South West Yorkshire Partnership NHS Foundation Trust

Trust Board (business and risk)
Tuesday 31 October 2017 at 9.30am
Meeting rooms 49/50, Folly Hall, Huddersfield

AGENDA

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

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

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

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

5. **Risk and assurance**

   5.1 Organisational risk register (attached)

   5.2 Assurance framework (attached)

   5.3 Strategic overview of business and associated risks (attached)

6. **Performance reports**

   6.1 Integrated performance report month 6 2017/18 including finance (attached)

   6.2 Customer services report quarter 2 2017/18 (attached)

   6.3 Workforce race quality standard (WRES) summary report (attached)

7. **Governance items**

   7.1 Safe Working Hours Doctors in Training report - quarter 1 2017/18 (attached)

   7.2 Learning from healthcare deaths report - quarter 1 2017/18 (attached)

7.2 Standards of Conduct in Public Service policy (attached)

8. Receipt of minutes of partnership boards (attached)

9. Assurance from Trust Board committees (attached)

- Audit Committee 10 October 2017
- Equality & Inclusion Forum 2 October 2017
- Nominations Committee 9 October 2017 and 24 October 2017
- Remuneration & Terms of Service Committee 30 October 2017

10. Trust Board work programme 2017/18 (attached)

11. Date of next meeting

The next meeting of Trust Board will be held on Tuesday 19 December 2017, Small Conference Room, Wellbeing & Learning Centre, Fieldhead, Wakefield.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Trust Board meeting held on 3 October 2017

Present:	Ian Black	Chair
	Charlotte Dyson	Deputy Chair
	Laurence Campbell	Non-Executive Director
	Rachel Court	Non-Executive Director
	Chris Jones	Non-Executive Director
	Angela Monaghan	Non-Executive Director
	Kate Quail	Non-Executive Director
	Tim Breedon	Director of Nursing and Quality
	Alan Davis	Director of HR, OD and Estates (Accounting officer)
	Mark Brooks	Director of Finance and Resources
Apologies:	Dr Adrian Berry	Medical Director / Deputy Chief Executive
	Rob Webster	Chief Executive
In attendance:	Carol Harris	District Director - Forensics and Specialist Services, Calderdale and Kirklees
	Sean Rayner	District Director - Barnsley and Wakefield (part)
	Karen Taylor	Director of Delivery (part)
	Dr Subha Thiyagesh	Deputy Medical Director
	Salma Yasmeen	Director of Strategy (part)
	Emma Jones	Company Secretary (author)

TB/17/69 Welcome, introduction and apologies (agenda item 1)

The Chair Ian Black (IB) welcomed everyone to the meeting. Apologies were received as above. Dr Subha Thiyagesh (SThi) was in attendance in the absence of Dr Adrian Berry (ABe) and Alan Davis (AGD) would be the Accounting officer for the meeting in the absence of Rob Webster (RW).

TB/17/70 Declaration of interests (agenda item 2)

The following declarations were considered by Trust Board in addition to those declared in 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.

Name	Declaration
OTHER DIRECTORS	
Salma Yasmeen	Spouse, owner of Insonova Ltd, who provide Quality and Risk Management consultancy services to the NHS and private companies.

Chris Jones (CJ) verbally declared a further interest as a Trustee of the Huddersfield Community Trust

There were no comments or remarks made on the Declarations, therefore, **it was RESOLVED to formally NOTE the Declarations of Interest.** It was also noted that the Chair had reviewed the declarations made and concluded that none present a risk to the Trust in terms of conflict of interests.

TB/17/71 Minutes and matters arising from previous Trust Board meeting held 25 July 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. The following matters arising were discussed:

TB/17/65a Kirklees Health & Wellbeing Plan - SY commented that the letter had been sent to the Kirklees Health & Wellbeing Board.

TB/17/55c Mental Health Act Committee 16 May 2017 - Tim Breedon (TB) commented that the necessary reporting had been put into place at the Mental Health Act Committee and any areas would escalated as needed.

TB/17/72 Chair and Chief Executive's remarks (agenda item 4)

AGD highlighted the following:

- As part of the West Yorkshire & Harrogate Sustainability and Transformation Plans (STP) we are discussing with other Trusts how we can work better together, share best practice and learning, and develop care pathways.
- Winter is approaching which will add pressure in the system. The Trust has an active flu vaccination campaign for staff to protect themselves as well as service users.
- Service changes in Barnsley is causing pressure for staff and it was important to continue to ensure the right support for operational managers and staff are in place so they have the right opportunities and we protect their employment rights where possible.

IB highlighted the following:

- Sadly Peter Walker, publicly elected Governor for Wakefield passed away last week. He would write a letter of condolences and thanks for his service to his family.

Action: Ian Black

The Trust Board and those in attendance observed a minute's silence.

- Annual Members' Meeting held on 19 September 2017.
- Attended a MacMillan coffee afternoon tea in the Newhaven unit.
- Attended and chaired the NHS Providers finance meeting and highlighted the pressure felt across the sector.

Charlotte Dyson (CD) provided an update from the Chair recruitment process. The Nominations Committee would meet on 9 October 2017 to decide the shortlist for the final interview process and meet again on 24 October 2017 to discuss the interview panel's recommendation for appointment. The appointment will be made by the Members' Council on 3 November 2017.

TB/17/73 Performance reports month 5 2017/18 (agenda item 5)

Integrated performance report month 5 2017/18 including finance (agenda item 5.1)

TB highlighted the following in relation to Quality:

- Safer staffing levels maintained, but pressure remains ins some areas
- Increase in under 18 admissions to acute adult wards remains a concern. They are admitted as the least worst option with the correct safeguards in place however it was important to ensure that it is not accepted we must make sure we don't accept this as normal.
- Safety huddles starting to produce positive results
- Complaints response time subject to improvement plan
- Quarter 1 CQUIN outturn in line with expectations
- Recognition received from the Care Quality Commission (CQC) on the work undertaken to improvement. The Trust has been asked to participate in case study due to be published new year.

CJ asked if there was a trend emerging in relation to delayed transfers of care. TB commented that it would be an area that would need to monitor as a result of the trend. There are factors that may be impacting the achievement around Local Authority funding and application of new guidance.

SY highlighted in relation to Priority Programmes that all programmes had clear governance arrangements in place from the Operational Management Group (OMG) to the Executive Management Team (EMT), Programme Board to EMT, or straight to EMT dependent on the programme. Most scopes had been agreed with the SROs.

Sean Rayner (SR) highlighted the following in relation to Locality - Barnsley BDU:

- Improving Access to Psychological Therapies (IAPT) challenge around 6 weeks and moving to recovery. A joint commissioner visit had taken place from the external support team and report yet to be received. Using feedback provided at the time of the visit until final report received.
- Neighborhood nursing service which is part of an alliance contract was discussed at the Nursing Institute and good feedback received with a request to write an article for their journal.

SR highlighted in relation to Wakefield BDU that the new building at Fieldhead was now open and the move of service users was being done over a phased period. Positive feedback had been received from staff and service users.

Carol Harris (CH) highlighted in relation to Locality - Calderdale and Kirklees BDUs that young people admitted to adult wards continues to be a concern and the average length of stay in older adults had increased.

CH highlighted in relation to Locality - Specialist and Forensic BDU:

- NHS England had asked the Trust to develop a scope for a community service for people with Learning Disabilities across West Yorkshire.
- Pressure in the system due to the Ministry of Justice relocating their office which caused a delay in the processing of service user leave.

MB highlighted that current achievement against the NHS Improvement indicators was largely positive, with area of focus around IAPT as only marginally achieving and an expansion of the priority metrics introduced last year.

Karen Taylor and Salma Yasmeen left the meeting.

MB highlighted in relation to 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. Out of area beds £726k overspent year-to-date. Reduction in overspend expected when the re-provided Unity ward opens in September. More work was needed on any seasonal pressures in this areas which would be picked up through the BDUs.
- 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.
- Cost Improvement Programme (CIP) delivery is £2.3m, which is £0.1m below plan.
- Cash balance of £19.7m is over £3m behind plan, one reasons is due to aged debts in NHS and with partners.

CD asked what plans were in place to address the shortfall in CIP plans. MB commented that just short of 80% of CIP came in from April 2017 with a lot of work taking place around Out of Area Beds, better rostering, sickness absence. There would be a meeting with BDU Directors next week to see what further actions can be put into place.

LC asked about the expenditure on drugs and change to the new system. MB commented that while it was the second highest area of non-pay expenditure there has not been a large increase in spend, however the estimated savings had not been achieved. Dr Subha Thiyagesh (SThi) added that discussion would take place with the Finance team to better understand the spend and that there was potentially more space available in the pharmacy that was not available during the changeover period from February to July.

IB asked if the public sector pay cap would impact the Trust. AGD commented that he felt the pay cap would be lifted however it may be for specific areas such as those where we find it difficult to recruit staff.

AGD highlighted the following in relation to Workforce:

- Sickness absence levels is 4.9% cumulatively and deteriorated to 5.2% for the month of August
- Appraisal completion for Band 6 and above is at 89%, just short of the 95% target
- Work is taking place around the retention of staff.

Kate Henry (KH) added that shorting had taken place for the upcoming annual staff Excellence Awards.

It was RESOLVED to NOTE the Integrated Performance Report.

TB/17/74 Exception reporting (agenda item 6)

TB 17/74a Serious incident report quarter 1 2017/18 (agenda item 6.1)

TB commented that the paper produced by the Patient Safety support team shows the data for incidents in quarter 1 and had been considered by the Clinical Governance & Clinical Safety Committee. Detailed reports have been produced and shared with each BDU at service line level. TB highlighted the following:

- 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 target due to capacity within the team, all of these have agreed extensions with Commissioners. From September 2017 the team of investigators are back to full resource and 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.

CD commented that the information had been scrutinised by the Clinical Governance and Clinical Safety Committee and had requested that in the areas where there is service change and pressure within the system they keep focus to see if there were any linkages to incidents. TB commented that these areas would be considered and discussed as part of the weekly risk scan meetings.

It was RESOLVED to NOTE the quarterly report on incident management.

TB/17/74b Safer staffing (agenda item 6.2)

TB reported that the six monthly update outlines the work being done to ensure ward areas provide staffing levels that are safe and effective. The information is received by the Safer Staffing Group, Executive Management, and the Clinical Governance and Clinical Safety Committee who monitor it closely. A safer staffing project lead is in place who is able to monitor capacity and demand on a day to day basis to enable any escalation if required.

TB highlighted the following:

- There is still no definitive guidance around staffing levels for Mental Health.
- The Trust continues to meeting its safer staffing levels however sometimes the skill mix was diluted and there are thresholds for escalation at 80 and 90%.
- The Care Quality Commission (CQC) identified ongoing challenges in recruitment and retention but also noted that the Trust demonstrates a commitment to achieve its longer-term plans in relation to the safer staffing fill rate, the reduction of agency spend, and workforce development, through the implementation of a number of measures that had been further embedded.
- NHS Improvement 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 and ward hours may need to be reviewed as a result.

CJ asked when information would be available in relation to review safer staffing in the community. TB commented that he would ask the Safer Staffing Group for an update and the review would be around caseloads rather than ratio in community based services.

Action: Tim Breedon

It was RESOLVED to RECEIVE the report as assurance that the organisation is meeting safer staffing requirements.

TB/17/75 Strategies and policies (agenda item 7)

TB/17/75a Information Management & Technology Strategy update (agenda item 7.1)

MB reported that the report provided an update to the Trust Board on the progress and developments made during the last six months in respect of the 2017/18 Information Management & Technology (IM&T) Strategy and highlighted the following:

- RiO record system had stablised.
- The Health Records Scanning Bureau went live Mid-April 2017 and had scanned over 5,100 records totaling nearly 714,000 pages.
- Tender for the procurement of a Mental Health clinical record system completed with a preferred provider selected.
- Procurement of support for the Business Intelligence programme approved and in place.
- A refresh of the Strategy would come to Trust Board in January 2018.

LC asked about the timescales leading up to the implementation of the new clinical records system and transfer of information between systems. TB commented that there were areas that needed to be addressed before the transfer of information to the new system and no urgent matters had arisen at this stage that would cause a delay.

AM asked how the Trust facilitated the use of digital feedback. KH commented that the Patient Safety team used technology to receive feedback such as via the Friend and Family Test. Part of the actions under the Trust's Digital Strategy would look at the culture of using digital technology and one potential pilot was in relation to a clinical pathways app for Child and Adolescent Mental Health Services (CAMHS).

IB asked about the impact of the General Data Protection Regulation (GDPR). MB commented that a paper would go to the next Audit Committee and a session for all Trust Board members would be scheduled prior to the Audit Committee meeting in January 2018.

Action: Mark Brooks

It was RESOLVED to NOTE the achievements made in respect of the 2017/18 milestones.

TB/17/75b Mortality review - learning from healthcare deaths policy (agenda item 7.2)
TB reported that 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. The policy was the Trust's response to the guidance which had been scrutinised by both Executive Management Team and Clinical Governance & Clinical Safety Committee. There had been a good discussion by these groups who understood the benefits of having the early review in April 2018, supported working as an alliance with other Trusts, the importance of focusing on the outcomes rather than the process, the potential impact on resources to deliver the requirements, and supported the approval of the policy by Trust Board. A named Non-Executive Director was required to take a lead responsibility for oversight of progress to act as a critical friend, holding the organisation to account for its approach in learning from deaths. Previously this was Julie Fox who was the previous Deputy Chair and Chair of the Clinical Governance and Safety Committee, it was therefore recommended that Charlotte Dyson now became the lead as part of her role.

It was RESOLVED to RECEIVE and APPROVE the Learning from Healthcare Deaths Policy and the next steps identified within the report.

TB/17/76 Annual reports (agenda item 8)

TB/17/76a Health and safety annual report 2016/17 (agenda item 8.1)
AGD reported that 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. The annual report provides an update of the key actions in 2016/2017 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. The paper also outlines the high level priorities for 2017/2018 which have been approved by the Executive Management Team and Clinical Governance and Clinical Safety Committee. A Health and Safety session would be scheduled for the Trust Board.

It was RESOLVED to APPROVED the health and safety annual report for and AGREE the action plan for 2017/18.

TB/17/76b Sustainability annual report 2016/17 (agenda item 8.2)
AGD reported that the report was to update the Trust 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 with examples outlined in the paper.

CD commented that there was more work that could be done to communicate the plans to staff to ensure it is embedded in everything we do.

AM asked what work was taking place to minimise food waste. AGD commented that minimising food waste was important both in relation to quality as well as the Cost Improvement Programme (CIP). A business case had been approved in relation to housekeeping which included assisting in the reduction of food waste.

IB commented that it was important to ensure other methods of communication are used for meetings as well as face to face. AGD commented that this was part of the work around agile working and travel budgets were reducing. The emphasis was still around face to face meetings making while also making other technology available.

It was RESOLVED to NOTE the report and progress to date.

TB/17/77 Governance matters (agenda item 9)

TB/17/77a Receipt of public minutes of partnership boards (agenda item 9.1)

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

- Barnsley Health and Wellbeing Board - 8 August 2017 - SR Carers Strategy really important and we have contributed to, we are represented on a steering group to drive that forward.
- Calderdale Health and Wellbeing Board 17 August 2017
- Kirklees Health and Wellbeing Board - 28 September 2017
- Wakefield Health and Wellbeing Board - 21 September 2017 - SR Care Home Vanguard report really well.
- South Yorkshire & Bassetlaw Accountable Care System - June 2017 - SR final MOU attached, new website has been launched.

Sean Rayner left the meeting.

TB/17/78 Assurance from Trust Board Committees (agenda item 10)

Clinical Governance and Clinical Safety Committee 19 September 2017

CD highlighted to following:

- Update on Child and Adolescent Mental Health Services (CAMHS).
- Learning from Healthcare Deaths Policy as per Trust Board under agenda item 7.2.
- Health & Safety Annual Report 2016/17 as per Trust Board agenda item 8.1.
- Managing Aggression and Violence (MAV) Annual Report 2016/17.
- Care Quality Commission (CQC) update.

Remuneration & Terms of Service Committee 5 September 2017

RC highlighted the following:

- Company Secretary appointment which was ratified by Trust Board at the private session on 5 September 2017.

Rachel Court left the meeting.

Mental Health Act Committee 1 August 2017
CJ highlighted the following:

- Progressing outstanding audit actions.
- Progress around Code of Practice.
- Progress around mandatory training.
- Equality and Diversity data continues to be an area of focus.
- Need to review discharged patients.
- Remuneration and Terms of Service Committee to consider how the Trust monitors the impact of training.

Action: Alan Davis

- Consideration needed when continuous amber RAG ratings become unacceptable and need to be escalated.

Equality & Inclusion Forum 2 October 2017
IB highlighted the following:

- Robertson Cooper staff survey.
- The Insight Programme, two new participants will be shadowing the Board.
- BAME staff network update and 1st year celebration.
- Working taking place to set up a Disability staff network.

It was RESOLVED to NOTE the updates provided.

TB/17/79 Use of Trust seal (agenda item 11)

It was RESOLVED to NOTE use of the Trust's seal since the last report in June 2017.

TB/17/80 Trust Board Work Programme (agenda item 12)

TB requested that the Safer Staffing report be added to the work programme in June and December.

Action: Emma Jones

It was RESOLVED to NOTE the work programme and amendment requested.

TB/17/81 Date of next meeting (agenda item 13)

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

Signed: **Date:**

South West Yorkshire Partnership NHS Foundation Trust

TRUST BOARD 3 OCTOBER 2017 – ACTION POINTS ARISING FROM THE MEETING

Actions from 3 October 2017

Min reference	Action	Lead	Timescale	Progress
TB/17/72 Chair and Chief Executive's remarks	Sadly Peter Walker, publicly elected Governor for Wakefield passed away last week. He would write a letter of condolences and thanks for his service to his family.	IB		Complete. Letter send. AM attended the funeral on behalf of the Trist Board.
TB/17/74b Safer staffing	CJ asked when information would be available in relation to review safer staffing in the community. TB commented that he would ask the Safer Staffing Group for an update and the review would be around caseloads rather than ratio in community based services	TB		
TB/17/75a Information Management & Technology Strategy update	IB asked about the impact of the General Data Protection Regulation (GDPR). MB commented that a paper would go to the next Audit Committee and a session for all Trust Board members would be scheduled prior to the Audit Committee meeting in January 2018.	MB		Complete. Briefing session scheduled for January 2018.
TB/17/78 Assurance from Trust Board Committees (Mental Health Act Committee 1 August 2017)	Remuneration and Terms of Service Committee to consider how the Trust monitors the impact of training.	AGD		
TB/17/80 Trust Board Work Programme	TB requested that the Safer Staffing report be added to the work programme in June and December.	EJ		Complete. Work programme updated.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 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:	The Board met three weeks prior to the production of this paper and received the latest copy of *The Brief* at that time. This is, therefore, a shorter Chief Executive's report to the Board. **National Context** ➢ **The Party Conference season has concluded**. There was a strong commitment to expanding workforce training and providing some support to EU citizens working in the NHS from the Conservatives. The Labour Party promised significant investment in the NHS and a scrapping of the Sustainability and Transformation Partnership process. NHS Providers' briefing on the main points is attached. ➢ **Brexit continues to dominate the agenda politically and a coalition of industry, research and NHS bodies has formed the Brexit Health Alliance.** This aims to work in the best interest of health on research, staffing, public health and innovation. It is co-chaired by Sir Hugh Taylor and Niall Dixon of the NHS Confederation. ➢ **The health lobby has begun to ramp up in advance of the budget.** The NHS Confederation briefing for MPs attached covers national and local politics and provides a useful compendium of the main issues. A range of other national representatives have been focusing on **winter and short term resources** required to deliver care. There are no confirmed reports of additional revenue for the NHS this year. There are continuing reports on the budget potentially including capital for the NHS. ➢ **Into this environment, the Care Quality Commission launched its latest report on the state of care.** This report showed that, "thanks to the efforts of staff and NHS leaders", the quality of care had been maintained despite unprecedented pressures. The CQC also suggested that "future quality is precarious". ➢ **NHS Improvement has continued to reinforce messages on**

financial performance and delivery during winter. This has been backed by the publication of benchmarking information on issues like theatre utilisation and management costs. MPs endorsed Baroness Harding as the new Chair of NHS Improvement last week. The process of appointing a new CEO will now take place as Jim Mackey steps down shortly.

- **NHS England continues to back local partnerships to deliver the Five Year Forward View.** The Accountable Care System Arrangements in South Yorkshire and the Sustainability & Transformation Partnership arrangements in West Yorkshire continue to develop in this context. Local partnerships are managing the consequences of the national row between local government and the NHS over the Better Care Fund. The last week has seen a process of panel reviews for places that had not agreed their plans for spending resources.

Local Context

- **Our two STPs continue to develop similar trajectories and arrangements.** The West Yorkshire & Harrogate Partnership is developing a suite of new arrangements to support its move towards greater autonomy. A draft document on "next steps" and a draft memorandum of understanding have been developed for sharing and comment and will come to Board shortly.
- **Within each STP area, we are seeing differential development of accountable care partnerships in each local area.** This has made the management of relationships even more critical and numerous partnership meetings have been taking place to make progress. These are covered in the public and private parts of the Board meeting today.
- **Carol McKenna has been appointed as the joint accountable officer for North Kirklees and Greater Huddersfield Clinical Commissioning Groups.** This means there are now 6 management teams running 11 CCGs in West Yorkshire.
- **I continue to meet local MPs to discuss political and practical issues.** These meetings are an essential part of the development of the Trust. Following these meetings, we are strengthening the relationship management arrangements with local MP offices. We are also putting on **training in mental health services and basic first aid for all MP offices.** This had been planned prior to the election but will now take place in November for staff and December for MPs.

Trust Context

- **The Integrated Performance Report, Board Assurance Framework and Risk Register** highlights the service, staffing and

	financial pressures we face. These are continuing and highlight the need for us to focus on delivery alongside transformation. ➢ **In doing so, we retain a focus on the health and wellbeing of staff.** Our #allofus campaign is ensuring that psychological and physical support is available for all staff. It is also driving the flu campaign this year and an update on take up will be provided at the Board. ➢ **The staff survey period is upon us and all staff are eligible this year.** The staff survey is now a comprehensive census rather than a sample. It will be helpful to see how our efforts to support staff have fared in an environment of tendering, decommissioning, transformation and service pressure. There are also significant quality incentive payments (CQUIN) attached to the results. ➢ **We continue to see excellent practice and innovation in the Trust.** This is seen in developments such as a £1.3m mental health service we help deliver in Barnsley Schools. It is also demonstrated by our excellence awards. These take place on 7th November. Outside of the Trust we continue to be recognised, most recently for our work on staff rostering, where we were runner up and highly commended in the Allocate Awards 2017 held in Manchester in the Workforce Intelligence Category. **Conclusion** We operate in a challenging context and face service, financial and strategic issues that are unprecedented in scale and volume. Our staff continue to be magnificent in dealing with these pressures and delivering safe, high quality care. We must now focus on a period of business planning and prioritisation that will allow us to support our staff to be successful and services to be sustainable.
Recommendation:	**Trust Board is asked to NOTE the Chief Executive's report.**
Private session:	Not applicable

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 October 2017
Agenda item 5.1

Title:	**Organisational risk register quarter 2 2017/18**
Paper prepared by:	Director of Finance and Resources
Purpose:	For Trust Board to be assured that a sound system of control is in place with appropriate mechanisms to identify potential risks to delivery of key objectives.
Mission / values:	The risk register is part of the Trust's governance arrangements and integral elements of the Trust's system of internal control, supporting the Trust in meeting its mission and adhere to its values.
Any background papers / previously considered by:	Previous quarterly reports to Trust Board.
Executive summary:	**Organisational risk register** The organisational risk register records high level risks in the organisation and the controls in place to manage and mitigate the risks. The risk register is reviewed by the Executive Management Team (EMT) on a monthly basis, risks are re-assessed based on current knowledge and proposals made in relation to this assessment, including the addition of any high level risks from BDUs, corporate or project specific risks and the removal of risks from the register. The Trust received 'significant insurance' following completion of an internal audit of risk management by 360 Assurance. The report was received by the Audit Committee on 10 October 2017. In August 2017, EMT agreed to change the risk reporting mechanism by way of aligning each risk to the Trust's priorities for 2017/18 and reviewing on a cyclical basis to feed into the quarterly Board report. Each risk is also aligned to one of the Trust Committees for review and to ensure that the Committee is assured the current risk level is appropriate.

Our six strategic priorities for 2017/18		
Improving health	**Improving care**	**Improving resources**
People at the centre	**Quality counts, safety first**	**Operational excellence**
Joined up care	**Compassionate leadership**	**Digital by default**

The organisational risk register contains the following **15+ risks**:

	Risk ID	Description
	812	Risk that Trust sustainability will be adversely impacted by the creation of local place based solutions which change clinical pathways and financial flows (e.g. ACO implementation).
	1078	Risk that the long waiting lists to access CAMHS and ASD services lead to delay in young people starting treatment.
	1119	Risk that forensic locks are now out of patent.
	1132	Risk to the Trust's reputation caused by long waiting lists delaying treatment and recovery.
	1077	Risk that the Trust could lose business resulting in a loss of sustainability for the full Trust from a financial, operational and clinical perspective.
	1080	Risk that the Trust's information systems could be the target of cyber-crime leading to theft of personal data.
	1114	Risk of financial unsustainability if the Trust is unable to achieve the transition identified in the two year plan.
	1151	Risk of being unable to recruit qualified clinical staff due to national shortages which could impact on the safety and quality of current services and future development.

The following risks have been reviewed by EMT and the **risk level has reduced** since the last Board report:

Risk ID	Description
275	Risk of impact on the demand for services as a result of continued reduction in Local Authority funding (LA as a provider)
695	Risk of adverse impact on clinical services if the Trust is unable to achieve the transitions identified in the Trust's strategic plan.
1099	Risk of untimely risk reports through management reporting system for forensic CAMHS, Wetherby.
772	Risk of continued reduction in Local Authority budgets may have a negative impact on level of financial resources available to commission services and to deploy social care resource to support mental health services and services for people with learning disabilities.
1153	Risk of potential loss of knowledge, skills and experience of NHS staff due to ageing workforce able to retire in the next five years.
1154	Risk of loss of staff due to sickness absence leading to reduced ability to meet clinical demand etc.
1155	Risk that pay restraint and new terms and conditions could cause increased industrial action and impact on morale.
1156	Risk of decommissioning of services at short notice that makes redeployment difficult and increased risk of redundancy.
1157	Risk that the Trust does not have a diverse and representative workforce and fails to achieve EDS2 and WRES.
1158	Risk of over reliance on agency staff which could impact on quality and finances.

Throughout the review of the organisational risk register by EMT, the following have been highlighted as potential 'new risks' to be added to the risk register:

- The impact of tendering activity on staff morale.
- Risk relating to changes taking place in Barnsley.
- The impact of the General Data Protection Regulation (GDPR).
- The Trust's capacity for change.

Risk appetite

The organisational risk register supports the Trust in providing safe, high quality services within available resources, in line with the Trust's Risk Appetite Statement.

Further work has been undertaken by EMT to review organisational level risks that have a risk level of less than 15 but remain outside of the Trust's Risk Appetite Framework. These risks have been summarised and appended within the risk register report for Board information, the following outlines the **highest rated under 15 risks** (not outlined above):

Risk ID	Description
522	Risk that the Trust's financial viability will be affected as a result of changes to national funding arrangements (such as, CCG allocation and the Better Care Fund) coupled with emerging intensified local acute Trust pressures.
773	Risk of impact of lack of engagement with external stakeholders leading to delay in transformational change impacting on service quality.
1159	Risk of arson.
850	Risk the upgrade to RiO V7 resulted in system functionality and operational issues which impacted on the Trust's ability to effectively support clinical services operationally as well as in the production and submission of central returns and accurately recording clinical coding information.
852	Risk of information governance breach leads to inappropriate circulation and / or use of personal data leading to a reputational and public confidence risk.
1004	Loss of records / inability to find them. The decentralised model for health records has resulted in teams making unilateral decisions on record keeping rather than following trust wide standards and guidance. This could have serious implications for the person whose record is lost (even if lost temporarily) and for the organisation's reputation.
1076	Risk that the Trust may deplete its cash given the inability to identify sufficient CIPs, the current operating environment and its high value capital expenditure programme committed to, leading to an inability to pay staff and suppliers without DH support.

Recommendation:	**Trust Board is asked to 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, and to DISCUSS if the target risk levels that fall outside of the risk appetite are acceptable or whether they require review.**
Private session:	Not applicable.

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk appetite:	
Strategic risks: Risks generated by the national and political context in which the Trust operates that could affect the ability of the Trust to deliver its plans.	
Clinical risks: Risks arising as a result of clinical practice or those risks created or exacerbated by the environment, such as cleanliness or ligature risks.	
Financial or commercial risks: Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income, inability to recruit or retain an appropriately skilled workforce, damage to the Trust's public reputation which could impact on commissioners' decisions to place contracts with the organisation.	
Compliance risks: Failure to comply with its licence, CQC registration standards or failure to meet statutory duties, such as compliance with health and safety legislation.	
Risk appetite	**Application**
Avoid / none (nil)	• Risk of breakdown in financial controls, loss of assets with significant financial value.
Minimal / low (1-3)	• Risk to service user, public or staff safety • Risks to meeting statutory and mandatory training requirements, within limits set by the Board • Risk of failing to comply with Monitor requirements impacting on license • Risk of failing to comply with CQC standards and potential of compliance action • Risk of failing to comply with health and safety legislation • Meeting its statutory duties of maintaining expenditure within limits agreed by the Board
Cautious / moderate (4-6)	• Reputational risks, negative impact on perceptions of service users, staff, commissioners • Risks to recruiting and retaining the best staff
Open / high (8-12)	• Delivering transformational change whilst ensuring a safe place to receive services and a safe place to work • Developing partnerships that enhance the Trusts current and future services • Financial risk associated with plans for existing / new services as the benefits for patient care may justify the investment
Seek / extreme (15-20)	• Innovating and safely changing practices

	Likelihood				
Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Green	1 – 3	Low risk
Yellow	4 – 6	Moderate risk
Amber	8 – 12	High risk
Red	15 – 25	Extreme / SUI risk

Our six strategic priorities for 2017/18		
Improving health	**Improving care**	**Improving resources**
People at the centre Joined up care	Quality counts, safety first Compassionate leadership	Operational excellence Digital by default

KEY: CEO=Chief Executive Officer, DFR=Director of Finance and Resources, DHR=Director of HR, OD and Estates, DMCE= Director of Marketing, Communication and Engagement, DNQ=Director of Nursing and Quality, MD=Medical Director, DS=Director of Strategy, DD= Director of Delivery, BWBDU=Barnsley & Wakefield Business Delivery Unit Director, CKFSBDU=Calderdale, Kirklees, Forensic & Specialist Services Business Delivery Unit Director

Trust Board (business and risk) – 31 October 2017

Risk level 15+

Risk ID	Description of risk	Current control measures	Consequence (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
812	Risk that Trust's sustainability will be adversely impacted by the creation of local place based solutions which change clinical pathways and financial flows. For example ACO implementation.	➢ Progress on system and service transformation reviewed by Board and EMT. ➢ Quality Impact Assessment process for CIP and QIPP savings in place. ➢ Alignment of contracting and business development functions to support a pro-active approach to retention of contract income and growth of new income streams. ➢ EMT monthly and Trust Board investment appraisal report. ➢ Regular review and update of strategy by Trust Board. ➢ Active engagement in West Yorkshire and South Yorkshire Sustainability and Transformation Plans (STP) / CEO leads the West Yorkshire STP. ➢ Financial control process to maximise contribution.	5 Catastrophic	3 Possible	15 Red / extreme / SUI risk (15-25)	Open / high (8-12)	➢ Trusts pro-active involvement and influence in system transformation programmes, which are led by commissioners and includes four vanguard programmes. (BWBDU / CKFSBDU) ➢ Alignment of our plans with CCGs commissioning intentions. (BWBDU / CKFSBDU) ➢ Horizon scanning for new business opportunities. (DS / DFR) ➢ Developing communications and engagement into a more systematic approach in stakeholder engagement. (DMCE) ➢ Review of CQUIN income attainment by EMT & OMG with action plan to improve. (DFR) ➢ Review of commissioning intentions by EMT and contract negotiation stances and meetings in place to progress agreements of contracts for 2018/19. (DFR) ➢ Emergent strategy – September 2017, with related communication plans in place by October 2017 (DS) ➢ Developing clear service strategies to engage commissioners and service users on the value of services delivered. (DS) ➢ Place based plans and other system transformation programmes developing and ensuring Trust participation. (DS) ➢ Management process including additional skills building an increase in joint bids with partners. Ongoing development of capability. (DS) Actions in green are completed or ongoing by their nature.	DS	Currently October 2017	EMT (monthly) Trust Board business and risk (half-yearly)	8 Amber / high (8-12)	AC	Risk appetite: Commercial risk target 8 – 12 Links to BAF, PSO 1 & 3	Every three months prior to business and risk Trust Board – October 2017

Risk ID	Description of risk	Current control measures	Consequence (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
1078	Risk that the long waiting lists to access CAMHS and ASD services lead to delay in young people starting treatment.	➢ Emergency response process in place for those on the waiting list. ➢ Demand management process with commissioners to manage ASD waiting list within available resource. ➢ Commissioners have established an ASD Board and local commissioning plans are in place to start to address backlog for ASD. ➢ Future in Mind investments are in place to support the whole CAMHS system ➢ Healthwatch Barnsley and Wakefield have carried out monitoring visits and are supporting local teams with the action plans. ➢ CAMHS performance dashboard for each district	4 Major	4 Likely	16 Red / extreme / SUI risk (15-25)	Minimal / low (1-3)	➢Work is ongoing to implement care pathways and consistent recording of activity and outcome data (CKFSBDU). ➢The team is working with commissioners to implement additional solutions for people waiting for ASD assessment and treatment (CKFSBDU). ➢The team is contributing to the locality plans and reviewing the impact of the Future in Mind investments on demand for specialist CAMHS. (CKFSBDU) ➢Investment into FPOC has demonstrated a positive impact on access and demand in Kirklees. The learning from this is being applied to other areas (CKFSBDU). ➢Ongoing dialogue with people on the waiting list to keep in touch and to carry out well-being checks (CKFSBDU) ➢Active participation in STP CAMHS initiative (CKFSBDU) ➢Recruitment to new waiting list initiative (CKFSBDU) ➢Recruitment to vacant positions is underway to increase capacity. This includes the consideration of new roles to improve opportunities to recruit. (CKFSBDU) ➢Extensive work, supported by the PMO, is underway to develop the care pathways and agree consistent recording and monitoring of activity and outcome data (CKFSBDU) Actions in green are completed or ongoing by their nature.	CKFS BDU	Review every three months	Performance reporting to EMT - monthly Assurance report to Clinical Governance Committee Individual district performance reports reviewed by BDU	6 Yellow / moderate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 3 Links to BAF, PSO 2	Every three months prior to business and risk Trust Board – October 2017
1119	Forensic BDU locks are now out of patent.	➢ Protected airlocks and procedures controlling the issue and return of keys. ➢ Controlled access and egress from the unit. ➢ Procedures re care and control of keys. ➢ Full induction support specifically addressing care and control of keys for all staff who work in the service.	5 Catastrophic	3 Possible	15 Red / extreme / SUI risk (15-25)	Minimal / low (1-3)	➢There is an agreed programme of work from 2017 to 2019 to renew all the locks (CKFSBDU / DHR) Actions in green are completed or ongoing by their nature.	CKFS BDU	Review of progress work March 2018. Expected completion March 2019.	EMT monthly. Progress report March 2018.	5 Yellow / moderate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 3 Links to BAF, PSO 2	Every three months prior to business and risk Trust Board – October 2017
1132	Risks to the Trust's reputation caused by long waiting lists delaying treatment and recovery.	➢ There is a common understanding of the issues with relevant commissioners. ➢ Waiting lists are reported through the BDU business meetings. ➢ Alternative services are offered as appropriate. ➢ People waiting are offered contact information if they need to contact someone urgently. ➢ Individual bespoke arrangements are in place within services and reported through the BDU business meetings. ➢ Bespoke arrangements to review pathways in individual services.	4 Major	4 Likely	16 Red / extreme / SUI risk (15-25)	Minimal / low (1-3	➢Waiting list information being developed with P&I and reported to EMT on the IPR. (BWBDU / CKFSBDU / DFR) ➢Further work on reviewing the pathways and the impact of this to be monitored in the BDU management meetings (BWBDU / CKFSBDU). ➢Maintaining communication with commissioners to push for waiting list initiatives where demand has exceeded an optimal service supply. (BWBDU / CKFSBDU) ➢The risks at BDU level will be monitored in BDU meetings (BWBDU / CKFSBDU). ➢Work ongoing with the commissioners to agree additional capacity in specific services. (BWBDU / CKFSBDU) Actions in green are completed or ongoing by their nature.	BW BDU / CKFS BDU	Ongoing	Performance reporting to OMG and EMT monthly. Assurance report to CG&CS Committee (CAMHS). Individual district performance reports reviewed by BDU.	6 Yellow / moderate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 3 Links to BAF, PSO 2	Every three months prior to business and risk Trust Board – October 2017

Risk ID	Description of risk	Current control measures	Consequence (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
1077	Risk that the Trust could lose business resulting in a loss of sustainability for the full Trust from a financial, operational and clinical perspective.	➢ Systematic and integrated monitoring of contract performance, changes in specification and commissioning intentions to identify and quantify contract risks. ➢ Regular reporting of contract risks to EMT and Trust Board. ➢ Stakeholder engagement strategy. ➢ Play full role in STPs in both West and South Yorkshire	4 Major	4 Likely	16 Red / extreme / SUI risk (15-25)	Minimal / low (1-3)	➢Formulation and delivery of proactive contract risk management plans for specific services (BWBDU / CKFSBDU). ➢Development and maintenance of longer term financial planning (DFR). ➢Development of targeted programme of business growth focused on specific services and markets and aligned to strategy (BWBDU / DD / CKFSBDU). ➢Refresh of Trust strategy to identify role the Trust can best play in each geography given rapidly changing operating environment (DS). ➢Scenario planning in Operational Plan and Strategy regarding place based developments, where this could result in step-changes in income in either direction (DS / BWBDU / CKFSBDU). ➢Develop an understanding of clinical and operational interdependencies and minimum volumes for high quality care (BWBDU / CKFSBDU). ➢Implement actions from stakeholder survey (DMCE). Actions in green are completed or ongoing by their nature.	DFR	Ongoing	EMT (monthly) Board (monthly)	6 Yellow / moderate (4-6)	AC	Risk appetite: Financial risk target 1 – 3 Links to BAF, PSO 1 & 3	Every three months prior to business and risk Trust Board – October 2017
1080	Risk that the Trust's IT infrastructure and information systems could be the target of cyber-crime leading to theft of personal data.	➢ McAfee anti-virus software in place including additional email security and data loss prevention. ➢ Security patching regime covering all servers, client machines and key network devices. ➢ Annual infrastructure, server and client penetration testing. ➢ Appropriately skilled and experienced staff who regularly attend cyber security events. ➢ Disaster recovery and business continuity plans which are tested annually. ➢ Data retention policy with regular back-ups and off-site storage. ➢ NHS Digital Care Cert advisories reviewed on an on-going basis & where applicable applied to Trust infrastructure. ➢ Key messages and communications issued to staff regarding potential cyber security risks.	5 Catastrophic	3 Possible	15 Red / extreme / SUI risk (15-25)	Minimal / low (1-3)	➢Explore potential to install Intrusion Detection and Intrusion Prevention. (DFR) ➢Implementation of three year (data Centre) infrastructure plan including security and firewall rules for key network and computer devices, and IT services business continuity and disaster recovery (DFR) ➢Daisy currently drafting a cyber-security overview to include recommendations for improvement (DFR) ➢Provision of Microsoft software licensing strategic roadmap will ensure future appropriate licensing cover and availability of on-going security updates for Microsoft products (DFR) ➢Increased training for information asset owners and managers. ➢Internal assurance report for the Trust controls and mechanisms in relation to the recent WannaCry Ransomware cyber-attack being finalised (DFR) Actions in green are completed or ongoing by their nature.	DFR	Ongoing	IM&T Managers Meeting (Monthly) EMT Monthly (bi -Monthly) Audit Committee (Quarterly) IT Services Department service management meetings (Trust/ Daisy) (Monthly)	5 Yellow / moderate (4-6)	AC	Risk appetite: Financial risk target 1 – 3 Links to BAF, PSO 2 & 3 The Trust were not impacted by the recent WannaCry Ransomware cyber-attack on 12 May 2017 as experienced within the NHS and private industry	Every three months prior to business and risk Trust Board – October 2017
1114	Risk of financial unsustainability if the Trust is unable to achieve the transition identified in the two year plan.	➢ Board and EMT oversight of progress made against transformation schemes. ➢ Active engagement in West Yorkshire and South Yorkshire STPs / CEO leads the West Yorkshire STP. ➢ Active engagement on place based plans. ➢ Enhanced management of CIP programme in 2017/18 including NHS I benchmarking data. ➢ Updated integrated change management processes.	5 Catastrophic	3 Possible	15 Red / extreme / SUI risk (15-25)	Minimal / low (1-3)	➢Increased use of service line management information by directorates. (DFR) ➢Increase in joint bids and projects to develop strategic partnerships which will facilitate the transition to new models of care and sustainable services. (DS) ➢Active engagement in West Yorkshire and South Yorkshire Sustainability and Transformation plans / CEO leads West Yorkshire STP. (CEO / MD) ➢Update five year forward plan in light of updated planning assumptions and system intelligence. (DFR) ➢Devise plans based on NHS I benchmarking data. (DFR) Actions in green are completed or ongoing by their nature.	DFR	Annual review	EMT (monthly) Trust Board (quarterly)	8 Amber / high (8-12)	AC	Risk appetite: Financial risk target 1 – 3 Links to BAF, PSO 3	Every three months prior to business and risk Trust Board – October 2017

Risk ID	Description of risk	Current control measures	Consequence (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
1151	Unable to recruit qualified clinical staff due to national shortages which could impact on the safety and quality of current services and future development.	➢ Safer staffing levels for inpatient services agreed and monitored. ➢ Agreed turnover and stability rates part of IPR ➢ Weekly risk scan by Director of Nursing and Medical Director to identify any emerging issues, reported weekly to EMT. ➢ Reporting to the Board through IPR ➢ Datix reporting on staffing levels. ➢ Marketing of the Trust as an employer of choice ➢ Strong links with universities ➢ New students supported whilst on placement ➢ Regular advertising ➢ Development of Associate Practitioner ➢ Workforce plans incorporated into new business cases ➢ Workforce strategy implementation	4 Major	4 Likely	16 Red / extreme / SUI risk (15-25)	Cautious / moderate (4-6)	➢ Workforce plans linked to annual business plans (DHR) ➢ Develop new roles e.g. Advanced Nurse Practitioner (DNQ / DHR / MD) ➢ Safer staffing reviewing establishment levels (DNQ) ➢ Working in partnership across W Yorks on international recruitment. (DHR)	DHR	Ongoing given external influence outside our control	BDU (weekly) EMT (monthly) Trust Board (each meeting through integrated performance report)	6 Yellow / moderate (4-6)	CG&CS	Risk appetite: Financial / commercial risk target 4 – 6 Links to BAF, PSO 2 & 3	Every three months prior to business and risk Trust Board – October 2017

Risk level <15+ - risks outside the risk appetite (unless stated)

Risk ID	Risk description	Lead director	Nominated Committee	Risk level (current)	Risk level (target)	Risk appetite
275	Risk of impact on the demand for services as a result of continued reduction in Local Authority funding (LA as a provider)	BWBDU	CG&CS	12 (4 x 3) Amber / high (8-12)	12 Amber / high (8-12)	Minimal / low (1-3)
695	Risk of adverse impact on clinical services if the Trust is unable to achieve the transitions identified in the Trust's strategic plan.	DS	CG&CS	12 (4 x 3) Amber / high (8-12)	8 Amber / high (8-12)	Minimal / low (1-3)
835	Achievement of the access and waiting time standard for Early Intervention in Psychosis (EIP) from 1 April 2016. The standard requires that more than 50% of people experiencing first episode psychosis will commence treatment with a NICE-approved care package within two weeks of referral.	DFR	CG&CS	6 (3 x 2) Yellow / moderate (4-6)	6 Yellow / moderate (4-6)	Minimal / low (1-3)
522	Risk that the Trust's financial viability will be affected as a result of changes to national funding arrangements (such as, CCG allocation and the Better Care Fund) coupled with emerging intensified local acute Trust pressures.	DFR	AC	12 (3 x 4) Amber / high (8-12)	6 Yellow / moderate (4-6)	Cautious / moderate (4-6)
744	If temperatures rise above 25 degrees there is a risk that medicines may deteriorate and not be effective or cause harmful effects. The use of any medicines stored outside conditions specified will not be covered by the manufacturer's product licence. Leaving the trust liable for any harm.	MD	CG&CS	6 (2 x 3) Yellow / moderate (4-6)	6 Yellow / moderate (4-6)	Minimal / low (1-3)
773	Risk of impact of lack of engagement with external stakeholders leading to delay in transformational change impacting on service quality.	DMCE / DS	CG&CS	12 (4 x 3) Amber / high (8-12)	6 Yellow / moderate (4-6)	Cautious / moderate (4-6)
905	Wards are not adequately staffed to meet safer staffing requirements, leading to increased usage of bank and agency staff which has financial implications and may impact on continuity of service user care.	BWBDU	CG&CS	9 (3 x 3) Amber / high (8-12)	6 Yellow / moderate (4-6)	Cautious / moderate (4-6)
1099	Risk of untimely risk reports through management reporting system for forensic CAMHS, Wetherby.	CKFSBDU	CG&CS	12 (4 x 3) Amber / high (8-12)	6 Yellow / moderate (4-6)	Minimal / low (1-3)
1159	Risk of arson.	DHR	TBC	12 (4 x 3) Amber / high (8-12)	6 Yellow / moderate (4-6)	Cautious / moderate (4-6)
164	Non submission of statutory returns.	DFR	AC	4 (4 x 1) Yellow / moderate (4-6)	4 Yellow / moderate (4-6)	Minimal / low (1-3)
772	Risk of continued reduction in Local Authority budgets may have a negative impact on level of financial resources available to commission services and to deploy social care resource to support mental health services and services for people with learning disabilities. *NB. This risk has been included in the report for information as the current risk level was reduced following review by the lead director and EMT and is now in line with the risk appetite.*	BWBDU	AC	12 (3 x 4) Amber / high (8-12)	12 Amber / high (8-12)	Open / high (8-12)
850	Risk the upgrade to RiO V7 resulted in system functionality and operational issues which impacted on the Trust's ability to effectively support clinical services operationally as well as in the production and submission of central returns and accurately recording clinical coding information.	DFR	AC	12 (4 x 3) Amber / high (8-12)	6 Yellow / moderate (4-6)	Minimal / low (1-3)
852	Risk of information governance breach leads to inappropriate circulation and / or use of personal data leading to a reputational and public confidence risk.	DFR	AC	12 (4 x 3) Amber / high (8-12)	4 Yellow / moderate (4-6)	Minimal / low (1-3)
875	If individuals holding key information relating to specific issues which has not been shared are absent from the trust for an extended period of time, the ability of the team to complete tasks or respond to queries would be affected. This could impact on systems, processes, business cases, relationships with internal and external customers. *NB. Request from lead director to keep on the organisational risk register as the system is unstable at present.*	DFR	AC	6 (3 x 2) Yellow / moderate (4-6)	6 Yellow / moderate (4-6)	Cautious / moderate (4-6)
1004	Loss of records / inability to find them. The decentralised model for health records has resulted in teams making unilateral decisions on record keeping rather than following trust wide standards and guidance. This could have serious implications for the person whose record is lost (even if lost temporarily) and for the organisation's reputation.	DFR	AC	12 (4 x 3) Amber / high (8-12)	4 Yellow / moderate (4-6)	Minimal / low (1-3)
1076	Risk that the Trust may deplete its cash given the inability to identify sufficient CIPs, the current operating environment and its high value capital expenditure programme committed to, leading to an inability to pay staff and suppliers without DH support.	DFR	AC	12 (4 x 3) Amber / high (8-12)	6 Yellow / moderate (4-6)	Minimal / low (1-3)
1079	Risk of not securing medication wholesale supply and pharmacy computer system from 1 April 2017.	MD	CG&CS	10 (5 x 2) Amber / high (8-12)	12 Amber / high (8-12)	Minimal / low (1-3)
1153	Risk of potential loss of knowledge, skills and experience of NHS staff due to ageing workforce able to retire in the next five years.	DHR	RTSC	12 (3 x 4) Amber / high (8-12)	6 Yellow / moderate (4-6)	Cautious / moderate (4-6)
1154	Risk of loss of staff due to sickness absence leading to reduced ability to meet clinical demand etc.	DHR	RTSC	9 (3 x 3) Amber / high (8-12)	6 Yellow / moderate (4-6)	Cautious / moderate (4-6)

1155	Pay restraint and new terms and conditions could cause increased industrial action and impact on morale.	DHR	RTSC	9 (3 x 3) Amber / high (8-12)	6 Yellow / moderate (4-6)	Cautious / moderate (4-6)
1156	Decommissioning of services at short notice makes redeployment difficult and increases risk of redundancy.	DHR	RTSC	9 (3 x 3) Amber / high (8-12)	6 Yellow / moderate (4-6)	Cautious / moderate (4-6)
1157	The Trust does not have a diverse and representative workforce and fails to achieve EDS2 and WRES.	DHR	RTSC	9 (3 x 3) Amber / high (8-12)	6 Yellow / moderate (4-6)	Cautious / moderate (4-6)
1158	Over reliance on agency staff which could impact on quality and finances.	DHR	RTSC	9 (3 x 3) Amber / high (8-12)	6 Yellow / moderate (4-6)	Cautious / moderate (4-6)

South West Yorkshire Partnership NHS Foundation Trust

Risk profile – Trust Board 31 October 2017

Consequence (impact / severity)	Likelihood (frequency)				
	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost certain (5)
Catastrophic (5)			< Risk that Trust sustainability will be adversely impacted by the creation of local place based solutions which change clinical pathways and financial flows (e.g. ACO implementation). (812) = Risk that the Trust's information systems could be the target of cyber-crime leading to theft of personal data. (1080) = Risk of financial unsustainability if the Trust is unable to achieve the transition identified in the two year plan. (1114) = Risk that forensic locks are now out of patent. (1119)		
Major (4)			*< Risk of impact on the demand for services as a result of continued reduction in Local Authority funding (LA as a provider) (275)* *< Risk of adverse impact on clinical services if the Trust is unable to achieve the transitions identified in the Trust's strategic plan. (695)* *< Risk of impact of the inability for forensic CAMHS in Wetherby Prison to access Trust Datix system. (1099)*	= Risk that the Trust could lose business resulting in a loss of sustainability for the full Trust from a financial, operational and clinical perspective. (1077) = Risk that the long waiting lists to access CAMHS treatment and ASD diagnosis and treatment could lead to a delay in young people starting treatment, with a deterioration in their mental health and a breakdown of their support networks. (1078) = Risk to the Trust's reputation caused by long waiting lists delaying treatment and recovery. (1132) = Risk of being unable to recruit qualified clinical staff due to national shortages which could impact on the safety and quality of current services and future development. (1151)	
Moderate (3)			*< Risk of loss of staff due to sickness absence leading to reduced ability to meet clinical demand etc. (1154)* *< Risk that pay restraint and new terms and conditions could cause increased industrial action and impact on morale. (1155)* *< Risk of decommissioning of services at short notice that makes redeployment difficult and increased risk of redundancy. (1156)* *< Risk that the Trust does not have a diverse and representative workforce and fails to achieve EDS2 and WRES. (1157)* *< Risk of over reliance on agency staff which could impact on quality and finances. (1158)*	*< Risk of continued reduction in Local Authority budgets may have a negative impact on level of financial resources available to commission services and to deploy social care resource to support mental health services and services for people with learning disabilities. (772)* *< Risk of potential loss of knowledge, skills and experience of NHS staff due to ageing workforce able to retire in the next five years. (1153)*	
Minor (2)			RA (1151)	RA (812)	
Negligible (1)			RA (1077), (1078), (1080), (1114), (1119), (1132)		

=	same risk assessment as last quarter	<	decreased risk rating since last quarter	RA	risk appetite
!	new risk since last quarter	>	increased risk rating since last quarter		

With **all of us** in mind.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 October 2017
Agenda item 5.2

Title:	**Assurance Framework Quarter 2 2017/18**
Paper prepared by:	Director of Finance and Resources
Purpose:	For Trust Board to be assured that a sound system of control is in place with appropriate mechanisms to identify potential risks to delivery of key objectives.
Mission / values:	The risk register is part of the Trust's governance arrangements and integral elements of the Trust's system of internal control, supporting the Trust in meeting its mission and adhere to its values.
Any background papers/ previously considered by:	Previous quarterly reports to Trust Board.
Executive summary:	**Assurance Framework 2017/18** The Board assurance framework provides the Trust Board with a simple but comprehensive method for the effective and focused management of the principal risks to meeting the Trust's strategic objectives. In respect of the assurance framework for 2017/18, the principle high level risks to delivery of the Trust's strategic objectives have been identified and, for each of these, the framework sets out: ➢ key controls and / or systems the Trust has in place to support the delivery of the objectives ➢ assurance on controls – where the Trust Board will obtain assurance ➢ positive assurances received by Trust Board, its Committees or the Executive Management Team (EMT) confirming that controls are in place to manage the identified risks and these are working effectively to enable objectives to be met ➢ gaps in control (if the assurance is found not to be effective or in place) ➢ gaps in assurance (if the assurance does not specifically control the specified risks or no form of assurance has yet been received or identified), which are reflected on the risk register. A schematic of the assurance framework process is set out as an attachment. The assurance framework will be used by the Board in the formulation of the Board agenda and in the management of risk and by the Chief Executive to support his review meetings with Directors. This will ensure Directors are delivering against agreed objectives and action plans are in place to address any areas of risk identified. In line with the organisational risk register, the assurance framework has been aligned to the strategic priorities for 2017/18:

Our six strategic priorities for 2017/18		
Improving health	**Improving care**	**Improving resources**
People at the centre **Joined up care**	**Quality counts, safety first** **Compassionate leadership**	**Operational excellence** **Digital by default**

EMT discussed and agreed to implement the same RAG rating system used within other organisational reports as follows:

RAG rating	
	On target to deliver within agreed timescales
	On trajectory but concerns on ability / confidence to deliver actions within agreed timescales
	Off trajectory and concerns on ability / capacity to deliver actions within agreed timescales
	Actions will not be delivered within agreed timescales
	Action complete

Following discussion of the assurance framework during Q2, EMT indicated an overall current assurance level of 'yellow'. The rationale and the individual risk RAG ratings are set out in the attached report.

Overview of current assurance level:

Strategic objective	Strategic risk (abbreviated)	Assurance level Q1	Assurance level Q2	Assurance level Q3	Assurance level Q4
Improving health (people at the centre, joined up care)	1.1 Differences in published local priorities could lead to service inequalities across the footprint	A	A		
	1.2 Trust plans for service transformation not aligned to a stakeholder requirements	Y	Y		
	1.3 Differences in the services may result in inequitable services offers across the Trust	Y	Y		
Improving care (quality counts, safety first, compassionate leadership)	2.1 Lack of suitable and robust information systems leading to lack of high quality management and clinical information	Y	Y		
	2.2 Inability to recruit and retain skilled workforce leading to poor service user experience	Y	Y		
	2.3 Failure to create learning environment leading to repeat incidents	Y	Y		
	2.4 Failure to embed mission, vision and values	G	G		
Improving resources (operational excellence, digital by default)	3.1 Failure to manage costs leading to unsustainable organisation and inability to deliver capital programme	Y	Y		
	3.2 Failure to develop commissioner relationships to develop services	Y	Y		
	3.3 Failure to deliver efficiency improvements / CIPs	A	A		
	3.4 Capacity / resource not prioritised leading to failure to meet strategic objectives	Y	Y		

Recommendation:	**Trust Board is asked to NOTE the controls and assurances against the Trust's strategic objectives for Q2 2017/18 and AGREE to an ongoing target for addressing gaps in control given the nature of the gaps and risks identified.**
Private session:	Not applicable.

ASSURANCE FRAMEWORK – STRUCTURE AND PROCESS

South West Yorkshire Partnership NHS Foundation Trust

Our mission: we help people reach their potential and live well in their community.

The Operational Context of the Board Assurance Framework (BAF)
Purpose: to provide a comprehensive method for the effective and focused management of the principal risks to achieving the corporate delivery objectives.
Provides direct evidence for: Annual Governance Statement and the Head of Internal Audit Opinion

Strategic direction: Strategic objectives And priorities as set out in our Annual Plan, underpinned by our values and linked to wider health economy and regulatory requirements.

Strategic Objectives

Approved by Trust Board and reviewed regularly

Controls
- Accountability
- Regular performance measures
- Operational plans
- Policy and procedure
- Systems and structures

Assurances
- Audit (including clinical audit) reports and opinions
- Actual performance measurement
- External and internal reports

Gaps
- Audit report, opinion and recommendations to be implemented
- Poor performance management and related actions

Principal risks linked to strategic objectives

Controls in respect of risks and strategic objectives

Assurances in respect of the controls and strategic objectives

Gaps in controls and assurances and actions required to address the gaps

Strategic level risks (15+) into organisational risk register, mitigated in accordance with Trust risk appetite statement. Summary reports into relevant risk committee of the Board where the risk is above the Trusts risk appetite.

Risks at directorate and local level identified and scored through DATIX in line with risk management strategy and procedure. These **may** include gaps identified in the BAF

Exec Management Team

Individual director/BDU assurance arrangements

Trust Board Committees

TRUST BOARD

Closure of gaps
- Time bound responsibilities identified plus lead

Corporate review of the Assurance Framework
- Trust Board quarterly review of the BAF in terms of the adequacy of assurance processes and the effectiveness of the management of principal risks and gaps
- Audit Committee review of process for development of BAF annually

With **all of us** in mind.

Assurance Framework 2017/18 Quarter 2

KEY: CEO=Chief Executive Officer, DFR=Director of Finance and Resources, DHR=Director of HR, OD and Estates, DMCE= Director of Marketing, Communication and Engagement, DNQ=Director of Nursing and Quality, MD=Medical Director, DS=Director of Strategy, DD= Director of Delivery, BDU=Business Delivery Unit Directors

AC=Audit Committee, EF-Estates Forum, EMT=Executive Management Team, CGCS=Clinical Governance & Clinical Safety Committee, MHA=Mental Health Act Committee, RTSC=Remuneration and Terms of Service Committee. OMG= Operational Management Group. MC=Members Council, ORR=Organisational Risk Register.

RAG ratings	
	On target to deliver within agreed timescales
	On trajectory but concerns on ability / confidence to deliver actions within agreed timescales
	Off trajectory and concerns on ability / capacity to deliver actions within agreed timescales
	Actions will not be delivered within agreed timescales
	Action complete

Strategic Objective:	Lead Director(s)	Key Board or Committee	Current Assurance Level			
			Q1	Q2	Q3	Q4
1. Improving health (people at the centre, joined up care)	As noted below	EF, EMT, CGCS, MHA	Y	Y		

	Strategic Risks that need to be controlled and consequence of non-controlling and current assessment	Rag Rating
1.1	Differences in published local priorities could lead to service inequalities across the footprint.	A
1.2	Trust plans for service transformation are not aligned to a multiplicity of stakeholder requirements.	Y
1.3	Differences in the services provided due to unnecessary internal variation in practice, may result in inequitable service offers across the whole Trust.	Y

	Controls – systems and processes (what are we currently doing about the Strategic Risks?)	Strategic risks	Director lead
C.1	Senior representation on local partnership boards, building relationships, ensuring transparency of agenda's and risks, facilitating joint working, cohesion of policies and strategies, ability to influence future service direction	1.1, 1.2	DS
C.2	Annual Business planning guidance in place standardising process and ensuring consistency of approach across the Trust, standardised process in place for producing businesses cases with full benefits realisation	1.1, 1.2	DFR
C.3	Formal contract negotiation meetings with clinical commissioning and specialist commissioners underpinned by legal agreements to support strategic review of services	1.1	DFR
C.4	Development of joint Commissioning for Quality and Innovation (CQUIN) targets with commissioners to improve quality and performance, performance monitoring regime of compliance with CQUIN targets in place.	1.1	DD
C.5	Trust performance management system in place with KPIs covering national and local priorities reviewed by Executive Management Team (EMT) and Trust Board	1.1, 1.2	DFR
C.6	Cross-BDU and Operational Management Group (OMG) performance meetings established to identify and rectify performance issues and learn from good practices in other areas	1.1, 1.3	DD
C.7	Director lead in place to support revised service offer through transformation programme and work streams, overseen by EMT	1.1, 1.3	BDU
C.8	Project Boards for transformation work streams established, with appropriate membership skills and competencies, PIDs, Project Plans, project governance, risk registers for key projects in place	1.2, 1.3	DS
C.9	Workforce plans in place identifying staffing resources required to meet current and revised service offers and meeting statutory requirements re training, equality and diversity	1.2	DHR
C.10	Further round of Middleground leadership programme being developed, delivered and evaluated linked to organisational and individual resilience to support staff, prepare for change and transition and to support new ways of working	1.2	DHR
C.11	Partnership Fora established with staff side organisations to facilitate necessary change	1.2	DHR
C.12	Framework in place to ensure feedback from customers, both internal and external (including feedback loop) is collected, responded to, analysed and acted upon	1.2, 1.3	DNQ
C.13	Communication, Engagement and Involvement Strategy in place for service users/carers, staff and stakeholders/partners , engagement events gaining insight and feedback, including identification of themes and reporting on how feedback been used	1.2	DMCE
C.14	Process for amending policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval	1.1	DFR
C.15	Governors engagement and involvement on Members' Council and on working groups, holding Non-Executive Directors (NEDs) to account	1.2, 1.3	DFR
C.16	Strategic Priority no. 1 and no. 2 (people at the centre and joined up care) and underpinning programmes supported through robust programme management approach	1.2, 1.3	DS

		Report Title/Date
A.1	Annual plan and budget and strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by NHS Improvement (DFR)	Updates to operational plans for 2017/18 and 2018/19 noted at Trust Board March 2017. Monthly financial reports to Trust Board and NHS Improvement plus quarterly exception reports. Process for updating operational plans commenced September 2017.
A.2	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan (DFR)	Audit Committee and Trust Board – April 2017. Audit Committee and Trust Board – April 2018.
A.3	Transformation plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through Transformation Boards and IPR (DS, BDU)	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. Quarterly report to CG&CS Committee re. quality impact.
A.4	Documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems (CEO)	Monthly / bi-monthly 1:1s , annual appraisal and mid-year reviews with each Director – key points and issues summarised following each review.
A.5	Business cases for expansion/change of services approved by Executive Management Team (EMT) and/or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework (BDU)	Contracting risks, bids & tenders update standing item on delivery EMT agenda. Report to Board bi-annually.
A.6	Integrated performance reports to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken (DFR)	IPR reported monthly to OMG, EMT and Trust Board.
A.7	Independent PLACE audits undertaken and results and actions to be taken reported to Executive Management Team (EMT), Members' Council and Trust Board (DHR)	Governors and Directors involved in assessments. Outcome report to CG&CS Committee September 2017.
A.8	Rolling programme of staff, stakeholder and service user/carer engagement and consultation events (DHR, DS, DMCEC)	Communication, engagement and involvement strategy 2016-2019 (approved October 2016). Weekly and monthly engagement with staff (huddles, the Headlines, the View and the Brief) plus staff listening events June 2017, monthly engagement with stakeholders (the Focus), various SU & carer engagement events across the year plus Annual Members' Meeting September 2017.
A.9	Audit of compliance with policies and procedures in line with approved plan co-ordinated through clinical governance team in line with Trust agreed priorities (DNQ)	Clinical audit and practice effectiveness (CAPE) annual plan CG&CS Committee April 2017.
A.10	Trust Board Strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives (CEO)	Quarterly Board strategic meetings.
A.11	Service user survey results reported annually to Trust Board and action plans produced as applicable (DNQ)	NHS Mental Health Service User Survey Results will be report to Trust Board when available.
A.12	Care Quality Commission (CQC) registration in place and assurance provided that Trust complies with its registration (DNQ)	The Trust is registered with the CQC and assurance processes are in place through the DNQ to ensure continued compliance – quarterly engagement meetings between DNQ & CQC.
A.13	Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), independent reports on visits provided to the Trust Board , CGCS and MC (DNQ)	Unannounced and planned visits programme in place – report to CG&CS Committee April 2017 and included in annual report to Board April 2017. Annual report - April 2018.
A.14	Quarterly Assurance Framework and Risk Register report to Board providing assurances on actions being taken. Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place (DFR)	Quarterly BAF and risk register reports to Board. Triangulation of risk, performance and governance present to each Committee.
A.15	Staff wellbeing survey results reported to Trust Board and/or Remuneration and Terms of Service Committee and action plans produced as applicable (DHR)	Staff wellbeing and work results – RTSC July 2017.
A.16	Annual Safeguarding report to Clinical Governance & Clinical Safety Committee (CG&CS), Members' Council and Trust Board (DNQ)	Safeguarding adults and children reports to CG&CS April 2017 and included in annual report to Board April 2017. Members' Council
A.17	Strategic Priorities and Programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR (DS)	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT).

Gaps in control and what do we need to do to address these and by when	Date
• Loss of business impacting on sustainability considered as part of business planning	Ongoing
• Impact on services as a result of local authority cuts – actions identified on the Organisational Risk Register	Ongoing
• Transformation and other change programmes at varying stages of completion – need to strengthen measurement and impact on strategic risks	October 2017
• Impact of local place based solutions and STP initiatives – recognition that some of this is out of our control and ensure engagement takes place in each area impacted	September 2017

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	Date
• Workforce plans require on-going development as transformation standard operating procedures are being finalised to deliver the revised service offers, transformation reports to Executive Management Team (EMT) setting out time lines for changing workforce plans, skills and competencies to deliver revised service offers.	Quarter 2
• Internal audit reports with partial assurance (see below) management actions agreed by lead Director	As per audit report

Rationale for current assurance level
• Effective and involved members of the Board • Health & Wellbeing Board place based plans – contributed to through board discussions and commented on. • Monitor Independent well-led review assessed the Trust as Green in two areas and amber/green in eight areas with action plan in place to move towards green. • In the main, positive Friends and Family Test feedback from service users and staff with the exception of Child and Adolescent Mental Health Services (CAMHS) (being addressed through joint action plan with commissioners). • Strong and robust partnership working with local partners, such as Locala to deliver the Care Closer to Home contract and establishment of Programme Board. • Establishment of locality Recovery Colleges and production of co-produced prospectus. • Increasing capacity of Creative Minds and Spirit in Mind through partnership development. • Regular Board-to-Board and/or Exec-to Exec meetings with partners. • Trust involved in local Vanguards and STP's. • Involved in development of Accountable Care Organisation in Barnsley and MCP in Wakefield. • Changes in Local Authority Commissioning arrangements for Smoking Cessation Contracts e.g. Loss of smoking cessation service in Kirklees and impact on our more vulnerable groups. • Stakeholder survey results and resulting action plan • Care Quality Commission (CQC) revisit overall rating of good, number of areas rated good or outstanding 90%, action plan to address remaining requirement notices • Integrated Performance Report (IPR) summary metrics re improving people's health and well-being – IPR Month 4 out of area beds – red, Improving Access to Psychological Therapies (IAPT) – green, % service users followed up within 7 days green (M3), 2 child/young people accommodated on an Inpatient ward • Strategic Priorities (1 and 2) and underpinning Programmes RAG rating all green re governance, all green for scoping phase with exception of 1.4 Physical and Mental Health yellow. • Internal audit reports: Delivering service change and clinical record keeping - partial assurance with improvements required • Internal audit reports: Corporate governance arrangements – significant assurance, Data quality performance metrics significant assurance with minor improvement opportunities.

Strategic Objective: 2. Improving care (quality counts, safety first, compassionate leadership)	Lead Director(s)	Key Board or Committee	Current Assurance Level			
			Q1	Q2	Q3	Q4
	As noted below	EMT, R&TSC, IM&T Forum, CGCS	Y	Y		

Strategic Risks that need to be controlled and consequence of non-controlling and current assessment		Rag Rating
2.1	Lack of suitable and robust, performance and clinical information systems leading to lack of timely high quality management and clinical information to enable improved decision-making	Y
2.2	Inability to recruit, retain, skill up, appropriately qualified, trained and engaged workforce leading to poor service user experience	Y
2.3	Failure to create a learning environment leading to repeat incidents impacting on service delivery and reputation	Y
2.4	Failure to create and communicate a coherent articulation of Trust Mission, Vision and Values leading to inability for staff to identify with and deliver against Trust Strategic objectives	G

Controls – systems and processes (what are we currently doing about the Strategic Risks?)		Strategic risks	Director Lead
C.1	Information Management & Technology (IM&T) strategy in place and quarterly report to Executive Management Team (EMT)and Trust Board in place	2.1	DFR
C.2	Development of data warehouse and business intelligence tool supporting improved decision making	2.1	DRI
C.3	Workforce plans in place identifying staffing resources required to meet current and revised service offers and meeting statutory requirements re training, equality and diversity	2.2	DHR
C.4	A set of leadership competencies developed as part of the leadership and management development plan supported by coherent and consistent leadership development programme	2.2	DHR
C.5	Human Resources processes in place ensuring defined job description, roles and competencies to meet needs of service, pre-employment checks done re qualifications, DBS, work permits	2.2	DHR
C.6	Trust Board sets the Trust vision and corporate objectives as the strategic framework within which the Trust works	2.4	CEO
C.7	Performance management system in place with KPIs covering national and local priorities reviewed by Executive Management Team (EMT) and Trust Board	2.1, 2.2, 2.3	DFR
C.8	Executive Management Team (EMT) ensures alignment of developing strategies with Trust vision and strategic objectives	2.4	DS
C.9	Weekly serious incident summaries to Executive Management Team (EMT) supported by quarterly and annual reports to EMT, Clinical Governance & Clinical Safety Committee and Trust Board	2.3	DNQ
C.10	Leadership and management arrangements established and embedded at BDU and service line level with key focus on clinical engagement and delivery of services	2.2, 2.3	BDU
C.11	Trust Board approved strategic objectives supporting delivery of Trust mission, vision and values monitored through appraisal process down through director to team and individual team member	2.4	CEO
C.12	Risk assessment and action plan for delivery of CQUIN indicators in place	2.1	DNQ
C.13	Risk assessment and action plan for data quality assurance in place	2.1	DFR
C.14	Values-based appraisal process in place and monitored through Key Performance Indicators (KPI's)	2.2, 2.4	DHR
C.15	Values-based Trust Welcome Event in place covering mission, vision, values, key policies and procedures	2.2, 2.4	DHR
C.16	Mandatory clinical supervision and training standards set and monitored for service lines	2.2	DHR
C.17	Communication, Engagement and Involvement Strategy approved by Board and action plan in place	2.2	DMCE
C.18	Medical Leadership Programme in place with external facilitation	2.2	MD
C.19	Organisational Development Framework and plan re support objectives "the how" in place with underpinning delivery plan, Strategic Priority no. 1 and no. 2 (People First and Joining up Care) and underpinning programmes supported through robust programme management approach	2.2	DHR
C.20	Risk Management Strategy in place facilitating a culture of horizon scanning, risk mitigation and learning lessons supported through appropriate training	2.3	DFR
C.21	Strategic Priority no. 3 and no.4 (Quality counts, safety first and compassionate leadership) and underpinning programmes supported through robust programme management approach	2.2, 2.4	DNQ
C.22	Programme established for implementing new clinical record system.	2.1	DS
C.23	Learning lessons reports, BDUs, post incident reviews.	2.3	DNQ

Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)		Report title/Date
A.1	Documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems (CEO)	Monthly / bi-monthly 1:1s, annual appraisal and mid-year reviews with each Director – key points and issues summarised following each review.
A.2	Trust Board Strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives (CEO)	Quarterly Board strategic meeting.
A.3	CQC registration in place and assurance provided that Trust complies with its registration (DNQ)	The Trust is registered with the CQC and assurance processes are in place through the DNQ to ensure continued compliance – quarterly engagement meetings between DNQ & CQC.
A.4	Planned internal visits to support staff and ensure compliance with CQC standards through the delivery of supported action plans (DNQ)	Unannounced and planned visits programme in place.

Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)		Report title/Date
A.5	Quarterly Assurance Framework and Risk Register report to Board providing assurances on actions being taken (DFR)	Quarterly BAF and risk register reports to Board. Triangulation of risk, performance and governance present to each Committee.
A.6	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place (DFR)	Quarterly triangulation of risk report to Audit Committee.
A.7	Assurance reports to Clinical Governance and Clinical Safety Committee covering key areas of risk in the organisation seeking assurance on robustness of systems and processes in place (DNQ)	Quarterly report to CG&CS Committee of risks aligned to the committee for review.
A.8	Integrated performance reports to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken (DFR)	IPR reported monthly to OMG, EMT and Trust Board.
A.9	Annual report to Trust Board to risk assess changes in compliance requirements and achievement of performance targets, in year updates as applicable (DFR)	IPR monthly to EMT and Trust Board. Quarterly quality performance/exception reporting to Trust Board.
A.10	Nursing and Medical staff revalidation in place evidenced through report to Trust Board (DNQ, MD)	Annual report to Trust Board - July 2017.
A.11	Data quality improvement plan monitored through Executive Management Team (EMT) deviations identified and remedial plans requested (DFR)	Included in monthly IPR to EMT and Trust Board. Regular reports to CG&CS Committee.
A.12	Serious incidents from across the organisation reviewed through the Clinical Reference Group including the undertaking of root cause analysis and dissemination of lessons learnt and good clinical practice across the organisation (DNQ)	Process in place with outcome reported through quarterly serious incident reporting including lessons learned to EMT, Clinical Governance & Clinical Safety Committee and Trust Board.
A.13	Annual appraisal, objective setting and PDPs to be completed in Q1 of financial year for staff in Bands 6 and above and in Quarter 2 for all other staff, performance managed by Executive Management Team (EMT) (DHR).	Included as part of the IPR to EMT and Trust Board.
A.14	Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), independent reports on visits provided to the Trust Board, Clinical Governance & Clinical Safety Committee (CGCS and Members' Council (DNQ)	Unannounced and planned visits programme in place – report to CG&CS Committee April 2017 and included in annual report to Board April 2017. Annual report due April 2018.
A.15	Information Governance (IG) Toolkit provides assurance and evidence that systems and processes in place at the applicable level, reported through Improving Clinical Information Group, deviations identified and remedial plans requested receive, performance monitored against plans (DFR)	Internal Audit of IG Toolkit Phase 2 report to Audit Committee - July 2017.
A.16	Monitoring of organisational development plan through Executive Management Team (EMT), deviations identified and remedial plans requested (DHR)	
A.17	Health Watch undertake unannounced visits to services providing external assurance on standards and quality of care (BDU)	
A.18	Independent Care Quality Commission (CQC) reports to Mental Health Act Committee provided assurance on compliance with Mental Health Act (DNQ)	Quarterly update report to MHA Committee on independent CQC visits.
A.19	Annual Patient Safety Strategy progress report to Clinical Governance & Clinical Safety Committee (CGCS) (DNQ)	
A.20	Strategic Priorities and Programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR (DS)	Monthly priority programmes item schedule for EMT. Included as part of the IPR to EMT and Trust Board.

Gaps in control and what do we need to do to address these and by when	Date
• Impact of waiting lists leading to a delay in access to services / treatment (in BDUs / CAMHS / ASD)	Ongoing
• Forensic BDU locks out of patent	March 2019
• Untimely risk reporting through management reporting system for forensic CAMHS, Wetherby	Ongoing
• Impact of national funding arrangements (e.g. CCG allocation , Better Care Fund) and local re-tendering	Ongoing
• Liability for any harm caused by drugs stored at temperatures above 25 degrees	Ongoing
• Potential delay in implementation or achievement of transformation change due to lack of engagement with external stakeholders	Ongoing
• Reliance on the use of bank and agency staff to ensure wards are adequately staffed to meet safer staffing requirements	Ongoing
• Risk of arson	Ongoing

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	Date
• Workforce plans require on-going development as transformation standard operating procedures are being finalised to deliver the revised service offers, transformation reports to EMT setting out time lines for changing workforce plans, skills and competencies to deliver revised service offers.	Quarter 2
• Further updates to Clinical Governance & Clinical Safety Committee and Audit Committees on capture of clinical information and impact on data quality.	Quarter 3
• Mandatory training standards not being delivered in all areas, routine reports to teams identifying individuals out of compliance.	Quarter 2
• Appraisal targets not being met, routine reporting to Executive Management Team (EMT) and Remuneration & Terms of Service Committee.	Quarter 2
• Internal audit reports with partial assurance (see below) management actions agreed by lead Director.	As per audit report

Rationale for current assurance level
• Monitor well-led review undertaken by independent reviewer demonstrated through stakeholder engagement that the Trust's mission and values were clearly embedded through the organisation.
• Staff 'living the values' as evidenced through values into excellence awards.

- In the main, positive Friends and Family Test feedback from service users and staff with the exception of CAMHS (being addressed through joint action plan with commissioners).
- Trio model bringing together clinical, managerial and governance roles working together at service line level, with shared accountability for delivery.
- Strong and robust partnership working with local partners, such as Locala to deliver the Care Close to Home contract and establishment of Programme Board.
- Care Quality Commission (CQC) revisit overall rating of good, number of areas rated good or outstanding 90%, action plan to address remaining requirement notices
- Internal audit reports –Patient property follow up, Patients bank, Agile working, IT capability, Delivering service change, Sickness absence, Clinical record keeping - partial assurance with improvements required,
- Internal audit reports – Information Governance (IG) Toolkit significant assurance, Significant and serious untoward incidents significant assurance with minor improvement opportunities
- CQUIN targets not achieved in full.
- Integrated Performance Report (IPR) summary metrics re improving the quality and experience of all that we do – IPR for month 2 shows: F&F Test MH yellow, F&F Test Community Green, Patient safety Incidents involving moderate or severe harm or death green, safer staff fill rates green, IG confidentiality breaches red
- Strategic Priorities (3 and 4) and underpinning Programmes rag rating all green for governance and scoping phase

Strategic Objective: 3. Improving resources (operational excellence, digital by default)	Lead Director(s)	Key Board or Committee	Current Assurance Level			
			Q1	Q2	Q3	Q4
	As noted	AC, EMTR&TSC	Y	Y		

Strategic Risks that need to be controlled and consequence of non-controlling and current assessment		Rag Rating
3.1	Failure to manage costs leading to unsustainable organisation and insufficient cash to deliver capital programme	Y
3.2	Failure to develop required relationships or commissioner support to develop new services/expand existing services leading to contracts being lost, reduction in income	Y
3.3	Failure to deliver efficiency Improvements/CIPs	A
3.4	Capacity and resources not prioritised leading to failure to meet strategic objectives.	Y

Controls – systems and processes (what are we currently doing about the Strategic Risks?)		Strategic risks	Director Lead
C.1	Independent survey of stakeholders perceptions of the organisation and resulting action plans (3.2)	3.2	DMCE
C.2	Annual financial planning process CIP and QIA process (3.1, 3.3)	3.1, 3.3	DFR,
C.3	Financial control and financial reporting processes (3.1, 3.3)	3.1, 3.3	DFR
C.4	Production of annual plan and strategic plan demonstrating ability to deliver agreed service specification and activity within contracted resource envelope or investment required to achieve service levels and mitigate risks (3.4)	3.4	DFR
C.5	Strategic Business and Risk Report including PESTEL/SWOT and threat of new entrants/substitution, partner/buyer power (3.2)	3.2	DS
C.6	Weekly Operational management Group chaired by DD providing overview of operational delivery, services/resources, identifying and mitigating pressures/risks (3.1, 3.3)	3.1, 3.3	DD
C.7	Standing Orders, Standing Financial Systems, scheme of Delegation and Trust Constitution in place and publicised re staff responsibilities (3.1)	3.1	DFR
C.8	Performance management system in place with Key Performance Indicators (KPIs) covering national and local priorities reviewed by EMT and Trust Board (3.1)	3.1	DFR
C.9	Project Management office in place with competencies and skills to support the Trust to make best use of its capacity and resources and to take advantage of business opportunities (3.4)	3.4	DS
C.10	Standardised process in place for producing businesses cases with full benefits realisation (3.1)	3.1	DFR
C.11	Innovation Framework in place to deliver service change and innovation (3.4)	3.4	DS
C.12	Service line reporting/ service line management approach (3.1)	3.1	DFR
C.13	Human Resources (HR) and Finance managers aligned to BDUs acting as integral part of local management teams(3.1,)	3.1	DHR
C.14	Workforce plans in place identifying staffing resources required to meet current and revised service offers and meeting statutory requirements re training, equality and diversity (3.4)	3.4	DHR
C.15	Contingency/reserves – budget for anticipated risks of slippage/ under-delivery (3.1)	3.1	DFR
C.16	Development of joint Commissioning for Quality and Innovation (CQUIN) targets with commissioners to improve quality and performance, performance monitoring regime of compliance with CQUIN targets in place. (3.3)	3.3	DD
C.17	Annual Business planning guidance in place standardising process, ensuring consistency of approach, standardised process for producing businesses cases with full benefits realisation (3.1)	3.1	DFR
C.18	Formal contract negotiation meetings with clinical commissioning and specialist commissioners underpinned by legal agreements to support strategic review of services (3.2)	3.2	DFR
C.19	Regular formal contract review meetings with clinical commissioning and specialist commissioning groups (3.4)	3.4	DFR
C.20	Strategic Priority no. 5 and no.6 (Operational excellence and digital by default) and underpinning programmes supported through robust programme management approach (3.1, 3.3)	3.1, 3.3	DS
C.21	Wellbeing plans in place	3.4	DHR
C.22	Quality Impact Assessment (QIA) process in place	3.2, 3.3	DNQ

Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)		Report Title/Date
A.1	Documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems (CEO)	Objectives for 2017/18 set for all Directors. Monthly one to one meetings between Chief Executive and Directors..
A.2	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken (DFR)	Monthly IPR to Executive Management Team (EMT) and Trust Board.
A.3	Audit Committee review evidence for compliance with policies, process, standing orders, standing financial instructions, scheme of delegation, mitigation of risk, best use of resources (DFR)	Trust Constitution (including Standing Order) and Scheme of Delegation reviewed by Audit Committee in January 2017 prior to approval by Trust Board and Members' Council. Further update to Scheme of Delegation reviewed by Audit Committee on April 2017 prior to approval by Trust Board and Members' Council.
A.4	Quarterly Investment Appraisal report – covers bids and tenders activity, contract risks, and proactive business development activity (DFR)	Monthly bids and tenders report to Executive Management Team (EMT). In April 2017, Trust Board agreed for the Investment Appraisal report to be received six monthly.
A.5	Annual Governance Statement reviewed and approved by Audit Committee and Trust Board and externally audited (DFR)	Annual Governance Statement 2017/18 reviewed by Trust Board and approved under delegation by Audit Committee in May 2017.
A.6	Quarterly strategic business and risk analysis to Trust Board ensuring identification of opportunities and threats (DS)	In April 2017, Trust Board agreed for the Investment Appraisal report to be received six monthly.
A.7	CQUIN performance monitored through Operational Management Group (OMG) and Executive Management Team (EMT), deviations identified and remedial plans requested (DD)	Monthly Integrated Performance reporting to OMG, EMT and Trust Board.
A.8	Remuneration and Terms of Service Committee receive HR Performance Reports, monitor compliance against plans and receive assurance from reports around staff development, workforce resilience (DHR)	Standing item at Remuneration and Terms of Service Committee.
A.9	Benchmarking of services and action plans in place to address variation (DFR)	Benchmarking reports are received by Executive Management Team (EMT) and any action required identified.
A.10	Annual plan and budget and strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by Monitor (DFR, DS)	Operational plan for 2017/18-2018/19 approved by Trust Board in December 2016 and submitted to NHS Improvement in accordance with required timescales. Monitored monthly through the IPR to EMT and Trust Board.
A.11	Business cases for expansion/change of services approved by Executive Management Team (EMT) and/or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework (BDU)	Bids and tenders report monthly to EMT.
A.12	Attendance of NHS Improvement/Monitor at Executive Management Team (EMT) and feedback on performance against targets (DFR)	NHS Improvement hold Quarterly Review Meetings with EMT.
A.13	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place (DFR)	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee.
A.14	Strategic Priorities and Programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through the Integrated Performance Report (IPR) (DS)	Monthly priority programmes item schedule for EMT. Included as part of the IPR to EMT and Trust Board.

Gaps in control and what do we need to do to address these and by when	Date
• Risk of loss of business impacting on financial, operational and clinical sustainability	Ongoing
• Risk of cyber –attack defeating NHS and Trust defences	Ongoing
• Risk of inability to achieve transitions identified in our plan	Ongoing
• Trust has a history of not fully achieving its recurrent CIP targets	March 2018
• Inability to recruit to qualified clinical staff vacancies	Ongoing
• Reduction in Local Authority budgets negatively impacting on financial resource available to commission staff / deploy social care resource	Ongoing
• Lack of growth in Clinical Commissioning Group (CCG) budgets combined with other local healthcare financial pressures leading to Mental Health and Community funding not increasing in line with demand for our services	Ongoing
• Potential loss of knowledge, skills and experience due to ageing workforce	Ongoing
• Impact of pay restraint and new terms and conditions on staff morale and potential for increased industrial action	Ongoing
• Increased risk of redundancy / lack of ability to redeploy if services are decommissioned at short notice	March 2018
• Workforce is not sufficiently diverse and representative of local population, failing to meet EDS2 and WRES	Ongoing
• Over reliance on temporary staff in some areas	
• Clinical record system upgrade affecting ability to deliver services	October 2018

• Requirement for succession planning / business continuity plans should individuals holding key information be absent from work • Record keeping / inappropriate destruction of records may lead to loss of information / data • Risk our engagement strategy is not effectively implemented	

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	Date
• Completion of review of decision-making framework (Scheme of Delegation) to inform delegated authority at all levels (to Audit Committee) • CIP delivery is currently behind plan and there is an overspend in relation to out of area bed placements • Internal audit reports with partial assurance management actions agreed by lead Director • Delivery of 17/18 financial control total is not assured • Some history of Information Governance (IG) breaches • Cash position is largely dependent on us delivering a surplus	Quarter 4 Quarter 4 As per Audit report Quarter 4

Rationale for current assurance level
• Positive well led results following CQC review • Holding some income steams with local authorities in the current climate will generate risk. • Contracts agreed with commissioners • NHS Improvement Single Oversight Framework rating of 2 – targeted support • Integrated Performance Report hot spots e.g.. out of area placements • Impact of non-delivery of CIPs and out of area placements on financial year end outturn. • Underlying profitability after adjusting for non-recurrent measures being taken. • Risk of potential STP and place based driven change may impact on our service portfolio. • Internal audit reports – Patient property follow up, Agile working, IT capability, Sickness absence – partial assurance with improvements required. • Internal audit reports – Information Governance (IG) toolkit, Risk Management and Assurance Framework, Corporate governance arrangements - significant assurance. Core financial controls, payroll, Capital project governance - significant assurance with minor improvement opportunities. • Integrated Performance Report (IPR) summary metrics provide assurance on majority of our performance and clearly identify where improvement is required • Introduction of enhanced programme management process

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 October 2017
Agenda item 5.3

Title:	**Strategic overview of business and associated risks**
Paper prepared by:	Director of Strategy
Purpose:	The purpose of this report is to: ➢ Support the Trust Board in reviewing the external environment in which the Trust operates. ➢ Evaluate the Trust's preparedness and strategic positioning in response to the external environment. ➢ Provide assurance of the alignment between the Trust's strategy, risk management and priority programmes.
Mission/values:	The process of analysing the external environment and our own readiness and capability to respond to those external factors is a key aspect of the strategy development process of the Trust. The Trust's strategy supports the achievement of our **mission** to **help people reach their potential and live well in their community.** The way in which we develop strategy in an **honest, open and transparent** manner demonstrates how we live the **values** of the Trust.
Any background papers/ previously considered by:	This paper continues the update to the Trust Board in April 2017 that reflected PESTLE (Political, Economic, Social, Technological, Legal/Regulatory and Environmental) and SWOT (Strengths, Weaknesses, Opportunities and Threats) analyses aligned with the Trust risk register and priority programmes.
Executive summary:	**1. Update** The report is again presented depicting the links between SWOT, PESTLE, risk and priority programmes. As in the previous report to the Board it is important to recognise that the purpose and content of the SWOT, PESTLE and risk register should be broadly coherent and allied but that a strict alignment and correlation of content is not to be expected. This reflects the complex and non-linear nature of the external environment that our PESTLE analysis in particular aims to reflect. Furthermore the emphasis on alignment with risks should not overshadow the ability of the PESTLE and SWOT to highlight positive and beneficial developments and opportunities for the Trust, as well as ensuring that negative influences are appropriately addressed. Fields in the record included: ➢ Date when the entry was first added to the record. Where this date is greater than 1 year this is referenced to help indicate where long term issues may require additional and specific attention. ➢ Date last updated - to help ensure the report is kept current and valid. ➢ Cross reference with the Trust organisational level risk register - to indicate alignment and highlight which issues are being managed through risk management action plans and mitigation measures.

- For SWOT analysis 'weaknesses' and 'threats' entries are also cross referenced with the 2017/18 Trust priority programmes.

Updates and additions made since the last report to Trust Board are indicated in Blue text. Entries updated in this report are also indicated with a 'tick'

An entry in the record which is no longer applicable is indicated with text crossed out.

2. PESTLE

- **Key updates:** Key updates in the PESTLE summary this time include:
  - Sustainability and transformation plans requiring re-alignment with local elected members and with Health and Wellbeing boards. Nine STP's announced as the first wave of ACS/ACO's and delivery plans are being developed and the control totals and impact are unclear.
  - Government plans to lift the 1% pay cap is likely to further increase financial risk but will provide relief on the recruitment and retention of staff experienced since the introduction of the pay cap in 2010
- **Frequency of updating:** There are 41 entries in the record. 12 of the 41 entries have been updated this time. 17 of the 41 entries remain unchanged for more than a year. These have however been checked that they are still current and up to date. Items that remain static for long periods will be reviewed for relevance and where it is suggested that they can be removed from the PESTLE analysis they will be 'crossed out' prior to removal from the record.
- **Alignment to risk register**: 9 out of the 41 entries are matched against current risks which are being managed on the Trust's organisational risk register, which highlights some correlation and alignment of issues. The majority of those issues are being managed within the agreed risk tolerance. This cross referencing is a continual and ongoing exercise to determine alignment between the Trust risk register and PESTLE analysis.
  Note: Not every entry on the PESTLE analysis constitutes a risk to the Trust and therefore a 100% correlation should not be expected.

3. SWOT

- **Key updates:** Key updates in the SWOT summary this time include:
  - the Trust being chosen as the winner of the organisation category at the 2017 Kate Granger awards for compassionate care confirms what the Care Quality Commissions report said about the Trusts staff treating people with kindness care and compassion, and that we are respectful and warm.
  - The positive result of our Care Quality Commission revisit provides opportunities to improve from good to outstanding and also positions the Trust well in relation to partnership and growth, supports an enhanced regulatory relationship and allows support to other system partners, in particular linked to partnership support work with Locala.
  - The threat of decommissioning of services, in particularly in places like Barnsley, may result in loss of services and financial income.
  - The Trusts new integrated change framework has been introduced to support innovation, change and improvement.

	- Through ACO and /MCP developments we have opportunities to provide integrated joined up care and engage local populations in their health. ACO developments particularly in Barnsley and Alliance developments in Wakefield and possibly in Calderdale have the opportunity to demonstrate this. - We need to be mindful that the focus on one or two particular issues could be a distraction to ensuring that all key performance metrics are given sufficient and appropriate focus and time. - The announcement that a supplier for our new clinical record system has been selected and a contract is being developed has created some changes to existing entries, and identification of a new entry, in the SWOT analysis. ➢ **Frequency of updating:** There are 54 entries in the record. 35 of the 54 entries have been updated this time – indicating a high level of validity. Two entries have been indicated as no longer applicable and are duly crossed out. These will be removed from the register Nine entries remain unchanged for more than 1 year. These have however been checked that they are still current, valid and up to date. ➢ **Alignment of priority programmes:** the table highlights where 'Weaknesses' and 'Threats' are matched against a priority programme in the Trust's plan for 2017/18. Generally there is strong alignment, but it also highlights several gaps that will be considered for inclusion in the Trust's forward programme. **Risk appetite** ➢ **Alignment to risk register**: Naturally Strengths and Opportunities are not 'risk register' aligned. A comparison between 'Weaknesses' and 'Threats' indicates that most (18 out of a possible 27) entries can be matched against risks in the Trust risk register. The table also shows that most risks are managed within the agreed risk tolerance.
Recommendation:	**Trust Board is asked to NOTE the content of the report and ADVISE on any further developments required.**
Private session:	Not applicable.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Strategic Overview of Business and Risks

Trust Board agenda item 5.3 – 31 October 2017

Director of Strategy

With **all of us** in mind.

PESTLE

Aspects of the PESTLE analysis which have changed since the last report to Trust Board in April 2017 are indicated in blue text for ease of identification. Entries updated in this report are also indicated with a 'tick'.
An entry in the record which is no longer applicable is indicated with text crossed out.

Category	Ref.	Description	Date First Added	Date Last Updated	Updated this time?	Cross Ref with Risk Register	Current Risk Level	Risk Appetite	Target Risk Level
Political	1.1	Public debate regarding social care funding gap and resulting tensions between local and central government related to tax revenue raising powers. Resulting in heightened debate around 'health and care' and increasing openness to challenge assumptions regarding future form and function of the NHS. Investment into social care re flow and delayed transfer of care (DTOC) creates opportunity and tension	Jan-17	Jan-17		n/a			
Political	1.2	Public debate regarding 'winter pressures' in urgent care and primary care starting to change expectations on targets, access and personal responsibility. Further highlighted by ongoing political comments on A&E four-hour targets	Jan-17	Jan-17		n/a			
Political	1.3	Sustainability and Transformation Plans/ Partnerships (STPs) require re-alignments with local elected members and Health and Wellbeing Boards. As these partnerships are developed there is potential for confusion and delay. Nine STP's announced as the first wave of ASC/ACO's and delivery plans are being developed and the control totals and impact are unclear.	Jan-17	Oct-17	✓	695			
Political	1.4	Impact of continued austerity for councils coupled with perception of strong 'NHS' focus of Sustainability and Transformation Plans/ Partnerships STP guidance may make local political alliances with elected members more difficult – may manifest through Health and Wellbeing Boards and Overview and Scrutiny Committees etc.	1 yr +	Oct-17	✓	772			
Political	1.5	Continued emphasis on collaborative place based approaches to improvement (Vanguards, STPs etc.) and associated changes in organisational form such as Accountable Care Organisations (ACOs), Multi-specialty Community Providers (MCPs) etc. may indicate a subtle shift away from market based drivers of improvement. May also highlight the importance of Trusts having clarity of strategic intent both at organisational and at service line level. Commitment to Vanguards continued into 2017/18 with funding, and alignment into Five Year Forward View (FYFV) Next Steps document. Also emergence of Sustainability and Transformation Partnership (STP) level Accountable Care Systems (ACS) adds a new dimension	1 yr +	Jul-17	✓	812			
Political	1.6	No Longer Applicable ~~Government ministerial changes, which may have unknown impacts on public policy affecting the NHS, and wider social and economic drivers of health and wellbeing. However consistency in terms of SoS for Health.~~	Oct-16	Aug-17	✓				

Category	Ref.	Description	Date First Added	Date Last Updated	Updated this time?	Cross Ref with Risk Register	Current Risk Level	Risk Appetite	Target Risk Level
Political	1.7	Uncertainty of the impact of the UK referendum decision on EU membership. Potential to alter previous assumptions regarding the quantum and focus of public spending, which underpin current Five Year Forward View (FYFV) NHS budget projections. Potential to impact on workforce availability. Longer term potential to impact on public procurement and other public law. Initially has at least re-affirmed the importance of the NHS to the public.	1 yr +	Jul-16		n/a			
Political	1.8	Increased Treasury influence over the style and emphasis of Department of Health (DoH) and NHS England (NHSE) communications, also impacting on regulatory regime.	Oct-16	Oct-16		n/a			
Political	1.9	Political stance on NHS employment contracts, e.g. Junior Doctors, emphasises potential for continued discontent and disruption. Changes to IR35 and to NHS Improvement expectations on agency use highlight changing political position and public affinity with healthcare professions acting as locums and agency workers	1 yr +	Jul-17	✓	n/a			
Economic	2.1	Gap between ideal of Five Year Forward View (FYFV) funding shift (prevention, primary care, mental health etc.) and reality of 2017 – 2019 contracts enabled debate with commissioning partners. Collaboration re mental health investment standard helping establish shared intent.	Jan-17	Jan-17		n/a			
Economic	2.2	Increased impact on jobs, services and income related to public health prevention services. Pace of change increased significantly, linked to continued austerity in local authorities	Oct-16	Oct-17	✓	772			
Economic	2.3	Increased impact of market forces on vulnerabilities in NHS markets for staff and flexible bed capacity. Experienced through agency usage and costs (mitigated by agency cap), and independent sector bed-day prices. NHS Improvement and HMRC interventions beginning to impact	Oct-16	Jan-17		n/a			
Economic	2.4	Impact of NHS financial control measures on both commissioners and providers – control totals, agency caps etc. Stronger financial interdependence across health systems through Sustainability and Transformation Plans, including STP-level control totals as underlined in Five Year Forward View Next Steps document re Sustainability and Transformation Partnership level Accountable Care Systems.	Oct-16	Oct-17	✓	812			
Economic	2.5	Impact of current employment market for clinical and IT staff, manifesting in buoyant agency market, driving cost growth for Trusts in excess of plans and 'cap'.	Oct-16	Oct-17	✓	905			
Economic	2.6	Major Cost Improvement Programme requirements of financially challenged NHS providers leading to sub-optimal approaches to pathways and partnerships within local health economies, and unintended consequences associated with services stopping/ failing	Jul-16	Oct-17	✓	275			
Economic	2.7	No Longer Applicable ~~Following Junior Doctors contract negotiation, continued emphasis on reform of NHS employment contracts, may drive more clinical colleagues towards agency work, hindering efforts to deflate the locum market.~~	Jul-16	Aug-17	✓				

Category	Ref.	Description	Date First Added	Date Last Updated	Updated this time?	Cross Ref with Risk Register	Current Risk Level	Risk Appetite	Target Risk Level
Economic	2.8	The deployment of Sustainability and Transformation Funding (and Clinical Commissioning Group 1%) is (in the short term at least) largely being directed towards improvement of the sustainability of acute care provision. This impacts on the prioritisation of community learning disability and mental health provision in funding terms. However there have been some opportunities to bid for transformation funding in mental health – bids successful in Perinatal mental health, improving access to psychological therapies (IAPT) and mental health liaison.	Jul-16	Oct-17	✓	522			
Economic	2.9	Government plans to lift the 1% pay cap is likely to further increase financial risk but provide relief on the recruitment and retention of staff experienced since the introduction of the pay cap in 2010	Sep-17	Oct 17	✓	n/a			
Socio-Cultural	3.1	High profile campaigns and celebrity endorsement, as well as local action all starting to impact on societal attitudes towards mental health, increasing recognition of widespread prevalence and relevance in the lives of all. Potentially increases likelihood of people seeking help, thereby increasing demand, but also potentially increases likelihood of people seeking help earlier increasing opportunities for effective early intervention.	Jan-17	Jan-17		n/a			
Socio-Cultural	3.2	Migration trends into the UK show increasingly diverse countries of origin, increasing complexity in service provision, and enriching local communities. Future impact of Brexit on European migration trends not yet fully understood.	Jan-17	Jan-17		n/a			
Socio-Cultural	3.3	Impact of demographic change on demand for services and also on workforce age profile	1 yr +	1 yr +		n/a			
Socio-Cultural	3.4	Changing expectations of services. Public expect greater personalisation, higher standards of customer service and responsiveness, greater level of co-production. Policy makers and commissioners expect more self-care and emphasis on prevention	1 yr +	1 yr +		n/a			
Socio-Cultural	3.5	All the above drive changed workforce requirements – new skills, new roles, new psychological contract at work	1 yr +	1 yr +		n/a			
Technological	4.1	Increased threat from cyber-crime impacting on NHS bodies – resulting in additional cost of defence and prevention, and heightened risk of disruption to service provision (mitigated by business continuity plans)	Jan-17	Jan-17		1080			
Technological	4.2	Key enabler and driver of change within the Trust and externally. Continued direction of travel in public service towards digital by default. In addition to political will, individuals and communities drive demand for health and care providers to keep pace with their use of technology in other aspects of their lives.	1 yr +	Jul-16		n/a			
Technological	4.3	Inequalities in technology access, competence, and acceptance are slowly being eroded, but persist as a factor impacting on service design and access. In some ways technology inequalities mirror broader socio-economic inequalities, and as such are of relevance to Trust mission and objectives.	Jul-16	Jul-16		n/a			
Technological	4.4	Continued growth in use of social media by a wide range of demographic groups, changes the way in which customer experience and service quality is evaluated – becoming more open, faster, and comparable – e.g. Patient Opinion. Supports choice agenda, potentially links to commissioner decision making.	1 yr +	Jul-16		n/a			

Category	Ref.	Description	Date First Added	Date Last Updated	Updated this time?	Cross Ref with Risk Register	Current Risk Level	Risk Appetite	Target Risk Level
Technological	4.5	Technology enables improved access and use of data – telehealth monitoring of vital signs, self-reported well-being etc. Creates a different dialogue between service user and healthcare service provider – supports personal control, self-care, and movement towards coaching approaches.	1 yr +	Jul-16		n/a			
Technological	4.6	Interoperability of clinical systems, and enhanced analytical functions (data warehouses, big data etc.) support evidence based care at system level and in relation to integrated care planning at an individual level. Creates demand for cross-organisational platforms for integrated working. Progress lags behind the vision	1 yr +	Jul-16		n/a			
Technological	4.7	Platform technology potentially allows Trust's to widen the range of offers available to service users e.g. mobile apps, enables more peer to peer support, promotes innovation and provides data on choice. Also platforms have potential to disrupt traditional 'supply chain' based markets – e.g. Uber, Air-BnB, Ebay etc.	Jul-16	Jul-16		n/a			
Technological	4.8	Increased use of communications technology for consultation – engagement of carers/ Multi-Disciplinary Teams etc.	1 yr +	Jul-16		n/a			
Technological	4.9	Technology opens up wider possibilities in terms of 'remote working', operating over a larger geography, and different option for provision of support services including more self-service, more collaboration and traded services between NHS partners.	1 yr +	Jul-16		n/a			
Legal / Regulatory	5.1	Increased pace of movement towards new organisational forms and partnership vehicles suitable for place based solutions (e.g. Accountable Care Organisation, Multi-specialty Community Provider), and for service line specific collaboration (e.g. mental health). Gap emerging between regulatory and legal frameworks and the intended future structures for integrated place based care provision	Jan-17	Jan-17		n/a			
Legal / Regulatory	5.2	Changing landscape of regulation and approaches from regulators – NHS Improvement's Single Oversight Framework and alignment with Care Quality Commission. Diminished emphasis on previous markers of independence such as Foundation Trust status and more focus on system-wide view of finance, quality and governance. Five Year Forward View Next Steps document further underlines the alignment of regulation, and clarifies intent to take a system view	1 yr +	Oct-16		n/a			
Legal / Regulatory	5.3	Care Quality Commission visit and subsequent publication of ratings of Trust services confirm regulatory position of the Trust overall and in relation to specific factors – this shapes future regulatory framework and frequency of review for the Trust.	Jul-16	Jul-16		n/a			
Legal / Regulatory	5.4	Some signals of changing commissioner alignment and relationships. In terms of commissioner to commissioner relationships, and also breaking down aspects of purchaser/ provider split. Committees in common in West Yorkshire and South Yorkshire, and provider to provider alliances starting to take shape	Oct-16	Oct-16		n/a			
Legal / Regulatory	5.5	Mergers and Acquisitions regulation and guidance – legal and regulatory framework unchanged but the anticipated approach to the practical application of this regulatory framework is uncertain in light of shift towards system based solutions.	1 yr +	1 yr +		n/a			
Legal / Regulatory	5.6	Choice agenda in health remains within NHS plans and policy, but pace of implementation slowed, with far less prominence than previously.	1 yr +	1 yr +		n/a			

Category	Ref.	Description	Date First Added	Date Last Updated	Updated this time?	Cross Ref with Risk Register	Current Risk Level	Risk Appetite	Target Risk Level
Environmental	6.1	Local Economic Partnership areas developing plans linked to local authority housebuilding and development control policy. Likely to increase density of population in some areas and change the environment.	Jan-17	Jan-17		n/a			
Environmental	6.2	Change in travel patterns as part of new service models and technological change – e.g. more home based care but fewer trips back to base. More support staff using video conferencing	1 yr +	1 yr +		n/a			
Environmental	6.3	Opportunities around renewable energy	1 yr +	1 yr +		n/a			

SWOT

In the context of an analysis of the external environment and the Trusts strategic objectives and priorities, the following strengths, weaknesses, opportunities and threats are highlighted:

Category	Ref.	Description	Date First Added	Date Last Updated	Updated This Time?	Cross Ref. with Risk Register	Current Risk Level	Risk Appetite	Target Risk level	Link to Strategic Priorities and Programmes
Strength	1.1	Compelling model for alternative capacity – Creative Minds, Recovery Colleges and Altogether Better is well aligned to Five Year Forward View, Sustainability and Transformation Partnership direction etc. and offers opportunities for partnership in local place-based solutions	1 yr +	Jul-16						
Strength	1.2	Clarity of approach to management of partnerships and contractual relationships with other providers, and track record of integrated teams and multi-agency joint-delivery, is a strength in formation of accountable care systems	Jul-16	Jan-17						
Strength	1.3	Partnership track record and place based delivery structure underpinned by clear FT governance arrangements including plans to fully engage and mobilise an active public membership – all key for system leadership in emerging Accountable Care Organisations/ Systems	Oct-16	Jan-17						
Strength	1.4	Developing partnerships with neighbouring providers of mental health and learning disability services, aligned to achievement of Sustainability and Transformation Partnership aims	Oct-16	Oct-16						
Strength	1.5	Devolved Business Delivery Unit structures offer tried and tested approach to operating as a multi-'place based' provider – increasingly relevant in development of accountable care systems	1 yr +	Jan-17						
Strength	1.6	'Centres of excellence' within services recognised internally and externally – e.g. Equipment Store recycling rates, Forensic Child and Adolescent Mental Health Service expertise shaping policy, leading implementation of suicide prevention strategy for West Yorkshire Sustainability and Transformation Partnership and leading on partnerships, e.g. in the Police Liaison scheme in Calderdale and Kirklees partnership	Jan-17	Sep-17	✓					
Strength	1.7	Clear commitment to the Trusts mission, good values base, and increased understanding and alignment around strategic priorities within all parts of the Trust	1 yr +	Jul-16						
Strength	1.8	Integrated approach to quality improvement ensures quality drives everything we do. The Trusts integrated change framework supports innovation, change and improvement	1 yr +	Aug-17	✓					
Strength	1.9	What the Care Quality Commission report confirmed about how staff treat people with kindness care and compassion, and that we are respectful and warm has been further confirmed with the Trust being chosen as the winner of the organisation category at the 2017 Kate Granger awards for compassionate care.	Jul-16	Oct 17	✓					

Category	Ref.	Description	Date First Added	Date Last Updated	Updated This Time?	Cross Ref. with Risk Register	Current Risk Level	Risk Appetite	Target Risk level	Link to Strategic Priorities and Programmes
Strength	1.10.	Our Care Quality Commission report highlights the outstanding features of end of life care services provided by the Trust. It also highlights consistent good ratings in most services	Jul-16	Jul-16						
Strength	1.11	Our Care Quality Commission report highlights that more than 90% of the individual ratings are good or outstanding and our overall rating is Good	Jul-16	Jul-16						
Strength	1.12	Our culture of supporting each other and our work with service users and carers makes us different to many other Trusts. This inspires staff and offers potential for building external relationships and engaging with commissioners	Jul-16	Jul-16						
Strength	1.13	Our partnership relationships and the way in which we conduct ourselves when working collaboratively demonstrates a real focus on the needs of the people who use our services	Jul-16	Jul-16						
Strength	1.14	The additional external responsibilities taken on by our Chair and Chief Executive in relation to leadership roles in Sustainability and Transformation Partnerships and on national bodies ensure we have high level connections and influence at a strategic level.	Jul-16	Jul-16						
Strength	1.15	Our stakeholder survey indicates partners consider the Trust to be well led with an important role to play in the formation and delivery of local place based plans.	Jan-17	Jan-17						
Weakness	2.1	Some elements of data quality undersell the true quality and contribution made by the Trust. Also examples of poor use of data that undermine stakeholder confidence and therefore impacts on reputation and sustainability.	1 yr +	Sep-17	✓	850				Data driven improvements and innovation
Weakness	2.2	There are some services where access to help can be too slow and needs to improve. This requires changes within services and support by commissioners to achieve the right level of capacity. However this has remained consistent for over 12 months	1 yr +	Jul-16		1078				West Yorkshire work – Tier 4 CAMHS Improving Autism and ADHD (psychology too?)
Weakness	2.3	We need to better recruit, retain, motivate and value the health and wellbeing of our staff. In common with other Trusts we experience difficulties in ensuring that we have the right workforce in some hot spots. e.g. staff grade doctors, ward based nursing staff, Psychological Wellbeing Practitioners in Improving Access to Psychological Therapies. Opportunity to re-think models of care and roles.	1 yr +	Oct-17	✓	905				Operational Excellence Health and wellbeing programmes (staff) Workforce and agency spend

Category	Ref.	Description	Date First Added	Date Last Updated	Updated This Time?	Cross Ref. with Risk Register	Current Risk Level	Risk Appetite	Target Risk level	Link to Strategic Priorities and Programmes
Weakness	2.4	Our IT systems don't always support the desired agile style of working, particularly for those working in community services and non-SWYPFT locations, where connectivity or access to systems is not effective.	1 yr +	Oct-17	✓	850				Clinical Record System Digitally Health
Weakness	2.5	Our CQC Report highlights that there is a requirement to improve our community learning disability services and our acute adult mental health inpatient services. And overall we need to improve our 'Responsiveness'	Jul-16	Jul-16		n/a				
Weakness	2.6	Sometimes we act in silos, with particular need to address gaps between operations and corporate support, and between strong local identities.	Jul-16	Sep-17	✓	n/a				Operational Excellence Change and Quality Improvements Leadership Development
Weakness	2.7	There is a gap between our brand and offer as we would like it to be – 'integrated holistic care' and the perceptions of many of our stakeholders, who often see us as focused on mental health alone	Oct-16	Jan-17		n/a				Supporting Place Based Plans
Weakness	2.8	Sometimes our approach is too bureaucratic, and colleagues and partners would like us to be faster in making decisions	Jul-16	Aug-17	✓	n/a				Well led Review and Trust Governance Operational excellence Quality Counts, Safety First
Weakness	2.9	Our approach to change takes too long, and is not always as engaging as it needs to be	Jul-16	Sep-17	✓	695				Change and Quality Improvements
~~**Weakness**~~	~~2.10.~~	No Longer Applicable ~~We have made improvements, but continue to make Information Governance breaches which undermine service user, commissioner, and regulator confidence and trust~~	~~Apr-17~~	~~Oct-17~~	~~✓~~	~~852~~	-	-	-	
Weakness	2.11	In our place based/accountable care discussions with partners our broad geography can be portrayed as a lack of 'belonging' to each specific place and community	Apr-17	Aug-17	✓	n/a				Supporting Place Based Plans
Weaknesses	2.12	Our clinical record system (RiO) has not been reliable, resilient nor robust since November 2015, due in most part to how the system has been developed by the vendor, which impacts on effectiveness and the morale of staff using the system.	Oct 17	Oct 17	✓	850				Clinical Record System

Category	Ref.	Description	Date First Added	Date Last Updated	Updated This Time?	Cross Ref. with Risk Register	Current Risk Level	Risk Appetite	Target Risk level	Link to Strategic Priorities and Programmes
Opportunity	3.1	We can build upon our relative stability, innovation, and partnership relationships to play a leading role in shaping place based solutions in each of our localities.	1 yr +	Sep-17	✓					
Opportunity	3.2	Through Accountable Care Organisation/ Multi-specialty Community Provider developments we have opportunities to provide integrated joined up care and engage local populations in their health. ACO developments in Barnsley and Alliance developments in Wakefield and possibly in Calderdale have the opportunity to demonstrate this.	Jan-17	Oct-17	✓					
Opportunity	3.3	We have an opportunity to become a national leader in shaping the future provision of low and medium secure forensic mental health	Jan-17	Sep-17	✓					
Opportunity	3.4	The integrated nature of our organisation with reach into several localities across many different services, means we are well placed to play a leading role in the changing shape of health and care provision, in which further integration is anticipated, of both a place based and a service-specific nature.	1 yr +	Sep-17	✓					
Opportunity	3.5	We can use our connectivity to Sustainability and Transformation Partnerships (STP) to forge stronger collaboration and promote the delivery and growth of innovation. In particular we have an opportunity to make a bigger contribution to the South Yorkshire STP/ emerging Accountable Care System, e.g. in the mental health and learning disabilities workstream, to secure sustainable pathways and West Yorkshire STP developments in new models of care	Jul-16	Sep-17	✓					
Opportunity	3.6	By fully rolling out our devolved approach to leadership we can empower and inspire more people – becoming an employer of choice and delivering great results in partnership with our service users	Jan-17	Jan-17						
Opportunity	3.7	We can use the learning from our stakeholder engagement work on brand and strategy to forge excellent relationships with primary care as the bed rock of place based care systems	Jan-17	Sep-17	✓					
Opportunity	3.8	We can use our skills in health and wellbeing and health coaching, to support our revised workforce strategy with a focus on retention and wellbeing	Jan-17	Aug-17	✓					
Opportunity	3.9	We can use the replacement of our clinical records IT system for mental health as an opportunity to improve quality, safety, and efficiency; and to create a system fit for the integrated place based systems of care envisaged in our Multi-specialty Community Provider and Accountable Care Organisation plans	Jan-17	Jan-17						
Opportunity	3.10.	We have an opportunity to transform the approach to the delivery of our current services through innovation that makes greater use of our unique approaches such as creative minds, recovery colleges and altogether better	Jan-17	Aug-17	✓					
Opportunity	3.11	Additional investment in social care to address flow and reduce delayed transfers of care (DTOC) offers an opportunity for innovative collaboration with partners, taking a system view using the Better Care Fund mechanism	Apr-17	Apr-17						

Category	Ref.	Description	Date First Added	Date Last Updated	Updated This Time?	Cross Ref. with Risk Register	Current Risk Level	Risk Appetite	Target Risk level	Link to Strategic Priorities and Programmes
Opportunity	3.12	The positive result of our Care Quality Commission revisit provides opportunities to improve from good to outstanding and also positions the Trust well in relation to partnership and growth, supports an enhanced regulatory relationship and allows support to other system partners, in particular linked to partnership support work with Locala.	Apr-17	Aug-17	✓					
Threat	4.1	Loss of autonomy arising from failure to achieve key financial and service delivery measures – resulting in increased regulatory attention, and diversion of effort away from progressive activities.	Jan-17	Jan-17		n/a				Operational Excellence Maintaining Outstanding, Safe and Equitable Services
Threat	4.2	If place based 'accountable care' systems are developed which result in significant loss of contracts for the trust this would be a de-stabilising factor requiring a step change reduction in organisational cost base, and therefore a threat to viability	Jan-17	Sep-17	✓	812				Deliver integrated holistic services Supporting Place Based Plans Operational Excellence
Threat	4.3	NHS sustainability agenda focuses primarily on the highly visible challenges to the viability of acute hospital model, which may marginalise the needs of community, learning disability, and mental health services in terms of funding and support.	1 yr +	Sep-17	✓	n/a				Deliver integrated holistic services Supporting Place Based Plans Operational Excellence
Threat	4.4	Focus on one or two particular issues could be a distraction to ensuring that all key performance metrics are given sufficient and appropriate focus and time.	Oct-16	Oct 17	✓	1078				People and Communities First Quality priorities Operational Excellence
Threat	4.5	Possible that well-developed infrastructure around service delivery and gaps between corporate support and operations may lead to a lack of agility to respond to changing priorities quickly enough.	1 yr +	Sep-17	✓	n/a				Leadership Development Quality and change improvement

Category	Ref.	Description	Date First Added	Date Last Updated	Updated This Time?	Cross Ref. with Risk Register	Current Risk Level	Risk Appetite	Target Risk level	Link to Strategic Priorities and Programmes
Threat	4.6	Impact of continued austerity on public spending (particularly Local Authorities) leading to additional unplanned pressures on the Trust. This manifests in terms of additional demand for Trust mental health services (e.g. as a result of benefit restrictions).	1 yr +	Oct-17	✓	275				Deliver integrated holistic Supporting Place Based Plans
Threat	4.7	Threat of decommissioning of services, in particularly in places like Barnsley may result in loss of services and financial income.	Jan-17	Oct 17	✓	772				Supporting Place Based Plans Accountable Care in Barnsley and Wakefield
Threat	4.8	Data quality and information governance issues may lead to regulatory action and reputational damage.	1 yr +	Sep-17	✓	852				Data Driven Improvements and Innovation Digital by Design
~~**Threat**~~	~~4.9~~	No Longer Applicable ~~There is a need to clarify Trust strategy with regard to the re-procurement of one of the Trust's main clinical information systems. Throughout any resulting transition it is critical that system functionality and user confidence is maintained. There is a clear strategy with systems being procured.~~	~~Oct-16~~	~~Oct-17~~	~~✓~~	~~850~~	-	-	-	
Threat	4.10.	Threat that the under-delivery of cost improvements reduces funding available for investment in required capital schemes including IM&T	Jan-17	Sep-17	✓	1076				Operational Excellence
Threat	4.11	Threat that the under-delivery of cost improvements impacts negatively on cash flow, necessitating undesirable urgent cost control measures, and negatively impacting on key operating measures that trigger regulatory action	Apr-17	Oct-17	✓	1114				Operational Excellence Effective use of supplies and resources
Threat	4.12	Threat of cyber-attack impacting on operational continuity and stakeholder confidence	Apr-17	Sep-17	✓	1080				Digital by Design Safety First
Threat	4.13	Threat that reduced investment into Intermediate Care services is not matched by corresponding reductions in cost for several months, leading to unplanned and unfunded expenditure and a negative deviation from forecast	Apr-17	Oct-17	✓	n/a				Supporting Place Based Plans

Category	Ref.	Description	Date First Added	Date Last Updated	Updated This Time?	Cross Ref. with Risk Register	Current Risk Level	Risk Appetite	Target Risk level	Link to Strategic Priorities and Programmes
Threat	4.14	The development of an Accountable Care System for South Yorkshire may lead to the Trust sharing accountability for achievement of a system wide control total. The detailed implications of this are not currently understood	Apr-17	Oct-17	✓	812				Supporting Place Based Plans
Threat	4.15	There is a threat of a sub-optimal implementation of the clinical record system (SystmOne), selected to replace our existing RiO system.	Oct-16	Oct 17	✓	850				Clinical Record System programme

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 October 2017
Agenda item 6.1

Title:	**Integrated Performance Report (IPR) Month 6 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 September 2017.
Mission/values/objectives	All Trust objectives
Any background papers/ previously considered by:	IPR is reviewed at Trust Board each month IPR is reviewed at Executive Management Team Meeting on a monthly basis
Executive summary:	**Quality** ➢ Safer staffing levels have been maintained, however pressures remain on some areas with skill mix dilution to maintain safety and ratios. ➢ Positive progress on falls continues ➢ Complaints improvement plan in place. **NHS Improvement (NHSI) Indicators** ➢ The Trust is performing well against the vast majority of NHSI metrics. ➢ Performance has dropped against the Improving Access to Psychological Therapies (IAPT) moving to recovery indicator - the final August position is lower than provisionally reported last month and as such was below the 50% threshold. Similarly the September position, whilst also estimated is again below target. ➢ 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. **Finance** ➢ Pre STF deficit of £232k in September). Cumulative position is now a deficit of £6k, which is in line with plan, but a significant deterioration compared to the first five months of the year ➢ Out of area beds £904k overspent year-to-date. Reduction in overspend given additional bed capacity has not yet materialised ➢ Other variances include CQUIN risk reserve and reductions in income

	➢ Agency staffing costs improved to £435k in-month. Agency spend in the first half of this year is 46% below the same period last year ➢ Use of resources risk rating remains at 1 ➢ CIP delivery is £3.5m, which is £357k below plan ➢ Cash balance improved to £21m in month with a high focus on aged debt ➢ Achievement of the year-end control total of is at risk **Workforce** ➢ Mental Health Act and Mental Capacity training continue to remain above the 80% threshold. ➢ Sickness absence decreased to 4.9% in September (4.9% year to date). ➢ Appraisal compliance for Band 6 and above is at 91%, just short of the 95% target. ➢ Appraisals completed for Band 5 and below has increased to 75.8% as at the end of September (was 46% at end of August 2017). The target is 95% by the end of September 2017. **Locality** ➢ Recruitment to the perinatal mental health workforce is almost complete ➢ The Adult Eating Disorders new community model is being developed across the West Yorkshire Sustainability and Transformation Plan (STP) footprint. ➢ Yorkshire wide capacity issue for FY1 and FY2 CORE training grades which means some places in the Trust are unfilled ➢ Forensic Child and Adolescent Mental Health Services (CAMHs) are working hard to develop the partnership agreements with other providers and supply an implementation plan to NHS England. Service due to commence November 2017. ➢ Further difficulties have been experienced in accessing Tier 4 beds, leading to use of beds on generic adult mental health wards (over 16 years only). Ward and CAMHS staff have worked closely to ensure the service offer is as safe and responsive as possible but the pressure on staffing levels and out of area placements must be highlighted ➢ The Learning Disability “At Risk of Admission” Risk Register has now been integrated within core management processes and is proving to be of significant benefit in ensuring a more coordinated response in meeting the needs of the most vulnerable service users. **Priority Programmes** ➢ A new integrated performance report framework for reporting progress on the Trust priorities has commenced this month.

	➢ The new reporting framework reports progress monthly for the priorities considered to be major transformation or significant improvements. ➢ Priorities that fall into other categories are reported bi-monthly on the IPR ➢ A schedule for reporting of the bi-monthly priorities is in place ➢ All projects now have defined scope Specific actions undertaken this month relate to ➢ Older Peoples Services : workforce modelling workshops have been held and draft standard operating procedures have been produced, ongoing engagement with commissioners in relation to the new model of care ➢ Flow and Out of area beds: Two wards at Fieldhead now open with subsequent increase in capacity. ➢ Clinical record system: 12 out of 15 positions have been filled. Engagement with individuals, management teams and groups continues. Second system demos held with a good attendance by staff ➢ Digital Health: Pilot with Orcha being planned with CAMHS services. We have 50 licenses available as part of the pilot which will enable people to have Apps 'prescribed' to support their mental health
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

September 2017

With **all of us** in mind.

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Introduction

Please find the Trust's Integrated Performance Report for September 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 month's 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	2							1
CQC Quality Regulations (compliance breach)		Green	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	2							1
% service users followed up within 7 days of discharge		95%	98.3%	97.5%	97.3%	93.3%	97.2%	96.1%							1
% clients in settled accommodation		*60%*	82.2%	82.5%	82.2%	81.8%	81.7%	80.8%							1
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks [1]		*TBA*	80.3%			87.5%									
Out of area beds [2]		<=100 Green, 101 -199 Amber, >=200 Red	282	348	254	357	391	429							3
IAPT –proportion of people completing treatment and moving to recovery		50%	45.6%	49.4%	56.4%	52.4%	49.0%	46.1%							1
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%							85%
Friends and Family Test - Community		98%	97%	99%	98%	95%	99%	99%							98%
Patient safety incidents involving moderate or severe harm or death			4	6	5	9	7	15							
Safer staff fill rates		90%	110%	111%	103%	112.6%	109%	111.8%							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	10	6							
% people dying in a place of their choosing [4]			Reporting established from Sept 17					82.6%							
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**
Projected CQUIN Shortfall		£4.2m	£346k	£664k	£842k	£869k	£856k	£856k							£136k
Surplus		In line with Plan	£26k	£53k	£95k	£204k	£226k	£232k							£1020k
Agency spend		In line with Plan	£501k	£426k	£500k	£457k	£446k	£435k							£7m
CIP delivery		£1074k	£472k	£1024k	£1643k	£2306k	£2950k	£3452k							£7.3m
Sickness absence		4.5%	4.8%	4.7%	4.7%	4.8%	4.9%	4.9%							4.50%
Mental Health Act training		>=80%	51.2%	56.9%	70.5%	75.0%	80.3%	81.6%							80%
Mental Capacity Act Training		>=80%	64.9%	69.6%	78.0%	82.5%	86.1%	87.6%							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 one face-to-face contact. 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. Recent development of this indicator has taken place in conjunction with commissioners. When first reported in Q1, reporting was against second contact, following review, it is felt that service delivery starts at the first contact and as a result the Q1 figure has been amended to reflect this.
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 October data which will be included in the November report.
4 - Data is now available for this indicator.
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 deficit of £232k in September). Cumulative position is now a deficit of £6k, which is in line with plan, but a significant deterioration compared to the first five months of the year
• Out of area beds £904k overspent year-to-date. Reduction in overspend given additional bed capacity has not yet materialised
• Other variances include CQUIN risk reserve and reductions in income
• Agency staffing costs improved to £435k in-month. Agency spend in the first half of this year is 46% below the same period last year
• Use of resources risk rating remains at 1
• CIP delivery is £3.5m, which is £357k below plan
• Cash balance improved to £21m in month with a high focus on aged debt
• Achievement of the year-end control total of is at risk

Quality
• In 2015/16 – there were 8 children admitted to adult wards, with a total number of 177 occupied bed days. The number of children admitted in 2016/17 increased to 11 with a total of 227 bed days and to date we have had 6 children admitted in 2017/18, with a total number of 152 occupied bed days.
Tier 4 capacity is being addressed at a regional and national level, however the benefits from this will inevitably take time. In the immediate period representations have been made to our commissioners and nationally.
• Safer staffing levels have been maintained, however pressures remain on some areas with skill mix dilution to maintain safety and ratios.
• Positive progress on falls continues
• Complaints improvement plan in place.

NHSI Indicators
• The Trust is performing well against the vast majority of NHSI metrics.
• Performance has dropped against the IAPT moving to recovery indicator - the final August position is lower than provisionally reported last month and as such was below the 50% threshold. Similarly the September position, whilst also estimated is again below target. Further detail regarding this underperformance can be seen in the National Metrics section of the report.
• 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

Locality
• Recruitment to the perinatal mental health workforce is almost complete
• The Adult Eating Disorders new community model is being developed across the West Yorkshire STP footprint.
• Yorkshire wide capacity issue for FY1 and FY2 CORE training grades which means some places in the Trust are unfilled
• Forensic CAMHs services are working hard to develop the partnership agreements with other providers and supply an implementation plan to NHSE. Service due to commence November 2017.
• Further difficulties have been experienced in accessing Tier 4 beds, leading to use of beds on generic adult mental health wards (over 16 years only). Ward and CAMHs staff have worked closely to ensure the service offer is as safe and responsive as possible but the pressure on staffing levels and out of area placements must be highlighted
• The Learning Disability “At Risk of Admission” Risk Register has now been integrated within core management processes and is proving to be of significant benefit in ensuring a more coordinated response in meeting the needs of the most vulnerable service users.

Priority Programmes

• A new integrated performance report framework for reporting progress on the Trust priorities has commenced this month.
• The new reporting framework reports progress monthly for the priorities considered to be major transformation or significant improvements.
• Priorities that fall into other categories are reported bi-monthly on the IPR
• A schedule for reporting of the bi-monthly priorities is in place
• All projects now have defined scope

Specific actions undertaken this month relate to

• Older Peoples Services : workforce modelling workshops have been held and draft standard operating procedures have been produced, ongoing engagement with commissioners in relation to the new model of care
• Flow and Out of area beds: Two wards at Fieldhead now open with subsequent increase in capacity. PICU is now mixed gender.
• Clinical record system: 12 out of 15 positions have been filled. Second system demos held with a good attendance by staff
• Digital Health: Pilot with Orcha being planned with CAMHS services. We have 50 licenses available as part of the pilot which will enable people to have Apps ‘prescribed’ to support their mental health

Workforce

• Mental Health Act and Mental Capacity training continue to remain above the 80% threshold.
• Sickness absence decreased to 4.9% in September (4.9% year to date).
• Appraisal compliance for Band 6 and above is at 91%, just short of the 95% target.
• Appraisals completed for Band 5 and below has increased to 75.8% as at the end of September (was 46% at 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	Sep-17	Q1 17/18	Q2 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	0	1	0	4
C-Diff	C Diff avoidable cases	Improving Care	Safe	TB	0	0	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	22% 11/50	19.8% 43/217	18.2% 38/208	4
Service User Experience	Friends and Family Test - Mental Health	Improving Health	Caring	TB	85%	72%	71%	71%		85%	82%	86%	89%	79%	85%	84%	84%	2
	Friends and Family Test - Community	Improving Health	Caring	TB	98%	98%	98%	98%	99%	97%	99%	98%	95%	99%	99%	98%	98%	4
Quality	Total number of reported incidents	Improving Care	Safety Domain	TB	N/A	3509	3405	3293	2946	847	1022	978	1081	1081	867	2847	3029	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	7	15	15	31	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	32	31	29	74	92	N/A
	MH Safety thermometer - Medicine Omissions	Improving Care	Safety Domain	TB	17.7%	16.8%	17.7%	Data not avail	18.70%	15.8%	13.0%	25.7%	24.2%	23.3%	25.3%	18.2%	24.3%	3
	Safer staff fill rates	Improving Care	Safety Domain	TB	90%					110%	111%	103%	112.6%	109%	111.8%	109%	111.1%	4
	Safer Staffing % Fill Rate Registered Nurses	Improving Care	Safety Domain	TB	80%					109.7%	109.7%	100%	96.5%	91.2%	94.5%	107%	94.1%	4
	Number of pressure ulcers (attributable) 1	Improving Care	Safety Domain	TB	N/A	98	95	78	86	27	25	30	32	31	29	82	92	N/A
	Number of pressure ulcers (avoidable) 2	Improving Care	Safety Domain	TB	0	1	4	3	2	0	1	1	0	1	0	2	1	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	17% 2/12	12.7% 8/63	12% 6/50	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%	3.3%	4.3%	3.3%	
	Number of Information Governance breaches 3	Improving Health	Effective	MB	<=8	36	25	29	36	9	12	12	6	10	6	33	22	
	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%	75%	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%	64%	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	35	81	113	N/A
	Eliminating Mixed Sex Accommodation Breaches	Improving Care	Safety Domain	TB	0	0	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	136					Data available Nov 17.	136		N/A
	Duty of Candour - Number of Stage One exceptions 4	Improving Health	Caring	TB	N/A	Reporting established from Oct 16		0	2	7						7		N/A
	Duty of Candour - Number of Stage One breaches 4	Improving Health	Caring	TB	0	Reporting established from Oct 16		0	1	2						2		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%	85.6%	85.2%	85.6%	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%	76%	75%	80%	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%	2.8%	1.6%	2.3%	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	39.5% (March 17)					48.1%					48.1%		
	Number of Falls (inpatients)	Improving Care	Safety Domain	TB	TBC	162	158	136	95	38	52	49	41	54	45	139	140	
	Number of restraint incidents	Improving Care	Safety Domain	TB	N/A	Data not avail				104	140	101	144	159	121	345	424	

** 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 has increased to 10 (was 9) this is due to further review and re-categorisation of the incidents tat were originally reported at the end of September 2017.

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. The data reported is a refreshed April – August position in this report. September data will be available in the next report. Data correct at 03/10/17. The two breaches relate to one in Kirklees Duty of Candour was not completed as the patient was not well enough at the time (self harm), and we were unable to ascertain next of kin details, the second was in Barnsley where it was agreed that at the time (due to the incident) it would not be suitable to offer Duty of Candour and it was discussed whether someone from the team would be the best person to do this. Duty of Candour was subsequently completed with the husband.

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 2017/17 the Trust undertook some work to develop the key quality measures. There are a small number that require additional development, particularly relating to CAMHS Referral to Treatment waiting times. For which some national guidance is awaited.

As part of the Trust's ongoing review of quality, additional metrics have been identified for reporting in 2017/18 relating to:

• **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 -** Work is underway to reviews the complaints investigation and sign off process to make sure that the Trust always responds in ways that ensure learning and to ensure response times improve. This work is being led by the Director of Nursing and Quality and progressed through the Operational Management Group. The new process will secure greater involvement of clinical leads in complaints resolution, putting the person first and centre and using feedback to support service improvement. Paper-light processes will be introduced to expedite sign off of complaints.

• **% of feedback with staff attitude as an issue -** 11 out of 50 complaints reported during September 17 related to staff attitude - this information is shared with BDUs and is reviewed during the investigation process.

• **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 - the position for September has now reduced back to expected levels.

• **% of prone restraint with duration of 3 minutes or less -** The number of restraint incidents occurring over 3 minutes during September 17 has increased. This relates to 5 incidents out of 21 being for 3 minutes or more. 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. The range of actual prone restraints over 3 minutes has been 4 – 8 in any one month in last 6 months. Because the overall numbers of prone restraints are usually relatively small, the percentage is always liable to be affected greatly by 1 or 2 extra as, for example, August recorded only 4 restraints above 3 minutes, giving a total 86.2% below 3 minutes, September had one more (5) but because there were actually 9 less prone restraints in total – the figure less than 3 minutes drops by 10% to 76%.

One of the MAV specialist advisors conducted a “deep dive” review of 10 prone restraints over 3 minutes and this was presented at this month’s MAVtag. It demonstrated that staff on every occasion had a justifiable cogent clinical reason for the restraint to last beyond 3 minutes..

• **NHS Safety Thermometer - Medicines Omissions –** This only relates to Inpatient areas in Calderdale, Kirklees and Wakefield. The overall inpatient medicines omissions has fallen from 25.7% in June to 24.2% in July to 23.3% for August and then to 25.3% in September. 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 People's Services (OPS) wards.

The trusts average figure for medication omissions is slightly over 20% compared to the national average of 14%.

Historically there have been difficulties with patient refusals on the OPS and Working Age Adults (WAA) have always had lower medication omissions. Over the past couple of months the OPS areas have reduced their medicines omissions significantly and are below the national average and for an unknown reason the WAA area have worsened. The focused effort on OPS areas has paid off and the dispensing at the patient interface has improved. We will focus our efforts on WAA and develop a strategy with the aim to get the figures nearer to the national average.

• **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 was an increase in the number of falls reported. On review of the data, this appeared 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. The number of falls reported in September has now reduced back to expected levels.

• Supervision – the figure does not include some staff within integrated teams at present. Once the baseline is finalise an improvement trajectory will be applied.

Safety First

Summary of incidents during Q1 17/18, September 2017

Summary of Incidents	Q1 17/18	Q2 17/18	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep-17
Green no harm	1762	1863	535	623	604	659	666	538
Green	780	849	228	286	266	320	294	235
Yellow	228	228	66	87	75	76	89	63
Amber	57	56	14	18	25	17	25	14
Red (should not be compared with SIs)	20	33	4	8	8	9	7	17
Total	2847	3029	847	1022	978	1081	1081	867

	Q1 17/18	Q2 17/18	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep-17
Suicide (incl apparent) - community team care - current episode	4	9	1	1	2	5	1	3
Information disclosed in error	1	1	0	1	0	0	0	1
Pressure Ulcer - grade 3	1	1	0	0	1	1	0	0
Suicide (incl apparent) - community team care - discharged	0	2	0	0	0	1	0	1
Physical violence (contact made) against other by patient	1	1	0	0	1	0	0	1
Death - cause of death unknown/ unexplained/ awaiting confirmation	1	1	0	0	0	0	0	1
Fire / Fire alarm related incidents	1	1	0	0	1	1	0	0
Self harm (actual harm) with suicidal intent	0	1	0	0	0	0	1	0
Death - confirmed related to substance misuse (drug and/or alcohol)	1	0	1	0	0	0	0	0
Self harm (actual harm)	2	0	0	1	1	0	0	0
Administration/supply of medication from a clinical area	0	1	0	0	0	1	0	0
Illegal Acts	1	0	1	0	0	0	0	0
Vehicle Incident	1	0	0	0	1	0	0	0
Homicide by patient	1	0	0	0	1	0	0	0
Physical/sexual violence by other	1	0	0	0	1	0	0	0
Total	16	18	3	3	9	9	2	7

- 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 Sept 2017

The information comes off a live system run 3rd October so is accurate at that time but is subject to changes following review by managers. This data set cannot be replicated at a future date as it will change.
- Red incidents are potential harm and /or actual harm, they cover a range of incidents in September including a patient fall, self harm and a number of deaths. The deaths may be subject to change in severity once the cause is identified. To date 5 have been confirmed as serious incidents and reported on STEIS -4 apparent suicides and one unexpected death through a fire.

Mortality Update

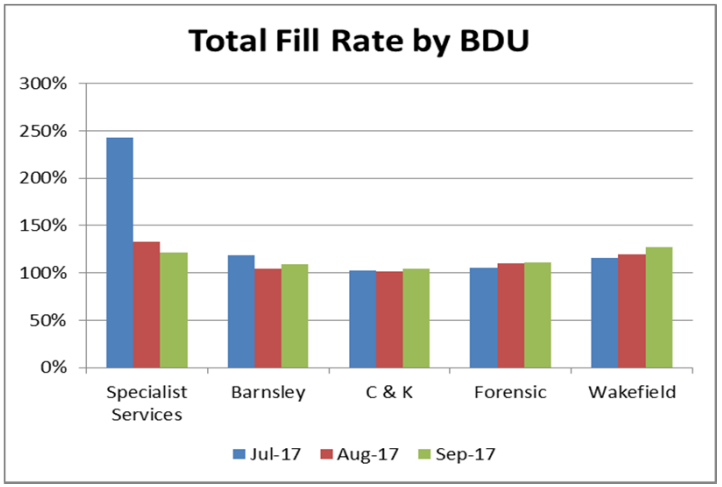
- A new Trust policy on 'Learning from Healthcare deaths – the right thing to do' was approved by Trust Board on 3 October 2017. The Policy sets out the Trust's approach to reporting and learning from deaths from 1 October 2017 in line with national guidance.
- Staff should ensure they understand their roles, responsibilities and which deaths should be reported on Datix, to ensure we do the right thing for service users who have died.
- An intranet page has been developed with further information and information on bereavement support. http://nww.swyt.nhs.uk/learning-from-deaths/Pages/default.aspx
- The policy was developed following work regionally with Mazars to agree common scope, improve mortality reporting and review arrangements.
- The scope of what is reportable on Datix as an incident has changed in the policy. All reportable deaths will require the manager to review and update both the 'Death of a service user' and 'Managers 48 hour review' sections on Datix to ensure timely processing of mortality data.
- Work continues to further develop the governance processes and ensuring our internal action plan progresses.

Safer Staffing

Overall Fill Rates: 111.8%
Registered fill rate: (day + night) 94.5%
Non Registered fill rate: (day + night) 128.4%

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

Fill Rate			
BDU	Jul-17	Aug-17	Sep-17
Specialist Services	242%	133%	121%
Barnsley	119%	105%	109%
C & K	103%	102%	105%
Forensic	106%	111%	111%
Wakefield	115%	119%	127%
Grand Total	**113%**	**109%**	**112%**



Overall

Following 2 wards dropping below a 90% overall fill rate in August there were no wards falling below this in September. Of the 32 inpatient areas 28 (87.5%) achieved greater than 100%, which is an increase of 2 wards from the previous month.

Registered On Days (Trust Total 89.4%)
The number of wards which are achieving 100% and above fill rate has remained constant at 5 in September. There has been a decrease in the number of wards that have failed to achieve 80%, 6 wards in all (18.75%) compared to 11 in August. These remain mainly focused in the Forensic BDU (Medium Secure Unit)

Registered On Nights (Trust Total 99.6%)
The number of wards who are achieving 100% and above fill rate on nights increased by 1 ward to 65.6% (increased from 60%). Thornhill, Women's service and Hepworth within the Forensic BDU fell below the 80% threshold.

Average Fill Rates for Barnsley BDU were 109%, an increase of 2%. Calderdale and Kirklees BDU were 105%, with an increase of 4%. Forensic BDU were 111% with an increase of 1%. Wakefield BDU were 127% with an increase of 8%. Specialist services were 121% with a decrease of 12% which has to be considered along with the agreed reduction in their staffing template.

Safer staffing was maintained through the application of the professional guidance tool.

Infection Prevention & Control

Incidents:
• There have been no MRSA bacteraemia cases reported anywhere in the Trust during Q2, a total of zero to date.
• Annual action plan for 2017/18 has been approved at IPC TAG – Q2 has progressed well with no areas at risk.
• There have been 5 IPC incidents reported on DATIX during Q2. Area of incidents = Wakefield - 0, Barnsley - 1, Forensics - 3, Calderdale/Kirklees - 1, Specialist Services - 0 and Corporate Support Services - 0. Severity rating – All incidents were risk rated green.
• Incident breakdown – 1 sharps related incident (no injury), 1 exposure to infection, 1 faeces related, 1 outbreak and 1 cleanliness issue. All incidents are appropriately investigated and supported by IP&C staff.
Surveillance:
• Q2 there has been 1 case of unavoidable C difficile at MVH Barnsley. This is a total of 2 C diff cases so far in 17/18. Barnsley BDU has a locally agreed C difficile Toxin Positive Target of 6.
• There has been an outbreak of Norovirus Ward 35 BHNFT (ward 5). 19 patients and 25 staff affected. The ward was closed and had outbreak precaution restrictions in place for 7 days.
• There have been a total of 3 cases of E.coli bacteraemia.
Training:
• The Trust remains compliant with all Infection prevention control standards.
• Annual Programme inclusive of audit programme 2017/18 is progressing well; all objectives scheduled for Q2 are in progress

Information Governance

The number of breaches during the month was 6. This is a reduction on previous months, with misdirected correspondence the most notable issue.

One of these incidents has been reported to the Information Commissioner's Office (ICO). The incident involved a letter being sent to a service user's home address where they had specifically requested no correspondence be sent. The incident resulted in the disclosure of personal sensitive data and has resulted n a formal complaint.

The other breaches involved confidential information being disclosed in error due to incorrect attachments being sent with letters and incorrect postal and email addresses being used.

The Trust continues to treat all IG incidents very seriously and continues to reinforce the importance of training and maintaining high information governance standards through regular communication.

Commissioning for Quality and Innovation (CQUIN)

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.

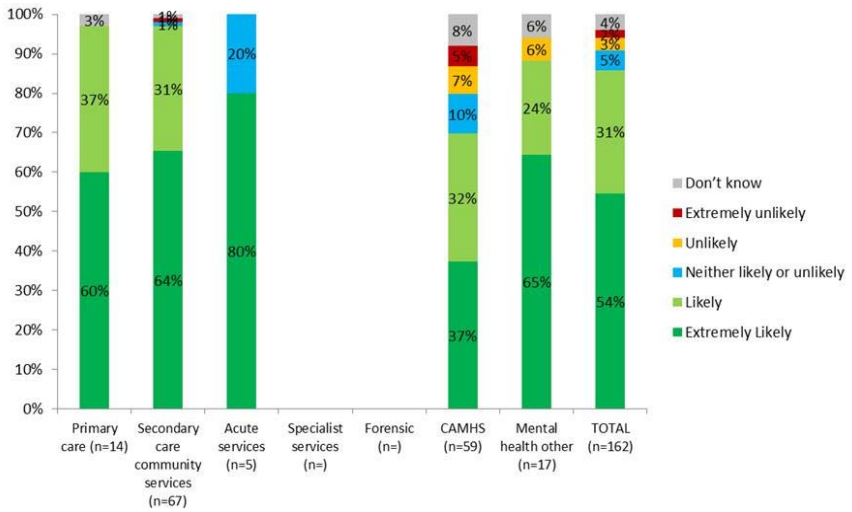
The Trust is currently forecasting a year end position of £856k shortfall, of which £720k relates to the STP indicator. NHSI have written to all trusts confirming further information will follow in relation to this Indicator, the Trust continues to rate this element of the scheme Red until further guidance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

Patient Experience

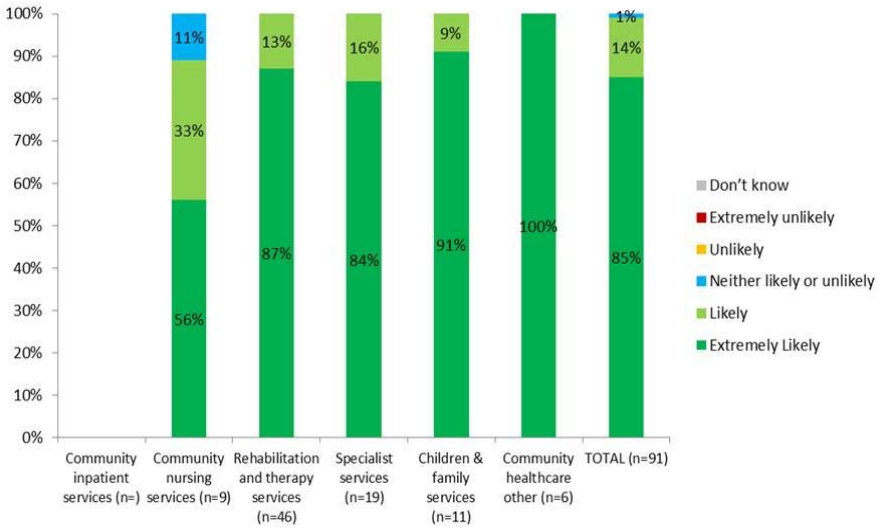
Friends and family test shows

- Community Services – 99% would recommend community services.
- All service lines achieved 56% or above for patients/carer's stating they were extremely likely to recommend the Trust's services.
- Mental Health Services – 80% would recommend mental health services.
- Significant variance across the services in the numbers extremely likely to recommend the Trust– between 37% (CAMH services) and 80% (Acute services)
- Small numbers stating they were extremely unlikely to recommend.

Mental Health Services



Community Services



NICE

At end of September 2017 there were 171 pieces of NICE Guidance and Technology Appraisals assessed as applicable to Trust services. There are currently no 'significant' internal risk grading's recorded against any relevant guidance.
Compliance and Risk Assurance of NICE guidance - There are currently 80 applicable published quality standards that will be used by the Trust to provide assurance of the quality of care within SWYPFT, of these 11 are registered on the audit programme for 2017/18.

Safeguarding Children

Datix:
• Total of 33 Child Protection Incidents were reported in Q2, with the highest number of incidents (11) reported from CAMHS. This is an increase of 6% on Quarter 1.
• 8 cases were reported for concerns re: the parental mental health, all of which were referred to Children's Social Care for an assessment of the home environment, parenting capacity and possible risks of physical abuse.
• The other incidents involved physical abuse, allegations of historical sexual abuse (where the parent of a child disclosed that they have been sexually abused and that they were concerned that they may become the perpetrator of abuse or that the perpetrator of the abuse may abuse their own child), domestic abuse, emotional abuse, self-harm, verbal aggression and admission of a child to an adult mental health inpatient ward.
• 82% of the Child Protection incidents resulted in a Request for Service into Social Care.

Training:
• Safeguarding Children level 1 remains above the Trust's mandatory 80%, levels 2 and 3 remain slightly below at 79% (specific areas have been contacted to ensure compliance with the 80% target for Q3). Hotspot areas include Inpatient Rehabilitation, Primary Care and Preventative Services, Forensic CAMHS, Barnsley CAMHS, Calderdale and Kirklees BDU and Wakefield BDU.
• Additional training has been provided to Adult Learning Disability Services and Forensic Services.
• The Safeguarding Children team have provided information to all four Safeguarding Children Boards in a timely manner, including information for a number of Serious Case Reviews and Lessons Learnt Reviews.
• Prevent training continues to be well attended and a workforce plan has been completed to ensure that the Trust achieves the NHS England's mandated target of 85% by March 2017.

Safeguarding Adults

Datix:
• Total of 66 Safeguarding Adults Incidents reported in Q2, 45 in Q1. Highest proportion in Q2 were from Specialist Services. Majority of the incidents, (50) were graded as green, (15) yellow and (1) recorded as amber. Specialist Services have been supported by the safeguarding team and the increase in incidents is a reflection of the support / advice.
• Q2 14 incidents of physical abuse reported, 10 of these incidents were 'domestic abuse incidents', allegations against either family members or intimate partners or ex partners. Of the other 3 incidents, 2 occurred in Care Homes and it was SWYPFT staff who raised the concern and the remaining incident was in relation to vigilante exposure of service user alleged to have been grooming an underage female on line.
• 13 incidents were neglect concerns, 11 domestic abuse, 9 financial abuse, 8 psychological, 7 sexual abuse, 2 self-neglect and 1 of human trafficking. The human trafficking was a historical incident and the lady is currently safe. 1 radicalisation concern, which was investigated by the Prevent officer and support offered and case closed.
• 1 amber incident in Q2 occurred in Kirklees. The case involved a serious sexual assault from an ex-partner and there were risks identified to the children due to exposure to domestic abuse. The staff member contacted the safeguarding team and due to the high risk factors, such as: controlling ex-partner, separation, pregnancy, and serious sexual assault, it was felt by the clinician that she was unable to protect herself, or the children, as there was frequent access to children and risks due to the ex-partners past history. Staff were advised to make a referral to MARAC and to children's social services.

Training:
• Safeguarding Adults levels 1 and 2 remain above the Trust's mandatory 80% requirement. Level 1 is 89% an increase from Q1 (87%) and level 2 has decreased from 87% in Q1 to 85% in Q2.
• Joint Safeguarding adults and Safeguarding children training delivered to level 3 for Forensic services.
• Team training delivered to District Nurses in Thurscoe and Barnsley to address previous hotspots.
• Current Hotspots - several red areas: Newhaven level 1 - reception staff. CAMHS (C&K) – level 2. Occupational health and Pharmacy level 2.
Emails sent to staff to prompt access to course, e learning or workbook dependent upon level required.

CQC

Following the January 2017 re inspection the CQC issued the Trust with 7 MUST Do and 15 SHOULD Do actions across 4 core service lines including 6 SHOULD do actions trust wide. We also have an outstanding regulatory breach from the March 2016 CQC visit which has been added to the 7 MUST Do actions from the March 2017 re-visit, therefore we now have 8 MUST Do actions.
The RAG ratings on the action plan were agreed on 19th October with the Clinical Governance Group.

	October 2017	
	MUST (n =8)	SHOULD (n=15)
Blue	1 (12.5%)	4 (26.5%)
Green	3 (37.5%)	6 (40%)
Green / Amber	1 (12.5%)	2 (13.5%)
Amber / Red	2 (25%)	3 (20%)
Red	1 (12.5%)	0

CQC action plan headlines

• Services continue to actively monitor their progress with their action plans.
• The majority of the 'must do' actions (92.5%) are either on course to deliver actions within agreed timeframes or are off trajectory but have confidence these can be delivered within agreed time frames.
• The majority of 'should do' actions (92.5%) have either been completed or are on track to be done within the given timescales.
• The amber/red rated 'must do' is in relation to completion and accessibility of clinical risk assessments onto the electronic care record system in community services for people with a learning disability or autism. Whilst improvements have been made and are ongoing, it is unlikely that the timescale for completion of these actions will be met.
• The amber/red 'should do' relates to staff having annual appraisals within our Forensics service. Whilst improvements remain ongoing, again there is concern that the actions will not be delivered within the agreed timeframes.
• The red 'must do' relates to psychology wait times in Barnsley and Kirklees locality - this is a regulation breach from the March 2016 inspection.

Monitoring of actions against our CQC action plan by the CQC

• We continue to submit our monthly action plan progress updates to CQC.
• These are also discussed within our regular engagement meetings when we meet directly with CQC and update them on our progress and improvements and about any areas where improvements are still needed.

CQC Staff Listening Event Feedback - Jo White, CQC

"During September I visited Trust sites in Barnsley, Calderdale and Huddersfield. The listening events gave me the opportunity to meet staff and see both hospital and community bases. Staff from a variety of services and disciplines attended, including nurses, social work, psychology, speech and language therapy, CAMHS, safeguarding, learning disabilities, customer service and the quality team.

The overall feeling I gained from staff was a sense of positivity and commitment to good patient care. It was evident that staff were proud of their work and felt supported. Staff also told me of the challenges they are experiencing in relation to transformation, particularly regarding the pace of change. Nevertheless, it was good to hear from services that were further into their transformation journey and were beginning to feel positive regarding the process, their own experiences and that of patients."

Jo White, CQC

A further listening event is scheduled for 6th December 2017 in Wakefield.

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	Sep-17	Q1 17/18	Q2 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%	95.7%	98.3%	96.8%	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%	100%	99.7%	100.0%	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%	95.2%	98.5%	96.6%	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%	96.1%	97.6%	95.5%	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%	99.7%	99.8%	99.7%	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%	60.1%	60.1%	59.6%	60.1%	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%	49.0%	46.1%	50.1%	49.2%	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%	80.9%	82.9%	81.9%	81.1%	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%	99.3%	99.3%	99.5%	99.4%	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%	80.9%	89.2%	84.4%	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%	81.8%	80.8%	82.2%	80.8%	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%	8.7%	9.0%	8.7%	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	Sep-17	Q1 17/18	Q2 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	21	4	108	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	2	7	N/A	
Number of detentions under the Mental Health Act	Improving Care	Safe	SR/CH	*TBC*	167	174	156	168	212			221			212	221	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%			13.6%			10.8%	13.6%	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	Sep-17	Q1 17/18	Q2 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%	97.9%	97.1%	98.7%	97.1%	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%	99.8%	99.7%	99.8%	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%	90.2%	90.3%	89.3%	90.3%	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.

% Service Users on Care Programme Approach (CPA) Followed up Within 7 Days of Discharge - Data currently being finalised.

IAPT - proportion of people completing treatment who move to recovery – August figure is the final position taken from the IAPT MDS refresh and has dropped from the provisional estimate and is now showing the Trust to be under performing against the 50% threshold. The September figure is a provisional figure as at 23rd October
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. August and September has seen an increase to reach above 50% in Barnsley.
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, Did Not Attends (DNAs) and Attrition rates as well as improving access for older people. Kirklees IAPT have not achieved the moving to recovery threshold in August (44.4%) or September (39.2%). Waiting times thresholds are being achieved in Kirklees. 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 - the Trust continues to remain above the threshold, 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 Referral to Treatment (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, it is anticipated that we will start to see the impact of this from next month.

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 decreased to 21 days during the month of September which is a reduction on the spike in August (45 days). Septembers data relates to the admissions of 2 patients - both aged 17. One of which one was admitted in September and discharged in September; one was admitted at the end of August and was discharged in September. 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 refresh figure has increased to above the threshold and the September primary submission indicates further improvement against the threshold.

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:

- Although internally, the service is making good progress in relation to CQUIN 4 (Improving services for people attending A&E) we are experiencing some challenges in meeting all requirements of the CQUIN for quarter 2 for areas that are outside the Trusts control. The local CQUIN working group are monitoring this position and this includes links with the lead commissioner.
- The service continues to experience challenges in meeting the 14 day access target. An increase in the number of referrals into the Single Point of Access (SPA) is a major factor and an additional post has been identified to support the team. The Trio is undertaking a full review of the under performance and formulating plans to address this in conjunction with colleagues from the Performance & Information team.
- Trajectories have been agreed to address the under performance in the IAPT service, these have been shared with the CCG and are being closely monitored by the Trio and at BDU Business meetings. Improvement has been seen against the 6 weeks access indicator, increasing from 67% (August) to 73% (September).
- The current plan for moving to the new model of care for Intermediate Care is December 4th. The Trust continues to work with all partners to ensure a smooth and safe transition

Calderdale & Kirklees BDU:

- Young person admissions to adult beds continue, with admissions in September and October. Specific additional capacity has been put in place to support a young person with Learning Disabilities. Male admissions have increased significantly. (The profile is of males with housing and substance misuse issues.) This has been raised with commissioners.
- Delayed Transfers of Care (DToC) in older adults in Calderdale and in adults have been subject to a great deal of activity and focus and has reduced as a result of the focus. Suitable onward accommodation remains a current pressure point in some areas.
- Sickness absence for the BDU has improved in 3 service lines. In the Rehab service line it has deteriorated slightly and is fully monitored but is mainly long term absence due to serious ill health.
- Perinatal Mental Health service continues to recruit to remaining vacancies. The workforce is nearly complete with the process of recruiting to the final positions underway.
- IAPT Kirklees/G Huddersfield. An NHS England (NHSE) review of the IAPT service commissioned for North Kirklees and Greater Huddersfield has been agreed in order to look at support needed in the system. The teams are undertaking weekly reviews of performance based on an agreed action plan with commissioners concerning access targets to treatment.
- The Adult Eating Disorders new community model is being developed across an STP footprint. SWYPT are actively engaged in developing the vision and Hub and Spoke model. A number of engagement and information meetings were held in Leeds, in October for staff to participate in and to contribute to the plans. A meeting with Trust clinicians and the Leeds project team is planned for 06/11/17.
- The BDU clinical leads are working to resolve medical staffing gaps for training grades. This is a Yorkshire wide capacity issue which means places are unfilled. We have had a number of Staff Grade and Consultant vacancies due to retirements and moves to other Trust posts. Recruitment is underway as well as creating acting up roles and increased sessions to fill in critical gaps.

Forensics BDU:

• Service Review – this work is continuing nationally. Further stakeholder event organised for mid-November. Our proposal for and LD Community Team across West Yorkshire was submitted. Further meeting arranged to pursue implementation by April 2018.

• Forensic CAMH services are working hard to develop the partnership agreements with other providers and supply an implementation plan to NHSE. Service due to commence November 2017. We have also been approached by NHSE to work with other Youth Offending Institute (YOI) providers (there are 4 nationally) to roll out Secure Stairs in the secure estate. This will involve potentially exploring a Lead provider or alliance contracting model to deliver this service which has attracted national funding.

• 25 Hours Activity-Significant improvements have been made in the delivery of 25hours meaningful activity. The service will continue to monitor this to ensure that improvements are embedded.

• Recruitment –The BDU has a robust and proactive recruitment programme and has successfully recruited 21 registered nurses recently. This has significantly reduced registered nurse vacancies to 7 across the BDU.

• The situation continues with regard to the graded response to request for leave from the Ministry of Justice (MOJ). This continues to remain a concern from clinicians regarding the impact on service user progress and satisfaction.

• Appraisal Figures and Cardio Pulmonary Resuscitation (CPR) training are key hotspots for the BDU. Requests for more training to be put in place to close the gap in CPR training have been submitted.

• Occupancy – currently at 85%.

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.

• Whilst appraisal completion is currently shown as being below target assurance has been provided at a service level the target has now been met.

CAMHS

• Further difficulties have been experienced in accessing Tier 4 beds, leading to use of beds on generic adult mental health wards (over 16 years only). Ward and CAMHS staff have worked closely to ensure the service offer is as safe and responsive as possible but the pressure on staffing levels and out of area placements must be noted.

• The business case progressed as part of the West Yorkshire STP has been approved subject to agreement of robust governance and risk sharing arrangements and pump-priming finance has now been released by NHSE. This will enable early (by Jan 2018) recruitment of 3 care navigators across the STP area. The role will facilitate more effective planning at the point of admission to, and discharge from, T4 beds.

• A proposal is being developed to establish all-age psychiatric liaison teams in Barnsley, Calderdale, Kirklees and Wakefield. The aim being to reduce the need for CAMHs on-call practitioner arrangements and improve responsiveness to crisis presentations of children and young people in A&E. The intention is to have a detailed proposal available for consideration/approval by end December 2017.

Learning Disability (LD)

• The 'At Risk of Admission Risk Register' has now been integrated within core management processes and is proving to be of significant benefit in ensuring a more coordinated response (including other providers, commissioners etc.) in meeting the needs of the most vulnerable service users.

• Service KPI reports as agreed through the LD transformation are now being flowed to commissioners. In 2017/18 these will be issued primarily to assure data quality and establish baseline performance standards.

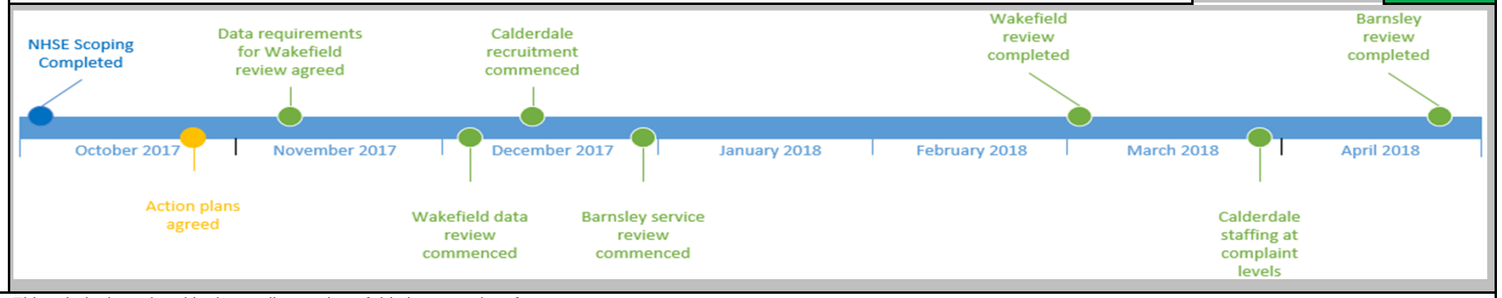
Wakefield BDU:

• Issues have been identified in relation to flow through of cases from Single Point of Access (SPA) to Core teams and how these are being recorded. This is impacting on the treatment within the 6 week target. This will be corrected and performance is expected to improve next month

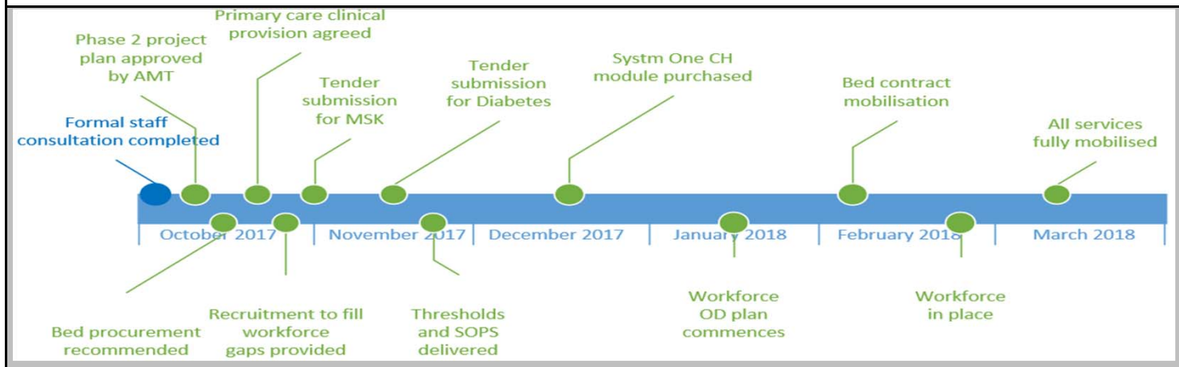
• There has been an increase in medical waiting times in Core East team. A new post holder is commencing next week and this position is expected to improve

• A dip in the Care Programme Approach (CPA) review performance has been identified. Work is on going to look at breaches and any data quality issues as this is an unusual variance. Performance against this indicator is usually particularly strong in the BDU.

Summary:
- New framework for reporting has commenced this month
- Major transformation and significant improvement priorities reported monthly. Other improvements are reported in this IPR bi-monthly
- All projects have defined scope
- Schedule for reporting of all priorities are in place

Priority	Scope	Update	Area	RAG
IMPROVING HEALTH				
Strategic Priority One: People First				
Enhancing Liaison Services	Transition to a new framework for liaison services. Identification of where current gaps in provision are and support development of plans for appropriate liaison services to support commissioner intentions to work towards CORE 24 compliance by 2020. Establishment of a benefits realisation framework to support the 3 year evaluation of the project.	• Each BDU has completed the submission of the NHSE liaison mental health assessment tool 2017, updating the Trusts position against key elements relating to liaison mental health and Core 24. • In Wakefield, recruitment to clinical posts continues and the new service is on target to commence from September 2017. Wakefield CCG have commissioned a review of Psychiatric Liaison Service and a task and finish group has been established. Work is ongoing to get the review data requirements finalised and data-sharing agreements organised. • In Calderdale steps have been taken to recruit workforce. • In all BDUs, steps will be taken to develop action plans.	Progress Against Plan	
		Risks are being managed and mitigated within the services	Management of Risk	
				
Improving People's Experience and Equalities	A structured approach to ensuring that we collect and act on patient experience feedback building upon our current strong foundations. We have identified five objectives for improvement during 2017/2018, including a programme to formally connect with other priority objectives.	This priority is updated in the quality section of this integrated performance report		
Recovery based approaches	Further develop a range of innovative initiatives which promote recovery focused approaches in order to meet the Trust mission, including: Co-produce an integrated recovery development plan Test new approaches to recovery, developing from what we learn in order to maximise effectiveness and impact Continue to build, support and sustain recovery work which has already been undertaken or is already planned	Progress on this priority is reported bi-monthly in the integrated performance report. The next scheduled update will be in December 2017.	Overall Priority Performance	N/A
Physical /Mental Health	Improve the physical health of people with mental health difficulties and the mental health of people with physical health difficulties	Progress on this priority is reported bi-monthly on the integrated performance report. The next scheduled update will be in December 2017.	Overall Priority Performance	N/A

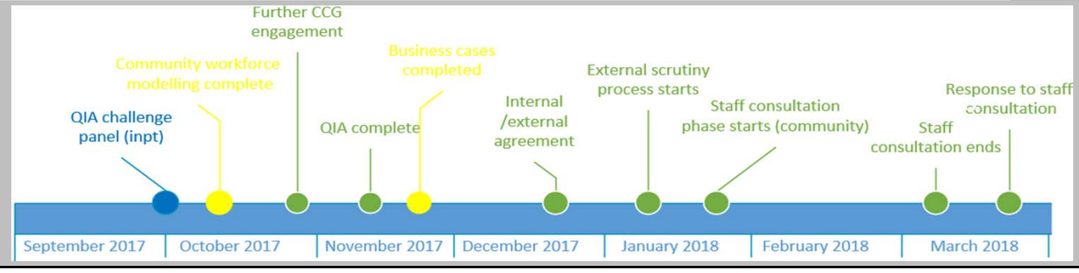
Strategic Priority Two: Joining up Care

Supporting place-based plans	Develop place based plans for each district which are part of the Trust Strategy	Discussed quarterly at Strategic Board and monthly updates to executive management team	Overall Priority Performance	N/A
Accountable Care in Barnsley and Wakefield	Work with partners as part of the development of accountable care systems. Influence the SWYPFT role in each ACO	Discussed quarterly at Strategic Board and monthly updates to executive management team	Overall Priority Performance	N/A
New models of care and vanguards Barnsley Intermediate Care, Respiratory, Diabetes and MSK	Work with partners to introduce new models of Care across SWYPFT footprint Barnsley Intermediate Care, Respiratory, Diabetes and MSK	• Barnsley CCG have stated their intention to re-procure Diabetes services in Barnsley with completion of the tender being November 2017. • Musculo-skeletal service tender has now been published with deadline of 1st November 2017. • Alliance contract for respiratory services commenced on 1st September 2017. The service, called Breathe, is managed on behalf of the Alliance by Barnsley Hospitals NHS Foundation Trust (BHNFT). • Respiratory nursing staff from SWYPFT have TUPE transferred into the new service. SWYPFT continue to provide Pulmonary Rehabilitation services and work is on going to refresh KPIs as part of the new contract. • Intermediate Care - governance structure is in place to manage the partnership project. Move of the two wards from Mount Vernon to BHNFT wards 35 and 36 has now taken place as an interim stepped approach towards implementation of the agreed new model of care prior to winter. Formal staff consultation has taken place. Owing to staff shortages and acuity of patients, the transition to one ward is taking longer than expected, placing greater pressure on the service. Daily reporting is in place to manage the situation. • The procurement of independent sector intermediate care bed provision has been halted. Spot purchase beds are in place as an interim measure. Within SWYPFT, work has commenced on mobilising the Neighbourhood Rehabilitation Team and Crisis Response Team elements of the Intermediate Care Service and formal staff consultation has taken place. • Registered Therapy investment is required in order to work towards seven day working in line with the rest of the service. SWYPFT is working with partners to fill workforce gaps.	Progress Against Plan	
		The Intermediate Care Service Partnership project team manages the risks and has produced a risk log on behalf of the Alliance which reports to the new models of care (NMOC) implementation group (and Alliance management team as appropriate) on a monthly basis.	Management of Risk	
				

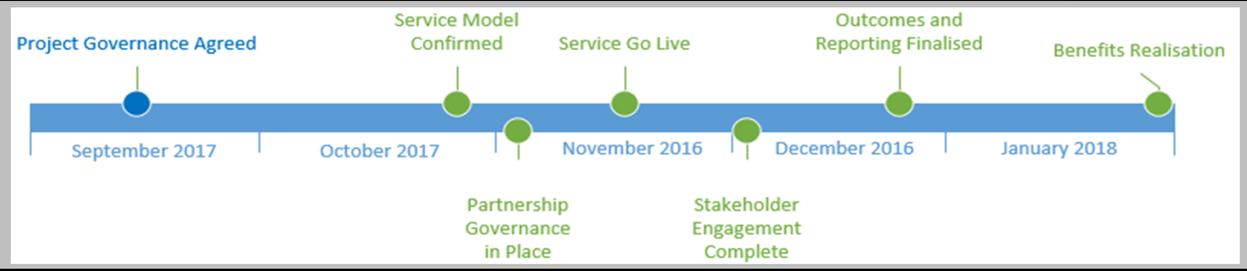
New models of care and vanguards Wakefield - care home vanguard and public health	Work with partners to introduce new models of Care across SWYPFT footprint Wakefield - care home vanguard and public health	• Vanguards being rolled out for NMoC and for Portrait of a Life (POAL) - training and support session on life story work and person centred care interventions have been provided to 6 of the care homes and the project is on track to meet KPIs • Wakefield connecting care Vanguard: Work is being undertaken to identify Wakefield governance structure and alignment of SWYPFT involvement.	Progress Against Plan	
		Risks are managed by the project which reports into the Holistic Assessment Team meeting as part of the Vanguard PMO on a monthly basis - there are no significant risks to date.	Management of Risk	
				

IMPROVING CARE

Strategic Priority Three: Quality Counts, Safety First

Patient Safety	Continue to implement the patient safety strategy including: Measuring and monitoring patient safety framework awareness & use in practice Establish a sustainable resource to support the roll out and continuing support for safety huddles. Develop a process and resources for considering human factors within incident review 'So what'… acting on learning from feedback	This priority is updated in the quality section of this integrated performance report		
Older People's transformation	Co-produce, develop and agree a new model of care for Older people with mental health difficulties that improves outcomes, experience and efficiency. To effectively implement this model and demonstrate the impact.	• A meeting is scheduled for 20 October to continue discussions and engagement with commissioners about proposed model including inpatient models. • The business case will then be complete and shared with EMT and partnership groups. • Workforce modelling workshops have been held. A first draft community workforce will be shared in October, then refined to support the community business case. • 1st draft standard operating procedures for the community model have now been received and work is ongoing to review and update. Work to commence shortly on inpatient SOPs. • Community Workforce model will be a key piece of work to enable the Trust to deliver the business case on time	Progress Against Plan	
		There is an ongoing risk of slippage in the project timescale due to limited capacity across the project and across the BDUs	Management of Risk	
				

Improving autism and ADHD	Address issues in relation to access and equity across these services. Work is occurring operationally internal to the Trust that will reflect developments through the West Yorkshire STP- yet to be developed	• Work is ongoing to finalise the detail for this priority • The integrated change team are supporting this work	Progress Against Plan	
		No known risks at this time	Management of Risk	
		Implementation plan in development		
Perinatal mental health	To implement the new service within the Trust. To evaluate the impact in terms of outcomes, experience and use of resources	• Service launched 01-09-17 (soft launch) • Full launch planned for December 2017 • Recruitment of remaining posts continues (2nd Psychiatrist, peer worker, Occupational Therapist) • Hub established at Fox view, Dewsbury • Trust-wide standard operating procedure now at final draft • Comms (internal) and development of service materials (leaflets etc.) • Multi-agency PMH Networks now established in all localities • Post-natal care plan developed • 17/18 spending plan reviewed with commissioners • Quality Standard Accreditation - Accreditation review visit in December 2017 • Commissioner review to be planned for 2018 to agree ongoing service funding	Progress Against Plan	
		Long term funding isn't received at the end of the NHS England funded phase. That we don't achieve performance targets – especially as performance targets are likely to evolve.	Management of Risk	
				
West Yorkshire work - CAMHS Tier 4	Work in this priority is focused on supporting Leeds Community Healthcare NHS Trust (LCH) as lead provider in the provision of Tier 4 CAMHS beds, led by Leeds Community Healthcare. Aim of the project is to improve access times. SWYPFT is a Partner in this contract together with Leeds and York Partnership NHS Foundation Trust and Bradford District Care NHS Foundation Trust Funding has been secured though STP NMoC workstream	• Initial draft business case to NHSE was produced on 4 August 2017. • Production of the final business case was scheduled for submission by 30 September 2017 but this has been delayed pending a review of NHSE funding for this new model of care. • Work continues in scoping the extent and role of Trust	Progress Against Plan	n/a
		Risk management has yet to commence for this priority as part of the planning phase for this new model of care	Management of Risk	n/a
		Implementation planning will be an integral part of the planning phase of this priority		
West Yorkshire work – Secure Adult MH	Forensics – Leading the work with other providers across Yorkshire and Humber	• 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. • Planning work is underway	Progress Against Plan	n/a
		Risk management has yet to commence for this priority as part of the planning phase for this new service	Management of Risk	n/a
		Implementation planning will be an integral part of the planning phase of this priority		

West Yorkshire work – Suicide prevention	Leading West Yorkshire STP wide work on zero suicides	This priority is updated in the Quality section of this integrated performance report		
West Yorkshire work Eating Disorders* (* added in year)	Eating Disorders- Provision of community treatment services for eating disorders across West Yorkshire lead by Leeds and York Partnership NHS Foundation	• Funding has been secured though STP NMoC workstream • Work near completion on the role of SWYPFT in the service • Governance arrangements now complete • Planning sessions timetabled to commence towards end of October	Progress Against Plan	
		No known risks at this time	Management of Risk	
		Implementation plan in development		
Quality priorities	Delivery of the quality priorities as set out in the Quality account	This priority is updated in the Quality section of this integrated performance report		
Community Forensic CAMHS	SWYPFT, as lead provider, to provide forensic CAMHS services across Yorkshire and Humberside in partnership with: Sheffield Children's Hospital; Tees, Esk and Wear Valleys FT and; Humber FT.	Work on the Community Forensic CAMHS project progresses well since award of the contract as lead provider was made by NHS England and the initial meeting with the national leads on 4th August 2017. Specific achievements in line with plan include: • Positive steering group meeting held with partners and commissioner on 15th September. Discussions conducted on the proposed model and how implementation of the model will be managed. • Implementation plan and supportive narrative finalised and submitted to NHSE. • Draft Memorandum of Upstanding (MoU) between partners drawn up • Workforce for initiation of project agreed. Interviews are planned for the 16th October for the Mental Health Practitioners. • Finances re-calculated with regard to changes in geographical coverage in North Lincolnshire and North East Lincolnshire • Implementation plan is still on track to commence accepting referrals into SPA by November 2017 with service fully in place by New year 2018.	Progress Against Plan	
		• There are currently no high level risks identified in this project. • Risk sharing agreements are being developed for the partnership	Management of Risk	
				

Strategic Priority Four: Compassionate Leadership				
Leadership development	Leadership and management strategy which includes development of an integrated change network	Progress on this priority is reported bi-monthly in the integrated performance report. The next scheduled update will be in November 2017.	Overall Priority Performance	N/A
Change and quality improvement	Develop and agree Quality Strategy which includes the Integrated Change Framework	Progress on this priority is reported bi-monthly in the integrated performance report. The next scheduled update will be in November 2017.	Overall Priority Performance	N/A
Membership	Develop an approach to membership which maximises the impact of members in key activities	Progress on this priority is reported bi-monthly in the integrated performance report. The next scheduled update will be in December 2017.	Overall Priority Performance	N/A

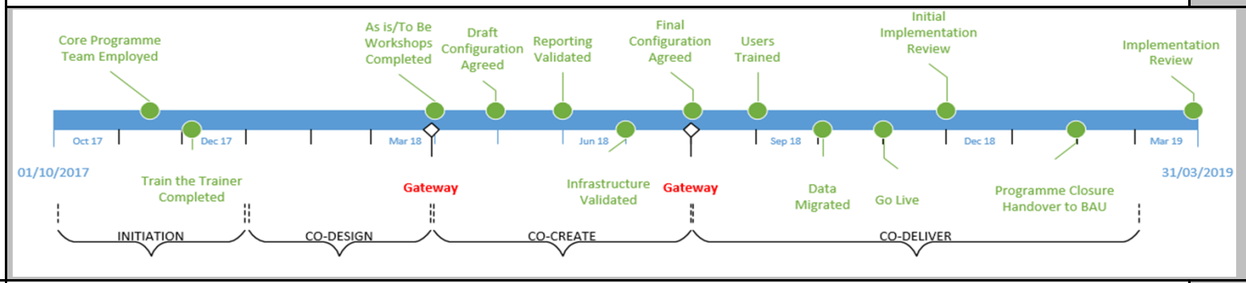
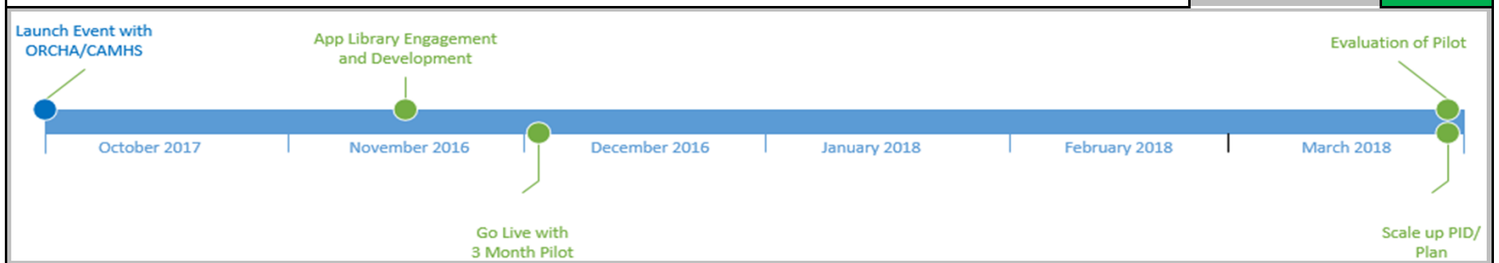
IMPROVING USE OF RESOURCES

Strategic Priority Five: Operational Excellence

Flow and out of area beds	Improve flow and reduce/eliminate use of out of area beds so that everyone is in the right bed including their own. This is part of the West Yorkshire STP workstream for acute inpatient shared bed base and development of PICUs. By March 2018 the Trust will have a shared bed base across West Yorkshire	• The two wards at Fieldhead are now open, increasing our capacity by eight acute male beds and four PICU beds. The PICU is now mixed gender. • In Calderdale the YHAHSN flow event has been postponed to January 2018 to support collection and analysis of data. A project team has met with a second meeting due mid-November 2017 • Outputs from the Out of Area bed summit are in progress: key areas for actions are reviewing service users with a long length of stay and people with repeat readmissions. P&I are producing data to support this work • An IHBT benchmarking exercise has taken place for Wakefield and Barnsley - some additional information is required to complete the data gathering so a report can be produced. • An STP wide acute mental health group has met, looking at acute services across West Yorkshire and how these can be developed to support an STP wide bed base. A priority area is PICU. • Performance & Information team have published a BETA version of an online trust wide bed use report, which is updated daily and shows total bed use by CCG, and where this use is.	Progress Against Plan	
		Current risk is that we continue to overspend on Out of Area Beds and people have to travel far for their care unless pressures on the system are reduced.	Management of Risk	
		A graphical timeline of the key milestones identified to end of March 2018 is being worked up. Planned activity for future reporting will include • Undertaking the IHBT benchmarking in Kirklees and Calderdale • Identifying key activities for the Intensive Home Based Treatment (IHBT) related work stream led by District Director for Barnsley and Wakefield. A meeting is scheduled for November 2017 to progress this. • Plan for addressing long lengths of stay and repeat admissions. A meeting is planned for 11 October to progress this. • Undertake an IHBT workforce analysis • Review senior medical decision-making around out of hours admissions • Review out of hours bed management functions		
Workforce – sickness, rostering, skill mix and agency	Effective management of workforce to increase effectiveness and efficiency. These are operational excellence projects to develop standards ways of working and increase efficiencies in areas of sickness, rostering and agency spend	This priority is updated in the Workforce section of this integrated performance report (IPR). Sickness absence performance is in the Summary section of the IPR under the heading 'Improve the use of Resources' and within the workforce section of the report performance is summarised for sickness absence; turnover and stability; and on the workforce performance wall.		
Effective use of supplies and resources	Effective use of non-pay money to support high quality care through effective use of resources	Progress on this priority is reported bi-monthly on the IPR. The next scheduled update will be in December 2017.	Overall Priority Performance	N/A
CQUIN	Deliver Trust CQUINS	This priority is updated in the Quality section of this integrated performance report		
Financial sustainability and CIP	Develop and deliver CIP	This priority is updated in the Finance and Contracts section of this integrated performance report		

Strategic Priority Six: Digital by Default

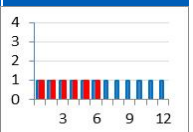
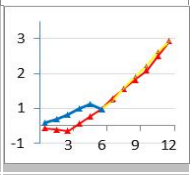
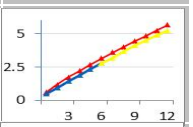
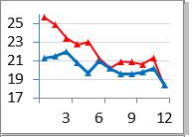
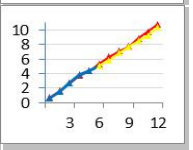
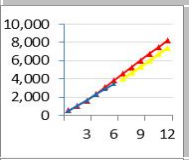
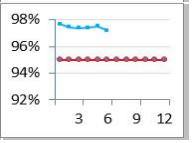
	Plan and deliver a new clinical record system which supports high quality care	• Second supplier led system demonstration delivered at Laura Mitchell Centre, Two other demonstrations scheduled for Barnsley and Dewsbury • 12 out of 15 team positions filled with five in post and a number awaiting imminent start dates • Contract detail being finalised, anticipate end of October 2017 to conclude • Engagement with individuals, management teams and groups continues	Progress Against Plan	

Clinical record system		High level risks being captured for analysis, reporting and management in project risk register and Datix	Management of Risk	
				
Digital health	Improve access to digital health opportunities. Identify our approach to supporting digital health developments. Increase digital clinical practice.	Digital health programme plan in place - several key actions and five discrete objectives identified including: • the i-hub challenge that has been launched • development of an horizon scanning framework which is in progress • the development of a digital change programme within our ICF which is in progress • development of a digital skills programme building capability in the ICT - in progress • ORCHA UK pilot with CAMHS and clinical services as identified. This ORCHA project is identified as a change project (the other four are serviced delivery initiatives) and as such has implementation plan in place and a milestones chart. We are in the process of co-designing the App Library/microsite and engaging with staff across CAMHS Trust wide. Whilst also exploring additional services who could test the license and prescribing functions of the website as there are 50 licenses available to pilot. • There are no financial costs associated with the three month pilot which will launch by 1st December. A scale up plan and PID will need to be developed to extend beyond the initial three month period, including our strategy for spread.	Progress Against Plan	
		ORCHA pilot - Limited capacity to engage with the extent of the App Library opportunity from Calderdale & Kirklees CAMHS (50 licenses available) Mitigation- extend Trust-wide and explore other prescribers who may use the 50 licenses alongside CAMHS e.g. YSF who have expressed an interest.	Management of Risk	
				
Data driven improvements and innovation	Increase the accessibility of good quality, easy to use data which informs improvement.	Progress on this priority is reported bi-monthly on the IPR. The next scheduled update will be in December 2017.	Overall Priority Performance	N/A

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

Overall Financial Performance 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 and use of resources risk rating is maintained at 1 for the 6 months to the end of September 2017. The individual I & E margin rating remains at 2 with an additional surplus of £620k required to achieve a rating of 1.	
2	Normalised Surplus (inc STF)	£0.5m	£2.4m	September 2017 finance performance excluding STF is a deficit of £232k. Including STF this is a deficit of £139k. This is below plan due to ongoing out of area bed costs and reduced income. Achievement of the full year control total represents a significant challenge.	
3	Agency Cap	£2.8m	£5.2m	Agency expenditure in September 2017 is broadly in line with previous months at £435k. This remains under the agency cap. Staffing pressures continue in a number of areas which may result in agency use to support activity and access.	
4	Cash	£21m	£18.4m	The cash position has improved in month bringing the Trust close to its plan (£0.2m below plan). Outstanding debts continue to be chased as part of Working Capital Management.	
5	Capital	£5m	£10.4m	During September the first phase of new Non Secure wards opened on the Fieldhead site and work is commencing on the next phase. Overall expenditure is slightly behind plan and schemes continue to be assessed against changing requirements.	
6	Delivery of CIP	£3.5m	£7.3m	Year to date CIP delivery is £357k behind plan. The forecast position is £0.9m 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 - Trust Board

Contracting Issues - General

A meeting was held in October with North Kirklees and Greater Huddersfield CCGs regarding Mental Health Five Year Forward View Investment. The new contract for Smoke Free Services in Sheffield commenced on 1 October 2017. SWYFT has been awarded the new contract for the provision of Smoke Free Services in Doncaster commencing 1 April 2018. The Integrated Health & Wellbeing Services contract for Rotherham, which includes Smoke Free Services currently provided by SWYPFT, has been awarded to Park Healthcare to commence 1 April 2018. 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. Contracts for 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 ASD Services for Adults. Key ongoing workstreams include the mobilisation and implementation of the expansion of IAPT 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

A meeting with Greater Huddersfield and North Kirklees CCGs was held in October to discuss Five Year Forward View investment and plans. 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

Contracting Issues - Wakefield

A key ongoing workstream includes the full implementation of the perinatal service across Barnsley, Wakefield, Calderdale and Kirklees. Transformation of CAMHs services remains a key priority and workstream with commissioners. The procurement for community TB services provision in Wakefield closed on 16 October 2017. Contract Award expected December 2017.

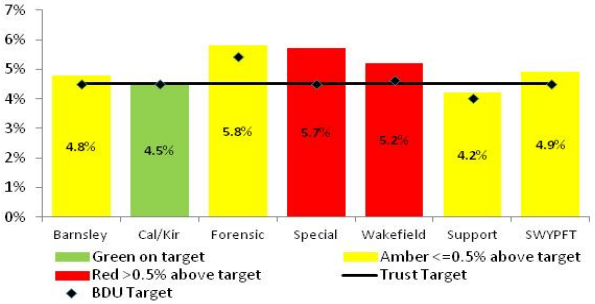
Contracting Issues - Forensics

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 and work has commenced with NHSE regarding mobilisation and contracting arrangements.

Contracting Issues - Other

The new contract for Smoke Free Services in Sheffield commenced on 1 October 2017. SWYPFT has been awarded the new contract for provision of Smoke Free services in Doncaster from April 2018. The Integrated Health & Wellbeing Services contract for Rotherham, which includes Smoke Free Services currently provided by SWYPFT, has been awarded to Parkwood Healthcare Ltd to commence 1 April 2018.

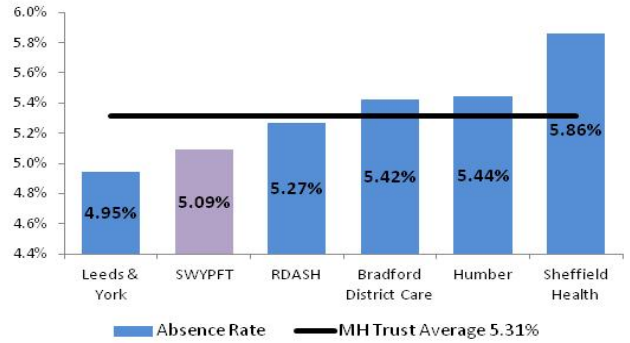
Sickness Absence



Current Absence Position - September 2017

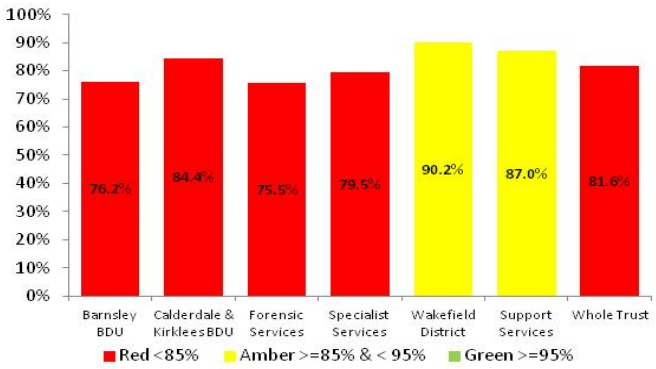
	Barn	Cal/Kir	Fore	Spec	Wake	Supp	SWYPFT
Rate	5.3%	4.6%	5.7%	6.2%	4.3%	3.5%	4.9%
Trend	↑	↓	↑	↑	↑	↓	↔

The Trust YTD absence levels in September 2017 (chart above) were above the overall 4.5% target at 4.9%.
The YTD cost of sickness absence is £2,919,313. If the Trust had met its target this would have been £2,697,517 saving £221,796.



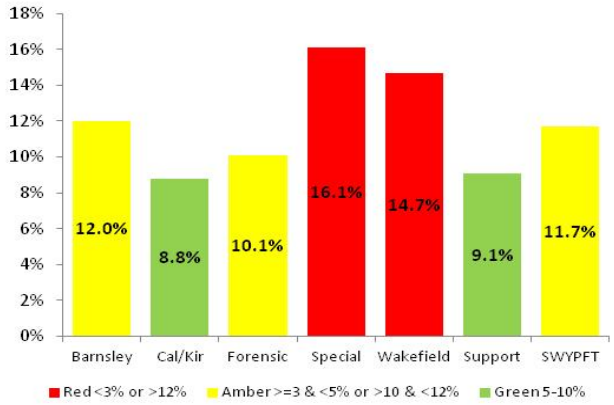
The above chart shows the YTD absence levels in MH/LD Trusts in our region for 12 months from March 2016 to April 2017.
During this time the Trust's absence rate was 5.09% which is below the regional average of 5.31%.

Appraisal Data - All Staff



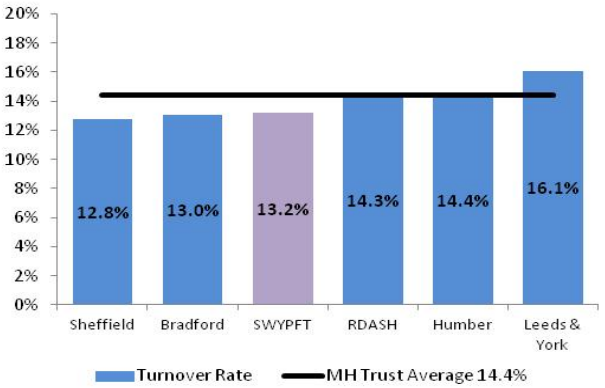
The above chart shows the appraisal rates for all staff for the Trust to the end of September 2017.
The appraisal target is 95% and over. For staff at Band 6 and above, all appraisals should be completed by the end of June and Band 5 and below, by end of September in each financial year.

Turnover and Stability Rate Benchmark



This chart shows the YTD turnover levels up to the end of September 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.

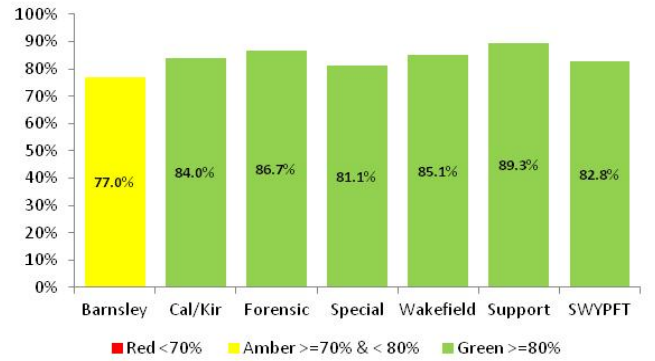
*Specialist Services figure excludes the transfer out of Supported Living (Barnsley)
Wakefield BDU have experienced some retirements.



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 September 2017. The Trust continues to achieve its 80% target for fire lecture training and only one area has dropped below the 80% target in September.

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	Sep-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%	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%	4.9%
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%	91.0%
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%	75.8%
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%	77.6%
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%	73.4%
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%	74.6%	77.3%	79.2%
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%	85.7%
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%	82.8%
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%	77.0%
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%	82.3%
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%	88.3%
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%	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%	87.6%
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%	81.6%
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%	86.3%
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%	84.8%
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%	94.2%
Bank Cost	Improving Resources	Well Led	AD	-	£486k	£458k	£477k	£505k	£493k	£722k	£398k	£457k	£579k	£576k	£518k	£614k
Agency Cost	Improving Resources	Effective	AD	-	£833k	£753k	£885k	£662k	£729k	£833k	£501k	£426k	£500k	£457k	£446k	£435k
Overtime Costs	Improving Resources	Effective	AD	-	£16k	£14k	£26k	£19k	£15k	£12k	£16k	£13k	£9k	£9k	£12k	£12k
Additional Hours Costs	Improving Resources	Effective	AD	-	£40k	£41k	£47k	£41k	£48k	£53k	£56k	£36k	£48k	£44k	£38k	£45k
Sickness Cost (Monthly)	Improving Resources	Effective	AD	-	£447k	£511k	£565k	£592k	£527k	£561k	£476k	£504k	£487k	£511k	£527k	£485k
Business Miles	Improving Resources	Effective	AD	-	328k	330k	316k	284k	287k	273k	289k	245k	285k	£299k	267k	283k

Workforce - Performance Wall cont…

Notes:

Mandatory Training
Green Compliance Status:
• Mental Health Act - 81.6% an increase on last month. Trust is currently developing eLearning refresher courses for MCA training. This will provide the resource for the refresher compliance requirement in the coming years
• Mental Capacity Act - 87.6%, this continues to increase each month. The Trust is currently developing eLearning refresher courses for MHA training. This will provide the resource for the refresher compliance requirement in the coming years
• Equality and Diversity - 85.7%%
• Fire Safety - 82.8% a slight increase on last month. There is now a 95% attendance requirement for ward staff that are likely to be involved in the direct evacuation of service users in the event of fire. This includes both clinical and non-clinical staff that are frequently based on wards
• Infection Control and Hand Hygiene - 82.3%
• Safeguarding Adults - 86.3%
• Safeguarding Children - 84.8%
• Sainsbury's Tool - 94.2%

Amber Compliance Status:
• Food Safety - 77% slight decline on last month. The Food Safety team are currently reviewing staff groups for Food Safety training and methods of training, which will aim to target training at staff groups according to their role
• Clinical Risk - 79.2% a further 2% 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) - 88.3% a 1% decline from last month.
• Aggression Management - 77.6% 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) is at 87.15% compliance
• Moving and Handling - 79.3% no change from last month
• Cardio Pulmonary Resuscitation - 73.4% a 1½% increase from last month.
The Team have considered how to address issues of low compliance and have introduced flexible start times. Training will continue to be provided in Barnsley, Halifax, Wakefield and Dewsbury. The Team are working with OMG and managers to 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.

Red Compliance Status:
There was no red compliance for any mandatory training subjects during September 2017

Workforce - Performance Wall cont…

Sickness
• The Trusts year to date position is 4.9%, which continues to be above the Trusts threshold.
• All BDUs with the exception of Barnsley and and Support Services saw a decrease in the monthly sickness position during September 17. Specialist BDU reported the highest level of sickness during the month (6.2%), which increases their year to date position to 5.7%. Forensic and Specialist Service (5.7%) 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.

Publication Summary

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

National Institute for Health and Care Excellence (NICE)
Intermediate care including reablement
This guideline sets out how health and social care staff can support people to be independent following a hospital stay or when daily life at home becomes too difficult. It covers how to assess intermediate care needs, including setting goals with the person so that they can overcome the problems they are experiencing.

Guidance

National Institute for Health and Care Excellence (NICE)
Smoking cessation interventions and services: guideline consultation
This draft guideline covers stop smoking interventions and services delivered in primary care and community settings. The recommendations focus on vulnerable groups who find it hard to quit or are heavy smokers. Feedback and comments are now being invited on this draft guideline and the accompanying documentation. The consultation closes on 1 November 2017.

Draft guideline

National Institute for Health and Care Excellence (NICE)
Transition between inpatient mental health settings and community or care home settings
This quality standard covers transitions for children, young people and adults between mental health hospitals and their own homes, care homes or other community settings. It includes the period before,
Standard

This section of the report identifies publications that may be of interest to the board and its members.

Childhood vaccination coverage statistics, England: 2016-17

NHS sickness absence rates: May 2017

Mixed sex accommodation breaches: August 2017

Direct access audiology waiting times: July 2017

NHS workforce provisional statistics: June 2017

NHS Improvement provider bulletin: 20 September 2017

Use of psychological therapies services, including reports on the integrated services pilot, England: June 2017

Psychological therapies: reports on the use of IAPT services, England, June 2017 final, including reports on the integrated services pilot

Provider bulletin: 27 September 2017 - includes application for NHS Leadership Academy's clinical executive fast track scheme

NHS Improvement provider bulletin: 4 October 2017 - includes consultation for oversight of NHS controlled providers, launch of improvement directors' network and six monthly data on reported patient safety incidents

Hospital admitted patient care activity, 2016-17

Estates Return Information Collection 2016/17

Mental Health Act statistics: annual figures 2016/17

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

Publication Summary

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

Monthly hospital activity data: August 2017

Early intervention in psychosis access and waiting time experimental statistics: August 2017

Diagnostics waiting times and activity: August 2017

Delayed transfers of care: August 2017

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

NHS Improvement provider bulletin: 11 October 2017

South West Yorkshire Partnership NHS Foundation Trust

Finance Report

Month 6 (2017/2018)

Appendix 1

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With **all of us** in mind.

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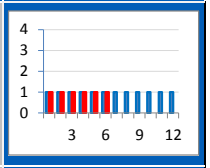
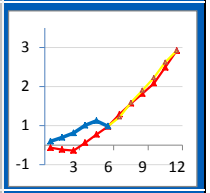
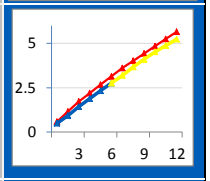
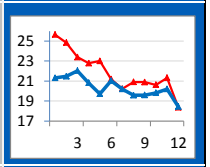
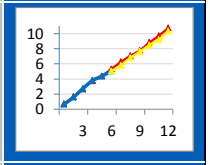
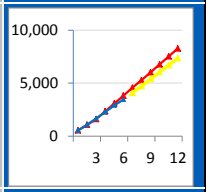
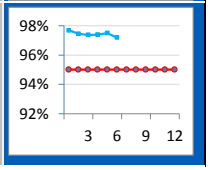
1.0 Executive Summary / Key Performance Indicators

Performance Indicator		Year to Date	Forecast	Narrative	Trend
1	NHS Improvement Finance Rating	1	1	The NHS Improvement financial and use of resources risk rating is maintained at 1 for the 6 months to the end of September 2017. The individual I & E margin rating remains at 2 with an additional surplus of £620k required to achieve a rating of 1.	
2	Normalised Surplus (inc STF)	£0.5m	£2.4m	September 2017 finance performance excluding STF is a deficit of £232k. Including STF this is a deficit of £139k. This is below plan due to ongoing out of area bed costs and reduced income. Achievement of the full year control total represents a significant challenge.	
3	Agency Cap	£2.8m	£5.2m	Agency expenditure in September 2017 is broadly in line with previous months at £435k. This remains under the agency cap. Staffing pressures continue in a number of areas which may result in agency use to support activity and access.	
4	Cash	£21m	£18.4m	The cash position has improved in month bringing the Trust close to its plan (£0.2m below plan). Outstanding debts continue to be chased as part of Working Capital Management.	
5	Capital	£5m	£10.4m	During September the first phase of new Non Secure wards opened on the Fieldhead site and work is commencing on the next phase. Overall expenditure is slightly behind plan and schemes continue to be assessed against changing requirements.	
6	Delivery of CIP	£3.5m	£7.3m	Year to date CIP delivery is £357k behind plan. The forecast position is £0.9m 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 6	
Area	Weight	Metric	Score	Risk Rating	Score	Risk Rating
Financial Sustainability	20%	Capital Service Capacity	3.0	1	3.1	1
	20%	Liquidity (Days)	16.9	1	13.0	1
Financial Efficiency	20%	I & E Margin	0.4%	2	0.4%	2
Financial Controls	20%	Distance from Financial Plan	0.0%	1	0.0%	1
	20%	Agency Spend	-11.9%	1	-12.1%	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.

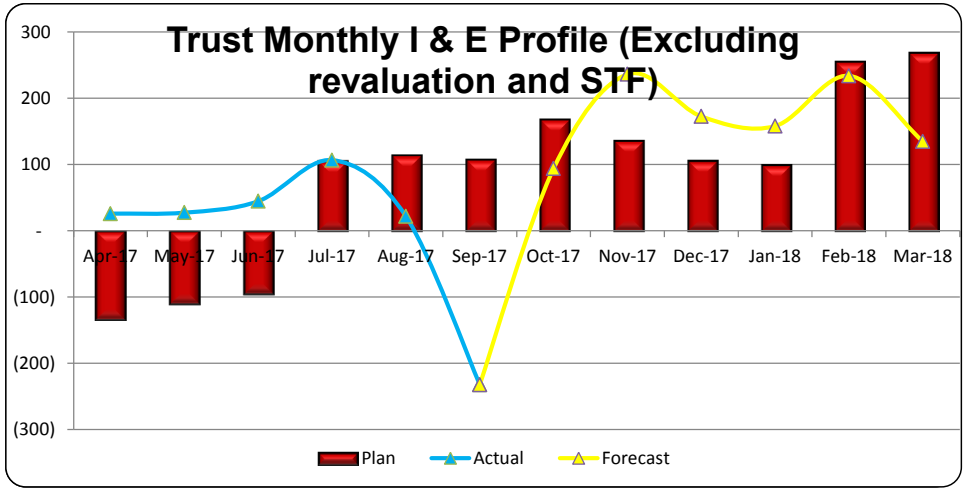
I & E Margin - the degree to which the organisation is operating at a surplus/deficit

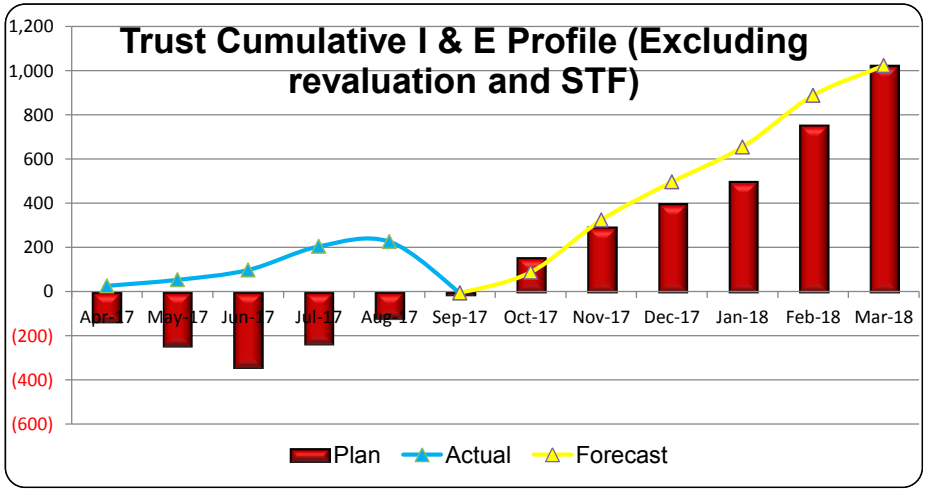
Distance from plan - variance between a foundation Trust's planned I & E margin and actual I & E margin within the year.

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**
				16,799	16,553	(246)	Clinical Revenue	103,040	102,415	(625)	205,515	202,382	(3,133)
				16,799	**16,553**	**(246)**	**Total Clinical Revenue**	**103,040**	**102,415**	**(625)**	**205,515**	**202,382**	**(3,133)**
				1,152	1,152	(1)	Other Operating Revenue	6,824	6,861	37	13,303	13,245	(58)
				17,951	**17,705**	**(246)**	**Total Revenue**	**109,864**	**109,276**	**(588)**	**218,818**	**215,627**	**(3,191)**
4,255	4,141	(114)	2.7%	(13,906)	(13,645)	261	Pay Costs	(85,250)	(83,208)	2,042	(169,843)	(167,088)	2,755
				(3,423)	(3,570)	(147)	Non Pay Costs	(20,278)	(21,117)	(840)	(40,412)	(42,612)	(2,201)
				255	76	(179)	Provisions	269	(182)	(451)	1,311	4,233	2,921
4,255	**4,141**	**(114)**	**2.7%**	**(17,075)**	**(17,139)**	**(64)**	**Total Operating Expenses**	**(105,258)**	**(104,507)**	**751**	**(208,943)**	**(205,467)**	**3,476**
4,255	**4,141**	**(114)**	**2.7%**	**877**	**566**	**(311)**	**EBITDA**	**4,606**	**4,768**	**162**	**9,875**	**10,160**	**284**
				(489)	(522)	(33)	Depreciation	(2,941)	(3,090)	(149)	(5,500)	(5,766)	(266)
				(283)	(279)	4	PDC Paid	(1,699)	(1,704)	(5)	(3,397)	(3,407)	(10)
				4	3	(1)	Interest Received	23	19	(4)	45	37	(8)
4,255	**4,141**	**(114)**	**2.7%**	**108**	**(232)**	**(340)**	**Normalised Surplus / (Deficit) Excl.STF**	**(11)**	**(6)**	**5**	**1,023**	**1,023**	**0**
				93	93	0	STF	488	488	0	1,394	1,394	0
4,255	**4,141**	**(114)**	**2.7%**	**201**	**(139)**	**(340)**	**Normalised Surplus / (Deficit) Incl SFT**	**477**	**482**	**5**	**2,417**	**2,417**	**0**
				0	0	0	Revaluation of Assets	0	0	0	0	0	0
4,255	**4,141**	**(114)**	**2.7%**	**201**	**(139)**	**(340)**	**Surplus / (Deficit)**	**477**	**482**	**5**	**2,417**	**2,417**	**0**





Income & Expenditure Position 2017 / 2018

Month 6 represents the first in month deficit of the financial year and results in an overall pre STF deficit for the period April to September 2017. Under these conditions delivery of the Trust financial control total remains extremely challenging.

Month 6

The September performance was disappointing with a deficit of £232k. Following five months of surplus the normalised year to date position is now a deficit of £6k excluding STF and a surplus of £482k including STF funding. This is £5k 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 (out of area beds and drug costs). Combined with a reduction in income this has led to the in-month deficit. STF has still been achieved however, as the year to date position remains marginally higher than plan.

Income

Provision continues to be made for under achievement of CQUIN income of £360k. A reduction in income in relation to Intermediate Care has been reflected in month 6. However the Trust is still incurring costs which exceed this level of income.

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 £461k a month. Expenditure maintained at this level would ensure that the Trust remains within the NHS Improvement cap. Bank expenditure has increased by £143k in September to £701k due to high acuity, sickness and cover during ward moves. The increased bank spend is not forecast to continue.

Non Pay Expenditure

September out of area bed spend was the highest of the year at £359k, taking the cumulative overspend to £904k. Drugs expenditure and clinical supplies such as dressings also remain pressures. These are currently being partly offset by non clinical spend areas such as travel or office costs and property.

Forecast

Full year forecast currently remains in line with plan, but there are a number of significant risks identified. These include out of area bed usage, CIP delivery, reduced service provision and CQUIN delivery. Mitigations are constantly considered and Accelerated depreciation of RiO to bring it in line with the transfer to the new Clinical Information System has created a pressure within depreciation. This has been partly offset by impairing inpatient wards at Mount Vernon.

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 contracts and therefore there is traditionally little variation to plan.

The budget values are reconciled against signed and agreed contracts with any movement highlighted. Budgets have been amended in month 6 for cessation of a pass through cost (both income and expenditure are no longer recognised within the Trust financial position) and a decommissioned service from February 2018.

The biggest income reduction and risk relates to changes in commissioned services with the largest linked to Intermediate Care in Barnsley. At this point in time the income for August and September for this service has not been fully agreed.

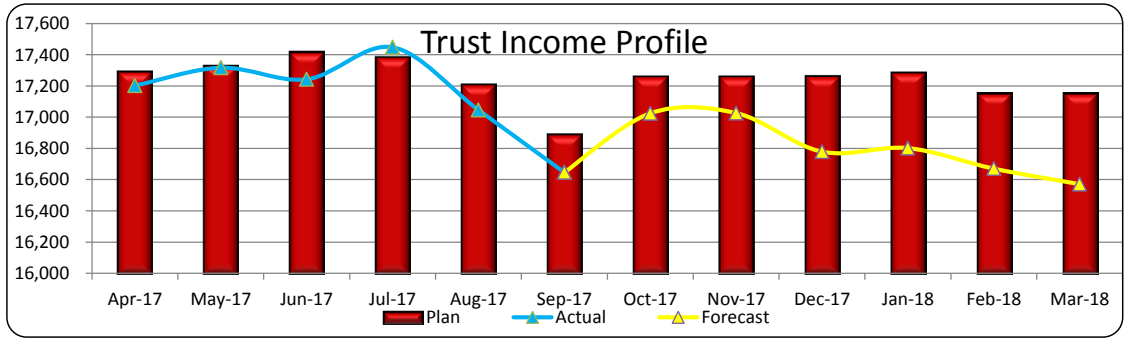
The income reduction in September is mainly a result of a one off adjustment to reflect changes to Barnsley social worker funding arrangements, income and costs will now sit within BMBC.

Further income risk relates to CQUIN as highlighted below. 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 risk reserve.

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

Commissioner	Year to Date Budget £k	Actual £k	Variance £k		Variance Headlines CQUIN £k	Other £k	Total £k
CCG	64,206	63,823	(382)		(360)	(22)	(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	19,535	19,474	(61)		0	(61)	(61)
Total	**103,040**	**102,415**	**(625)**	**0**	**(360)**	**(265)**	**(625)**

	Forecast Budget £k	Actual £k	Variance £k	Variance Headlines CQUIN £k	Other £k	Total £k
CCG	150,381	149,402	(979)	(856)	(123)	(979)
Specialist Commissioner	23,333	23,333	(0)	0	(0)	(0)
Alliance	13,712	11,270	(2,442)	0	(2,442)	(2,442)
Local Authority	4,732	4,732	0		0	0
Partnership	6,909	6,909	(0)	0	(0)	(0)
Other	6,448	6,736	288	0	288	288
Total	**205,515**	**202,382**	**(3,133)**	**(856)**	**(2,277)**	**(3,133)**



CQUIN Risk	YTD	Forecast
Wellbeing Improvement	0	136
STP Reserve	360	720
Total	**360**	**856**

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.

2.1 Pay Information

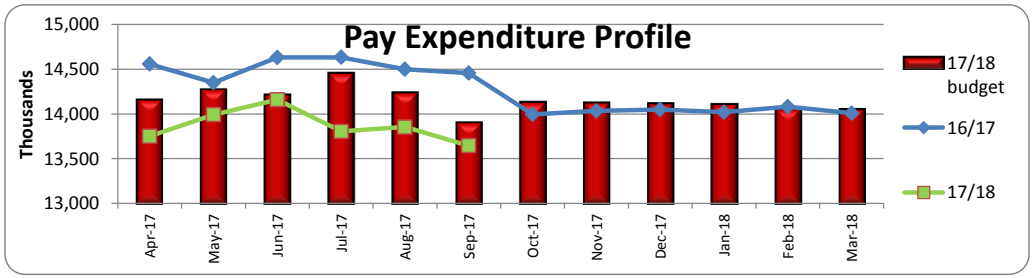
Our workforce is our greatest asset and one in which we continue to invest in ensuring that we have the right workforce in place to deliver safe and quality services. In total workforce spend accounts for circa 75% of total Trust expenditure.

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	12,509							**77,176**
Bank & Locum	411	472	620	505	558	701							**3,267**
Agency	501	426	500	457	446	435							**2,765**
Total	**13,752**	**13,992**	**14,161**	**13,804**	**13,854**	**13,645**	**0**	**0**	**0**	**0**	**0**	**0**	**83,208**
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%	5.1%							3.9%
Agency as %	3.6%	3.0%	3.5%	3.3%	3.2%	3.2%							3.3%

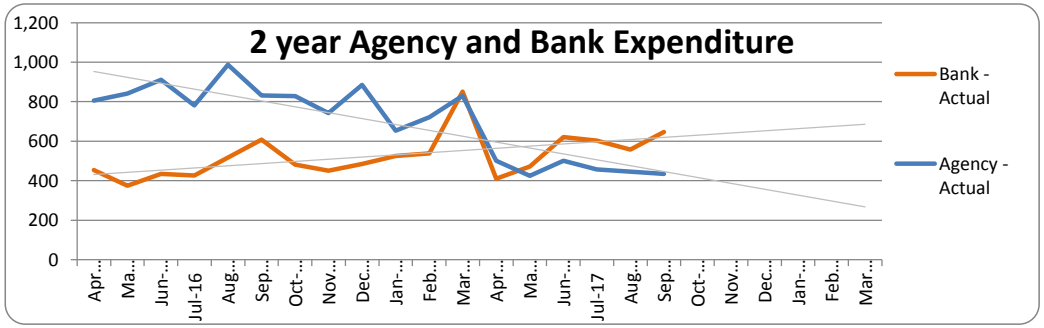
Year to Date expenditure - by staff group

	Substantive £k	Temp £k	Agency £k	Total £k
Medical	9,009	173	1,293	10,475
Nursing Registered	27,058	1,184	298	28,540
Nursing	8,927	1,378	635	10,939
Other	19,325	191	506	20,022
Admin	12,857	342	33	13,232
Total	**77,176**	**3,267**	**2,765**	**83,208**



Sept WTE Analysis

	Budgeted	Contracted	Bank	Agency	Variance
Medical	212	177	2	14	(19)
Qualified Nursing	1,439	1,278	66	12	(84)
Unqualified Nursing	681	656	116	43	134
Other Clinical	847	772	7	6	(62)
A & C	846	754	32	0	(61)
Other	337	304	7	2	(24)
Staff Vacancy Factor	(107)	0	0	0	107
Total	**4,255**	**3,940**	**229**	**78**	**(9)**



Key Messages

Both 2016/17 and 2017/18 have seen a focus on reducing agency staffing. The graph above shows the 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. The increase in Septembers bank costs is due to increased bed utilisation, acuity, higher sickness and additional staffing required to facilitate ward moves. It is worth noting that total pay costs of £13.6m in September were the lowest of the year so far. In part this is due to no longer recognising pay costs transferred to Barnsley Council.

2.1 Agency Expenditure Focus

Agency Spend is currently within the NHS Improvement agency cap.

Spend in September is £35k 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 are 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 especially 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.

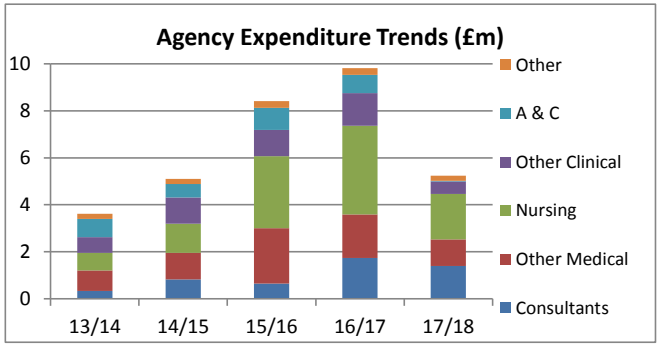
* Reduction in the hourly rate paid. In particular this relates to qualified nursing staff who are now all paid within the NHS Improvement capped rates. 11 out of 15 medical locums continue to be paid higher than the NHSI caps. These have been individually approved by the Trust Medical Director and are reported weekly to NHSI.

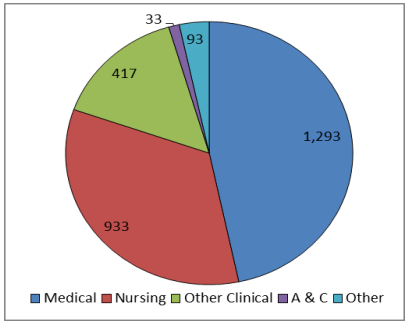
The weekly NHSI agency return is being expanded in October to also include collection of bank information.

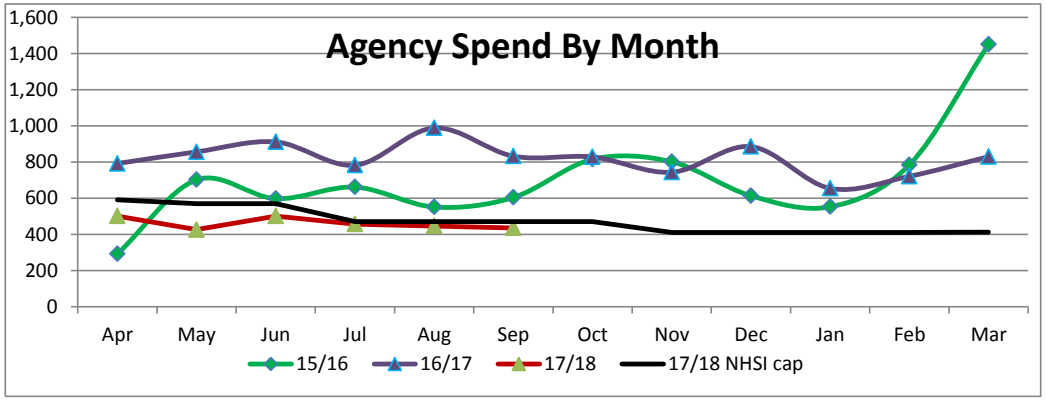
Across all agency categories spend has reduced on 2016 / 2017. YTD has reduced by £2.4m (46%).

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

When the agency cap reduces to £410k a month in November the month on month expenditure is forecast to exceed the cap. The YTD and forecast spend will remain below the cap. The forecast outturn at September is £0.4m below the full year cap.







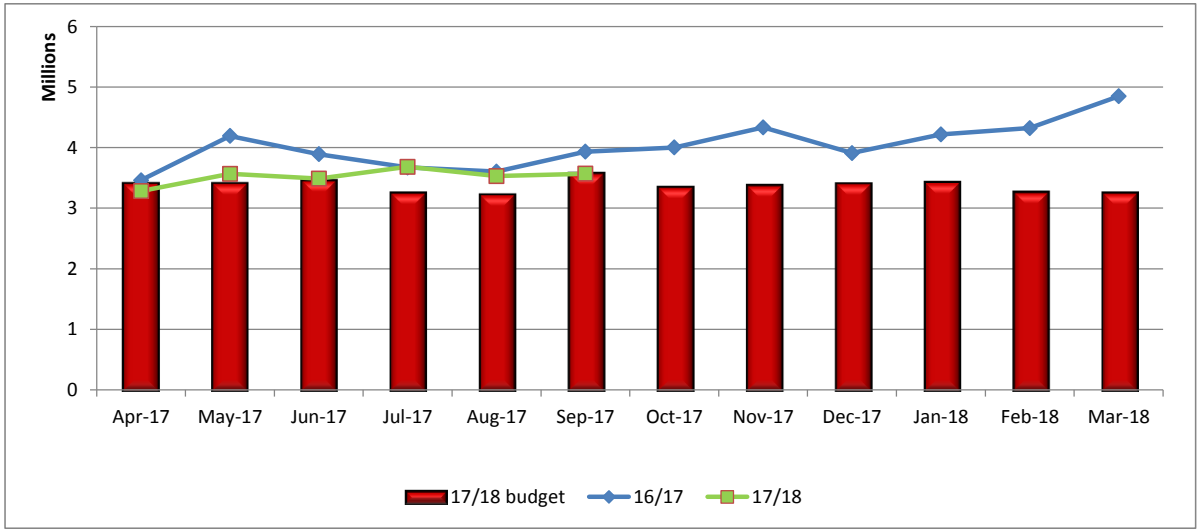
2.1 Non Pay Expenditure

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 £1.6m less than the same period in 2016 / 2017. This is driven by a number of key areas which are highlighted below. Excluding the impact of out of area and drugs a saving against plan of £615k has been achieved to date.

	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	3,570							**21,118**
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 YTD £k	Actual YTD £k	Variance £k
Clinical Supplies	1,521	1,717	(196)
Drugs	1,502	2,052	(551)
Healthcare subcontracting	1,756	2,660	(904)
Hotel Services	1,052	886	166
Office Supplies	2,102	2,038	64
Other Costs	2,296	2,042	254
Property Costs	3,112	3,007	105
Service Level Agreements	3,039	3,055	(16)
Training & Education	359	357	2
Travel & Subsistence	2,200	1,961	240
Utilities	567	557	10
Vehicle Costs	772	786	(14)
Total	**20,278**	**21,118**	**(840)**
Total Excl OOA and Drugs	**17,020**	**16,405**	**615**



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 efficiencies.

Central funding of Microsoft licences ceased in June creating a pressure of £433k in the year.

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 (£)

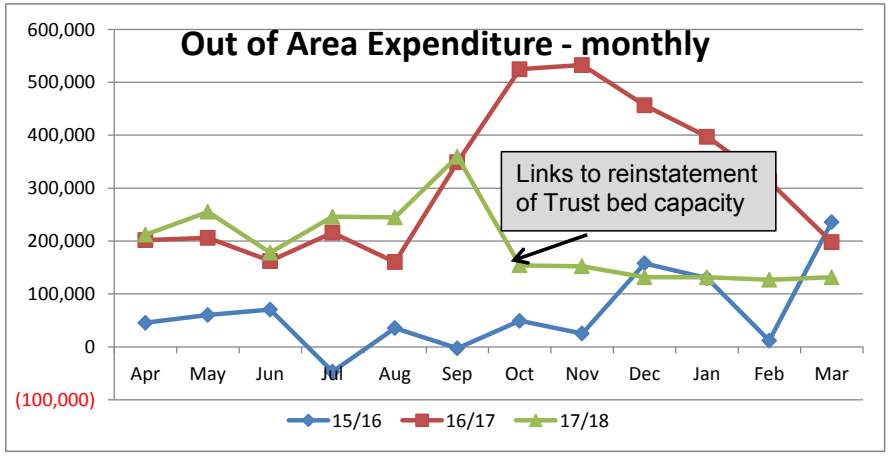
	Apr £000	May £000	Jun £000	Jul £000	Aug £000	Sep £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	Mar £000	Total £000
15/16	46	60	71	(47)	36	(3)	49	25	158	130	12	236	**772**
16/17	202	206	162	216	160	349	525	533	457	397	313	198	**3,718**
17/18	212	255	178	246	245	359							**1,496**

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	429							**2,055**

Bed Day Information 2017 / 2018 (by category)

PICU	198	176	168	169	213	217							**1,141**
Acute	84	170	85	178	148	182							**847**
Gender	0	0	0	0	30	30							**60**



Expenditure on Out of Area placements increased significantly during 2016 / 2017 but through continued action usage did reduce in Quarter 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.

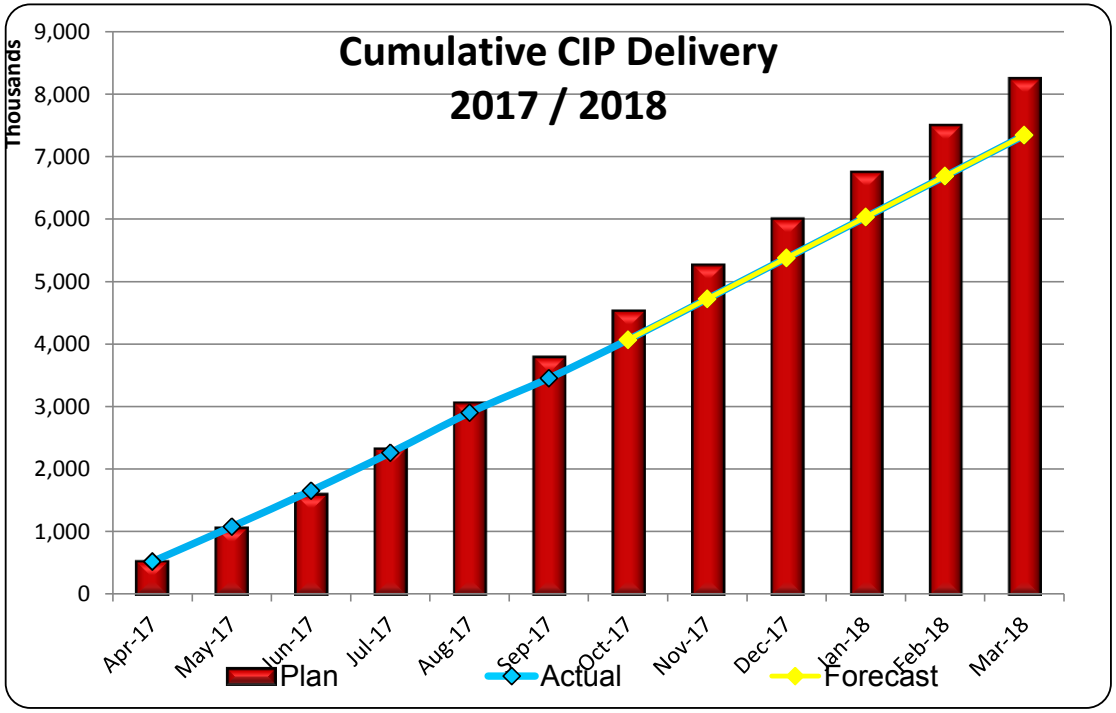
Demand, and expenditure has increased again and September is the highest month for the year to date. Work continues through the Project Board to ensure that this is minimised. Future costs are forecast to reduced from Quarter 3 as the Trust bed capacity is reinstated with the opening of the first unit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

The year to date overspend is £904k.

The Trust is still awaiting final settlement of the insurance claim relating to the fire at Fieldhead. This has now been agreed and payment is expected imminently.

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	3,809	8,262
Delivery as originally planned	401	809	1,272	1,769	2,261	2,744	3,239	3,753	4,266	4,780	5,294	5,808	2,744	5,808
Mitigations - Recurrent & Non-Recurrent	116	266	378	490	639	708	829	971	1,112	1,253	1,394	1,535	708	1,535
Total Delivery	**516**	**1,075**	**1,650**	**2,259**	**2,900**	**3,452**	**4,068**	**4,723**	**5,378**	**6,033**	**6,688**	**7,343**	**3,452**	**7,343**
Variance	(20)	1	40	(82)	(172)	(357)	(478)	(560)	(642)	(735)	(827)	(919)	(357)	(919)



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 delivered.

Savings identified against the Cost Improvement Programme total £3.5m to date. This is £357k behind plan. The majority (79%) has been delivered in line with original savings plans.

Schemes relating to income are forecast to fully achieve the plan, BDU workforce changes are forecast to deliver 92% of plan, admin and management schemes are forecast to deliver 89% of plan.

Task and Finish groups, including e-rostering and non pay review, continue and as new savings are identified they will be captured in this report.

3.0 Balance Sheet 2017 / 2018

	2016 / 2017 £k	Plan (YTD) £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	111,199	114,217	113,165	1
Current Assets				
Inventories & Work in Progress	166	215	166	
NHS Trade Receivables (Debtors	2,138	2,299	1,894	2
Other Receivables (Debtors)	8,289	7,457	7,839	3
Cash and Cash Equivalents	26,373	21,193	21,031	4
Total Current Assets	**36,966**	**31,164**	**30,930**	
Current Liabilities				
Trade Payables (Creditors)	(7,213)	(6,634)	(4,172)	5
Capital Payables (Creditors)	(1,157)	(752)	(459)	5
Accruals	(9,912)	(10,757)	(11,013)	6
Deferred Income	(754)	(950)	(710)	
Total Current Liabilities	**(19,036)**	**(19,093)**	**(16,355)**	
Net Current Assets/Liabilities	**17,929**	**12,071**	**14,575**	
Total Assets less Current Liabilities	**129,128**	**126,288**	**127,740**	
Provisions for Liabilities	(7,550)	(6,763)	(7,207)	
Total Net Assets/(Liabilities)	**121,578**	**119,525**	**120,533**	
Taxpayers' Equity				
Public Dividend Capital	43,665	43,665	43,665	
Revaluation Reserve	18,766	18,413	17,239	
Other Reserves	5,220	5,220	5,220	
Income & Expenditure Reserve	53,928	52,227	54,410	7
Total Taxpayers' Equity	**121,578**	**119,525**	**120,533**	

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. In September the service provided from 2 Mount Vernon wards was transferred to another Trust. As such these wards are now vacant and were impaired resulting in a reduction in value of the Trust asset base.

2. There has been some success in-month reducing the level of aged debtors.

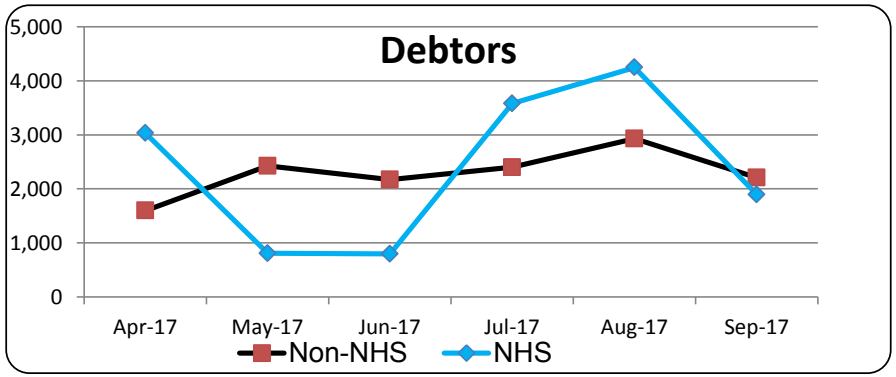
3. Other debtors remain slightly higher than planned, including £1.0m from Locala(reduced by £0.6m), £0.1m from PSS. Further payments have been received in October 2017 and all debts continue to be chased by the team.

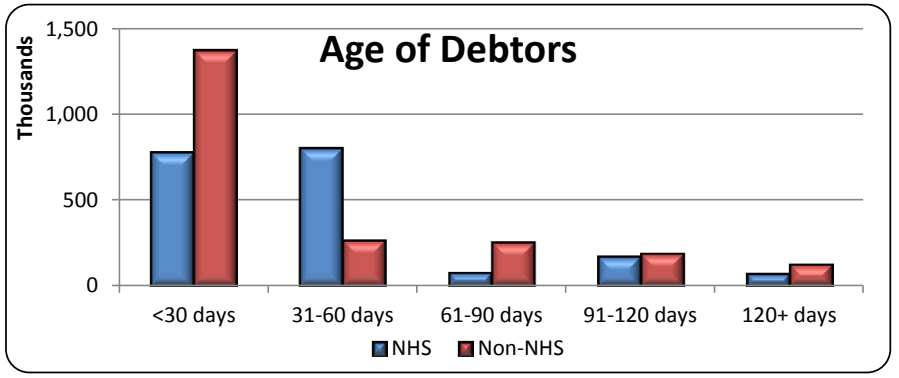
4. The reconciliation of actual cash flow to plan compares the current month end position to the annual plan position for the same period. This is shown on page 17.

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

6. Accruals are higher than planned.

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

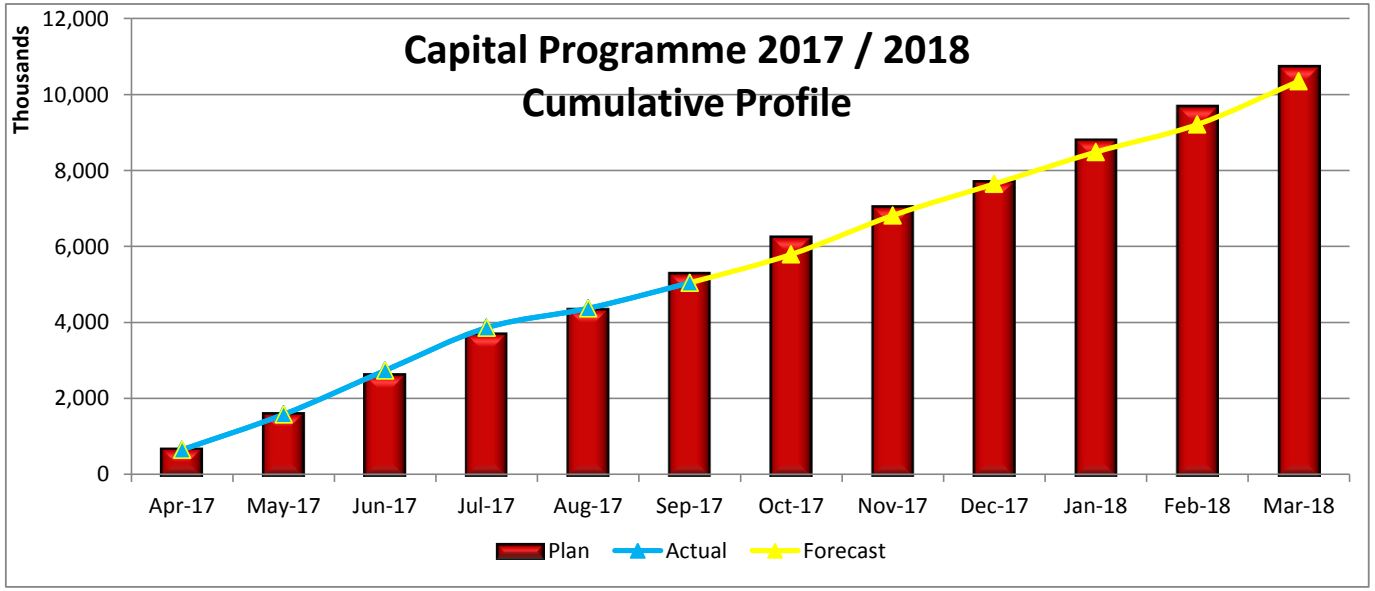




3.1 Capital Programme 2017 / 2018

	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	838	391	(447)	1,597	39	3
Equipment Replacement	44	44	35	(9)	44	(1)	
IM&T	2,121	791	400	(391)	1,992	(129)	
Major Capital Schemes							
Fieldhead Non Secure	7,030	3,654	4,256	602	6,757	(273)	2
VAT Refunds	0	0	(37)	(37)	(37)	(37)	
TOTALS	**10,753**	**5,327**	**5,044**	**(282)**	**10,352**	**(401)**	1

Spend remains marginally behind plan for the year to date. Schemes are continually reviewed to ensure value for money.



Capital Expenditure 2017 / 2018

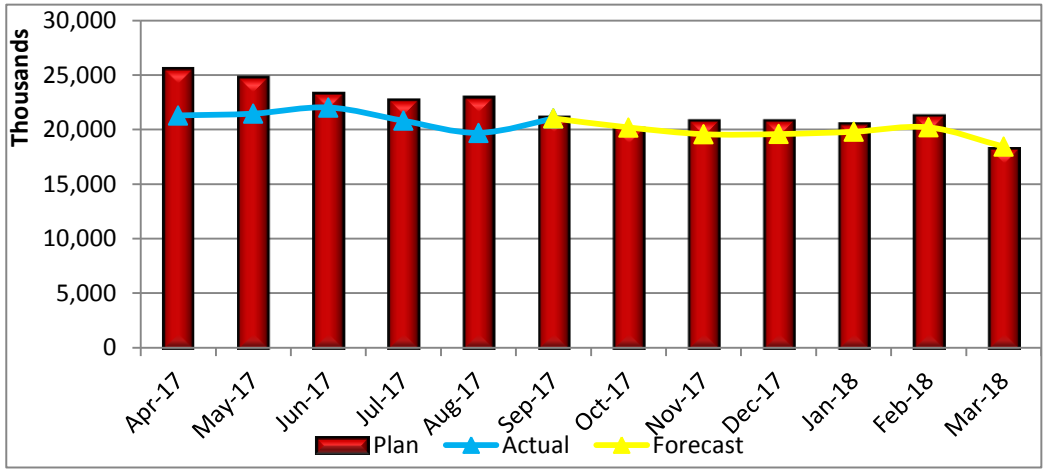
1. The year to date position is £282k lower than plan (5%). Excluding the benefit arising from successful VAT recovery agreed with HMRC this is £320k lower than plan.

2. Phase 1 is complete and the new wards operational. Demolition of Trinity will be completed by the end of November 2017.

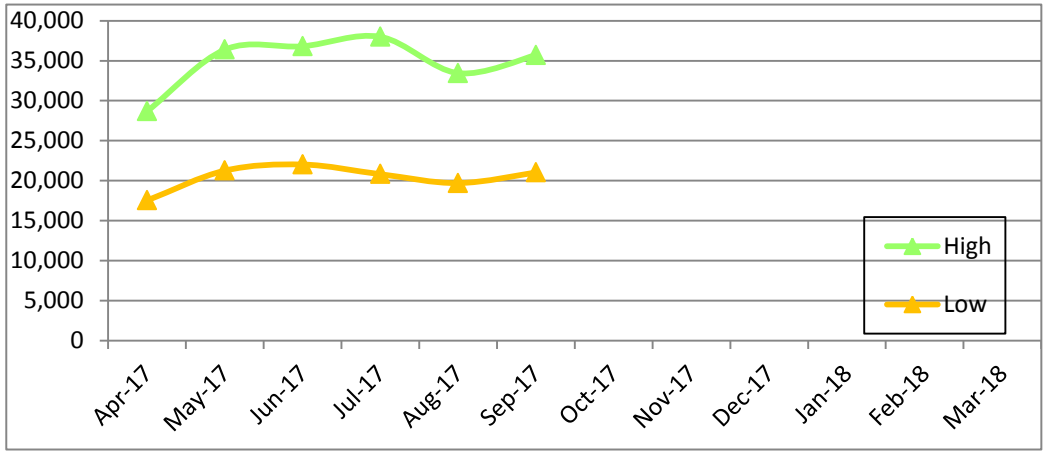
3. Minor works are being reviewed to take account of new works needed to vacate Mount Vernon.

4. The forecast capital expenditure for the full year is currently being reviewed.

3.2 Cash Flow & Cash Flow Forecast 2017 / 2018



	Plan £k	Actual £k	Variance £k
Opening Balance	25,495	26,373	
Closing Balance	21,193	21,031	(162)



Actions in September 2017 have brought the cash position back in line with plan. These continue so as to improve the position further. Cash improved by £3m from last month.

In month the team have proactively reduced the value of debtors ensuring that the cash position is maximised.

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

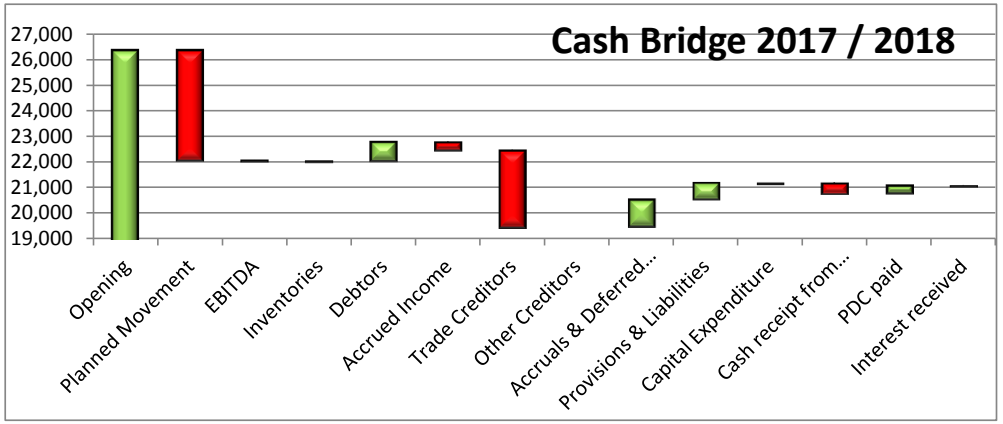
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is:	£35.7m
The lowest balance is:	£21m

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)	5,201	5,175	(26)	5
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	(500)	252	752	2
Accrued Income / Prepayments	(1,002)	(1,326)	(324)	6
Trade Payables (Creditors)	0	(2,993)	(2,993)	7
Other Payables (Creditors)	0	0	0	
Accruals & Deferred income	0	1,058	1,058	3
Provisions & Liabilities	(1,000)	(343)	657	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(5,327)	(5,743)	(416)	
Cash receipts from asset sales	0	310	310	4
PDC Dividends paid	(1,698)	(1,751)	(53)	
PDC Dividends received			0	
Interest (paid)/ received	24	19	(5)	
Closing Balances	**21,193**	**21,031**	**(162)**	



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. Debtors are lower than plan. Successful action was taken in month to collect old and high debt.

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. Surplus position, and that specifically related to cash, is marginally lower than planned.

6. Accrued income continues to be higher than plan. The majority of this relates to CQUIN payments (200k) still to be agreed.

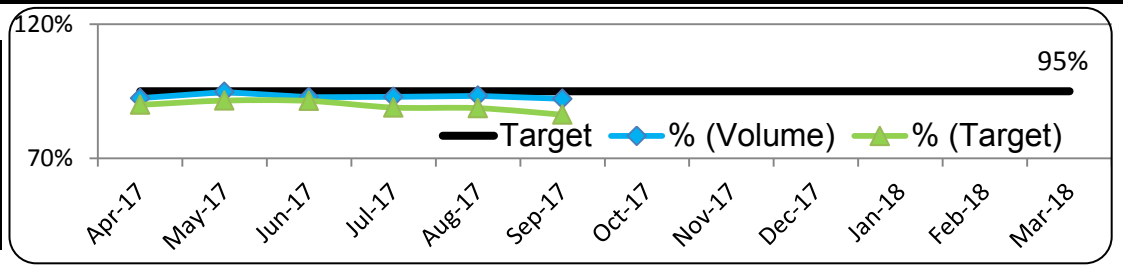
7. Creditors are lower than planned. Invoices are paid in line with the Trust Better Payment Practice Code.

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

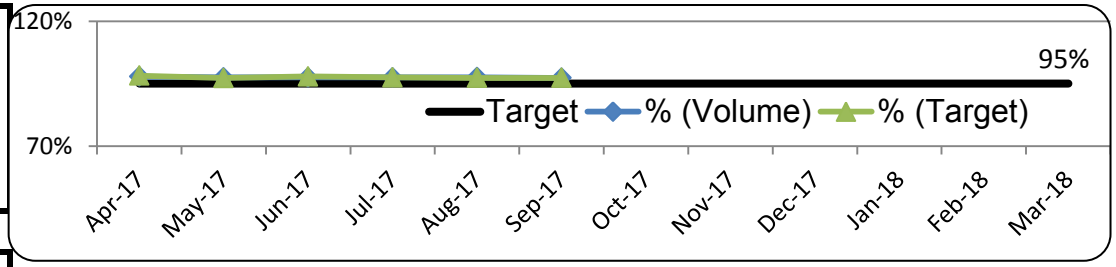
4.0 Better Payment Practice Code

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.

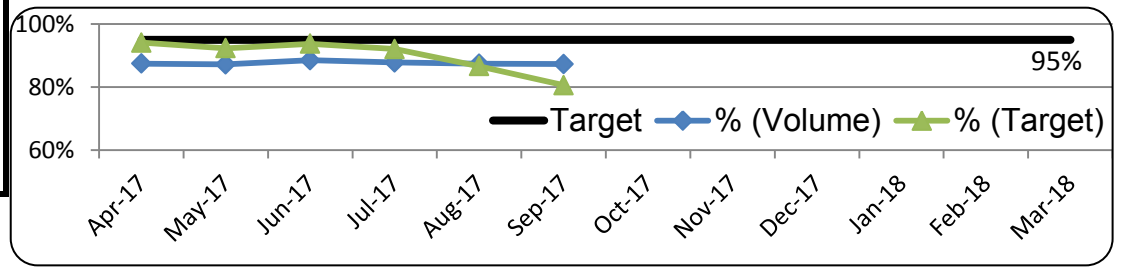
NHS	Number %	Value %
Year to August 2017	93%	89%
Year to September 2017	92%	86%



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



Local Suppliers (10 days)	Number %	Value %
Year to August 2017	87%	87%
Year to September 2017	87%	81%



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 (£)
04-Sep-17	Property Rental	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	3045694	212,219
11-Jul-17	Pharmacy SLA	Wakefield	Mid Yorkshire Hospitals NHS Trust	3040980	182,666
21-Aug-17	Property Rental	Barnsley	Barnsley Metropolitan Borough Council	3044703	147,662
28-Jul-17	Pharmacy SLA	Wakefield	Mid Yorkshire Hospitals NHS Trust	3042606	105,558
21-Aug-17	Drugs FP10´s	Trustwide	NHSBSA Prescription Pricing Division	3044593	67,380
25-Jul-17	Drugs FP10´s	Trustwide	NHSBSA Prescription Pricing Division	3042223	52,573
14-Sep-17	CNST contributions	Trustwide	NHS Litigation Authority	3047106	47,581
01-Aug-17	Staff Recharge	Trustwide	Leeds and York Partnership NHS FT	3042790	36,878
17-Jul-17	Staff Recharge	Trustwide	Leeds and York Partnership NHS FT	3041570	36,454
05-Sep-17	Property Costs	Trustwide	Mid Yorkshire Hospitals NHS Trust	3045904	31,010
04-Sep-17	Staff Recharge	Trustwide	Leeds and York Partnership NHS FT	3045711	25,341

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	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.30%	4.40%	4.50%	4.60%	4.70%	4.80%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	4.30%	4.50%	4.60%	5.00%	5.20%	5.30%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	7.00%	24.00%	70.30%	82.70%	84.60%	86.10%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	3.20%	8.20%	25.00%	39.90%	50.30%	70.70%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	77.50%	71.90%	81.70%	78.40%	80.00%	78.40%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	81.90%	79.10%	78.20%	78.00%	74.70%	76.40%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	76.00%	74.70%	79.10%	82.70%	84.30%	86.60%
Equality and Diversity	Resources	Well Led	AD	>=80%	88.20%	88.50%	89.00%	89.70%	89.70%	88.90%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	78.80%	80.80%	79.80%	78.30%	77.20%	77.00%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	77.50%	76.10%	73.30%	69.30%	67.10%	63.30%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	86.40%	87.10%	87.10%	85.50%	84.50%	81.60%
Information Governance	Resources	Well Led	AD	>=95%	91.30%	89.80%	89.60%	88.00%	85.40%	84.30%
Moving and Handling	Resources	Well Led	AD	>=80%	83.10%	81.90%	82.30%	82.70%	82.60%	82.50%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	89.50%	89.30%	86.50%	86.90%	85.60%	85.80%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	88.00%	86.50%	86.50%	86.10%	85.80%	85.60%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	94.70%	94.60%	93.90%	94.90%	96.00%	95.50%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	54.60%	56.90%	64.30%	73.60%	76.50%	79.40%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	44.60%	41.20%	55.60%	64.10%	68.00%	71.80%
Agency Cost	Resources	Effective	AD		£92k	£109k	£118k	£109k	£84k	£71k
Overtime Costs	Resources	Effective	AD		£7k	£3k	£4k	£2k	£3k	£3k
Additional Hours Costs	Resources	Effective	AD		£32k	£20k	£21k	£22k	£21k	£21k
Sickness Cost (Monthly)	Resources	Effective	AD		£124k	£136k	£136k	£159k	£164k	£167k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		111.33	108	113.58	111.16	110.21	108.86
Business Miles	Resources	Effective	AD		108k	91k	97k	104k	96k	98k

Calderdale and Kirklees District

Month	Objective	CQC Domain	Owner	Threshold	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.20%	4.20%	4.30%	4.40%	4.50%	4.50%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	4.20%	4.20%	4.50%	4.50%	5.10%	4.60%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	3.00%	14.90%	52.80%	81.20%	89.10%	92.60%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	0.80%	2.50%	8.60%	21.70%	40.50%	78.00%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	74.30%	72.30%	73.90%	74.20%	75.90%	77.40%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	75.20%	75.40%	77.30%	72.80%	70.10%	70.90%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	72.40%	71.30%	73.10%	79.20%	80.60%	81.30%
Equality and Diversity	Resources	Well Led	AD	>=80%	86.20%	84.50%	82.00%	82.50%	83.00%	82.00%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	81.10%	80.50%	79.40%	82.70%	84.40%	84.00%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	79.60%	78.30%	79.20%	77.70%	80.90%	79.60%
Infection Control and Hand Hygiene	Quality & Experience	Well Led		>=80%	78.00%	78.80%	80.20%	79.90%	80.50%	80.50%
Information Governance	Resources	Well Led	AD	>=95%	92.80%	92.60%	90.70%	91.00%	90.80%	90.40%
Moving and Handling	Resources	Well Led	AD	>=80%	79.30%	76.10%	76.00%	75.40%	74.00%	76.00%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	87.40%	86.80%	85.40%	83.00%	82.80%	82.90%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	83.00%	82.80%	80.60%	78.90%	78.00%	79.00%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	95.50%	93.30%	93.30%	95.60%	95.40%	95.70%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	61.10%	75.40%	83.30%	88.10%	89.50%	90.60%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	52.30%	67.10%	77.60%	84.00%	85.00%	86.30%
Agency Cost	Resources	Effective	AD		£76k	£61k	£79k	£58k	£84k	£65k
Overtime Costs	Resources	Effective	AD		£3k	£3k	£1k	£2k	£2k	£6k
Additional Hours Costs	Resources	Effective	AD		£1k	£-2k	£2k	£3k	£0k	£1k
Sickness Cost (Monthly)	Resources	Effective	AD		£91k	£91k	£97k	£98k	£117k	£103k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		85.41	75.52	71.45	80.1	88	89.58
Business Miles	Resources	Effective	AD		62k	58k	68k	69k	54k	68k

Appendix - 2 - Workforce - Performance Wall cont…

Forensic Services

Month	Objective	CQC Domain	Owner	Threshold	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Sickness (YTD)	Resources	Well Led	AD	<=5.4%	7.00%	6.20%	5.90%	5.70%	5.80%	5.80%
Sickness (Monthly)	Resources	Well Led	AD	<=5.4%	7.00%	5.50%	5.10%	5.40%	6.20%	5.70%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	10.30%	21.20%	63.30%	93.20%	93.50%	93.50%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	1.70%	7.40%	29.60%	39.30%	45.00%	70.40%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	85.80%	85.30%	87.40%	84.30%	82.30%	84.10%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	68.30%	74.00%	73.30%	75.10%	77.60%	77.40%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	54.70%	65.00%	71.00%	73.50%	75.60%	75.30%
Equality and Diversity	Resources	Well Led	AD	>=80%	89.20%	86.60%	85.90%	87.70%	87.70%	84.20%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	85.90%	83.40%	86.20%	86.20%	84.20%	86.70%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	89.20%	88.30%	88.80%	90.00%	90.00%	87.20%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	81.70%	84.90%	86.70%	87.70%	86.70%	85.70%
Information Governance	Resources	Well Led	AD	>=95%	91.50%	92.70%	92.30%	91.40%	88.40%	88.80%
Moving and Handling	Resources	Well Led	AD	>=80%	84.90%	82.90%	84.10%	85.20%	85.20%	85.00%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	92.30%	91.70%	90.50%	90.60%	89.90%	88.80%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	88.40%	87.90%	85.70%	84.00%	86.20%	84.50%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	75.00%	51.70%	64.50%	70.00%	70.00%	69.00%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	65.70%	70.70%	84.10%	85.40%	90.40%	89.30%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	56.00%	61.90%	77.50%	79.30%	86.00%	82.50%
Agency Cost	Resources	Effective	AD		£58k	£54k	£46k	£43k	£51k	£68k
Overtime Costs	Resources	Effective	AD		£0k	£0k		£0k	£6k	£0k
Additional Hours Costs	Resources	Effective	AD		£2k	£2k	£4k	£3k	£3k	£5k
Sickness Cost (Monthly)	Resources	Effective	AD		£63k	£51k	£47k	£48k	£55k	£50k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		49.29	47.49	48.04	55.16	48.61	40.43
Business Miles	Resources	Effective	AD		8k	5k	5k	5k	6k	9k

Specialist Services

Month	Objective	CQC Domain	Owner	Threshold	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	5.80%	5.90%	5.70%	5.60%	5.60%	5.70%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	5.80%	6.10%	5.30%	5.50%	5.50%	6.20%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	3.80%	9.40%	36.30%	57.70%	82.70%	87.80%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	0.60%	1.80%	15.60%	26.30%	46.20%	66.40%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	72.70%	75.20%	77.40%	75.60%	75.60%	74.20%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	70.70%	69.20%	68.20%	64.60%	68.10%	74.60%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	43.50%	46.50%	52.40%	63.20%	72.50%	78.80%
Equality and Diversity	Resources	Well Led	AD	>=80%	85.70%	84.80%	83.20%	84.40%	87.30%	85.60%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	78.60%	80.20%	80.00%	83.40%	81.10%	81.10%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	59.10%	56.50%	56.50%	56.50%	58.30%	66.70%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	84.40%	83.30%	82.10%	83.80%	83.90%	83.30%
Information Governance	Resources	Well Led	AD	>=95%	92.80%	91.50%	92.30%	90.80%	91.30%	91.30%
Moving and Handling	Resources	Well Led	AD	>=80%	75.70%	75.80%	76.50%	80.10%	80.90%	78.90%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	82.10%	82.40%	83.60%	82.30%	83.30%	86.20%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	86.80%	85.20%	86.30%	85.70%	86.10%	87.00%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	87.80%	86.90%	88.90%	88.50%	92.10%	92.80%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	58.30%	62.70%	75.90%	79.60%	86.50%	90.10%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	54.70%	57.80%	71.40%	73.00%	81.40%	83.70%
Agency Cost	Resources	Effective	AD		£178k	£167k	£169k	£163k	£156k	£147k
Overtime Costs	Resources	Effective	AD		£2k	£3k	£1k	£2k		£0k
Additional Hours Costs	Resources	Effective	AD		£5k	£4k	£4k	£4k	£2k	£2k
Sickness Cost (Monthly)	Resources	Effective	AD		£60k	£75k	£58k	£60k	£63k	£70k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		53.47	51.56	52.4	55.96	41.72	44.58
Business Miles	Resources	Effective	AD		39k	33k	38k	47k	39k	43k

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
ICO	Information Commissioner's Office
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 31 October 2017
Agenda item 6.2

Title:	**Customer Services Report – Quarter 2 (July to September) 2017/18**
Paper prepared by:	Director of Nursing and Quality
Purpose:	To note feedback on experience of using Trust services received via the Customer Services function, the themes arising, learning, and action taken in response to feedback. To note also the summary Friends and Family Test results, comments and benchmarking and the number and types of requests received by the Trust under the Freedom of Information Act.
Mission/values:	A positive service user experience underpins the Trust's mission and values. Ensuring people have access and opportunity to feedback their views and experiences of care is essential to delivering the Trust's values and is part of how we ensure people have a say in public services. The Trust is committed to responding openly and transparently to all requests for information under the Freedom of Information Act.
Any background papers/ previously considered by:	Trust Board approves Customer Services Policy, with the last review in June 2017. The Board also reviews feedback received via the Customer Services function on a quarterly basis. Trust Board reviews Key Performance Indicators (KPIs) on complaints management via the monthly Integrated Performance Report. Work is underway to reviews the complaints investigation and sign off process to make sure that the Trust always responds in ways that ensure learning and becomes more responsive where service issues arise. This will mean services will see the issues first, with a supportive and thorough process second. The Director of Nursing and Quality is leading on this work which will be taken forward through the Operational Management Group. The new process will secure greater involvement of clinical leads in complaints resolution, putting the person first and centre and using feedback to support service improvement. This will also support improved timeliness in complaints handling. Fortnightly reporting to Business Deliver Units (BDUs) enables increased scrutiny of issues and themes, complaints investigation, response timeframes and action planning, to support service improvement in response to feedback. The Customer Services Team continues to promote the function through leaflets and posters. The team also work with services and teams to encourage signposting to Customer Services as a single gateway to raise issues with the Trust.
Executive summary:	**Customer Services Report – Quarter 2 2017/18** This report provides information on feedback received through Customer Services, the themes indicated, lessons learned and action taken in response to feedback. This report supplements information provided to BDUs every 2 weeks. In Quarter 2, there were 87 formal complaints, 96 compliments, 188 general enquiries, 165 staff contacts were responded to and there were 112 requests to access information under the Freedom of Information Act.

	Most complaints contain a number of issues; the most frequently raised issues were values and behaviours, communication, clinical treatment, admission and discharge, appointments and patient care. **Key areas to note:** ➢ There were 19 fewer formal complaints about Trust services than in the previous quarter. There were no complaints about application of the Mental Health Act. ➢ The Customer Services Team continues to remind services to share compliments to ensure they are acknowledged, recorded at corporate level and best practice shared. 24 more compliments were recorded than in the previous quarter. ➢ Work is being progressed through the Operational Management Group to improve the timeliness of complaints handling. Greater involvement of clinical leads in complaints resolution and ensuring learning from feedback will support this. ➢ The Parliamentary and Health Service Ombudsman (PHSO) was requested to review 2 complaints in the quarter. 3 PHSO decisions were received - 1 partially upheld, with action planning underway and 2 cases not upheld, with no action required by the Trust. ➢ The Trust results for the Friends and Family Test (FFT) showed a recommend rate of 89% at July 2017. The average recommend rate for England in July was also 89%. Trust results in FFT continue to be high in absolute terms and overall average. ➢ The Trust continues to process a substantial number of FOIs, with an additional 34 requests received compared to the previous quarter. ➢ 1 Freedom of Information (FOI) request appeal remains with the Information Commissioner. A second has been escalated via the Commissioner's own appeal process to HM Courts and Tribunal Service. Both relate to information requests from 2016 regarding art therapy in Calderdale. This report is shared with the Members' Council, and is subject to discussion with commissioners at Quality Boards. Complaints information is also reviewed through monthly contract monitoring. The information is also reviewed internally at BDU governance meetings. **Risk Appetite** The Customer Services report provides information to the Board on feedback about the quality of Trust services. Issues are escalated to the medical and nursing director and to the relevant service director to ensure action in line with the Trust's Risk Appetite Statement. Reporting is being reviewed to determine how intelligence from Customer Services can be linked to other risk information. Complaint responses are reviewed by the investigator, by general managers and service directors and signed off by the Chief Executive. Delivery of action plans in response to learning from feedback is monitored by BDUs and overseen by service directors.
Recommendation:	**Trust Board is asked to REVIEW and NOTE the feedback received through Customer Services in Q2 of financial year 2017/18.**
Private session:	Not applicable.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

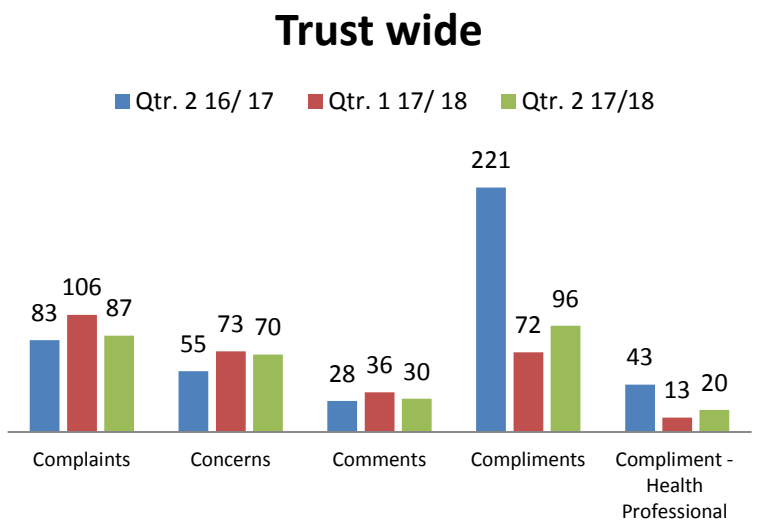
Customer Services Report Quarter 2 2017- 2018

With **all of us** in mind.

Summary:

- The Trust received 303 items of feedback in the form of complaints, concerns, comments and compliments in Qtr. 2. This is in line with the previous quarter when feedback totalled 300.
- **87** formal complaints were received, a **decrease** on the previous quarter figure of **106**. **60** formal complaints were closed.
- **100** comments/concerns were received **(109** in the previous quarter).
- **96** compliments were received (72 in Qtr. 1). The Customer Services team promotes the importance of submitting compliments so that they can be formally acknowledged and best practice shared.
- **188** general enquires were responded to in the period in addition to 4C's management. Sign-posting to Trust services was the most frequent enquiry. **165** staff contacts were recorded.
- **Values and behaviours** was identified as the most frequently raised negative issue **(36).** This was followed by **communication (23), clinical treatment (18)** , **admission and discharge (18) , appointments (17)** and **patient care (16)**. Most complaints contained a number of themes.
- **91%** of people who completed the Friends and Family Test said they would recommend Trust services, **6%** were unsure and **3% would not recommend them.**

Work is underway to review the complaints investigation and sign off process to make sure that the Trust always responds in ways that extract every ounce of learning and become more responsive where service issues arise. This means services will see the issue first, with a supportive and thorough process second. Tim Breedon, Director of Nursing and Quality, is leading on this work which will be taken forward through the Operational Management Group and secure greater involvement of clinical leads in complaints resolution, putting the person first and in the centre and using feedback to support improvement.



Values and Behaviours (staff)

The Trust received 35 complaints in Qtr. 2 that included staff attitude as a factor. Staff attitude was the only factor in 19 complaints and the primary subject matter in 16 complaints .

Across staff groups this related to 17 nurses, 4 consultants, 6 administrative staff and 8 allied health professionals.

A further 16 comments and concerns were received which referenced staff attitude. These were resolved by the service line to the individual's satisfaction.

Joint Working

National guidance emphasises the importance of organisations working together where a complaint spans more than one health and social care organisation, including providing a single point of contact and a single response.

The Trust works with partners to ensure the complaints process is as simple and straight forward to access as possible and to ensure a joined up approach to responding to feedback about health and social care services.

The Customer Services function also makes connection to local Healthwatch to promote positive dialogue and respond to any requests for information. Healthwatch are provided with copies of quarterly reports, request additional information from the Trust on occasion and signpost local people to the team to share feedback.

Joint working in Qtr. 2

	complaint	concern	comment
Barnsley Hospital NHS Foundation Trust	1	0	0
NHS Calderdale CCG	1	0	0
Health Watch	1	0	0
Care Quality Commission	0	1	0
Member of Parliament	5	2	1

NHS Choices

The Trust recognises that NHS Choices is an external source of information about the Trust. Survey materials promote NHS Choices as an additional means to offer feedback about the Trust and its services. The website is monitored to ensure timely response to feedback is posted.

11 individuals posted comments on NHS Choices and Patient Opinion in Qtr. 2. 4 positive experiences were recorded - 1 related to Wakefield Community Mental Health services, 1 to Wakefield Older Peoples Services, 1 to the Barnsley Stroke Unit, and 1 service which was not named or identifiable. 7 negative comments were noted, 1 related to mental health services at Folly Hall, Huddersfield and 6 negative comments did not identify the service the feedback related to.

The Trust acknowledges feedback to the site and offers contact details should the author wish to discuss their concerns directly with the Trust. Follow up in this way is limited.

PHSO

The PHSO was requested to review two complaints about Trust services in Qtr. 2. Relevant information has been provided.
The Trust also received formal decisions from the Ombudsman regarding 3 cases:

- **Calderdale and Kirklees Inpatient -Older Peoples 'Services (OPS) . Complaint partially upheld and action plan being developed to ensure Mental Health Act Assessment is undertaken as appropriate on admission to hospital and that the outcome of assessment is shared with family members. The action plan will be shared with the complainant and delivery of the plan will be monitored by the service.**
- **Calderdale and Kirklees Community Mental Health Services – complaint regarding lack of support not upheld by the Ombudsman.**
- **Barnsley Mental Health Inpatient Service (OPS) - complaint regarding lack of support not upheld by the Ombudsman.**

Mental Health Act

No complaints were raised with the Trust during Qtr. 2 regarding detention under the Mental Health Act.

When complaints are made about application of the Act, these are reported to the Mental Health Act Sub Committee of the Trust Board.

Care Quality Commission (CQC)
The CQC contacted the Trust regarding a concern brought to their attention by an a person being cared for at The Dales. Customer Services contacted the person directly but they decided to withdraw their concerns and did not wish to pursue. CQC were updated and information passed to ward manager.

Information Commissioner 's Office (ICO)
The Trust is currently in contact with the ICO regarding 2 Freedom Of Information requests. The subject matter for both is art therapy in Calderdale:

- An ICO decision which found no further action required of the Trust was appealed by the requester. This is currently subject to further review by HM Courts and Tribunal Service in line with ICO appeal procedures. All requested information has been provided by the Trust and Hempsons Solicitors has reviewed and endorsed the Trust's response.
- The ICO is reviewing an appeal by a requester following information provided in response to an FOI request in April 2016. The Trust awaits the ICO decision.

Equality Data

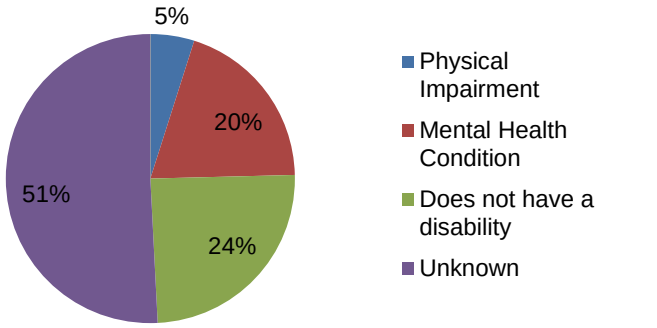
Equality data is an indicator of who accesses the complaints process. It is about the person raising the issue, who is not necessarily the person receiving services. Data is captured, where possible, at the time a formal complaint is made, or as soon as telephone contact is made following receipt of any written concerns. Information is shared with the complainant explaining why collection of this data is important to the Trust to measure equality of access to the complaints process. We offer assurance that providing data has no impact on care and treatment or on the progression of a complaint.

60 complaints were closed. Complaints were raised by service users (25), and carers/ and/ or family members (26) and by third party (9) . Equality data was collected for 38 contacts, 4 complainants declined to provide equality data. Data is not collected about third party agents. Data was not collected for 9.

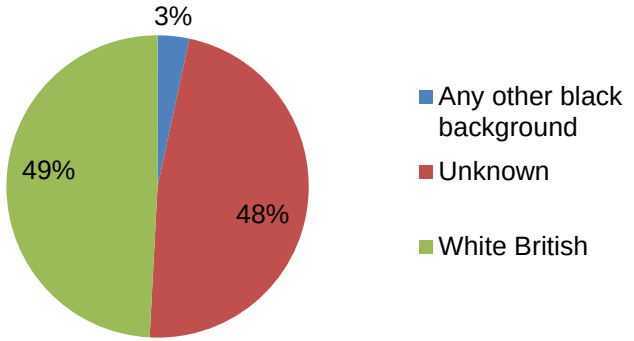
The Team continues to explore best practice in equality data capture, both internally with teams and externally with partner organisations and networks, and incorporates any learning into routine processes.

The pie charts show, where information was provided, the breakdown in respect of ethnicity, gender, disability, age and sexual orientation. Equality data is collated Trust wide.

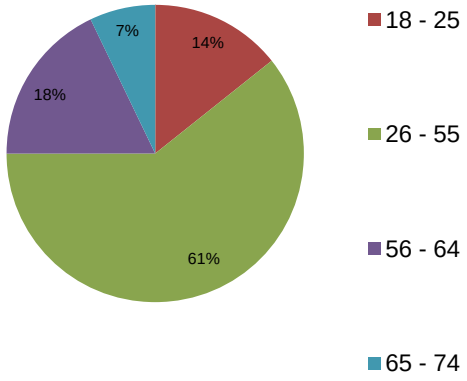
Trust wide - Disability



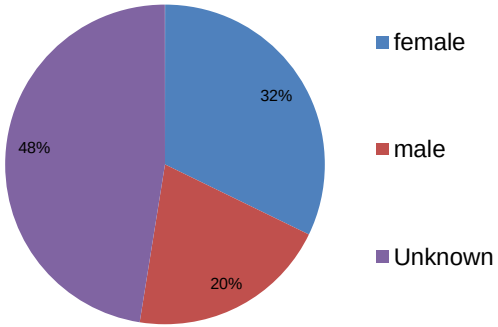
Trust wide - Ethnicity



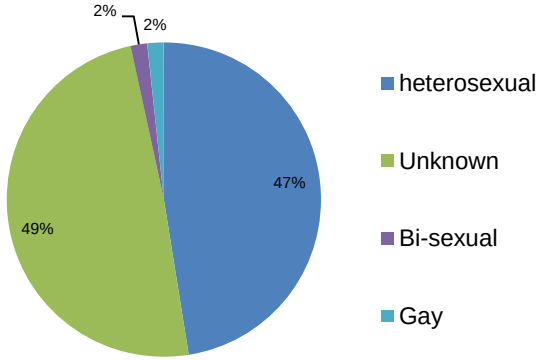
Trust wide - Age



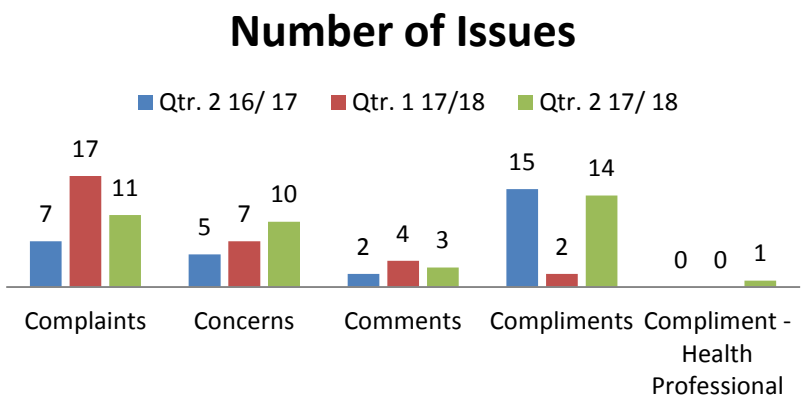
Trust wide - Gender

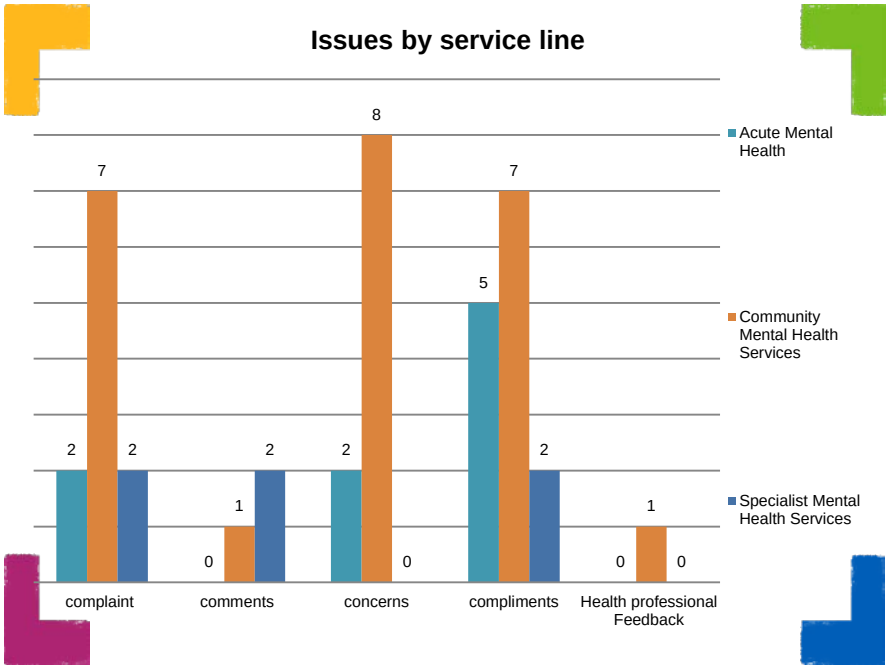


Trust wide - sexual orientation



Barnsley Business Delivery Unit
Mental Health Services





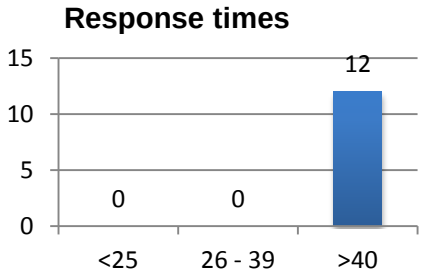
Learning:

- Staff have been reminded of the need to be proactive and responsive to ensure that people's needs are met – **Memory Service**
- The team have been reminded to contact people waiting for services to explain the wait time and to offer a point of contact in the interim – **CMHT (North)**

Top Five Themes

1. **Appointments and discharge**
2. **Values and behaviours**
3. **Access to treatment and drugs**
4. **Communication**
5. **Patient care**

"I feel attending the 'recovery through reading' sessions saved me. This was such a big thing for me and I feel sure that attending the reading group has played a part in accessing help for me to move forward" IAPT



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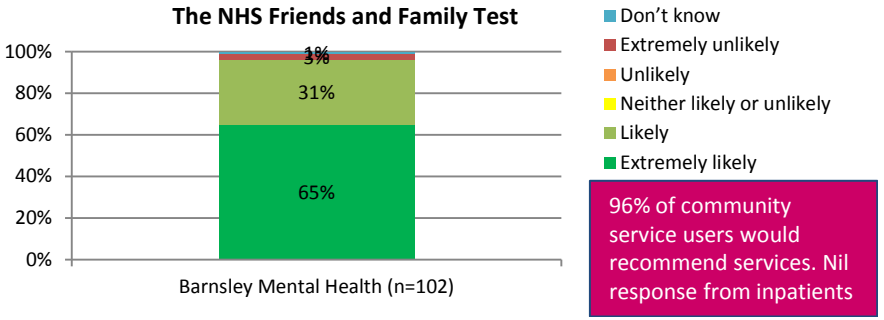
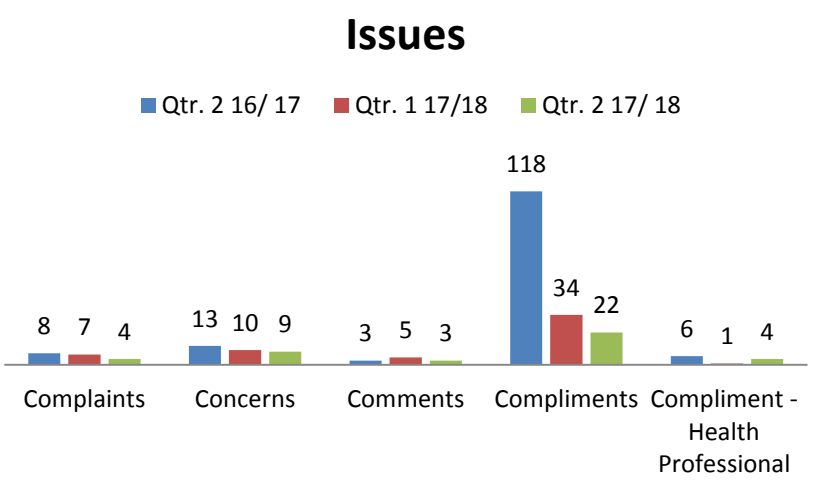
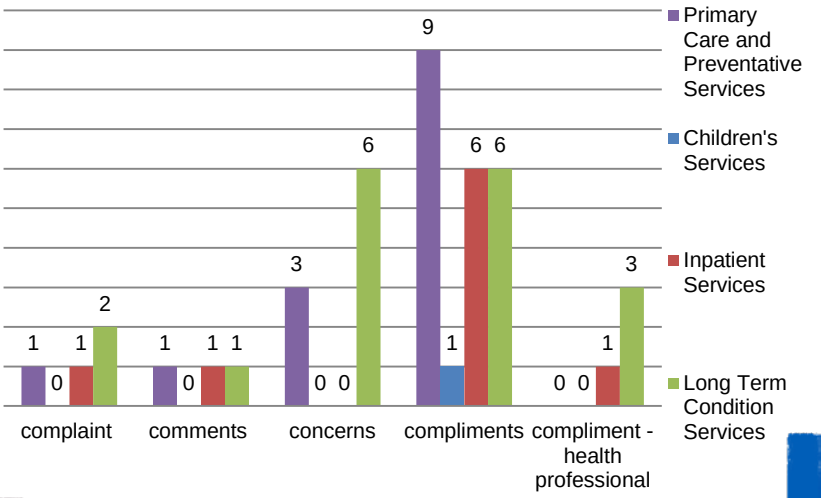


96% of community service users would recommend services. Nil response from inpatients

Barnsley Business Delivery Unit
General Community Services





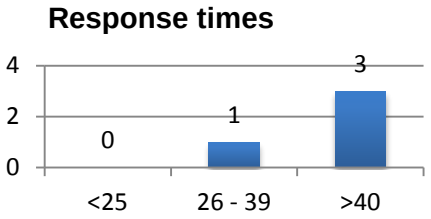
Learning:

- Service have confirmed that bigger and better placed signage will be displayed in reception areas . This follows feedback that small handwritten signs were difficult to see – **Podiatry Service**
- Explanation provided regarding the aims of rehabilitation offered by intermediate care service – **Long Term Condition Services**

Top Five Themes

1. Clinical treatment
2. Access to treatment and drugs
3. Appointments and discharge
4. Patient care
5. Trust admin/policies/ procedures

"I would like to express my thanks and gratitude to all the district nurses who have cared for my husband over the past two years with professionalism and kindness for which I will always be grateful". District Nursing



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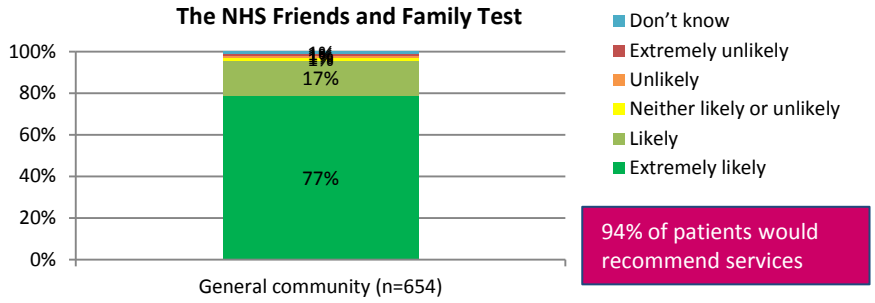
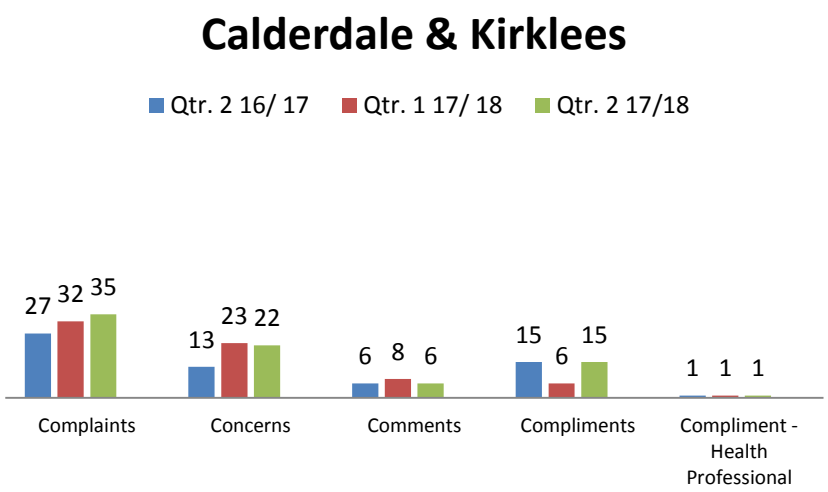
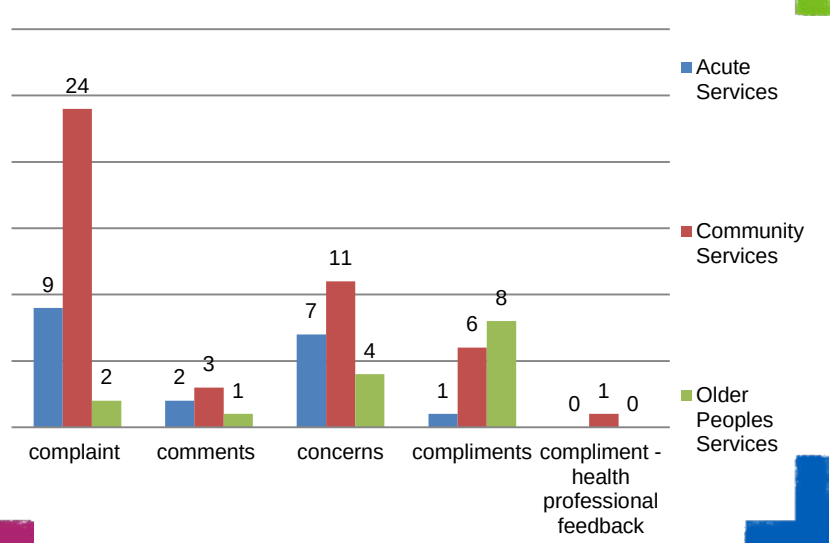


94% of patients would recommend services

Calderdale & Kirklees Business Delivery Unit





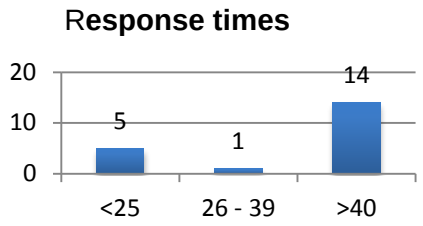
Learning:

- Apologies provided regarding the attitude of the member of staff. The team manager will share the service user experience with staff for reflection – **CMHT (Lower Valley)**
- Explanation provided as to why ongoing psychology support was not indicated. Apology given regarding contacts not being followed up in a timely manner – **Community Therapies (North Kirklees)**

Top Five Themes

1. **Communication**
2. **Values and behaviours**
3. **Clinical treatment**
4. **Admission and discharge**
5. **Appointments**

"We express our heartfelt thanks for your much appreciated help, support and compassion. Without your professional, positive guidance at this stressful time we do not know what we would have done. You sincerely are a credit to your profession". Memory Services



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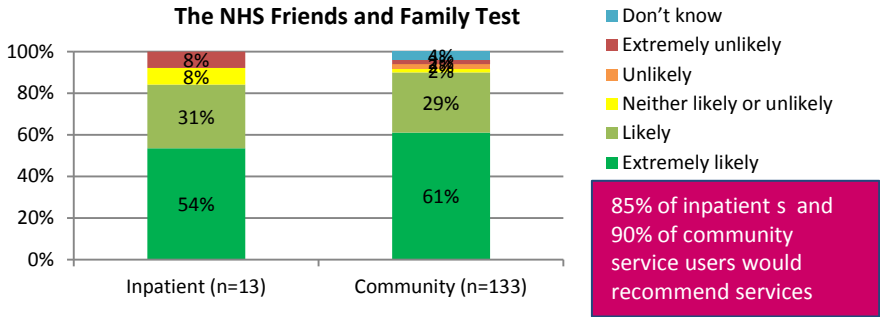
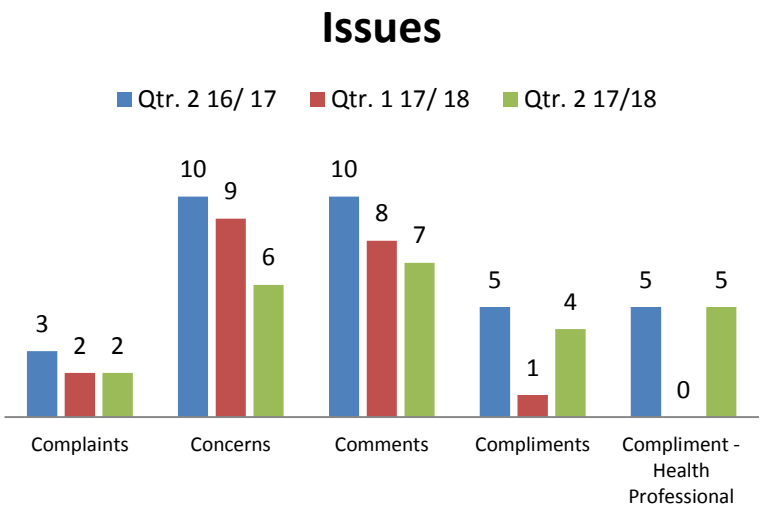
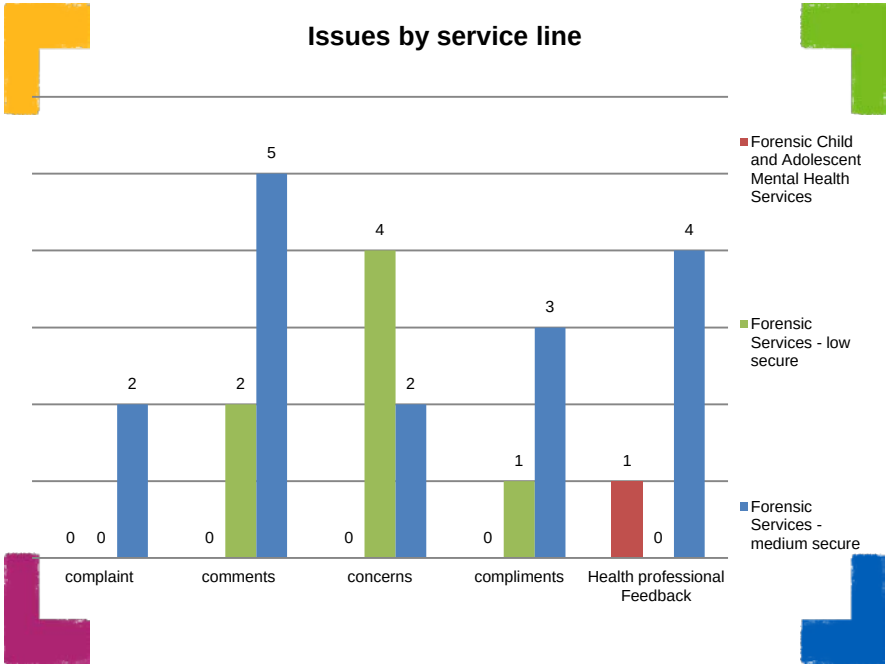


85% of inpatient s and 90% of community service users would recommend services

Forensic Business Delivery Unit





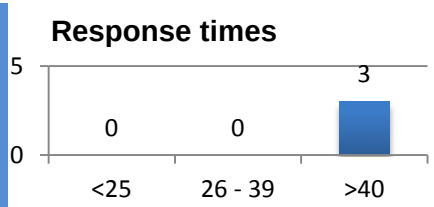
Learning:

Staff have been reminded to ensure clear information regarding discharge and personal property is provided –

Appleton Ward, Newton Lodge.

Top Five Themes

1. Values and behaviours
2. Prescribing
3. Communications
4. Patient care
5. Trust admin/policies procedures



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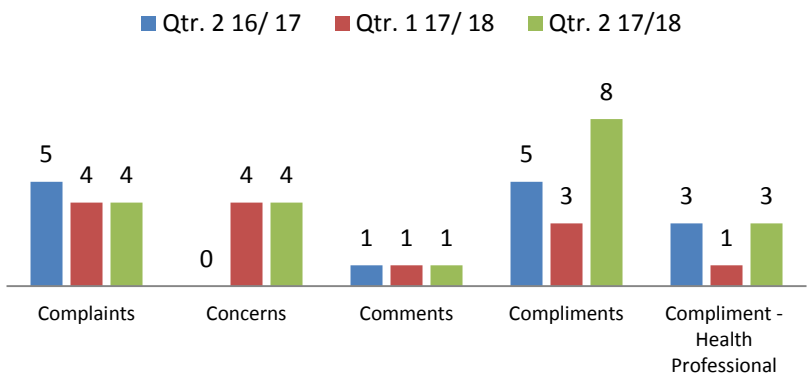
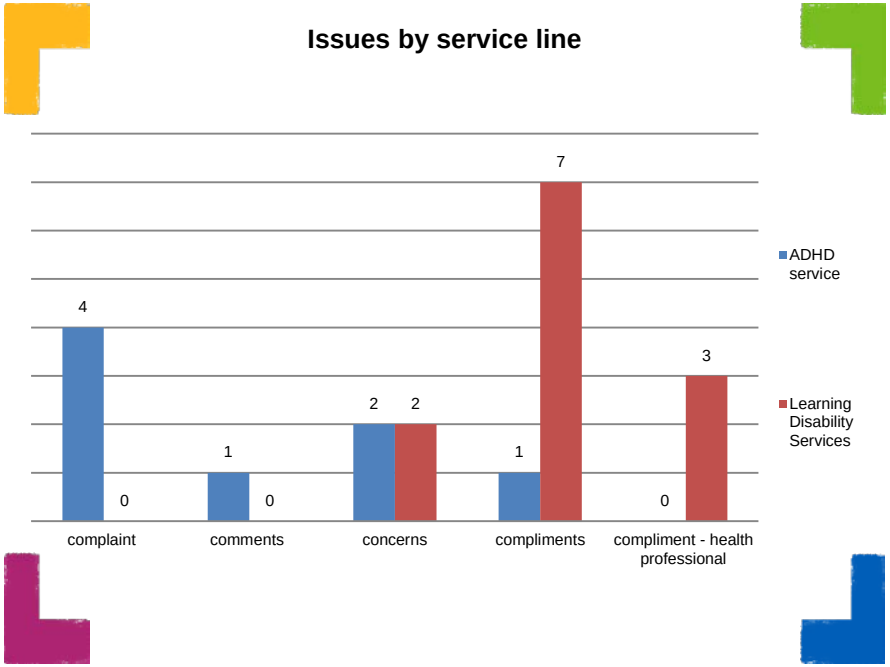
There was no collection of Friends and Family Test survey results in Forensic Services in Qtr. 1

"Thank you so very much to all the staff. As a family we are very grateful for the care received. We felt that as a team you were like one big family" – **Newhaven Forensic Disability Unit**

Specialist Services Business Delivery Unit excluding CAMHS





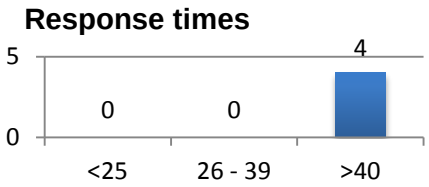
Learning:

- Staff reminded to provide clear explanation about the service offer and about access to services – **ADHD Service**
- Staff to ensure that clear explanation is provided regarding service changes that have resulted in improvements to the way in which referrals are now processed – **Wakefield Community Learning Disability Team**

Top Five Themes

1. **Waiting times**
2. **Access to treatment and drugs**
3. **Patient care**
4. **Appointments**
5. **Admission and discharge**

"We would like to show our appreciation and thanks for all the help and support you have given us over the past few months and continue to give us" Kirklees Community Disability Team.



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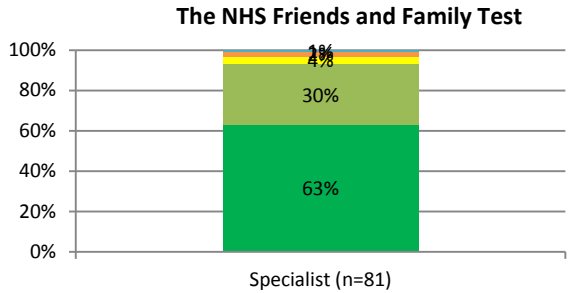
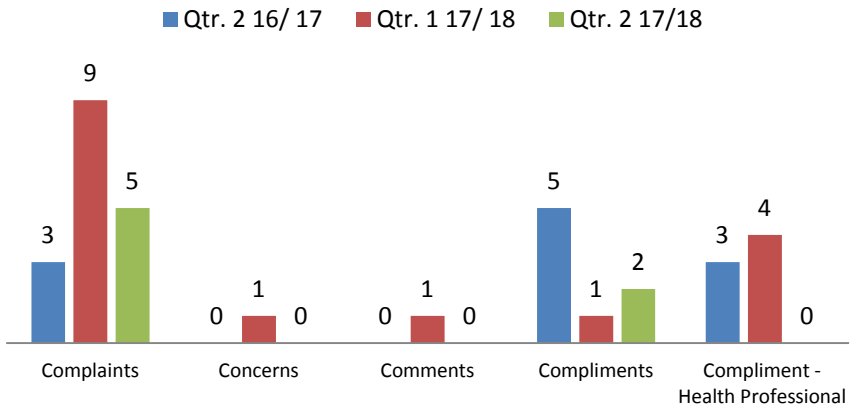


93% of service users would recommend services

Child and Adolescent Mental Health Services - Barnsley

CAMHS - Barnsley



What was good about your experience?

"I like all the toys and chalk and chalk board and books"

"Very knowledgeable staff "

"Friendly staff"

What would have made your experience better?

"Longer sessions"

"Have more toys"

"Have a finish time"

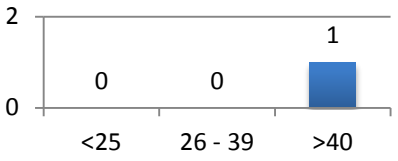
Learning:

Staff have been reminded of the importance of checking parents understanding of information provided.

Top Four Themes

1. Waiting times
2. Values and behaviours
3. Patient care
4. Access to treatment and drugs

Response times



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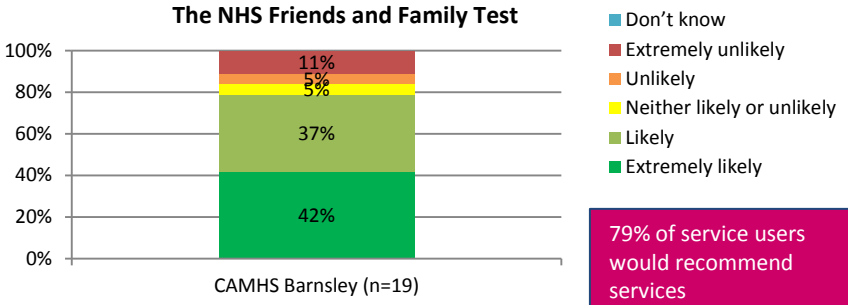
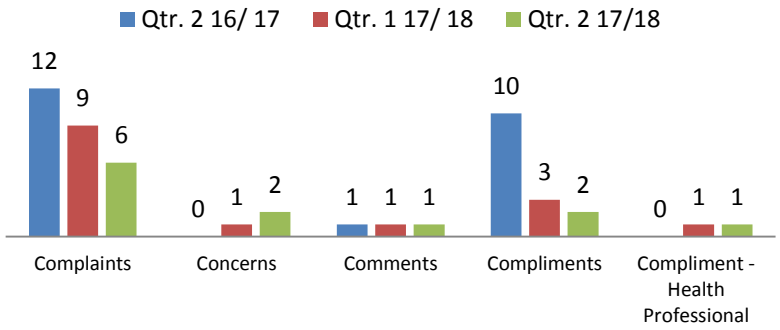
The NHS Friends and Family Test



79% of service users would recommend services

Child and Adolescent Mental Health Services – Calderdale & Kirklees

Issues



What was good about your experience?

"They listened to my problems and worked with me to the best of their ability to find the best solution"

"Being able to talk freely without arguing"

"Great knowledge of our problems"

What would have made your experience better?

"More psychiatric nurses like staff member who was excellent but only here on a temp contract"

"To get the right person that helps you for what you need"

"Calm music in the waiting room a bit more decoration and a clock in the room"

"Lower waiting time for appointments"

Learning:

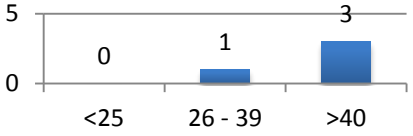
- All staff have been reminded of the importance of clearly recording in healthcare records any instructions received from service users and their families – **CAMHS Calderdale**
- Explanation provided by staff to parent regarding the delay being experienced in accessing services – **CAMHS Kirklees**

Top Five Themes

1. Admission and discharge
2. Patient care
3. Access to treatment and drugs
4. Waiting times
5. Values and behaviours.

"You have completely changed my quality of life. I cannot thank you enough. You were the only person to ever put things together and enabled me to fully understand" CAMHS Kirklees

Response times



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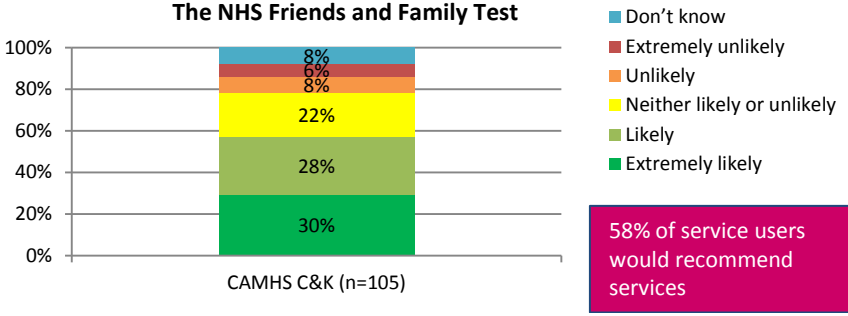
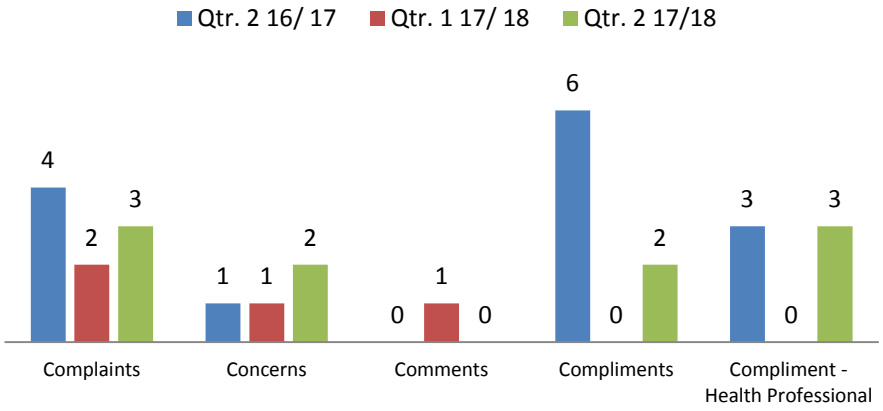


58% of service users would recommend services

Child and Adolescent Mental Health Services - Wakefield

Issues



What was good about your experience?

"On arrival I thought the receptionist was rude, but after that the staff were great and put us at ease"

"They are always there for you and when you need help they are there to help"

"The observation and the write up at the end. I just hope the referral goes through and it will help get my son more support at school"

"Tell me what's wrong with me"

"Shorter waiting list"

"Try to be less patronising"

"Quicker appointments and support"

No learning recorded in Qtr. 2

Top Four Themes

1. Appointments
2. Access to treatment and drugs
3. Commissioning
4. Clinical Treatment

What would have made your experience better?

The smell of the clinic

Cut wait times

You could have made it better by sorting what day my grandma comes and what day my mum comes

No complaints were closed in the period.

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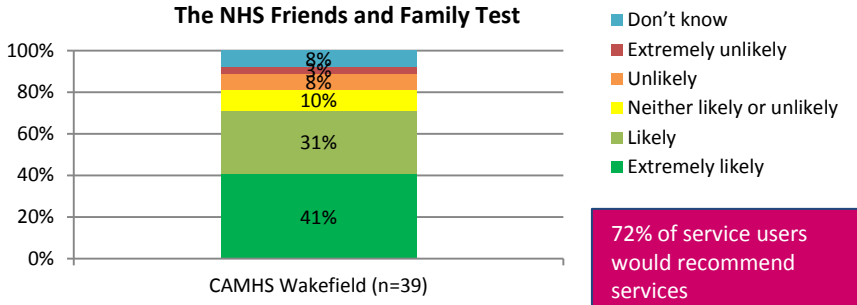
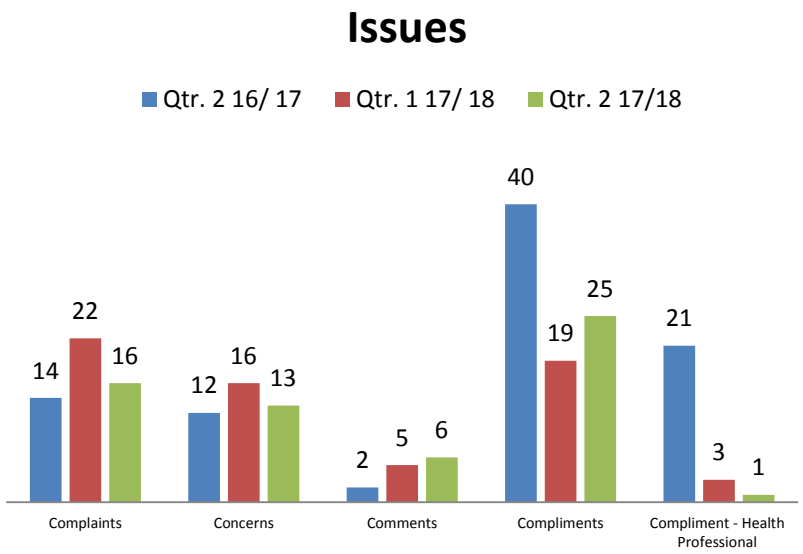
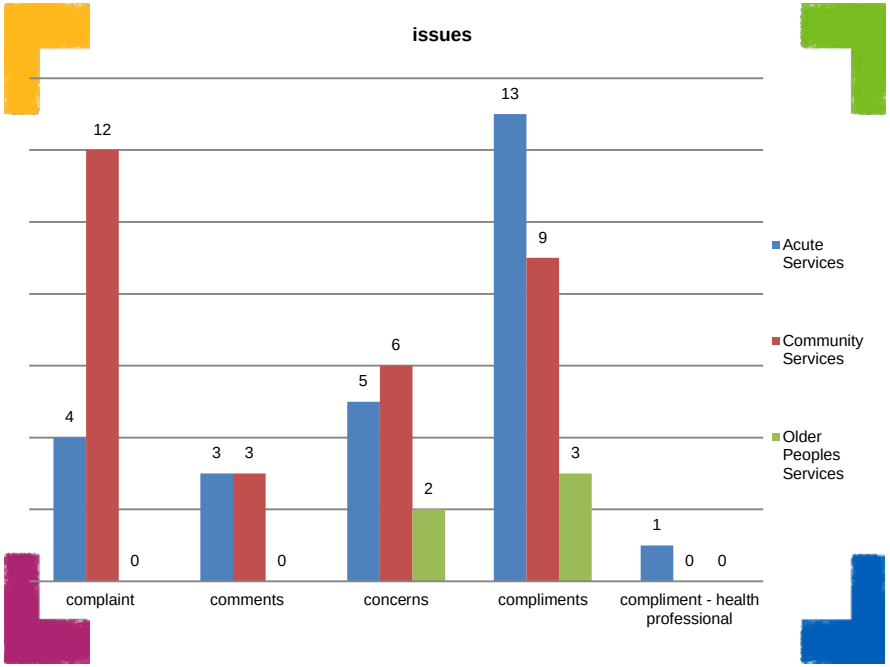


72% of service users would recommend services

Wakefield Business Delivery Unit





Learning:

- Approved Mental Health Practitioner Team, IHBTT and Single Point of Access Team will meet and review the issues regarding capacity to consent. Staff will also be reminded of the importance of ensuring that carers and family members are provided with the rationale and understand why decisions have been made – **Intensive Home Based Treatment Team (IHBTT)**

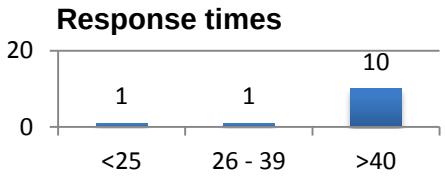
- All emails relating to service user appointments are now passed to the Team Leader or Duty Worker to review and acted on as soon as possible. Reassurance provided that the Trust is exploring several options to enable email contact in the future as it is acknowledged that email is a preferred method of contact for many people – **Core Team East**

Top Five Themes

1. **Values and behaviours**
2. **Admission and discharge**
3. **Patient care**
4. **Access to treatment and drugs**
5. **Communications**

"Thank you all so much for your diligence, care, attention and kindness towards our family – Priory ward

Knowing you are appreciated and not judged on your disability gives a sense of optimism for the future. I feel gratitude towards those who give their time to help people in recovery" Recovery College



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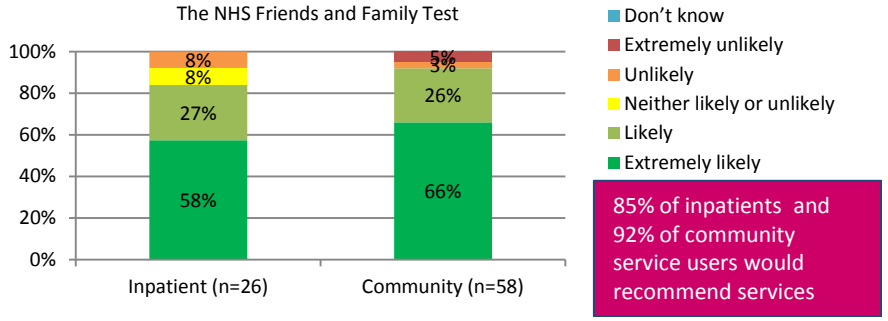
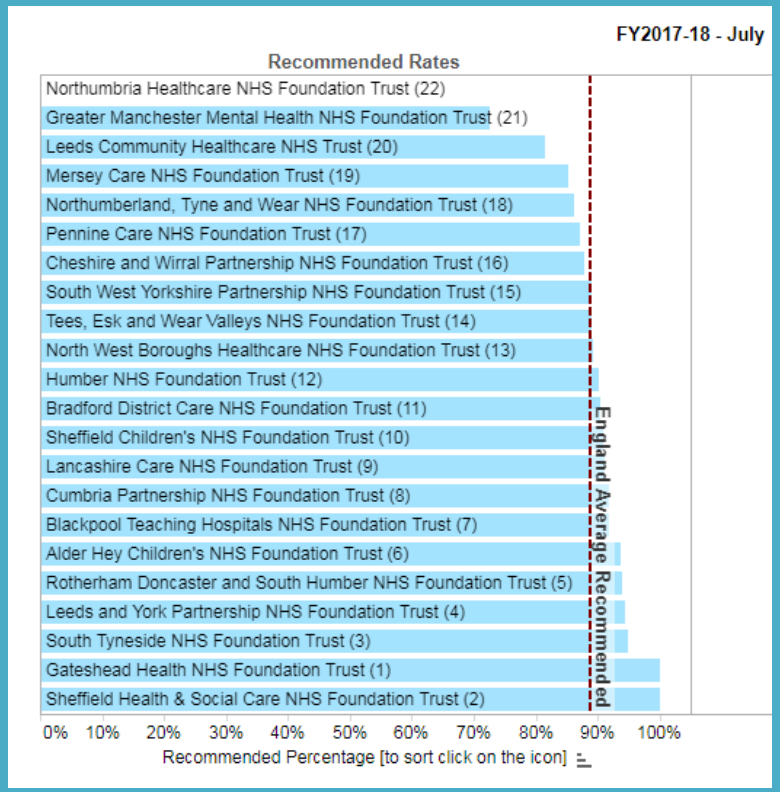


85% of inpatients and 92% of community service users would recommend services

Friends and Family Test Comments and Benchmarking

Benchmarking

NHS Improvement has launched the 'Patient Experience Headlines Tool'. The tool was developed in partnership with Trusts to enable staff to access key sources of published patient experience measures in one place. The most up to date published data on comparison of FFT scores relates to July 2017 (so does not marry with trust reporting schedules).



The graph above shows a comparison of Mental Health Trusts from the North of England's, FFT recommend rate. SWYPFT scored in the lower – middle quartile for July 2017 with a recommend rate of 89%. The average recommendation rate for England in July was also 89%.

What was good?

"Put at ease, explained everything clearly, the lady is a true professional. It could not have been better" – Wakefield Rapid Access Service

"They help you when you need it the most. they always listen to you and they always try and help you to help you change" – Calderdale CAMHS

"Having the 24hr phone number was vital support. The regular visits seemed relaxed and not rushed. Was at no point judged on circumstance" – Community physio

"Learning new things. How small exercises can help sustain personality and the correct way to walk and sit. Lynda was delightful and explained everything thoroughly" – Move more Doncaster

"I feel that over the course of 20 sessions I have learned to accept myself more and lower my anxiety" – Mental health access team Barnsley (IAPT)

What could have been better?

"Waited 2 hours for transport which was redirected to emergency - allow own transport to be used - this also saves NHS funds" – The Poplars

"To see less people. It made it difficult seeing different people and having to discuss my difficulties each time" – Barnsley IHBTT

"Learn to communicate better, listen to parents concern, follow through on help needed and offered to child" – Calderdale CAMHS

"Although a great building - not the right environment for older people with 'memory difficulties'. Should be done at home" – Podiatry

"Do arts and crafts stress relief classes on weekends here and more play therapy for people with Autism and Asperger's" – Kirklees CAMHS

"Being in a judgment free environment so I could open up" – Psychology South Kirklees

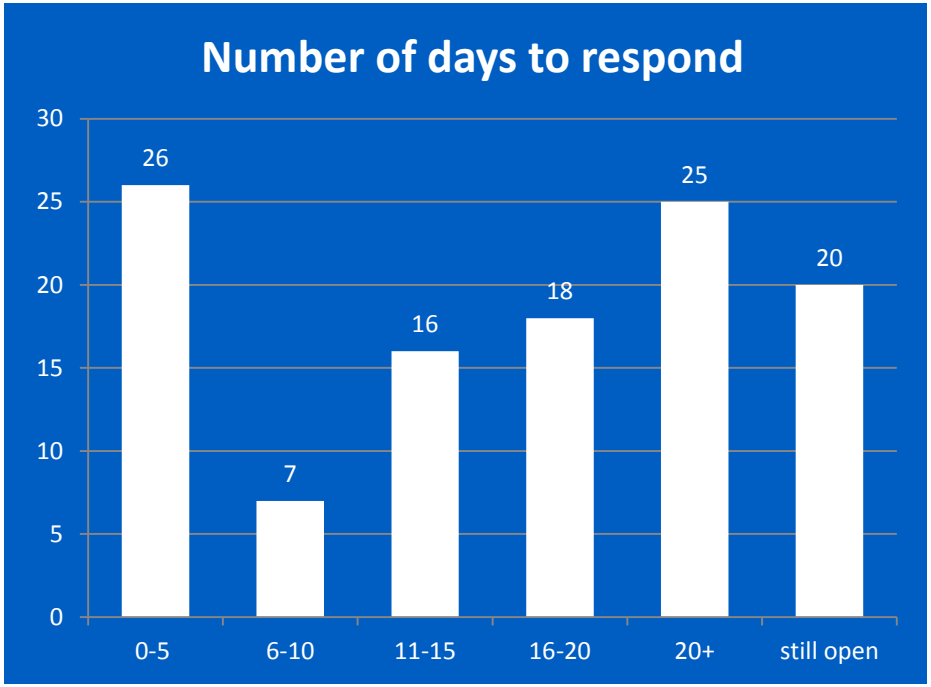
Freedom of Information requests

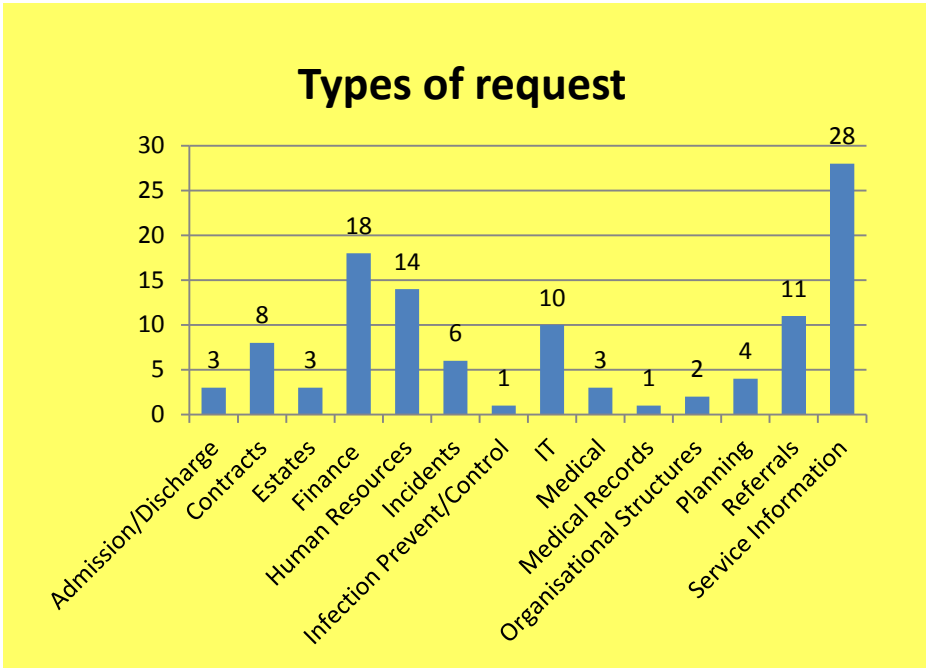
112 requests to access information under the Freedom of Information Act were processed in Qtr. 2, an increase on the previous quarter when 78 requests were processed. Most requests were detailed and complex in nature and required significant time to collate an appropriate response working with information owners across Trust services.

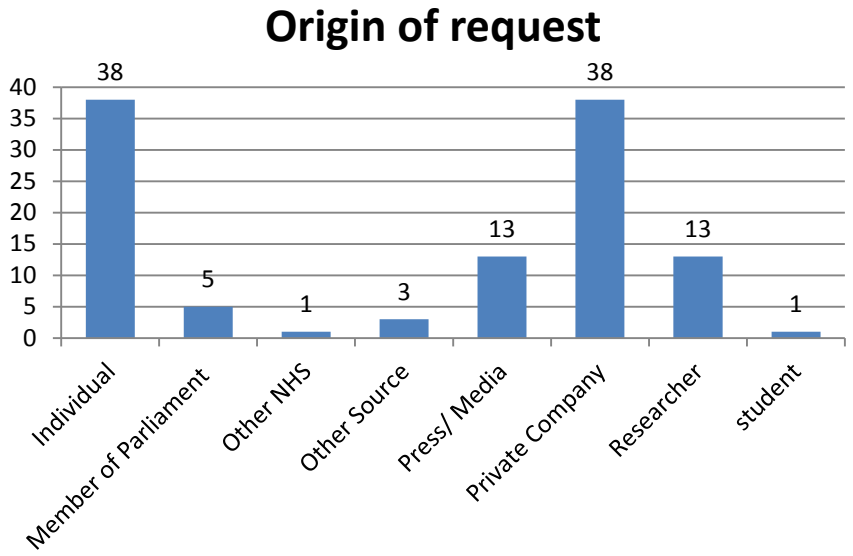
During the quarter the following exemptions were applied:

- Information already accessible (Exemption 21)
- Prejudice to law enforcement (Exemption 31)
- Personal identifiable information (Exemption 40)
- 2 x Prejudice to commercial interest (Exemption 43)

The Trust is currently in contact with the ICO regarding 2 Freedom Of Information requests. The subject matter for both is art therapy in Calderdale. An ICO decision which found no further action required of the Trust was appealed by the requester. This is currently subject to further review by HM Courts and Tribunal Service in line with ICO appeal procedures. The outcome of an appeal regarding the second FOI is still awaited.







South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 October 2017
Agenda item 6.3

Title:	**Workforce Race Equality Standard (WRES) summary report and action plan**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates
Purpose:	WRES Summary Report requires Board sign off prior to submission and publication
Mission/values:	The Trust serves a diverse population across a large geographical area and it is important we strive for a workforce that reflects the local population. A diverse workforce is vital to enable all parts of the communities served by the Trust to reach their potential. Equality and Diversity is core to the Trust's values and is an important part of its service and workforce objectives.
Any background papers/ previously considered by:	The Trust established an Equality and Inclusion Forum which is a sub-committee of the Board to drive forward and oversee equality and diversity agenda within the organisation. WRES and Equality Delivery System (EDS) have been at the forefront of the Equality and Inclusion Forum work over the past 12 months. The issues within the WRES action plan have been central to a number of discussions at the Equality and Inclusion Forum and it was agreed at the meeting on 2 October 2017. The WRES action plan has been also agreed by the Executive Management Team (EMT). Key background papers are the Trust Equality Workforce Monitoring Annual Report 2016.
Executive summary:	The Trust recognises the importance in delivering culturally sensitive services that meet the needs of the communities we serve and a diverse workforce is critical to achieving this aim. The WRES, which is a requirement for NHS Trusts and has been included in the NHS standard contracts since 2015, provides a framework which will support the embedding of workforce equality. The main purpose of the WRES is to help local and national NHS organisations to review their workforce data against nine indicators. This review should then enable organisations to produce action plans to close any gaps in workplace experience between White and Black and Ethnic minority (BME) staff and to improve BME representation at a senior level of the organisation. The WRES is believed to be the best means of helping the NHS as a whole to improve its workforce race equality performance. There is considerable evidence across the NHS that suggests BME staff experience less favourable treatment than white staff which then has a significant impact on the efficient and effective running of services. The Trust has a key leadership role to play in shaping a collective and inclusive culture across all protected characteristics and a lot of the action can be equally applied across the organisation.

The Trust's WRES action plan integrates with the Equality Delivery System 2 (EDS2) to ensure a consistent approach and reflects the commitment to moving this agenda forward. The action plan also recognises that the key objective around senior appointments, will require the Trust to work in partnership with other NHS and public sector organisations.

The WRES data does need to be treated with some caution given the small size of respondents. The 8 reported indicators in all but 2 areas has shown improvement from the 2016 report to the 2017 report:

WRES Indicators	2016 Report	2017 report
Relative likelihood of White staff being appointed for shortlist compared to BME staff being appointed from shortlist	2.01	0.9 (improved)
Relative likelihood of BME staff entering disciplinary process compared to White staff	2.09	1.36 (improved)
Relative likelihood of White staff accessing non mandatory training and continuous professional development as compared to BME staff	0.88	1.00 (in line will target)
Percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	52.2%	31.25 (improved)
Percentage of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months	13.0%	15.63% (deteriorated)
Percentage of BME staff believing the Trust provides equal opportunities for career progression or promotion	85.2%	85.71% (stayed same)
Percentage of BME staff experiencing discrimination at work from manager/team leader or other colleague	4.2%	9.32% (deteriorated)

Green = in line with or better than national target levels

Amber = slightly worse than national target levels

Red = worse than national target levels

An important development in 2016 was the establishment of the BAME staff network and they celebrated its anniversary in September with highlights of key achievements. They will play an important role in supporting the Trust in delivering the WRES action plan.

The action plan has been developed in response for the feedback from staff. A key action is to open up the NHS Staff Survey to all staff which should improve the response rate.

Recommendation:	**Trust Board is asked to APPROVE the WRES action plan and its ongoing monitoring through the Equality and Inclusion Forum.**
Private session:	Not applicable.

Workforce Race Equality Standard
REPORTING TEMPLATE
Template for completion

Name of provider organisation	**Date of report; month/year**	
	Month: August	Year: 2017
Name and title of Board Lead for the Workforce Race Equality Standard		
Alan Davis, Director of human resources, organisational development and estates		
Name and contact details of lead manager compiling this report		
Claire Hartland, HR business manager, claire.hartland@swyt.nhs.uk 07881 008185		
Names of commissioners this report has been sent to		
Wakefield CCG, Barnsley CCG, North Kirklees CCG, Greater Huddersfield CCG, Calderdale CCG., NHS North of England SCT		
Names and contact details of co-ordinating commissioner this report has been sent to		
Paul Harding	Contract Manager	NHS Barnsley Clinical Commissioning Group	paulharding@nhs.net Karen Pollard	Senior Contract Manager	NHS Calderdale & NHS Greater Huddersfield CCG	karen.pollard@greaterhuddersfieldccg.nhs.uk Jonathan Hepworth |Senior Supplier Manager, Mental Health	NHS England, North of England Specialised Commissioning Team (Yorkshire & Humber Hub)	jonathan.hepworth@nhs.net		
Unique URL link on which this report will be found (to be added after submission)		
http://www.southwestyorkshire.nhs.uk/about-us/performance/workforce-equality-information/		

This report has been signed off by on behalf of the Board on (insert name and date)
Alan Davis, Director of human resources, organisational development and estates – 4.10.17

Report on the WRES indicators

1. Background narrative

a. Any issues of completeness of data
There are issues with the data relating to Indicator 2. An updated link between NHS Jobs 2 and the Electronic Staff Record (ESR) resulted in data being lost in May 2015. The required data for this indicator is therefore only available from June 2015 onwards.

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

2. Total numbers of staff

a. Employed within this organisation at the date of the report
There were 4482 staff employed by South West Yorkshire Partnership NHS FT as at 31st March 2017

b. Proportion of BME staff employed within this organisation at the date of the report

8.44% BME staff in the workforce as at 31st March 2017

3. Self reporting

a. The proportion of total staff who have self-reported their ethnicity
100% of staff have self-reported their ethnicity

b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity
The Trust uses ESR employee self-service which staff have been encouraged to use to self-report and check their own data. The reporting level is now at 100%

c. Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity
N/A

4. Workforce data

a. What period does the organisation's workforce data refer to?
Years ending 2015/16 and 2016/17

5. Workforce Race Equality Indicators

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

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	For each of these four workforce indicators, the Standard compares the metrics for White & BME staff.				
1	Percentage of staff in each for the AfC bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Percentage of staff in each of the AfC bands 1-9- or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.	Please see Appendix 1	Please see Appendix 1	The % of BME staff in the workforce has increased by 0.62 in the current year. The Trust has reviewed demographic workforce data for Trusts in Yorkshire and Humber. This has identified there is a lack of available candidates from across the region. The Trust is sponsoring BME staff onto the NHS Leadership Academy 'Stepping Up' programme and is supporting staff onto the Moving Forward programme in partnership with Bradford DCT. Our internal Moving Forward programme is due to come on stream October 2017.	~ Discussions have taken place on a regional breakthrough programme and funding will be sought for Autumn 2017 ~The Workforce strategy supports encouraging BME staff development by means of coaching & mentoring, succession planning and talent management. ~Workforce report includes AfC band data by ethnicity, monthly reports showing this data are also produced. ~The secondment guidance will be reviewed and a sample of acting up arrangements will be looked at to ensure an appropriate and transparent approach is being taken ~Explore with the Chief Executive's office the opportunities to promote staff governor roles to BME staff
2.	Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts	0.9	2.01	The data shows that BME applicants are more likely to be shortlisted than white applicants. This is an improvement from the previous year's figures.	~ Continue to engage with BME communities in North Kirklees through 'New Horizons' project with the local schools to encourage consideration of the Trust and the NHS as an employer of choice. ~ Promote Apprenticeship's in North Kirklees by means of a targeted approach with the BME communities
3.	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal	1.36	2.08	The average figure required by the Indicator shows that BME staff are 1.36 times more likely to enter a formal disciplinary process than White staff. This is an improvement from the	~ Data for past 2 year's disciplinary cases involving BME staff has been validated. ~ A task group will be set up involving staff side, BME rep, HR and service manager to review

	disciplinary process, as measured by entry into a formal disciplinary investigation* *Note: this indicator will be based on data from a two year rolling average of the current year and the previous year			previous rolling 2 years figures.	the past 2 years disciplinary data.
4	Relative likelihood of BME staff accessing non-mandatory training and CPD as compared to White staff	1.00	0.88	The data show that BME staff are equally as likely to access non-mandatory training and CPD as White staff. The data includes medical staff.	~ Maintain robust process for training data collection and collation, including focus on break down by staff group ~ In line with Values Based Appraisal policy will continue to monitor uptake and will undertake random sample on qualitative data. The data for 2016 shows a 26.42% uptake of all external training across non-white British ethnic groups. ~Look at breakdown of medical and non-medical staff accessing training.

	Indicator	**Data for reporting year**		**Data for previous year**		**Narrative – the implications of the data and any additional background explanatory narrative**	**Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective**
	For each of these four staff survey indicators, the Standard compares the metrics for each survey question response for White and BME staff						
5.	KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	27.64	White	27.66	The 2016 staff survey was sent to a sample of 1219 staff. The response rate was good at 44%, slightly lower than the previous year (50% in 2015) however, this is average compared with other similar NHS organisations The Trust works with wellbeing specialist Robertson Cooper, and undertakes an annual wellbeing survey for staff which now captures WRES issues. Data from survey completed June 2017 currently being analysed, the findings will inform wider Trust strategies and	~ Recognise that the NHS survey size is too small therefore 2017 survey will be sent to all staff ~ Continue to work to maintain the return rate of the staff survey by supporting managers to understand the importance of regular staff feedback ~ Engage with BME staff network to improve understanding of the survey issues, actions that can be taken, support that can be given ~Clinical network to be established to review support and actions required regarding harassment and bullying from service users
		BME	31.25	BME	52.17		

						plans. 2016 staff survey indicates that the BME staff who responded indicated they were more likely to experience harassment and bullying from service users and carers than white staff	and carers
6.	KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	21.72	White	19.73	2016 staff survey indicates that the BME staff who responded indicated they were less likely to experience harassment and bullying from staff than white staff	~ Recognise that the NHS survey size is too small therefore 2017 survey will be sent to all staff ~ Continue to work to maintain the return rate of the staff survey by supporting managers to understand the importance of regular staff feedback ~ Engage with BME staff network to improve understanding of the survey issues, actions that can be taken, support that can be given
		BME	15.63	BME	13.04		
7	KF21. Percentage believing that the Trust provides equal opportunities for career progression or promotion	White	90.11	White	91.01	2016 staff survey indicates that the BME staff who responded indicated they were more negative regarding believing the Trust provides equal opportunities for career progression or promotion than white staff.	~ Recognise that the NHS survey size is too small therefore 2017 survey will be sent to all staff ~ The Workforce strategy supports encouraging BME staff development by means of coaching & mentoring, succession planning and talent management. ~Continue to network and benchmark with other Trusts, for example, through the regional E&D network and look at examples of good practice nationally
		BME	85.71	BME	94.12		
8	Q17b. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White	5.07	White	5.07	2016 staff survey indicates that the BME staff who responded indicated they were more likely to experience discrimination at work from their Manager/team leader or other colleagues than white staff.	~Recognise that the NHS survey size is too small therefore 2017 survey will be sent to all staff ~ Continue to work to maintain the return rate of the staff survey by supporting managers to understand the importance of regular staff feedback. ~Engage with BME staff network to improve
		BME	9.38	BME	4.17		

							understanding of the survey issues ~ The Bullying and Harassment policy is currently being refreshed and will be shared with the BME staff network for their views prior to submission to the policy group.
	Board representation indicator. For this indicator, compare the difference for white and BME staff						
9	Percentage difference between the organisations Board voting membership and its overall workforce	-2.6		-7.77		There is currently no BME representation on the organisations Board voting membership Barnsley 2.13% BME population Calderdale 10.32% BME population Kirklees 20.87% BME population Wakefield 4.57% BME population	~ Trust's Equality & Inclusion (E&I) forum to continue to work with Gatenby Sanderson which works with Trusts on mentoring schemes for BME individuals who are interested in non-executive appointments. ~ Look at how the Shadow Board programme may support the development of a more diverse Board. ~ NED compliment increased to 7 w.e.f August 2017. This gives the opportunity to increase the voting executive director representation to the Board by 1.

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

Report on the WRES indicators, continued

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

The Trust also publishes a detailed Equality Workforce Monitoring Annual Report on our website, link at No 7 below. Progress regarding the Equality agenda is monitored by the Trust Board at the Equality and Inclusion Forum.

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

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

The Trust has developed an integrated EDS2 and WRES workforce action plan, please see link below:
http://www.southwestyorkshire.nhs.uk/about-us/performance/workforce-equality-information/

Appendix 1

WRES data for summary report 2017 Indicator 1

	2015/2016				2016/2017			
	Non Clinical		Clinical		Non Clinical		Clinical	
Grade	**White**	**BME**	**White**	**BME**	**White**	**BME**	**White**	**BME**
Band 1	130	6	3		133	9	3	
Band 2	152	5	243	9	153	8	277	17
Band 3	370	12	600	51	371	9	558	47
Band 4	210	9	101	1	190	11	90	5
Band 5	115	6	641	65	115	4	616	69
Band 6	62	8	794	57	64	9	744	51
Band 7	43		364	17	48	3	350	16
Band 8a	39		131	8	42	1	135	7
Band 8b	13		59	1	20		57	1
Band 8c	4		23		2		21	
Band 8d	5		8	1	11		8	1
Band 9					1		1	
Medical & Dental Consultants			37	49	1	1	36	51
Medical & Dental Non-consultant career grade			15	32			19	45
Medical & Dental Trainee grades			9	20			5	11
Medical & Dental Other			2				2	
VSM*	31		10	1	7		8	1
Grand Total	**1174**	**46**	**3040**	**312**	**1158**	**55**	**2930**	**322**
Not Started	**25**				**17**			
Total Staff Number	**4597**				**4482**			

	2015/2016				2016/2017			
	Non Clinical		Clinical		Non Clinical		Clinical	
Grade	**White**	**BME**	**White**	**BME**	**White**	**BME**	**White**	**BME**
Band 1	2.83%	0.13%	0.07%		2.97%	0.20%	0.07%	0.00%
Band 2	3.31%	0.11%	5.29%	0.20%	3.41%	0.18%	6.18%	0.38%
Band 3	8.05%	0.26%	13.05%	1.11%	8.28%	0.20%	12.45%	1.05%
Band 4	4.57%	0.20%	2.20%	0.02%	4.24%	0.25%	2.01%	0.11%
Band 5	2.50%	0.13%	13.94%	1.41%	2.57%	0.09%	13.74%	1.54%
Band 6	1.35%	0.17%	17.27%	1.24%	1.43%	0.20%	16.60%	1.14%
Band 7	0.94%		7.92%	0.37%	1.07%	0.07%	7.81%	0.36%
Band 8a	0.85%		2.85%	0.17%	0.94%	0.02%	3.01%	0.16%
Band 8b	0.28%		1.28%	0.02%	0.45%		1.27%	0.02%
Band 8c	0.09%		0.50%		0.04%		0.47%	
Band 8d	0.11%		0.17%	0.02%	0.25%		0.18%	0.02%
Band 9					0.02%		0.02%	
Medical & Dental Consultants			0.80%	1.07%	0.02%	0.02%	0.80%	1.14%
Medical & Dental Non-consultant career grade			0.33%	0.70%			0.42%	1.00%
Medical & Dental Trainee grades			0.20%	0.44%			0.11%	0.25%
Medical & Dental Other			0.04%				0.04%	
VSM*	0.67%		0.22%	0.02%	0.16%		0.18%	0.02%
Grand Total	**25.54%**	**1.00%**	**66.13%**	**6.79%**	**25.84%**	**1.23%**	**65.37%**	**7.18%**
Not Started	**0.54%**				**0.38%**			
Annual Total	**100.00%**				**100.00%**			

WRES Technical guidance, 2017, for VSM now has a clearer definition of “very senior manager”. Previously VSM included occupational codes GO for Band 8a and above. For 2016/2017 data the VSM definition only includes Chief Executives, Executive Directors and other senior managers with Board level responsibility.

Integrated EDS2 and WRES workforce action plan progress update June 2017

EDS2 Goal 3 outcomes		WRES indicators		Actions	Progress to date
3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	1	% of staff in each of the AfC bands 1-9 and VSM(inc Executive Board members) compared with the % of staff in the overall workforce	Actions • The guidance for the Trust's centralised exit interviews for all staff has been approved and the process is now in operation.	The first 6 monthly report on exit interviews is due October 17
		2	Relative likelihood of staff being appointed from shortlisting across all posts	• Trust participation in the Insight programme (to increase Trust Board BME representation) continues and the second cohort is now with the organisation.	
		9	% difference between the organisations' Board voting membership and it's overall workforce	• Continuing with the 'New Horizons' project, working with schools and colleges in North Kirklees. Project includes engaging with the local BME community on the areas of mental health awareness, employability skills and promoting the Trust and wider NHS as an employer of choice.	Project evaluation from both students and teachers from the work in 2016 was very positive with a recommendation to build on this success in the future. A second programme of work is scheduled for September/October 2017
				• Stepping Up programme: x 1 attendee Moving Forward programme: x 3 (x 2 on current programme with BDCT plus x 1 deferred with guaranteed place to below) • Continue to develop partnering arrangements with BDCT & Mid-Yorkshire HT to deliver 'Moving Forward' programme from October 2017	
				• Update recruitment information to include use of social media showing a diverse workforce	Using social media for all non-medical, Director level posts and bank staff recruitment
				• To ensure progress the Staff Wellbeing survey will include questions for both EDS2 and WRES	Actions to be included in the overall staff wellbeing action plan

3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations			Actions • Pay audit to be undertaken in Quarter 4	
3.3	Training and development opportunities are taken up and positively evaluated by all staff	4	Relative likelihood of staff accessing non-mandatory training and CPD	Actions • Ensure all training is recorded and monitored and study leave forms completed across the Trust.	Training budget now centralised. Training outcomes are identified though formal learning needs analyses with services to inform a training delivery plan with associated resources and costs included
3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source	5 6	KF25 - % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months KF26 - % of staff experiencing harassment, bullying or abuse from staff in the last 12 months	Actions • Clinical network established to review approach to harassment and bullying from service users, carers and visitors • Trust reviewing overall strategy around harassment and bullying	First meeting 10th August
3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives			Actions • Reviewed flexible working policy and procedure • Impact of introduction of 12 hour shifts discussed by Safer Staffing group	Approval by staff partnership forum expected 24th July Review to be carried out

3.6	Staff report positive experiences of their membership of the workforce			Actions • Values into Behaviours initiative • Staff wellbeing and engagement survey • NHS staff survey to be sent to all staff in 2017 • Friends and Family test	To go to extended EMT 26th July and EMT in August Report on BME staff responses to key questions relevant action plan developed …… " …… …… " ……
		3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation	Actions • Work with staff side, management, BAME network representatives, HR and Nursing colleagues to look at BAME disciplinary cases over the last 2 years	
		7	KF21 - % believing the Trust provides equal opportunities for career progression or promotion	Actions • Evaluate experiences of staff attending 'Stepping-Up' & Moving Forward programmes to inform design of internal offer • Continue to develop partnering arrangements with BDCT & Mid-Yorkshire HT to deliver 'Moving Forward' programme from October 2017 • Continue to develop partnering arrangements with BDCT and Leeds & York CMHT to deliver Shadow Board programme from December 2017 • Finalise arrangements for 'Medical Leaders' development programme in October & November 2017	Working with BAME network planning action learning sets re 'Stepping Up', the NHS Leadership Academy programme and partnering with BDCT to deliver 'Moving Forward' programme. Our internal Moving Forward programme is due to come on stream later this year.
		8	Q17 b – In the last 12 months have you personally experienced discrimination at work from manager/ team leader or other colleagues	Actions • Continue to monitor and take action as appropriate	Wellbeing survey undertaken May 17, 42% response rate. Results have improved and stayed stable. Will undertake full census NHS staff survey in October 17.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 October 2017
Agenda item 7.1

Title:	**Safe Working Hours Doctors in Training report - Quarter 1 2017/18 (April-June 2017)**
Paper prepared by:	Deputy Medical Director
Purpose:	To inform the Board of the process for monitoring safe working hours within the new Doctors in Training contract. Trust Board is asked to note the report.
Mission/values:	Provision of out of hours clinical care is essential to support the Trust's mission in helping people to reach their potential and live well in their communities. The training of the next generation of substantive psychiatrists is of strategic importance for not only the Trust's succession planning but to ensure provision of a highly trained medical workforce within the wider mental health system.
Any background papers/ previously considered by:	Briefing paper presented to Trust Board on 25 April 2017. Quarterly report presented to Trust Board 27 June 2017 (covering February – March 2017).
Executive summary:	The introduction of a new contract for Doctors in Training impacted on the Trust in February 2017 with new employees moving onto the contract at that point. In order to ensure that concerns raised during the negotiation process about the potential for unsafe working practices to be introduced, a specific role has been developed in order to oversee Doctors in Training contracts and, in particular, their working hours. The Trust appointed Dr Richard Marriott as the Guardian of Safe Working and the 2017-18 Quarter 1 report highlights the following: ➢ The number of exception reports has remained low this quarter (5 in Feb-March 2017 and now in 2017-18 Q1 there were 3) and could continue to be impacted on by reluctance amongst Trainees to raise concerns through such a formal reporting mechanism. Positive engagement with the Trainees to address issues as and when they arise continues. ➢ The Calderdale first on-call rota had to be redesigned in order to be compliant with the new contract regulations and this, combined with the continuing issue of functional gaps in the rota means there are still considerable difficulties in the implementation of the rota. Work around potential rota redesign to address these issues progresses. ➢ The development of a Trust medical bank to which all Trainees and other medical staff are able to engage on their commencement of their work in the Trust and can also remain available for future employment. This has now gone live. ➢ A Junior Doctors' forum has been developed and quarterly meetings continue. In summary, there is confidence that the generic work schedules include rota patterns that remain compliant with the Terms and Conditions of the new Junior Doctor contract but challenges remain because of the level of vacancies within the on-call rotas, specifically in Calderdale. This risk has been identified and managed within the Kirklees and Calderdale Business Delivery Unit.

Recommendation:	**Trust Board is asked to NOTE the report.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

QUARTERLY REPORT ON SAFWORKING HOURS:
DOCTORS IN TRAINING (Apr-Jun 2017)

Introduction

The 2016 junior doctors' contract has introduced stronger safeguards to prevent junior doctors from having to work excessive hours. The safety of patients is a paramount concern for the NHS and significant staff fatigue is a hazard both to patients and to the staff themselves. In this respect, the new contract introduced the role of Guardian of Safe Working Hours. The Guardian is responsible for protecting the safeguards outlined in the 2016 Terms and Conditions of Service (TCS) for doctors and dentists in training. The Guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and/or employer, as appropriate; and will provide assurance to the Trust Board or equivalent body that doctors' working hours are safe.

The Guardian is independent of Trust management and the Guardian's main roles are to:

- Champion adherence to safe working hours
- Oversee safety-related exception reports and monitor compliance with the system
- Escalate issues for action where not addressed locally
- Request work schedule reviews to be undertaken where necessary
- Intervene as required to mitigate safety risks
- Intervene where issues are not being resolved satisfactorily
- Provide assurances on safe working and compliance with TCS
- Submit a quarterly report to the Trust Board on the functioning of the contract and exception reporting.

This report outlines:

- Challenges
- The Junior Doctors' Forum
- The number and distribution of doctors in training across the Trust
- A summary of exception reports (ERs) submitted by doctors in training
- Fines
- Work schedule reviews
- Rota gaps and cover arrangements
- Locum Work carried out by Trainees
- Medical Bank
- Qualitative information
- Issues arising
- Actions taken
- Summary.

High level data

Number of doctors in training (total):	52
Amount of time available in job plan for Guardian to do the role:	1 Programmed Activity (PA)
Admin support provided to the Guardian:	Ad hoc
Amount of job-planned time for educational supervisors:	0.125 PAs per Trainee

Challenges

1) **IT System**: The Trust is using the IT system; Doctors Rostering System (DRS) to both develop the rota patterns for junior doctors and manage Exception Reports (ERs). The system has had a number of teething problems and was not ready for use for ERs until the day doctors started on the new contract, so no testing was possible. The system was previously provided free of charge from HEE. A charge has been introduced at short notice, from April 2017. The Trust has committed to continue using the system for the next 12 months but there is a plan to look at alternatives available on the market. Ideally, a system would reduce the amount of administration time required. As yet the functionality of the system does not support rota administrators. There are plans in place to improve the management and monitoring of rotas and the gaps that need to be covered.

2) **Cost/Salary Implications**: The contract has been largely cost neutral but has resulted in considerable changes in salary for different grades of doctor which may have implications for recruitment in the future. Higher trainees without pay protection will be particularly worse off.

3) **Trainee and Clinical Supervisor Engagement**: The contract remains new to all doctors, many of whom have expressed confusion regarding its implications. To introduce the Guardian role and Exception Reporting System, presentations have been undertaken at the Induction Programme for each cohort of new junior doctors, the Medical Leaders Advisory Group and the Medical Staff Committee. As well as the Junior Doctors' Forum, attendance at the Medical Education Trust Action Group, which has oversight of all issues to do with Medical Education within the Trust, is made.

4) **Trainee concerns**: Trainees have been reluctant to complete ERs and have expressed anxiety about the exception reporting process.

5) **Interaction with other Trusts**: a number of the Trust's Trainees are employed by partner organisations, one of whom has delayed introduction of the new contract, and a number have different systems for Exception

Reporting. All Trainees have been asked to use the SWYPFT reporting system whilst in a SWYPFT post.

Development of a Junior Doctors' Forum

The setting up of a Junior Doctors' Forum is a key requirement of the new contract. The forum will meet quarterly and this quarter, met in May. The role of the forum is to advise the Guardian in all aspects of the role and the focus in the most recent meeting was the concerns about the Calderdale rota.

All junior doctors within the Trust are invited to the forum but particular efforts have been made to ensure that representatives of all the BDUs and rotas are able to attend. The other key attendees are the AMD for Postgraduate Medical Education, LNC Chair or representative and the HR Business Partner. The local BMA representative has also been invited to attend a meeting but as yet has not been able to do so.

Distribution of Trainee Doctors within SWYPFT

The Trust covers a wide geographical area and receives Trainees from a number of different rotational training schemes (Foundation Programme, General Practice Vocational Training Schemes, Psychiatry Core Training Schemes and Psychiatry Higher Training Schemes). Approximately half of the Trainees are employed by the Trust, with the remainder employed by other organisations.

Each locality (Barnsley, Calderdale, Kirklees and Wakefield) has a 1st on-call rota staffed by junior doctors. These are trainees from the local Core Psychiatry Scheme, the Foundation Year 2 Scheme or GP Vocational Training Scheme. The 2nd on-call rotas for each locality are staffed partly by Higher Trainees and partly by non-training Specialty Doctors, the latter whose contracts are subject to different terms and conditions.

Tables shown in the appendices demonstrate the breakdown of the different grades of Trainees in each locality, also noting the areas where there are vacancies. Recruitment to the Foundation programme has been good and all posts have been filled. Most GP posts have been filled but due to pregnancy/maternity, there are currently gaps on both the Calderdale and Wakefield rotas. Poor recruitment to core training posts in Psychiatry has led to a number of gaps with 2 out of the 7 Wakefield posts vacant and 3 out of 10 posts on the Calderdale and Kirklees Core Training Scheme.

Exception reports (with regard to working hours)

The Exception Reporting (ER) system is the main safeguard in the new junior contract that ensures junior doctors are not being forced to work excessive hours and are able to meet the training requirements of their contract. The hours and rest rules are complicated and a helpful factsheet covering the key features can be found at: http://www.nhsemployers.org/~/media/Employers/Documents/Need%20to%20know/Factsheet%20on%20rota%20rules%20for%20guardians%20August%202016%20v2.pdf.

Each Trainee receives a work schedule prior to commencement of their post, which outlines the rota pattern, hours and pay arrangements for that post. If a Trainee is required to work beyond those hours, or if work commitments prevent them from attending required training, the Trainee is encouraged to complete an ER. This details the circumstances of the 'exception'. The report goes to the Trainee's clinical supervisor. If the clinical supervisor agrees the ER, the options are for the Trainee to be given time off in lieu or to be paid for the extra time.

There have only been a few ERs completed. The following tables show the ERs by area and doctor's grade, with the third table showing the response time by clinical supervisors. The main issue of note is that the majority have been completed by Trainees in Calderdale. A number of factors have led to the situation in Calderdale being difficult:

1) It is a busy unit.
2) There are only 9 training posts which is only just sufficient to staff the current shift system.
3) A number of the doctors currently in post are unable to do on-call shifts (e.g. due to health issues, pregnancy or lack of experience).

As a result of these problems there are numerous gaps on the rota (see section regarding rota gaps) and the lack of staff means that the remaining Trainees cannot be expected to do all the extra shifts.

Exception Reports By Area				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Barnsley	0	0	0	0
Calderdale	0	2*	2*	0
Kirklees	0	0	0	0
Wakefield	0	1	1	0
Forensic	0	0	0	0
Total	0	3*	3*	0

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	0	0	0
F2	0	0	0	0
GPVTS	0	0	0	0
CT1-3	0	2*	2*	0
ST4-6	0	1	1	0
Total	0	3*	3*	0

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	0	0	0	0
F2	0	0	0	0
GPVTS	0	0	0	0
CT1-3	0	0	2*	0
ST4-6	0	1	0	0
Total	0	1	2*	0

*Due to a problem with the IT system, whereby it was not clear to trainees if the exception report had been logged by the system, 2 incidents lead to multiple exception reports being logged. After liaising with staff at DRS one trainee's duplicate exception reports was removed. The supervisor working with the other trainee signed off 4 reports relating to one incident. The figures above show the number of separate exceptions but viewing the DRS system, it would appear that there were 5 exception reports completed by CT trainees in Calderdale.

For the exceptions noted in the tables above, the actions were:

1) Extra payment was made for 1 exception when a higher trainee was asked to act down to cover a gap in the junior trainee rota.
2) Time off in lieu was granted for 1 exception.
3) No specific action was required for 1 exception regarding the individual trainee. However, the issues noted will be fed in to the discussions regarding how best to manage workload in Calderdale where there is shortage of doctors.

There have been some issues with response time, partly due to consultant annual leave and lack of familiarity with the IT system used. The system was still in development as the contract was implemented and there have

been a number of issues with the system. Also, it appears that notifications from DRS were being caught by the Trust Spam-filter. This has hopefully been resolved after liaision with the Trust's IT department to white-list Skills For Health emails. All clinical supervisors have addressed the ERs once prompted.

There are still a number of doctors that remain on the old 2002 junior doctors' contract. Historically, the response rate for rota monitoring exercises under the old contract has been poor. It has therefore been decided not to attempt to monitor these doctors' working hours separately. They have all been given access to the DRS system and have been encouraged to complete ERs if they have concerns about their working patterns or hours.

Fines

Should certain of the hours and rest rules under the new contract be broken, a fine will be incurred, with a penalty hourly rate paid to the doctor and the remainder of the fine paid to the Guardian to use to improve training within the Trust. None of the ERs received so far have resulted in a fine.

Work schedule reviews

The new contract requires that generic work schedules detailing work patterns and pay be sent to trainees prior to commencement of the post and this was achieved. Following commencement of the post the generic work schedule should be used to develop a personalised work schedule according to the doctor's learning needs and training opportunities within the post.

The Work Schedule Review is the process whereby concerns about a doctor's working hours or access to training are reviewed. There were no work schedule reviews required during this period. However, as mentioned above, the whole of the Calderdale and Kirklees rotas are under review due to concerns raised both informally and in exception reports.

Rota gaps and cover arrangements

The following table details rota gaps by area and how these have been covered. As discussed, the areas with the most vacancies have the most gaps. Due to the number of gaps, it has been necessary to use agency or external staff on a number of occasions. In addition, there were 3 shifts where it was not possible to obtain junior doctor cover.

Gaps by rota April/May/June '17					
Rota	Number (%) of rota gaps	Number (%) covered by trainees	Number (%) covered by agency / external	Number (%) covered by other trust staff	Number (%) vacant
Barnsley 1st	1 (0.5%)	0	0	1 (100%)	0
Calderdale 1st	51 (28%)	16 (31%)	22 (43%)	6 (12%)	2 (4%)
Kirklees 1st	4 (4%)	4 (100%)	0	0	0
Wakefield 1st	26 (14%)	10 (31%)	8 (31%)	7 (27%)	1 (2%)
Total 1st	82 (13%)	30 (37%)	30 (37%)	14 (17%)	3 (4%)
Wakefield 2nd	25 (27%)	8 (32%)	5 (20%)	12 (48%)	0

Up until now, no data has been captured about the financial cost to the Trust of covering rota gaps. Discussions have been had with colleagues in Finance to look at ways that this information can be collated moving forward. It is hoped this can be presented in future reports.

Locum work carried out by Trainees

The Trust is largely reliant on the current Trainees to do locum shifts to fill the gaps on the rota. However, the number of gaps that have been required to be filled has left staff stretched. Agency staff have been used in Calderdale to fill gaps. Junior doctors were concerned that locum pay rates offered under the new TCS were unattractive, especially compared to other Trusts. It has been agreed that all locum shifts will be paid at £35/hour for junior doctors.
During this quarter it was noted that some Trainees had done locum shifts without signing the European Working Time Directive (EWTD) waiver. There are now systems in place across the Trust to address this via the postgraduate administrators.

Medical Bank

A Trust Bank that all Trainees are able to join on commencement of work with the Trust has now gone live. Discussions with the other Mental Health Trusts in West Yorkshire aimed at setting up a county wide bank, to increase the pool of doctors that can cover vacant shifts are continuing, but this is not likely to be available in the near future.

Qualitative information

Anecdotally, there is awareness that a number of Trainees have been anxious that completion of ERs will be looked upon negatively by supervisors, affecting references or ARCP progression. Reassurances have been given to all the trainees at induction and at the Junior Doctors' Forum that this will not be the case.

Issues arising

There are a number of issues that arise out of the implementation of the new junior doctors' contract:

1) **Recruitment:** The biggest current challenge and one that is largely out of the hands of the Trust, is recruitment to training posts, particularly core training posts in Psychiatry. Given that the situation is unlikely to improve in the near future, staff managing the rotas need to be creative as to how we maintain a safe service to our patients while ensuring high quality training and safe working patterns for our Trainees. In particular, the Calderdale rota needs urgent review.

2) **Management of Rota Gaps:** The process for managing rota gaps needs to improve and hopefully the Medical Bank will be a significant step forward in supporting and monitoring this.

3) **Education and Support**: Clinical Supervisors are still getting to grips with their role in the new contract both in relation to development of personalised work schedules and exception reporting. They are likely to require on-going support to ensure that they fulfill the requirements of the new contract. Close working with the new AMD for Postgraduate Medical Education to develop a more robust system to support clinical supervisors and monitor the educational aspects of the new contract.

4) **IT System Issues:** The DRS system was developed at the last minute prior to implementation of the contract and there is some evidence that the system is improving. The main competitor, Allocate, appears to have advantages but that too has had teething problems and it is not recommended the Trust switches to another, more expensive system at this stage. This should be kept under review.

Actions taken to resolve issues

Currently the main actions include:

1) Urgent review of the Calderdale rota. Options to change the rota were presented to junior staff but there were great concerns that there may be impacts on patient safety. There has been a monitoring exercise looking at the type of work junior doctors are being asked to carry out,

especially overnight. Managers are considering the possibility of extending the roles of nursing staff on the ward to carry out certain tasks that would otherwise fall to the doctor on-call such as phlebotomy and ECG recording. However there are concerns about the capacity of nurses to be able to undertake such tasks. A further meeting to look at progress on the developments is being arranged.

2) Close working with the Postgraduate Medical Education Coordinator is being undertaken to develop systems to support all the clinical leads and rota administrators to understand the contract more fully and record important information to allow us to ensure that rotas and especially cover of gaps, is managed appropriately.

3) From 1st September a new Associate Medical Director for Postgraduate Medical Education was appointed. The post holder has taken over the line management responsibility for the three College Tutors across the Trust and will work closely with them and the Guardian to work to address the issues identified around education and support as highlighted in the previous section of this report.

Summary

There is confidence that all generic work schedules include rota patterns that are compliant with the terms and conditions of the new junior doctors' contract.

The Postgraduate Medical Education Coordinator is implementing processes trust-wide to ensure that trainees doing extra shifts have signed the EWTD waiver and that the number of shifts they do remains within safe limits.

The main concerns continue to arise out of vacancies and the management of gaps on the rota. Up until now there has been inconsistency about the management of on-call rotas. The development of the Trust Medical Bank will go some way to addressing concerns but there remains no central system to monitor the impact of vacancies from a financial point of view i.e. the cost to the Trust of covering vacant posts. The structures of the new contract offer an opportunity to develop better systems to ensure both patient safety and better training experiences for our junior medical staff.

As described above, most ERs have been generated by staff in Calderdale and the most pressing need is to develop a solution to manage the workload issues there in the context of recruitment difficulties.

Questions for consideration

Trust Board is asked to note this report. There are currently concerns about working patterns, especially in Calderdale, and in the overall management of rota gaps. There has been some progress since the last report but these concerns have not yet been fully resolved. Any unresolved issues will be included in the next quarterly report.

Appendix

Distribution of Trainees by Locality

Barnsley

Grade of Trainee	Number Expected	Number in post (WTE)	Employer
ST4-6	3	2	South West Yorkshire Partnership NHS FT
GP Trainee	1	1	South West Yorkshire Partnership NHS FT
CT1-3	4	4	Sheffield Health and Social Care Trust
FY2 FY1	1 1	1 1	Barnsley Hospital NHS Foundation Trust

Calderdale

Grade of Trainee	**Number Expected**	**Number in Post (WTE)**	**Employer**
ST4-6	1	1	South West Yorkshire Partnership NHS FT
GP Trainee	3	3*	South West Yorkshire Partnership NHS FT
CT1-3	4	2.8*	South West Yorkshire Partnership NHS FT
LAS (covering Training gaps)	N/A	1*	South West Yorkshire Partnership NHS FT
FY2 FY1	3 1	3 1	Calderdale and Huddersfield NHS FT Calderdale and Huddersfield NHS FT

*In post but a total of 3 doctors unable to do on-call

Kirklees

Grade of Trainee	Number Expected	Number in post (WTE)	Employer
ST4-6	1	1	South West Yorkshire Partnership NHS FT
GP Trainee	2	2	South West Yorkshire Partnership NHS FT
CT1-3	6	4	South West Yorkshire Partnership NHS FT
LAS (covering Training gaps)	N/A	2	South West Yorkshire Partnership NHS FT
FY2 FY1	1 1	1 1	Calderdale and Huddersfield NHS FT Calderdale and Huddersfield NHS FT

Wakefield

Grade of Trainee	Number Expected	Number in post (WTE)	Employer
ST4-6	4	3.6	South West Yorkshire Partnership NHS FT
GP Trainee	4	2.6	Leeds and York Partnership NHS FT
CT1-3	7	5	Leeds and York Partnership NHS FT
LAS (covering training gaps)	N/A	2	South West Yorkshire Partnership NHS FT
FY2 FY1	2 3	2 3	Mid Yorkshire NHS Trust Mid Yorkshire NHS Trust

Newton Lodge

Grade of Trainee	Number	Employer
ST4-6	3	South West Yorkshire Partnership NHS FT
ST4-6	1	Sheffield Health and Social Trust

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board 31 October 2017
Agenda item 7.2

Title:	**Learning from healthcare deaths report - Quarter 1 2017/18**
Paper prepared by:	Director of Nursing and Quality
Purpose:	The purpose of the paper is to provide assurance to Trust Board that learning from healthcare deaths arrangements are in place and to provide the first quarter data for publication.
Mission/values:	The report demonstrates the Trust's commitment to delivering safe and effective services.
Any background papers/ previously considered by:	Trust Board has received papers about the introduction of this national requirement and the policy.
Executive summary:	➢ Scrutiny of healthcare deaths has been high on the government's agenda for some time, reports such as Francis report and Southern Healthcare has intensified this. ➢ Nationally there is a requirement to produce learning from healthcare deaths policy. The Trust policy has a short review date of April 2018; this is to ensure this is working and to incorporate further national policies (e.g. engaging with service users) when published. ➢ Trusts must also report and publish data from April 2017 from quarter 3 2017/18 onwards. ➢ The report provides overarching figures and then the deaths and scope and number that have been reviewed. ➢ While this work is being developed and to introduce the process in a manageable way, from April 2017 to September 2017 the Trust started reviewing all deaths reported on Datix, using an incremental approach. The policy will result in more deaths being in scope from 1st October 2017. ➢ The Trust has adopted the three levels of scrutiny suggested in the National Quality Board guidance: o Death Certification o Case record review, through Structured Judgment Record Review o Investigation – that could be service level, serious incident reported on STEIS or other review e.g. Learning Disability Mortality Review (LeDeR), safeguarding. ➢ Total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of death = 967 ➢ Total number of deaths reported on Datix by staff (by reported date, not date of death) NB: Date range of Datix reported deaths is December 2016 - June 2017 =158 ➢ Total reviewed =158

	➢ Total in scope as described in report =26 ➢ Learning from quarter one Structured Judgement Record Reviews / Investigations is included in the report. This section will develop over time. **Next steps** ➢ Publish the report on the Trust website. ➢ To further develop processes and report working with other providers in the North of England. **Risk appetite** Risk identified –the trust continues to have a good governance system of reporting, analysing and investigating healthcare deaths. This report covers assurance for: ➢ Compliance risk - Risk of failing to comply with CQC standards and potential of compliance action. This meets the risk appetite - minimal/low and the risk target 1-3. ➢ 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. ➢ Financial or commercial risks - Reputational risks, negative impact on perceptions of service users, staff, commissioners. Risk appetite Cautious/Moderate 4-6. The Trust has developed Datix and worked with performance and information to ensure information is available. A policy has been developed which meets current national requirements. Training to review records has been provided. The outcome which is now the important aspect continues to be developed.
Recommendation:	**The Trust Board is asked to RECEIVE and COMMENT on the report and APPROVE publication.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Learning from healthcare deaths - The right thing to do

Introduction

Scrutiny of healthcare deaths has been high on the government's agenda for some time. Reports such as Francis report and Southern Healthcare has intensified this. A significant amount of work has been commissioned nationally which will take some time to deliver and implement.

Healthcare providers were asked to develop a healthcare deaths policy by September 2017 that sets out how it identifies, reports, investigates and learns from a patient's death. The Trust policy has a short review date of April 2018; this is to ensure this is working and to incorporate further national policies (e.g. engaging with service users) when published.

Trusts must also report and begin to publish data from April 2017 from quarter 3 2017/18 onwards.

This report is the Trust's first report on healthcare deaths. This will be an incremental development and work in progress. The report will develop over time and ongoing feedback and suggestions about this development would be useful.

The Trust fully supports the approach and has developed this with other providers in the North of England as part of our collaborative approach to learning from deaths.

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

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.

The Trust will review/investigate deaths we have agreed are in scope through the policy. Working with families/carers of patients who have died could offer an invaluable source of insight to learn lessons and improve services.

Scope

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.

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.

While this work is being developed and to introduce the process in a manageable way, 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
- Learning Disability Mortality Review (LeDeR) deaths in scope. All deaths were reviewed but then excluded deaths that took place in acute trusts as they would be undertaking the review and linking with SWYPFT if required. We still ensured all deaths had been reported to the LeDeR programme.
- Existing Serious Incident Framework – deaths requiring reporting through this system on STEIS
- 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

The Trust has adopted the three levels of scrutiny as suggested in the National Quality Board guidance:

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

This scope is further developed in the policy Learning from healthcare deaths – the right thing to do. This will be followed from October 2017 onwards.

The process has been validated throughout its development through the Trust's mortality review group and risk panel.

The dashboard on the following pages presents the Trust's reporting for Quarter 1 2017/18.

South West Yorkshire Partnership NHS Foundation Trust

Learning from Deaths Dashboard - Reporting Period - 2017/18
Data Taken from the Trust's Incident Reporting System

Table 1: Total Summary Information for Quarter 1 2017/18 (1 April 2017 - 30 June 2017)

Total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of date of death	967
Total number of deaths reported on Datix by staff (by reported date, not date of death) NB: Date range of Datix reported deaths is December 2016 - June 2017	158
Total number of deaths reviewed	158
Total Number of deaths reported on Datix that were in scope (see scope criteria above)	26
Total Number of deaths not in the Trust scope for Quarter 1 and 2 (where the Trust was not the lead provider of care; and there were no concerns raised about care provided)	132

Table 2: Breakdown of the Total Number of Deaths reviewed by service area

Total Number of Deaths reviewed	Mental Health Community	Mental Health Inpatient	General Community	General Community Inpatient	Specialist Services Learning Disability	Specialist Services CAMHS	Specialist Services ADHD	Forensic
Q1	Q1	Q1	Q1	Q1	Q1	Q1	Q1	Q1
158	**143**	**3**	**0**	**7**	**4**	**0**	**1**	**0**
Q2	Q2	Q2	Q2	Q2	Q2	Q2	Q2	Q2
Q3	Q3	Q3	Q3	Q3	Q3	Q3	Q3	Q3
Q4	Q4	Q4	Q4	Q4	Q4	Q4	Q4	Q4
YTD	YTD	YTD	YTD	YTD	YTD	YTD	YTD	YTD
158	**143**	**3**	**0**	**7**	**4**	**0**	**1**	**0**

Table 3: Summary of total number of in scope deaths and Review process

Total Number of Deaths in scope	Total Number of In-Patient Deaths	Total Number of Deaths Reviewed in Line with SI Framework***	Total Number of Deaths (other investigation)***	Total number of deaths subject to Structured Judgement Record Review**	Total number of deaths that were certified*	Total number of deaths with learning (being collated)
Q1	Q1	Q1	Q1	Q1	Q1	Q1
26	**10**	**10**	**1**	**4**	**11**	**0**
Q2	Q2	Q2	Q2	Q2	Q2	Q2
0	**0**	**0**	**0**	**0**	**0**	**0**
Q3	Q3	Q3	Q3	Q3	Q3	Q3
0	**0**	**0**	**0**	**0**	**0**	**0**
Q4	Q4	Q4	Q4	Q4	Q4	Q4
0	**0**	**0**	**0**	**0**	**0**	**0**
YTD	YTD	YTD	YTD	YTD	YTD	YTD
26	**10**	**10**	**1**	**4**	**11**	**0**

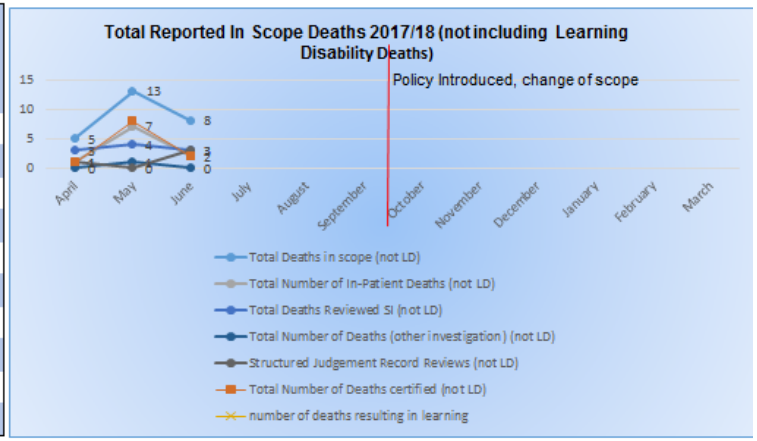
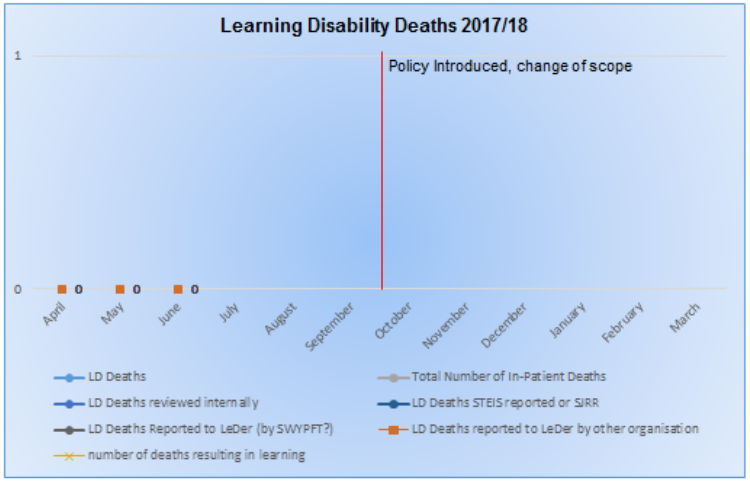


Table 4: Summary of total number of Learning Disability deaths which were in scope

Total Number of Learning Disability Deaths	Total Number of In-Patient Deaths	Total Number of Deaths Reviewed internally	Total Number of Deaths Reviewed in Line with SI Framework* or Structured Judgement Record	Total number of deaths reported through LeDer (By SWYPFT)**	Total number of deaths reported through LeDer (By other organisation)**	Total number of deaths with learning
Q1	Q1	Q1	Q1	Q1	Q1	Q1
0	**0**	**0**	**0**	**0**	**0**	**0**
Q2	Q2	Q2	Q2	Q2	Q2	Q2
0	**0**	**0**	**0**	**0**	**0**	**0**
Q3	Q3	Q3	Q3	Q3	Q3	Q3
0	**0**	**0**	**0**	**0**	**0**	**0**
Q4	Q4	Q4	Q4	Q4	Q4	Q4
0	**0**	**0**	**0**	**0**	**0**	**0**
YTD	YTD	YTD	YTD	YTD	YTD	YTD
0	**0**	**0**	**0**	**0**	**0**	**0**



Learning from Structure Judgment Record Reviews and Investigations

This section contains a summary of learning identified from reviews and investigations that have been completed so far from Quarter 1. Further learning will be added as these are completed.

1) Learning from Investigations

Of the 11 deaths reported in Quarter 1 2017/18 resulting in investigations (10 serious incident investigation and one serious case review), four investigations have been completed at the date of reporting (20/10/17). The remaining investigations are underway and any learning identified will be added at the conclusion of the investigation process.

The four completed Serious Incident investigations resulted in 12 recommendations being made. Analysis of these recommendations has identified five emerging themes. The top theme is consistent with that identified in the 2016/17 Incident Management Annual report.

The themes are:

- **Record keeping** – this was the most common theme emerging from the four Serious Incident Investigations. This resulted in five recommendations and appeared in three of the four cases
- **Team working** - There were three recommendations which were identified in one Serious Incident
- **Risk assessment** - There were two recommendations which were identified in one Serious Incident
- **Policy in place but not adhered to** - There was one recommendation identified relating the discharge policy
- **Medication Management** - There was one recommendation identified

2) Learning from Structured Judgments in Mortality Reviews in Quarter 1 2017/18

4 Structure Judgment Record Reviews (SJRR) have been completed for deaths reported in Quarter 1 with the outcome being:

1 with adequate care
2 with excellent care
1 for further review

Summary of areas for learning from SJRR in Quarter 1

It is difficult to draw themes from four structured judgement record reviews, however there was much more evidence of positive practice, for example:

"Overall the care was excellent. Input from a wide variety of disciplines, with regular review and regular consideration of which pharmacological options would suit him and his circumstances best. High-quality physical health care. Measures taken to increase observation/avoid falls to keep him safe. Family indicated that they were happy with his care."

"The initial assessment by senior nurse was closely followed up by psychiatrist review. Equally thorough and well documented medic care plan."

"Advocacy contacted on his behalf."

Areas to consider for improving practice.

- The person was at risk of falls and died as a result of a fall at home. There was no evidence of using the skills of the whole team in mitigating risk e.g. Occupational Therapy assessment.
- Convening best interest case conference or strategy meeting to discuss service user's capacity would be valuable. Robust plan to further review their capacity in the community would also be useful.

Action

Mental capacity training is now mandatory and training has been rolled out across the Trust.

Next Steps

- Continue to use the Structure Judgment Record Review for analysis of themes
- Develop experience in the use of Structure Judgment Record Review
- Continue to theme recommendations arising from Serious Incident investigations
- Further detailed information on learning will be provided to the Mortality Review Group

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 October 2017
Agenda item 7.3

Title:	**Standards of Conduct in Public Service Policy (conflicts of interest)**
Paper prepared by:	Director of Finance Director of Human Resources, Organisational Development and Estates
Purpose:	NHS England issued new guidance for the NHS organisations on managing staff conflicts of interests (https://www.england.nhs.uk/ourwork/coi/). This policy is an update to the Trust's policy to align with the guidance.
Mission/values:	The NHS as a whole spends a large amount of public money and therefore it is vital that this is done in the best interest of the population served. The Trust's Standards of Conduct in Public Service Policy, which is supported by NHS England's guidance, is designed to ensure that all staff are clear about the importance that decisions are seen to be arrived at without undue influence. This policy supports all the Trust's values but in particular the commitment to be honest, open and transparent.
Any background papers/ previously considered by:	Update to the previous Standards of Business Conduct which forms part of all staff contracts of employment. The update has been reviewed by the Executive Management Team on 19 September 2017 and Audit Committee on 10 October 2017 who support its approval.
Executive summary:	The Trust's Standards of Conduct in Public Service Policy sets outs clear expectations and responsibilities of staff whilst at work and in summary these are: Staff of the Trust are expected to: ➢ Ensure that the interest of patients remains paramount at all times; ➢ Be impartial and honest in the conduct of their official business; ➢ Use the public funds entrusted to them to the best advantage of the service, always ensuring value for money. Staff have a responsibility not to: ➢ Abuse their official position for personal gain or to benefit their family or friends; ➢ Accept bribes; ➢ Seek to advantage or further private business or other interests, in the course of their official duties NHS England guidance on managing conflict of interests: ➢ introduced common principles and rules for managing conflicts of interest ➢ provided simple advice to staff and organisations about what to do in common situations ➢ supported good judgement about how interests should be approached and managed NHS England's guidance defines a conflict of interest as "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold."

	Categories of interests are set out as: ➢ **Financial Interests**: Where an individual may get direct financial benefit from the consequences of a decision they are involved in making. ➢ **Non-Financial Professional Interests**: Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career. ➢ **Non-Financial Personal Interests**: Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career. ➢ **Indirect Interests**: Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making The guidance and Policy details principles, rules and the declaration process for the following areas: ➢ Gifts ➢ Hospitality ➢ Outside Employment ➢ Shareholding and other ownership interests ➢ Patents ➢ Loyalty interests ➢ Donations ➢ Sponsored events ➢ Sponsored research ➢ Sponsored posts ➢ Clinical private practice Note, there are separate conflict of interest policies for the Trust Board (*Trust Board declaration and register of fit and proper persons, independence, interests, gifts and hospitality and Members' Council*) and Members' Council (*Members' Council declaration and register of interests, gifts and hospitality*) which support the specific requirements of Directors and Governors within the Trust's Constitution, the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and Monitor's Code of Governance for Foundation Trust. These policies are next due for review in 2018. **Risk appetite** As the Trust's Standards of Conduct in Public Service Policy is compliant with the NHS England guidance there is no change to any identified risks and it remains consistent with the agreed risk tolerance.
Recommendation:	**Trust Board is asked to APPROVE the updated policy which is aligned with the guidance issued by NHS England on managing conflicts of interest.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Document name:	Standards of Conduct in Public Service Policy (including Business Conduct and Manager's Code of Practice)
Document type:	Policy
What does this Policy replace?	Update of previous version
Staff group to whom it applies:	All staff
Distribution:	Trust Wide
How to access:	Intranet
Issue date:	Version 3 October 2017
Next review:	October 2019
Approved by:	Executive Management Team Trust Board
Developed by:	HR Business Manager Deputy Director of Finance
Director leads:	Director of Finance and Resources Director of HR, OD and Estates
Contact for advice:	Corporate Governance Team

Conflicts of Interest Policy for South West Yorkshire Partnership NHS Foundation Trust

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1 Policy Summary

Adhering to this policy will help to ensure that we use NHS money wisely, providing best value for taxpayers and accountability to our service users/patients for the decisions we take.

As a member of staff you should…	As an organisation we will…
• Familiarise yourself with this policy and follow it. Refer to the guidance for the rationale behind this policy https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf. • Use your common sense and judgement to consider whether the interests you have could affect the way taxpayers' money is spent. • Regularly consider what interests you have and declare these as they arise. If in doubt, declare. • **NOT** misuse your position to further your own interests or those close to you. • **NOT** be influenced, or give the impression that you have been influenced by outside interests. • **NOT** allow outside interests you have to inappropriately affect the decisions you make when using taxpayers' money.	• Ensure that this policy and supporting processes are clear and help staff understand what they need to do. • Identify a team or individual with responsibility for: o Keeping this policy under review to ensure they are in line with the guidance. o Providing advice, training and support for staff on how interests should be managed. o Maintaining register(s) of interests. o Auditing this policy and its associated processes and procedures at least once every three years. • **NOT** avoid managing conflicts of interest. • **NOT** interpret this policy in a way which stifles collaboration and innovation with our partners

2 Introduction

South West Yorkshire Partnership NHS Foundation Trust (the 'Trust'), and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our service users/patients. These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. But there is a risk that conflicts of interest may arise.

Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community. As a Trust and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of patients.

This policy replaces Standards of Conduct in Public Service Policy (May 2012). The structure follows the national model policy and incorporates Trust specific elements. All staff must follow the principles set out in the policy.

All staff are responsible for ensuring that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties.

3 Purpose

This policy will help our staff manage conflicts of interest risks effectively. It:

- Introduces consistent principles and rules
- Provides simple advice about what to do in common situations.
- Supports good judgement about how to approach and manage interests

The core principles underpinned by this policy include that staff are expected to :

- Ensure the interest of patients remains paramount at all times
- Be impartial and honest in the conduct of their official business
- Use public funds entrusted to them to the best advantage of the services, always ensuring value for money.

It is the responsibility of staff to ensure that they do NOT:

- Abuse their official position for personal gain or to benefit their family or friends;
- Accept bribes;
- Seek to advantage or further private business or other interests in the course of their official duties.

This policy should be considered alongside these other Trust policies:

- Standing Financial Instructions
- Whistleblowing Policy

4 Key terms

A ‘conflict of interest’ is:

> “A set of circumstances by which a reasonable person would consider that an individual’s ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.”

A conflict of interest may be:

- Actual - there is a material conflict between one or more interests
- Potential – there is the possibility of a material conflict between one or more interests in the future

Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

5 Interests

Interests fall into the following categories:

- **Financial interests:**
  Where an individual may get direct financial benefit[1] from the consequences of a decision they are involved in making.
- **Non-financial professional interests:**
  Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.
- **Non-financial personal interests:**
  Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.
- **Indirect interests:**
  Where an individual has a close association[2] with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

[1] This may be a financial gain, or avoidance of a loss.
[2] A common sense approach should be applied to the term ‘close association’. Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates, and business partners.

6 Staff

At the Trust we use the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as 'staff' and are listed below:

- All salaried employees
- All prospective employees – who are part-way through recruitment
- Bank staff
- Contractors and sub-contractors
- Agency staff; and
- Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the Trust)
- Volunteers

This policy applies to all staff and it is the responsibility of all staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties.

It is the responsibility of managers within the Trust to ensure that the policy is brought to the attention of all staff.

7 Decision Making Staff

Some staff are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this guidance these people are referred to as 'decision making staff.'

Decision making staff in this Trust are:

- Trust Directors
- Trust Board members
- Senior Managers with responsibility for commissioning of services and /or the purchasing of goods and services.

Note, there are separate Declaration of Interest policies for the Trust Directors, Trust Board members, and governors of the Members' Council.

8 Identification, declaration and review of interests

8.1 Identification & declaration of interests (including gifts and hospitality)

All staff should identify and declare material interests at the earliest opportunity (and in any event within 28 days). If staff are in any doubt as to whether an interest is material then they should declare it, so that it can be considered. Declarations should be made:

- On appointment with the Trust.
- When staff move to a new role or their responsibilities change significantly.

- At the beginning of a new project/piece of work.
- As soon as circumstances change and new interests arise (for instance, in a meeting when interests staff hold are relevant to the matters in discussion).

A declaration of interest(s) form is available at Appendix D.

Declarations should be made to the Trust Company Secretary.

After expiry, an interest will remain on register(s) for a minimum of 6 months and a private record of historic interests will be retained for a minimum of 6 years.

8.2 Proactive review of interests

We will prompt decision making staff annually to review declarations they have made and, as appropriate, update them or make a nil return.

9 Records and publication

9.1 Maintenance

The Trust will maintain a single Register of Interest.

All declared interests will be promptly transferred to the register by the Company Secretary, at least monthly.

9.2 Wider transparency initiatives

The Trust fully supports wider transparency initiatives in healthcare, and we encourage staff to engage actively with these.

Relevant staff are strongly encouraged to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. These “transfers of value” include payments relating to:

- Speaking at and chairing meetings
- Training services
- Advisory board meetings
- Fees and expenses paid to healthcare professionals
- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK
- Donations, grants and benefits in kind provided to healthcare organisations

Further information about the scheme can be found on the ABPI website: http://www.abpi.org.uk/our-work/disclosure/about/Pages/default.aspx

10 Management of interests – general

If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:

- restricting staff involvement in associated discussions and excluding them from decision making
- removing staff from the whole decision making process
- removing staff responsibility for an entire area of work
- removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant

Each case will be different and context-specific, and the Trust will always clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken.

Staff who declare material interests should make their line manager or the person(s) they are working to aware of their existence.

11 Management of interests – common situations

This section sets out the principles and rules to be adopted by staff in common situations, and what information should be declared.

11.1 Gifts

- Staff should not accept gifts unless to do so causes offence. These should be politely but firmly declined.

Gifts from suppliers or contractors:

- Gifts from suppliers or contractors doing business (or likely to do business) with the Trust should be politely but firmly declined, whatever their value.
- Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6[3] in total, and need not be declared.

Gifts from other sources (e.g. patients, families, service users):

- Gifts of cash and vouchers to individuals should always be declined.
- Staff should not ask for any gifts.
- Gifts of a low intrinsic value such as chocolates or flowers can be accepted but must be declared.
- If a gift is accepted a Declaration of Interest form (Appendix D) should be completed.
- Any gift accepted should be accepted on behalf of the Trust and other related Charities.

11.1.1 What should be declared

- Staff name and their role with the Trust.
- A description of the nature and value of the gift, including its source.
- Date of receipt.

[3] The £6 value has been selected with reference to existing industry guidance issued by the ABPI: http://www.pmcpa.org.uk/thecode/Pages/default.aspx

- Any other relevant information (e.g. circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.2 Hospitality

- Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.
- Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event. (It would be normal and reasonable for hospitality to be provided)
- Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable. Senior approval, by a General Manager or equivalent, must be obtained.

Meals and refreshments:

- Under a value of £25 - may be accepted and need not be declared.
- Of a value between £25 and £75[4] - may be accepted and must be declared.
- Over a value of £75 - should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on the Trust's register(s) of interest as to why it was permissible to accept.
- A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate).

Travel and accommodation:

- Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.
- Offers which go beyond modest, or are of a type that the Trust itself might not usually offer, need approval by senior staff, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on the Trust's register(s) of interest as to why it was permissible to accept travel and accommodation of this type. A non-exhaustive list of examples includes:
    - offers of business class or first class travel and accommodation (including domestic travel)
    - offers of foreign travel and accommodation.

11.2.1 What should be declared

- Staff name and their role with the Trust.
- The nature and value of the hospitality including the circumstances.
- Date of receipt.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.3 Outside Employment

[4] The £75 value has been selected with reference to existing industry guidance issued by the ABPI http://www.pmcpa.org.uk/thecode/Pages/default.aspx

Employees of the Trust are advised not to engage in outside employment, which may conflict with their NHS work, or be detrimental to it.
Outside employment could include working in a private clinic / hospital, registered nursing or residential care home. Other areas may include consultancy work, or involvement in running of a voluntary sector organisation (even in a voluntary capacity).

- Staff must declare any existing outside employment on appointment and any new outside employment when it arises.
- Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks.
- Where contracts of employment or terms and conditions of engagement permit, staff are required to seek prior approval from the Trust to engage in outside employment.

11.3.1 What should be declared

- Staff name and their role with the Trust.
- The nature of the outside employment (e.g. who it is with, a description of duties, time commitment).
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.4 Shareholdings and other ownership issues

- Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the Trust.
- Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.
- There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

11.4.1 What should be declared

- Staff name and their role with the Trust.
- Nature of the shareholdings/other ownership interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.5 Patents

- Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the Trust.
- Staff should seek prior permission from the Trust before entering into any agreement with bodies regarding product development, research, work on

pathways etc, where this impacts on the Trust's own time, or uses its equipment, resources or intellectual property.
- Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

11.5.1 What should be declared

- Staff name and their role with the Trust.
- A description of the patent.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)

11.6 Loyalty interests

Loyalty interests should be declared by staff involved in decision making where they:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are aware that their Trust does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

11.6.1 What should be declared

- Staff name and their role with the Trust.
- Nature of the loyalty interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.7 Donations

- Donations made by suppliers or bodies seeking to do business with the Trust should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.
- Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the Trust, or is being pursued on behalf of the Trust's own registered charity or other charitable body and is not for their own personal gain.
- Staff must obtain permission from the Trust if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the Trust's own.
- Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.

- Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

11.7.1 What should be declared

- The Trust will maintain records in line with the above principles and rules and relevant obligations under charity law.

11.8 Sponsored events

- Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit the organisations and the NHS.
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.
- No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.
- At the Trust's discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event.
- The involvement of a sponsor in an event should always be clearly identified.
- Staff within the Trust involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.
- Staff arranging sponsored events must declare this to the Trust through the Declaration of Interest form.

11.8.1 What should be declared

- The Trust will maintain records regarding sponsored events in line with the above principles and rules. This must include:
    - Purpose of Sponsorship
    - Names of companies involved
    - Sponsorship value

11.9 Sponsored research

- Funding sources for research purposes must be transparent.
- Any proposed research must go through the relevant health research authority or other approvals process.
- There must be a written protocol and written contract between staff, the Trust, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.
- The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.
- Staff should declare involvement with sponsored research to the Trust through the Declaration of Interest form.

11.9.1 What should be declared

- The Trust will retain written records of sponsorship of research, in line with the above principles and rules.
- Staff should declare:
    - their name and their role with the Trust.
    - Nature of their involvement in the sponsored research.
    - relevant dates.
    - Other relevant information (e.g. what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.10 Sponsored posts

- External sponsorship of a post requires prior approval from the Trust.
- Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.
- Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided.
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

11.10.1 What should be declared

- The Trust will retain written records of sponsorship of posts, in line with the above principles and rules.
- Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy.

11.11 Clinical private practice

Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises[5] including:

- Where they practise (name of private facility).
- What they practise (specialty, major procedures).
- When they practise (identified sessions/time commitment).

Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

[5] Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf

- Seek prior approval of their Trust before taking up private practice.
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.[6]
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf

Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

11.11.1 What should be declared

- Staff name and their role with the Trust.
- A description of the nature of the private practice (e.g. what, where and when staff practise, sessional activity, etc).
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

12 Management of interests – advice in specific contexts

12.1 Strategic decision making groups

In common with other NHS bodies the Trust uses a variety of different groups to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts.
- Awarding grants.
- Making procurement decisions.
- Selection of medicines, equipment, and devices.

These groups should adopt the following principles:

- Chairs should consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the Trust's register(s).
- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement.

If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting.
- Excluding the member from receiving meeting papers relating to their interest.
- Excluding the member from all or part of the relevant discussion and decision.

[6] These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf)

- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate.
- Removing the member from the group or process altogether.

The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

12.2 Procurement

Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients and the public.

Those involved in procurement exercises for and on behalf of the Trust should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

By participating in tendering exercises prospective suppliers should also be in agreement with, and adhere to, the Trust's Supplier Code of Conduct. A copy of which is included within the tender documentation. Any supplier not wishing to comply with this term should provide details of their objections which will be duly noted and considered within the contract award process.

13 Dealing with breaches

There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as 'breaches'.

13.1 Identifying and reporting breaches

Staff who are aware about actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns to:

- Line Manager
- Deputy Director of Finance
- Human Resource Business Partner
- Company Secretary
- Local Counter Fraud Specialist

To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Ever individual has a responsibility to do this. For further information about how concerns should be raised please refer to the Trust's Whistleblowing Policy available on the Intranet document store (http://nww.swyt.nhs.uk/docs/Documents/Forms/AZ.aspx)

The organisation will investigate each reported breach according to its own specific facts and merits, and give relevant parties the opportunity to explain and clarify any relevant circumstances.

7.4. Following investigation the organisation will:

- Decide if there has been or is potential for a breach and if so the what severity of the breach is.
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum.
- Consider who else inside and outside the organisation should be made aware
- Take appropriate action as set out in the next section.

13.2 Taking action in response to breaches

Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the organisation and could involve organisational leads for staff support (e.g. Human Resources), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and organisational auditors.

Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures.
- Consideration as to whether HR/employment law/contractual action should be taken against staff or others.
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Protect, the Police, statutory health bodies (such as NHS England, NHS Improvement or the CQC), and/or health professional regulatory bodies.

Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the organisation can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Employment law action against staff, which might include
    - Informal action (such as reprimand, or signposting to training and/or guidance).
    - Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal).
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be.
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach.
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

13.3 Learning and transparency concerning breaches

Reports on breaches, the impact of these, and action taken will be considered by the Trust Executive Management Team (EMT) and reported, at least annually, to the Trust Audit Committee.

14 Review

This policy will be reviewed bi-annually unless an earlier review is required. This will be led by the Human Resources Business Partner in conjunction with the Deputy Director of Finance and Company Secretary.

15 Associated documentation

Freedom of Information Act 2000
ABPI: The Code of Practice for the Pharmaceutical Industry (2014)
ABHI Code of Business Practice
NHS Code of Conduct and Accountability (July 2004)

Appendix A - Equality Impact Assessment Tool

To be completed and attached to any policy document when submitted to the Executive Management Team for consideration and approval.

Date of Assessment: 4th September 2017

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
1	**Name of the document that you are Equality Impact Assessing**		Standards of Conduct in Public Service Policy
2	**Describe the overall aim of your document and context?** **Who will benefit from this policy/procedure/strategy?**		To ensure that employees adhere to the expected standards of business conduct required of NHS staff and that there is an appropriate means of declaring legitimate interests All staff and the Trust
3	**Who is the overall lead for this assessment?**		Human Resources, OD and Facilites Director of Finance
4	**Who else was involved in conducting this assessment?**		Human Resources Integrated Governance Manager Deputy Director of Finance Staff Side
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?**		Staff Side
6	**What equality data have you used to inform this equality impact assessment?**		Reviewed data in the equality workforce monitoring report
7	**What does this data say?**		Data of numbers of staff in different equality groups
8	**Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavourably:**	**Yes/No**	
8.1	**Race**	No	This policy applies equally to all groups of staff
8.2	**Disability**	No	This policy applies equally to all groups of staff
8.3	**Gender**	No	Some female staff may have more than one job role

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
			however this policy does not restrict outside employment unless there is a conflict of interest.
8.4	**Age**	No	This policy applies equally to all groups of staff
8.5	**Sexual orientation**	No	This policy applies equally to all groups of staff
8.6	**Religion or belief**	No	This policy applies equally to all groups of staff
8.7	**Transgender**	No	This policy applies equally to all groups of staff
8.8	**Maternity & Pregnancy**	No	This policy applies equally to all groups of staff
8.9	**Marriage & Civil partnerships**	No	This policy applies equally to all groups of staff
8.10	**Carers*Our Trust requirement***	No	This policy does not apply to carers
9	**What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-**		
9a	**Promotes equality of opportunity for people who share the above protected characteristics;**		This policy applies equally to all staff.
9b	**Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;**		Declarations of interests will be reviewed to ensure that appropriate advice/support is provided to different staff groups.
9c	**Promotes good relations between different equality groups;**		This policy applies equally to all staff.
9d	**Public Sector Equality Duty – "Due Regard"**		This policy applies equally to all staff.
10	**Have you developed an Action Plan arising from this assessment?**		N/A
11	**Assessment/Action Plan approved by**		**Signed:** A Hambling, HR Business Manager Rob Adamson Deputy Director of Finance **Date:** 4th September 2017
12	***Once approved, you must forward a copy of this Assessment/Action Plan to the partnerships team:*** **partnerships@swyt.nhs.uk**		

	Equality Impact Assessment Questions:	Evidence based Answers & Actions:
	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.**	

If you have identified a potential discriminatory impact of this policy, please refer it to the Director of Corporate Development or Equality and Engagement Development Managers together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Director of Corporate or Equality and Engagement Development Managers.

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	Clear policy which enables management and staff to make correct decisions, deal effectively and comply with legislation, Trust processes and good working practices.
	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?	No	
	Are people involved in the development identified?	Yes	Utilise national policy framework but HR, finance and governance involved prior to Staffside and Members review
	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	Applies to all staff
	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	
	Are supporting documents referenced?	Yes	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
6.	**Approval**		
	Does the document identify which committee/group will approve it?		
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	Yes	Will be subject to discussion and agreement with staff side
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?	N/A	
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	

Appendix C - Version Control Sheet

This sheet should provide a history of previous versions of the policy and changes made

Version	Date	Author	Status	Comment / changes
1.0	Aug 03	James Corson	Superseded	
2.0	May 12	James Corson	Superseded	An extensive rewrite and change of title. It incorporates elements of the Barnsley PCT policy and reference to the Bribery Act and the revised CIPS professional Code. It also now makes reference to the Code of conduct for NHS Managers. This single procedure now replaces all the previous disciplinary documents for the forerunner organisations: Barnsley, Calderdale and Wakefield PCT's
2.0a	Apr 13	James Corson	Superseded	Links embedded in the document updated
2.0b	Dec 13	James Corson	Superseded	Addition of further information on Fraud/bribery/corruption following a Focussed Quality Assessment
2.0c	Feb 15	James Corson	Superseded	Further clarification of when staff can engage in outside employment. See para 5.8
3	3/10/17	HR Business Manager / Deputy Director of Finance	Current	Updated in accordance with national guidance.

South West Yorkshire Partnership NHS Foundation Trust

Appendix D - Declaration Form

IN STRICT CONFIDENCE - INTERESTS DECLARATION FORM		
Name and Base		
Job Title		
Description of Interest		
Relevant dates	From:	To:
The information submitted will be held by South West Yorkshire NHS Foundation Trust ('the Trust') for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that South West Yorkshire NHS Foundation Trust holds. I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to South West Yorkshire NHS Foundation Trust as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, internal disciplinary, or professional regulatory action may result. I **do / do not** give my consent for this information to published on registers that South West Yorkshire NHS Foundation Trust holds. If consent is not given please give reasons.		
Signed:	**Date:**	
Comments of Line Manager and/or Head of Service (as appropriate)		
Signed:	**Date:**	
Action required, if any:		
• **Copy to Personal File**	• **Original to Register of Interests File**	

PLEASE RETURN THIS FORM TO: Company Secretary, Block 7, Fieldhead, Wakefield

GUIDANCE NOTES FOR COMPLETION OF INTERESTS DECLARATION FORM

Name and Base Insert your name and location

Job Title Insert your position/role in relation to the Trust

Description of Interest: Provide a description of the interest that is being declared. This should contain enough information to be meaningful (e.g. detailing the supplier of any gifts, hospitality, sponsorship, etc). That is, the information provided should enable a reasonable person with no prior knowledge should be able to read this and understand the nature of the interest.

Types of interest:

Financial interests - This is where an individual may get direct financial benefits from the consequences of a decision they are involved in making

Non-financial professional interests - This is where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or status or promoting their professional career

Non-financial personal interests - This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career

Indirect interests - This is where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making.

A benefit may arise from both a gain or avoidance of a loss.

Further comments:

Detail any action taken to manage an actual or potential conflict of interest. It might also detail any approvals or permissions to adopt certain course of action.

Relevant Dates: Detail here when the interest arose and, if relevant, when it ceased.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 October 2017

Agenda item 8 – Receipt of public minutes of partnership boards

Barnsley Health and Wellbeing Board

Date	3 October 2017
Member	Rob Webster/Sean Rayner
Items discussed	➢ Annual Report of the Barnsley Local Safeguarding Adults Board ➢ Annual Report of the Barnsley Local Safeguarding Children Board ➢ Better Care Fund (BCF) ➢ Local Digital Road Map ➢ CLeaR Peer Assessment ➢ CQC Local System Reviews
Minutes	Papers and draft minutes (when available): http://barnsleymbc.moderngov.co.uk/mgCommitteeDetails.aspx?ID=143

Calderdale Health and Wellbeing Board

Date	19 October 2017
Non-Voting Member	Dr Adrian Berry/Karen Taylor
Items discussed	➢ Delivery of Single Plan for Calderdale ➢ Emotional Health and Wellbeing for Children and Young People - Local Transformation Plan ➢ Better Care Fund ➢ Calderdale Food Network ➢ Calderdale's Digital Strategy
Minutes	Papers and draft minutes (when available): https://www.calderdale.gov.uk/council/councillors/councilmeetings/agendas-detail.jsp?meeting=24530

Kirklees Health and Wellbeing Board

Date	Next meeting scheduled for 14 December 2017
Invited Observer	Rob Webster/Karen Taylor
Items discussed	➢ To be confirmed
Minutes	Papers and draft minutes (when available): https://democracy.kirklees.gov.uk/mgCommitteeDetails.aspx?ID=159

Wakefield Health and Wellbeing Board

Date	Next meeting scheduled for 23 November 2017
Member	Rob Webster/Sean Rayner
Items discussed	➢ To be confirmed
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

West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups (CCGs)

Date	5 September 2017
Attendee	Rob Webster
Items discussed	➢ Mental Health Work Programme update
Papers	Papers attached.

West Yorkshire and Harrogate Sustainability and Transformation Partnership

West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups

Summary report			
Date of meeting: **5 September 2017**		Agenda item: 15/2017	
Report title:		**Mental Health Work Programme update**	
Joint Committee sponsor:		Helen Hirst	
Clinical Lead:		TBC	
Author:		Emma Fraser, Programme Director	
Presenter:		Emma Fraser and Helen Hirst	
Purpose of report:			
Decision		Comment	**Y**
Assurance	**Y**		

Executive summary

The purpose of this paper is to provide the CCG Joint Committee with an update on the West Yorkshire & Harrogate Health and Care Partnership Mental Health Programme, drawing out both strategic considerations and also commissioning aspects that are likely to require future decisions.

The programme is now well established and has a clear aim and ambition. The relationship between the six place based plans and West Yorkshire and Harrogate is critical requiring each place to deliver a strong local offer for people with mental health needs. Supporting people in crisis as close to their own home as possible is the ultimate aim. We acknowledge that this may require a scaling up of local services to be available across West Yorkshire as well as bespoke services developed on a West Yorkshire footprint.

As well as understanding and endorsing the objectives within each work programme the committee is invited to consider whether it would support a review of our current commissioning arrangements in order to strengthen them and improve our ability to deliver the benefits of the mental health work programme.

Recommendations and next steps

- Endorse the continued work of the programme and the collaborative approach to Mental Health in WY&H.
- Support the proposal to develop improved system oversight approach to Mental Health to further support improvements to services and delivery of Mental Health 5 Year Forward View.
- Support the development of the NCMs for CAMHs & Adult Eating Disorders specifically ensuring we make best use of the collective resources as a system to make service improvements.
- Advise on the approach to be taken as to developing commissioning

Delivering outcomes:
The Mental Health Programme is framed within the ambition of developing a local service framework for mental health in WY&H; reducing local variation in the quality of services and providing a consistent pathway for patients. Working in this way will ensure that our services provide the best value for money and release efficiencies through economies of scale which can be reinvested in Mental Health services as part of our commitment to the mental health investment standard. As a system we have agreed a number of priority areas, mainly secondary care mental health services, where it makes sense to take a WY&H approach and do the work once. The majority of transformation and delivery of the 5YFV for mental health will be delivered in local place.

Impact assessment	
Clinical outcomes:	See programme overview
Public involvement:	Place based engagement is evident in local plans (see engagement summary produced for the partnership). Service change linked with the programme will be coproduced with people. A full public involvement plan will be developed to support WY&H wide proposals.
Finance:	Each CCG with their mental health provider gave assurance earlier in the year that the Mental Health Investment standard was being met. Any additional investment required from the programme will form part of a business case for decision. There are no financial implications as a result of the recommendations in this paper. CCGs are aware of the likelihood that additional resources will be required to address unmet needs in respect of ASD/ADHD.
Risk:	There is a risk that each place does not make the changes required to reduce the variation in outcomes (particularly out of area placements) which compromises the plans being developed at a West Yorkshire level. There is a programme risk register overseen by the Mental Health Steering Group.
Conflicts of interest:	Conflicts of interest are currently managed effectively within the programme.

West Yorkshire and Harrogate Joint Committee of CCGs
Mental Health Programme Update

1. Introduction
The purpose of this paper is to provide the CCG Joint Committee with an update on the West Yorkshire & Harrogate Health and Care Partnership Mental Health Programme, drawing out both strategic considerations and also commissioning aspects that are likely to require future decisions.

2. Background & Overview
Mental health is both a national priority and a local priority. The mental health five year forward view clearly sets out the service transformation required and was as reaffirmed in the national Five Year Forward View Next Steps document.

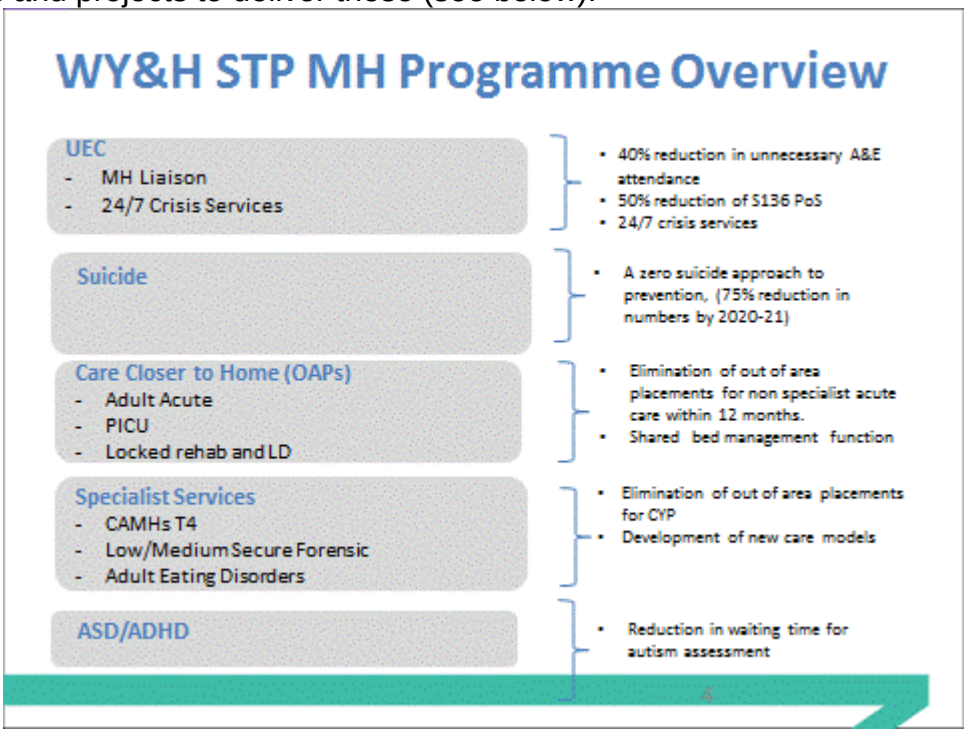
The Partnership has agreed to work at a WY&H level on mental health in order to share best practice, reduce variation and achieve better outcomes for the people of WY&H.

The Mental Health Programme is framed within the ambition of developing a local service framework for mental health in WY&H; reducing local variation in the quality of services and providing a consistent pathway for patients.

Working in this way will ensure that our services provide the best value for money and release efficiencies through economies of scale which can be reinvested in Mental Health services as part of our commitment to the mental health investment standard.

As a system we have agreed a number of priority areas, mainly secondary care mental health services, where it makes sense to take a WY&H approach and do the work once. The majority of transformation and delivery of the 5YFV for mental health will be delivered in local place.

The aims of the programme have been established along with a number of work streams and projects to deliver these (see below).



The Mental Health Trusts in West Yorkshire (Bradford District Care Foundation Trust, Leeds & York Partnership Foundation Trust, South West Yorkshire Partnership Foundation Trust and Leeds Community Healthcare NHS Trust) are committed to the development of standardised operating models that achieve benefits from collaborative working. Tees, Esk and Wear Valley Foundation Trust, the main provider of services to the Harrogate CCG population, also engages with the programme where it makes strategic and operational sense.

The interconnectivity between the WY&H programme and the 6 places is essential. The premise is that there is a local offer that is delivered consistently in each of the 6 places ensuring people are managed to prevent crises and, when someone is in crisis, ensure that that the offer to them is as local to that person as possible – hopefully in place but where necessary in West Yorkshire.

Reducing variation and supporting each other to 'level up' in place is critical. We know there is variation in quality and service offers across the patch and we have committed to understand this in more detail. Some of this variation will be warranted in line with local needs or reflect a different operating environment. Where it results in worse outcomes for people with no clear and accepted rationale then the programme regards this as unacceptable.

Recommendation

In order to be cohesive as a system it is proposed that we establish a clear performance framework that takes a strategic view of mental health service delivery in WY&H and ensures the partnership is making best use of its collective resources supporting both place based and WY&H delivery.

This will support the approach being taken by NHS England and NHS Improvement who are now looking more to STPs for delivery against national priorities. For example, we understand there will be a need to set STP trajectories for reducing out of area placements in the autumn.

3. Update on Key Workstreams/Projects

i) Urgent Care

Develop and implement a blueprint for WY&H crisis services (as per the aspirations established as part of the UEC WY Vanguard). This will be developed with local partners including how we ensure we develop new creative solutions with the voluntary sector. This will build on established crisis care concordats.

The development will include a WY&H A&E Liaison service model that will extend mental health screening at the front door of ED departments across the region at the point of triage and presentation within ED. This scaled-up model of mental health liaison will involve hospital in-reach screening and training for hospital clinical staff. We were successful in receiving transformation funds to support this development of Core 24 A&E liaison team in Leeds, Calderdale & Huddersfield and Mid Yorkshire hospitals. Whilst this will be delivered locally and is part of wider UEC plans being developed by A&E Delivery Boards we will develop a WY&H business case to ensure a sustainable MH liaison.

ii) Care Closer to Home (Out of Area Placements)

We will take forward our committed to eradicating acute area placements in line with national direction. This has already been achieved in some parts of the region and we will capitalise on this by sharing the learning and best practice across the system. The principle of accessing a bed locally in place underpins the approach alongside the development of a shared approach to bed management ensuring all people can be treated in WY&H.

Managing people in recovery and rehabilitation (locked rehabilitation) units a long way from home has both quality of care and financial implications. We will develop a consistent case management approach and explore opportunities to bring people back closer to home. A similar approach is being taken for people with learning disabilities under the transforming care programme across a Yorkshire and Humber footprint and there may well be opportunities to collaborate further on this area of work.

iii) New Care Models for - CAMHs T4 and Adult Eating Disorder Services

The Partnership has recently been successful in becoming a national new care model site for tertiary mental health services. This means that secondary mental health providers will manage care budgets for tertiary mental health services (currently commissioned by NHS England Specialised Commissioning) under a central programme taking an 'accountable care system' approach to managing and redesigning care for the local population. The combined budget for the two services is c£12m.Leeds Community Healthcare NHS Trust will be the lead provider for CAMHs T4 and Leeds & York Partnership Foundation Trust will be the lead provider for Adult Eating Disorders.

This is an opportunity to develop high quality integrated services locally, in the least restrictive setting close to home, eliminating costly and avoidable out of area placements. Both business cases set out how the development of a new care model; increased community services (Tier 3.5) providing a standard level of service and outcomes, will reduce admissions and out of area placements.

The ongoing funding for these services is predicated on this reduction. There is more work to do to understand the level of financial risk and agreement on how we best manage this in the future.

iv) ASD/ADHD

Each local place/CCG is challenged by providing a timely service to people waiting for a diagnosis and assessment of autism/ADHD. The CCGs have agreed to collaborate on this area to develop a WY&H commissioning strategy based on a robust needs assessment and a specification for a diagnostic and assessment service. This work will also require providers to identify how they can collaborate to create improvements in current access times as well as delivery against the revised specification. It is only through collaborative efforts that we can mitigate some of the additional costs of meeting the increasing prevalence of ASD/ADHD.

Recommendation

That CCGs support the ambition of the new care models and the commitment to making best use of the collective resources to improve care across WY&H.

4. Better Integration of Mental & Physical Health

In addition to the specific improvements to mental health services being taken forward by the programme we can't lose sight of the wider system opportunities and benefits to people in WY&H by ensuring we support physical and mental health in a more integrated way. This is something that needs to be addressed by all place based and WY&H programmes.

We discussed the case for change and potential opportunities in WY&H of better integration at the last Healthy Futures leadership day and look to all the other programmes to consider how they will contribute to improving the health outcomes, care experience and life chances of people with mental health conditions and people with learning disabilities.

Specifically we are looking at Liaison Mental Health Services as mentioned above and, following discussion at a CCG collaborative meeting earlier in the year are scoping the opportunity relating to better management of medically unexplained symptoms.

5. Approach to Mental Health Commissioning

The collaborative approach to MH transformation described above and supported through the ongoing development of the WY&H programmes is likely to require a different commissioning response in the future. MH providers have driven the programme of work thus far and commissioners need to develop a shared view on what the future commissioning arrangements for MH could look like and where there is benefit in a collaborative commissioning strategy alongside place based commissioning approaches. CCG resources (human) in mental health commissioning are often quite sparse when compared to the resources in physical health commissioning and there could be an opportunity to maximise our collective commissioning resource which would benefit the whole population.

Recommendation

That CCGs are invited to comment on the view that commissioning of mental health services would benefit from a review.

6. Recommendations:

The Joint CCG asked to:

- Endorse the continued work of the programme and the collaborative approach to Mental Health in WY&H.
- Support the proposal to develop improved system oversight approach to MH to further support improvements to services and delivery of MH 5YFV.
- Support the development of the NCMs for CAMHs& Adult Eating Disorders specifically ensuring we make best use of the collective resources as a system to make service improvements.
- Advise on the approach to be taken as to developing commissioning

West Yorkshire and Harrogate
Sustainability and
Transformation Partnership

Mental Health Programme

Update for Joint CCG Committee

5 September 2017

What are we trying to achieve through the programme

- WY&H local service framework - reduce local variation in the quality and performance of services and provide a consistent pathway for people in WY&H
- Development of standard operating models and outcomes
- Improving across the board to the level of the best
- Pooling our efforts and resources where that is the only way we can ensure our investments in mental health can deliver
- Ensure that our services are the best value for money and achieve efficiencies through economies of scale which will be re-invested in mental services

NHSE View

We need to get to all STPs delivering their share of…

NHS England

70,000 more children will access evidence based mental health care interventions	Intensive home treatment will be available in every part of England as an alternative to hospital. Older People	No acute hospital is without all-age mental health liaison services, and at least 50% are meeting the 'core 24' service standard Older People
At least 30,000 more women each year can access evidence-based specialist perinatal mental health care	10% reduction in suicide and all areas to have multi-agency suicide prevention plans in place by 2017 Older People	Increase access to evidence-based psychological therapies to reach 25% of need, helping 600,000 more people per year Older People
The number of people with SMI who can access evidece based Individual Placement and Support (IPS) will have doubled	280,000 people with SMI will have access to evidence based physical health checks and interventions Older People	60% people experiencing a first episode of psychosis will access NICE concordant care within 2 weeks including children
Inappropriate out of area placements (OAPs) will have been eliminated for adult acute mental health care	New models of care for tertiary MH will deliver quality care close to home reduced inpatient spend, increased community provision including for children and young people	There will be the right number of CAMHS T4 beds in the right place reducing the number of inappropriate out of area placements for children and young people

WY&H MH Programme Overview

UEC
- MH Liaison
- 24/7 Crisis Services

- 40% reduction in unnecessary A&E attendance
- 50% reduction of S136 PoS
- 24/7 crisis services

Suicide

- A zero suicide approach to prevention, (75% reduction in numbers by 2020-21)

Care Closer to Home (OAPs)
- Adult Acute
- PICU
- Locked rehab and LD

- Elimination of out of area placements for non specialist acute care within 12 months.
- Shared bed management function

Specialist Services
- CAMHs T4
- Low/Medium Secure Forensic
- Adult Eating Disorders

- Elimination of out of area placements for CYP
- Development of new care models

ASD/ADHD

- Reduction in waiting time for autism assessment

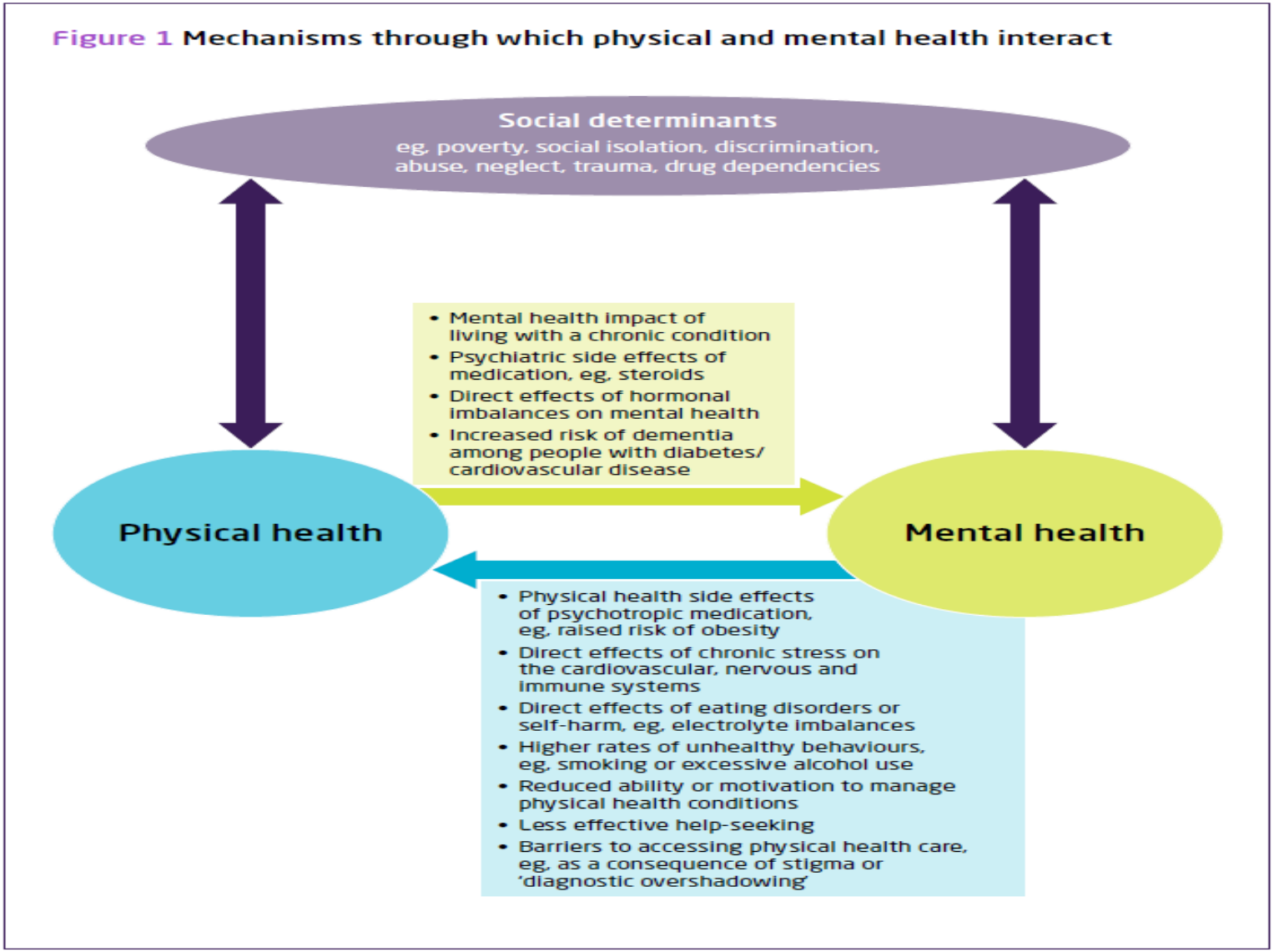
Each place needs to ensure they..

- Have the best **local support** available in their community to prevent crises
- When someone is in crisis that the offer is as local to that person as possible – hopefully in place but where necessary in West Yorkshire
- **Investment in Mental Health** - have a credible funded plan to deliver transformation to mental health services (MH 5YFV)

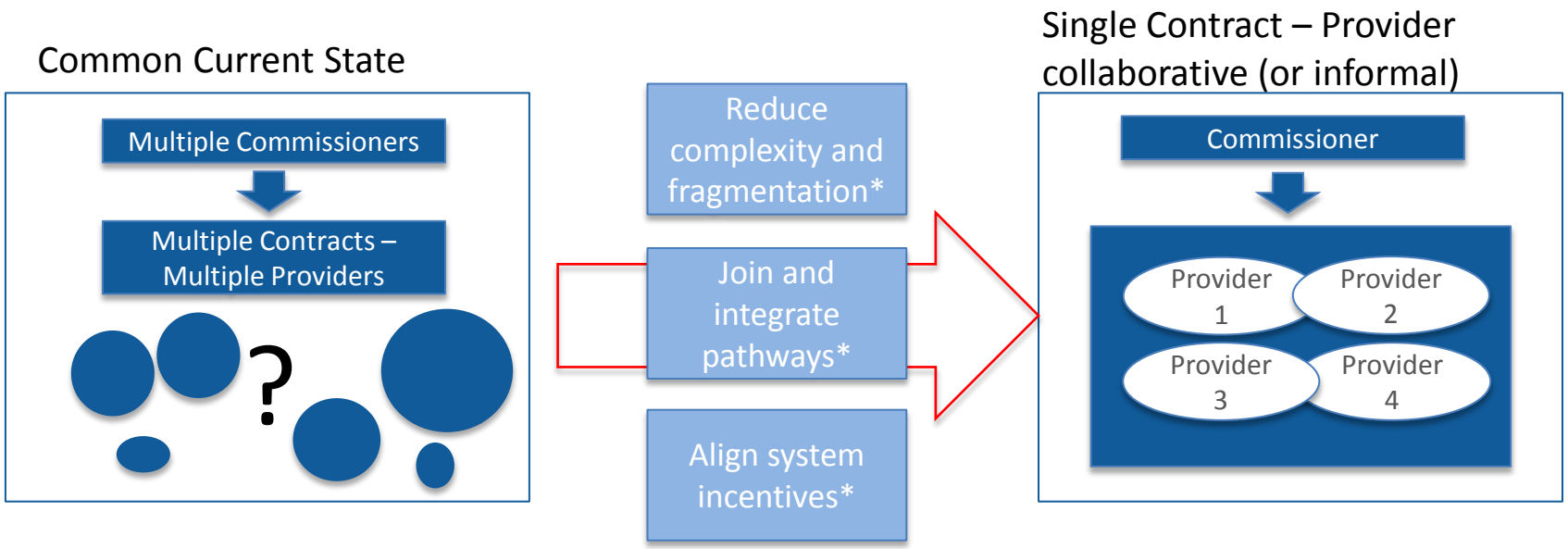
Programme Headlines

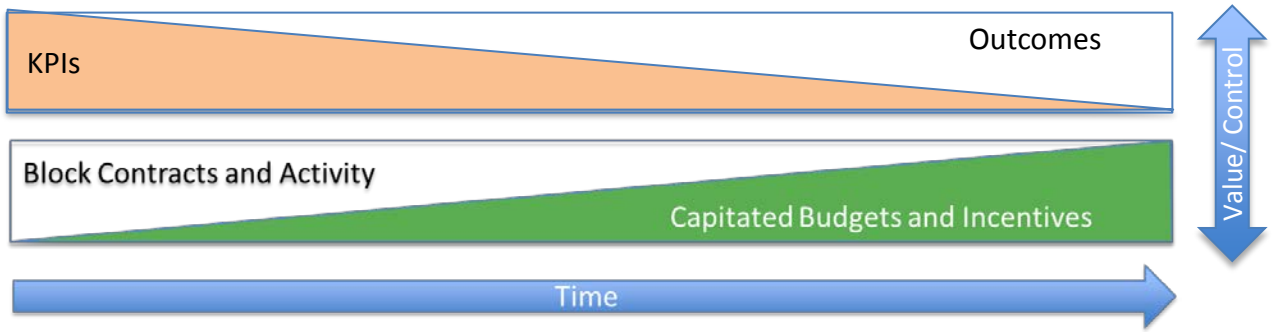
- Collaborative approach to sharing best practice and bed management with aim of **reducing OAPs**
    - Acute
    - PICU
    - Rehabilitation & Recovery
- Develop and implement a **blueprint** for WY&H 24/7 **crisis services**. Work needs to be bolder and more creative solutions developed e.g. role of VCS
- **NCM national pilot for CAMHs & Adult ED**. Transfer of specialised commissioning budget to providers. Further development of community services in order to reduce distance travelled by CYP for a bed when needed and reduce LOS.
- Collaborative approach to the commissioning and provision of **ASD/ADHD** diagnosis and assessment services in WY&H

Wider System Opportunities -Integration of Mental and Physical Health



Future Provider & Commissioning Development





Recommendations & Next Steps

- Endorse the continued work of the programme and the collaborative approach to Mental Health in WY&H.
- Support the proposal to develop improved system oversight approach to MH to further support improvements to services and delivery of MH 5YFV.
- Support the development of the NCMs for CAMHs& Adult Eating Disorders specifically ensuring we make best use of the collective resources as a system to make service improvements.
- Advise on theapproach to be taken as to developing commissioning

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 31 October 2017

Agenda item 9 – Assurance from Trust Board Committees

Audit Committee

Date	10 October 2017
Presented by	Laurence Campbell
Key items to raise at Trust Board	➢ Risk effect of STPs. ➢ General Data Protection Regulation (GDPR) implementation and issues associated with that including explicit vs implied consent and right to erasure. ➢ Data quality assurance, how are we as a Trust Board gaining assurance on data quality and how do we use data to help inform us of hotspots. ➢ Standard of conduct in public service policy.

Equality and Inclusion Forum

Date	2 October 2017
Presented by	Ian Black
Key items to raise at Trust Board	➢ Robertson Cooper and staff feedback and how it has informed the WRES action plan. ➢ Equality strategy action plan ➢ BAME staff network 1st anniversary. ➢ Disability staff network.

Nominations Committee

Date	9 October 2017 and 24 October 2017
Presented by	Charlotte Dyson
Key items to raise at Trust Board	➢ Chair recruitment.

Remuneration and Terms of Service Committee

Date	30 October 2017
Presented by	Rachel Court
Key items to raise at Trust Board	A verbal update will be provided at the Trust Board meeting.

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		✘		✘		✘		✘
Corporate Trustees for Charitable Funds# (annual accounts presented in July)	✘		✘		✘		✘	
Half yearly items								
Strategic overview of business and associated risks	✘				✘			
Investment appraisal framework	✘				✘			
Safer staffing report		✘				✘		
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		✘						

Agenda item/issue	Apr	June	July	Sept	Oct	Dec	Jan	Mar
Code of Governance compliance		✘						
Customer services annual report		✘						
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.