%	79.90%	80.50%
Information Governance	Resources	Well Led	AD	>=95%	97.50%	92.80%	92.60%	90.70%	91.00%	90.80%
Moving and Handling	Resources	Well Led	AD	>=80%	79.80%	79.30%	76.10%	76.00%	75.40%	74.00%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	88.60%	87.40%	86.80%	85.40%	83.00%	82.80%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	83.70%	83.00%	82.80%	80.60%	78.90%	78.00%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	95.80%	95.50%	93.30%	93.30%	95.60%	95.40%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	58.00%	61.10%	75.40%	83.30%	88.10%	89.50%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	49.40%	52.30%	67.10%	77.60%	84.00%	85.00%
Agency Cost	Resources	Effective	AD		£165k	£76k	£61k	£79k	£58k	£84k
Overtime Costs	Resources	Effective	AD		£3k	£3k	£3k	£1k	£2k	£2k
Additional Hours Costs	Resources	Effective	AD		£1k	£1k	£-2k	£2k	£3k	£0k
Sickness Cost (Monthly)	Resources	Effective	AD		£112k	£91k	£91k	£97k	£98k	£117k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		40.79	85.41	75.52	71.45	80.1	88
Business Miles	Resources	Effective	AD		57k	62k	58k	68k	69k	54k

Appendix - 2 - Workforce - Performance Wall cont…

Forensic Services

Month	Objective	CQC Domain	Owner	Threshold	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Sickness (YTD)	Resources	Well Led	AD	<=5.4%	6.40%	7.00%	6.20%	5.90%	5.70%	5.80%
Sickness (Monthly)	Resources	Well Led	AD	<=5.4%	6.20%	7.00%	5.50%	5.10%	5.40%	6.00%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	93.70%	10.30%	21.20%	63.30%	93.20%	93.50%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	90.00%	1.70%	7.40%	29.60%	39.30%	45.00%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	84.50%	85.80%	85.30%	87.40%	84.30%	82.30%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	66.60%	68.30%	74.00%	73.30%	75.10%	77.60%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	50.80%	54.70%	65.00%	71.00%	73.50%	75.60%
Equality and Diversity	Resources	Well Led	AD	>=80%	92.00%	89.20%	86.60%	85.90%	87.70%	87.70%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	86.70%	85.90%	83.40%	86.20%	86.20%	84.20%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	88.00%	89.20%	88.30%	88.80%	90.00%	90.00%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	82.20%	81.70%	84.90%	86.70%	87.70%	86.70%
Information Governance	Resources	Well Led	AD	>=95%	97.60%	91.50%	92.70%	92.30%	91.40%	88.40%
Moving and Handling	Resources	Well Led	AD	>=80%	87.20%	84.90%	82.90%	84.10%	85.20%	85.20%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	92.30%	92.30%	91.70%	90.50%	90.60%	89.90%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	87.80%	88.40%	87.90%	85.70%	84.00%	86.20%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	80.00%	75.00%	51.70%	64.50%	70.00%	70.00%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	65.40%	65.70%	70.70%	84.10%	85.40%	90.40%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	55.80%	56.00%	61.90%	77.50%	79.30%	86.00%
Agency Cost	Resources	Effective	AD		£95k	£58k	£54k	£46k	£43k	£51k
Overtime Costs	Resources	Effective	AD		£3k	£0k	£0k		£0k	£6k
Additional Hours Costs	Resources	Effective	AD		£5k	£2k	£2k	£4k	£3k	£3k
Sickness Cost (Monthly)	Resources	Effective	AD		£54k	£63k	£51k	£47k	£48k	£53k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		50.2	49.29	47.49	48.04	55.16	48.61
Business Miles	Resources	Effective	AD		9k	8k	5k	5k	5k	6k

Specialist Services

Month	Objective	CQC Domain	Owner	Threshold	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	5.00%	5.80%	5.90%	5.70%	5.60%	5.60%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	5.70%	5.80%	6.10%	5.30%	5.50%	5.40%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	87.50%	3.80%	9.40%	36.30%	57.70%	82.70%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	71.20%	0.60%	1.80%	15.60%	26.30%	46.20%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	72.30%	72.70%	75.20%	77.40%	75.60%	75.60%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	70.40%	70.70%	69.20%	68.20%	64.60%	68.10%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	39.70%	43.50%	46.50%	52.40%	63.20%	72.50%
Equality and Diversity	Resources	Well Led	AD	>=80%	87.40%	85.70%	84.80%	83.20%	84.40%	87.30%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	80.10%	78.60%	80.20%	80.00%	83.40%	81.10%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	60.00%	59.10%	56.50%	56.50%	56.50%	58.30%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	85.90%	84.40%	83.30%	82.10%	83.80%	83.90%
Information Governance	Resources	Well Led	AD	>=95%	97.30%	92.80%	91.50%	92.30%	90.80%	91.30%
Moving and Handling	Resources	Well Led	AD	>=80%	77.00%	75.70%	75.80%	76.50%	80.10%	80.90%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	83.00%	82.10%	82.40%	83.60%	82.30%	83.30%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	84.70%	86.80%	85.20%	86.30%	85.70%	86.10%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	87.90%	87.80%	86.90%	88.90%	88.50%	92.10%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	55.60%	58.30%	62.70%	75.90%	79.60%	86.50%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	42.70%	54.70%	57.80%	71.40%	73.00%	81.40%
Agency Cost	Resources	Effective	AD		£261k	£178k	£167k	£169k	£163k	£156k
Overtime Costs	Resources	Effective	AD		£2k	£2k	£3k	£1k	£2k	
Additional Hours Costs	Resources	Effective	AD		£5k	£5k	£4k	£4k	£4k	£2k
Sickness Cost (Monthly)	Resources	Effective	AD		£74k	£60k	£75k	£58k	£60k	£61k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		57.42	53.47	51.56	52.4	55.96	41.72
Business Miles	Resources	Effective	AD		31k	39k	33k	38k	47k	39k

Appendix 2 - Workforce - Performance Wall cont…

Support Services

Month	Objective	CQC Domain	Owner	Threshold	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Sickness (YTD)	Resources	Well Led	AD	<=4.0%	4.80%	4.30%	4.30%	4.30%	4.40%	4.30%
Sickness (Monthly)	Resources	Well Led	AD	<=4.0%	4.80%	4.30%	4.30%	4.40%	4.50%	4.20%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	93.70%	7.10%	17.40%	83.00%	97.80%	98.90%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	95.50%	0.20%	1.10%	5.20%	15.20%	37.60%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	71.10%	68.60%	73.00%	71.30%	68.40%	68.20%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	86.50%	86.10%	86.80%	82.90%	79.30%	62.10%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	20.00%	100.00%	16.70%	28.60%	0.00%	0.00%
Equality and Diversity	Resources	Well Led	AD	>=80%	87.80%	87.50%	86.40%	86.50%	86.70%	86.60%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	85.90%	87.70%	87.10%	84.80%	82.40%	88.30%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	96.80%	99.20%	98.30%	96.70%	97.60%	97.50%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	84.80%	85.50%	86.00%	85.70%	84.70%	85.50%
Information Governance	Resources	Well Led	AD	>=95%	93.40%	92.20%	93.40%	92.90%	91.70%	91.40%
Moving and Handling	Resources	Well Led	AD	>=80%	85.80%	85.80%	72.60%	78.90%	79.60%	81.30%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	90.90%	90.90%	89.80%	89.50%	88.50%	89.10%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	86.40%	86.10%	86.60%	82.50%	89.80%	91.70%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	100.00%	100.00%	20.00%	33.30%	0.00%	0.00%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	92.90%	93.70%	94.80%	97.40%	98.10%	98.50%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	33.30%	38.80%	53.10%	64.40%	68.20%	78.40%
Agency Cost	Resources	Effective	AD		£33k	£8k	£5k	£10k	£0k	£-3k
Overtime Costs	Resources	Effective	AD		£0k	£5k		£3k	£1k	£0k
Additional Hours Costs	Resources	Effective	AD		£13k	£14k	£8k	£13k	£10k	£9k
Sickness Cost (Monthly)	Resources	Effective	AD		£84k	£77k	£77k	£76k	£74k	£68k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		52.39	23.23	43.12	40.07	41.18	37.56
Business Miles	Resources	Effective	AD		39k	40k	29k	39k	38k	34k

Wakefield District

Month	Objective	CQC Domain	Owner	Threshold	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Sickness (YTD)	Resources	Well Led	AD	<=4.6%	5.40%	5.00%	4.70%	5.00%	5.20%	5.50%
Sickness (Monthly)	Resources	Well Led	AD	<=4.6%	6.00%	5.00%	4.50%	5.60%	5.90%	6.50%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	94.60%	2.10%	16.10%	63.10%	82.40%	95.10%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	91.00%	4.40%	11.80%	36.20%	48.80%	65.80%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	80.40%	81.10%	80.40%	80.80%	80.10%	79.40%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	62.60%	65.00%	69.70%	66.00%	64.50%	66.20%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	59.70%	63.40%	61.50%	65.00%	68.20%	69.00%
Equality and Diversity	Resources	Well Led	AD	>=80%	87.10%	86.00%	86.80%	86.50%	86.80%	87.50%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	83.10%	78.90%	80.90%	82.50%	83.60%	85.80%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	75.20%	76.70%	75.00%	72.90%	71.20%	71.30%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	78.40%	77.80%	77.10%	79.30%	81.10%	80.90%
Information Governance	Resources	Well Led	AD	>=95%	97.20%	91.80%	92.30%	93.50%	92.90%	91.70%
Moving and Handling	Resources	Well Led	AD	>=80%	75.00%	72.60%	71.30%	71.50%	71.00%	69.90%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	87.50%	86.40%	85.30%	85.60%	87.20%	88.10%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	79.40%	77.90%	77.40%	78.70%	80.00%	81.10%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	93.10%	93.50%	92.50%	93.40%	93.40%	94.10%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	57.60%	59.30%	59.10%	73.10%	73.70%	83.70%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	49.30%	50.30%	49.70%	66.90%	67.20%	78.40%
Agency Cost	Resources	Effective	AD		£164k	£88k	£31k	£77k	£83k	£74k
Overtime Costs	Resources	Effective	AD				£4k		£1k	£3k
Additional Hours Costs	Resources	Effective	AD		£3k	£2k	£4k	£4k	£2k	£2k
Sickness Cost (Monthly)	Resources	Effective	AD		£69k	£52k	£46k	£59k	£56k	£64k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		64.28	50.56	48.56	43.91	45.19	45.35
Business Miles	Resources	Effective	AD		34k	32k	29k	38k	37k	38k

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
MARAC	Multi Agency Risk Assessment Conference
Mgt	Management
MAV	Management of Aggression and Violence
MBC	Metropolitan Borough Council
MH	Mental Health
MHCT	Mental Health Clustering Tool
MRSA	Methicillin-resistant Staphylococcus Aureus
MSK	Musculoskeletal
MT	Mandatory Training
NCI	National Confidential Inquiries
NHS TDA	National Health Service Trust Development Authority
NHSE	National Health Service England
NHSI	NHS Improvement
NICE	National Institute for Clinical Excellence
NK	North Kirklees
NMoC	New Models of Care
OOA	Out of Area
OPS	Older People's Services
ORCHA	Preparatory website (Organisation for the review of care and health applications) for health related Applications
PbR	Payment by Results
PCT	Primary Care Trust
PICU	Psychiatric Intensive Care Unit
PREM	Patient Reported Experience Measures
PROM	Patient Reported Outcome Measures
PSA	Public Service Agreement
PTS	Post Traumatic Stress
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
QTD	Quarter to Date
RAG	Red, Amber, Green
RiO	Trusts Mental Health Clinical Information System
SIs	Serious Incidents
S BDU	Specialist Services Business Delivery Unit
SK	South Kirklees
SMU	Substance Misuse Unit
SRO	Senior Responsible Officer
STP	Sustainability and Transformation Plans
SU	Service Users
SWYFT	South West Yorkshire Foundation Trust
SYBAT	South Yorkshire and Bassetlaw local area team
TB	Tuberculosis
TBD	To Be Decided/Determined
WTE	Whole Time Equivalent
Y&H	Yorkshire & Humber
YHAHSN	Yorkshire and Humber Academic Health Science
YTD	Year to Date

KEY for dashboard Year End Forecast Position / RAG Ratings	
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 3 October 2017
Agenda item 6.1

Title:	**Serious incident report Quarter 1 2017/18**
Paper prepared by:	Director of Nursing and Quality
Purpose:	This report provides information in relation to incidents in Quarter 1 and more detailed information in relation to serious incidents.
Mission/values:	➢ We are respectful, honest, open and transparent ➢ We put the person first and in the centre ➢ We are always improving
Any background papers/ previously considered by:	Previous quarterly reports which have been submitted to Trust Board. The annual incident report which was submitted to Trust Board in July 2017. The learning journey reports.
Executive summary:	➢ This report is produced by the patient safety support team and shows the data for incidents. Detailed Quarterly reports have been produced and shared with each BDU; this is available at service line level. ➢ The actions from incidents are managed at BDU level. Patient safety support team produces information on completion of action plans from serious incidents and these are monitored through the operational managers group. ➢ This report has overall figures for incident reporting – Trust reporting is showing a slight downwards trend in the previous two quarters. Quarter 1 had 2,790 incidents which is slightly lower than the previous three quarters. ➢ The annual reports show an overall trend in incident reporting is upwards in line with a good reporting culture. We will need to monitor the reduction this quarter to see if this is part of a downward trend. ➢ Almost 89% of incidents are graded as “low” or “no harm” suggesting a positive culture of reporting and risk management. ➢ Physical aggression/threat (no physical contact) by patient was the most reported category, as per four of the previous five quarters. Physical aggression continues to be the highest reported incident. Staff report that fluctuations in aggression can be linked to individual service users. There are also concerns that some incidents are linked to the current smoking policy in the Trust. This is being examined in more detail and figures & information from Datix have been provided to the smoking policy review group. ➢ There have been no ‘Never Events’ reported in the Trust during Quarter 1, the last Never event reported was in 2010/11. ➢ The total number of serious incidents reported through the Strategic Executive Information System (STEIS) in Quarter 1(19), this is similar to previous two quarters which had 24 and 15 serious incidents. This year the number of incidents is higher than the previous year at this stage by 6. The highest category of serious incident is Suicide (incl apparent) - community

	team care –current episode (5). This is in line with previous quarters. ➢ The category of apparent suicide at point of reporting is similar in the rolling last 4 quarters - 7, 7, 8, 8, This is 30 in total and below the level of estimated cases based on National Confidential Inquiry numbers and our population - 33/34. ➢ 23 investigations have been submitted to the Commissioner during the quarter and 10 have been closed by Commissioners. ➢ Many reports are outside the 60 day target, all of these have agreed extensions with Commissioners. There have been changes in staffing that have impacted on timely reporting, although external and bank investigators have been employed to cover the backlog wherever possible. We also have a contingency plan to use other members of staff as investigators but from September 2017 the team of Serious Incident investigators are back to full resource so we would expect to see the overdue reports reduce over the next two quarters. ➢ Within the report are some examples of learning from specialist advisors and a workstream for the highest reported incidents. **Risk appetite** ➢ Risk identified –the trust continues to have a good governance system of reporting and investigating incidents including serious incidents. ➢ This report covers assurance for compliance risk for health and safety legislation and compliance with Care Quality Commission (CQC) standards for incident reporting. This meets the risk appetite –low and the risk target 1-3. ➢ The clinical risk –risk to service user/public safety and risk to staff safety which is again low risk appetite and a risk target of 1-3. ➢ The incident management process supports the drive to reduce harm and learn from incidents to reduce risk and prevent recurrence in the future.
Recommendation:	**Trust Board are asked to NOTE the quarterly report on incident management.**

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TRUSTWIDE INCIDENT MANAGEMENT SUMMARY REPORT

QUARTERLY REPORT FOR THE PERIOD 1 APRIL 2017 – 30 JUNE 2017

(QUARTER 1)

This summary report has been prepared by the Patient Safety Support Team to bring together Trustwide information on incident activity during Quarter 1 17/18 (1 April 2017 to 30 June 2017), including reported serious incidents.

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

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

1 UPDATES FROM THE PATIENT SAFETY SUPPORT TEAM

1.1 INCIDENT REPORTING AND DATIXWEB UPDATES

- The Datix team continue to provide the following training click here for further information:
    - Reports training where Datix users have the opportunity to learn how to analyse their team's data on request.
    - Training for managers and Specialist Advisors (new staff or refresher) on how to review incidents and navigate around Datix continues. This takes various forms such as one to one sessions and phone coaching and advice.
    - The team offers a variety of ways for teams to learn about incident reporting via video guides, and user guides. These are available on the patient safety intranet pages click here.
- From June 2017, the Datix team also have some training dates available at each of the main Trust sites which can be booked by staff. These sessions run on a one to one basis and provide practical support to Datix users with log ins. Users are required to bring their own laptops and ideas on what they would like to explore on Datix. This might be new manager or refresher training, navigating dashboards or how to produce a report from Datix. Dates can be found on the intranet.
- The team continue to deliver System / Root Cause Analysis training to staff who are required to carry out investigations. Training dates can be found in the Training Brochure on the intranet.
- The Incident Management Annual Report and Our Learning Journey report for 2016/17 are available on the Patient Safety intranet pages click here.
- Previous quarterly reports are available on the Patient Safety intranet pages click here.
- All staff with Datix log in details have access Datixweb Dashboards. The module displays incident data in various report formats which are systematically generated from incidents reported through Datixweb. The data in the Dashboards are continuously updated to provide a live stream of data to staff, depending on their area of responsibility. The module is a useful tool, showing trends/patterns in a more accessible, visual format. Video guides are available to guidance staff around this feature.
- Managers, specialist advisors and TRIO's with Datix log in details have access to pinned queries that have been set up. These enable staff to access incidents easily where information is missing. Once the required information is entered the number of incidents reduces from the pinned query. Pinned queries set up include duty of candour incidents for review and investigations ongoing.
- The business continuity plan for the Patient Safety Support Team has been reviewed and revised.
- From 1 April 2017 there have been significant changes to the Datixweb incident reporting system for reporters and managers. Many changes are in response to the national requirements around reporting of deaths, which will mean prompts for important information when a death is reported. The Patient Safety Support Team have also used

this as an opportunity to review other sections of the form to improve the quality of data collected to help with decision making, investigation, learning and audit.

Changes include:

- **Death of a service user section** - when the result is death, further questions will appear
- SI additional Information changes – this has been replaced by **'Manager's 48 hour review'** section and now incorporates the Information Governance section Details of **ligatures** and **ligature points** used in inpatient self harm/suicide using ligature (this will inform the annual ligature audit process)
- **Learning** identified (to capture narrative of what happened, what the review identified, what changes/improvements were made and their impact)
- **Sharing learning – closing the loop** (to capture where learning has been shared and where support is needed to share more widely)
- **Suicide audit** questions for serious incidents (for completion by SI investigators)

- Specialist Advisor Datix guidance has been produced by the team and circulated following an action from an SI.

Managers should contact the patient safety support team on 01924 316180 or Datix@swyt.nhs.uk for advice as needed.

1.2 WORK IN PROGRESS FOR IMPLEMENTATION IN QUARTER 2 17/18

- Development and implementation of Security Incident Reporting System (SIRS) on Datixweb in conjunction with the Security Team.

- Changes to be made to Datix to set up the new core and enhanced teams in Kirklees and Calderdale BDU following transformation.

1.3 CHANGES IN SERVICES IN QUARTER 1 17/18

Following transformation in Barnsley Mental Health BDU, the new core and enhanced teams in the Community Mental Health Service Line have been set up on Datix.

Also following transformation in Wakefield BDU, the new core and enhanced teams in the Community Services (Adult) Service Line have been set up on Datix.

1.4 INCIDENT ANALYSIS AND TRAINING REQUESTS FROM BDU'S

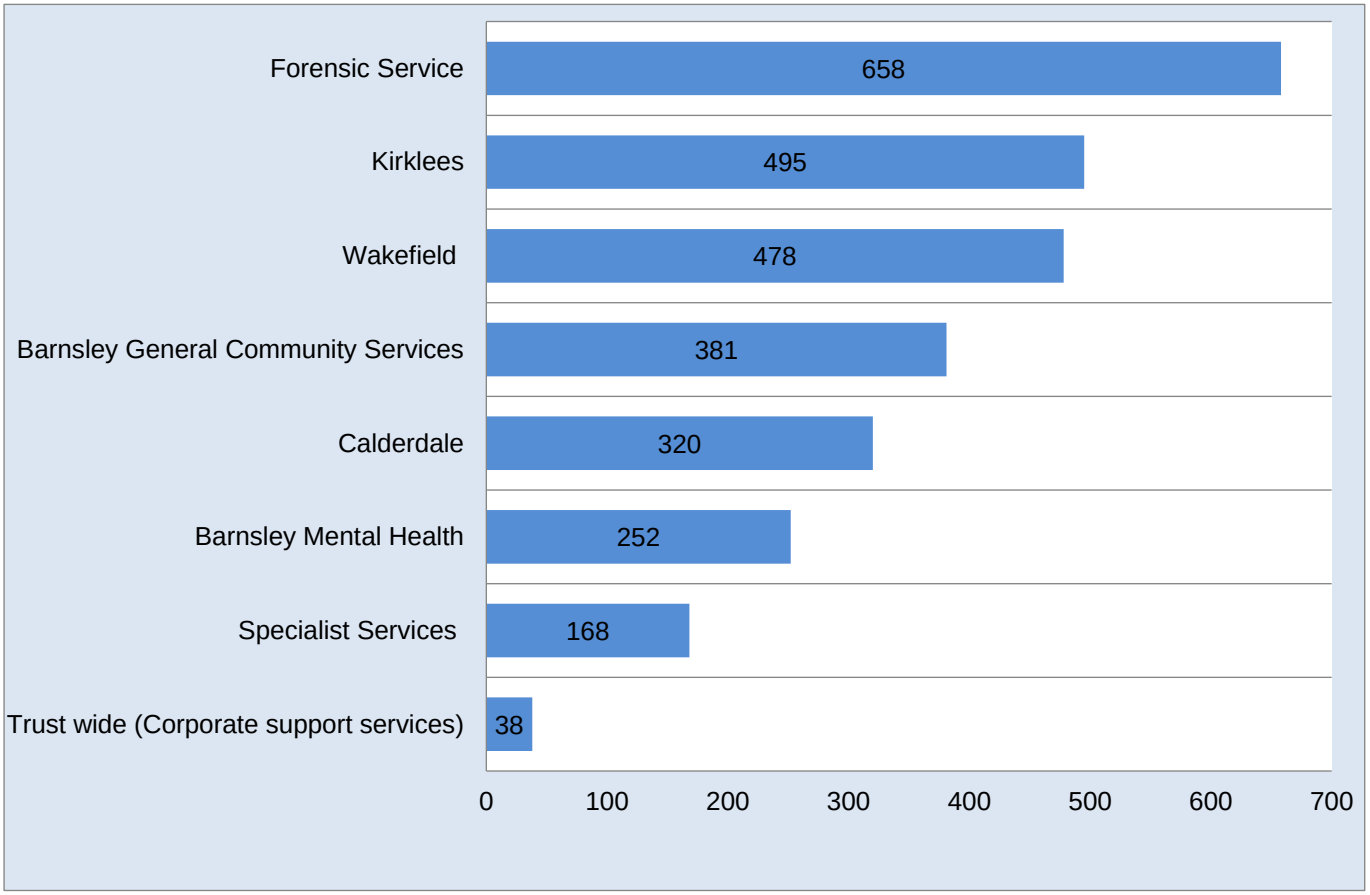
During Quarter 1, the Patient Safety Support Team has received the following requests for analysis of incident data and training:

BDU	**Quarter 1 17/18**
Kirklees and Calderdale BDU	AWOL incident report for Ashdale ward
Wakefield BDU	Request for Datix training for Practice Governance Coaches.
Barnsley BDU	No requests for specific training/reports
Forensic BDU	Report for specific patient related incident activity
Specialist Services BDU	Request for Datix training for Practice Governance Coaches in CAMHS.
Trustwide (corporate)	Request for incident report in relation to the number of incidents mapped to introduction of the smoke free environment re: Violent and aggressive behaviour, Restraints, Fire safety issues from 01/12/2015. Request for report for information governance incidents that occurred during the financial year 2016/17 by BDU.

1.5 FREEDOM OF INFORMATION REQUESTS RECEIVED WITHIN QUARTER 1

Request Reference	Information Requested
FOI 1628	1. In the last two calendar years, how many injuries have been reported at your trust that occurred while a patient was being restrained? This relates to injured patients, not injured staff or members of the public. Please break this information down by calendar year for 2015 and 2016. 2. How many of these patients injured while being restrained were under the age of 18? Please state their ages, and break down by year. 3. How many of these patients required medical assistance as a result of injuries that occurred while being restrained? Please provide a brief description of these injuries, in a list form if possible. Again, please break down by year.
FOI 1649	I am requesting the following information under the Freedom of Information Act (2000): 1. The total number of Serious Incidents (formally referred to as Serious Untoward Incidents – SUIs) recorded by your Trust (accompanied by a list of these recorded incidents – where possible), during the financial year of: a. 2016 – 17

2. INCIDENTS REPORTED TRUSTWIDE WITHIN THE QUARTER BY BDU



The descending order of BDU incident reporting is similar to previous quarters. Specialist services have decreased the number of incidents being reported if compared with last 4 quarters. Individual service users who are involved in many incidents over a short timeframe can impact on fluctuation in incident frequency. BDUs have the information by service line within the reports.

2.1 TRUSTWIDE COMPARATIVE DATA 01 APRIL 2016 TO 30 JUNE 2017 (ROLLING YEAR)

	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
Total Incidents Reported	3457	3349	3242	2910	2790
Total Number of Green (No Harm) Incidents Reported	2105	2008	1891	1772	1700
Total Number of Green (Low Harm) Incidents Reported	957	943	975	813	776
Total Number of Yellow (Moderate) Incidents Reported	301	307	282	237	232
Total Number of Amber Incidents Reported	83	73	70	71	55
Total Number of Red Incidents Reported	11	18	24	17	27
Most Reported Category of Incident	Physical aggression/threat (no physical contact): by patient	Breach of Smoke Free Policy	Physical aggression/threat (no physical contact): by patient	Physical violence (contact made) against staff by patient	Physical aggression/threat (no physical contact): by patient
Team who reported most signifcant number of incidents	Elmdale Inpatient Services Ward	Ward 18, Priestley Unit	Elmdale Inpatient Services Ward	Elmdale Inpatient Services Ward	Elmdale Inpatient Services Ward
How many "Lessons Learnt were extracted from the incidents reported within the quarter (note more than one "Lessons Learnt" can be selected. Not all incidents will have included Lessons Learnt)	969	860	703	728	554
Most Frequent Lessons Learned Theme is	Patient engagement	Physical healthcare	Physical healthcare	Physical healthcare	Physical healthcare

In section 2.1 there have been 27 red incidents reported. This data is live data at the point of producing the report. The incident may be initially graded red for a number of reasons. An example would be a death (for healthcare deaths we have been encouraging staff to report on Datix) but we later find out this is natural causes or not been involved with Trust services for over six months. This may be re-graded and not reported on STEIS.

2.2 INCIDENTS REPORTED TRUSTWIDE WITHIN THE QUARTER BY SEVERITY AND BDU/DIRECTORATE

	Barnsley Mental Health	Barnsley General Community	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Trustwide (Corporate support services)	Total
Green (no harm)	155	234	184	271	236	482	110	28	1700
Green	75	102	99	161	156	134	42	7	776
Yellow	15	11	29	49	77	37	12	2	232
Amber	2	34	4	4	4	3	3	1	55
Red	5	0	4	10	5	2	1	0	27
Total	252	381	320	495	478	658	168	38	2790

2.3 INCIDENTS REPORTED TRUSTWIDE WITHIN THE QUARTER BY TYPE AND BDU/DIRECTORATE

	Barnsley Mental Health	Barnsley General Community	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Trustwide (Corporate support services)	Total
Violence and Aggression	70	10	58	121	146	321	59	5	790
Care Pathway, Clinical and Pressure Ulcer Incidents	11	245	21	25	39	11	17	1	370
Legislation and Policy	6	0	53	58	29	113	0	7	266
Health and Safety (including fire)	22	15	17	36	48	58	14	4	214
Self Harm	29	0	50	62	53	9	8	0	211
Medication	24	23	25	30	34	34	10	0	180
Slips, Trips and Falls	11	40	17	43	36	14	1	4	166
Death (including suspected suicide)	29	7	24	39	27	1	5	0	132
Security Breaches	12	1	4	7	15	52	8	6	105
All Other Incidents	10	6	14	20	17	27	10	0	104
Information Governance Incidents	8	9	5	9	2	2	18	9	62
Missing/absent service users	11	0	16	22	9	3	0	0	61
Safeguarding Adults	2	4	5	10	12	9	3	1	46
IT Related Issues	1	16	6	5	7	2	5	0	42
Safeguarding Children	5	1	3	7	3	0	8	1	28
Infection Prevention/Control	1	4	2	1	1	2	2	0	13
Total	252	381	320	495	478	658	168	38	2790

3. LEARNING IDENTIFIED BY SPECIALIST ADVISORS

Specialist Advisors have been asked to provide the Patient Safety Support Team with information on any significant learning, identified peaks or notable advice given, on a quarterly basis for sharing in this report. Any queries related to this information should be referred to the relevant specialist advisors.

Safeguarding Adults

Recently the safeguarding adult team provided specialist advice to a 'long term seclusion' incident on Datix which had been submitted by an acute mental health inpatient ward. The information provided by the safeguarding team and consultation with the Practice Governance Coach highlighted that the Long Term Segregation Toolkit (LTST) requires a review and update to ensure that it is aligned with MHA Code of Practice and that the Risk Assessment does not assist with the decision to use the LTST. The outcome of this joint working has ensured that the LTST will be discussed at the next PMVA-TAG meeting.

Safeguarding Children

At a recent mock Joint Targeted Area Inspection, it was identified that there does not appear to be a consistent approach to the management of neglect across all agencies. There was a lack of evidence based tools used by practitioners, which often led to cases not meeting thresholds and being accepted for assessment by social care. For teenage children there was evidence of drift and delay and often young children were identified as the problem/difficult to engage child rather than the intervention being acted upon within a timely manner. The outcome of these findings are that an action plan has been produced by the safeguarding team to address the concerns raised, actions include briefing papers, training, promotion of evidence based practice and awareness raising re: the impact of neglect.

Patient Safety Support Team

<u>Hot Spots from weekly clinical risk panel</u>

There have been a number of incidents recently where it has been identified that the patient involved posed a significant risk to others, e.g. where there was a known history of fire setting. In cases where an individual's mental disorder is linked to an interest in fire setting, a forensic assessment should always be considered, given the potential risks.

The Bretton Centre and Newhaven, Low Secure Service, Guidelines for Referrers - March 2016 states in the Service Aims and Objectives section 2.2:

"*Referral should be made on the basis of significant risk to others, whether arising from offending or offence paralleling behaviour, in the context of mental disorder. There may or may not be criminal justice system involvement."*

<u>Messages to BDU's</u>

Any changes in services and staff who review incidents should be communicated to the Patient Safety Support Team as soon as possible to enable to team to update the Datix settings. Without this, those who need to know about incidents will not receive notification to review them, and to act on them. This causes delays in the system and additional work.

Delays are being noted in managers completing the 'Managers 48 hour review' section on Datix for potential serious incidents (amber and red). This information is used to determine next steps in the investigation process and whether an incident is externally reportable. It is reviewed in the weekly clinical risk panel. It is also used to provide further information to CQC and NHS England on request. Please keep the Patient Safety Support team updated with any reason for delay.

Following the introduction of new mortality fields on Datix, please can managers ensure all fields are completed. The initial review of over 50 deaths in April had a lot of data gaps which has led to mortality reviews not being able to be completed on time. This included fields about if a death was expected or not, age of the person, where they died.

3.1 PROGRAMMES OF WORK FOR HIGHEST REPORTED INCIDENTS

Incident information is contained in many of the work streams within the Trust. In the last five quarters there have been two areas as the highest incidents.

Breach of smoke free policy - the incident numbers only show part of the picture as incidents of violence and aggression also result out of issues linked to service users being unable to smoke on wards or have easy access to the means of smoking. A group has recently been set up to review the smoking policy.

Patient safety team has provided the group with a range of data to assist this review.

Violence and aggression- There are a number of initiatives and requests for information linked to this. Below are some pieces of work

- **Sign up to safety –** A number of targets have been set around reducing harm from restrictive interventions (originating **incident**). For incidents of restraints, the aim is to reduce the frequency (use of) of prone restraint and the duration of prone restraints. Training has been updated and rolled out. The results are positive to date.
- **Safe wards-** This work is part of the patient safety strategy. A number of units are using the tools available and sharing practice.
- **Safety Huddles–** again this sits under the patient safety strategy and some wards have chosen to have their huddles on reducing violence and aggression incidents. Chantry ward has received their silver award from the academy for achieving a stretch target for a number of days without an incident.
- **Significant event analysis (SEA)-** Work has taken place between patient safety support team, management of violence and aggression team and health and safety to pilot use of a tool focusing on human factors following an incident of violence and aggression that has resulted in a Riddor reportable incident. The benefits of this will be reviewed in three months.
- **Staff wellbeing –** a campaign has been launched to ensure the support available to staff is known across the Trust.

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TRUST WIDE SERIOUS INCIDENT (SI) REPORT FOR QUARTER 1 2017/18 (DATA AS AT 3 JULY 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 Department of Health Strategic Executive Information system (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.

Table 1 Number of Never Events reported during 2017/18 by quarter

Q1	Q2	Q3	Q4
0			

1. 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 1 2017/18 there have been 19 serious incidents reported on STEIS, as shown in Table 2 by financial quarter, with comparative data for previous years. Table 3 shows the SI reported in the quarter (19) by the team type and BDU.

Table 2 Serious Incidents reported to the Commissioner by financial year and quarter up to the date of this report (2013/14 - 2017/18)

Financial quarter	13/14	14/15	15/16	16/17	17/18
Quarter 1	14	31	18	13	19
Quarter 2	27	24	23	13	
Quarter 3	31	30	15	15	
Quarter 4	29	21	20	24	
Totals	**101**	**106**	**76**	**65**	

Table 3 Serious Incidents reported by team types and BDU during Q1 2017/18

	Barnsley MH&SMS	Barnsley General Community	Calderdale	Kirklees	Wakefield	Forensic	Total
Acute Inpatients (Adult)	0	0	0	1	0	0	**1**
CMHTs (Adult)	0	0	2	4	0	0	**6**
CMHT's (OPS)	0	0	0	0	1	0	**1**
Core pathway	1	0	0	0	0	0	**1**
Crisis/IHBTT (Adult)	1	0	2	2	0	0	**5**
District Nursing	0	1	0	0	0	0	**1**
Enhanced Pathway	0	0	0	0	1	0	**1**
Forensic CAMHS Services	0	0	0	0	0	1	**1**
General Community Therapy Services	0	1	0	0	0	0	**1**
Low Secure Community Teams (FSLS)	0	0	0	0	0	1	**1**
Total	**2**	**2**	**4**	**7**	**2**	**2**	**19**

All serious incidents are subject to a manager's report. This is to enable any themes, trends or issues to be reported as close to services as possible. No themes emerging from managers initial reports.

Table 4 Serious Incidents reported by incident category and BDU during Q1 2017/18

	Barnsley Mental Health	Barnsley General Community	Calderdale	Kirklees	Wakefield	Forensic Service	Total
Suicide (incl apparent) - community team care - current episode	0	0	1	4	2	1	**8**
Self harm (actual harm)	1	0	1	0	0	0	**2**
Death - confirmed related to substance misuse (drug and/or alcohol)	0	0	1	0	0	0	**1**
Fire / Fire alarm related incidents	0	0	0	1	0	0	**1**
Homicide by patient	0	0	0	0	0	1	**1**
Illegal Acts	0	0	1	0	0	0	**1**
Information disclosed in error	0	1	0	0	0	0	**1**
Physical violence (contact made) against other by patient	0	0	0	1	0	0	**1**
Physical/sexual violence by other	1	0	0	0	0	0	**1**
Vehicle Incident	0	0	0	1	0	0	**1**
Pressure Ulcer - grade 3	0	1	0	0	0	0	**1**
Total	**2**	**2**	**4**	**7**	**2**	**2**	**19**

The highest category of serious incidents during Quarter 1 related to apparent suicide of current service users in contact with community teams. Table 5 shows the method used.

Table 5 Apparent Suicides reported on STEIS between 01/07/16 – 30/06/17 by Sub-category

	Calderdale	Kirklees	Wakefield	Forensic Service	Total
Hanging - self injury	0	1	1	1	**3**
Other - self poisoning	1	1	0	0	**2**
Cutting - self injury	0	1	0	0	**1**
Illicit drug - self poisoning	0	0	1	0	**1**
Jumping from height	0	1	0	0	**1**
Total	**1**	**4**	**2**	**1**	**8**

The most common method of suicide is hanging in England (43%), self-poisoning (25% and jumping/multiple injuries (15%). The Trust data for quarter 1 is small in numbers but includes these methods.

2. Suspected Suicide reported to the Commissioners

The National Confidential Inquiry (NCI) 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

Table 6 shows the populations of the BDUs and some average suicide rates which would be consistent with the figures produced by the NCI.

Table 6 BDU populations and average suicide rates

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	1,215,801	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

Table 7 Apparent Suicides reported on STEIS between 01/07/16 – 30/06/17 by Quarter and geographical area

	Barnsley Mental Health	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	**Total**
16/17 Q2	0	2	3	2	0	0	**7**
16/17 Q3	3	0	2	2	0	0	**7**
16/17 Q4	1	0	3	1	1	2	**8**
17/18 Q1	0	1	4	2	1	0	**8**
Total	**4**	**3**	**12**	**7**	**2**	**2**	**30**

The rolling 4 quarter data (Table 7) shows that the Trust is below the expected number of suicides based on the National Confidential Inquiry figures (Table 6) for a population the size of the Trust and patient suicide (28%). This figure (30) includes apparent suicides occurring in specialist services (CAMHS and Forensics). Barnsley, Calderdale and Wakefield are below the expected number for their respective geographical areas, Kirklees has the expected number. 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. The financial quarters are also based upon when it was reported as a Serious Incident, not when it occurred (see Appendix 1 for further information).

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 apparent suicides 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

- **23** 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 **27** open SI investigations taking place across the Trust (as at 03/07/17) see Table 8 and further breakdown in Table 9.

Table 8 Current position on open SI investigations as at 3/7/17

	Barnsley Mental Health	Barnsley General Community	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Total
IG investigation	0	1	0	1	0	0	0	**2**
Lead Investigator being allocated	2	0	0	1	0	2	0	**5**
Investigation panel being established	0	0	0	2	0	0	0	**2**
Investigation within 60 working days and on track	0	1	2	2	2	0	0	**7**
Investigation within 60 working days but off track	0	0	2	2	0	0	0	**4**
Investigation report over 60 working days but extension agreed	0	0	0	1	0	0	1	**2***
Investigation report over 60 working days, no extension agreed	0	0	0	2	1	0	0	**3***
Investigation being led by external investigator	0	0	0	0	0	2	0	**2***
Total	**2**	**2**	**4**	**11**	**3**	**4**	**1**	**27**

In Table 8, some of the SIs are marked with an asterisk. This is where investigations are ongoing but the investigation has passed the standard 60 working day timeframe. Further breakdown of these is shown in Table 9 which does include one of the IG incidents.

Table 9 Breakdown of SI investigations that are over the original timescales

	Kirklees	Wakefield	Forensic Service	Specialist Services	Total
4-6 months since reported on STEIS	4	0	1	1	**6**
7-9 months since reported on STEIS	0	0	1	0	**1**
10-12 months since reported on STEIS	0	1	0	0	**1**
Total	**4**	**1**	**2**	**1**	**8**

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.

In summary 19 are within timescales at differing stages and eight are overdue.

As shown in Table 9, there are 8 reports that are more than 60 working days since the incident was reported on STEIS. The incident in Wakefield was originally reported as an SI by SWYPFT, and was to be led by the CCG. The investigation was delayed but the Trust has now agreed to lead and produce so this is now progressing. The other investigations are 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. Some of the investigations have involved a number of organisations and this adds to the complexity.

The Patient Safety Support Team occasionally experiences difficulties in allocating investigations due to fluctuations and spikes in reporting rates. Capacity in the investigation team was impacted by changes in personnel. External and bank investigators have been used to manage some of this pressure and a contingency plan has been agreed to use other staff if required. By end of September 2017, additional full time investigator will be in place and backlog will reduce over next two quarters if SI reporting trends are similar to previous years.

3. 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 Clinical risk report for Operational Management group report. 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.

4. 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 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.

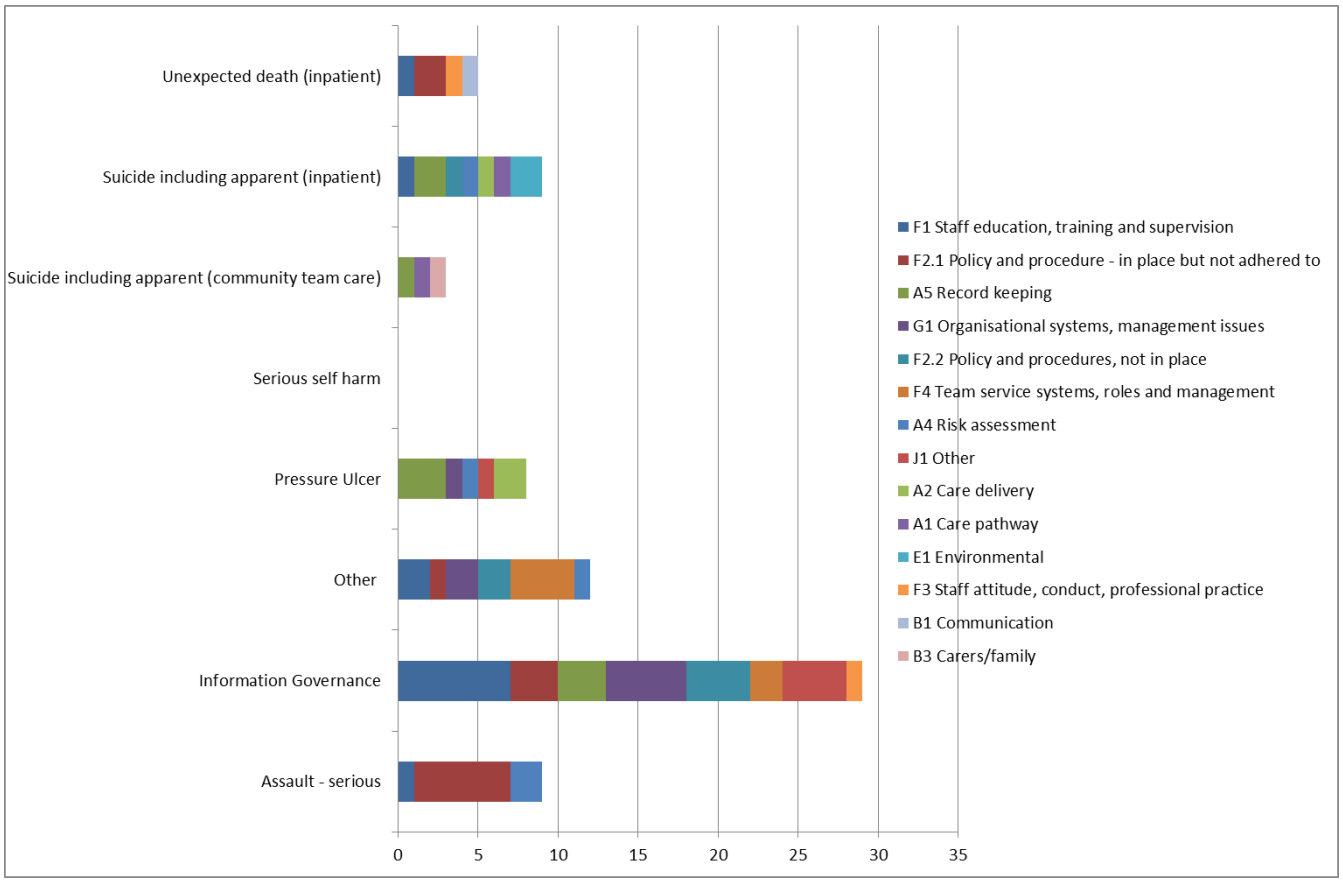
- **2011/11370** has been subjected to a domestic homicide review which is a multi-agency review and overseen by the Home Office. The Local Area Team have reed to close the action plan.

5. Serious Incident themes

Reporting on SI learning is included in '*Our learning journey' reports* which are on the Trust's intranet.

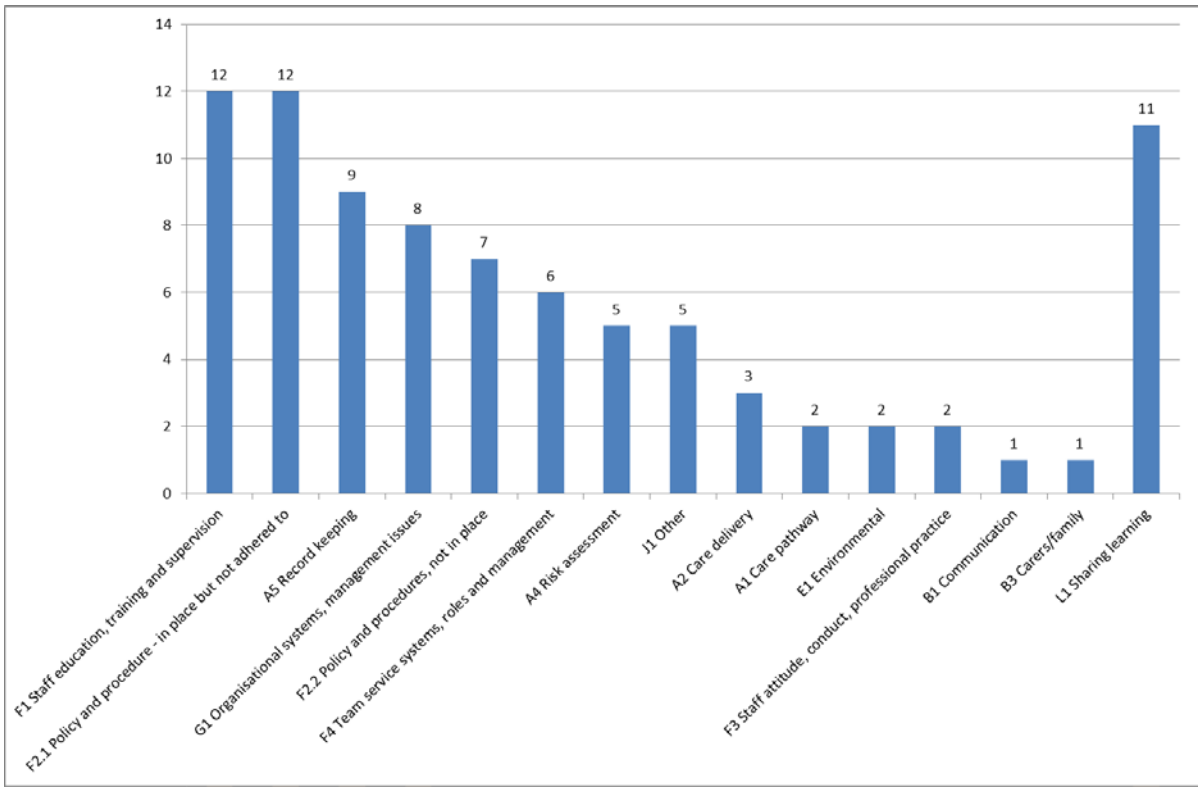
During Quarter 1, the number of investigations completed and sent to the commissioners was 23, which is an increase on the previous quarter (8). Nineteen of these SI investigations had an action plan. There were 75 separate recommendations made to improve the system or process to prevent recurrence.

Graph 1 Quarter 1 2017/18 Completed SI Investigation reports – Recommendations by theme and serious incident type



Information Governance incidents had the largest number of recommendations, which correlates with the number of investigations sent to the commissioners in the quarter (7). There are two themes which are joint top this quarter - Staff education, training and supervision and policy and procedure in place but not adhered to. Record keeping continues to be within the top three recommendations.

Graph 2 Quarter 1 2017/18 completed reports recommendations by themes



Many actions take time to implement. These are monitored through the operational managers group and BDU governance groups. Sharing learning is an action the patient safety support team have added to action plans; Eleven action plans included this as a specific action. This is to support learning being shared across the teams, service, BDU, Trust and wider health economy.

Within quarter 1:-

- A number of individual teams have taken time to share and discuss the learning from particular incidents.
- The incidents were shared in the team, service line and BDU.
- A flyer was produced for information governance incident so it could be circulated across the whole BDU.
- Incident learning has been shared with risk managers across West Yorkshire
- The trust wide alert system on Datix has been used to immediately share newly identified ligature point on In patient wards.
- Fire safety training now includes the action plan from a recent fire.
- Work is taking place to ensure business continuity plans learn and are updated from the fire on Trinity.

There were 2 incidents where the recommendation was in relation to staff attitude both of these were quickly actioned before the report was completed.

The learning from action plans is reported in the learning journey. A piece of work has also been included in the patient safety strategy and is part of the integrated change programme.

Patient Safety Support Team
10/7/17 updated 25/9/17

Appendix 1

Serious incident definition and reporting information

Serious Incidents are incidents which meet specific criteria as defined in the Serious Incident Framework dated March 2015 (NHS England 2015), which moved to the responsibility of NHS Improvement in April 2016. The 2015 Serious Incident Framework - supporting learning to prevent recurrence document builds on earlier guidance and explains the responsibilities and actions for dealing with Serious Incidents and the tools available. It outlines the process and procedures to ensure that Serious Incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again. There is a requirement that these incidents are reported on the DOH database, StEIS, and are subject to an internal investigation by the Trust. Some require further independent review.
The Clinical Commissioning Groups or NHS England Local Area Team for specialised commissioned services will monitor incidents and action plans.

The SI criteria, reporting and external monitoring process means that there are potentially 3 dates associated with an SI:-

- Actual incident date (if known)
- Date the incident is recorded on Datix
- Date the incident is reported on the DOH database StEIS, when it has been confirmed as an SI.

There could be differences and gaps between these dates for a number of reasons, for example:

- Suicide by a person in current contact with Trust services or within 12 months from discharge from Trust services. However the Trust may not be made aware of the suicide until sometime after the event, and in the case of the suicide of a discharged service user sometimes months afterwards.

- The cause of death may be thought to be due to natural physical causes and only confirmed or suspected as due to suicide or a patient safety incident some time afterwards (this is usually from information provided by the Coroner following further investigations).

- Information about an incident may become available after the event, or may change – so the date of the incident and the date it becomes reportable as an SI could be different. For example, the medical condition of a service user or staff member may be unclear for some time after an incident.

The Trust, along with other Trusts, bases its SI data on the date the incident was logged on the StEIS system and reported to the CCG. The reason for this is:

- To ensure consistency with the CCG, which monitor and count SIs based on the date the event was reported on the DOH database, StEIS.
- There can be significant differences in the incident date and the date the incident is reported as an SI (for the reasons listed above)
- The data the Trust uses has been analysed in this way since 2003; to change this would affect comparative data.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 3 October 2017
Agenda item 6.2

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.
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. Capacity and demand are monitored closely and escalation processes in place to maintain safe staffing levels.
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. The Trust currently meets its safer staffing requirement overall with staffing fill rates continuing to exceed 100%, although the planned levels of registered nursing 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 2017 has resulted in increased staffing fill rates, successful recruitment of registered and non-registered staff, significant reduction in agency use 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 was developed. 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 identified ongoing challenges in recruitment and retention but also noted that the trust demonstrated a commitment to achieve its longer-term plans in relation to the safer staffing fill rate across the trust, the reduction of agency spend, and workforce development, through the implementation of a number of measures that had been further embedded since the last inspection. They also noted that patients' section 17 leave and meaningful activities took place on wards and they were not adversely affected by insufficient staff on the wards. In August 2017 NHS Improvement (NHSi) asked all trusts to complete an audit of care hours per patient day, to be completed in October 2017. This and current plans will 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 ➢ 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 ➢ The 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 ➢ Continue recruitment onto staff bank ➢ Establish Safer Staffing Specialist Advisor post on a permanent basis ➢ Support over-recruitment of peripatetic staff within BDUs ➢ Align Safer Staffing initiatives with new Trust Workforce Strategy ➢ Develop the Medic Bank capability ➢ Ensure bank policy is updated ➢ Ensure effective use of the awarded agency master vendor contract for both Nursing and AHP ➢ Expanding the bank to support other areas including admin ➢ Complete NHSi Care Hours Per Patient Day (CHPPD) audit by end of October 2017 ➢ Review ward establishments after the NHSi analysis of staffing figures which is currently being collated ➢ Submit proposal to recruit international nurses to EMT ➢ Review QNI community nursing tool

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
22nd September 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 the work we have undertaken and what our future plans are to ensure that our clinical areas remain appropriately staffed so that they can run safely and effectively.

1.0 INTRODUCTION

At a national level, there continues to be some key changes around the delivery of this agenda. Interest in safer staffing arose from concerns nationally regarding acute 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, there will continue to be an engagement process within community teams to scope what safer staffing means to them and what support can be provided following transformation processes.

Although there has been progress made in some areas within Mental Health Services there has been no definitive publication on Safer Staffing guidance for inpatient Mental Health wards. Given the lack of progress in the area of mental health 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.

The Trust continues to maintain accurate and up-to-date information of "composite indicators" on the electronic staff record system (ESR) in relation to the proposed Safer Staffing Indicators as follows:

1. Staff sickness rate, taken from the ESR at the end of August 2017;

- *Inpatient areas* –5.9% *compared to the Trust 4.9% (down from 6.5% in March 2017)*

2. The proportion of mandatory training completed at the end of August 2017;

- Inpatient areas: 84.1% compared to the Trust figure of 83.8% (down from 84.7% in March 2017)

3. Completion of a appraisals at the end of August 2017;

- Inpatient areas – unavailable until the end of September 2017

- Staff views on staffing, taken from the 2016 National staff survey measure;

  Key Finding 14. Staff satisfaction with resourcing and support shows a Trust score of 3.38 from 5 (very satisfied), which is above the national average for Trusts that are combined MH/LD and Community (3.33).

Based on these indicators, there remain some positive findings but we continue to be faced with some challenges. Within SWYPFT, significant financial investments have already been made since 2014 to develop interventions around the Safer Staffing agenda including increasing some ward establishments following the production of a business case, establishing a peripatetic workforce and centralising the Trust staff bank.

The Trust has also made the decision to combine the function of the Trust staff bank Manager with that of the Safer Staffing Project Lead to ensure a consistent and coordinated approach to Safer Staffing.

2.0 SUMMARY OF PREVIOUS REPORT AND ACTIONS

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

1. **Continue to build upon and improve data in exception reports**

Action: Monthly exception reports continue to 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). Monthly Exception Reports have allowed us to develop an enhanced picture of the inpatient ward areas regarding Safer Staffing. These reports now;

- Utilise the new dashboards for Datix incidents and reporting
- Triangulate DATIX, exception reporting and HR information
- Extend the narrative and analysis of the information

2. **Extend and maximise functionality within current e-rostering system as part of the centralisation programme for the Trust staff bank**

Action: This has led to the development of a report being sent weekly to the inpatient area Managers and General Managers providing an analysis of each ward's use of the e-roster system. This enables Managers to anticipate and plan for where they could make better use of their available resources and enables them to reflect on the previous week. This provides an understanding of areas which may require support and training to alleviate staffing issues, which can be influenced through the utilisation of current resources

3. **Continue to provide effective and efficient support to meet establishment templates**

Action: Where wards have experienced a sustained identifiable need for more staff, a system has been established to enable ward's to make changes to their establishment template following the identification of what changes are required to meet the demand, how this would be funded and what if any impact this would have on the standard of care delivered.

This process is supported by the Nursing Directorate and Safer Staffing and follows a robust process including a Risk and Quality Impact Assessment.

4. **Project Manager to work closely with 'hotspot' wards where there is pressure on meeting staffing numbers**

Action: Where wards are experiencing staffing shortfalls for any reason, support is offered through the Project Manager. This has allowed for temporary contracts to be offered through the staff bank as well as the effective deployment of Peripatetic Workers (PWs). This has been particularly effective when dealing with short term anomalies or bespoke care packages.

5. **Involvement in the development of a National Safer Staffing tool for inpatient Mental Health areas**

Action: Continued representation within The National Performance Advisory Group for Safer Temporary Staffing which ensures we are kept abreast and involved in national developments

around Safer Staffing. We have recently begun to collaborate with Northern NHS Trusts to get a consensus on reporting and managing safer staffing.

6. Continue to develop, manage and deploy the peripatetic workforce

Action: As well as establishing the peripatetic workforce within all the BDUs, the number of staff recruited onto this workforce has increased substantially. This allows a rapid and flexible response to any particular needs as stated in point 4 above. This has also allowed inpatient teams to draw on peripatetic staff to fill team vacancies reducing recruitment times, vacancy drag and orientation time as the member of staff invariably brings organisational experience with them

7. Support recruitment of Allied Health Professional's (AHP's) and assist in the development of links with Universities

Action: A procurement process was initiated which led to the appointment of a Master Vendor and subsequent contract for AHP's within the Trust. This should lead to an improvement in filling short and longer term vacancies in addition to providing a saving on the current agency spend within this area.

8. 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

Action: the roles of Safer Staffing Project lead and Bank Manager have been combined to ensure a consistent and coordinated approach to staffing. A localised recruitment drive utilising local newspapers, in addition to the usual advertising channels, has successfully taken place. This allowed for the recruitment of a diverse range of staff. There have been 167 entrants onto our staff bank since April 1st this year. This covers a variety of disciplines and there are ongoing recruitment drives for Registered and Non-registered staff.

9. Establish Safer Staffing Specialist Advisor post on a permanent basis

Action: A job description and person spec have been completed and the advert should be published imminently. The role has been developed to have a strategic overview of staffing within the Trust including the staff bank, band 5 assessment centres and managing the central peripatetic workforce.

10. Support over-recruitment of peripatetic staff within BDUs

Action: Recruitment and management of this core of staff has been ongoing. Each BDU has identified their particular needs and active recruitment is taking place. This will allow for a more responsive approach to increases in acuity within BDU's as well as having a flexible workforce to support vacancies arising through sickness, maternity or secondments.

11. Respond to Ruth May NHS Improvement guidance for safer staffing once confirmed

Action: As this guidance has been released, meetings and communication have taken place between the specialist areas identified and Safer Staffing Project Manager. This has resulted in the Trust being able to anticipate any impact this advice would have and respond accordingly. This will continue with the release of any new guidance

12. Align Safer Staffing initiatives with new Trust Workforce Strategy

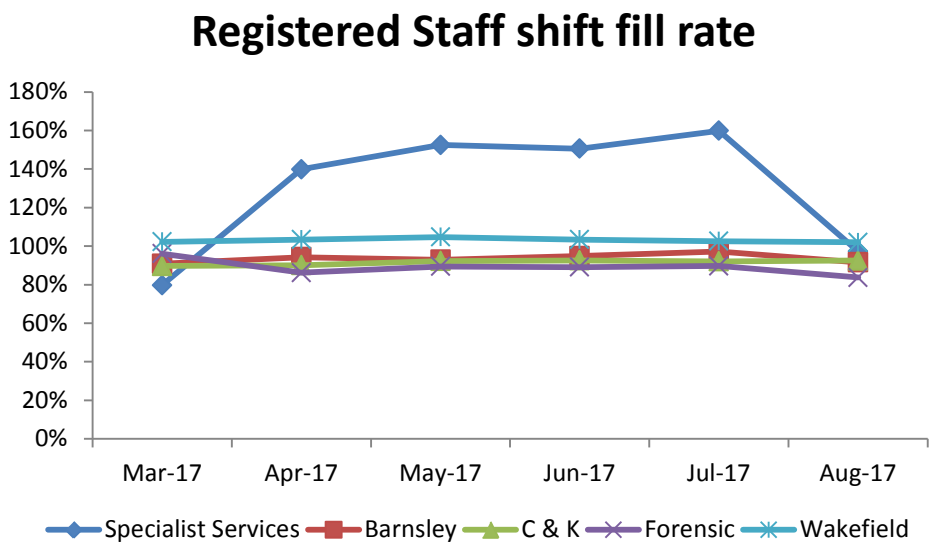
Action: Close co-ordination with the workforce planning team has allowed the Trust to develop a strategy around the numbers of peripatetic staff needed in the Non-Registered workforce to support

clinical acuity, which has resulted in a zero vacancy factor within inpatient areas. The projected number of bank staff needed to meet the demands of the inpatient areas is being assessed at present.

3.0 ANALYSIS OF FILL RATES March 2017 – August 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 per BDU**



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

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

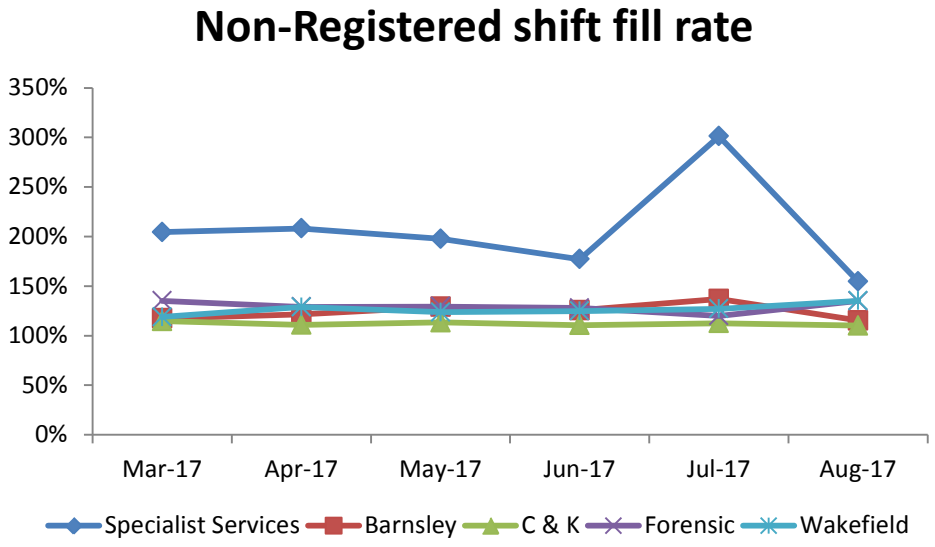
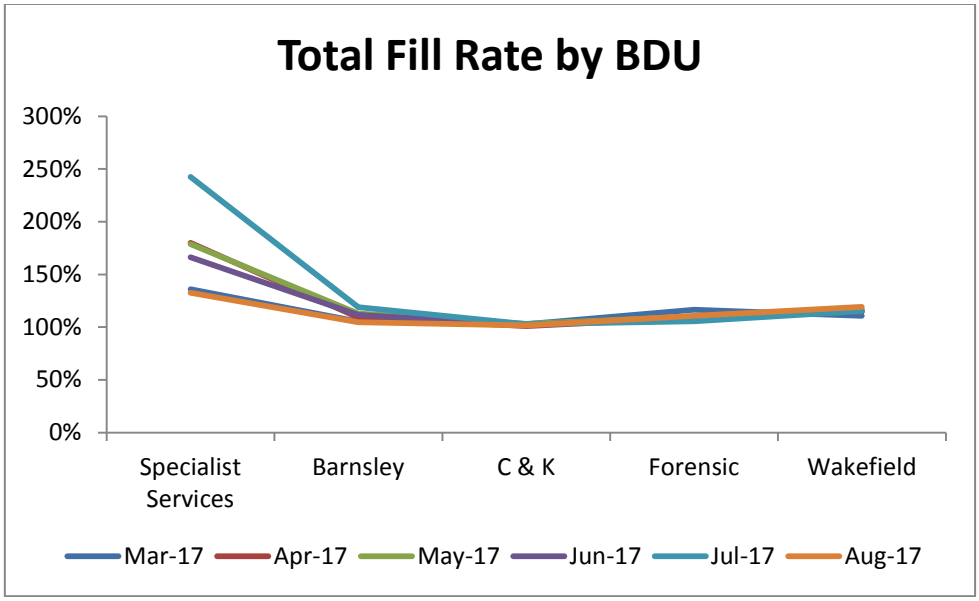


Figure 3. **Overall Nurse Fill Rate Inpatient Areas per BDU**



Summary of fill rates

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 July and August showing a slight decrease form 113% in July to 109% in August. This is to be expected due to increased annual leave, sickness and a general reluctance to fulfil bank shifts over the school holiday period. This trend shows a consistency in overall fill rate for registered nurses particularly, which is as a result of our centralised recruitment process where we again recruited over 60 registered staff throughout the year, the majority being students who finished their courses in September. This process continues and 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 Chippendale not achieving the registered fill rate for days on a consistent basis. This has been 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 areas.

To be able to provide a balanced understanding of why some wards are not achieving fill rates, we are looking at introducing the ability for ward areas to cancel a shift as opposed to showing it as an unfilled shift. This would only be an exceptional intervention based on the clinical needs of the ward (e.g. when number of inpatients reduces) and ensuring that there is no negative impact on the Service Users within that area.

Additionally, most areas have experienced an increase in acuity and the need for closer 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 BDU's 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.

4.0 ANALYSIS OF DATIX INCIDENTS RELATED TO STAFFING

In the 12 months leading up to the 31st August 2017, there were 351 Datix incident reports highlighting staffing issues. Although this is a large decrease from the 559 incidents reported in 2016 and it continues to equate to less than one Datix incident per 31 shifts and none in the serious incidents category. This excludes all mid shifts. This decrease has been discussed at the safer staffing meetings and, as well as reclassifying some of the incident categories to facilitate appropriate responses, we are aware that there must be a continued engagement with staff to facilitate the understanding of the role the reporting plays in the strategic direction that is embarked upon.

5.0 PERIPATETIC STAFFING PROJECT

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 new non-registered staff being deployed throughout the Trust as well as three band 3 'at risk' staff who joined the peripatetic workforce. This has led to an increase in the inpatient staffing capacity.

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 are providing much needed capacity. There has also been a decision reached by the BDU's that there will be a total of 47 peripatetic staff recruited. They will be split between a centrally managed cohort of seven staff and the rest will be directly managed by the BDU's, which should facilitate a quicker response to internal requirements, as well as a reduction of agency spend on non-registered staff.

6.0 CQC INSPECTION AND REPORT ON SAFER STAFFING

The CQC published their re-inspection report in April 2017 following a comprehensive re-inspection of SWYPFT services between November 2016 and February 2017. 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 'appropriate' staffing fill rates. However, they accepted that this was above a 'minimum' staffing fill rate. They also highlighted that the trust has taken significant steps in dealing with what is a national shortage of registered staff.

'The trust demonstrated a commitment to achieve its longer-term plans in relation to the safer staffing fill rate across the trust, the reduction of agency spend, and workforce development, through the implementation of a number of measures that had been further embedded since the last inspection.'

Although we are aware of the current challenges and are exploring every avenue to improve the recruitment and retention of staff, particularly registered staff, the CQC acknowledges that there is minimal impact on the delivery of care within the inpatient areas.

'However, staff in the acute service continued to report there was insufficient staffing. Some patients on the acute wards and the forensic wards said that section 17 leave did not always take place or one to one meetings due to staffing levels, although there was good evidence, particularly in the forensic services that patients' section 17 leave and meaningful activities took place and was not affected adversely by insufficient staff on the wards'

Another area that was identified as an issue was agency staff having access to our RIO system. This is being actively addressed and there is plan in place which will allow agency staff to attend training provided by our trust. Initially this will be for registered agency staff with a decision to be reached regarding non-Registered staff. We are awaiting the training date and in the interim, agency staff are supported by our existing staff when accessing clinical information.

6.1 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 September 2016 the Trust has held monthly assessment center's to recruit Band 5 nurses. Eight assessment centers have been held in total with an overall attendance of 114 shortlisted candidates. Of the 103 candidates who have attended a total of:

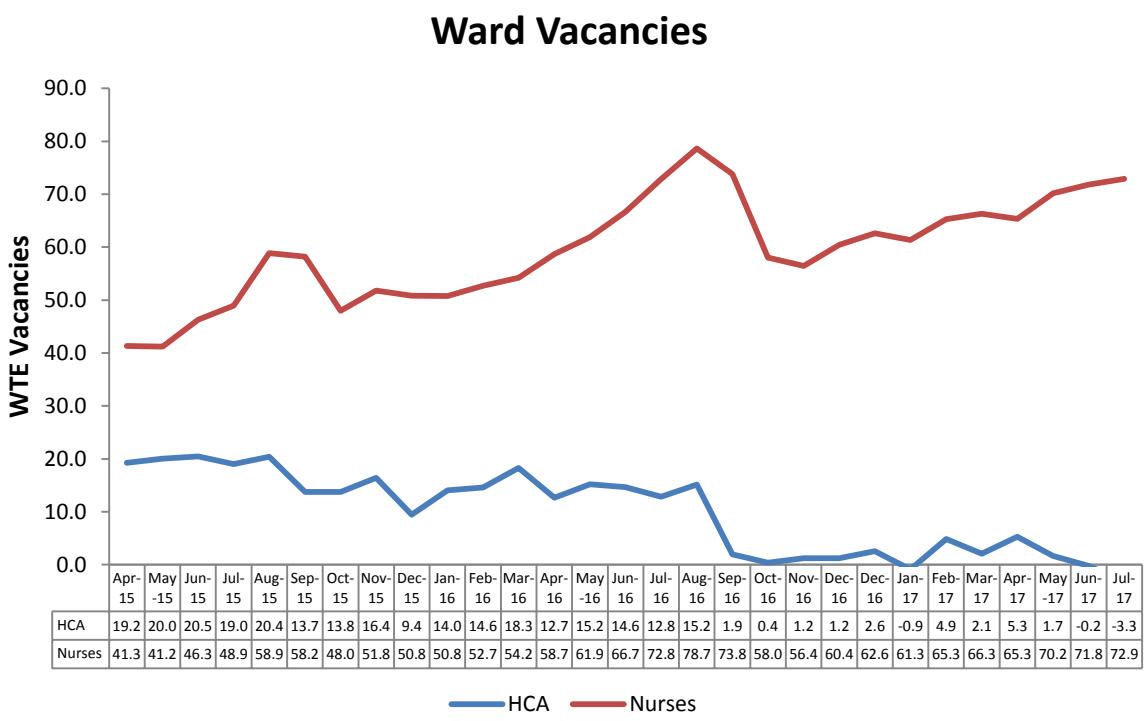
- 82 have been offered posts within inpatient services
- 9 have accepted and commenced employment within SWYPFT
- 52 have verbally accepted their offer but are yet to have completed the pre-employment checks and/or are yet to complete their nurse training and obtain registration. The majority will begin work this month
- 21 declined the offer of employment. Reasons ranged from 3 candidates accepting community posts within SWYPFT, 7 accepting posts nearer to home, 11 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.

We are also planning to recruit nurses from Poland via our agency master vendor. Subject to due diligence a proposal is currently being developed and report prepared for EMT.

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

Figure 4 **Inpatient vacancies**

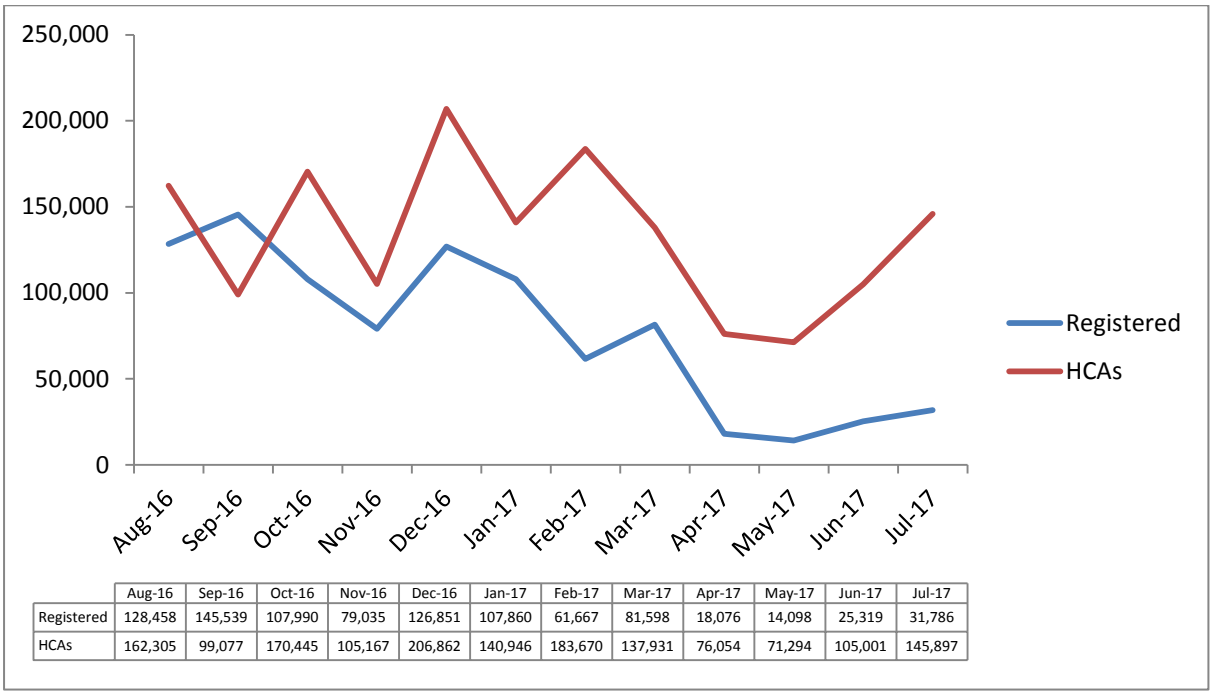


	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
HCA	19.2	20.0	20.5	19.0	20.4	13.7	13.8	16.4	9.4	14.0	14.6	18.3	12.7	15.2	14.6	12.8	15.2	1.9	0.4	1.2	1.2	2.6	-0.9	4.9	2.1	5.3	1.7	-0.2	-3.3
Nurses	41.3	41.2	46.3	48.9	58.9	58.2	48.0	51.8	50.8	50.8	52.7	54.2	58.7	61.9	66.7	72.8	78.7	73.8	58.0	56.4	60.4	62.6	61.3	65.3	66.3	65.3	70.2	71.8	72.9

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 (e.g. 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 June to August 2016 and again in 2017. This coincides with the timing of students qualifying and taking up post. Figures 5 shows the positive impact that the recruitment drives, new agency vendor, the centralisation and expansion of the bank office and peripatetic workforce has had on the trust agency spend..

Figure 5 **Inpatient Registered and Non-registered Agency Spend**



	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Registered	128,458	145,539	107,990	79,035	126,851	107,860	61,667	81,598	18,076	14,098	25,319	31,786
HCAs	162,305	99,077	170,445	105,167	206,862	140,946	183,670	137,931	76,054	71,294	105,001	145,897

6.2 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 between the 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 is essential that this is led by the community teams and supported by the Deputy Director of Health Intelligence and the Safer Staffing Project Manager. Within this schedule of work, an evaluation of the possible impact that the proposed Queens Nursing Institute tool on integrated community health and social teams, will take place.

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, the 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 further financial savings whilst providing higher quality staffing and safer care for service users.

In August 2017 NHS Improvement (NHSi) asked all trusts to complete an audit of care hours per patient day, to be completed in October 2017. Current plans will provide the platform from which to explore this and 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;
    a. Utilise the new dashboards for Datix incidents and reporting
    b. Triangulation of DATIX, exception reporting and HR information
    c. Extend the narrative and analysis of the information
    d. Weekly roster analysis including unfilled shifts, acuity and bed occupancy
    e. Understanding any significant increase in staffing fill rates
- 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
- The 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
- Continue recruitment onto staff bank
- Establish Safer Staffing Specialist Advisor post on a permanent basis
- Support over-recruitment of peripatetic staff within BDUs
- Align Safer Staffing initiatives with new Trust Workforce Strategy
- Develop the Medic Bank capability
- Ensure bank policy is updated
- Ensure effective use of the awarded agency master vendor contract for both Nursing and AHP
- Expanding the bank to support other areas including admin
- Complete NHSi Care Hours Per Patient Day (CHPPD) audit by end of October 2017
- Review ward establishments after the NHSi analysis of staffing figures which is currently being collated
- Submit proposal to recruit international nurses to EMT
- Review QNI community nursing tool

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 3 October 2017
Agenda item 7.1

Title:	**Information Management and Technology (IM&T) Strategy update**
Paper prepared by:	Director of Finance
Purpose:	To provide the Trust Board with a review of the progress made on the 2017/18 IM&T strategy milestones.
Mission/values:	"Digital by Default" is one of the 6 priorities supporting delivery of our strategic objectives in pursuit of our mission. Our IM&T Strategy supports our values of being open, honest & transparent; and to be always improving
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. IM&T strategy update presented to Trust Board in March 2017
Executive summary:	The purpose of this report is to inform the Board of the progress and developments made during the last 6 months in respect of the 2017/18 IM&T Strategy milestones following on from the update paper provided in March 2017 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 aligned with our strategic objectives and aim 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 Appendix A of this report are the activities that have been and are currently being implemented and progressed in support of the agreed 2017/18 IM&T Strategy key domain milestones. These include: ➢ Business Case for Microsoft Licensing Agreement produced, approved and in place – June 2017 ➢ Business Case for Strategic Data Centre Modernisation produced and approved ➢ Tender for the procurement of a Mental Health clinical record system completed with a preferred provider selected ➢ Procurement and implementation of a medicines management system ➢ Smartphone Deployment/BlackBerry replacement programme completed – August 2017 ➢ End User Computing Replacement Programme Proposal developed in draft – September 2017 ➢ Procurement of support for the Business Intelligence programme, approved and in place – September 2017 ➢ The Health Records Scanning Bureau went live Mid-April 2017 and has scanned over 5,100 records totalling nearly 714,000 pages In addition to the above the focus on cyber-attacks has increased within the NHS and whilst the Trust was not adversely affected by the Ransomware outbreak in May this year additional controls have been put in place in respect of cyber security The strategy will be reviewed during quarter three 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 £1.5m in both 2017/18 and 2018/19. **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. This may necessitate further prioritisation of IM&T projects depending on resource availability. Another notable risk is the increasing risk of cyber-attacks on systems used by our staff.
Recommendation:	**Trust Board is asked to NOTE the achievements made in respect of the 2017/18 milestones** 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.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

IM&T Strategy

Progress Report

Head of IT Services & Systems Development

September 2017

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

Purpose of Report

The purpose of this report is to inform the Board of the progress and developments made during the last 6 months in respect of the Information Management and Technology (IM&T) Strategy, with particular focus on those milestones scheduled for completion during 2017/18.

Summary of Strategy and Progress

The current 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 re-designing services.
- Share information that supports the delivery of care, improves data quality 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
- Training & Development

Detailed within appendix A is a more detailed summary of the activities and progress to date over the last six months in respect of the 2017/18 milestones for each domain of the strategy and follows on from the last IM&T Strategy update provided in March 2017.

The provision of an effective IM&T 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 in delivering Trust objectives. Below is a summary of the main achievements/work completed during April to September 2017.

- Business Case for Microsoft Licensing Agreement produced, approved and in place – June 2017
- Business Case for Strategic Data Centre Modernisation produced and approved
- Tender for the procurement of a Mental Health clinical record system completed with a preferred provider selected
- Procurement and implementation of a medicines management system
- Smartphone Deployment/BlackBerry replacement programme completed – August 2017
- End User Computing Replacement Programme Proposal developed in draft – September 2017
- Procurement of support for the Business Intelligence programme, approved and in place – September 2017
- The Health Records Scanning Bureau went live Mid-April 2017 and has scanned over 5,100 records totalling nearly 714,000 pages

In addition to the above the focus on cyber-attacks has increased within the NHS and whilst the Trust was not adversely affected by the Ransomware outbreak in May this year additional controls have been put in place in respect of cyber security.

When the IM&T strategy was originally developed consideration was given to how it would link to the Trust's business plan. Given that we are now approaching mid-point of the implementation of the strategy, it is worth noting that there have been a number of changes in the operating environment. Following the completion of a number of initiatives combined with these changes in environment the IM&T strategy is being re-appraised during the third quarter. Any proposed changes will first be taken through the Executive Management Team (EMT) and then the Trust Board.

Financial Investment

In order to meet the priorities outlined in this report capital investment of circa £1.5m has been made available during 2017/18 and a similar sum has been provisionally allocated for 2018/19. The following table provides indicative details of the capital expenditure requirements over the next two years.

Scheme	17/18 (£k)	18/19 (£k)
Mental Health Clinical Records System	500	850
Pharmacy System	75	0
Data Centre/Disaster Recovery	400	400
Infrastructure/WAN	250	250
Server Hardware Refresh		200
Integration & Portals	100	60
Digital dictation		225
Inter-operability	100	100
Other	96	
Total	**1,521**	**1,485**
Committed to date	**921**	

Spend on the Mental Health Clinical Record System and a number of 2018/19 schemes has yet to be built up in detail. As such these numbers are subject to change, but will be managed within total resources available.

Risks and Hotspots

As previously identified 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 remains currently higher than the target (a score of 4-6 as was the position in the update provided in March 2017). The priorities set out in 2017/18 and summarised above will continue to reduce the likelihood of risk of system failure. This includes the work activities focused on: -

- The Infrastructure Modernisation Programme including data centre enhancement to improve resilience
- The establishment of a Trust agreement for Microsoft products that provides a path from which to replace end of support approaching software versions, thus reducing risks associated with cyber threats

- Continuous review and improvements to Trust capability to safeguard against the growing potential threat of cyber-attacks

Ability to deliver on all of the 2017/18 priorities in line with the timescales identified is very much dependent on availability of suitable resource. There are two particular points to note.

1) Additional staffing is required within the programme team, IM&T and other areas of the Trust to facilitate and support the implementation of the Mental Health clinical records system, as well as balancing the other organisational priorities that rely upon IM&T services. Securing appropriately skilled resources is extremely challenging and it is a very competitive market across the region. The continued restriction on use of personal service companies and agency staff further serves to heighten this issue.

2) 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. Whilst some in-roads to recruitment have been made, it remains a challenge in securing and retaining the necessary specialised skills. A range of recruitment approaches are being taken to minimise this risk.

The learning from the RiO v7 upgrade along with the associated recommendations has been provided for consideration to feed into the implementation plans and activities for the new Mental Health clinical records system, so as to ensure as seamless an experience for clinical services as possible. The issues arising from the RiO v7 upgrade have been addressed through system software fixes, changes to ways of working where appropriate and increased staff training where it was felt necessary.

Summary

The information included in Appendix A clearly articulates the breadth and scale of the IM&T work programme that is underway. Updates for the remaining unfinished schemes undertaken in 2016/17 have been provided for the purpose of closure.

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 6 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 for 2016/17 have been completed, the IM&T services are in a much better position, which hopefully this update evidences in respect of progress against the 2017/18 priorities.

During the first half of 2017/18 the Trust has concluded the procurement activities of a Mental Health Clinical Information System, with the outcome being a planned move to SystmOne.

Mobilisation activities led by the Change & Innovation team have commenced to oversee and manage the planning and implementation for this major programme of work. It is recognised and understood that to achieve a positive outcome will require the release of specialist IM&T staff to support the implementation. This in turn may impact on the ability of the IM&T service and resources to deliver on all other IM&T priorities within current planned timescales. However, this will be subject to close scrutiny and management.

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, it is planned that 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 recent milestones and progress to date in working towards the 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.

Key:

🔵	***Completed***	🟢	***On Track***
🟡	***Off Track but in Control***	🔴	***Off Track requires attention***
⭕	***Future Planning***		

Appendix A

*Post March 2017 position update for **2016/17** milestone closure purposes and completed milestones for **2017/18** to date:*

Completed Milestones for 2016/17				
Domain	***Work Programme***	***Description***	***Milestone***	***Date Achieved***
Infrastructure	**Service User Internet Access (Patient WiFi) Forensic Unit Pilot**	➢ Service User Internet Access has been implemented within the Forensic unit which was completed by 1 April 2017 as planned. **Outcomes Achieved:** • Improves the overall patient experience by providing internet access to our service users. • Further supports the drive towards paperless NHS by 2020 and supporting the Local Digital Roadmap (LDR) plans as well as aspirations of STPs,	***Q4 2016/17***	***Q4 2016/17***
Infrastructure	**User Engagement**	➢ IM&T operational drop-in clinics held across BDU sites completed during 2016/17. Continuing into 2017/18. **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.	***Q4 2016/17***	***Q4 2016/17***
Infrastructure	**Smartphone Deployment**	**Purpose:** To replace the entire legacy BlackBerry estate with a more modern Trust standard Smartphone that further supports the Digitisation agenda. **Key Activities:** ➢ The rollout of the new smartphones to replace the 600+ legacy BlackBerry devices commenced during the latter half of Q4 2016/17 and has now been completed following extensive communications, engagement and a series of clinic sessions held across the Trust. **Outcomes Achieved:** • Allows staff to utilise apps approved for use by the Trust in support of the Digitisation agenda.	***Commenced Q4 2016/17***	**Aug 2017**

Information Sharing	**Records Scanning**	➢ The Trust's Records Scanning Bureau is now live. Since Mid-April 2017 to date, over 5,100 records have been scanned, totalling nearly 714,000 pages and made available in a searchable web front end. **Outcomes Achieved:** • Reduced reliance on off-site storage (avoidance of increased costs) • Improved governance through having easy, electronic access to all records related to a Trust client, supporting the digitisation and paperless NHS agendas	***Q4 2016/17***	***Q1 2017/18***
Digitisation	**Agile Working**	➢ The work has been completed with all services identified by BDUs in the original business case as requiring support and technology to adopt agile working. The project team is finalising project closure/lessons learned activities and the transition from a project state to business as usual operations. **Outcomes Achieved:** • 80 clinical services across Trust supported to adopt agile working • Circa 2,500 laptops in use by agile workers • 605 of these users have 4G Mobile Broadband enabling them to access real time information when working within community, including in people's homes • 1,895 Agile Workers with VPN allowing them to work from their own home, and other non-Trust WiFi connections: • 1,914 Skype for Business users able to use both Audio and Video conferencing facilities via their laptop/desktop computer regardless of location (provided they've got a network connection) • Skype for Business Video Conferencing facilities available in Folly Hall, Laura Mitchell and Priestly Unit. • Skype for Business Audio calling facilities available in Drury Lane, Baghill House and Fieldhead	***Q4 2016/17***	***Q4 2016/17***
Completed Milestones for 2017/18				
Infrastructure	**Microsoft Licensing Review**	**Purpose:** To conduct a review of the Trust's current and future Microsoft Licensing requirements and explore the most appropriate and cost effective way forward for continued provision and access to Microsoft products used by the Trust ahead of the National NHS agreement expiring. **Key Activities:** ➢ The Trust IT Service commissioned a review of existing Microsoft licensing arrangements from Microsoft Licensing Specialists (TrustMarque) to identify the future software licensing options available to the Trust.	***Q1 2017/18***	***Q1 2017/18***

		➢ During this undertaking, it came to light that there was a time limited opportunity for the Trust to secure the discounted rates from Microsoft ahead of a price increase planned from 1 July 2017. This position accelerated the need for urgent consideration for future cost avoidance (circa 30% increase in Microsoft licensing prices from 1 July 2017. Therefore the development of the business case was expedited and approved in June 2017. ➢ Enter into a 3 year subscription agreement with Microsoft in June 2017, which will be reviewed on an annual basis to ensure that the Trust is appropriately licensed. **Outcomes:** • Ensures compliance with Microsoft products already in use plus access updated versions • Provides a migration path from which to move away from software versions approaching end of life support, thus reducing associated risks (cyber security threats etc.) • Ability to secure pricing for next 3 years allowing Trust to increase or decrease quantities at annual anniversaries without impacting unit cost	***Q1 2017/18*** ***Q1 2017/18***	***Q1 2017/18*** ***Q1 2017/18***
Clinical & Corporate Systems	**Pharmacy System (Medicines Management)** **(Pharmacy Led)**	➢ Procurement of a medicines management system (JAC) has been completed and the new system was implemented successfully as planned in June 2017 when the provision and access to the Mid-Yorks NHS Trust hosted JAC system ended. **Outcomes Achieved:** • Continuity of service and provision of Pharmacy services within the Trust • Improved management visibility and information.	***Q1 2017/18***	***Q1 2017/18***

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 **2017/18** milestones for the Infrastructure domain are:*

Work Programme	*Status*	*Description*	*Milestones*	*Date Achieved*
User Engagement		**Purpose:** IM&T drop-in clinics were established during 2016/17 as a follow on response to a survey issued to staff to provide feedback on IM&T services and how services would like IM&T to engage and communicate. **Expected Outcomes:** • 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 throughout 2017/18***	
Infrastructure Modernisation Programme **Phase 3: Data Centre Improvements**	  	**Purpose:** This is a 3 year programme of work spanning 2017-20 that focuses on the review and modernisation of the Trust's two existing data centres located at Fieldhead and Kendray. The purpose is to provide a strategic, robust and secure IT environment, removing single points of failure, which therefore provides the Trust with the necessary assurances, business resilience and disaster recovery capabilities to support the digital future. **Key Activities:** ➢ A business case was produced detailing the requirement for additional investment in the Trust's Core Data Centre environments so as to ensure the Trust's IT infrastructure remains fit for purpose. This business case was approved in July 2017. ➢ The IT capital plan for 2017/18 has been refined to account for the programme of works that have been prioritised, and technical plans established for required activities throughout the remainder of 2017/18. ➢ Orders have been placed and implementation activities have commenced. **Expected Outcomes:** • Improved resilience by removing single points of failure and introducing development potential, thus providing the Trust with the ability to easily switch from	**Q4 2016/17** **Aug 2017** **Q2-Q4 2017/18**	**July 2017** **Aug 2017**

		one data centre to another in the event of a disaster (e.g. from Fieldhead to Kendray) • No requirement for short term investment in event of a disaster • Improved resilience of core IT infrastructure • Improved end user experience • Introduction of enhanced software monitoring, which would in turn enable better management of Microsoft licensing (potentially reducing costs) • Proven Disaster Recovery position with confirmed recovery points and associated timelines • Enhanced Cyber Security position would bring about improved resilience and greatly reduce the risk from cyber-attack, malicious or otherwise.		
Microsoft Licensing Agreement Usage Review	  	**Purpose:** Following the establishment of a licensing agreement with Microsoft, the aim of this work is to conduct a review of the Trust's requirements for Microsoft products based on usage with a view to reducing/rationalising existing Trust license volumes where possible. **Key Activities:** ➢ Initiate and implement a programme of work that looks to review and rationalise the number of secondary/redundant devices and associated licenses in use across the Trust has commenced. ➢ Work with Communications colleagues to inform and advise staff during this process and throughout the term of this agreement the Trust IT Service will review license usage across the organisation and establish a process mechanism for services to fund any additional licensing requirements. ➢ Incorporate an annual review within the IM&T work programme throughout the term of the agreement. **Expected Outcomes:** • Ensures compliance with Microsoft products already in use plus access updated versions • Provides a migration path from which to move away from software versions approaching end of life support, thus reducing associated risks (cyber security threats etc.) • Ability to secure pricing for next 3 years allowing Trust to increase or decrease quantities at annual anniversaries without impacting unit cost • Supports the Strategic Data Centre Modernisation programme which will add resilience, improve performance for end users, and build in contingency in event of network failure	***From Q2 2017/18*** ***From Q2 2017/18*** ***From Q2 2017/18***	

		• Provides an opportunity for the Trust to rationalise number of devices to reduce licensing costs in years 2 and 3		
Public Sector Wi-Fi Access (Govroam)	●	**Purpose:** Govroam has evolved from eduroam, an established Wi-Fi service used by the further and higher education and the research sector which runs on the UK's national research and education network, JANET. The govroam service solution is now being actively implemented by public sector organisations. **Key Activities:** ➢ Implementation of Govroam is in planning/early implementation stages. This solution will provide connectivity for staff when working out of non-Trust sites e.g. local authority/NHS sites where Wi-Fi is not currently available to SWYPFT staff. Mid Yorkshire is the only NHS organisation yet to enable WiFi connectivity with SWYPFT. **Expected Outcomes:** • Improved ability for agile and remote working for Health and Social care staff by provision of access to Trust systems when/where required and in partner organisation sites which supports the Local Digital Roadmap (LDR) plans and aspirations of STPs, further demonstrating our commitment to joint working and in meeting commissioner intentions.	***Q3 2017/18***	
Trust Wide Service User Internet Access (Patient WiFi)	● ● O	**Purpose:** This builds on the initial pilot deployment completed within the Forensic unit at the end of 2016/17. The scope of this work is planned to be for all inpatient areas where service users are detained under the Mental Health Act. **Activities:** • A review of the deployment within the Forensic unit is underway and a business case is being developed to support the Trust wide deployment of service user access to the Internet incorporating feedback from service user experiences within the Forensic unit. • Detailed plans, priorities and activities to be established subject to Trust approval of the business case for • Implementation/wider deployment to commence during 2018/19. **Expected Outcomes:** • Improves the overall patient experience by providing internet access to our service users. • Further supports the drive towards paperless NHS by 2020 and supporting the Local Digital Roadmap (LDR) plans as well as aspirations of STPs	***Q3 2017/18*** ***Q3 2017/18*** ***Q1 2018/19***	

N3 Replacement (Wide Area Network)		**Purpose:** This initiative focuses on the replacement of the existing N3 (NHS-wide National network) with the new Health & Social Care Network (HSCN). The N3 network connections are centrally funded and the introduction of the new HSCN network connections will see central funding allocations being passed down to fund annual support costs locally. **Key Activities:**		
	●	➢ The Trust is currently reviewing future requirements in preparation for the replacement of the N3 connections with the new Health and Social Care Network (HSCN) and is contributing to the tendering activities to procure HSCN network provision on behalf of public sector organisations via the (Yorkshire & Humber Public Sector Network YH PSN).	***Q3 2017/18***	
	●	➢ The Trust is awaiting further details from NHS Digital regarding the allocation of central funding to fund the annual support costs locally (£115k including VAT) for the existing N3 connections. This funding is expected to be received by 2017-18 Q3.	***Q3 2017/18***	
	●	➢ The replacement of N3 and implementation of HSCN circuits are anticipated to take approximately 2 years to complete commencing from the start of 2018/19. At this stage the installation costs have not been determined and as of yet NHS Digital has not confirmed funding arrangements (this could be a potential cost pressure).	***Throughout 2018/19 & 2019/20***	
		Expected Outcomes: • Continuity of Wide Area Network (WAN) connections that essentially provide inter-connectivity between Trust sites and the wider NHS/Social Care infrastructure. • Improved resilience of core IT infrastructure.		
Cyber Security & Threat Monitoring		**Purpose:** The potential threat of cyber-attack is on the increase as witnessed by the events on 12 May 2017 where a number of public sector/NHS and private sector organisation's business operations were impacted. Although on this occasion SWYPFT were not impacted by this cyber outbreak, the Trust continues to take such threats extremely seriously and has established a number of steps to safeguard against such threats. However, it must be noted that it is impossible to provide 100% guarantees against such instances impacting the Trust in future. The controls and measures in place are summarised below: - **Key Activities:**		
	●	➢ Cyber threat monitoring has been incorporated into the monthly review meetings	***From July***	

		with Daisy IT Services. The Trust is routinely reviewing the actions taken or required to be taken to mitigate and establish safeguards against the threat of cyber-attacks.	***2017***	
		➢ The Trust IT Service is also actively engaged in cyber awareness and collaboration opportunities with Daisy IT Services along with our partners across the wider STP footprints.	***Ongoing***	
		➢ The Trust IT Service, together with Daisy, is also reviewing current infrastructure, solutions, tools and processes in line with Cyber Essentials which was developed by UK Government and industry in 2014 and which builds upon 10 Steps To Cyber Security (GCHQ 2012).	***Q3 2017/18***	
		➢ Staff vigilance remains an integral defence, Regular communications are issued to staff and staff are advised to raise any questions or concerns with the IT Service Desk in the first instance at the earliest opportunity.	***Ongoing***	
		➢ Cyber security survey to Trust staff to gauge awareness and understanding planned for distribution is September 2017.	***Sept 2017***	
		➢ A Quarterly Highlight Report is being produced summarising NHS Digital CareCert notifications issued during the last three months and the measures, controls and remedial actions being taken to safeguard the Trust against potential cyber threats.	***From Oct 2017***	
		Expected Outcomes: • Continued vigilance and awareness of the threat of cyber-attack • Pro-active monitoring of hardware/software solutions to counter the potential of cyber threats and adoption of industry standard best practices, as appropriate.		
Email Mailbox Limits		**Purpose:** This initiative is something that the Trust needs to introduce from a mailbox management perspective and ensure overall performance of email accounts for users is within acceptable levels. Basically, the greater the mailbox size, the more issues staff have with individual email account performance. This work is a pre-cursor to the future review of the Trust Email platform that is planned for Q4 2017/18. The introduction of a 5 GB limit is a starting point and it is recommended that this be reduced further in the future.		
		Activities: ➢ Communications have been issued to staff and following this the Trust IT Service will undertake a review to work towards the email mailbox limits being set to a maximum of 5 GB later this year.	***From Q2 2017/18***	

	●	➢ Clinics and focus sessions will be provided to enable staff to make the best use of available resources and to promote best practice recommendations.	***From Q3 2017/18***	
	●	➢ Further general and targeted communications are to be published, including offering of training, prior to mailbox limits being introduced which are to be subject to a soft implementation approach (i.e. no block on send/receive at this point). **Expected Outcomes:** • Introduces good practice and readiness for the future. • Helps to ensure that end user experience and email performance levels are maintained within acceptable levels	***From Q3 2017/18***	
End User Computing Replacement Programme		**Purpose:** The Trust IT Service is developing a proposal to introduce an End User Computing (desktop/laptop) replacement programme, potentially from 2018-19. This proposal also incorporates the plan to initiate the migration from the existing Windows 7 operating system to Windows 10, with the deployment set to commence during 2018/19. This replacement programme sets out to replace a proportion of the End User Computing estate on an annual basis. **Activities:**		
	●	➢ Consideration and approval of the End User Computing Replacement Programme proposal	***Sept 2017***	
	○	➢ Detailed plans and activities to be established subject to Trust approval of the proposal to initiate the migration from Windows 7 to Windows 10 and introduce an End User Computing Replacement Programme from 2018/19. **Expected Outcomes:** • Enables the Trust to provision new and replacement end user computing devices in a strategic and planned manner making better use of available resources • Improved equity and balance through coordinated use of resources • Centralised control of all end user computing assets and therefore maximises utilisation across the Trust • Improves overall end user experience • Provides greater assurance and controls from which to minimise risk of cyber threats through continuous availability to software security updates.	***2018/19***	
Trust Email Platform Review		**Purpose:** To conduct a review of future options for the Trust's corporate email platform (NHS Mail v Microsoft Exchange/Outlook) **Activities:**		
		➢ Conduct a review and options appraisal to support the development of a business	***Q4 2017/18***	

	o o	case that determines a strategic way forward for the Trust with regards to the corporate email platform ➢ Detailed plans and activities to be established following Trust approval of the proposed recommendations detailed within the business case. **Expected Outcomes:** • Ensures the Trust has a stable and resilient corporate email platform which is cost effective and makes best use of available resources.	***Q1 2018/19***	

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

Work Programme	*Status*	*Description*	*Milestones*	*Date Achieved*
Clinical Portal Development		**Purpose:** 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. **Activities:**		
	🟡	➢ The SWYPFT Clinical Portal (now named PORTIA) is currently in use by a number of early adopter services. Over half the early adopter target of 500 patient records have been viewed, but the majority are from a small number of services, so coverage is not sufficiently representative. Initial feedback received from staff within early adopter services is that training requirements are relatively low, however this needs formal consideration and agreement. Efforts are ongoing to engage with additional early adopter services to ensure representation is as wide as possible.	***Q4 2016/17 Now Q2/Q3 2017/18***	***Partially Achieved***
	🟢	➢ Further interface development and testing of additional data sources to feed into the holistic clinical portal care record are progressing (specifically for TeleHealth and community equipment systems)	***Q3 2017/18***	
	🟡	➢ Wider deployment of the SWYPFT Clinical Portal across the organisation – BDU service priority areas to be determined to aid the deployment planning. **Expected Outcomes:** • Provision of a single integrated holistic patient record view • Sourcing data from Trust internal systems reducing the need to access multiple systems & moving forward from partner systems • Supports informed clinical decision making and patient care delivery.	***Now Q3/Q4 2017/18***	
eCorrespondence		**Purpose:** This development enables the Trust to reduce the reliance and flow of paper both internally and with our partners in respect of delivering patient care. This also supports the digitisation agenda and the drive towards a paperlight/paperless NHS by		

		2020. **Activities:** ➢ eDischarge: Electronic Discharge Summaries (eDischarge) has been subject to delays due to technical constraints/business dependencies such as the ability for electronic receipt/acceptance of messages by non-Trust pharmacies. From a technical perspective, required software updates to the RiO system and further changes to the eDischarge message format to allow electronic documents to be sent and received successfully by GP practices have been completed. Testing activities are progressing to confirm successful send/receipt of eDischarge summaries with GP practices. Once completed, this work provides the blueprint from which to enable other documents to be sent/received electronically. **Expected Outcomes:** • Supports the drive towards digitisation of the NHS and the paperless NHS by 2020, further supporting the Local Digital Roadmap (LDR) plans and aspirations of STPs, further demonstrating our commitment in meeting commissioner intentions. • Potential to improve ongoing client care through the provision of discharge information to GPs in a much improved timeframe • 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	***Q4 2016/17 Now Q3 2017/18***	
Clinical Systems for Community Services (SystmOne)		**Purpose:** Development of SystmOne to support Community Services development priorities, service re-design and new models of care agendas. **Activities:** ➢ Diabetes SPA (Completed) ➢ Integrated Intermediate Care Service ▪ "Lift & Shift": To support the 'Lift & Shift' from Mount Vernon Hospital to BHNFT ▪ New Model of Care: With partners work collectively to facilitate and co-ordinate the IM&T activities to support the development of the new model of care. ➢ Mental Health Navigators ▪ Mental Health Primary Care Navigator team to be setup on SystmOne in Wakefield Integrated Respiratory "Breathe" Service (BHNFT Led) ➢ New Model of Care: In support of the Integrated Respiratory Services being established from September 2017. Working with BHNFT and Barnsley Healthcare	***Q1 2017/18*** ***Q2 2017/18*** ***Q3 2017/18*** ***Q4 2017/18*** ***Q3 2017/18***	***Q1 2017/18***

		Federation in developing the IM&T requirements to meet the needs of the service. There is an expectation and reliance on the use of SystmOne which presently places a dependency on the SWYPFT systems team to support which is outside of the current programme of work for 2017/18. **Expected Outcomes:** • To ensure continuity of care with key clinical documentation re-designed to meet service needs and provide easier access to clinical information. • To support the development of new integrated models of care.	***TBD***	
Clinical Systems for Mental Health Services (RiO Version 7)		**Purpose:** Development of RiO to support Mental Health Services development priorities, service re-design and new models of care agendas. **Activities:** ➢ RiO v7 Lessons Learnt Report: The joint lessons learnt report produced in collaboration with Servelec Healthcare has been agreed and this report was approved by the Systems Development Board in July 2017. ➢ Remaining RiO v7 Issues: System fixes have been applied to address outstanding issues following the RiO 7 upgrade. These appear to have been successful. ➢ The RiO development plan which sets out the work programme and priorities for the remainder of 2017/18 was agreed by the Systems Development Board at the August meeting. . **Expected Outcomes:** • To ensure continuity of care with key clinical documentation re-designed to meet service needs and provide easier access to clinical information. • To support the development of new integrated models of care.	***Q4 2016/17*** ***Q2 2017/18*** ***Q4 2017/18***	***July 2017***
Mental Health Information System Implementation (SystmOne)		**Purpose:** Preparation and mobilisation of the programme of work to oversee and support the planning and implementation of the new Mental Health Information System (SystmOne). This is a major change initiative which is being led by the Change & Innovation team with support from IM&T as appropriate. **Activities:** ➢ The Trust has extended the contract with the RiO system supplier for initially 12 months covering 2017/18 with the option to extend the contract period for up to a further 12 months through to 31 March 2019. ➢ The procurement activities have now been concluded with the contract awarded to TPP for the provision of SystmOne as the new Mental Health Clinical Record	***Q1 2017/18*** ***Q2 2017/18***	***June 2017*** ***July 2017***

		System. ➢ A programme manager (Ed Reid) has been seconded from NHS Digital to oversee this major system's deployment ➢ Additional resources to aid the implementation activities are currently being recruited including internal secondment/staff development opportunities. ➢ Formal contractual discussions are underway ➢ A series of demonstrations to provide staff with the opportunity to gain further insight into the new system (SystmOne) are being arranged in September.	***Q2 2017/18*** ***Q2 2017/18*** ***Q2 2017/18*** ***Q2 2017/18***	***July 2017***
Legacy Systems Data Repatriation		**Purpose:** Data repatriation of iPM and SAP system data previously held by NHS Digital/National Programme. This forms part of the decommissioning activities of the former Connecting for Health programme and data from systems that were deployed previously by NHS Barnsley and where SWYPFT are now the incumbent data controller organisation.	***Q3 2017/18***	
eReferrals (Mental Health Services)		**Purpose:** Implementation of the e-referral solution that offers integration with the Trust's Clinical Information systems which enables the capability to receive referrals electronically via the eReferral Service (formerly known as Choose & Book). **Activities:** ➢ Consider the potential deployment of the solution and identification of pilot services for early adopter implementation of the solution (BDU/Business to determine) **Expected Outcomes:** • Supports the drive towards digitisation of the NHS and the paperless NHS by 2020, further supporting the Local Digital Roadmap (LDR) plans and aspirations of STPs, further demonstrating our commitment in meeting commissioner intentions. • Potential to improve service user care through more timely receipt of referral to services via electronic capabilities • Electronic interfacing capabilities that support care delivery and reduce operational overheads & inefficiencies in the health system thus allowing referrals to be considered and signposted into services more readily.	***Not Started***	
Patient Portal		**Purpose:** To support the development of a SWYPFT Patient Portal that enables service users to access their own electronic care records information. Activities:		

	O	➢ Preparatory activities and plans are being established to support the development of a Trust Patient Portal that will provide patients with access to their own electronic care record. It is intended that this work will commence during 2018/19 **Expected Outcomes:** • Provides patients with access their own medical records electronically. This is a national target for 2020 as part of the digitisation agenda.	***from Q4 2017/18***	

Business Intelligence & Performance Information – ***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 **2017/18** milestones for the Business Intelligence domain are:*

Work Programme	*Status*	*Description*	*Milestone*	*Date Achieved*
Business Intelligence / Data warehouse (information hub & dashboards)		**Purpose:** To support the development of a SWYPFT Business Intelligence/Data Warehouse that facilitates the provision of an information hub and dashboards to improve access to business performance information that informs service improvements and delivery. **Activities:** ➢ Business Intelligence (BI) Release 1: Intensive Home Based Treatment team are testing their Whiteboard and initial analytic reports (trend and summary data).	***Q1 2017/18***	
		➢ Business Intelligence Release 2 – Datix-based Release: Mapping of coding structures in Datix to those in the data warehouse and reports are underway. Initial mortality report for investigation of deaths combining registry of deaths, Datix, SystmOne and RiO data is ready for testing.	***Q2 2017/18***	
		➢ Business Intelligence Release 3 – Integration of SystmOne into the data warehouse: The tender process has been completed and Redwing chosen as the preferred supplier. There will be a 6 month release of data in support of Neighbourhood Nursing to test the warehouse and provide daily operational reporting. **Expected Outcomes:** • Continue to improve and make available the use of real time information to support operational services and transformation agendas.	***Q4 2017/18***	
Mental Health Information System Implementation – Reporting Requirements		**Purpose:** Planning and development activities in support of meeting the reporting requirements of the Trust as part of the implementation of the new Mental Health Clinical Information System (SystmOne). **Activities:** ➢ Consider the reporting requirement of the new system in line with the programme of work	***TBD***	

		Expected Outcomes: • Ensure that the Trust can meet its responsibilities and obligations for both internal and external reporting and data submissions.		

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 **2017/18** milestones for the Information Sharing domain are:*

Work Programme	*Status*	*Description*	*Milestone*	*Date Achieved*
Partnership Working – Local Digital Road Maps		**Purpose:** Local Digital Road Maps (LDR) form part of the STP work and requires each Local Health Community to jointly develop the Local Digital Road Maps. The Trust is participating in		
		**Activities:** ➢ The SWYPFT component for the Local Digital Roadmap was amended to reflect the Trust priorities and progress against the key criteria in June 2017.	***June 2017***	***June 2017***
		➢ Further updates to the SWYPFT component of the Local Digital Roadmap will be scheduled as deadlines for revision become available.	***on-going***	
		Expected Outcomes: • This work will support the development of a five-year vision for digitally-enabled transformation which will look at capability, outlining how, through driving forward 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.		
Partnership Working – STP Digital		**Purpose:** Across the STP regions in which SWYPFT is a key stakeholder, work has been progressing a variety of digital interventions through the work of the place-based Local Digital Roadmaps and digital maturity, the Working Together Partnership		

Workstream		Vanguard and the Perfect Patient Pathway Test Bed. **Activities:** ➢ Trust participation in the development of the digital roadmaps, and STP digital work stream initiatives in collaboration with health and social care partners continues **Expected Outcomes:** • The vision will lead to an integrated digital infrastructure across STP regions, making more effective use of the technical expertise available and allowing our collective digital capabilities to develop in parallel with technological advancement. • Technologies developed and piloted will drive investment into the regions directly influencing the solutions that are available to clinicians and patients we serve. • Local systems will be supported to deliver and evaluate digital pilots within their respective areas and the scaling up of successful interventions will be coordinated by Digital Work streams and the supporting key interventions.	***on-going***	
Partnership Working SWYPFT Digital Maturity Index Refresh		**Purpose:** The Digital Maturity Self-Assessment was developed in 2015 to support the identification of key strengths and gaps in providers' digital capabilities. Since publishing the first round of results in April 2016, NHS England and NHS Improvement have worked with a range of stakeholders to update the self-assessment and are now requesting a refresh to capture progress made over the last 18 months. **Activities:** ➢ A refresh of the Trust Digital Maturity Index self-assessment previously submitted by the Trust is scheduled for completion by 20 October 2017. The updated position that reflects Trust progress will be reported to EMT prior to formal submission. **Expected Outcomes:** • Following submission, validation processes will be concluded in November 2017 and subsequent publication of the data collected will be available in January 2018	***Sept/Oct 2017***	
Records Scanning	  	**Purpose:** Continue to develop the onsite scanning bureau and work towards meeting the 2020 paper free target. **Activities:** ➢ To date, over 5,100 records have been scanned, totaling nearly 714,000 pages since Mid-April 2017. ➢ Establishment of a test & training environment underway ➢ Key Performance Indicators are in development	***Ongoing*** ***Q2 2017/18*** ***Q3 2017/18***	

		➢ Planning to implement access to records via the Trust's clinical portal solution. **Expected Outcomes:** • Continue to minimise off-site storage costs • Improved governance through having electronic access to all records related to a Trust client	***Q4 2017/18***	
Information Governance		**Purpose:** To ensure that the Trust achieves compliance with its information governance responsibilities and statutory obligations. General Data Protection Regulations (GDPR) is the new legal framework in the EU that will take effect from 25 May 2018, irrespective of the UK's decision to leave the EU. The regulations enhance data subjects' rights, introducing new rules that govern how data is collected, processed, shared and retained. Organisations will have significantly more legal liability if they are responsible for a breach with fines increased substantially compared to those currently in operation. Activities:		
		➢ <u>Information Governance Training:</u> NHS Digital released the new e-learning solution for Information Governance Training at the end of July 2017 which is now available via ESR. Classroom based IG training continues to be rolled out for staff groups who do not have ready access to a computer. Feedback from staff undertaking the new training solution is being obtained.	***Ongoing***	
		➢ <u>Information Governance Toolkit:</u> The 2017/18 toolkit was released in mid-July 2017 and work to gather evidence is underway for the first submission. However, due to the timings of the release nationally there is no baseline submission in July 2017, the first one will be in October 2017.	***Oct 2017***	
		➢ <u>General Data Protection Regulations (GDPR):</u> An initial assessment of the requirements of GDPR has taken place with a full appraisal and review taking place at the ICIG meeting in September. From this a more detailed implementation plan will be developed. **Expected Outcomes:** • Mandatory Information Governance Training target is achieved • Information Governance Toolkit target of level 2 compliance is maintained • Preparedness for the GDPR is assured and processes established to ensure compliance	***Q4 2017/18***	

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

Work Programme	*Status*	*Description*	*Milestone*	*Date Achieved*
New Technologies	 	**Purpose:** To continue to assess, review and implement new technologies to support the Trusts Digitisation Agenda, Transformation programme and service redesign/development aspirations. **Activities:** ➢ Active role within the Trust's Digital Strategy Group and associated activities with a focus on IM&T as an enabler. ➢ Review BDU/service requirements as part of annual planning processes **Expected Outcomes:** • Supports the Trust's digitisation strategy and aligns with the wider digitisation of the NHS • Supports the drive towards paperless NHS by 2020 • Further demonstrating our commitment in meeting commissioner aspirations/intentions.	***Ongoing*** ***Oct 2017***	
Centralised Mailing		**Purpose:** To explore ways to reduce IG incidents relating to service user information being mailed to incorrect correspondence addresses. **Activities:** ➢ Review options for centralised mailing and explore opportunities to reduce IG related incidents resulting from misdirected mail. **Expected Outcomes:** • Reduced mailing costs and potential to reduce IG incidents related to clients being mailed to incorrect address. • Alignment with eCorrespondence to consider opportunities for electronic transfer and messaging, communications in line with the drive towards a paperless NHS by 2020.	***Q4 2017/18***	
Paperlight		**Purpose:** Paperlight forms part of the wider Care Record Digitisation agenda and aims		

	O O	for all clinical services (predominantly those services that currently use RiO or SystmOne as their main clinical information system) to work towards achieving paperlight accreditation. **Activities:** ➢ A project was established during 2015/16 to assist services to become Paperlight accredited. This work remains ongoing. ➢ In response to a growing demand from operational clinical services, IM&T are planning to review the paperlight approach and evaluate how IM&T can best support the accreditation assurance process. **Expected Outcomes:** • Reduces/removes the creation of paper records/case files for new service users • Reduces the demand for paper records storage and space in the future • Supports the Trust's drive towards achieving paperless services by 2020 as part of the wider national paperless agenda.	***Q3 2017/18***	
Digital Dictation	O	**Purpose:** Digital dictation forms part of the wider Care Record Digitisation agenda and aims for reduce overheads associated with manual processes associated with the generation of clinical correspondence (letters) through the exploitation of technology and solutions **Activities:** ➢ A project commenced to gather information and requirements to inform a business case for the introduction of a Trust-wide digital dictation solution. However, due to changing priorities and capacity constraints within IM&T this project was put on hold during 2016/17 following a review by EMT against IM&T priorities. **Expected Outcomes:** • Reduces/removes the creation of paper records/case files for new service users • Reduces the demand for paper records storage and space • Supports the Trust's drive towards achieving paperless services by 2020 as part of the wider national paperless agenda.	***On Hold***	

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

Work Programme	*Status*	*Description*	*Milestone*	*Date Achieved*
Basic/Essential IT Training	 	**Purpose:** Provision of basic/essential IT skills training to staff, predominantly in relation to clinical and corporate information systems usage. **Activities:** ➢ A schedule of basic/essential IT training provided in conjunction with major change programmes within the Trust (e.g. Implementation of the new Mental Health Information System) ➢ Collaborative working with Learning & Development to consider opportunities for wider eLearning training provision **Expected Outcomes:** • Appropriately skilled workforce in terms of basic/essential IT Skills capabilities • Supports the wider digital agenda and strategy	***Ongoing*** ***Ongoing***	
Role-based Clinical Information Systems Training	  	**Purpose:** Provision of role-based clinical information systems training programme/schedule in relation to RiO and SystmOne. **Activities:** ➢ To address how training can be provided to junior doctors, discussions were held with the Medical Staffing Team and an approach agreed. Consultants who are the university leads were engaged in this process. The approach was implemented and trialled the April 2017 intake. ➢ A schedule of clinical information systems training for RiO and SystmOne ➢ Periodic review and revision of training/guidance materials, to reflect system changes and introduction of new functionality **Expected Outcomes:** • Customer focused training provided to staff • Improved availability of training across each locality making it easier for staff to access or attend training sessions. • A more responsive approach to meeting front-line services training needs	***Q1 2017/18*** ***Ongoing*** ***Ongoing***	

		• Ability to record training attendance/completion the Trust's eLearning system which enables training histories to be recorded against the staff record.		

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 3 October 2017
Agenda item 7.2

Title:	**Learning from Healthcare Deaths policy**
Paper prepared by:	Director of Nursing and Quality
Purpose:	In line with the National Quality Board (NQB) guidance on Learning from Deaths, every Trust must have a policy in place that sets out how it identifies, reports, reviews, investigates and learns from a patient's death. This policy is the Trust's response to the guidance.
Mission/values:	This policy is in line with the Trust 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
Any background papers/ previously considered by:	The Board has been briefed on the need for the Policy and advised on progress during development. The Clinical Governance & Clinical Safety Committee and EMT have reviewed the Policy in detail.
Executive summary:	This policy has been scrutinised by both Executive Management Team (EMT) and Clinical Governance & Clinical Safety Committee (CGCS) The CGCS stated that:- ➢ The policy is well written and meets the Trust standards. ➢ They supported the review date in April 2018 in light of potential for early learning across the system. ➢ Working as part of the Alliance of northern trusts was extremely beneficial ➢ Acknowledged the importance of maintaining a focus on the desired outcomes rather than the process ➢ Acknowledged the potential impact upon capacity and supported the need for an early business case to understand the potential cost pressure. ➢ **Recommend that Board approve the Policy and next steps. EMT supported the views of CGCS.** **Summary** ➢ The Trust has benefited from working with a northern alliance of mental health trusts to develop the principles and scope of reviews. The agreement was 80% across the group with a local 20% to meet the specific organisation process and requirements. ➢ This policy has a short review date of April 2018; this is to ensure this is working and incorporate further national policies e.g. engaging with service users (when published).

	➢ The Trust has spent time testing and refining the processes to collect the correct information and test the process for reviewing. This work has included sharing aspects of this with the Northern alliance and learning from work they have done. ➢ The policy lays out the Trust process for reporting deaths and which deaths will be in scope for reviewing to - describe responsibilities, including those of the Trust Board who are accountable for ensuring compliance with the 2017 NQB guidance on Learning from Deaths; - work towards achieving the highest standards in mortality governance; and - Ensure quality improvement remains a priority by championing and supporting learning that leads to meaningful and effective actions that continually improve patient safety and experience and supports cultural change. This can be achieved by demonstrating commitment to the work e.g. spending time developing Board thinking; ensuring a corporate understanding of the key issues around the deaths of service users and by ensuring that sufficient priority and resource is available for the work. ➢ The policy includes the national "must dos" in terms investigations. ➢ It also describes what the Trust along with the Northern Alliance of Trusts has agreed is in-scope for review and the deaths the trust examined in the first six months as part of the incremental development. . ➢ This work further builds on existing policies and information provided in the annual incident management report. ➢ Reporting on the data and outcomes will commence during quarter 3. The reporting will be on quarter 1 data. ➢ Staff identified to carry out structured judgement record reviews have received training. There will be a future requirement to repeat this to ensure we have enough staff skilled to undertake these reviews. This is a new commitment for the Trust in terms of resources. ➢ Trust's statutory duties relating to equality and diversity have been met and an Equality Impact Assessment has been undertaken. **Next steps** ➢ The northern alliance of mental health trusts will continue to work on the outcome from the reviews/investigations and consider how to work together on themes and trends. ➢ The first dashboard will be available in October 2017 and then quarterly. ➢ The policy and dashboard must be publically available and published on the Trust intranet. ➢ The Trust will continue to develop and refine the process and move the focus to the outcomes from these reviews and investigation. ➢ We need to develop a business case to ensure the resources available for the additional administration, coordination and analysis of data. ➢ The policy will be disseminated and power point slides have been

	created to support the message in team meetings **Risk appetite** Risk identified – Trust must have a policy in place that sets out how it identifies, reports, reviews, investigates and learns from a patient's death. The development of this policy and processes to implement covers assurance for: ➢ **Compliance risk:** with CQC standards for reviewing healthcare deaths. This meets the risk appetite –low and the risk target 1-3. ➢ **Financial or commercial risks:** Reputational risks, negative impact on perceptions of service users, staff, commissioners. Cautious/moderate risk appetite and a risk target of 4-6 ➢ **Clinical risks:** risk to service user/public safety and risk to staff safety which is again low risk appetite and a risk target of 1-3. The reporting, reviewing, investigating and learning from healthcare deaths and implementing change supports the drive to reduce the number of healthcare related avoidable deaths.
Recommendation:	**Trust Board is asked to RECEIVE and APPROVE the Healthcare Deaths policy and the NEXT STEPS identified.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Document name:	Learning from Healthcare Deaths The right thing to do
Document type:	Policy
What does this policy replace?	New policy
Staff group to whom it applies:	Trust staff with a responsibility for patient care
Distribution:	The whole of the Trust
How to access:	Intranet
Issue date:	October 2017
Next review:	April 2018 or when new guidance nationally results in the policy requiring review
Approved by:	Clinical Governance and Clinical Safety Committee, Executive Management Team, Trust Board 3 October 2017
Developed by:	Assistant Director Patient Safety Patient Safety Manager
Director leads:	Director of Nursing and Quality
Contact for advice:	Deputy Director of Nursing, Assistant Director of Patient Safety Patient Safety Manager

Contents

1.0. Introduction

Most people will be in receipt of care from the NHS at the time of their and they experience excellent care from the NHS for the weeks, months and years leading up to their death. However, for some people, the experience is different and they experience poor quality provision for a number of reasons including system failure.

It is the right thing to do to review and investigate deaths where care and service delivery problems occurred so that we can learn and prevent recurrence.

This policy is in line with the Trust 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

The Five Year Forward View for Mental Health identified that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people. Therefore it is important that organisations widen the scope of deaths which are reviewed in order to maximise learning.

The Confidential inquiry into premature deaths of people with learning disabilities showed a very similar picture in terms of early deaths.

We will make it a priority to work more closely with families and carers of patients who have died and to ensure meaningful support and engagement with them at all stages, from the notification of the death of their loved one, right through to actions taken following on from any investigation.

The Trust will also look at a selection of cases to learn from examples of good care and share this.

A report by independent auditors Mazars, commissioned by NHS England was published in December 2015. It commented on services run by Southern Health NHS Foundation Trust.
The report found:-

- Failings in the way the Trust investigate serious incidents.
- Too few deaths were investigated and some should have been investigated further.
- The Trust could not demonstrate a comprehensive systematic approach to learning from deaths

These findings were reinforced in the recent *Care Quality Commission (CQC) report Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England 2016*. It revealed that in some organisations learning from deaths was not being given sufficient priority and that valuable opportunities for improvements were being missed. Importantly the CQC also point out that there is much more we can do to engage families and carers, and recognising their insights and experiences is vital to our learning.

The National Quality Board (NQB) guidance on Learning from Deaths (2017) is the starting point to initiate a standardised approach to the way NHS Trusts report, review, investigate and learn from patient deaths, which should lead to better quality investigations and more embedded learning. These reviews will eventually provide the Trust with valuable information in deciding how avoidable the death may have been and how Executive Teams and Boards can use these findings.

The Trust fully supports the approach it has developed with mental health providers in the North of England Alliance as part of our collaborative approach to learning from deaths. The trusts participating are:

- Bradford District Care NHS Foundation Trust
- Cumbria Partnership NHS Foundation Trust
- Humber NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Northumberland, Tyne and Wear NHS Foundation Trust
- Rotherham, Doncaster and South Humber NHS Foundation Trust
- Sheffield Health & Social Care NHS Foundation Trust
- South West Yorkshire Partnership NHS Foundation Trust
- Tees, Esk and Wear Valley NHS Foundation Trust

Working collaboratively will enable shared learning and good practice, valid comparisons across organisations and shared capacity.

This policy sets out the principles that guide our work and how we will implement them.

South West Yorkshire Partnership NHS Trust provides a range of services alongside its mental health portfolio –including learning Disability Services, Physical Health services and these have been considered when writing the policy. We have and will continue to liaise with physical health colleagues.

This policy should be read in conjunction with:-

- Being open policy
- Incident reporting and management (including serious incidents) policy
- Investigating and analysing incidents, complaints and claims to learn from experience policy

NHS Improvement is fully aware that many organisations, particularly mental health and community care providers, have less clarity on methodologies and scope for the new requirements of learning from deaths. Therefore it does not expect providers to have developed perfect processes by autumn 2017 and acknowledges that further support will need to be provided over the course of the next 12 months.

The Trust will therefore review this policy to ensure it continues to reflect best practice after six months in April 2018.

2.0. Purpose and scope of the policy

Working with families/carers of patients who have died offers an invaluable source of insight to improve services. Therefore there is a need to ensure appropriate support is provided at all stages of the review process and an understanding that treating bereaved families/carers as equal partners in this process is vital.

In line with the National Quality Board guidance on Learning from Deaths, every Trust must have a policy in place that sets out how it identifies, reports, reviews, investigates and learns from a patient's death. This should include the care leading up to the patient's death and consider if this could have been improved.

This policy informs the organisation of staffs' roles and responsibilities relating to learning from deaths and promotes a culture of learning lessons.

Learning from a review about the care provided to patients who die in our care is integral to the Trust's governance and quality improvement work.

2.1. Purpose

The Trust will implement the requirements outlined in the Learning from Deaths framework as part of the organisation's existing procedures to learn and continually improve the quality of care provided to all patients.

It will set out the Trust's expectation / principles on how it responds to deaths in our care and identifies the scope of review for each death and how the Trust will learn from them.

This policy sets out how staff can support the involvement of families and carers when a death has occurred and how to engage with them to ensure there are easy opportunities to discuss or ask questions about the care received by their loved one to their preferred timescale.

2.2. Objectives

While a focus on process is important, everything that is done should place emphasis on the outcomes of learning from deaths and supporting families and carers.

The core objectives of this policy are:

- To prioritise and enable consistently effective, meaningful engagement and compassionate support between families, carers and staff that is open and transparent to allow them to raise questions about the care provided to their loved one.
- To help to identify what can be improved to ultimately reduce the inequality in the life expectancy of people with a severe mental illness/learning disability.

- To standardise approaches to reviewing deaths across the northern cohort of mental health trusts in order to share information and key learning.
- To ensure there is a consistent and coordinated approach for undertaking mortality reviews for physical health care.
- To enhance learning at a personal, team and organisational level.
- To ensure the Trust engages with other stakeholders (Acute Trusts, Primary Care, Public Health, Safeguarding, Health and Wellbeing Boards etc.) to work collaboratively, sharing relevant information and expertise to maximise learning from deaths.
- To support the evaluation of the Trust's approach to learning from deaths in line with the northern alliance of mental health trusts agreed principles.

2.3. Scope

This policy applies to all Trust staff with a responsibility for patient care.

The National Quality Board Guidance on Learning from Patients Deaths applies to all acute, mental health/learning disability and community NHS Foundation Trusts.

3.0. Definitions

Term	Definition
Certification	A death that has been certified by a doctor at the time of death.
Structured Judgement Record Review (SJRR)	Reviewing case records/notes to determine whether there were any problems in the care provided to the patient who died, in order to learn from what happened. The Royal College of Physicians Structured Judgement Review methodology provides an agreed template for this.
Death due to a problem in care	A death that has been clinically assessed using a recognised methodology of case record/note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.
LeDer	The Learning Disabilities Mortality Review (LeDeR) programme has been commissioned by NHS England to support local areas in England to review the deaths of people with a learning disability to: •identify common themes and learning points and: •provide support to local areas in their development of action plans to take forward the lessons learned.
Investigation	The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies and procedures, guidance, good practice and observation – in order to identify the problems in care or

	service delivery that preceded an incident to understand how and why it occurred. This may be a service level investigation or an investigation reported to commissioners
STEIS	Strategic Executive Information System is the national system for reporting Serious Incident (SI) that enables electronic logging, tracking and reporting of Serious Incidents with NHS Improvement
Main provider of care	When the Trust is the main provider of care as described in section 5.5.
Deaths in scope	Deaths that the Northern mental health trusts and the Trust for general community services have determined require further review under this policy.
Severe Mental Illness	The term is generally restricted to psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder

4.0. Duties

This policy applies to all Trust staff with a responsibility for patient care as set out below:

Mortality governance is a priority for all Trust Boards and the Learning from Deaths Framework places a greater emphasis on the importance of Board Leadership to ensure that learning from patient deaths becomes embedded in the organisation.

Role	Responsibility
Chief Executive, Executive Trust Board Directors and Non-Executive Directors	Trust Boards are accountable for ensuring compliance with the 2017 NQB guidance on Learning from Deaths and working towards achieving the highest standards in mortality governance. They must ensure quality improvement remains a priority by championing and supporting learning that leads to meaningful and effective actions that continually improve patient safety and experience and supports cultural change. They can do this by demonstrating their commitment to the work e.g. spending time developing Board thinking; ensuring a corporate understanding of the key issues around the deaths of service users and by ensuring that sufficient priority and resource is available for the work. The Director of Nursing and Quality has been identified as the Board level 'Patient Safety Director' with responsibility for learning from deaths. Additionally a named Non-Executive Director has taken lead responsibility for oversight of progress to act as a critical friend, holding the organisation to account for its approach in learning from deaths. The Board will ensure: • That robust systems are in place for reporting, reviewing and investigating deaths • That bereaved families are engaged and supported • That there is evident learning from deaths both internally and with our external partners and quality improvement is championed • That processes focus on learning, can withstand external scrutiny, by providing challenge and support and assurance of published information
Directors, Medical Staff, Consultant Nurses, Business Delivery Management, Ward and Team Managers and all Registered Nurses & Allied Healthcare Professionals	Staff should familiarise themselves with this policy and understand the process for learning from deaths. Identify the key changes required to implement this policy and ensure all appropriate action is taken. Staff must record in a timely way information about deaths on clinical systems, including all details know about the cause and place of death. Staff must report any death on Datix if the Trust is the main provider of care (see flowchart in section 5.5) or if there have been any concerns raised by family, clinical staff or through governance process. Staff should engage with families to offer condolences, in line with Being Open and Duty of Candour when this applies. To support staff to review and investigate deaths ensuring they have the time to carry out this process in a skilled way to a high standard, and as part of that to:

	• Ensure staff have the right level of skill through training and experience; • To promote learning from deaths; • That sufficient time is assigned in local governance forums to outline and plan for any lessons learned; • To ensure that learning is acted on. Patient safety support team will provide support.
The Patient Support Team, Performance and Information, Customer Services and Legal team	These corporate Trust departments have a responsibility to ensure: • New data is collected and published to monitor trends in deaths (April 2017 onwards) with Board level oversight of this process • Ensuring the Datix incident reporting system is used to its full potential to record deaths (as agreed by what is in scope/where the Trust is the main provider of care) in accordance with Trust policy. • Processing information consistently and precisely and in a meaningful way to fulfill governance processes required to ensure high standards in mortality governance are maintained. The Patient safety support team will provide support across the Trust

The Trust requires all staff to be open, honest and transparent about reporting deaths and for engaging with families and carers, actively enabling them to ask questions about care and identify if care can be improved.

5.0. Principles of the policy

5.1. Encouraging a learning from deaths culture

The Trust already does significant work with working with families following deaths where care delivery may be an issue. We also involve service users and families in the development of services and provide opportunities to provide feedback on all aspects of care and services delivery.

We will continue to educate staff and encourage a more open culture of listening to the views and opinions of families and carers following all deaths. Staff will become more confident in identifying what can be done differently and improve systems and share systems and processes that are working well.

5.2. Family engagement

We will reinforce the importance of family engagement following deaths. Dealing respectfully, sensitively and compassionately with families and carers when someone has died is crucially important. At times, families may have questions, and/or concerns they would like answers to in relation to the care and treatment their loved one received but don't always want to make a complaint.

If you are reading this as a family member of someone who has recently died, and has received care from our Trust and you have anything you would like to discuss, you can contact the clinical team involved to discuss or you can contact customer services direct on 01924 316060.

When a service user dies, staff will often be the first to offer condolences and offer support and to give appropriate information.

They also need to ask if the families have any comments they may wish to make about the care provided. This early discussion supports ensuring that deaths were families raise concerns are reviewed or investigated. If there are any concerns this must be reported on Datix.
When staff make contact they should ensure they follow the Being Open Policy which includes Duty of Candour when this is required.

There are however some circumstances where the Trust may find out about the death of a service user after some delay. In these circumstances a discussion should take place between the Patient Safety Support Team and the clinical team involved to determine the best approach.

If we are the main provider there is a Trust expectation that contact will be made with families /carers.

For deaths in scope for review/investigation we need to provide information regarding the opportunity to be involved in the review of the care.

We have begun a dialogue with families about how they would wish to be involved in reviews in scope of a family member's death or in an investigation. This work will inform the Trust's practice in the future as will anticipated national guidance*.

It is understood that dealing with the death of a loved one is a sensitive matter for families, carers and staff and that all situations are different. Staff may need to offer the opportunity for on-going involvement in-keeping with the family's needs and wishes.

The Trust's approach should be to treat the family/carer as an equal in the review/investigation process from the beginning taking their views and opinions into account at each stage.
Families can choose how they wish to be involved, this may include:

- agreeing the level of the review / investigation (see 5.4);
- contributing to the terms of reference for serious incident reviews;

- providing evidence / contributions to the review or investigation e.g. providing a pen portrait of the person, time-line of events
- Commenting on a draft report.

When this is an investigation families/carers should also be given the option of seeing a final reports to ensure they are comfortable with any findings. Ideally this should be undertaken in a face to face meeting with a staff member talking the family member/carer through the report.

To support families, we will provide a range of information for relatives that explain these processes and what they can expect. Current information is available on the Trust internet and will develop further following the production of national guidance*.

If the family member/carer decides they do not want to be involved in the review/investigation process staff should make it clear they can contact us at any time should their decision change and that any relevant information can still be shared. If the family does not want contact at all about the process or findings, this should be honoured and staff should record their wishes.

Staff should be prepared for the types of questions that families may have such as:

- Why is there an investigation?
- Can I access the records for my relative?
- Can I speak to the staff who were caring for my relative?

One way to ensure that answers are provided to the questions that families/carers have is to ask them, at an early stage, what they want to know and to involve them in writing the terms of reference of any review or investigation. Further information and support can be accessed by the Patient Safety Support Team as this is already practice in serious incident investigations.

*Note: The NQB guidance states that a "further development" in 2017 /18 will be: the development of "*guidance for bereaved families and carers. This will support standards already set for local services within the Duty of Candour and the Serious Incident Framework and cover how families should be engaged in investigations*". The Trust will review this policy in this context and as part of the policies evaluation.

5.3. Identifying and Reporting Deaths

The Trust has systems that identify and capture the known deaths of its service users on its electronic patient administration system (PAS) and on its Datix system where the death requires reporting. This is to help ensure that the Trust Board has a comprehensive picture of the deaths of all its services users and the opportunities to learn from them.

The Trust's Performance and Information team is also working with local registration of deaths services to ensure data on deaths is accurate and timely, and this will develop over time.

Trust staff must report deaths where we are the main provider of care or there are concerns from family, clinical staff or through governance processes that they are made aware of on Datix within 24 hours of being informed and provide the cause of death where known. The Trusts In patient deaths must include certified cause of death or state whether this has been referred to the Coroner and why. Once the Datix is completed staff must immediately attempt to engage with the family and or carers unless otherwise instructed. In the first instance this would take the form of a condolence letter with contact numbers for contacting the service.

All deaths where we are the main provider of care or there are concerns from family, clinical staff or through governance processes, that staff are made aware of must be reported through the Datix system to start the process of learning from patient deaths.

All deaths reported on Datix are reviewed by the Patient Safety Support Team on a daily basis. A flowchart has been developed to illustrate the mortality review process and categories of death which supports whether a review or investigation takes place. See flowchart on the intranet.

To ensure there is consistency in recording a number of categories has been develop by Mazars. These have been added to Datix. The patient safety support team record these during the review of the death

- Expected natural (EN1) – e.g. Terminal illness
- Expected natural (EN2) –e.g. cancer, expected but not in timescale
- Expected unnatural (EU) –e.g. death expected but not cause e.g. drug and alcohol
- Unexpected natural (UN1) –e.g. cardiac arrest, stroke, road traffic accident
- Unexpected natural (UN2) –e.g. alcohol dependency but care concerns
- Unexpected unnatural (UU) - e.g. suicide, homicide, abuse, neglect

5.4. The decision to investigate or review

The Trust collects data on all known deaths and has a process in place to determine the scope of deaths to be reported on Datix which require further review or investigation.

The information below sets out these processes:-

- Existing Serious Incident Framework which remain

- For people with a Learning Disability the Trust supports the approach of the LeDer programme.

- Child (under 18) death reviews should be undertaken in accordance with national guidance, Working Together to Safeguard Children. The Department for Education's 'Form C' should be used as a reporting template. This includes the small number of children who die on adult wards.

- The NQB National Guidance on Learning from Deaths provides the context to the review or investigation of deaths and establishes a number of “must dos” in terms of investigations. These include:

1. all deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision;
2. all in-patient, out-patient and community patient deaths of those with learning disabilities
3. all deaths in a service specialty, particular diagnosis or treatment group where an ‘alarm’ has been raised with the provider through whatever means
4. all deaths in areas where people are not expected to die, for example in relevant elective procedures;
5. deaths where learning will inform the provider’s existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider. To maximise learning, such deaths could be reviewed thematically;
6. a further sample of other deaths that do not fit the identified categories so that providers can take an overview of where learning and improvement is needed most overall. This does not have to be a random sample, and could use practical sampling strategies such as taking a selection of deaths from each weekday.

5.5. Scope of deaths

In order to support consistency in determining the scope of deaths for further review, the alliance of Northern Mental Health Trusts has agreed the core principles and the Trust have added to this to reflect the range of Trust services.

Where the Trust provides a wide range of clinical services across inpatient, community and other provider organisations this can lead to both a degree of confusion as to who is responsible for the reporting and investigating of a patient’s death and the risk of double reporting and investigation.

To support staff in their decision making, staff should refer to the following guidelines. However if there is any doubt staff should contact their line manager for advice.

A We are the main provider if at the time of death the patient was subject to:

- An episode of inpatient care within our service.
- An episode of community treatment under CPA.
- An episode of community treatment due to identified mental health, learning disability or substance misuse needs.
- A Community Treatment order.
- A conditional discharge.
- An inpatient episode or community treatment package within the 6 months prior to their death (Mental Health services only).
- Guardianship

B Patients who meet the above criteria but are inpatients within another health care provider or custodial establishment at the time of their death.

In these circumstances the death will be reported by the organisation under whose direct care the patient was at the time of their death. That organisation will also offer condolences and exercise the responsibilities under being open and duty of candour if required. However there will be a discussion to agree on if it is to be a joint or single agency investigation (this will be determined by the cause of death) and in the case of joint investigations who the lead organisation will be.

C Services provided by the Trust where we are not classed as the main provider.

For the following services the Trust is only providing a small component of an overarching package of care and the lead provider is the patients GP.

- Tissue viability
- Dietetics
- District Nursing
- The drug and alcohol shared care services
- Care home liaison
- Acute hospital liaison
- Community physiotherapy
- Macmillan Nurses
- Podiatry
- Memory monitoring
- End of life team
- Primary care prevention services
- 0-19 service
- Recovery college deaths
- Health and wellbeing
- Telehealth
- Long term conditions

D Exception.

In addition to the above, if any act or omission on the part of a member of Trust staff where we are not classed as the main provider is felt to have in any way contributed to the death of a patient, an investigation will be undertaken by the Trust. These MUST be reported on Datix

Where problems are identified relating to other NHS Trusts or organisations the Trust should make every effort to inform the relevant organisation so they can undertake any necessary investigation or improvement. A culture of compassionate curiosity should be adopted and the following questions should be asked:

- Which deaths can we review together?
- What could we have done better between us?

- Did we look at the care from a family and carers perspective?
- How can we demonstrate that we have learnt and improved care, systems and processes?

In addition the Northern Mental Health alliance has identified a number of potential triggers for a Review / Investigation.

These include deaths:

1. Where a Family / clinical staff / governance staff flag or raise a concern;
2. Patient deaths of people with severe mental illness (SMI)
3. Where medication with known risks such as Clozapine was a significant part of the treatment regime;
4. From causes or in clinical areas where concerns had already been flagged – (possibly at Trust Board level or via complaints or from data);
5. Where they had been subjected to a care intervention where death wouldn't have been an expected outcome e.g. ECT, rapid tranquilisation;
6. Where the service user had no active family or friends and so were particularly isolated e.g. with no one independent to raise concerns;
7. Where there had been known delays to treatment e.g. assessment had taken place or a GP referral made but care and treatment not provided, or where there was a gap in services;
8. Associated with known risk factors / correlations

Also:

9. Particular causes of death e.g. epilepsy;
10. Deaths in Distress which might include: drug and alcohol deaths, or deaths of people with an historic sex offence e.g. people who might not be in crisis but need support and from whose experience there may be learning from a thematic review;
11. Where a proactive initial assessment of a death has potentially identified that there was a deterioration in the physical health of a service user which wasn't responded to in a timely manner;
12. Random sampling. When identifying the numbers for random sampling the Trust needs to consider that services such as Community Specialist Palliative Care Service already review and record significant data that is subject to analysis. They also provide minimum data sets for palliative care for the national council for palliative care.

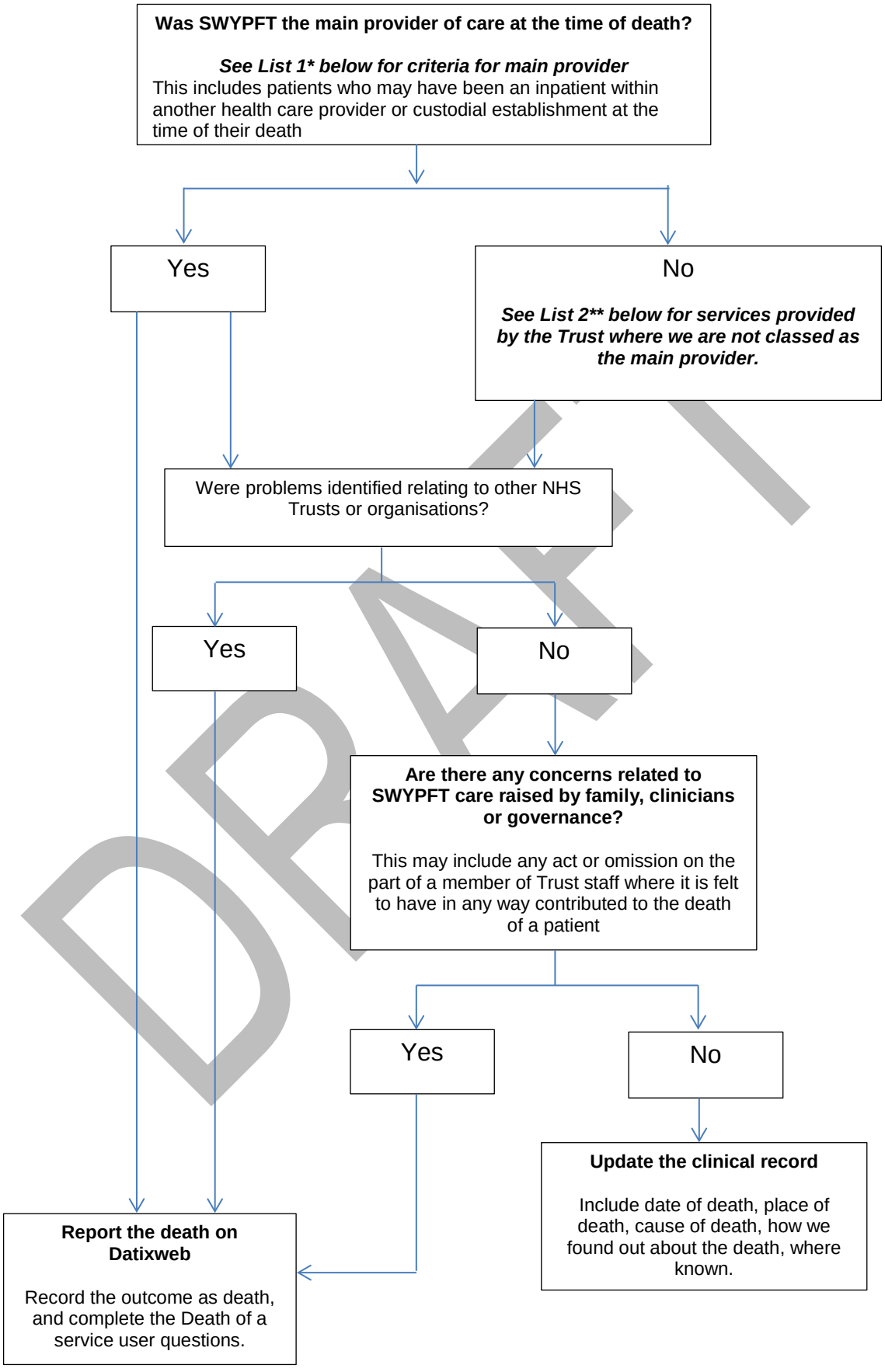
In relation to this requirement, there is currently no single agreed definition of which conditions/criteria would constitute SMI. The term is generally restricted to the psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder.

It is acknowledged that there is substantive criticism of this definition; personality disorders can be just as severe and disabling, as can severe forms of eating disorders, obsessive compulsive disorder, anxiety disorders and substance misuse problems.

Further national guidance is expected to clarify expectations about mortality review in mental health and community services in the future however in the meantime, Trusts have been asked to use the above description of SMI.

These will be subject to a review of the case at the Mortality review group and a decision made on an individual basis as to whether and what type of review is required.

Main provider flowchart



List 1 – Main provider
We are the main provider if at the time of death the patient was subject to:

1. An episode of inpatient care within our service.
2. An episode of community treatment under CPA.
3. An episode of community treatment due to identified mental health, learning disability or substance misuse needs.
4. A Community Treatment order.
5. A conditional discharge.
6. An inpatient episode or community treatment package within the 6 months prior to their death (Mental Health services only).
7. Guardianship

List 2 – Not main provider
Services provided by the Trust where we are not classed as the main provider:
For the following services the Trust is only providing a small component of an overarching package of care and the lead provider is the patients GP.

- Tissue viability
- Dietetics
- District Nursing
- The drug and alcohol shared care services
- Care home liaison
- Acute hospital liaison
- Community physiotherapy
- Macmillan Nurses
- Health Visitors
- Podiatry
- Memory monitoring
- End of life team
- Primary care prevention services
- 0-19 service
- Recovery college deaths
- Health and wellbeing
- Telehealth
- Long term conditions

5.6. The types of review

Practice varies across Trusts in the northern alliance with regard to how deaths are reported and categorised.

Each Trust has core processes around:

- An initial screen of each death e.g. at a weekly Mortality review group, at a Huddle which will always necessitate the collection of core data around the service user and his or her death and sometimes the use of a structured tool;
- A way of making a judgment about which deaths are subject to further review which might be explicit and transparent against a set of criteria or sometimes more reliant on individual and clinical judgment;
- A way of deciding the level of further review; however this is described e.g. local review, clinical review. In this practice around the use of SJRR is still emerging.

5.7 Local review

The Trust has adopted the three levels of scrutiny suggested in the NQB guidance.

1. Death Certification
2. Case record review, through Structured judgment Record Review
3. Investigation – that could be service level, serious incident reported on STEIS or other review e.g. LeDeR, safeguarding.

Certification

If the death has been certified by a doctor as a natural death and they have not reported the death to the coroner, no further review will usually be necessary unless the Trust is aware of any concerns expressed by family and clinical staff or through governance processes. The clinical team will normally review the case and make a note on Datix if they feel any further review may be required.

Of note is that once the reform of death certification comes into place, the medical examiners will be mandated to give bereaved relatives a chance to express any concerns and to refer to the coroner any deaths appearing to involve serious lapses in clinical practice or patient safety.

Structured Judgment Record Reviews

A Structured Judgment Record Review (SJRR) blends a traditional clinical judgement based review with a standard format that enables reviewers to make safety and quality judgements over phases of care and which provides explicit written comments and a score for each phase. A SJRR provides a relatively short but rich set of information about each case in a format that can be aggregated to provide knowledge about clinical services and systems of care. The Trust has trained a number of staff to be able to undertake these reviews.

Service level investigation/serious incident investigation requiring STEIS reporting

Investigations are a review of care provided using recognised systems analysis tools. These are either undertaken at service level for a service level investigation or through a central dedicated team for serious incidents. The aim of the review is for the Trust to learn and prevent recurrence.

The Trust will use the SJRR or investigation will take place on all the other deaths.

When the family/carers wish to be involved, their preference regarding how, when and where they want to engage will be paramount and built on the principles of compassionate engagement. The findings will always be shared with the family subject to confidentiality requirements. We will always share the outcome and learning.

Service level investigation/serious incident investigation joint investigation

There are some instances when a joint approach is required with another organisation to investigate. The Trust has developed links with neighbouring acute Trusts to enable this to take place when needed. Either organisation can request this to take place.

Other investigations

The Trust is an active member in Safeguarding Boards and should a death require investigation through the Safeguarding process the Trust will work through that process in line with serious incident framework.

5.8 Process

When the Trust becomes aware of a death, the **clinical team** review the case and using the Main provider check flowchart (page 16) they determine if they are the main provider of care and if so, this is a reportable death on Datix. If they are not the main provider of care, and the case does not meet the exceptions set out in the flowchart, the clinical team would update the clinical system only.

The **patient safety support team** review each death reported on Datix and prompt teams to ensure full and accurate information is recorded if this has not been already completed. If this is a STEIS reportable incident, this is reported through STEIS and an investigation takes place as per Trust policy.

If this requires further discussion it is taken to the weekly risk panel that involves medical and nursing directors to make a final decision or agree next steps.

Patient safety mortality checks take place for each death reported on Datix to determine if the case is in scope or out of scope for the Trust mortality review process.

The In scope deaths are reviewed at **mortality review group** where a decision is made about the level of scrutiny, if this has not already been determined by STEIS reporting or in the weekly risk panel meeting.

From April to September the Trust has examined all deaths reported on Datix and developing the process and ensuring meaningful data is being collected. The trust has also worked with the Northern Alliance of Trusts to develop the principles and policy. To ensure the trust reviews the outputs from the reviews and investigations to inform quality improvements the Trust need to develop further its **clinical mortality review and improvement group.** This groups needs to have strong clinical input from Business delivery units, clinical governance and commissioners.

From April 2017 to September 2017 the Trust started reviewing all deaths reported on Datix, this has been an incremental approach and to date has subjected the following to further review:

- All inpatient deaths or where they had been discharged in last 30 days
- LeDeR deaths
- Any reportable STEIS death
- Deaths subjected to service level investigation
- Any death where there were family, clinical or governance concerns that did not meet any of the above
- A case where we were not the main provider at the time of death but worked with the acute Trust
- Other processes such as serious case review

6.0. Governance process / ensuring Learning

The prime objective of the Learning from Death Policy is that we can improve services and the experience of those services for the people that use them.

We are working with eight other mental health trusts and will work locally with services to develop a consistent framework around learning. This will focus on whether the activity we do under the guidance of this policy (i.e. talking to the families of those who died, the investigations, thematic reviews, the analysis of data, the review of case notes including SJRR) makes a difference.

How we measure the impact of the work will develop over time as the information we access improves, as we evaluate the policy overall including feedback from families and as the national guidance emerges.

We will all assess learning against a common framework that:

1. Identifies potential improvements;
2. Develops a shared understanding of what these improvements might be across the Trust;
3. Leads to a series of actions locally, that should be able to be measured;
4. Provides knowledge of the difference made by those actions.

We will take the opportunity to share learning with our partner Trusts and other, local stakeholders. For example, there may be common issues where we could commission thematic reviews.

The actual practice in each Trust will differ for a variety of reasons: different cultures, priorities and policies. This co-existence of cohesion and diversity will be a strength as we will have the opportunity (through our continued regional work) to share and learn from each other's approaches and see which ones work best.

The Trust will ensure that lessons learnt result in change in organisational culture and practice by; identifying themes and trends in formal meetings and in the Quality Account; commissioning thematic reviews on a regular basis by the Mortality Review group and ensuring that associated action plans are implemented.

We will ensure learning is cascaded to frontline clinical staff on a regular basis by use of learning lessons events, learning journey reports and other methods being determined through a programme in the integrated change programme.

We will ensure transparency in decision making and accountability.

7.0. Data reporting

From Quarter 3 2017/18, Trusts are required to publish information on deaths, reviews and investigations via a quarterly agenda item and paper to its public Board meetings.

The Northern Mental Health Trusts alliance has agreed a common dashboard and will continue to develop this over the next six months.

When counting 'total number of deaths in scope' and 'total number of deaths reviewed' it should be possible to see what percentage of deaths has been reviewed in a particular period. In other words, the number of deaths reviewed should be reported as a percentage of the number of deaths. To do this means that it is helpful to have a time lag in the reporting period - for example Q1 data would be reported at the end of Q2.

The dashboard will include:

- Scope narrative
- Narrative on deaths not recorded on Datix system
- Total deaths registered on PAS
- Total deaths on Datix system
- Total number of deaths in scope
- Community (MH, LD) and Inpatient (MH, LD)
- In patients Barnsley community services, Barnsley community services other
- How many reviewed via MRG, SJRR, SI, SLI etc.
- Explain rational for not reporting 'avoidable' and include root causes and contributory factors for SI deaths

Understanding the data around the deaths of our service users is a vital part of our commitment to learning from ALL DEATHS.

Working with eight other mental health trusts in the north of England, we are developing a reporting dashboard that brings together important information that will help us to do that. We will continue to develop this over time, for example by looking in to some areas in greater detail and by talking to families about what is important to them. We will also learn from developments nationally as these occur.

The Northern Alliance of Trusts has decided not to report initially on what are described in general hospital services as "avoidable deaths" in inpatient services. This is because there is currently no research base on this for mental health services and no consistent accepted basis for calculating this data. We also consider that an approach that is restricted to inpatient services would give a misleading picture of a service that is predominately community focused. We will review this decision not later than April 2018 and will continue to support work to develop our data and general understanding of the issues.

8.0. Equality Impact Assessment

Equality Impact Assessment completed (see appendix A).

9.0. Dissemination and implementation arrangements (including training)

- This policy will be disseminated on the intranet.
- A presentation will be prepared for BDUs to share on key points from the policy.
- Patient safety support team has already spent much time and resources setting up the collection of the recording deaths on Datix, this will be refined through implementation of this policy.
- Performance and information team are aware and setting up reports on all deaths recorded on PAS and working with local registrars.
- Customer services are aware they may have contacts from families but they do not see this as additional to what is already available.
- Serious incident investigators are within the Trust and this needs to remain.
- A number of staff have been trained in structured judgment record reviews, this will need to be repeated in the future to ensure we have enough staff so it does not become a burden on a few.
- Training of staff by patient safety support team to undertake service level investigations will need to continue.
- A clinical group to review the SJRR and examine themes, review in scope deaths for future years and support the key messages for sharing and implementation needs to be established.
- A business case to support administration and coordination of this needs to be developed and considered within the business planning process.

9.1. Process for monitoring compliance and effectiveness

• This policy will be ratified by the Trust Board and published on the Trust's intranet and external website.
• Line managers will disseminate this policy to all Trust employees through a line management briefing. This is mandated through The Brief.
• As further national guidance emerges over the next 12 months, including family engagement, the Trust will review the policy and its implementation to ensure it continues to reflect best practice.
• The policy and processes and procedures will be audited by the Quality Improvement and Assurance Team and Patient Safety Support Team, initially following 6 months of implementation and then annually. The results of which will be considered at the Clinical Governance and Clinical Safety Committee. • The audit tool will be designed to capture both qualitative and quantitative data to

demonstrate the lessons learned and how they have been shared and used to improve the quality of services.

9.2. Review and revision arrangements (including archiving)

The policy will be reviewed in April 2018 and then as required by national changes but at least in April 2019.

10.0. References

This Policy document is to be read in conjunction with the Trust's:

- Incident reporting and management (including serious incidents) policy
- Being open (incorporating Duty of Candour) policy
- Investigating and analysing incidents, complaints and claims to learn from experience policy

And these national documents:

- National Quality Board: National Guidance on Learning from Deaths 2017
- NHSE Serious Incident Framework 2015: Supporting learning to prevent recurrence
- CQC Regulation 20: Duty of Candour 2014
- Working Together to Safeguard Children.
- The Department for Education' forms for reporting child deaths

Appendices

All policies should include completed versions of the following:

- Equality Impact Assessment (see appendix A);
- Checklist for the Review and Approval of Procedural Document (see appendix B);
- Version control sheet (see appendix C).

Appendix A

Equality Impact Assessment

Date of assessment: 4/9/2017

	Equality Impact Assessment Questions:	Evidence based answers & actions:
1	**Name of the document that you are Equality Impact Assessing**	Learning from Healthcare Deaths - The right thing to do
2	**Describe the overall aim of your document and context?** **Who will benefit from this policy/procedure/strategy?**	Working with families/carers of patients who have died offers an invaluable source of insight to improve services. Therefore there is a need to ensure appropriate support is provided at all stages of the review process and an understanding that treating bereaved families/carers as equal partners in this process is vital. In line with the National Quality Board guidance on Learning from Deaths, every Trust must have a policy in place that sets out how it identifies, reports, investigates and learns from a patient's death. This should include the care leading up to the patient's death and considering if this could have been improved.
3	**Who is the overall lead for this assessment?**	**Julie Eskins**
4	**Who else was involved in conducting this assessment?**	**Helen Roberts**
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?**	The Trust has worked with a northern alliance of other trusts to develop this policy. A national policy re involving families is to be produced this year so the policy will be reviewed in light of this. A recognised national figure ran a workshop with the northern alliance. A discussion has taken place at a carers group in Kirklees The Trust has also consulted with staff and families in developing policy and resources for undertaking investigations. We have linked with one neighbouring acute Trust. All of the key recommendations have been added in this policy.
6	**What equality data have you used to inform this equality impact assessment?**	CQC review in December 2016, 'Learning, candour and accountability: a review of the way trusts review and investigate the deaths of patients in England' found that some providers were not giving learning from deaths sufficient priority and so were missing valuable opportunities to identify and make

			improvements in quality of care. The Five Year Forward View for Mental Health identified that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people. Reports and case studies have consistently highlighted that in England people with learning disabilities die younger than people without learning disabilities.
7	**What does this data say?**		As above
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**	**N**	
8.2	**Disability**	**N**	
8.3	**Gender**	**N**	
8.4	**Age**	**N**	
8.5	**Sexual orientation**	**N**	
8.6	**Religion or belief**	**N**	
8.7	**Transgender**	**N**	
8.8	**Maternity & Pregnancy**	**N**	
8.9	**Marriage & civil partnerships**	**N**	
8.10	**Carers (Our Trust requirement)**	**N**	
9	**What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-**		This policy covers healthcare deaths irrespective of characteristics. Some diagnostic or age groups are specifically highlighted. The mortality review meetings will pick up any reported areas of concern. Any difficulties later found that are related to an Impact Equality will be addressed
9a	**Promotes equality of opportunity for people who share the above protected characteristics;**		This policy covers healthcare deaths irrespective of characteristics.
9b	**Eliminates discrimination,**		Recognised tools are available to support reviewing

	harassment and bullying for people who share the above protected characteristics;	care in line with trust policies and procedures
9c	**Promotes good relations between different equality groups;**	All equality groups will be reviewed to the same standard.
9d	**Public Sector Equality Duty – "Due Regard"**	We are confident that the Trust healthcare deaths policy approach contributes to the effective Public Sector Equality Duty – "Due Regard"
10	**Have you developed an Action Plan arising from this assessment?**	**No**
11	**Assessment/Action Plan approved by (Director Lead)**	**Sign: Tim Breedon** **Date: 21.09.2017** **Title: Director of nursing and quality**
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.**	

Appendix B

Checklist for the Review and Approval of Procedural Document

To be completed and attached to any policy document when submitted to EMT for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
	Is it clear in the introduction whether this document replaces or supersedes a previous document?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is the method described in brief?	Yes	
	Are people involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	Are supporting documents referenced?	Yes	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/a	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	Yes	
8.	**Document Control**		
	Does the document identify where it will be held?	Yes	
	Have archiving arrangements for superseded documents been addressed?	Yes	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible implementation and review of the document?	Yes	

South West Yorkshire Partnership NHS Foundation Trust

Appendix C

Version Control Sheet

Version	Date	Author	Status	Comment / changes
Draft 1	Sept 2017	J.Eskins /H.Roberts	Draft	For consultation with CGCSC, EMT
Draft 2	Sept 2017	J.Eskins /H.Roberts	Draft	Updated minimally from consultation ready for Trust Board
Draft 3	Sept 2017	J.Eskins /H.Roberts	Draft	Updated following Trust Board review of papers
Version 1	Oct 2017	J.Eskins /H.Roberts	Current	Approved by Trust Board

Datix Death Notification and Mortality Review flowchart

South West Yorkshire Partnership NHS Foundation Trust

Death of patient occurs

If the service is the main provider of care, or there are care concerns (see policy), the incident is recorded on Datix completing related questions

Staff will need to engage with families to offer condolences in line with Being Open

Datix includes questions to capture if there are care concerns raised by family, clinical staff or governance

Clinical systems updated

Manager reviews death and gives initial unexpected/expected view

EXPECTED NATURAL ← →UNEXPECTED / UNNATURAL

Expected natural (EN1)

Eg terminal illness

No further action at present time

Expected natural (EN2)

Eg Cancer, expected but not expected timescale

Expected unnatural (EU)

Eg death expected, but not cause, eg drugs or alcohol

Unexpected natural (UN1)

Eg cardiac arrest, stroke, Road Traffic Accident

Unexpected natural (UN2)

Eg alcohol dependency but care concerns

Unexpected unnatural (UU)

Eg suicide, homicide, abuse, neglect

Was deceased seen within 6 months prior to death?

Yes

No

Manager's 48 hour review (Datix)

Includes review of physical and mental health care and concludes with the manager view of if they feel further investigation is needed

If death certified and no concerns raised, no further action

Deaths reported on Datix are reviewed by Patient Safety Support Team and level of mortality review identified: Certification, Structured Judgment Record Review or investigation

Weekly review of activity, decision re investigation level, terms of reference at ***Clinical Risk Panel***

Monthly review of all death reported on Datix at ***Mortality Review Group***

Deaths outside Trust remit/timeframe/scope/reporting requirements

Datix updated with rationale
Coding updated, eg natural causes

If not Trust incident, reject on Datix (will remain in system in case of future query, but will not be included in routine data)

If patient had learning disability

Agreed scope

Learning Disability Review (LeDER)
Ages 4-74

Under 18 Child Death Review

Service level investigation

STEIS
Investigation report
action plan
themes

Other Review eg
Safeguarding
Domestic homicide Review
Homicide
Other Trust leading
Joint review/investigation

Structured Judgment Record Review

Mortality Surveillance Group

- Assurance to Trust Board on mortality
- Review of care statistics
- Outcomes from review/investigations
- Death data
- Total death figures, trends
- Learning themes from SIs

Outcomes recorded

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 3 October 2017
Agenda item 8.1

Title:	**Health and Safety Annual Report 2016/17 and Action Plan 2017/18**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates
Purpose:	The Trust Board has a duty to ensure that the health, safety and welfare of service users, staff and visitors remains a high priority within the organisation and as far as reasonably possible, risks are mitigated or reduced. This paper is devised to give assurance that the Trust has the systems and processes, so far as practicable, to ensure the health, safety and welfare for service users, carers, staff and visitors.
Mission/values:	Safety and effectiveness in a complex caring environment is vital to ensuring carers can have confidence individuals receive care that enables them to live well in their communities.
Any background papers/ previously considered by:	The Clinical Governance and Clinical Safety Committee receives regular health and safety updates including a report for the health and safety Trust Action Group at each meeting. The Committee also receives and scrutinises the Safety Services Annual Report and action plan which is attached to this paper. The Executive Management Team has also considered and agreed the attached Safety Services Annual Report and action plan.
Executive summary:	The role and responsibilities of the Trust Board for health and safety is set out in the Health and Safety Policy approved by the Board in 2015. The policy states that the responsibility of the Board is to ensure, so far as reasonably practicable: 'That all steps are taken to ensure the health, safety and welfare of all staff, partners, service users, visitors and others' To discharge its responsibilities the Trust has well established and robust management and governance arrangements for health and safety management. These arrangements include: ➢ The Clinical Governance and Clinical Safety Committee having delegated responsibility for the regular oversight of health and safety management within the Trust. The Committee agrees and signs off the annual health and safety programme, receives and scrutinises the annual health and safety report, receives an update at each meeting from the health and safety Trust Action Group as well as receiving ad hoc reports. ➢ An executive director on the Trust Board, Director of Human Resources, Organisational Development and Estates has been appointed as the lead for health and safety.

	➢ The Trust has an established and well attended Health and Safety, Emergency Preparedness Trust Action Group supported by two locality based sub-groups. These groups provide a strong management system, in line with national guidance, for ensuring that effective health and safety management is embedded across the Trust. To ensure strong engagement, these groups consist of specialist advisers, managers, clinicians and staff side representatives and there has been good attendance throughout the year. ➢ An annual health and safety audit is undertaken each year to ensure compliance with health and safety and fire safety related policies. This enables the Trust to identify any potential gaps requiring immediate action and/or use it as a base to inform the annual programme. ➢ The Trust runs significant safety training programmes and monitors attendance. ➢ Health and Safety performance is measured regularly through the analysis of a number of data sources including: - Datix Reports - Specialist Advisers reports - Annual monitoring returns - Ad hoc health and safety visits - Any external reports e.g. CQC - Sickness reports ➢ The Trust's capital programme prioritises schemes related to health and safety and fire compliance. The attached Safety Services report is designed to provide an update of the key actions related to the above for 2016/2017. The report also details the high level priorities for 2017/2018 which have been signed off by the EMT and Clinical Governance and Clinical Safety Committee, the key themes are: ➢ Continue to embed a robust risk based monitoring and audit programme. ➢ Refine the set of performance indicators ➢ Continue to deliver and improve health and safety training. ➢ Develop regular communications framework for health and safety. ➢ Ensure the Trust responds to ongoing learning from the Grenfell fire ➢ Revise the Trust's Health and Safety Policy ➢ Trust Board training following recent NHS corporate manslaughter cases **Risk appetite** Risk identified – the Trust continues to have a good governance system of proactive safety support to all levels of service. This report covers assurance for compliance of risk for health and safety and other safety related issues i.e. Fire, Security and

	Emergency Planning. Further, the report demonstrates legislative and compliance with CQC standards for safety issues. This meets the risk appetite – low and the risk target 1-3.
Recommendation:	**Trust Board is asked to approve the health and safety annual report for and AGREE the action plan for 2017/18.**
Private session:	Not applicable.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Safety Services

Annual Report 2016/2017

Head of Estates & Facilities

Produced in conjunction with Safety Service Advisers

Contents

Appendices

1. Executive Summary

This year has been extremely busy with the Safety Team as an overall service supporting the Trust through its ongoing change processes and through some key events in the year notable issues in 2016/17 have been:

- Excellent overall improvement in staff Health & Safety, up to 91% from 85% achieved in 2015/16.
- The annual audit of the health and safety in all Trust premises across the geographical sites in Barnsley, Calderdale, Kirklees and Wakefield. All Business Delivery Units were covered with an overall Trust wide 86% compliance
- Strengthened partnership working with third party Trusts, Local Authorities and the Health & Safety Executive (HSE);
- Strong interdepartmental links and partnership working, involving Specialist Advisers and Staff Side;
- The Health, Safety & Emergency Preparedness TAG has been a success following the merge of the Health & Safety TAG and the Emergency Preparedness, Resilience and Response TAG. Both the TAG and Sub Groups continue to meet regularly and work effectively;
- Excellent uptake of safety related training at Mandatory/Core training days, including Fire Safety, Health & Safety Awareness and Lone Worker training
- Involvement in the Flu campaign which has seen the Trust obtain its highest ever score and obtain the full CQUIN delivery;
- Support in the fire on Trinity 2 and the subsequent relocation exercise;
- The roll out of the lone worker devices renewal programme which has significantly expanded within the Trust to over a thousand devices;
- Support to staff moving into the new hubs;
- Delivery of all training needs;
- Achieving all possible requirements against the NHS protect standards;
- The roll out of a new Directors on call pack;

The 2017/2018 action plan builds on the previous years and is designed to:-

- Continue to embed a robust risked based monitoring and audit programme;
- Refine a set of key performance indicators to help manage risk and improve health and safety arrangements in the Trust;
- Continue to improve access to health and safety training;
- Develop regular communication framework for health and safety.

2. Introduction

This report is designed to provide an overview of the key achievements from all respective areas; health & safety, security, fire safety and emergency preparedness, during 2016/2017, and any areas of development within 2017/2018. Areas of development will be provided by way of action plans and added as appendices to this document.

The report furnishes the Executive Management Team (EMT) with an up to date summary on Trust activities during the previous financial year and also proposed work streams for 2017/2018.

All teams have worked throughout the year to achieve both internal targets and external targets and legislation, for instance, the NHS Protect Security Standards, Fire Safety Legislation, Mandatory Training targets and the Care Quality Commission (CQC) standards; to name a few. Details of such achievements will be referenced throughout the report.

The team work consistently towards implementing national safety legislation into policy, procedure and practice, including the Health & Safety at Work etc. Act 1974 and the Management of Health & Safety at Work Regulations 1999.

Overall the Trust and Trust Board has met its obligations in terms of managing Health and Fire safety as set out in the Health and Safety and Fire Safety policies and exhibits an open culture in its management of these agendas. The Sub groups and the TAGs which report into the Clinical Governance and Clinical Safety Committee ensure that the Trust has a robust reporting mechanism for these agendas, in addition the use of Datix to monitor and manage risks and provide robust reporting functions for managers to use is regarded as a strong management tool.

3. Health & Safety

2016/17 has proved to be a busy year for the Health & Safety Team. The 2016/17 Annual Action Plan provided a solid platform for the prioritisation of works. These works were achieved in addition to other key work streams, such as joint partnership working on the launch of the new Wakefield and Pontefract hubs. The completion of these works has not only resulted in key achievements which are noted below, but has also highlighted potential risks that will need to be addressed via the 2017/2018 Annual Action Plan, all of which are noted below.

The Quality Improvement and Assurance Team (QIAT) was also commissioned by Roland Webb, Health and Safety Manager on behalf of the Health and Safety Trust Action Groups to undertake the annual audit of the health and safety in all Trust premises across the geographical sites in Barnsley, Calderdale, Kirklees and Wakefield. All Business Delivery Units were covered with an overall Trust wide 86% compliance

Where gaps in Health & Safety requirements were identified, these were noted at early stage by the Health & Safety Team who proactively supported Services with suitable action plans.

Of note however, is the excellent overall improvement in staff Health & Safety, up to 91% from 85% achieved in 2015/16.

Achievements

There have been a number of achievements noted during the reporting year; the majority of which were pre planned work streams from the Annual Action Plan 2016/17. These achievements include:

- Strengthened partnership working with third party Trusts, Local Authorities and the Health & Safety Executive (HSE);
- Strong interdepartmental links and partnership working, involving Specialist Advisers and Staff Side;
- The 2016 Health & Safety Monitoring programme was distributed centrally from the Health & Safety Team, with access to responses made available via the electronic data collection platform, the "Survey Monkey system". Follow up audits and inspections are being planned as a result of early analysis of responses;
- The Health, Safety & Emergency Preparedness TAG has been a success following the merge of the Health & Safety TAG and the Emergency Preparedness, Resilience and Response TAG. Both the TAG and Sub Groups continue to meet regularly and work effectively;
- Excellent uptake of safety related training at Mandatory/Core training days, including Fire Safety, Health & Safety Awareness and Lone Worker training (see Appendix 5).

Areas of Concern during the Current Financial Year

It has been discovered that a number of ligature risk assessment action plans had not been sent to the Estates TAG for review and funding allocation which has led to the delay of works. The process for these action plans is being reviewed to ensure future provision is achieved. This has been resolved by the assessments being reported to EMT with a costed solution approved. Going forward the ligature and suicide group is tasked with ensuring the assessments are undertaken and completed in a timely manner with recommendations being fed back to the group for action.

The new Hubs BDU have opened in Wakefield and Pontefract. Staff members working from the hubs have been provided with equipment to enable agile working. Ongoing support is being provided to staff in order to assist transition from a fixed based role to an agile role. The main concerns being reported from this workstream are lone working and the undertaking of DSE (Display Screen Equipment) assessments. Both of these concerns are being monitored through the sub groups and the overall TAG with solutions available through the Trusts existing provision.

Key Risks for 2017/2018

The number of Reporting of Injuries, Diseases and Dangerous Occurrence Regulations 2013 (RIDDOR) reported during the financial year has increased by 15% from the previous year. Analysis has shown that this is primarily due to an increase in injuries sustained during Violence & Aggression Incidents. In addition to this, the timeliness of both reporting incidents and updating incidents to inform of injury and absence length will need to be addressed, given the strict deadlines for reporting incidents imposed by the HSE.

The HSE have noted that Stress in the Workplace is now the second most commonly reported cause of occupational ill health, accounting nationally for 37% of all work related ill health cases. Stress in the Workplace is taken very seriously within the Trust, with strong support mechanisms in place for staff via the in house Occupational Health Service.

A fast track Occupational health referral process is in place for both stress and MSK related illness. The Trust also has an in-house staff consultancy and counselling service which staff can access by self-referral. A mental health and well-being (stress) policy provides advice to managers to manage stress issues within the workplace. A stress pathway also provides advice and guidance to staff experiencing work or personal stress. The Trust also has an active pastoral and spiritual care service who run regular staff retreats throughout the year allowing staff who are experiencing health issues to attend retreats to improve their well-being. Access to mindfulness training is also provided and regular mindfulness sessions are held. In the summer of 2017 the Trust provided access to yoga for staff to improve physical and mental well-being. A support group for women experiencing the menopause was also established. The Trust also has a comprehensive well-being intranet site which signposts staff to services.

The most common reported cause of occupational ill health, noted at 41% is musculoskeletal disorders. The Trust again has support mechanisms in place with a staff Physiotherapist who can work with staff to prevent absence from work and aid in the recovery from musculoskeletal injuries. The Health & Safety team will continue to work in conjunction with these teams and monitor sickness absence via Key Performance Indicator reports provided to the Board. The Trust also has an MSK group which review well-being survey data and provide targeted support to service areas. Specialist training is provided as well as workplace assessments. The Trust has administered annual well-being at work surveys working with Robertson Cooper, occupational psychologists, since 2009. The survey in 2017 received 1900 responses enabling targeted action planning.

In September/October 2017 the Trust ran a number of health at work roadshows providing advice and support to staff to improve their well-being including health checks. A staff magazine to promote well-being is being distributed in October.

Priority Actions for 2017/2018

Three priority actions have been identified for the Health & Safety Team to focus on during 2017/18, these being:

1. Undertake audits and inspections, based on the outcomes of the 2016 Annual Monitoring Tool, providing support to teams where required; These will be undertaken throughout the year
2. Review Health and Safety policies and procedures to ensure that they remain fit for purpose; This will be completed at the end of the year as part of the overall refresh due in May 2018
3. Revise the manager's Health & Safety training programme which is scheduled for implementation during the 2017/18 financial year commencing in October

4. Fire Safety

The Fire Safety Team continues to ensure that the Trust and its employees remain protected against the impact of fire. This has had its most severe test this year with the significant fire on Trinity 2. It is clear from the actions of the ward staff on the night that they were confident in their ability to undertake a staged evacuation of the ward during an actual fire. This is a tribute to them and can only be possible where a Trust has robust training in place. This staged evacuation was supported by the works required by the Fire Safety Team to ensure fire stopping on the buildings is maintained to the highest standard.

The team has reduced by one person during the year and this along with future changes has emphasised the need for close cooperation with the rest of the safety team and the need to succession plan for staff changes to ensure training and inspections continue to be delivered effectively.

Achievements

Key achievements noted in 2016/17 are noted below:

- There were 156 fire alarm activations recorded on Trust managed sites during the reporting year; this was a decrease on the 143 reported in the previous year. Of the 156 activations, 14 required attendance by the Fire Service and 135 were classified as false alarms;
- 7 minor incidents of fire have been dealt with internally by staff, without intervention from the Fire Service; these incidents include setting alight paper in bedroom bins causing small fires that were managed by staff. All incidents were recorded on the Datix system and noted damage from the incidents. These incidents occurred as a result of individuals breaching the Smoke Free Policy.

Priority Actions for 2017/2018

Four priority actions have been noted for 2017/2018, which are as follows:

- Review the Trust Fire Policy to reflect changes to Trust departmental and BDU structures;
- Continue to provide suitable training opportunities to meet the requirements of the mandatory training and fire policies, including increased use of the practical fire training unit at Fieldhead;
- Review and update the Fire Plans and Fire Compartment drawings in Trust owned premises;
- Provide Fire Safety and Fire Marshal Training staff working in new hubs in new locations across the Trust.
- The Trust has also responded to the NHS England process following the Grenfell Fire completing all fire returns in order to achieve compliance. Due to the responses the Trust gave no follow up action was required and the Trust has had routine inspections completed post this exercise with no identified issues.
- To provide a risk assessed priority list for Sprinkler systems in ward areas for consideration by the Estates TAG for capital funding in 2018/19 and beyond.

5. Security

The Security Team have worked towards achieving the NHS Protect Security Standards for Providers throughout the reporting period. This is a requirement from the NHS Business Services Authority to ensure that a safe and secure physical environment that has systems and policies in place to protect NHS staff from violence, harassment and abuse; safeguard NHS property and assets from theft, misappropriation, or criminal damage. Out of these standards 2 main areas of work focussed staff efforts; including the Security Incident Reporting System (SIRS) and also the provision of assessment reviews across all Trust premises.

In addition to these pre planned works, the building works at Fieldhead and additional teams moving to Fieldhead has increased pressure on the Security Team, needing to provide additional support to staff with regards to parking across the site.

Achievements

Key achievements in 2016/17 include:

- Achievement of 28 out of 29 Security Management Standards for Providers. The 1 remaining standard relates to the implementation of the SIRS system. SIRS became inaccessible to all users from 01 April 2017 following the closure of NHS Protect, and as such the will be decommissioned and no longer implemented in the Trust.
- Minor capital schemes for Pinpoint and CCTV upgrades approved and installation finalised by financial year end;
- Roll out of the Lone Worker Project for 1200 devices continued throughout the financial year, with only 160 devices left to allocate. E-learning is now available to alleviate travel pressures for those staff who require a device;
- Support provided for the opening of the new Hubs and also closure of numerous buildings across the Trust;
- Forging partnerships and strengthening relationships with Police, Councils and CCG's across all regions of the Trust's geographical area.

Key Risks during 2017/2018

Due to numerous projects being undertaken there have been a number of risks that need addressing over the coming 12 – 18 months.

The lockdown profiles for clinical units need to be finalised so to provide assurance to the Trust, NHS Protect and also NHS England that in the event of an incident, clinical areas can effectively lockdown their services in order to protect patients, staff and property. Work is underway, led by the Emergency Planning Team, who are collecting clinical unit lockdown profiles and subsequently arranging a table top exercise to test arrangements. The Security Team are assisting this piece of work. This work is an ongoing process the first lockdown exercise was completed on the 19th of July this year with a further exercise on the 2nd of August which was a communications test. These exercises will continue going forward with learning being shared through the EPRR TAG.

As part of our service redesign, a number of services have relocated to the Fieldhead main site. This and the major non-secure rebuild scheme have impacted somewhat on the access to available vehicle spaces. However, to reduce the impact on space availability 54 additional spaces have been created in various locations across the site. Further to this, at the entrance of the site a car parking vehicle space availability board has been erected to assist staff in identifying which car parks are accessible throughout the day. The Security Team continue to monitor and assist motorists at busy periods throughout the day. A Car Parking Group has also been established to streamline and implement management processes to help alleviate parking issues. All strategies' that have been implanted are continually monitored to ensure staff and service disruption is minimised.

Empty premises pose a security risk, as even though premises are alarmed the chance for buildings to suffer damage and vandalism is still prevalent. The team are working closely with Gough & Kelly to monitor activity on these premises until such a time they are no longer part of the Trust portfolio. CNDH has been boarded and all other premises are evaluated and measures implemented to mitigate identified risks.

Priority Actions for 2017/2018

NHS Protect closed its security management section at the end of the reporting financial year which has resulted in no support and guidance in relation to the security management standards. The Team need identify a strategy to forward plan and identify arrangements and support mechanisms that need to be implemented within the Trust so to continue to provide an effective, up to date security service.

There will still be a requirement for the following 2 years to adhere to and achieve compliance against the Security Management Standards. A new service, NHS Counter Fraud Authority will be established from 03 July 2017; however this service will not oversee the standards.

The Crime Reduction Surveys for Trust premises will need to be completed based on the dictated frequency and risks associated with the premises; a review of the schedule will dictate the number of reviews that need completing. All ward areas are surveyed annually with other areas surveyed on a two or three yearly cycle dependent on risk. The schedule is held with the Health and Safety Team and reported as an estates KPI through Estates TAG.

6. Emergency Preparedness

Every year the core standards for EPRR increase. Whilst works to comply with standards should roll over year on year, the Emergency Planning Team must review and ensure standards continue to be achieved and cater works to implement and achieve new standards. In 2016/2017, new standards relating to Business Continuity were implemented relating to the Business Continuity of Contractors and Sub Contractors employed within the NHS.

Achievements

The NHS England Core Standards for Emergency Planning form an action plan for the Emergency Planning team to work against. Key achievements during the reporting period include:

- The implementation of a Director on Call pack and BDU specific Managers on Call packs. The Directors on Call pack is due its 6 monthly review in order to monitor its effectiveness.
- Established links with neighbouring councils and health providers so to ensure strong communications in the event of a serious incident;
- Strategic Leadership in a Crisis training was provided to members of EMT in January and February 2017. Feedback from delegates was positive and the team are now looking to request funding for an additional session so to ensure all required staff are trained.

Key Risks for 2017/2018

With the Trust estate reducing, BDU teams need to review their BCP contingencies so they can operate their services effectively. One potential risk that has been highlighted is the loss of a hub building. This loss could impact on the delivery of operational services. This risk will hopefully be addressed in the revision of departmental Business Continuity Plans to ensure staff are aware of actions to be taken in the event of a loss of service.

Priority Actions for 2017/2018

To continue to fulfil the NHS England Core Standards for Emergency Preparedness, Resilience and Response, the Emergency Planning team need to monitor systems that are already in place. Actions for the 2017/2018 plan include:

- The Directors on Call pack needs to be reviewed in full to establish its effectiveness. A paper is to be sent to EMT requesting feedback;
- Business Continuity Awareness week takes place between the 15th & 19th May 2017, with a reference topic of Cyber Security. The team need to liaise with Information Services to promote the event and also deliver Trust appropriate information to raise awareness of cyber-crime. It is also intended for Business Continuity to be an additional topic to promote at the event;
- All key staff are to be trained in Strategic Leadership in a Crisis training; the provision of further training is to be discussed with Learning & Development; this training was delivered in two sessions in quarter 1 of the year
- All BDU's to be contacted and requested to update their Business Continuity Plans, providing a copy to the Emergency Planning team. All old plans are to be archived as they have passed review date. This work is an ongoing process but all areas have been contacted and have responded with the plans they have in place at the moment. These plans are being updated and progress against this is measured at the EPRR TAG.

7. Conclusion

2016/2017 has been a productive and challenging year across the Safety Service function with a number of notable achievements recognised from each work stream. The success of the Health & Safety Monitoring Tool roll out, the notable reduction in Unwanted Fire Safety Calls to the respective Fire Brigades, the roll out of the Lone Worker Project and implementation of new on call packs for Managers and Directors are a number of key achievements discussed within this report.

2017/2018 will be just as challenging if not more for staff within the function, with changes in legislation potentially impacting policies and procedures, the need to redesign training packages to meet the changing workforce, the creation of suitable support mechanisms following closure of national NHS bodies and also the implementation of new standards to achieve compliance against. New targets will be implemented to enable the teams to meet the requirements of the Trust, its staff and external standards throughout the next reporting year.

Appendix 1

Health & Safety Action Plan 2017/2018

Task/objective	Lead Director/ Senior Manager	Lead Officer(s)	Rationale	Target For Completion	Comments
Audit/Inspection spreadsheet held by Health & Safety Team to be updated from results of H&S 16/17 Monitoring programme. Visits To be planned for 17/18	Director of human resources, organisational development and estates /Head of estates and facilities	Health and safety manager/Fire safety advisor/Emergency planning and safety advisor	To ensure support can be accurately and promptly targeted to services & teams	Q1 Audit programme now in place	Planned audits, inspections and visits to teams are a fundamental element of the Trust's approach to HSG65.
Deliver H&S Update Briefing Session to Trust Board & EMT	Director of human resources, organisational development and estates /Head of estates and facilities	Health and safety manager	To ensure the Executive and Senior Team have access to current issues	Q2 This to be done at September Board	Health & Safety legislation constantly evolves and with new colleagues joining the Executive Team, a Safety update will ensure colleagues have pertinent information to fulfil their legal H&S obligations.
Travel at Work Policy & Guidance to review	Director of human resources, organisational development and estates /Head of estates and facilities	Health and safety manager	Existing policy is maturing and requires refreshing	Q3 To be completed in December 2017	Travel at Work issues continue to be of concern and a high priority for the Health & Safety Executive.
RIDDOR Policy & Guidance to review	Director of human resources, organisational development and estates /Head of estates and facilities	Health and safety manager	Existing policy is maturing and requires refreshing	Q3	RIDDOR is a legal requirement and continues to be a high priority for the HSE & Trust. HSE now share RIDDOR intelligence with CQC in some circumstances
Implement and complete audit/inspection programme by end of March and prepare for 2017/2018 monitoring programme	Director of human resources, organisational development and estates /Head of estates and facilities	Health and safety manager/Fire safety advisor/Emergency planning and safety advisor	Ensure effective Trust wide approach to health & safety monitoring/inspections for Trust Board assurance.	Q4 This programme is delivered throughout the year	The annual health & safety monitoring programme, including the audit and inspection schedule all underpin Trust Board re-assurance of effective health & safety measures within the Trust.
Develop further, effective and robust links with a range of key Trust Business partners, including local partner Trusts, CiC's CCG's and Local Authorities	Director of human resources, organisational development and estates /Head of estates and facilities	Health and safety manager Roland Webb	To develop a consistent Trust wide approach with Trust business partners in line with existing models	Q4	Health & Safety will be supporting and working with partner organisations, "so we can be relevant today and ready for tomorrow"
Update Health & Safety Intranet pages and ensure policies and all H&S Information is current with correct contact details	Director of human resources, organisational development and estates /Head of estates and facilities	Health and safety manager/Fire safety advisor/Emergency planning and safety advisor	To ensure Trust staff have reliable and pertinent access to Health & Safety Information	Q4	As the roll out of new services evolve and working practices modernised Health & Safety information will be updated as required.

Appendix 2

Security Management Action Plan 2017/2018

Task/objective	Lead Director/ Senior Manager	Lead Officer(s)	Rationale	Target Date For Completion	Comments
Progress Security Assessment Reviews across the trust with particular attention paid to imminent building closures and projected closures.	Director of human resources, organisational development and estates/Head of emergency planning, resilience and response and security	Local security management specialists	To support the Security Standards and to provide cost effective solutions for building closure and security target hardening	March 2018	Review frequency and risk ratings of all assessments and implement new schedule.
Continue to manage the external security provider through Key Performance Indicators and review effectiveness and cost benefits of current provision with a view to tender out the contract in 2018.	Director of human resources, organisational development and estates/Head of emergency planning, resilience and response and security	Local security management specialists	Cost effective fit for purpose security provision across the Trust.	March 2018	
Continue to monitor usage, effectiveness and compliance of lone worker device provision across the Trust.	Director of human resources, organisational development and estates/Head of emergency planning, resilience and response and security	Local security management specialists	More staff becoming agile; continue to support through various lone working provisions.	March 2018	
Review all systems and processes that relate to the devolvement of NHS Protect and the birth of the new NHSCF Team.	Director of human resources, organisational development and estates/Head of emergency planning, resilience and response and security	Local security management specialists	The loss of support from NHS Protect results in the need to review all systems and processes relating to security management.	July 2017	Complete

Appendix 3

Emergency Preparedness Action Plan 2017/2018

Task/objective	Lead Director/ Senior Manager	Lead Officer(s)	Rationale	Target Date For Completion	Comments
Arrangements ensure the ability to communicate internally and externally during communication equipment failures.	Director of human resources, organisational development and estates/Head of emergency planning, resilience and response and security	Emergency planning and safety advisor		January 2017	Completed December 2016
Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity plans.	Director of human resources, organisational development and estates/Head of emergency planning, resilience and response and security	Emergency planning and safety advisor		May 2017	Completed February 2017
Demonstrate organisation wide (including on call personnel) appropriate participation in multi-agency exercises	Director of human resources, organisational development and estates/Head of emergency planning, resilience and response and security	Emergency planning and safety advisor		March 2017	December 2016
Preparedness ensures all incident commanders (on call directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.	Director of human resources, organisational development and estates/Head of emergency planning, resilience and response and security	Emergency planning and safety advisor		May 2017	Linked to Objective 2. Completed February 2017
The Accountable Emergency Officers has ensured that their organisation, any providers they commission and any sub-contractors have robust business continuity.	Director of human resources, organisational development and estates/Head of emergency planning, resilience and response and security	Emergency planning and safety advisor		June 2017	Communication with Head of Procurement to identify how to ensure sub-contractors have appropriate BCP's in place at point of tender.

Appendix 4

Key Performance Indicators

INCIDENTS/EVENTS

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)

RIDDOR requires the Trust to report all over seven day injuries to the Health & Safety Executive; a total of 44 such incidents were reported during 2016/2017. This was a 13% increase from 15/16, with violence and aggression related incidents being the major incident factor.

Safety Related Incidents

A total of 4972 of safety related incidents were recorded in 2016/2017, down 20% (1277 incidents) from 2015/2016, with violence and aggression accounting for 58% of incidents reported. The reported violence and aggression incidents mirror the increase in RIDDOR notifications from the year.

Slips, Trips & Falls

A total of 663 reports of Slips, Trips and Falls (a 29% reduction from 2015/2016), were recorded across the Trust. The majority of reported incidents affected clients within the clinical setting, followed by staff members sustaining injury whilst undertaking their daily tasks.

Security Related Incidents

429 security related incidents were recorded during the financial year, with Property Incidents noted as the highest reported type, followed by Building Environment and Security.

All incidents were investigated accordingly with support provided where necessary to affected staff members.

Appendix 5

Safety Related Training Statistics

A total of 7597 staff members received a form of safety related training during 2016/2017. Fire Safety is the only mandatory training session listed within the table below. Total attendance for all fire safety training for the year was 84.27% which exceeds the minimum attendance target of 80%.

Training is offered to all staff with the option to deliver dace to face training; pre organised events and also attendance at team meetings is available to provide a training session. During 2016/2017 a total of 420 face to face training sessions were provided by the Safety Services Team.

Training Type	Number of Participants
Conflict Resolution	28
Conflict Resolution Refresher	54
Conflict Resolution E-learning	23
COSHH Workbooks	160
Emergency Aid	1
Fire Safety Training	3026
Fire Safety E-learning	2085
First Aid	26
First Aid Refresher	12
Health & Safety Awareness	394
Health & Safety E-learning	4
Health & Safety Workbooks	131
Lone Worker Training (Identicom Device Training)	1365
Trust Welcome Day	550
Strategic Leadership in a Crisis	56
Risk Assessment	42

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 3 October 2017
Agenda item 8.2

Title:	**Sustainability Update - 2016/17**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates
Purpose:	To note the activity undertaken in 2016/17 to support the organisation to evidence it operates within the Good Corporate Citizen framework and delivers against Trust strategy. To note ongoing commitment to efficiency and effectiveness in this area of operations.
Mission / values:	The Trust's mission is to enable people to reach their potential and live well in their community. The Trust will not achieve this unless it ensures it operates sustainably in the use of resources and in how it works with local communities. Sustainable operations support all the Trust's values and delivery of strategic objectives through improving people's health and wellbeing, improving people's experience of services and the efficient and effective use of resources.
Any background papers / previously considered by:	Sustainability Strategy 2015/16 – 2019/20 and associated policy.
Executive summary:	The purpose of this summary report is to update the Board on work to integrate sustainability into Trust operations, as defined in the Trust's Sustainability Strategy which runs to 2020. The strategy provides a framework covering national goals as well as energy and carbon management, procurement, transport, travel and access, water, waste, designing the built environment and adaptation, organisational and workforce development and partnerships and networks. Staff who focus on specific areas of the agenda continue to deliver good results. Examples include: ➢ Successful implementation of a commercial waste management contract which has enabled the removal of accumulated waste which is subject to specialist handling and disposal. ➢ Segregation of waste for recycling. The Trust has exceeded targets for recyclable and non-hazardous waste. ➢ Exceeding carbon reduction targets with an updated target for 2020 of 34% reduction on the 2010-11 baseline. This equates to an overall planned reduction of over 4500 Tonnes of carbon emissions. Energy efficiency improvements, implementation of the Estates Strategy by rationalisation of the property portfolio and agile working have all contributed to a reduction of 32.63% by the end of 2016/17. ➢ Green Travel plans are being developed to support further reduction in business miles to minimise the impact of travel on the environment in the context of running an efficient business.

	Continued efforts are required to promote the agenda and associated initiatives via all Trust communications channels, with staff encouraged to participate via i-hub to identify best practice and suggest challenges for improvement. The Trust has noted work by the Sustainable Development Unit to improve the Good Corporate Citizen Development (self-assessment) Tool. The new version is expected to be live later this year and is intended to help organisations evidence and track performance. The Trust will review the new version and determine whether self-assessment will add benefit in 2017/18 once green travel plans are in place. A new baseline score would need to be determined and an evidence pack and action plan created. **Risk appetite** The Sustainability update provides information to the Board on delivery of this agenda. Issues are reviewed in estates and facilities forums and through good governance around other services including procurement, creative partnerships and volunteer activity. Issues are escalated to appropriate directors to ensure action in line with the Trust's Risk Appetite Statement.
Recommendation:	**Trust Board is asked to NOTE the report and progress to date.**
Private session:	Not applicable

South West Yorkshire Partnership NHS Foundation Trust

Sustainability

Summary report

2016 / 17

Trust Board – 03 October 2017

September 2017

With **all of us** in mind.

Sustainability Summary Report – September 2017

Introduction

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

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

Sustainability Strategy

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

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

The Trust is working to a five year sustainability strategy covering the period 2015/16 - 2019/20. The strategy provides the framework to ensure the integration of sustainability into Trust operations and in engagement with staff, service users and local communities. The Trust's service, communications, engagement and involvement, equality and digital strategies also support this agenda.

The sustainability strategy covers the three national goals as well as energy and carbon management, procurement, transport, travel and access, water, waste, designing the built environment and adaptation, organisational and workforce development and partnerships and networks.

Staff who focus on specific areas of the agenda continue to deliver good results across the areas described above. There is work to do to re-energise broader staff connection to the sustainability agenda. Sustainable initiatives will be promoted via all Trust communications channels, with staff encouraged to participate via i-hub to identify best practice and suggest challenges for improvement.

Sustainable Development and Carbon Management

Trust's Carbon Management Plan:

Carbon Emissions – Data Analysis

Data

	Carbon Emissions		
	CO_2 (tonnes) 2010-11 Baseline Emissions	**CO_2 (tonnes) 2015-16**	**Overall %Reduction**
Stationary	11,515	8,336	-27.61%
Transport	1,404	1,127	-19.73%
Further Sources	452	64	- 86.72%
	13,373	**9,527**	**-28.76%**

Sustainability Strategy

The Trust set an original Carbon Reduction Target of 18% (2,407 Tonnes (CO_2) based on its Carbon Emissions in 2010-11 Tonnes **13,373** (CO_2). This ambitious reduction in Stationary, Transport and Further Sources committed the Trust to actively pursue areas of specific improvement. Through a targeted operational and energy efficiency investment plan, coupled with the Trust's Estates Strategy that recognises service change with agile working and estates rationalisation, the planned reduction has been exceeded.

This accomplishment has made a significant contribution to reducing the Trust's Carbon Footprint. Aligning with the Trust's sustainability goals, the planned 5 year target has been extended to 2020 with a new target reduction of 34%. This will require the Trust to reduce Carbon Emissions by 4,547 Tonnes CO_2.

- Trust Updated Carbon Reduction Target (2020) – 34% Overall Planned Reduction **4,547** Tonnes (CO_2)

Trust's Carbon Management Plan:- 2016-17 Update

Source - ERIC Data for 2016-17; Carbon Trust assessment tool

Data

	Carbon Emissions		
	CO_2 (tonnes) 2010-11 Baseline Emissions	**CO_2 (tonnes) 2016-17**	**Overall %Reduction**
Stationary	11,515	8,273	-28.15%
Transport	1,404	683	-51.35&
Further Sources	452	52	-88.50%
	13,373	**9,009**	**-32.63%**

- Actual Reduction in 2016-17 – 518 Tonnes (CO_2) - 5.44%

Sustainable Development & Carbon Management Plan

The Trust's ongoing commitment to reducing carbon emissions is crucial to delivering the Sustainable Development & Carbon Management Plan. A targeted investment in Energy Efficiency Improvements, a robust approach to monitoring and the contribution made through the implementation of the Trust's Estates Strategy by the rationalisation of the property portfolio, supported by agile working, have contributed to an impressive overall reduction of 4,364 Tonnes (CO_2), 32.63% from the Base Year 2010-11

Procurement

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

The main procurement challenges for the remainder of 17/18 include:

- To monitor environmental and sustainability in all goods and service tenders
- To work with suppliers who are environmentally aware and hold the relevant accreditations

- To undertake large contracting exercises
- To identify purchasing Cost Improvement Plans
- To develop skills in the procurement team to enable positive change
- To update the Sustainable Procurement Strategy.
- To update the Trust's Procurement Strategy which will include the recommendations detailed in the Carter Report (February 2016) where applicable to the Trust
- To update the department operating procedures and policies with the longer term aim of achieving level 3 of the NHS Procurement Standards.

Sustainable Travel & Agile Working

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

Green Travel

To support further reduction in business mileage the Trust is developing a green travel plan to minimise the impact of travel on the environment within the context of running an efficient business. The plan will be presented to the Executive Management Team in December 2017 and will include a range of measures aimed at promoting sustainable travel choices and reducing reliance on car travel. If effective, this will bring environmental, social and health benefits to both staff and to our communities.

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

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

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

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

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

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

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

Baseline assessment:

To assist development of a green travel plan, a detailed understanding of the current position is required. Travel surveys at Fieldhead and Kendray, undertaken in early 2017 have provided intelligence from which to better understand demand.

We know that staff use cars for convenience and to undertake other activity on the way to and from work. Time and cost savings are also major factors.

In respect of business miles travelled, on the base year of 2014/15 an average monthly total of 310,000 business miles was recorded through payroll.
The annual business mileage in 2015/16 was 3,735,911 for the trust as a whole (excluding white fleet). In 2016/17 the figure was 3,584,609 a reduction of 4% which is a significant saving as follows:

- Carbon Dioxide saving 60 Tonnes per annum
- Financial saving of £45,000 per annum

Access to public transport is varied across the Trust. Comprehensive assessment was undertaken 4 years ago and there are plans to refresh this as part of Green Travel plans. Car share and cycling schemes are already in place and publicised to staff, with cycle storage available at larger sites.

The following with be included in the Green Travel Plans:

- Providing public transport information on the intranet and the Trust's website, ensuring this is subject to regular update
- Bike to Work and staff cycle incentive schemes, with reminders about safe cycle storage
- Staff invited to join task and finish groups for specific pieces of work, providing a forum to consult staff on the implementation of the Travel Plan and to develop ideas for further improvement.
- Survey of staff travel to work choices

- Explore alternative messages and methods of communication to encourage a reduction in business mileage, evidencing a 4% reduction.
- Extension to car sharing schemes with Liftshare, with further incentives around parking
- Smarter Driving lessons for staff to reduce fuel and carbon emissions
- Work with local bus companies to provide better public transport links, for example to community hubs.
- Publicise that staff can access the Mid Yorkshire bus services to Pinderfields and Pontefract Hospitals, following recent negotiations.

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

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

- The Trust's agile working team continues to support teams to become agile across the Trust. Typically this involves workshops tailored for individual teams and equipment deployment.
- The agile working team has worked with partners to support reciprocal WiFi sharing arrangements to allow staff to work from partner sites rather than return to base during and after meetings. The locations are:
    - Barnsley Hospital NHS Foundation Trust
    - Huddersfield Royal Infirmary
    - Calderdale Royal Hospital
    - Broad Lea House, Bradley
    - Batley Health Centre
    - Beckside Court, First Floor
    - Cleckheaton Health Centre
    - Dewsbury Health Centre
    - Eddercliffe Health Centre
    - Fartown Health Centre
    - White Rose House, Wakefield
    - Mill Hill Health Centre
    - Holme Valley Memorial Hospital
- Skype for Business Audio Conferencing Facilities available at:
    - Fieldhead Hospital
    - Kendray Hospital
    - Folly Hall
    - Laura Mitchell Health & Wellbeing Centre
    - Drury Lane Health & Wellbeing Centre
    - Baghill House Health & Wellbeing Centre
    - Priestly Unit Dewsbury
- Skype for Business Video Conferencing Facilities available at:
    - Folly Hall
    - Laura Mitchell Health & Wellbeing Centre
    - Priestly Unit Dewsbury
- Skype for Business Video Conferencing Facilities will soon be available at:
    - Fieldhead Hospital
    - Kendray Hospital
    - Beckside Court

    - Ravensleigh Resource Centre
- Over 2500 laptops are in use across the Trust by agile workers
- There are 605 users of 4G Mobile Broadband which supports working in community settings and in people's homes
- There are 1895 agile workers with VPN enabling home working and other otherwise unsecured WiFi connections
- There are over 1900 Skype for Business users, having access to both audio and video conferencing facilities via laptop/desktop computers regardless of location (provided there is network connection)
- Hot desking is available at the following locations to support staff in reducing travel:

Barnsley	**Calderdale**	**Kirklees**	**Wakefield**
Kendray Hospital	Laura Mitchell	Folly Hall	Baghill House
Worsbrough LIFT	The Dales	Beckside Court	Drury Lane
Apollo Court MC	Hope Street Resource Centre	Priestly Unit	Fieldhead
Cudworth LIFT	Hebden Bridge HC	Fox View	
Goldthorpe LIFT		Pathways	
Hoyland LIFT		Ravensleigh Resource Centre	
Athersley Roundhouse			
Mount Vernon Hospital			

The typical improvement in mileage savings for staff working across a district where 4G connectivity has been provided is 15%, though the largest recorded improvement is almost a 30% saving on the previous year.

Whilst some services that have relocated to hubs have not made any savings, claims have remained relatively static, indicating more efficient travel as 'base' is further away from caseload geography than it used to be.

'My caseload covers the whole of Calderdale, so if I'm visiting right down in Lancs (Todmorden), or in Brighouse or Ripponden, I don't have to travel up-to 16 miles back to base before I can use RIO. This is much more economical for working hours. I can also (if I choose to) start work earlier in the morning and/or continue to work later in the day. This doesn't happen often, but is very convenient if it does.'

CPN, Calderdale Memory Services.

'I have found Agile working fantastic. I am able to access information whilst assessing patients at home and input patient assessments during visits appropriately. Inputting is within timescales and I am working in my contracted hours, no longer staying at work to input after 5 pm. I am also able to see more patients each day due to this. I am reducing mileage as I can work out on my area not needing to come back to base'

MacMillan Nurse

'It's also really useful to be able to access RiO and emails first thing in the morning, at home, to confirm or make any appointments for the day, rather than driving all the way to a base just to get a phone number for somewhere that might be on my way into work, and therefore it's much easier to phone before I leave. It really saves on travel time, and also makes me work more efficiently, as I don't have a cluttered desk anywhere, and can set up for work anywhere.'

Specialist Speech and Language Therapist, Kirklees Intensive Support Team

Water

The Trust continued to reduce water consumption using water efficient technologies and continued metering, monitoring and leak detection. Water efficiency is considered in all maintenance, refurbishment and new build projects. Smart meters are installed as standard into building and refurbishment projects. The water consumption for 2016/17 was 84,956 m3.

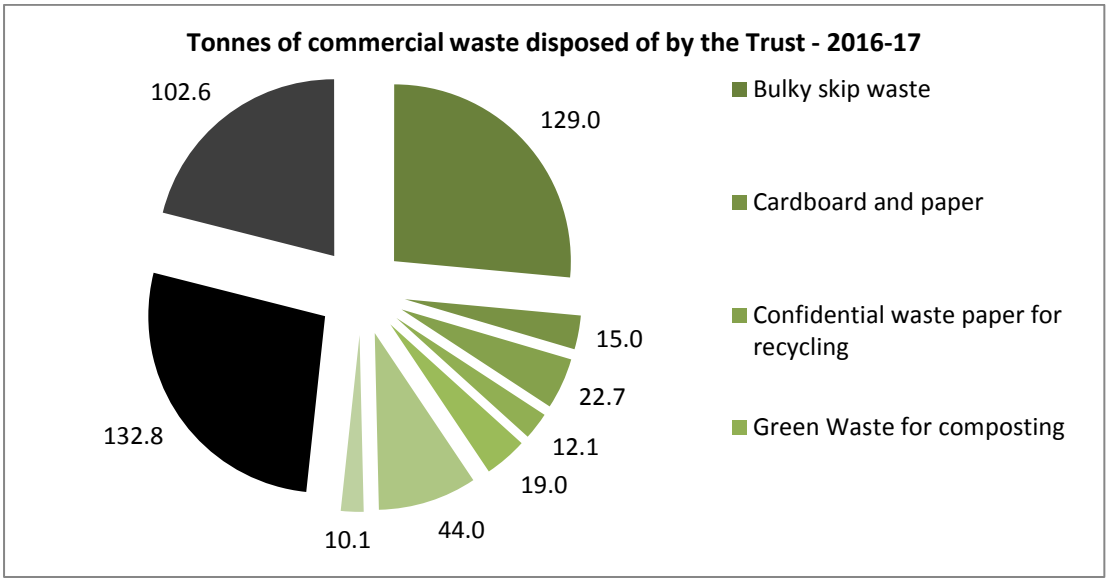
Waste Management

In 2016/17 the Trust's Waste Compliance Team implemented the New Commercial Waste Contract. This means the Trust is now able to record the weights and destinations of the majority of waste generated.

Evidencing the Trust as a 'sustainable waste disposer' is a primary aim for the Compliance Team. Prior to implementation of the new waste contract the Trust has an accumulation of specialist waste, not previously removed due to the nature of the specialist handling and disposal required. The accumulated waste has now been cleared away from Trust premises.

The majority of Trust skip waste is now segregated for recycling at mixed recycling facilities (MRF). Any general waste which is not recycled is used for energy/ electricity, predominantly at Sheffield to minimise transport emissions. The table below shows the Waste Compliance Team's targets for minimising the impact of the Trusts general waste on the environment.

	Target	percentage							
Recyclable and non-hazardous industrial waste		**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**
Segregated for recycling: metals, paper, card, green, wood	**≥10%**	18	14	24	31	10	17	16	24
Waste sent to Materials Recovery Facility (MRF)	**≥ 20%**	15	68	46	50	70	16	20	43
Waste sent to Energy recovery Facility (ERF)	**≤70%**	67	18	31	19	19	67	64	33
Waste sent to landfill	**≤10%**	0	0	0	0	0	0	0	0
	total	100	100	100	100	100	100	100	100



Recycling furniture

Rationalisation of Trust premises resulted in large amounts of furniture becoming surplus to requirements. A plan was initiated to maximise furniture sent for re-use which included:

- An 'open day' at Castleford and Normanton District Hospital (CNDH), creating the opportunity for staff to view equipment/furniture which was available for re-use.
- Sharing listed items with Mid Yorkshire Hospital Trust, Calderdale and Huddersfield Trust and Wakefield Council, with Mid Yorkshire collecting many items of furniture.
- Surplus equipment was offered to charities via the Furniture re-use Network (FRN). The following charities benefitted from furniture for re-use from CNDH, the volume of which filled 12 lorries:
    - St Vincent de Paul Society
      Emmaus
      SLATE
    - Scope
    - Sue Ryder
- Remaining items not suitable for re-use or sale by charities were sent by skips to a mixed recycled facility where the materials were segregated and sent for recycling.

Waste Management Procedure Policy

The Trust's Waste Management Procedure Policy is subject to update as and when there are changes in environmental and waste legislation.

All employees generating waste are responsible for the correct segregation of waste. Where staff treat or care for a person in their own home, any waste produced is considered to be produced by that care professional. Part of the Duty of Care is to

ensure that the waste is dealt with appropriately, from point of production to final disposal.

Barnsley Metropolitan Borough Council (BMBC) has advised its residents to dispose of offensive waste alongside general waste, which may not be appropriate for some offensive healthcare waste. As a result the Community Healthcare Waste Manual has been produced in partnership with the community nurses to ensure healthcare waste produced in domestic premises is disposed of appropriately.

Waste management challenges 2017/18:

- Risk assess and manage how over 30 categories of waste are segregated, packaged, classified and managed for collection from Trust premises.
- Provide contractors with accurate descriptions of the waste which requires collection and disposal from each of the Trust's premises.
- Carry out risk assessments for changes to the Trust's property portfolio.
- Review and update the Waste Procedures for compliance with recently published codes of practice
- Manage healthcare waste produced by Trust employees in domestic premises.
- Audit and address anomalies in healthcare waste production and multiple occupancy premises.
- Carry out activity specific waste assessment and procedures for hazardous waste.

Designing the Built Environment and Adaptation

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

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

The Trust works to the Climate Change Mitigation and Adaptation Plan and BDUs are supported to embed resilience activity into their operations. The Trust aims to be a leading exemplar in the management of major and extreme events and has

incorporated the impacts of climate change into the scenarios utilised for testing plans.

In addition the Trust has invested in the redevelopment of the Fieldhead site for non-secure services with the first phase of the development being occupied in September 2017. This building incorporates high levels of insulation together with photo voltaic electricity panels and natural stack ventilation to reduce the consumption of fossil fuels.

Organisational and workforce development

- The Sustainability Strategy encourages all staff to become 'sustainable aware', to act responsibly in their roles and to understand the actions the Trust is pursuing to reduce its impact on the environment. This links to the Trust's strategic objective to improve our use of resources.
- Efforts continue to promote initiatives and schemes which support staff to contribute to a sustainable environment, including Bikes for the NHS, cycle to work schemes, recycling information and best practice updates.
- All staff are encouraged to be efficient and effective in their use of Trust resources and to adopt agile principles into working practices wherever possible.
- Further staff engagement is planned in Qtr. 4 17/18, through the use of digital platforms, to promote good practice and invites suggestions for innovative practice in this area.

Partnerships and Networks – Good Corporate Citizen

Creative Minds / Spirit in Mind

The Trust continues to work to embed creative approaches across the organisation and with community partners to enhance the service offer. Projects add substantial value to the Trust's overall offer, by exploring service delivery areas beyond the existing provision and co-creating new and innovative solutions to the issues faced by individuals and communities.

Over the last year Creative Minds has supported the development of over 80 new creative projects in partnership with over 130 voluntary, third sector, not-for-profit organisations and other community groups. It has delivered creative arts, spiritual, sporting and environmentally based group activities to more than 5,000 contacts. Creative Minds has brought together funding streams from statutory and community sources to deliver these partnership approaches. Partners have raised over £250,000 in match funding to contribute to projects from a wide variety of community sources including Big Lottery and Arts Council England.

In 2016/17, Creative Minds became a linked charity and is able to apply for additional sources of funding, for example Children in Need (with a current bid to set up a youth choir). Examples of successful projects in year include a dementia

friendly garden at Sandal Library, a peer led Choir in Helsicar, partnerships with Greetland, Shelley and Barnsley football clubs and a ‘Good Mood’ cricket league with local cricket clubs.

Spirit in Mind is supporting and adding a further dimension to the work already being implemented in the Trust through the Creative Minds Strategy. Building on the success of that model, Spirit in Mind enables the Trust to significantly extend its partnership working and community outreach and involvement.

Partnerships have been developed between the Trust and a number of community and faith partners which represent the cultural and religious diversity of the areas served by the Trust.

Volunteering

Volunteers enhance Trust services and offer people the opportunity to gain new skills and experiences. Over the last 12 months the number of volunteers has steadily grown and the Trust currently benefits from 236 volunteers, who have offered over 37000 hours of volunteering over the year. The number and variety of volunteer roles has increased with people supporting in Recovery Colleges, Expert Patient Programme, in-patient settings and departments. Volunteers include service users, staff, student and members of the public.

The Trust achieved accreditation against the national Investing in Volunteers standard in 2016 and continues to work proactively with NHS England and the national association NAVCO to embed best practice and to ensure a positive volunteering experience. These connections help the Volunteer Service to develop in line with national guidelines.

Innovative approaches to creating volunteer opportunities in 2016/17 include:

- A pilot in forensic services to enable 2 female service users, detained under the Mental Health Act, to volunteer with Trust catering teams. Volunteering opportunities have now been rolled out across forensic services, with a volunteer recently securing paid work.
- Development of a training module for CAMHS service users to enable them to volunteer to support service recruitment. Young people now contribution to the interview selection process.
- Volunteers have undertaken roles in the Quality Support team, Mental Health Museum, Library, adult psychology and have offered lived experience through roles as peer mentors. They have supported recruitment for non-executives and a Lead Governor and led on improvement projects such as charitable funds.
- Establishing links to partners and offering volunteering opportunities; Mind, Richmond Fellowship and Choice support have recently provided volunteers for Trust services.

Volunteer services continue to work with BDUs to explore opportunities for volunteer roles and are linking with communities and partners to promote volunteering. This includes both general promotion and targeted activity, for example working with the

Women's Action Group in Calderdale to promote links to the BAME community and joint working with NOVA Wakefield.

Challenges in respect of volunteering in the coming months include:

- Continuing to raise the profile of the volunteering function and create new opportunities
- Working with services to identify volunteer opportunities
- Recruitment of volunteers to undertake identified roles
- Improving the ease with which people can volunteer and the support offered with the application process
- Engagement with community groups to promote volunteering
- Re-evaluate the training offer to volunteers
- Introducing a digital volunteer offer – to include promotion, expression of interest, application, recruitment, training, volunteer news.
- To increase the number of staff volunteers, with 'leaders by example'
- Increase community involvement, including among seldom heard groups
- Work to quantify social return on investment
- Continue to expand the range of volunteer opportunities, for example a buddy scheme for carers and a volunteer driver scheme in older peoples services.
- Promote the benefits of volunteering to staff planning for retirement.

Good Corporate Citizen

The Trust continues to review specialist advice and source best practice in relation to this agenda. The Good Corporate Citizen self-assessment tool (developed by the Sustainable Development Unit (SDU), which works across NHS England and Public Health England) has been used to review performance, and the Trust achieved a score of 78% in 2015/16. Improvement in this score was dependent on the adoption of a green travel plan, with evidence of delivery and positive results, therefore further assessment was not undertaken in 2016/17. Green travel plans are currently being developed by Estates and Facilities and will be presented to the Executive Management Team for consideration in December 2017.

Over recent months the Sustainable Development Unit has been working to improve the Good Corporate Citizen Development Tool. The new version is expected to be live later this (calendar) year. The SDU have advised the new tool and statement set will be much shorter, with goals aligned to the UN Sustainable Development Goals, so that organisations can track that local action is supporting important global goals. It will cover the following areas (as described by SDU):

- Corporate Approach
- Asset Management & Utilities
- Travel and Logistics
- Adaptation
- Capital Projects
- Green Space & Biodiversity
- Sustainable Care Models
- Our People

- Sustainable Use of Resources
- Carbon / GHGs

The tool will have a new scoring system, and due to the difference in statement sets, scores won't be comparable with any previous results.

The Trust acknowledges that using the tool is a helpful means to evidence and monitor performance. When the new version is live, the Trust will review and determine whether self-assessment will add benefit in 2017/18 once green travel plans are in place. A new baseline sore would need to be determined and an evidence pack and action plan created.

Summary and forward plan

Work continues to deliver the Trust's Sustainability Strategy and to monitor performance. Staff who focus on specific areas of the agenda continue to deliver good results across the areas described in this report.

Changes in director portfolios have resulted in the transfer of responsibility for this agenda from the Director of Corporate Development to the Director of Human Resources, Organisational Development and Estates. Actions will continue to be monitored and update provided to Trust Board on an annual basis. The forward plan to ensure continued high performance includes:

- Continued analysis to ensure achievement of stretching targets in relation to carbon management / carbon reduction.
- The development and adoption of Green Travel plans to minimise the impact of travel on the environment within the context of running an efficient business.
- The Green Travel Plan will be presented to the Executive Management Team in December 2017 and will include a range of measures aimed at promoting sustainable travel choices and reducing reliance on car travel. If effective, this will bring environmental, social and health benefits to both staff and to our communities.
- Plans to engage Trust staff and local communities in supporting delivery of this agenda – through awareness raising and publicising initiatives and best practice examples. This work will be progressed with the Trust's communications, engagement and involvement team and maximise opportunities to engage across all channels.
- The Trust will encourage staff and community views on initiatives to ensure Trust operations are sustainable.
- The Good Corporate Citizen assessment tool will be reviewed, once live, to determine the benefits of self-assessment and monitoring of performance against the identified goals.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 3 October 2017

Agenda item 9.1 – Receipt of public minutes of partnership boards

Barnsley Health and Wellbeing Board

Date	8 August 2017
Member	Rob Webster/Sean Rayner
Items discussed	➢ Feel Good Barnsley Video ➢ Health and Wellbeing Board Action Plan Highlight Report ➢ Better Care Fund: Guidance & Principles ➢ Carers' Strategy ➢ Healthwatch Annual Report ➢ Pharmaceutical Needs Assessment (PNA) 2018-2020
Minutes	Papers and draft minutes (when available): http://barnsleymbc.moderngov.co.uk/mgCommitteeDetails.aspx?ID=143

Calderdale Health and Wellbeing Board

Date	17 August 2017
Non-Voting Member	Dr Adrian Berry/Karen Taylor
Items discussed	➢ Calderdale Plan Progress Report ➢ Director of Public Health Report – Action Plan ➢ Healthwatch Update ➢ Hospital Reconfiguration
Minutes	Papers and draft minutes (when available): https://www.calderdale.gov.uk/council/councillors/councilmeetings/agendas-detail.jsp?meeting=24529

Kirklees Health and Wellbeing Board

Date	28 September 2017
Invited Observer	Rob Webster/Karen Taylor
Items discussed	➢ West Yorkshire and Harrogate Sustainability and Transformation Partnership Update ➢ Updated Kirklees Joint Strategic Assessment (KJSA) Overview 2017/18 ➢ Kirklees Integrated Healthy Child Programme update report ➢ Primary Care Strategy Update - Greater Huddersfield CCG and North Kirklees ➢ Pharmaceutical Needs Assessment Notification and Preparation for Consultation ➢ NHS Greater Huddersfield - CCG Annual Report and Accounts 2016/17
Minutes	Papers and draft minutes (when available): https://democracy.kirklees.gov.uk/mgCommitteeDetails.aspx?ID=159

Wakefield Health and Wellbeing Board

Date	21 September 2017
Member	Rob Webster/Sean Rayner
Items discussed	➢ Mid Yorkshire Hospitals NHS Trust Update ➢ SEND Inspection Report ➢ Sustainability and Transformation Plan - West Yorkshire and

	➢ Harrogate ➢ Feedback from the Health and Wellbeing Board Development Session ➢ Better Care Fund Plan ➢ Care Home Vanguard Evaluation Report
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

South Yorkshire & Bassetlaw Accountable Care System

Date	June 2017
Member	Dr Adrian Berry/Salma Yasmeen/Sean Rayner
Items discussed	➢ Final Memorandum of Understanding (as discussed by Trust Board on 25 July 2017).
Papers	Attached.

Health and Care Working Together

South Yorkshire & Bassetlaw Accountable Care System

Memorandum of Understanding
'Agreement'

June 2017

Foreword

This document has been developed with South Yorkshire and Bassetlaw Health and Care partners. It is not a plan or a legal contract. We have already published our Plans across the five local Places and system in South Yorkshire and Bassetlaw. At the same time, each of our individual organisations has contracts in place.

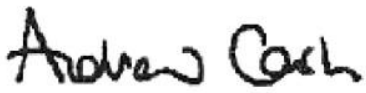
It does not replace the legal framework or responsibilities of our statutory organisations but instead sits alongside the framework to complement and enhance it. This document recognises the complexity of how health and care organisations currently work and interact together to provide the best possible care and services. It is also mindful of how health and care organisations are coming together to form partnerships locally in place; integrating health and care, commissioning and providing, including voluntary, community, GP, mental health and hospital services. At the same time, some of those same organisations have formed partnerships and are coming together across South Yorkshire and Bassetlaw to plan and commission strategically to ensure safe, sustainable and equitable acute services. In short, we are seeing increased collaboration, joint planning and integration of services that are focused entirely on bringing the greatest benefits to our population.

It is a complex picture and one which we must work through together as we continue to focus on what matters – the people in the populations we serve. This means constantly reviewing our approach, together with our staff, patients and citizens. We will also continue to build trust between us, working through what is best for our populations while using best practice where it exists and national guidance and support where we need it.

This document summarises and sets out our shared commitment to continue to work together on improving health and care for the people of Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield and collectively South Yorkshire and Bassetlaw. We still have much to work through and our plans and our approaches to delivering them continue to evolve.

This is our best assessment for 2017-19 on how we will work together, what we will work on and what we need to accelerate our vision and plans – the 'Give' and 'Get' which lies at the core of this MoU.

As we are in transition it is helpful to clarify how we are using terminology and acronyms for the purposes of this document. Sustainability and Transformation Plan (STP), Accountable Care System (ACS) and South Yorkshire and Bassetlaw Health and Care Partnership (SYB) are used throughout and they refer to the same thing – our SYB Partnership and our collaborative approach.



Sir Andrew Cash, ACS Lead

Contents

1. Introduction and context

1.1. This document has been developed with South Yorkshire and Bassetlaw Health and Care partners. It is not a plan or a legal contract. We have already published our Plans across the five local Places and system in South Yorkshire and Bassetlaw. At the same time, each of our individual organisations has contracts in place.

1.2. It does not replace the legal framework or responsibilities of our statutory organisations but instead sits alongside the framework to complement and enhance it, setting out the framework within which our organisations will come together to establish how we will develop as an Accountable Care System.

1.3. South Yorkshire and Bassetlaw has five strong health and social care communities of Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield which have a long history of working together in each local Place and across South Yorkshire and Bassetlaw (SYB) to achieve positive change and improvements for local people.

1.4. The links between poverty and ill health are well established and are the driving force behind our joint working. Creating jobs, ensuring availability of affordable, good quality housing and targeting resources towards areas of greatest need and reducing inequalities are all important to reduce poverty and improve our health and wellbeing.

1.5. Our collective and collaborative approach is increasingly focused therefore on prevention, integration, physical and mental health and crucially, co-production with citizens and communities; addressing the wider determinants of health together. These are inextricably linked and include:

- Employment, opportunity and business
- Adult and child health and social care, enabling independence
- Raising levels of education and skills to improve opportunity
- Safe, clean and green environment
- Life chances for all

1.6. Each health and social care organisation in each Place already has plans which have been developed in partnership and in some cases, for example the Better Care Fund Plan, these plans are jointly owned between health and social care.

1.7. There is a shared view that in order to transform our services to the degree required to achieve excellent and sustainable services in the future, we need to have a single shared vision and single shared plan both for each Place and for South Yorkshire and Bassetlaw. For this reason, leaders from across health and social care in each Place have come together to develop a single shared vision and single shared plan which has resulted in Place Plans and the SYB Plan.

1.8. South Yorkshire and Bassetlaw is therefore in a good position with a single shared vision and plan in each Place. This is made possible by the commitment and significant contributions of each constituent organisation.

1.9. This puts each of our localities, and system as a whole, in a strong position to develop and realise an ambitious set of health and social care services for our patients and service users; ensuring the best possible quality of care within available resources.

1.10. In developing a joint vision and plans in each Place, we intend to maximise the value of our collective action and, through our joined up efforts, accelerate our ability to transform the way we deliver services. Our Plans are not starting from scratch or replacing individual partners' plans- they build on existing plans, taking a common view and identifying areas where it makes sense for us to work together and collaborate.

1.11. Central to these ambitions is developing different relationships with each other in Place, across the system and with those that assure and regulate our health services. This will enable us to focus on integrating health and social care services and ensuring safe, sustainable and equitable hospital services for everyone.

1.12. We are committed to ensuring citizens and staff have the opportunity to be involved in conversations to help shape the direction of travel in the ACS and in Place. This ranges from their role in wellness, prevention and self-care; identifying what's important to the them in the delivery of services; as well as more specific consultation about service changes; and on the ongoing transparency and opportunity for them to hold us to account for delivery.

1.13. A key test of our new relationships will be the extent to which we adopt, as a first principle, an altruistic approach to each other as partners 'working as one'. How we respond as partners in times of need will be crucial and we must always put the needs of individuals, patients and the public first.

1.14. This document sets out how we propose to organise ourselves to provide the best health and care, ensuring that decisions are always taken in the interest of the patients we serve. It allows us to push even further beyond organisational need and allows us to build on working together in each Place *and* working together across SYB - to take collective strategic decisions across the whole of South Yorkshire and Bassetlaw to lift the standard of care no matter where people live or the organisation charged with planning or delivering care.

1.15. South Yorkshire and Bassetlaw set out its strategic ambition and priorities to improve health and wellbeing for all local populations in the Health and Care plan published in November 2016, together with how this will be implemented in each of the five Place Plans across Bassetlaw, Barnsley, Doncaster, Rotherham and Sheffield.

1.16. Following publication of the Next Steps in the Five Year Forward View, South Yorkshire and Bassetlaw has been confirmed as a high performing system and named as one of the eight Accountable Care Systems nationally. This means being supported centrally with additional funding, capacity and capability to be able to have more local control over health and care resources and in the delivery of transformational changes to services for people of South Yorkshire and Bassetlaw. This ability to have more local control is mainly reflective of the potential devolved responsibilities from health, its regulatory and assurance framework and health funding and resources.

1.17. This 'Agreement' sets out the framework within which our partner organisations, including NHS England and NHS Improvement will come together 'working as one', in 2017/18 to establish how South Yorkshire and Bassetlaw will develop as an Accountable Care System. We will agree together the delegated powers and new relationships we adopt between partner organisations, health regulators and health assurers to better achieve ambitions set out in the Plan and five Place plans.

1.18. The MoU sets out the approach to collaborative working and ambition to work as a shadow Accountable Care System in 2017/18, together with key milestones to move to a full ACS in 2018/19. SYB will engage with NHS England centrally, the Department of Health and the national Arm's Length Bodies (ALBs) to work through in 2017/18 *how* and *what* devolved NHS powers it will receive in 2018 as an Accountable Care System and which will be reflected in and subject to separate and specific agreements both with NHS England and local statutory organisations. Throughout this process we will be mindful of the legal duties placed on each partner organisation.

1.19. This 'Agreement' should be read in conjunction with the Plan, published in November 2016 and the five local Place plans across South Yorkshire and Bassetlaw. It should be viewed as a framework to enable collaborative working, secure central funding and support new

relationships with Arms Length Bodies (ALBs) in the pursuit of becoming an ACS to better deliver improved health and care for the population of South Yorkshire and Bassetlaw.

1.20. This 'Agreement' recognises the importance of integration of health and social care in each *Place* and that this will be an important factor in working through how the emerging Accountable Care Partnerships - which are being developed in each Place across partners and complement the ACS - develop to deliver improved care.

2. Parties to and partners in the Agreement

2.1. In developing this Agreement consideration has been given to the different relationships with constituent member organisations within the SYB ACS and the different relationship that organisations may wish to have with it. There are many partners working together - NHS and non NHS including local authorities and the voluntary sector each have respective governance, accountabilities and in many cases regulation responsibilities.

2.2. It is accepted that not all partners would want to be subject to many aspects of this agreement or indeed it would not be appropriate. NHS England and NHS Improvement have assisted SYB to establish clarity on which organisations should be *Parties* to and which might be *Partners* in this Agreement in context of NHS governance, accountability, regulation and assurance. For clarity, collectively, Parties to and Partners in are all members of the SYB Collaborative and its associated Partnership Board.

2.3. STP geographies were, in the large part, nationally defined. Core and associate partner terminology has been established over the course of developing the Plan to describe different partners and to support a wide and diverse partnership and to enable cross geographical boundary relationships and working.

2.3.1. For the purposes of this MoU core partners ('Parties to' the MoU) are NHS partners who have the majority relationships (patient flows and contracts) within and across SYB while Associate partners ('Partners in' the MoU) have majority relationships (patient flows and contracts) as core members of neighboring STPs, and relationships in SYB generally confined to a *Place* or Accountable Care Partnership (ACP). Associate partners are also likely to be subject to collaborative agreements in neighboring STPs or local ACP and receive support consistent with respective STPs. For clarity, collectively, 'Parties to' and 'Partners in' are all members of the SYB Collaborative and its associated Partnership Board

2.3.1. In the case of Chesterfield Royal Hospital NHS Foundation Trust, the trust became a core member in the partnership on the basis of its strong history of clinical networks within and across South Yorkshire and Bassetlaw including the Cancer Network and more recently the Cancer Alliance and its history of collaboration with acute trusts as part of the Acute Vanguard, resulting in significant acute flows into SYB. Early on in the plan development process, formal representation was made to NHS England and NHS Improvement jointly between the Partnership and Chesterfield Royal Hospital NHS FT for it to become a full partner in SYB which was supported.

2.3.1. It is recognised that Chesterfield sits within a neighboring STP and likely that it may be subject to agreements with the neighboring STP which will need to be worked through to establish the medium and longer term relationships with SYB ACS which may change. There may also be changes to the way other organisation engage in the MoU as we develop and mature as an ACS. This also applies to emerging organisations, federations and legal partnership including primary care federations and therefore we will need to review as we develop.

2.4. It is anticipated that Parties 'to' will sign the agreement as an emerging ACS in SYB, be subject to delegated NHS powers and a new relationship with each other, with both NHS regulators and assures and package of support to transform health and care.

2.5. It is anticipated that Partners 'in' will support the direction of travel and work in partnership with SYB ACS. In some cases they may be subject to separate agreements in neighboring ACS and aligned agreements in ACP in Place within SYB.

2.6. The Parties to this agreement are:

2.6.1. Commissioners

- NHS Bassetlaw Clinical Commissioning Group
- NHS Barnsley Clinical Commissioning Group
- NHS England
- NHS Doncaster Clinical Commissioning Group
- NHS Rotherham Clinical Commissioning Group
- NHS Sheffield Clinical Commissioning Group

2.6.2. Healthcare Providers

- Barnsley Hospital NHS Foundation Trust
- Chesterfield Royal Hospital NHS Foundation Trust
- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
- Sheffield Children's Hospital NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- The Rotherham NHS Foundation Trust
- Sheffield Health and Social Care NHS Foundation Trust
- Rotherham, Doncaster, South Humber NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust

2.6.3. Heath Regulator, Assurer, Education and Training

- NHS England
- NHS Improvement
- Health Education England
- Public Health England

2.7. The Partners in this agreement are:

2.7.1. Local Authority partners

- Barnsley Metropolitan Borough Council
- Doncaster Metropolitan Borough Council
- Nottinghamshire County Council / Bassetlaw District Council
- Rotherham Metropolitan Borough Council
- Sheffield City Council

2.7.2. Provider partners

- Nottinghamshire Healthcare NHS Foundation Trust
- South West Yorkshire Partnership NHS Foundation Trust
- East Midland Ambulance Service NHS Trust
- Doncaster Children's Services Trust

3. Scope

3.1. The scope of South Yorkshire and Bassetlaw's transformational plan covers all aspects of health and care, specifically:

- Public health
- Social care
- Primary care (including GP contracts)

- Community services
- Dental and screening services
- Mental health services
- Acute services
- Specialised services
- Research and development
- Health education and innovation
- Governance
- Assurance
- Regulation
- Resources and finance
- Capital and estate
- Information sharing and digital integration
- Workforce
- Communication and engagement

3.2. Key enablers to include:

- Appropriate governance and regulation
- Delegation of resources from relevant national partners in line with the delegation of statutory functions
- Access to fiscal and regulatory levers that enable the improvement of health and wellbeing outcomes through wider determinants e.g. education, employment etc.
- Empowered system leadership, supported by effective governance and accountability arrangements
- A shared strategic approach to capital and estates planning
- A shared strategic approach to communications and engagement
- A shared strategic approach to workforce planning (clinical and non-clinical)
- Development of new payment mechanisms that remove perverse incentives and encourage/ support new models of care
- Development of new information sharing system/ processes

3.3. Operating as a shadow ACS through 17/18, will require flexibility in terms of ways of working. As a result, it is expected that the scope will remain fluid over this time period, to allow arrangements to be tested and amended as required to secure the optimal outcomes.

4. System objectives

4.1. In our STP submission we set out the objectives for the SYB systems aligned to the dimensions of the triple aims of the STP. These are summarised below:

4.2. The parties share the following system objectives

4.3 Care and quality

- Joined up, high quality services across hospitals, care homes, general practices, community and other services
- Easy and convenient access to services across settings and times of day
- Greater availability of services closer to home
- Better quality, more specialised hospital based care
- Greater availability and variety of non-health services that enhance people's health

4.4 Health and wellbeing

- Better support for individuals in relation to physical and mental wellness and prevention
- A wider variety of healthy living schemes aimed at all communities within the population
- Active networks and links that connect people across communities and provide support
- Greater collaboration across the public sector relevant to the wider determinants of health

4.5 Finance and sustainability

- High quality, efficient services which provide good value for money for tax payers
- Reduced waste and greater efficiency in service delivery
- Greater use of available funding in enabling individuals to stay well and providing care closer to their homes
- A workforce and service that works flexibly to respond to individual needs and how people live locally, ensuring that the right skills and services are present in the right place and the right time

4.6 The NHS Constitution and Mandate sets out clearly what patients, the public and staff can expect from the NHS. SYB wants to build upon the rights and pledges of the Constitution and provide further opportunities for patients and the public to be involved in the future of their NHS - building on the Plan and the early conversations we have had with the citizens, patients and staff on these ambitions during February and March 2017.

4.7. The NHS Next Steps on the Five Year Forward View articulates why change is urgently needed, what that change might look like and how it can be achieved. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery. It sets out the development of new models and SYB is committed to being an early implementer and a test bed for new, innovative approaches of:

a. An Accountable Care System across SYB, with devolved freedoms, accountabilities and responsibilities and new relationships with member organisations, including NHS England, NHS Improvement and the ALBs
b. A closer relationship between commissioning and providing, integrating and aligning approaches to strategic planning and transformation of services
c. Accountable Care Partnerships with providers across SYB, delivering new models of acute and specialist care
d. New models of commissioning at system level for acute services, reducing variation and duplication and minimising transactional activity
e. Operating and managing a system control total for health
f. Accountable Care Partnerships in each local Place delivering integrated health and social care aligned to an overall SYB ACS

4.8. SYB needs to develop different relationships and have freedoms and responsibilities to optimise its potential. This Agreement builds the collaborative partnership established to develop the Plan, creates the platform for SYB to build on these to implement its ambitions through the invitation to SYB commissioners and providers to develop an emerging ACS.

5. Overarching principles

5.1. In the documents that were submitted as part of the STP submission on 21 October 2016, STP partners made a commitment to upholding the principles summarised below:

- Improving quality and outcomes - As a system, partners will work collectively to improve quality and population outcomes for people and reduce health inequalities for all of our local populations.
- 'No worse off' principle – Decision making will be focused on the interests of people in SYB and our collaborative partnership will work to ensure those interests are served. We will ensure that our collective working and decisions do not lead to increased health inequalities or a worsening of health outcomes for any of our populations across SYB
- Inclusiveness - All stakeholders (including commissioners, providers, patients, carers and partners) will be included in decision making and empowered to shape the system as it continues to develop. This will require active and sustained communications and engagement, informing and involving people early and in ways that allow them to get involved and help shape the direction of travel as we tackle the challenges
- Participation - SYB will be involved in all decisions that materially impact on the health and care provided to its population or by its local partners
- Integration - Partners will work to support improvements in outcomes through increased integration
- Subsidiarity - Partners will work to support delegation of decision making to the most appropriate level, subject to robust governance and accountability mechanisms
- In the NHS family - Healthcare services in SYB will remain part of the NHS. All the commitments described in this Agreement aim to (i) strengthen health and care in SYB and (ii) uphold the NHS values and standards
- Transparency - Decision making will be underpinned by transparency and open information sharing between and amongst local and national partners
- Co-production - National partners will take a co-production approach with SYB, in which decision making is facilitated by national partners to devolve and by local partners to 'receive' and deliver delegated functions
- Form aligned to function - the delivery of shared outcomes will drive changes to organisational form where appropriate
- Wider system (NHS) focused - Further delegation decisions will continue to be subject to consideration by national partners.
- Local partners commit to working with national partners to ensure alignment between national policy objectives and the strategic direction taken locally.
- Local partners will continue work to support nationally agreed priorities, including those set out in the Five Year Forward View.
- Accountability - All organisations will retain their current statutory accountabilities for health and social care and any commitments made will remain subject to organisations' continuing ability to meet these accountabilities.

6. Direction of travel and key milestones

6.1. This document outlines our desire, individually and collectively, to achieve our vision of health and care in SYB. A significant amount of work has been delivered through working together locally to progress the system to its current state. However, we know that more

work remains to be done and that a clear roadmap, agreed with all parties, will provide a clear and transparent way forward. We will continue to work together as local partners and with national colleagues to define the specific mechanisms and timescales associated with any further delegation of responsibilities and associated funding. Delegation of functions from national partners to local partners on behalf of the "system" will take place in a series of agreed steps, the speed and scale of which will likely be determined by:

- The achievement of assurance criteria determined by national partners
- Demonstrated capability
- The strength/ appropriateness of governance arrangements
- The clarity of the delivery plan
- Suitability of gateway milestones

6.2. This approach will ensure that the system will only take on greater responsibilities and powers when it has the capability and resources to manage them appropriately.

Key milestones in the process include:

- By end July 2017, an MoU Agreement between SYB Parties giving the Framework by which SYB will 'work as one' to develop as an Accountable Care System and implement its Plan.
- By September 2017, taking staff and public feedback into account, we will refresh and rebrand the STP from a communications and engagement perspective to reflect becoming an ACS and what this means for the future of health and care
- By September 2017 we will agree a delivery plan for 2017/19 for SYB 'working as one' to include priority areas including urgent and emergency care, primary care, mental health and learning disabilities and cancer to demonstrate delivery and enable testing of key ACS objectives outlines in 4.7.
- By September 2017, governance and an approach for agreeing and monitoring investment decisions within the ACS will be agreed
- By the end of October 2017, with capital and transformation funding, we will agree how we will operate a system control total for health in 18/19
- By end October 2017, we will agree a new NHS single oversight and assurance framework for SYB to be operational by April 2018 with aligned resources to support an integrated SYB ACS oversight and assurance function which will work with streamlined regional and national oversight arrangements.
- By end of October 2017, we will agree system and place commissioning responsibilities for agreed functions and services to enable alignment for ACPs to focus on new ways of contracting and allocating resources including population budgets, population health management and segmentation approaches for Place tier 0 - 1 and a system commissioning function for tier 2 and 3 services (all to be agreed).
- By April 2018, we will agree governance and approach for delivery of tier 2 services following the hospital services review outcome to support a horizontally integrated accountable network of hospital based services.
- Each of the five Places has confirmed they wish to continue to develop their Accountable Care arrangements and it is anticipated that these will be in shadow form in 2017/18.
- By October 2017, SYB ACS will be 'working as one' with NHS England and NHS Improvement and working with ACPs in shadow form to provide support so that they will be legally constituted partnerships by April 2018 (at the latest).

7. Governance, accountability and assurance

7.0.1. This MoU does not replace the legal framework or responsibilities of our statutory organisations but instead sits alongside the framework to complement and enhance it. It recognises the complexity of how health and care organisations currently work and interact with each other to provide the best possible care and services.

7.0.2. Our health and care organisations are already coming together to form partnerships in Place; integrating health and care, commissioning and providing, including voluntary, community, GP, mental health and hospital services. These are taking varying forms and the governance and how this best supported in an overall ACS will be a key priority in 2017/18 and will be an area for which we will receive national guidance and support.

7.0.3. At the same time, some of these same organisations are forming necessary partnerships and coming together across South Yorkshire and Bassetlaw, either our hospitals, to ensure safe, sustainable and equitable acute services as a 'group of hospitals' or our health commissioners to make consistent strategic planning and commissioning decisions as a system commissioner. In all of this, how the traditional separation between health commissioning and providing and the focus on competition is giving way to a focus on collaboration and integration.

7.0.4. All of this 'pushes' at the boundaries of the existing legal frameworks but other systems have found ways to work where there is evidence that it better serves to make improvement to the populations we serve.

7.0.5. Current statutory requirements for CCG assurance

7.0.5.1 NHS England has a duty under the NHS Act 2006 (as amended by the 2012 act) to assess the performance of each CCG each year. The assessment must consider, in particular, the duties of CCGs to: improve the quality of services; reduce health inequalities; obtain appropriate advice; involve and consult the public; and comply with financial duties. The 2012 Act provides powers for NHS England to intervene where it is not assured that the CCG is meeting its statutory duties.

7.0.5.2 NHS England must publish a report each year which summarises the results of each CCG's assessment. The detail of the CCG assurance framework which underpins the publication is NHS England policy rather than set in statute or regulation.

7.0.6. Current statutory requirements for Foundation Trust oversight

7.0.6.1. NHS Improvement (NHSI - the operational name which brought together Monitor and the Trust Development Authority (TDA) and their associated teams on 1 April 2016) has a duty under the NHS Act 2012 to ensure the operation of a licensing regime for Foundation Trusts (and other providers of NHS services). The licensing regime covers requirements on FTs in relation to: general conditions; pricing; choice and competition; integrated care; continuity of services; and governance. The 2012 Act provides powers for NHS improvement to enforce or set conditions on a provider's license.

7.0.6.2. The licensing regime is underpinned by the NHS Improvement Single Operating Framework which aims to help providers attain and maintain CQC ratings of good or outstanding. The framework is NHS Improvement policy rather than set in statute regulations.

7.1 Principles and underpinning assumptions

7.1.1. The Agreement is drafted by all *Parties* including NHS England, NHS Improvement and the ALBs where this is appropriate. The Agreement is intended to be flexible to achieve the right balance of '*Give*' and '*Get*' - financial, capacity, capability or devolved freedoms and flexibilities in return for improved delivery, operational, financial, quality, and transformational change.

7.1.2. There will be continual engagement and consultation with Boards, Governing Bodies and Councils throughout development. ACSs are not statutory bodies - they supplement accountabilities of individual statutory organisations. 2017/18 will be the first phase of SYB ACS and statutory organisations will continue with statutory accountabilities and relationships with NHS England and NHS Improvement, which will retain legal responsibility for CCG assurance and FT oversight respectively.

7.1.3. From September 2017, SYB Health and Care Partnership will adopt the 'Working Together' brand and as such will continue to deliver NHS Constitution and Mandate commitments in full and remain part of the wider NHS System. The Health and Care Working Together Partnership will deliver the FYFV ambitions through the development of an Accountable Care System with five constituent Accountable Care Partnerships and implementation of its Health and Care Working Together Plan (October 2016, revised April 2017) and five Place Plans.

7.1.4. The development of the Accountable Care System during 2017/18 will establish how individual organisations will be held to account for their contribution to the delivery of NHS Constitution and Mandate and the Health and Care Working Together Plan. Each of the five Places has confirmed they wish to continue to develop their Accountable Care arrangements and it is anticipated that these will be in shadow form in 2017/18. What constitutes 'shadow' is to be worked through and to be discussed and agreed with statutory organisations. SYB ACS 'working as one' with NHS England and NHS Improvement will work with ACPs providing support where required, especially where ACPs look to move to legal forms.

7.1.5. Operational management of the assurance and oversight processes will be through SYB working together and we will deliver the principles of the two national frameworks with a locally developed model with an integrated single oversight and assurance process within the ACS.

7.1.6. SYB will be assured once, as a place, for delivery of the NHS constitution and mandate, financial and operational control and quality.

7.2. NHS assurance, regulation and accountability

7.2.1. We would expect to move to a SYB relationship with NHSI and NHSE providing a single 'one stop shop' regulatory relationship with NHSE and NHSI in the form of streamlined oversight arrangements. An integrated CCG Improvement Assessment Framework (IAF) and Trust single oversight framework. CCGs will still require an annual review with NHSE. This will be in place from April 2018.

7.2.2. Single Accountability Framework

Within 2017/18, SYB working with NHS England and NHS Improvement will establish a Single Accountability Framework (SAF) which brings together the NHS England CCG Assurance

Framework and the NHS Improvement Single Operating Framework at a local level. The SAF will be implemented from 1 April 2018 and will set out:

- The roles and responsibilities of the parties to this Agreement (CCGs, providers, NHS England and NHS Improvement)
- The scope of the SAF including NHS constitutional commitments, national targets, quality indicators and productivity measures
- The internal governance, assurance and reporting system within SYB to support delivery of the SAF
- The external assurance and reporting system for SYB to NHS England and NHS Improvement
- The agreed trigger points and process where NHS England and NHS Improvement may exercise their statutory responsibilities for intervention.

7.2.3. The Single Accountability Framework will operate in shadow form within 2017/18. In shadow form, its scope will reflect the priorities of SYB (for example, cancer and urgent & emergency care).

7.2.4. The scope of the SAF will widen as the ACS matures until it covers the full range of NHS responsibilities. The timeline for the development of the scope of the SAF will be agreed between the Parties to the Agreement.

7.2.5. In 17 / 18 we will align NHS England and NHS Improvement functions and resources to support delivery of the 'integrated within SYB ACS' element of the Single Accountability Framework.

7.3. Quality and safety

7.3.1. South Yorkshire and Bassetlaw has a well established quality and safety approach at, organisation, Place and System level. Very much of what is described in this MoU is about improving quality and safety. This is both through our organisations choosing to work together on common challenges and on those issues which are most in need of a different way of working or most likely to deliver improvements through our joint efforts.

7.3.2. We commit to reviewing our approaches in light of developing as an ACS in 2017/18 to ensure our quality and safety oversight and assurance best supports how we are coming together in Place, as emerging ACPs and across SYB as an overall ACS.

7.3.3. There is growing evidence that the improvements we are aiming to achieve within our plan will give measurable improvements in quality ahead of any financial efficiency improvements. We would therefore want to develop clear quality metrics for SYB to enable us to track these quality improvements.

7.4. Financial

7.4.1. There are a number of areas that the ACS wishes to develop in conjunction with NHS England and NHS Improvement to support robust governance, accountability and assurance. The proposals will be developed through the SYB Directors of Finance Steering Group and ultimately approved by the Collaborative Partnership Board. The areas to be considered are outlined below.

7.4.2 How a system control total would work across the ACS?

This would focus on the following areas:

- How to create in year flexibilities including the potential use of a contingency or other specific business rules?
- How to reflect the impact of an agreed transformational scheme which differentially impacts organisational financial performance?
- Consideration of Place based control totals?
- Consideration of monitoring, management and reporting arrangements?
- Whether a set of efficiency indicators could be used to inform the application of a system wide control total?

7.4.3 Consideration of moving to a risk based approach to contracts?

Consideration will be given to developing a risk based approach to contracts where risks are identified and aligned to the organisation best placed to manage the risk and which supports the development of a system wide solution.

7.4.4 Investment decisions and business case development?

Agreeing a process to ensure investment decisions are optimal for the ACS footprint and are consistent with the ACS strategy. This will include a process on how any additional capital, transformation and any other external funding can be best deployed across the ACS. Developing a process to agree financial principles and assumptions to be used in ACS business cases

7.4.4 Agreeing a process for business planning, financial reporting and performance

To develop an ACS business planning process including agreement to a consistent set of planning assumptions, where appropriate, and taking into account national guidance. To develop in partnership with NHS England and NHS Improvement a monthly ACS report which covers both financial performance and performance against key operational targets.

7.5. Operational

7.5.1. In 2017/18 and as part of our approach to developing an integrated single oversight and assurance approach within SYB, we will review operational assurance and oversight including our approach to planning and delivery assurance so that it is integrated within SYB. We will also align NHS England and NHS Improvement functions and resources.

7.6. Shadow Accountable Care System

7.6.1. In 2017/18, SYB will develop as an Accountable Care System. This will include collective decision making, governance and a single accountability framework which will align the individual statutory responsibilities of Parties to the Agreement to the delivery of the Health and care Plan (November 2016).

7.6.2. Where it serves to improve population health outcomes and to meet the needs of patients, we will develop integrated working between commissioners and providers to transform services and reduce transactional costs in the system.

7.6.2. Each of the five Places will develop an Accountable Care Partnership (ACP) to deliver the ambition set out in its Place Plan and the wider Health and Care Plan (2016). The five ACPs will operate in shadow form within 2017/18 and will be legally constituted partnership by 1 April 2018, at the latest.

7.6.3. The five ACPs will bring together health and care services from statutory and non-statutory organisations to create a vertically integrated care system in each Place. This will include hospital services from tier 1.

7.6.4. Each of the five Places will explore new ways of contracting and allocating resources to its ACP including population budgets, population health management and segmentation approaches.

7.6.5. The five ACPs will connect between the five Places and with a horizontally integrated network of hospital based care (tiers 2 and 3) to support seamless care for patients and to create the overall accountable care system (ACS) for South Yorkshire and Bassetlaw.

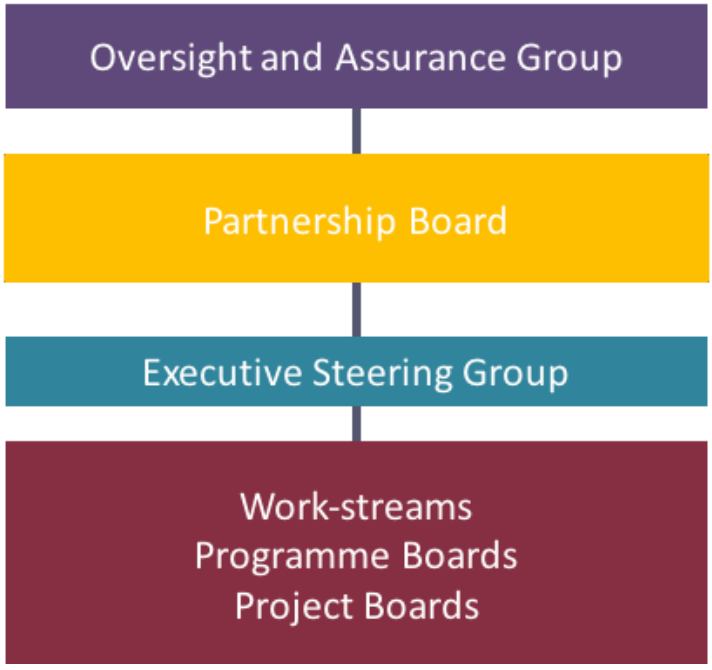
7.6.6. A system wide commissioning function will be in place within 2017/18 which will result from a reform of commissioning. We will build on approaches we have established in SYB, integrating approaches to planning and transformation and explore new ways of contracting and allocating resources to network of hospital based care. From April 2018, we will start to test the 'contract once' with the 'network of provider' to support sustainable services and drive improved outcomes for patients.

7.7. ACS governance

7.7.1. South Yorkshire and Bassetlaw has established collaborative governance. This governance recognises statutory governance of member organisations and where statutory organisations have come together to formally delegate to a joint committee or Committees in Common. It serves to support and supplement where agreed and appropriate, statutory governance and is the basis from which we will develop as an ACS.

7.7.2. A summary of SYB governance includes an Oversight and Assurance Group, a Collaborative Partnership Board, an Executive Steering Group and a range of programme Boards and project Boards.

Summary schematic - *South Yorkshire & Bassetlaw Health and Care Working Together Partnership Governance*



7.7.2.1. Oversight and Assurance Group: membership includes chairs from constituent statutory bodies including providers, commissioners, and Health and Wellbeing Boards with chief executives (CEOs) and accountable officers (AOs) in attendance.

7.7.2.2. Collaborative Partnership Board: membership includes CEOs and AOs from partner organisations including mental health and primary care, commissioning and local authority organisations, voluntary action groups, Healthwatch, NHS England and the ALBs. We also have clinical membership from primary and acute care. We plan to strengthen our Collaborative Partnership Board and review primary care input and wider clinical input and with lay membership.

7.7.2.3. Executive Steering Group: this group combines both the former STP executive steering group and the former finance oversight committee. Membership includes CEO and AO representation, together with directors of strategy, transformation and delivery and directors of finance.

7.7.2.4. Programme Boards: we have a range of programme boards delivering key priorities which are all led by a CEO and AO senior responsible officer (SRO). Each has a director of finance lead and a programme manager supporting.

7.7.3. This governance will remain in place for 2017/18 and during this time SYB will work with the Department of Health, NHS England, NHS Improvement and the ALBs as an ACS to review and establish governance that will best support us. This will be in place for 1 April 2018.

7.8. Joint Committees and Committees in Common

7.8.1. SYB CCGs, in partnership with North Derbyshire and Wakefield CCGs, have already established a joint committee and CCG governing bodies have delegated authority for the review of children's surgery and hyper acute stroke services. The membership includes accountable officers, clinicians and lay members. During 2017/18, we will review the scope of delegation to reflect the outcomes of the Hospital Services Review and the Commissioning Review so that formal governance arrangements are in place by 1 April 2018.

7.8.2. SYB acute providers, in partnership with Chesterfield Royal Hospital NHS Foundation Trust and Mid Yorkshire Hospital NHS Trust, have established a Committees in Common (*CiC*) to better support collaborative working between trusts including streamlining decision making. The collaboration has already supported changes in a number of programme areas including support services (back office functions) and a number have been joint with commissioners working together across the same geographical area.

7.8.3. During 2017/18, we will review the scope of delegation to reflect outcomes of the Hospital Services Review and Commissioning Review so that governance arrangements are in place by 1 April 2018. At this stage, the wider acute provider partnership includes both acute providers and community mental health providers. However the CiC does not currently extend to community mental health providers

7.8.4. The two programme offices and teams supporting commissioning and provider collaborations have now co-located to provide a joined up approach to planning and transformation delivery of acute services across SYB.

7.9. Place and accountable care development

7.9.1. CCGs and local authorities will continue to receive their respective health and care funding and to be statutorily accountable for their allocation.

7.9.2. Within 2017/18 each CCG will agree with its corresponding local authority the integrated governance structure which will support the allocation of resources to their ACP based on delivery of their agreed Place plan, wider Health and Care plan and agreed local outcomes.

8. Delivery improvement 2017/18-19

8.0.1. South Yorkshire and Bassetlaw has developed a number of priorities to support delivery of its Plan. These are led by chief executives and accountable officers with strong input from senior clinicians, public health, senior finance and operational colleagues from member organisations.

8.0.2. Transformation priority workstreams include:

- Urgent and emergency care
- Cancer
- Healthy lives, living well and prevention
- Primary care
- Mental health and learning disabilities
- Elective care and diagnostics
- Maternity and children's

8.0.2.1. Enabler workstreams

- Workforce
- Digital and IT
- Carter, estates and shared services
- Finance
- Communications and engagement

8.0.3. For 2017/18 – 19 South Yorkshire and Bassetlaw has identified a focused number of key priorities for delivery improvement 'working as one'. We will align resources and priority workstreams to support delivery of these key priorities at all levels within the emerging Accountable Care System and we will use these priorities to test new ways of working together and with NHS England and NHS Improvement to show additional benefits to patient and service delivery:

1. at organisational level
2. at Place (ACP) level
3. at System (ACS) level

8.0.4. Catalyst for change – in 2017/18 we will focus delivery improvements in urgent and emergency care, primary care, mental health and learning disabilities and cancer (or subsets of these priority areas) where we plan to make tangible improvements which will serve as a real catalyst for change across SYB. Each of our transformational workstreams has taken a unique perspective on how best they can contribute to delivering the 'key improvements' set out in the Next Steps on the Five Year Forward View. We will also take a unified approach to tackle efficiency improvement 'working as one' where this makes sense to do so.

8.1. Efficiency programmes, back office, Carter, Naylor

8.1.1. The efficiency programmes agenda is being addressed through two workstreams.

8.1.2. Firstly; The Provider Efficiency Group, which is responsible for the oversight of the acute and mental health trust providers programme and is addressing the eight nationally defined corporate service areas to ensure that collaborative opportunities are identified and maximised, including consolidation where appropriate. Its strategic objective is to develop systems that capture and optimise the cost effectiveness of corporate services so that services are assessed not only on direct costs and non financial quality indicators, but in relation to professional influence in driving efficiencies across trust systems, policies and processes. Its key aim is to reduce service costs with the summary data for showing the SYB position as 27/44, with potential savings of £4.4m to £10m, taking into account the national median and upper quartile benchmarking data from 2015/16. This is in line with estimated savings contained in the case for change submission October 2016.

8.1.3. The workstream's immediate priority is to achieve efficiency savings that will help to reduce the financial gap and, in particular, focus on savings and innovations that can be delivered during 2017/18. To enable effective oversight and delivery of collective solutions, a phased approach has been agreed on the key service areas that have shown, through the benchmarking data, the greatest saving opportunities, and which take into account the synergies and dependencies between these service areas. These are HR services, finance including payroll, and procurement.

8.1.4 . The ambition and commitment is to have regional networked arrangements using the same financial, HR and procurement solutions that will use consolidation and integration of transactional services as an enabler for common standardisation and streamlining of e-processes across all trusts to make efficiencies. Where and when appropriate, market testing may be undertaken.

8.1.5. The focus is therefore not just on changes to operating models but where with the use of technology and removal of transactional activity, significant efficiencies could be made. This is also reflected through formal HR streamlining and standardisation of priorities that target reduction of unwarranted variation and duplication across: workforce systems and compliance (including collaborative commercial relationships); general recruitment; bank and agency management (phase one focusing on medical agency including case for collaborative bank); occupational health/absence management; mandatory and statutory training; common bandings/gradings.

8.1.6. Secondly; there is a system wide Strategic Estates Group, the role of which is to provide strategic oversight, planning and direction to SYB clinical workstreams and the CCG Local Estate Forums (LEFs), enabling the delivery of more effective, Place based health facilities, property assets and health/public land across South Yorkshire and Bassetlaw. This workstream will support the implementation of a sustainable estate strategy that will help to deliver those objectives and also consider the findings of the Hospital Services Review and support the development and implementation of estates strategies arising from it. This will ensure a more integrated approach through the delivery of a smaller, more cost effective and efficient estate which is aligned more closely with the delivery of frontline public services.

8.1.7. The Strategic Estates Group brings together organisations which own health facilities, property assets and health/public land to facilitate the better use of all health and public

sector estate and will review principles for collaborative use of built assets. Its immediate priorities for 2017/18 – 2018/19 are based on three themes: strategic estates planning; aligning investment and disinvestment; and estates intelligence and spatial mapping.

8.1.8. Key outcomes are the production of a strategic estates plan and accompanying action plan, which sets out clear priorities for the delivery of better use of all local public land and property assets within respective geographical areas to deliver the estate objectives highlighted within the Health and Care Plan. It will also review the findings of the Naylor Review of surplus land and challenge partner organisations to address any recommendations, which will support the development of affordable estates and infrastructure plans and associated capital strategy

8.2. Managing demand and optimising care

8.2.1. The elective and diagnostic care workstream will be responsible for the planning, oversight and governance of a regional or sub regional elective and diagnostic care system. Closing the elective workstream's gap will be achieved by focusing on two priorities: reducing system demand and improving efficiencies in how we deliver our services. These themes will be delivered at Place and System levels through eight interventions; however, immediate priorities for 2017-2019 are described below.

8.2.2. Correct referral pathway – we will implement best practice demand management approaches that will reduce unnecessary or inappropriate referrals and ensure patients reach their most appropriate treatment first time. This will be achieved by piloting local solutions to advice and guidance and referral support with consideration to developing a regional solution. We will undertake local place based reviews of clinical pathways to reduce demand and attendance in hospital by developing community based services. We will support local organisations to improve utilisation of non face-to-face clinic delivery, alternative workforce models to drive efficiency and ensure effective access and discharge policies are in place to reduce unnecessary follow up appointments.

8.2.3. Procedures of low clinical value and clinical thresholds – we will develop a SYB policy for effective commissioning including a common set of controls and clinical thresholds for procedures to ensure adherence to best practice guidance.

8.2.4. Diagnostics – we will implement workforce and IT solutions that will reduce the demand and capacity gap in radiology reporting. We will work with the cancer workstream to develop diagnostic solutions that support early diagnosis.

8.2.5. Clinical efficiency – we will use benchmarking analysis (Getting It Right First Time) to identify and target variation along clinical pathways in order to deliver efficiencies. We will ensure our surgical activity is aligned to the appropriate setting and we will identify and transfer activity that can be delivered closer to home in the community.

8.3. General practice and primary care

8.3.1. Supporting and investing in general practice and primary care is a national priority mirrored by key priorities for all of our local Places. During the course of 2017 -19 we will deliver extended access to general practice for 100% of the local population by March 2019 and where possible, take steps locally to boost GP numbers including improving retention.

8.3.2. Expand multidisciplinary care including clinical pharmacists, mental health therapists, physician associates and increase the number of nurses in general practice.

8.3.3. Ensure 100% of GP practices are working together in hubs or networks by March 2019 that offer a greater scope of services which are increasingly capable of taking on population health responsibilities.

8.3.4. Expand multi-disciplinary care by deploying SYB's share of 1300 clinical pharmacists and 1500 mental health therapists, as well as physicians' associates and increase the number of nurses in general practice.

8.4. Urgent and emergency care (UEC)

8.4.1. We will continue to develop and strengthen the urgent and emergency care networks and partnership working through the UEC Steering Board, which builds upon the UEC Network established in 2015. A programme of work is currently being developed to take account of national requirements and the case for change described in the Health and Care Plan, with delivery models developed at place with a joint focus on redesigning the urgent and emergency care system and developing out of hospital services to reduce demand on A&E and acute beds.

8.4.2. The Five Year Forward View identified seven UEC priorities which will be included in the work programme. Specific priorities for 2017/18 include;

- We will work within Place and collectively across the System to ensure delivery of the four hour A&E standard and we will work as one with NHSE/I to agree improvement trajectories at System level with oversight on place delivery.
- We will work with Place to ensure the implementation of primary care streaming for each emergency department and with NHSE/I to agree at system level targets for activity flows through primary care streaming.
- We will work with Place to develop and identify the requirements for a clinical advisory service at three levels, 1) Place, 2) System 3) Regional to develop a hub and spoke arrangement to clinical advice using local clinicians/services where possible and scaling to system level where it is more efficient to do so.
- We will work as one with NHSE/I to agree at System level a realistic improvement trajectory to increase the volume of calls transferred from 111 to a clinician, working with providers of 111, out of hours and with place to deliver the ambition of 50% by March 2018 ensuring that NHS 111 connects into the appropriate clinical services and patients are directed to the most appropriate clinician/service.
- We will express an interest in becoming a pilot at system level for NHS 111 online in 2017/18 subject to the national rollout plan.
- We will work with Place to develop a plan to have at least one designated urgent treatment centre established by March 2018, which will include a review of existing urgent care centres, minor injury and walk in services to establish the baseline position and develop a plan to have a model for urgent treatment centres across the System in place by 2019.
- We will work with ambulance providers to implement the ambulance response programme and work as one with NHSE/I to develop realistic implementation plans. This will include working with Place to develop consistent offers on alternative pathways to conveyance to A&E.

- We will work with Place to improve patient discharges and flow through hospitals, including the establishment of a pilot to roll out the use of care home electronic bed states.
- We will work with Place to establish a common and shared approach to escalation management developing a plan to roll out a single system for better connections between Place and allow System level oversight of pressures in the UEC system.
- We will work as one with NHSI and NHSE to align differential standards to secure delivery of integrated urgent care between 111 and out of hours providers.

8.5. Mental health and learning disabilities (MHLD)

8.5.1 A number of priorities for the MHLD workstream have been identified, reflecting the requirements set out in *Implementing the Five Year Forward View for Mental Health* and identifying where and how a System level approach offers opportunities for improvements in service development and delivery. Key objectives for the workstream are:

- Development of core 24 liaison mental health services in all acute hospitals to support a reduction in pressure on the urgent and emergency care system, including reducing emergency admissions and length of stay for people with mental health problems.
- Providing support across all areas to develop integrated improving access to psychological therapies (IAPT) to ensure that people with long term conditions have their mental health needs met, reduce presentations for people with medically unexplained symptoms and improve patients' ability to self-manage to reduce reliance on healthcare services.
- Taking a collaborative approach to developing perinatal mental health pathways and services.
- Working with specialised commissioning on specialist beds and community alternatives across children and young people's and secure mental health services.
- Improving the management of people with complex dementia needs, as part of moving care closer to home across the mental health and learning disabilities health and social care system.

8.5.2 In addition to supporting delivery of national objectives, the workstream is proactively addressing local issues, including gaps in services for adults with autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD) and workforce issues. It will also work closely with the healthy lives, living well and prevention workstream to roll out innovations around social prescribing and employment support.

8.5.3 SYB will also oversee and support delivery of national objectives around access to services, including increasing access to psychological therapies, delivery of the 18 week referral to treatment target, and access to physical health checks for people with severe mental illnesses.

8.5.4 The workstream is also looking to explore opportunities for alternative commissioning and provider models where these will improve outcomes for patients, secure efficiency savings and secure service capacity and quality across SYB; including provider alliances and system commissioning.

8.6. Cancer

8.6.1. We will strengthen the newly formed Cancer Alliance by working with member organisations and at Place across the Cancer Alliance footprint; South Yorkshire, Bassetlaw and North Derbyshire. Our mandate and deliverables are explicitly articulated through the

Next Steps on the Five Year Forward View, the Cancer Taskforce strategy and our own Cancer Alliance Delivery Plan. Immediate priorities are outlined below:

- We will work to deliver the 62 day referral to treatment standard at System level as a single measure across our provider organisations by March 2018. This will create capacity to focus not only on the target but also enable us to focus on measures which hold the greatest significance to people affected by cancer such as quality of life, whilst also working to improve inter provider transfers within 38 days and improve earlier diagnosis.

- We will work with Place to implement interventions to achieve earlier diagnosis of cancer through raising awareness of signs and symptoms and maximising uptake in screening. We will understand capacity and demand across our diagnostics services, priorities in access to diagnostics and explore new models of access to diagnostics.

- We will support the delivery, through the local Cancer Alliance, of the strategic priorities to improve early diagnosis, services and outcomes for cancer patients as per the Cancer Taskforce report and facilitate the introduction of bowel cancer screening and primary HPV testing for cervical screening.

- We will continue to work with Place to fully deliver person centered care for people affected by cancer by implementing the living with and beyond cancer (LWABC) model of care.

- We have established an 'advisory board' of people affected by cancer to support decision making as part of our Living With and Beyond Cancer programme, one of our four Cancer Alliance workstreams. The Cancer Alliance board will also access this group on a topic by topic basis to support decision making on a range of issues such as performance.

8.7 Children's and maternity care

8.7.1 We have established a Children's and Maternity Delivery Board to support system transformation across three initial priority areas:-

1. Following public consultation, to reconfigure children's surgery and anaesthesia, developing new models of care with consistent management across providers, with sustainable care pathways that meet the newly specified standards of care.

2. For the acutely ill child, there is variation in the provision of care, and local assessment (in line with the national picture) identifies the current models are not sustainable, particularly in terms of workforce sustainability and coordinated care pathways. Therefore, there is a need to plan across a larger footprint and network provision. The immediate priority is to work together to develop sustainable new models of care for acute paediatrics, ensuring equity for children right across the SYB area through the adoption of a consistent 'blueprint' for services in each Place. This will be supported by a managed clinical network (MCN), ensuring a strong clinical input throughout. The blueprint will include paediatric acute services and consistent management across hospital settings, promoting demand management and supported discharge models in community settings, and the use of short stay assessment models.

3. For maternity services, we will work together to review the current offer and develop a single implementation plan for maternity care across SYB proposing changes in line with the implementing better births, through our Local Maternity Systems (LMS).

8.8. Workforce

8.8.1. The Local Workforce Action Board (LWAB) is the main vehicle for driving and managing the workforce work stream. There is an overarching aim and ambition to make SYB an attractive place to work to both attract and retain staff.

The LWAB is focusing on three initial priorities:

- Development of the South Yorkshire and Bassetlaw region excellence centre (1 of 7 in England) which aims to raise the standard for support staff by promoting vocational education including focusing on apprenticeships, sharing resources and acting as a vehicle for innovation.
- Creation of a faculty of advanced clinical practice for the region which aims to ensure consistent practice standards and secure resources for advanced clinical practitioners (ACPs) and physician associates (PAs).
- Sustainable primary care; plans include an increase in GP, practice nurse and clinical support worker numbers, plus further development of physician associates, AHP practitioners, care navigators and clinical pharmacists.

8.8.2. As an enabling work stream, the LWAB is committed to supporting the SYB workstreams to identify their workforce requirements and transform their services.

8.9 Digital and IT

8.9.1. We will be relentless in focusing on the needs of our citizens and our patients and will seek opportunities for technology to improve the ability of our staff and our partners to meet those needs. Therefore, on the journey towards achieving our vision we will:

- Directly support and influence the work of the SYB priority and enabling workstreams to ensure they are able to maximise the benefit of digital solutions.
- Transform the way in which we engage with patients and citizens, supporting them to maintain their own health and wellbeing through digital solutions.
- Improve the way in which health and care providers engage at all levels to ensure an integrated approach to digital transformation.
- Accelerate mechanisms that promote record and data sharing as more care is delivered outside a hospital environment, enabling clinicians to provide the best care in all settings, particularly via the use of mobile technology.
- Exploit big data analytics to inform frontline clinical decision making, provide real time system level management information and better targeting of prevention initiatives.
- Support and empower our staff, patients and citizens so they can maximise the potential of new technologies as they become available to them.
- Invest in interoperability and infrastructure to enable change

8.9.2. Focus areas from a recent development workshop (and a draft programme of interventions) are:

- Digital inclusion
- Self help connect
- Wellbeing and recovery
- Healthcare co-ordination

- Sharing data, predictive analytics
- Shared services and information governance
- Technical interoperability
- Digital health innovation

8.10 Development of accountable care in Place and System

8.10.1. In 2017/18, SYB will develop as an Accountable Care System. This will include collective decision making, governance and a single accountability framework which will align the individual statutory responsibilities of Parties to the MoU to the delivery of the Health and Care Plan (November 2016).

8.10.2. Where it serves to improve population health outcomes and to meet the needs of patients, we will develop integrated working between commissioners and providers to transform services and reduce transactional costs in the system.

8.10.3. Each of the five Places will develop an Accountable Care Partnership (ACP) to deliver the ambition set out in its Place Plan and the wider Health and Care Plan (2016). The five ACPs will operate in shadow form within 2017/18 and will be legally constituted by 1 April 2018, at the latest.

8.10.4. The five ACPs will bring together health and care services from statutory and non statutory organisations to create an integrated care system in each Place. This will include hospital services from tier 1 (to be determined).

8.10.5. Each of the five Places will explore new ways of contracting and allocating resources to its ACP including population budgets, population health management and segmentation approaches.

8.10.6. The five ACPs will connect between the five Places and with a horizontally integrated network of hospital based care (Tiers 2 and 3 to be determined) to support seamless care for patients and to create the overall accountable care system (ACS) for South Yorkshire and Bassetlaw.

8.10.7. A system wide commissioning function will be in place within 2017/18 which will result from a reform of commissioning. We will build on approaches we have established in the STP, integrating approaches to planning and transformation and we will explore new ways of contracting and allocating resources to the integrated network of hospital based care.

8.11. Commissioning reform

8.11.1. During 2017/18, we will undertake a review of commissioning as part of our system reform. This will consider the development of ACP in Place and the developing ACS and will need to influence and respond to:

a. The five ACPs bringing together health and care services from statutory and non statutory organisations to create a vertical and horizontal integrated care system in each Place, include hospital services from tier 1 (to be determined).

b. Developing new ways of contracting and allocating resources to its ACP including population budgets, population health management and segmentation approaches.

c. Connect between the five Places and with a horizontally integrated network of hospital based care (tiers 2 and 3 determined by the hospital services review and

delivery of safe and sustainable services) to support seamless care for patients and to create the overall Accountable Care System (ACS) for South Yorkshire and Bassetlaw.

d. Having a system wide commissioning function in place within 2017/18 with new ways of contracting and allocating resources to the integrated network of hospital based care. From April 2018, contracting once for a range of agreed services with the network to support sustainable services and drive improved outcomes for patients.

Organisations have agreed to fully engage in the review to support the objectives and also to support implementation of the review recommendations.

8.12. Specialised Services

8.12.1. In many clinical areas, including cancer, mental health and learning disabilities, the commissioning of services is often split across a number of different organisations, which makes it much more difficult to plan the provision of integrated care. Different sets of commissioners make separate decisions about areas of provision which – for the patient – combine to form their whole patient journey. In children and young people's mental health, for example, young people move between types of provision that are commissioned and provided by separate organisations.

8.12.2. Whilst commissioning responsibilities have become more dispersed over recent years, our collective responsibility is to ensure that any differentiation in the commissioning of services does not manifest itself in fragmented services for patients. The development of the ACS gives the opportunity for specialised commissioners to work with local systems to ensure that joined up pathways are both commissioned and delivered across multiple health and social care settings and that the transitions between services are explicitly supported.

8.12.3. Commissioning specialised services across SYB helps remove some of the structural barriers that reinforce the separation between different elements of provision. It means that integration – for example between inpatient services and community services in mental health, or between chemotherapy and follow-up care in cancer – is 'designed-in' to local NHS services by joining up the commissioning processes across specialised and non specialised services, and across NHS and local authority care. Decision making is shifted as far as possible from the national to the local, to ensure it is based on the specific requirements of that geographical locality, giving local systems more say on how specialised budgets are spent in their area, making use of their deep understanding of their local population and giving them a voice in how resources are used locally in line with the established national service specifications.

8.12.4. The specialised services commissioned by NHS England include a diverse range of services, from the rare and highly specialised to more common/higher volume services. It follows that the most appropriate footprint for planning these services also varies (depending on a range of factors such as: patient numbers, shape of provision, financial risk, service specifications, strategy). NHS England has worked with its regional teams to undertake an initial segmentation of the services. This has resulted in developing a list of 20 services that are suitable for planning at populations up to 2.5m and thus at SYB level. During 17/18, work will take place with SYB and specialised commissioners to explore areas of focus that would be most relevant to work towards being part of the ACS.

8.12.5. Milestones:

- Areas of focus for specialised services to be planned at an SYB level agreed - Mar 18
- Shadow run budget for areas of focus for specialised services agreed - from Apr 18

- Ensure that for areas of focus agreed, any decisions on changes to services is made in partnership with SYB – from Apr 18
- 18/19 – work towards integration of services within ACS.

Further work is still required to understand the staff resource implications of this work and this will be explored during 17/18.

8.13. Hospital services review

8.13.1. Both commissioners and acute providers across South Yorkshire and Bassetlaw, North Derbyshire and Wakefield have all committed to support an independent review of hospital services. The review will be completed in 2017/18. The terms of reference have been established and include the following key review objectives:

a) Define and agree a set of criteria for what constitutes 'Sustainable hospital services' for each Place and for South Yorkshire and Bassetlaw, North Derbyshire and Mid Yorkshire (in the context of South Yorkshire and Bassetlaw).

b) Identify any services that are unsustainable and not resilient against these criteria, in the short, medium and long-term, including tertiary services delivered within and beyond SYB.

c) Put forward a future service delivery model or models which will deliver sustainable hospital services.

d) Consider the future role of a district general hospital in best meeting patient needs in the context of the aspirations outlined in the South Yorkshire and Bassetlaw Health and Care Plan and emergent models of sustainable service provision.

9. National and regional support from the Department of Health, NHS England, NHS Improvement and the Arms Length Bodies

9.1. Capacity and capability

9.1.1. To support SYB ACS development there will be a process of aligning resources from ALBs to support delivery and establishing ACS integrated single assurance and regulation approach.

9.1.2. National capability and capacity will be available to support SYB from central teams including governance, finance and efficiency, regulation and competition, systems and national programme teams, primary care, urgent care, cancer, mental health, including external support.

9.2. Financial including transformation and capital funding

9.2.1. In year one, an allocation of central funding has been ring fenced for the eight accelerating ACSs only.

9.2.2. SYB will therefore receive a share of the £450 million transformational funding allocated for the eight high performing systems and a share of the £325 million capital funding. How this funding is allocated to deliver our system plan is to be worked through and agreed.

9.2.3. Bespoke support to work through financial governance and operating a shared system control total and alternative payment models.

9.3. Nationally supported workstreams and peer support

9.3.1. National ACS workstreams/learning set have been established to work with and support the eight named Accountable Care Systems including:

- Communications and public engagement
- Leadership
- Scaling up primary care
- Urgent and emergency care
- Devolved transformation funding
- Spreading new care models and integrating care
- Capital funding
- Shared system control totals
- Alternative payment models
- System wide efficiency opportunities
- Governance
- Streamlining oversight
- Future of commissioning functions
- External partnerships to support population health

10 Glossary of terms and acronyms

ACP	Accountable Care Partnership. The partnerships forming in each of the five local places of Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield.
or	Advanced Clinical Practitioner
ACS	Accountable Care System; here covering South Yorkshire and Bassetlaw with five constituent Places of Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield
ALB	Arm's Length Body; see https://www.gov.uk/government/publications/arms-length-bodies/our-arms-length-bodies
AO	Accountable Officer at a Clinical Commissioning Group
Carter	Lord Carter's review: 'Unwarranted variation: A review of operational productivity and performance in English NHS acute hospitals' (2016)
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CiC	Committees in Common
CPB	Collaborative Partnership Board
CQC	Care Quality Commission, the independent regulator of all health and social care services in England
DoH	Department of Health
FT	Foundation Trust; a semi--autonomous organisational unit within the NHS
FYFV	Five Year Forward View; a strategy for the NHS (2014)
GB	Governing Body - governance of Clinical Commissioning Groups
GP	General Practitioner
GPFV	General Practice Forward View
HEE	Health Education England
HSR	Hospital Services Review
IAPT	Improving Access to Psychological Therapies
JC CCG	Joint Committee of Clinical Commissioning Groups - a statutory body where two or more CCGs come together to form a joint decision making forum. It has delegated commissioning functions.
LA	Local Authority, an administrative body in local government

LWAB	Local Workforce Action Board sub regional group within Health Education England
MCP	Multi-specialty community provider
MHLD	Mental Health and Learning Disabilities
MoU	Memorandum of Understanding; a formal agreement between two or more parties to establish official partnerships
Naylor Review	Sir Robert Naylor's review of NHS property and estates and how to make best use of the buildings and land (2017)
NHS	National Health Service
NHS 111	A national free to call single non-emergency number medical helpline
NHSE	NHS England
NHSI	NHS Improvement; operating name for Monitor, NHS Trust Development Authority and teams from 2016
PA	Physician's Associate
PACS	Primary and Acute Care System
Place(s)	One of five geographical subdivisions of SYB with the same footprint as the ACPs
SAF	Single Accountability Framework
SRO	Senior Responsible Officer, the visible owner of the overall business change, accountable for successful delivery
STP	Sustainability and Transformation Plans (2016); the NHS and local councils have come together in 44 areas covering all of England to develop proposals and make improvements to health and care
SYB	South Yorkshire and Bassetlaw
TBA	To be announced
TBC	To be confirmed
UEC	Urgent and emergency care
Vertical integration	FYFV delivery next steps: horizontally operating provider organisations simultaneously operating as vertically integrated care system, partnering with local GP practices formed into clinical hubs serving 30,0000 – 50,000 populations
Horizontally integrated	FYFV delivery next steps: Where provider organisations collaborate to form care systems. There are different forms; from virtual to actual mergers, for example, having 'one hospital on several sites' through clinically networked service delivery

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 3 October 2017

Agenda item 10 – Assurance from Trust Board Committees

Clinical Governance and Clinical Safety Committee

Date	19 September 2017
Presented by	Charlotte Dyson
Key items to raise at Trust Board	➢ Update on Child and Adolescent Mental Health Services (CAMHS). ➢ Learning from Healthcare Deaths Policy. ➢ Health & Safety Annual Report 2016/17. ➢ Managing Aggression and Violence (MAV) Annual Report 2016/17. ➢ CQC update.

Mental Health Act Committee

Date	1 August 2017
Presented by	Chris Jones
Key items to raise at Trust Board	➢ Progressing outstanding actions. ➢ Progress around Code of Practice. ➢ Progress around training. ➢ Equality and Diversity data. ➢ Need to review discharged patients – action. ➢ Remuneration and Terms of Service Committee to consider how the Trust monitors impact of training. ➢ Consider when continuous amber RAG ratings become unacceptable.

Remuneration and Terms of Service Committee

Date	5 September 2017
Presented by	Rachel Court
Key items to raise at Trust Board	➢ Company Secretary appointment.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 3 October 2017
Agenda item 11

Title:	**Use of Trust seal**
Paper prepared by:	Company Secretary
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 one (1) time since the report to Trust Board in June 2017 in respect of the following: ➢ Contract for the sale and transfer deed of Darfield Health Centre, Church Street, Barnsley.
Recommendation:	**Trust Board is asked to NOTE use of the Trust's seal since the last report in June 2017.**
Private session:	Not applicable.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board annual work programme 2017-18

Agenda item/issue	Apr	June	July	Sept	Oct	Dec	Jan	Mar
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								
Assurance framework and risk register	✘		✘		✘		✘	
Customer services quarterly report	✘		✘		✘		✘	
Guardian of safe work hours *(from July 2017)*			✘		✘		✘	
Serious incidents quarterly report		✘		✘		✘		✘
Use of Trust Seal		✘		✘		✘		✘
Strategic overview of business and associated risks	✘				✘			
Investment appraisal framework	✘				✘			
Corporate Trustees for Charitable Funds# (annual accounts presented in July)	✘		✘		✘		✘	
Annual items								
Draft Annual Governance Statement (final approval by Audit Committee)	✘							
Audit Committee annual report	✘							
Compliance with NHS Improvement/Monitor licence (date to be confirmed by NHS Improvement)	✘							
Planned visits annual report	✘							
Risk assessment of performance targets, CQUINs and Single Oversight Framework and agreement of KPIs	✘							
Annual report, accounts and quality accounts update on submission		✘						
Code of Governance compliance		✘						
Customer services annual report		✘						

Agenda item/issue	Apr	June	July	Sept	Oct	Dec	Jan	Mar
Health and safety annual report		✘						
Serious incidents annual report		✘						
Equality and diversity annual report			✘					
Medical appraisal/revalidation annual report			✘					
Sustainability annual report				✘				
Assessment against NHS Constitution						✘		
Operational plan						✘		
Trust Board annual work programme						✘		
Eliminating mixed sex accommodation (EMSA) declaration								✘
Information Governance toolkit								✘
Strategic objectives								✘
Policies and strategies								
Membership Strategy *(next due for review in April 2019)*	✘							
Digital Strategy *(next due for review in April 2020)*	✘							
Quality Improvement Strategy *(next due for review in July 2017)*			✘					
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)*								
Information Management and Technology Strategy *(next due for review in April 2019)*								
Communication, Engagement and Involvement strategy *(next due for review in December 2019)*								
Organisational Development Strategy *(next due for review in December 2019)*								
Workforce Strategy *(next due for review in March 2020)*								

	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.	