South West Yorkshire Partnership NHS Foundation Trust

**Trust Board (performance and monitoring)**
**Tuesday 19 December 2017 at 1.00pm**
**Small conference room, Wellbeing & learning centre, Fieldhead, Wakefield**

# 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 31 October 2017** (attached)

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

5. **Performance reports**

   5.1. Integrated performance report month 7 2017/18 (attached)

   5.2. Finance report month 8 2017/18 (attached)

   5.3. Serious incident report quarter 2 2017/18 (attached)

6. **Governance matters**

   6.1. Single Oversight Framework update (attached)

   6.2. NHS Constitution assessment (attached)

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

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

   - Clinical Governance and Clinical Safety Committee 14 November 2017
   - Mental Health Act Committee 21 November 2017

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

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

**10. Date of next meeting**

The next public meeting of Trust Board will be held on Tuesday 30 January 2018 in the Boardroom at Kendray in Barnsley.

South West Yorkshire Partnership NHS Foundation Trust

# Minutes of Trust Board meeting held on 31 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 |
| | Rob Webster | Chief Executive |
| **Apologies:** | Dr Adrian Berry | Medical Director / Deputy Chief Executive |
| **In attendance:** | Carol Harris | District Director - Forensics and Specialist Services, Calderdale and Kirklees |
| | Sean Rayner | District Director - Barnsley and Wakefield |
| | Salma Yasmeen | Director of Strategy |
| | Emma Jones | Company Secretary (author) |



## TB/17/82 Welcome, introduction and apologies (agenda item 1)

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

## TB/17/83 Declaration of interests (agenda item 2)

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

## TB/17/84 Minutes and matters arising from previous Trust Board meeting held on 3 October 2017 (agenda item 3)

**It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 3 October 2017 as a true and accurate record.** The following matters arising were discussed:

TB/17/74b Safer staffing (community)

Tim Breedon (TB) was awaiting details on the trajectory on reporting timescales in relation to the review safer staffing in the community. It was hoped information would be available for the first Clinical Governance & Clinical Safety Committee in 2018.

TB/17/75a Information Management & Technology Strategy update (impact of General Data Protection Regulation (GDPR))

Mark Brooks (MB) advised that an implementation plan has been developed to meet the requirements of GDPR. These would need to reflect guidance nationally which was still awaited. Prior to the Trust Audit Committee meeting in January 2018 the Trust Board has been invited to attend a briefing session with Deloitte LLP

TB/17/78 Assurance from Trust Board Committees (Mental Health Act Committee 1 August 2017) (monitoring the impact of training)
Alan Davis (AGD) advised that a report would go to the first Remuneration and Terms of Service Committee meeting in 2018.

## TB/17/85 Chair and Chief Executive's remarks and Service User Story (agenda item 4)

Chair's remarks
IB highlighted the following

- Flu jabs are slightly ahead of last year, and the Chair had his the previous day. AGD advised that the current rate is 37%. Kate Henry (KH) commented that feedback from staff last year was that local engagement, having peer vaccinators, and the availability of clinics assisted them in getting vaccinated, therefore the campaign this year was broadly the same. Last year, three out of four people had the vaccinations.
- The recommendation for the appointment of a new Chair would go to the Members' Council on 3 November 2017 for decision. The Chair thanked everyone who was involved in the process.
- Staff Excellence Awards will be held the following week, recognising the work staff and teams are doing. Feedback from staff was that being nominated was positive. The Chair thanked those involved in organising and judging. RW noted that Sean Rayner (SR) and Carol Harris (CH) were writing thank you cards to all staff who were nominated and not shortlisted to ensure that there efforts were recognised.

Service user story
CH read a story in the service user's own words:

> "Mark", medium secure, how my hospital ward staff took me on a long journey and we enjoyed ourselves and to say how organised my Doctor was in preparing the big day.
>
> *Brief description of your story* - Through Recovery College I met a face from my last hospital who had an opportunity for me to display my artwork at a Church in London. I counted down the days from when my Doctor told me I would go. The morning came and we had a nice train journey, arrived at Kings Cross and took the tube train to a place called Borough. We found our destination and were invited into a Church called St George the Martyr where I saw my artwork on display, we had a bite to eat and drink all the time looking after each other, I even took my medication with me. It was a great day, very memorable.
>
> *What was good about the care and/or support received?* My Doctor, Psychologist Ward Manager and staff from our ward all kept me posted with the arrangements for the big day, helped me order my medication for Teatime as I wouldn't be back at the Hospital in time for them. I owe credit too for the help I had in the time keeping too. The day was a big success.
>
> *What is planned in the future?* To carry on displaying my artwork, I have even sought info on how to display my paintings at a gallery and have had a Charitable Funds bid granted for materials for Recovery College.
>
> *Who were the Staff that helped me?* Escort (Healthcare), Psychologist (Recovery College), Doctor who encouraged me to go on the visit,

*Is there anything else you would like to tell about this service user story?* To say you never know what you might get unless you ask.

CH advised that she rang "Mark" and thanked him. Her reflections on this story were:

- Going on a day trip is something that we might take for granted – or it might be something that we have to do some planning for.
- We would have to organise ourselves around transport and timings and think about what we need to take with us.
- When you have been in a medium secure unit for a long time, you can get out of practice with making choices and decisions and a day trip like this although he looked forward to it can seem really daunting.
- "Mark" wanted me to tell you how important it was that the staff supported him to be able to go to London and to see his art work. In his story he referred to the importance of getting support with organising this – he used the example of having his tea time tablets for example.
- "Mark" talks about him and the staff looking after each other and when I spoke with him he was keen to thank the staff for trusting him to go on such a long journey. Working together with him to achieve his goals was really important to him.
- "Mark's" story is a positive example of the Recovery College's excellent work – he is proud to have his art work on display and this has improved his self-esteem and confidence.
- It is clear that "Mark" was right in the centre of the support our staff gave. This provides an everyday example of the way our staff work with people to achieve their potential and live well in their community.

RW commented that at Board when we discuss "safer staffing" levels we should note an important point that these are set at an optimal level to allow service users to take leave. Simply focusing on the "safe" level does not. When the Board receives reports that services are under pressure it means we can't do trips like this or even those which are every day and local. This service user story demonstrates what a positive difference we can make to someone's life. The work we do in Creative Minds and the recovery colleges overlaps with other services and is a unique selling point for our Trust.

The Board discussed the positive impact the Trust's services had on someone's life and that it would be equally as important to hear when things did not go as well and lessons learned. The Board supported having more stories in future, with clear links to agenda items where possible.

<u>Chief Executive's report</u>
RW highlighted the following from his report:

- The political environment remains important – there is a focus on Brexit, but the latest opinion polls show the biggest issue for people is the NHS.
- The Autumn Budget - the NHS Confederation has led a coalition of representative bodies lobbying for more funding for the NHS. They collectively wrote to the Government to say that we are failing to meet statutory duties set out in the NHS constitution and they must support the NHS. There has been a suggestion that there may be some money in relation to capital. Across the Sustainability and Transformation Plans (STPs) there have been coordinated bids for these resources. These are examples of how aligned we are and understanding the pressures in the system.

- The Care Quality Commission (CQC) State of Care report – this outlined that quality of care had been maintained due to the exceptional work of managers and frontline staff. The CQC also stated that the future quality of care looked precarious.
- Accountable Care arrangements - are continuing to develop, seeing some local mergers around Clinical Commissioning Groups (CCGs) and closer working with Local Authorities. We continue to work with local MPs who are interested in mental health and the NHS. As a Trust we are yet to see investment levels flowing as a consequence of accountable care or the Mental Health Investment Standard.
- Sickness absence and rostering - The Trust's decision to appoint Karen Taylor as Director of Delivery is paying dividends around operational excellence, such as reductions in temporary staff and we have just been commended in our use of rostering in national awards. We do have higher sickness levels than we want, albeit better than other local Trust averages, and we need to keep a focus on this area. We will continue to reinforce the importance of our staff completing the NHS Staff Survey.

CD asked if the required investment from CCGs in relation to the Mental Health Five Year Forward View (MHFYFV) has been received. MB advised as part of the arrangements around national contract assurance, we know that CCG investments have been agreed at different levels. Meetings have taken place recently to agree the progress of the MHFYFV investments with each CCG. Not all of the required investment was necessarily invested with our Trust as there are other mental health providers. There are a small number of investments that were earmarked for our Trust still being confirmed. RW commented that other providers of mental health services are not necessarily seeing significant growth, and it was likely that investment was either going elsewhere or into pressures on areas like continuing healthcare.

CJ asked what the role is of the STP in assisting with the allocation of resources. RW commented that within the West Yorkshire & Harrogate STP there was a mental health work stream and a financial strategy. STP plans were being refreshed and investment levels need to be applied to the work stream to ensure they match requirements. The allocation and assurance of resources still sits with NHS England. The South Yorkshire & Bassetlaw STP also has a workstream and a financial strategy that has been applied differently. As an Accountable Care System (ACS) however, they will be required to performance manage the delivery of Mental Health Five Year Forward View and oversee investments. Both local STPs will be asked by national bodies for delivery plans on four clinical priorities including mental health. The timing for this has yet to be agreed.

## TB/17/86 Risk and assurance (agenda item 5)

TB/17/86a Organisational risk register (agenda item 5.1)

MB reported the process undertaken by the Executive Management Team (EMT) over the course of the last quarter and thanked Emma Jones (EJ) and Aimee Gray, Corporate Governance Manager for their time spent improving the process. It was agreed that to best manage the process we should have a cyclical process of reviewing risks by linking them with strategic objectives. The Executive Management Team (EMT) reviewed the risk process to ensure:

- the language used is more concise;
- all the controls were identified and effective;
- the actions would reduce the risk score where possible; and
- to be clear where this had now changed the risk score.

The risks have also been allocated to the four main committees of the Board for review and challenge. The next quarter would continue this work focusing on risks with a score of less than 15. As part of the process and area identified for review was the Trust's risk appetite which was agreed last year. Some risks after mitigation are still above the Trust's risk appetite and the Board, supported by sub committees, would need to consider if that is acceptable or whether the risk appetite was still appropriate. There were strong reasons why this should be the case for some areas – where a risk score of 4 or 5 was the minimum, given the consequences, that could be achieved but the requirement was to manage the risk to a score of 3 or less.

EJ added that the Trust received 'significant insurance' following completion of an internal audit of risk management with the audit report received by the Audit Committee on 10 October 2017. A survey had also been sent by the internal auditors to all Trust Board members that would form part of the Head of Internal audit opinion for 2017/18.

LC, as Chair of Audit Committee, commented that he felt the Organisational Risk Register had been reviewed and challenged throughout the last quarter and agreed that the risk appetite would be an area for further discussion. He commented that he felt it was a live document and it was important to continue to maintain the focus and identify emerging risks.

CD, as Chair of Clinical Governance & Clinical Safety Committee, commented that having the discussion at committees in advance of Board allows the committees to have an in-depth discussion and extra focus. She agreed it felt like a live document.

CJ, as Chair of the Mental Health Act Committee, commented that while there were currently no specific risks aligned to the committee there was a potential risk identified for further review in relation to safer staffing and an ability to give service users leave, as well as compliance around legal requirements.

RC, as Chair of the Remuneration & Terms of Service Committee, commented that it was good to have structure around the review of risks. The committee was able to look at risk and gain assurance from agenda items. The committee identified a potential risk for further review in relation to the removal of the pay cap in the NHS.

The Board discussed that they felt the changes were the right approach including the review and discussion in committees to provide the Board with assurance. In relation to risk appetite, it was felt that the concept of longer term target being higher than the appetite did not feel right unless it was an interim target and further discussion was needed.

**Action: Mark Brooks / Emma Jones**

**It was RESOLVED to NOTE the key risks for the organisation and the actions being taken to mitigate them.**

TB/17/86b Assurance framework (agenda item 5.2)

MB reported that a lot of the discussion on the risk register also related to the assurance framework. The review followed the same process by the EMT aligned to the strategic priorities for 2017/18 to provide assurance to the Board that the Trust was covering all its key risks and, where any gaps were identified, the actions that were in place.

AM commented, as a new member of the Board, she had seen a significant improvement in the risk register and assurance framework in a short space of time. She felt that it was important to recognise these improvements, which were a real credit to the work taking place.

**It was RESOLVED to NOTE the controls and assurances against the Trust's strategic objectives for Quarter 2 2017/18.**

TB/17/86c Strategic overview of business and associated risks (agenda item 5.3)
SY highlighted the following:

- STPs continued to develop with an alignment of local plans with local elected members and Health and Wellbeing Boards
- Government's plans to lift the NHS pay cap.
- Awarded 'Best Organisation' category by Kate Granger Awards for compassionate care which affirms CQC findings, which is really positive.
- Commissioning risks becoming more real.
- Trust has adopted new Integrated Change Framework.
- Development of ACOs provide opportunities to strengthen joined up care.

AM asked while the weaknesses and threats of the priority programmes were matched against risks, could the risks be matched against the opportunities to ensure we are capitalising on them and have enough resources in place? SY advised that whether there was a relationship between existing risks and opportunities would be included in the next report to Trust Board. RW commented that it was important to identify commissioning and other opportunities and whether we have the right capacity to realise them. A paper for discussion in the private session further identifies opportunities and this was a helpful approach taken by the Trust.

**Action: Salma Yasmeen**

**It was RESOLVED to NOTE the content of the report.**

## TB/17/87 Performance reports (agenda item 6)

TB/17/87a Integrated performance report month 6 2017/18 including finance agenda item 6.1)
TB highlighted the following in relation to headlines:

- Concern around the number of under-18 admissions to adult wards. This is only ever used as a "least worst" option when there is no bed available in a children's unit. As it is not the best option, this needs continued focus to resolve that issue, which is felt locally and nationally. CH commented that the day-to-day impact is that a young person in an adult bed could also displace an adult to out of area. They are only admitted when it is no longer safe to keep the young person at home. These admissions can also impact staff, with the CAMHS team providing an in-reach service to the adult wards. The Board noted that the children in question tended to be closer to their 18th birthday.
- Out of area beds (OOA) - numbers are still not decreasing as hoped. SR commented that it was anticipated at the start of the year that capacity would increase at Fieldhead when the Unity Centre opened and OOA bed use would come down. This has not materialised. The project group is focusing on areas both inside and outside of the Trust's control. CH commented that there was also a focus on moving patients through inpatient care faster, learning from processes in Acute Trusts. CD commented that she felt assured through the actions taking place that we are doing what we can to reduce OOA usage.
- Improving Access to Psychological Therapies (IAPT) - the national team has offered to visit Kirklees to provide challenge around access targets and recovery levels. Actions are being are being monitored through the Operational Management Group (OMG).

- Safer staffing levels - have been maintained. Where there are pressures we have used the professional guidance tool to manage the skill mix and staffing to safe levels. This means pressures remain in some areas with skill mix dilution to maintain safety and ratios.
- Mental Health Act/Mental Capacity Act mandatory training – the thresholds have been reached, and it's now important that we maintain that position.
- The improvement against current target relating to people dying in place of their choosing. At the end of quarter three we will be able to determine the future target we would like to set.

The Board noted the continued and maintained improvement in agency costs as a real credit to the whole Trust.

TB highlighted the following in relation to Quality:

- Medicines management - data has now been received in relation to medicines management.
- Working age adults - work to take place to understand the deterioration in this indicator.
- Complaints - there is an improvement plan in place to address the quality and the response time. This involves greater ownership from clinical leads and services, with support from the Customer Services Team.
- Duty of Candour – continues to be delivered. There has been a breach relating to a situation where we were unable to make contact with the person and the Board discussed whether this was a breach or not.
- Prone restraint - all incidents are reviewed and had oversight by the Managing Aggression and Violence (MAV) team and are reported to the Clinical Governance and Clinical Safety Committee. The increase in numbers shown previously was in relation to an individual and has since decreased.
- Supervision - now recorded as a result of a CQC inspection. Work is taking place to strengthen the capturing of data and a baseline for improvement will be set once established.
- Safety first - incident reporting levels are within expected ranges but have slightly deteriorated and will be subject to review. Findings will be included in the next quarterly report.
- Mortality report - included on the agenda.

MB highlighted in relation to NHS Improvement (NHSI) Indicators that performance had dropped against the IAPT moving to recovery indicator. The final August 2017 position was lower than provisionally reported last month and as such was below the 50% threshold. Similarly the September position, whilst also estimated, was below target. CH commented that Kirklees services had fallen below target on recovery. Data was being checked to ensure it was being captured correctly and work had taken place around improvements on the access targets. SR advised that Barnsley was showing improvement and was just under trajectory on the access within six weeks targets. TB commented that re-admission may be an area to review through the Clinical Governance & Clinical Safety Committee.

SY highlighted the following in relation to Priority Programmes:

- 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 in the implementation team. Engagement with individuals, management teams and groups continues. The second set of system demos had been held with a good attendance by staff
- Digital Health: A pilot with Orcha was 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.

- 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 integrated performance report.
- A schedule for reporting of the bi-monthly priorities is in place.

IB asked for clarification in relation to the clinical records system, which has an overall risk rating of green, however the overview of risks shows implementation as red. MB commented that the current programme of implementation was on track and therefore Green. The consequence of failure may be red however the overall risk would not be and plans were in place to mitigate the risk.

MB highlighted the following in relation to Finance:

- There had been a pre Sustainability and Transformation Funding (STF) deficit of £232k in September 2017. The 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 are £904k overspent year-to-date. Reduction in overspend given additional bed capacity has not yet materialised.
- Barnsley intermediate care funding is subject to agreement with the CCG on a monthly basis based on actual costs incurred
- 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. This is a real achievement and focus will be required to maintain it.
- CIP delivery is £3.5m, which is £357k below plan.
- The cash balance improved to £21m in month.
- Achievement of the year-end control total is at risk, due to pressures associated with Out Of Area beds, reduced income and CIP delivery

LC asked if a saving was anticipated in relation to drug spending. MB commented that a new system had been put in place, but initially this was focused on delivering the existing service provision. RW commented that it was important to not underestimate the amount of work that took place to maintain the drug supply whilst changing systems and that this had rightly been the focus. Any CIP to reduce the spend which would need leadership capacity and a focused programme. MB acknowledged that focused resource and attention will be required to fully understand the scale of financial opportunity in respect of drugs costs
AGD highlighted the following in relation to Workforce:

- Staff Friends and Family Test continues to show improvement.
- Sickness absence decreased to 4.9% in September (4.9% year to date). Performing well compared to our peers. A lot of good work is taking place and we need to continue traction within the organisation. The area for most focus is around long term absence. Calderdale and Kirklees have seen a significant reduction in long term. Forensic although above target has good trends in long term sickness.

There are hot spots in Specialist Services and Wakefield BDU. AD reinforced the need to ensure support is in place.

- Mental Health Act and Mental Capacity training continue to remain above the 80% threshold.
- Turnover rates in the Trust are affected by decommissioning and tender issues. The Trust is now part of an NHS Improvement programme around improving retention rates.
- On mandatory training, work is taking place around a risk-based approach to the appropriate levels.

**It was RESOLVED to NOTE the Integrated Performance Report.**

TB/17/b Customer services report quarter 2 2017/18 (agenda item 6.2)
TB highlighted the following:

- 19 fewer formal complaints and none received in relation to the Mental Health Act.
- Work taking place with the Operational Management Group to improve timeliness of responses.
- There are an increasing number of Freedom of Information (FOI) requests and work would take place to look at the management of responses. MB commented that it was important to not underestimate the amount of time it takes staff to respond to requests.
- Future reports would look at the incorporation of patient experience and the move to a more rounded experience report.

CD asked if there was a theme identified in CAMHS in Calderdale and Kirklees where number of complaints were going down, however in the Friends and Family Test the number of people who would recommend the service was lower than other areas. TB commented that this was being discussed by the Clinical Governance and Clinical Safety Committee.

RC asked whether given the Trust's focus on being a value-led organisation, are there themes from complaints in relation to staff attitude that can be applied for all staff. TB commented that this does take place however he felt it was not currently systematic enough above BDU level.

LC commented that he felt surprised that there were a lot of complaints in relation to community services. TB commented that work was taking place to understand these and he felt it may be linked to national pressures. RW commented that it would be a good area to triangulate complaints with sickness absence rates and commissioning changes, given the level of change and uncertainty in Barnsley particularly.

IB commented that it would be useful to include in future reports trend information in relation to FOI requests in comparison to information that is publically available.

**Action: Tim Breedon**

**It was RESOLVED to NOTE the feedback received through Customer Services in Quarter 2 2017/18.**

TB/17/87c Workforce race quality standard (WRES) summary report (agenda item 6.3)
AGD reported that the paper had been reviewed the by the Equality and Inclusion Forum and EMT and highlighted that there had been an improvement in the indicators. A number of initiatives had been introduced. This was reflected in the BAME staff network celebrating its 1st anniversary and engagement with schools in Kirklees. A programme around leadership and management development would start in December 2017.

IB as Chair of the Equality and Inclusion Forum supported the report.

AM commented that the Remuneration and Terms of Service Committee discussed the risk around achievement of WRES and whether it should be monitored by the Equality and Inclusion Forum. AGD commented that it was important to get the right level of scrutiny and he would discuss with TB as the lead Director for the Forum.

**Action: Alan Davis / Tim Breedon**

**It was RESOLVED to APPROVE the WRES action plan and its ongoing monitoring through the Equality and Inclusion Forum.**

## TB/17/88 Governance items (agenda item 7)

TB/17/88a Safe Working Hours Doctors in Training report - quarter 1 2017/18 (agenda item 7.1)

AGD highlighted the following on behalf of the Deputy Medical Director:

- An area of focus has been ensuring junior doctors felt safe in reporting any problems and a lot of work had taken place around building confidence in this area.
- In Calderdale the rota was not compliant and work has taken place to address this with staff.
- Implementation of the new contract has gone generally well and the Medical Director and Deputy Medical Director have worked to ensure it has been implemented in the right way.

LC asked if the risk in relation to the Calderdale rota was within the Trust's risk appetite. AGD commented that in terms of safety, the risk was being managed, however it may have impacted the medical agency spend figures.

AM asked where the Trust would sit within benchmarking on implementation. AGD would see if benchmarking information was available.

**Action: Alan Davis**

**It was RESOLVED to NOTE the report.**

TB/17/88b Learning from healthcare deaths report - quarter 1 2017/18 (agenda item 7.2)

TB highlighted the following:

- This quarterly report follows on from the policy approved by Board last month. It is the practical application of the policy showing the data and learning.
- 960 deaths were reported onto the system (RiO and SystmOne) plus those on the Barnsley Death Registry who were linked to our services. This included anyone who had at least one contact in the last 118 days.
- 26 of these were in the scope that requires the Trust to review. Of these, 10 were already covered by a Serious Incident (SI) investigation process, 1 was subject to another investigation process, 11 were subject to death certifications, and 4 would have judgment case reviews, which is a new part of the process.
- This interim approach will be reviewed in April 2018.

RW asked whether the numbers relating to Learning Disability were expected, given the genesis of this work. TB confirmed that the numbers for our Trust were expected, given that the main care for many people with a learning disability would not be within specialist services.

RW asked who the responsible body was for finding who was within scope for which organisation. TB commented that the Trust's role was to be clear about those that we believe are in scope and communicate this to our commissioners and also raise challenge if there are areas we feel are not being pursued with systems in place to address this. RW suggested that Quality Surveillance Groups should have a role. TB to confirm who the responsible body was for system-wide oversight.

**Action: Tim Breedon**

**It was RESOLVED to RECEIVE the report and APPROVE publication.**

TB/17/88c Standards of Conduct in Public Service policy (agenda item 7.3)
EJ reported that, as previously advised to Trust Board, NHS England had issued new guidance for NHS organisations on managing staff conflicts of interests. This policy was an update to the Trust's previous policy (Standards of Business Conduct) which forms part of all staff contracts of employment to further align with the guidance. The Trust's Standards of Conduct in Public Service Policy sets outs clear expectations and responsibilities of staff whilst at work. The update was reviewed by the Executive Management Team on 19 September 2017 and Audit Committee on 10 October 2017 who support its approval. EJ highlighted that there were 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 were next due for review in 2018.

LC as Chair of the Audit Committee supported the approval of the policy and advised that the Audit Committee had suggested in relation to sponsorships that consideration be given if a sponsor has a contract with the Trust that was due to expire within 12 months.

**It was RESOLVED to APPROVE the updated policy which is aligned with the guidance issued by NHS England on managing conflicts of interest.**

## TB/17/89 Receipt of minutes of partnership boards (agenda item 8)

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

- Barnsley Health and Wellbeing Board 3 October 2017.
- Calderdale Health and Wellbeing Board 19 October 2017.
- West Yorkshire & Harrogate Joint Committee of CCGs 5 September 2017 - RW reported that the meeting was held in public with a mental health work programme update provided which was included in the papers. By 1 April 2018 next year, it was agreed that a single commissioner would coordinate beds for acute care, which aligned with the mental health work programme and was a good example of using STP arrangements.

## TB/17/90 Assurance from Trust Board committees (agenda item 9)

Audit Committee 10 October 2017
LC highlighted the following discussed by the Committee:

- The effect of STPs on our strategic risks and whether they should be specifically identified. MB commented that this is currently on the Assurance Framework but could be looked at further.

**Action: Mark Brooks**

- General Data Protection Regulation (GDPR) implementation and associated issues 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 & Inclusion Forum 2 October 2017
IB highlighted the following discussed by the Forum:

- Robertson Cooper survey and staff feedback and how it has informed the WRES action plan.
- The equality strategy action plan
- BAME staff network 1st anniversary. AGD commented on the "self-managed" leadership of the group and the progress seen at the anniversary demonstrates the significance of that.
- Disability staff network. AGD commented that this was taking the same approach as the BAME network. A set up meeting was held on 7 October 2017 with a lot of enthusiasm generated.

Nominations Committee 9 October 2017 and 24 October 2017
CD highlighted the following discussed by the Committee:

- The process undertaken for recruitment of the Chair. A Chair recruitment recommendation will go to Members' Council 3 November 2017.

Remuneration & Terms of Service Committee 30 October 2017
RC highlighted the following discussed by the Committee:

- Risk as discussed previously.
- Update on the Workforce Strategy work plan which was on track. The Committee has asked for feedback around effectiveness.
- An update on confidential items has been emailed to the Board.

## TB/17/91 Trust Board work programme 2017/18 (agenda item 10)

**It was RESOLVED to NOTE the work programme.**

## TB/17/92 Date of next meeting (agenda item 11)

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

**Signed:** **Date:**

South West Yorkshire Partnership NHS Foundation Trust

# TRUST BOARD 31 OCTOBER 2017 – ACTION POINTS ARISING FROM THE MEETING

**Actions from 31 October 2017**

| Min reference | Action | Lead | Timescale | Progress |
|---|---|---|---|---|
| TB/17/86a Organisational risk register | In relation to risk appetite, it was felt that the concept of longer term target being higher than the appetite did not feel right unless it was an interim target and further discussion was needed. | MB / EJ | | Will be scheduled for further discussion at the strategic session of Trust Board in February 2018. |
| TB/17/86c Strategic overview of business and associated risks | AM asked while the weaknesses and threats of the priority programmes were matched against risks, could the risks be matched against the opportunities to ensure we are capitalising on them and have enough resources in place? SY advised that whether there was a relationship between existing risks and opportunities would be included in the next report to Trust Board. RW commented that it was important to identify commissioning and other opportunities and whether we have the right capacity to realise them. | SY | April 2018 | |
| TB/17/b Customer services report quarter 2 2017/18 | IB commented that it would be useful to include in future reports trend information in relation to FOI requests in comparison to information that is publically available. | TB | January 2018 | Noted for inclusion in next report. |
| TB/17/87c Workforce race quality standard (WRES) summary report | AM commented that the Remuneration and Terms of Service Committee discussed the risk around achievement of WRES and whether it should be monitored by the Equality and Inclusion Forum. AGD commented that it was important to get the risk level of scrutiny and he would discuss with TB as the lead Director for the Forum. | AGD / TB | | |
| TB/17/88a Safe Working Hours Doctors in | AM asked where the Trust would sit within benchmarking on implementation. AGD would see if benchmarking information was available. | AGD / ABe | | |

| Min reference | Action | Lead | Timescale | Progress |
|---|---|---|---|---|
| Training report - quarter 1 2017/18 | | | | |
| TB/17/88b Learning from healthcare deaths report - quarter 1 2017/18 | RW asked who the responsible body was for finding who was within scope for which organisation. TB commented that the Trust's role was to be clear about those that we believe are in scope and communicate this to our commissioners and also raise challenge if there are areas we feel are not being pursued with systems in place to address this. RW suggested that Quality Surveillance Groups should have a role. TB to confirm who the responsible body was for system wide oversight. | TB | | Discussed with Clinical Governance & Clinical Safety Committee via Quality Boards and both clear the Quality Surveillance Groups should have a role but not necessarily acknowledged. To be raised at Quality Surveillance Groups and offer made to lead work across West Yorkshire. |
| TB/17/90 Assurance from Trust Board committees (Audit Committee 10 October 2017) | The effect of STPs on our strategic risks and whether they should be specifically identified. MB commented that this is currently on the Assurance Framework but could be looked at further. | MB | | |

**Outstanding actions from 3 October 2017**

| Min reference | Action | Lead | Timescale | Progress |
|---|---|---|---|---|
| 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 | | Update provided 31 October 2017: Awaiting details on the trajectory on reporting timescales in relation to review safer staffing in the community. It was hoped information would be available for the first Clinical Governance & Clinical Safety Committee in 2018. |

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 19 December
# 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/Objectives:** | 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 should consider and note the contexts of this report. In particular:<br>➢ National developments, including progress on staffing in relation to Brexit; additional resources in the Budget and how they are playing out; Children's Mental Health Services; and changes to the leadership of NHS Improvement<br>➢ Local developments, including a focus on Sustainability and Transformation Partnerships; local partnerships, with £10m for sport and health in Calderdale from Sport England; and our collaboration with other providers of mental health services<br>➢ Trust developments, including pressure on services; the stocktake of progress against the Care Quality Commission domains; innovation and excellence; and the end of inpatient services provided by the Trust at Mount Vernon with the transfer of staff to Barnsley Hospitals.<br><br>**Risk Appetite**<br>The Executive Management Team (EMT) have reviewed the Board Assurance Framework and Risk Register, with support and scrutiny from the Board Committees. The contents of this paper have informed the Assurance Framework and Risk Register, including areas that fall outside of our current risk appetite. These are reflected in all of the Board paper cover sheets. |
| **Recommendation:** | **Trust Board is asked to NOTE the Chief Executive's report.** |
| **Private session:** | Not applicable. |

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

# Trust Board 19 December 2017
# Agenda item 4
# Chief Executive's Report

## Purpose

1. This paper sets the strategic context for the Board discussion. It helps the Board understand the issues that will affect the way we do business.

## National Context

2. **Brexit continues to dominate national politics.** An initial deal has been reached on allowing EU citizens to remain in the UK and vice versa. This is good news for the workforce, where a significant downturn in interest in coming to the UK has staunched the flow of staff from the EU into the NHS. Although a relatively minor issue for the Trust, this is a material issue for our partners.

3. **The budget including additional funding for the NHS for this winter and for subsequent years.** This is welcome and necessary, though many national commentators have stated that it is not sufficient. The Board should be aware that:

    a. **£337m has been made available for the NHS in England for this winter.** This is split between £200m that will be allocated directly to NHS acute trusts and £137m that is subject to a rapid bidding cycle through local A&E Delivery Boards. Of this £20m has been earmarked for mental health schemes. We have supported bids through the local delivery boards, including bids for enhancing Trust services for mental health inpatients and to support A&E delivery. A verbal update will be provided at the Board.
    b. **£1.6bn additional revenue will be allocated to the NHS next year.** This is welcome. It falls short of the £4bn that was widely quoted from think tanks and national lobby groups. There are many unanswered questions about these resources in terms of how they will be allocated, how the resources are then contracted to trusts and other providers and the delivery/services required for the additional resources. Until these questions are answered, we should remain sanguine about prospects for additional income for the Trust.
    c. **Up to £10bn of capital will be made available, including an additional amount identified for Sustainability and Transformation Partnerships [STPs].** This includes **£13m for a new CAMHs unit in Leeds.** This will have 18 acute beds and 4 PICU beds. A site has been identified and work should begin next year. This is a major boost for services across West Yorkshire and Harrogate and good news for our partnerships locally. The process for allocating the additional public capital is developing. The Board should be aware that the £10bn figure is for the medium term and includes receipts from the sale of NHS land and estates.

d. **No resources were made available for Social Care.** This has received widespread criticism.
e. **NHS England's public Board meeting discussed the consequences of their budget.** The meeting reaffirmed the commitment to the national clinical priorities of Urgent Care, Cancer, Primary Care, Maternity and Mental Health and that there would be consequences for other areas of spending and performance. This will be described in the revised mandate between the Government and NHS England. This is being negotiated currently. The Board should note that there may be consequences for subsequent requirements to refresh plans. The Board should also note that the current mandate was published after operational plans and contracts were signed.

4. **NHS Improvement has a new Chief Executive.** Ian Dalton joined NHS Improvement from a short stint as Chief Executive at Imperial in London. He has a long career in the NHS and in the Private Sector. With the appointment of Dido Harding as chair of NHS Improvement, we wait to see whether there will be changes in approach and style from one of our regulators. This will be accompanied by the changes to the **Standard Oversight Framework** which now includes indicators on out of area placements, for example. The Director of Finance and Resources will brief the Board on changes and the consequences for our licence.

5. **NHS England continues to back local partnerships to deliver the Five Year Forward View.** The Accountable Care System [ACS] arrangements in South Yorkshire and the Sustainability & Transformation Partnership [STP] arrangements in West Yorkshire continue to develop in this context. National bodies are increasingly using ACS and STPs for planning and coordination. Recent examples include an exercise to align commissioner and provider views on financial forecasts for this year and the management of capital bids for budget monies. This trend will continue into the future.

6. **Finance and performance across the NHS continues to be under severe strain and there is a focus on Winter.** High profile resignations of chairs of large organisations in special measures and sector wide reports on quarter 2 performance from organisations such as NHS Providers show the individual and system wide consequences of the pressure we face.

7. **There are welcome signs that systemic issues are in focus nationally.** This is demonstrated by the recognition of the role that community services will play in the management of patient flow – as described in the NHS Improvement letter on the six things we are expected to deliver this winter in our community services – and the small amount of resources earmarked for mental health this winter. The Business Delivery Unit Director for Barnsley attended the NSH Improvement session on community services which was genuinely helpful.

8. **The Green Paper on the mental health of children and young people was published.** This sets out a range of suggested improvements to the support that could be made available to children and families, backed by up to £300m of investment from 2019 and shorter waits for services. This is subject to consultation and we will be supporting the Mental Health Network in its response.

**Local Context**

9. **Our two STPs continue to develop similar trajectories and arrangements and will play a role in our business in the future:**
    - The **West Yorkshire & Harrogate** Partnership is developing a suite of new arrangements to support its move towards greater autonomy. The draft document on "next steps" and a draft memorandum of understanding have been developed for sharing and comment and will come to Board shortly. A briefing session at the joint overview and scrutiny committee helpfully engaged scrutiny in holding the partnership to account.
    - The **South Yorkshire and Bassetlaw** Accountable Care System [ACS] is developing a performance dashboard to hold local partnerships to account, including in Barnsley. This will be shared with the Board via the local Barnsley Accountable Care Partnership Board. In addition, the ACS "Acute Services Review" is developing and beginning to consider its processes and focus. We have put forward clinical representatives on stroke and mental health. Early decisions on the siting of Hyper Acute Stroke Units in South Yorkshire may have consequential impacts on our rehabilitation unit in Barnsley, given changes at Barnsley hospital. The Board should note that we will be working to ensure that the excellent services and outcomes noted in this unit are preserved and maintained.

10. **Within each STP area, we are seeing differential development of accountable care partnerships.** The Board has discussed this in relation to the restatement of our Trust Strategy. Work continues to develop and is reflected in the minutes of partnership Boards. Of particular note are developments in Barnsley, where the governance around the Accountable Care Partnership Board and Accountable Care Shadow Delivery Board are due to change. The Partnership Board will become a vehicle for chairs and chief executives only and the leadership of the Delivery Board may also change. This is subject to discussion on 20th December at the Partnership Board meeting.

11. **Good news in Calderdale, where Sport England have funded £10m for a joint bid from partners on exercise in the borough.** Creative Minds have been actively involved in the developments and we will work through the consequences using the partnership arrangements in place for the Health and Wellbeing Board and emerging accountable care arrangements.

12. **The chairs and chief executives of mental health providers in West Yorkshire meet on 13 December to discuss our joint programme of work.** A verbal update will be provided to the Board. The discussion will include an update on improving our joint governance and progress on our shared work programmes.

**Trust Context**

13. **The Integrated Performance Report, Board Assurance Framework and Risk Register** highlight the service, staffing and financial pressures we face as an organisation. These are due, in part, to risks identified at the beginning of the year materialising later in the year. Other issues are proving more difficult to resolve – such as out of area placements for Psychiatric Intensive Care and Acute Care. The former is an issue for all providers and we are working collectively on a resolution. Service pressures in Child and Adolescent Mental Health, Psychology, community mental health services, intermediate care are also being managed.

14. **The submission of the Prior Information Request for the Care Quality Commission [CQC] provides an opportunity to take stock.** These documents include a self-assessment of progress in services and against the areas of redress we are required to make. These have been shared with the Board and maintain a focus on quality and safety in these tough times.

15. **We retain a focus on the health and wellbeing of staff.** Our #allofus campaign and our drive for flu vaccination uptake continues. The staff survey will help show what progress we are making and where we still need to work if we are to really get people across the Trust to feel valued.

16. **We continue to see excellent practice and innovation in the Trust alongside the pressure we face.** This was epitomised by the Learner, Long Service and Excellence Awards held in November. Congratulations to all of the staff involved who were nominated, shortlisted or in receipt of an award. The joy shared by people in receipt of a 25/40 year service award, a certificate for a qualification or because they had come top in their category was palpable.

17. **Our charity relaunch sees a new chapter for the Trust.** Alongside new branding – the EyUp! Brand developed in house – and new capacity, we are looking at greater contribution to our charitable work from grant giving organisations and corporate bodies. This will be part of the sustainable approach to ensuring we can deliver Creative Minds, Spirit in Mind, and the work of the Museum.

18. **Finally, 30 November 2017 was the final day of in-patient care being provided in the Trust directly by staff who have worked recently at Mount Vernon Hospital.** Board members will recall that we recently 'lifted and shifted' the last two wards at Mount Vernon to Barnsley Hospital. As part of the implementation of the new service model for Intermediate Care this service will cease and Barnsley Hospital will take on the provision of a 'Transition Ward' at the Hospital with some of our staff transferring to Barnsley Hospitals NHS Foundation Trust.

19. **There has been an in-patient service provided at Mount Vernon Hospital in Barnsley for decades.** This has been a service that has cared for many vulnerable older people at stages of their lives where they have needed the compassion and professional interventions undertaken by the staff to support their rehabilitation in a

    measured way to return to their communities, but also on occasion to be cared for and supported at the end of their lives. When the CQC inspected the service at Mount Vernon, it was rated as 'Good' in all domains, and the service feedback from friends/families/patients has invariably been very positive. This has been testament to the leadership shown by the dedicated clinical staff supported by the porters, domestics, admin staff and many others, too numerous to mention who have delivered and contributed to excellent patient care.

20. It has been a huge privilege to work with these colleagues, their resilience and commitment particularly during the recent significant service changes and uncertainty has been outstanding. I am sure we would want to extend to them all our best wishes for the future.

**Conclusion**

21. We continue to operate in a challenging context and face service, financial and strategic issues that are unprecedented in scale and volume. The final four months of this year will be a period where we must focus on operational excellence and business planning for a sustainable future. This will require substantial work and some difficult choices to be made. At these times we must be guided by our values and informed by the best evidence and insight available to us. As a successful Foundation Trust, we should do so form a position of strength in a system that needs our services to be sustained.

Rob Webster
Chief Executive

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 19 December 2017
# Agenda item 6.1

| | |
|---|---|
| **Title:** | **Integrated Performance Report Month 7 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 October, 2017. Any available updates relating to November will be provided verbally at the meeting |
| **Mission/values/objectives** | All Trust objectives |
| **Any background papers/ previously considered by:** | ➢ IPR is reviewed at Trust Board each month<br>➢ IPR is reviewed at Executive Management Team Meeting on a monthly basis |
| **Executive summary:** | The November finance report will be included as a separate paper within the agenda. Any other updates relating to November performance will be provided verbally at the meeting where they are available.<br><br>**Quality**<br>➢ The number of under 18 admissions to adult wards remains a concern although the appropriate governance is in place. Tier 4 capacity is being addressed at regional and national level but the timescales for resolution remain unclear<br>➢ Safe staffing levels have been maintained, however pressures continue to be present in some areas, resulting in a dilution of skill mix to maintain safe ratios<br>➢ Medicine omission rates met target<br>➢ Provider information request has been received from CQC which initiates our well led review<br><br>**NHSI Indicators**<br>➢ The Trust is performing well against the vast majority of NHSI metrics.<br>➢ % of service users followed up within 7 days of discharge fell slightly below the 95% thrshold<br>➢ Within IAPT people moving to recovery indicator the rate achieved is 51.9%, which is marginally above threshold<br>➢ Whilst below target data completeness priority metrics for mental health improved from 60.1% to 69.1% in October<br><br>**Finance**<br>➢ Pre STF deficit of £151k in October. Cumulative position is now a deficit of £158k, which is £315k adverse to plan |

| | |
|---|---|
| | ➢ Out of area beds £1.3m overspent year-to-date.<br>➢ Other adverse variances include the CQUIN risk reserve, reductions in income and under-delivery against CIPs<br>➢ Agency staffing costs were the highest of the year at £515k in-month, but remains below both last year and the cap<br>➢ Use of resources risk rating remains at 1, although two individual metrics are now rated as 2<br>➢ CIP delivery is £3.5m, which is £357k below plan<br>➢ Cash balance of £20.5m is slightly ahead of plan<br>➢ Achievement of the year-end control total remains at risk<br><br>**Workforce**<br>➢ Mental Health Act and Mental Capacity training continue to remain above the 80% threshold.<br>➢ Sickness absence increases to 5.2% in October (4.9% year to date).<br>➢ Appraisal compliance for Band 6 and above is at 92.7%%, just short of the 95% target.<br>➢ Appraisals completed for Band 5 and below has increased to 82.7% as at the end of October (was 46% at end of August 2017). The target is 95% by the end of September 2017.<br><br>**Locality**<br>➢ Intermediate Care ward scheduled to transfer to the management of Barnsley Hospital on December 1st<br>➢ Positive feedback received in relation to the South Yorkshire Liaison and Diversion scheme<br>➢ Work to the showers at The Dales completed, resulting in available bed capacity increasing by two<br>➢ A number of medical staffing gaps in Kirklees and Calderdale<br>➢ Configuration of forensic beds under review across West Yorkshire<br>➢ Significant improvement in learning Disability waiting times<br>➢ Positive results from a good practice visit to the memory service in Wakefield<br><br>**Priority Programmes**<br>➢ Work progressing well on Forensic Community CAMHs<br>➢ Production of community workforce modelling for Older People's Transformation slightly delayed |
| **Recommendation:** | **Trust Board is asked to NOTE the Integrated Performance Report and COMMENT accordingly.** |
| **Private session:** | Not applicable |

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

# Integrated Performance Report

## Strategic Overview

**October 2017**

With **all of us** in mind.

# Table of Contents

# Introduction

Please find the Trust's Integrated Performance Report for October 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 to 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 identifies 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. NHS Improvement has issued an updated Single Oversight Framework (SOF) following a period of consultation. A separate paper has been provided on these changes, with the most significant impact on the Trust likely to be the introduction of a metric relating to out of area beds
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 | 2 | | | | | | 1 |
| CQC Quality Regulations (compliance breach) | | Green | 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 | 3 | | | | | | 1 |
| % service users followed up within 7 days of discharge | | 95% | 98.3% | 97.5% | 97.3% | 93.3% | 97.2% | 96.1% | 94.7% | | | | | | 1 |
| % clients in settled accommodation | | *60%* | 82.2% | 82.5% | 82.2% | 81.8% | 81.7% | 80.8% | 80.7% | | | | | | 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 | 285 | 377 | 255 | 347 | 370 | 433 | 477 | | | | | | 3 |
| IAPT –proportion of people completing treatment and moving to recovery | | 50% | 45.6% | 49.4% | 56.4% | 52.4% | 49.06% | 51.25% | 51.95% | | | | | | 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% | 86% | | | | | | 85% |
| Friends and Family Test - Community | | 98% | 97% | 99% | 98% | 95% | 99% | 99% | 97% | | | | | | 98% |
| Patient safety incidents involving moderate or severe harm or death | | | 19 | 22 | 31 | 29 | 29 | 25 | 42 | | | | | | |
| Safer staff fill rates | | 90% | 110% | 111% | 103% | 112.6% | 109% | 111.8% | 112.9% | | | | | | 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 | 5 | | | | | | |
| % people dying in a place of their choosing [4] | | | Reporting established from Sept 17 | | | | | 82.6% | 90.9% | | | | | | |
| **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 | £856k | | | | | | £136k |
| Surplus | | In line with Plan | £26k | £53k | £95k | £204k | £226k | £6k | £158k | | | | | | £1020k |
| Agency spend | | In line with Plan | £501k | £426k | £500k | £457k | £446k | £435k | £515k | | | | | | £7m |
| CIP delivery | | £1074k | £472k | £1024k | £1643k | £2306k | £2950k | £3452k | £4117k | | | | | | £7.3m |
| Sickness absence | | 4.5% | 4.8% | 4.7% | 4.7% | 4.8% | 4.9% | 4.9% | 4.9% | | | | | | 4.50% |
| Mental Health Act training | | >=80% | 51.2% | 56.9% | 70.5% | 75.0% | 80.3% | 81.6% | 83.4% | | | | | | 80% |
| Mental Capacity Act Training | | >=80% | 64.9% | 69.6% | 78.0% | 82.5% | 86.1% | 87.6% | 88.9% | | | | | | 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 £151k in October. Cumulative position is now a deficit of £158k, which is £315k adverse to plan
• Out of area beds £1.3m overspent year-to-date.
• Other adverse variances include the CQUIN risk reserve, reductions in income and under-delivery against CIPs
• Agency staffing costs were the highest of the year at £515k in-month, but remains below both last year and the cap
• Use of resources risk rating remains at 1, although two individual metrics are now rated as 2
• CIP delivery is £3.5m, which is £357k below plan
• Cash balance of £20.5m is slightly ahead of plan
• Achievement of the year-end control total remains at risk

**Quality**
• The number of under 18 admissions to adult wards remains a concern although the appropriate governance is in place. Tier 4 capacity is being addressed at regional and national level but the timescales for resolution remain unclear.
• Safe staffing levels have been maintained, however pressures continue to be present in some areas and resulting in a dilution of skill mix to maintain safe ratios
• Medicine omission rates meet target
• Provider information request has been received from CQC which initiates our well led review.

NHSI Indicators
• The Trust continues to perform well against the vast majority of NHSI metrics
• Within the IAPT people moving to recovery indicator the rate achieved is 51.95%, which is marginally above threshold - further detail can be seen in the national metrics section of the report.
• Whilst below target data completeness priority metrics for mental health improved from 60.1% to 69.1% in October
• In month under performance has been seen against the 7 day follow up indicator - 7 patients discharged out of 133 were not followed up within the 7 day timeframe. 5 of those that breached were followed up but outside 7 day window, 2 that breached were due to being unable to engage with service user.

**Locality**
• Intermediate Care ward scheduled to transfer to the management of Barnsley Hospital on December 1st
• Positive feedback received in relation to the South Yorkshire Liaison and Diversion scheme
• Work to the showers at The Dales completed, resulting in available bed capacity increasing by two
• A number of medical staffing gaps in Kirklees and Calderdale
• Configuration of forensic beds under review across West Yorkshire
• Significant improvement in learning Disability waiting times
• Positive results from a good practice visit to the memory service in Wakefield

**Priority Programmes**
• Work progressing well on Forensic Community CAMHs
• Production of community workforce modelling for Older People's Transformation slightly delayed

**Workforce**
• Mental Health Act and Mental Capacity training continue to remain above the 80% threshold.
• Sickness absence increases to 5.2% in October (4.9% year to date).
• Appraisal compliance for Band 6 and above is at 92.7%%, just short of the 95% target.
• Appraisals completed for Band 5 and below has increased to 82.7% as at the end of October (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 | Oct-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 | 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 | 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 | 3% 2/69 | 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% | 86% | 84% | 84% | 2 |
| | Friends and Family Test - Community | Improving Health | Caring | TB | 98% | 98% | 98% | 98% | 99% | 97% | 99% | 98% | 95% | 99% | 99% | 97% | 98% | 98% | 4 |
| Quality | Total number of reported incidents | Improving Care | Safety Domain | TB | N/A | 3509 | 3405 | 3293 | 2946 | 848 | 1025 | 980 | 1091 | 1084 | 903 | 982 | 2853 | 3078 | 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 | 6 | 11 | 14 | 15 | 26 | 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 | 19 | 22 | 31 | 29 | 29 | 25 | 42 | 72 | 83 | 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% | 17.5% | 18.2% | 24.3% | 3 |
| | Safer staff fill rates | Improving Care | Safety Domain | TB | 90% | | | | | 110% | 111% | 103% | 112.6% | 109% | 111.8% | 112.9% | 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% | 99.5% | 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 | 16 | 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 | 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 | 0% 0/18 | 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% | 2.7% | 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 | 5 | 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 | 56 | 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 | 0 | 4 |
| | Number of Duty of Candour applicable incidents 4 | Improving Health | Caring | TB | N/A | 73 | 86 | 83 | 86 | 154 | | | | | | | 154 | | N/A |
| | Duty of Candour - Number of Stage One exceptions 4 | Improving Health | Caring | TB | N/A | Reporting established from Oct 16 | | 0 | 2 | 9 | | | | | | Data avail Dec 17 | 9 | | N/A |
| | Duty of Candour - Number of Stage One breaches 4 | Improving Health | Caring | TB | 0 | Reporting established from Oct 16 | | 0 | 1 | 1 | | | | | | | 1 | | 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% | 81.4% | 85.2% | 85.6% | 4 |
| | % of prone restraint with duration of 3 minutes or less 8 | Improving Care | Safety Domain | KT/SR/CH | 80% | Reporting Established from July 16 | 79.7% | 75.6% | 66.3% | 68.40% | 75.70% | 75% | 77% | 80% | 80% | 79% | 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% | 2.78% | 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) | | | | 38.3% | | | 36.90% | | | To be reported at end of Q3 | 38.3% | 36.90% | |
| | Number of Falls (inpatients) | Improving Care | Safety Domain | TB | TBC | 162 | 158 | 136 | 95 | 38 | 52 | 49 | 39 | 54 | 46 | 41 | 139 | 139 | |
| | Number of restraint incidents | Improving Care | Safety Domain | TB | N/A | Data not avail | | | | 104 | 140 | 101 | 144 | 159 | 121 | 134 | 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.

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 – September position in this report. October data will be available in the next report. Data correct at 03/11/17. The breach relates to Kirklees, where 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.

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 (excluding medical staff) who were employed during the reporting period 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.

8 - The threshold has been locally identified and it is recognised that this is a challenge. From June 17, the monthly data reported is a rolling 3 month position.

## 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 Nov 17.

• Complaints closed within 40 days - The Trust takes complaints about services very seriously and wants to ensure a response that resolves the issues raised. The Trust is committed to learning lessons from feedback recognising the valuable opportunity to reflect on the care offered and use this as a means of improving.

The Trust adopts an approach to complaints and feedback that promotes resolving issues at service line wherever and whenever this is possible. Trust policy and procedures on complaints management were most recently reviewed by Trust Board in July 2017 and have been favourably reviewed by the Care Quality Commission (CQC) and highlighted as best practice as part of accreditation against the national Customer Services Excellence standard. The Customer Services Team work with people to resolve their issues and work with staff to support investigation of what happened, identification of any learning and an appropriate response to the complainant. The Team will continue to maintain central oversight and management of the complaints process with the same level of support offered to service colleagues.

The quality of the Trust's resolution of complaints is under review. The current process involves investigators, general managers, service directors, nursing and medical directors as appropriate and the Chief Executive. Given the number of people involved, this can result in delay in offering a response, often exceeding the internal 40 day target. The 40 day target was by the Trust and is much more ambitious than the national six month target set under NHS complaint regulations.

The purpose of the review is to increase ownership of issues at service line and promote a more timely response to the complainant. The Director of Nursing and Quality is leading on this work which is being taken forward through the Operational Management Group. The intention is to introduce steps to ensure service involvement as soon as possible when issues are raised and scrutiny of completed investigation toolkits by Trios before they are returned to Customer Services. Draft responses will then be prepared in Customer Services. Drafts will be reviewed by Trios to ensure all clinical issues are identified and addressed and that the investigation has provided sufficient information to enable a full response. Deputy district directors will then review and sign off the draft response, with a final (edited if required) version shared with the Chief Executive for review and signature.

The review has inevitably impacted on the performance of the Trust and this is reflected in the time taken to resolve complaints and in meeting the 40 day target. However, it is anticipated that the new arrangements will improve both the quality and timeliness of complaints resolution and a pilot of the new process is due to take place in selected BDUs starting in December 2017.

• % of prone restraint with duration of 3 minutes or less - The number of restraint incidents occurring over 3 minutes during October 17 has increased. This relates to 9 incidents out of 34 being for 3 minutes or more. The percentage has decreased as the numbers of prone restraints overall rose in October 2017 from 25 to 34 due to an increase in clinical acuity. 3 of the 9 were in Wakefield PICU and other 6 in different wards. All had cogent reasons including management of assaults on staff (5/9), preventing absconding of individuals intent on self harm (2/9), use of property as weapons and to facilitate use of seclusion. 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. 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 – 9 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%.

• NHS Safety Thermometer - Medicines Omissions – This only relates to Inpatient areas in Calderdale, Kirklees and Wakefield. October 17 has seen an improvement in the number of inpatient medicines omissions and is now at its lowest level so far this year. Work from last year has focussed on improving the medication omissions particularly "patient refusals" on Older People's Services (OPS) wards.

The figures from the mental health safety thermometer show a downward trend since the start of the sign up to safety campaign.

Average percentage of service users who had at least one medicine omitted

2015/16 23.5%

2016/17 19.9%

2017/18 Quarter 1 18.1%; Quarter 2 24.3%; Quarter 3 17.5% to date

Medicines Refused remains the most common reason for omission. Omitted for a valid clinical reason is the next most common. We are employing a variety of different behavioural change techniques including awareness raising through bulletins and posters, visual prompts on charts and face to face discussions within multidisciplinary teams to further reduce the burden of missed doses on both individuals and the trust.

• 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 has reduced 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 more comprehensive Falls Risk Assessment Tool (FRAT18) has been implemented across the trust's in-patient areas to replace the previous falls screening tool the FRAT5. The FRAT18 is NICE guidelines compliant and covers a greater spectrum of areas screened that have been demonstrated to contribute to falls. 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 October continues to be within expected levels. In Barnsley in-patient falls across all wards (mental health & non- mental health) remains low with 4.02 falls per 1000 bed days which is very favourable when compared to national average of 4.8 (average of all acute hospitals, OPS & MH areas are significantly higher). A detailed audit undertaken in Barnsley has shown that compliance to NICE Guidelines has improved across the BBDU. The 2017 re-audit shows an improvement of 22% from the previous audit (68%) in 2016. 90% of services are demonstrating best practice and adherence to NICE Guidelines.

• 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, October 2017

| Summary of Incidents | Q1 17/18 | Q2 17/18 | Apr 2017 | May 2017 | Jun 2017 | Jul 2017 | Aug 2017 | Sep-17 | Oct-17 |
|---|---|---|---|---|---|---|---|---|---|
| Green no harm | 1768 | 1907 | 536 | 626 | 606 | 671 | 669 | 567 | 592 |
| Green | 781 | 853 | 228 | 287 | 266 | 317 | 294 | 242 | 270 |
| Yellow | 227 | 230 | 66 | 86 | 75 | 77 | 89 | 64 | 87 |
| Amber | 57 | 58 | 14 | 18 | 25 | 17 | 25 | 16 | 21 |
| Red (should not be compared with SIs) | 20 | 30 | 4 | 8 | 8 | 9 | 7 | 14 | 12 |
| **Total** | 2853 | 3078 | 848 | 1025 | 980 | 1091 | 1084 | 903 | 982 |

| | Q1 | Q2 | Apr 2017 | May 2017 | Jun 2017 | Jul 2017 | Aug 2017 | Sep 2017 | Oct 2017 | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Suicide (incl apparent) - | 4 | 10 | 1 | 1 | 2 | 5 | 2 | 3 | 4 | 18 |
| Suicide (incl apparent) - community team care - discharged | 0 | 2 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 3 |
| Physical violence (contact made) against other by patient | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 3 |
| Pressure Ulcer - grade 3 | 1 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 3 |
| Fire / Fire alarm related incidents | 1 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 2 |
| Information disclosed in error | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 2 |
| Self harm (actual harm) | 2 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 2 |
| Administration/supply of medication from a clinical area | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| Death - cause of death unknown/ unexplained/ awaiting confirmation | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 |
| Death - confirmed related to substance misuse (drug and/or alcohol) | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Illegal Acts | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Vehicle Incident | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| Homicide by patient | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| Physical/sexual violence by other | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| Total | 15 | 18 | 3 | 3 | 9 | 9 | 2 | 7 | 7 | 40 |

- 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 October 2017

The information comes off a live system so is accurate at the time the report is ran but is subject to changes following review by managers. This data set cannot be replicated at a future date as it will change.

**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.
- The policy has a review date of April 2018 to ensure it can capture any national and local developments quickly. The data and learning from Quarter 1 has been published on the internet - http://nww.swyt.nhs.uk/learning-from-deaths/Pages/default.aspx, the plan is future is to include this on a quarterly basis within the performance report.
- 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.
- 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.

A report has been completed on Apparent Suicides reported in 2016/7. In future this will be part of the annual incident report and replaces the previous undetermined death audit. The report examines key pieces of data similar to that supplied to the National Inquiry into Suicide and Homicide. The report has been circulated to the clinical reference group by the associate medical director who is coordinating the response with suggestions of recommended pieces of work. This will then be submitted to EMT.

In 2015, the Trust developed a patient safety strategy 2015-18 to build on the existing robust governance processes. This supports the Trust priority to improve care by ensuring quality counts and safety is put first. The aims of the Strategy are to:-
1. Improve the safety culture throughout the organisation whilst supporting people in their recovery journey.
2. Reduce the frequency and severity of harm resulting from patient safety incidents.
3. Enhance the safety, effectiveness and positive experience of the services we provide.
4. Reduce the costs both personal and financial associated with patient safety incidents.

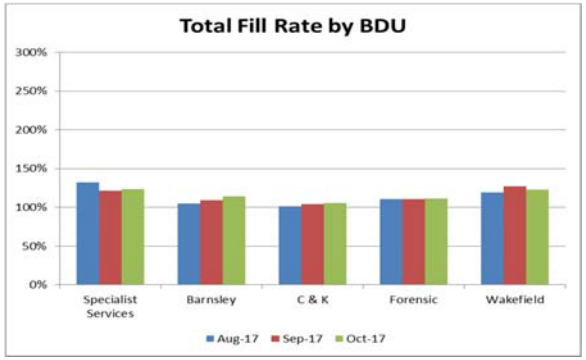
This year, the implementation plan has focused on 10 overarching priority areas including:
- Each Business Delivery Unit identified their top 5 patient safety priorities for 2017 which they are progressing locally
- Improved Patient Safety information internally and externally
- Work has been done to explore a range of improvement methodologies and how they could be used in the Trust to improve patient safety. This has included researching and piloting safety huddles, which has shown some results in reducing harm. Plans are being developed to scale this up. Other work around promoting safety conversations and Human factors is underway.
- We have been improving our understanding of safety culture through the introduction of a safety culture survey in teams who are introducing safety huddles
- Sign up to safety work has continued and 2016 data showed some positive improvements
- Suicide prevention strategy implementation group has continued

## Safer Staffing

**Overall Fill Rates: 112.9%**
Registered fill rate: (day + night) 99.5%
Non Registered fill rate: (day + night) 126.2%

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

| Fill Rate | Month | | |
|---|---|---|---|
| BDU | Aug-17 | Sep-17 | Oct-17 |
| Specialist Services | 133% | 121% | 124% |
| Barnsley | 105% | 109% | 114% |
| C & K | 102% | 105% | 106% |
| Forensic | 111% | 111% | 111% |
| Wakefield | 119% | 127% | 123% |
| Grand Total | 109% | 112% | 113% |




For the second consecutive month no ward fell below a 90% overall fill rate in October. Of the 32 inpatient areas 25 (78.1%) achieved greater than 100%.

Registered On Days (Trust Total 94.5%)

The number of wards which are achieving 100% and above fill rate has increased to 12 (37.5%) in October. There has been a decrease in the number of wards that have failed to achieve 80%, five wards in all (15.6%) compared to six (18.75%) in October. Chippendale had a significant increase (13.5%). These remain mainly focused in the Forensic BDU (Medium Secure Unit)

Registered On Nights (Trust Total 104.6%)

The number of wards which are achieving 100% and above fill rate on nights increased by three wards to 75.% (increased from 65.5%). Thornhill and Elmdale fell below the 80% threshold however both were within 5% of achieving the 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.

## Infection Prevention & Control

## Information Governance

No incidents were reported to the ICO during the month of October 2017. One incident is being investigated internally as it involved a staff member sending person identifiable data to a colleague outside normal working hours via Facebook messenger. Other breaches relate to prescriptions being hand-delivered to the wrong address, correspondence to an incorrect address and filming taking place where staff were accessing clinical systems

## 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.

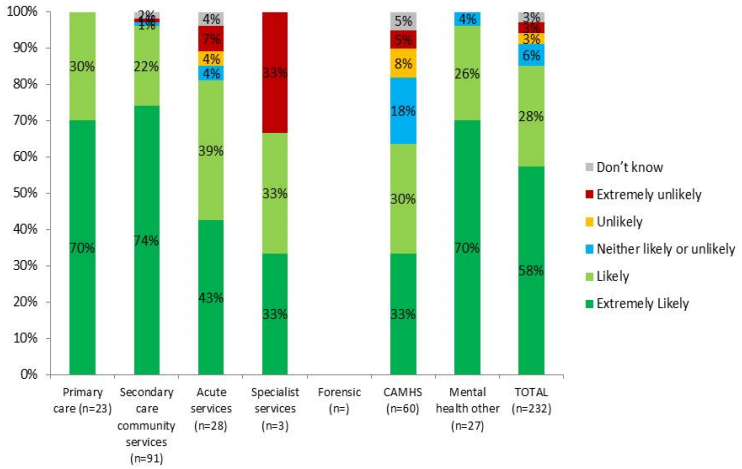
The Trust is currently forecasting a year end position of £856k shortfall, of which £720k relates to the STP indicator. NHSI have written to all trusts confirming further information will follow in relation to this Indicator, the Trust continues to rate this element of the scheme Red until further guidance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

## Patient Experience

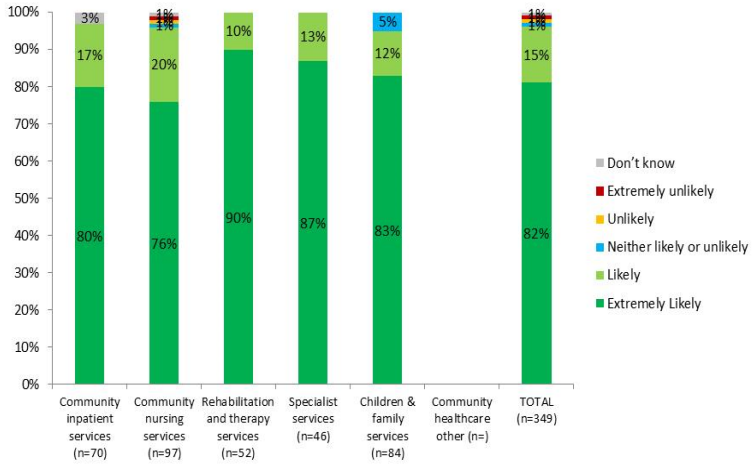
**Friends and family test shows**

- Community Services – 97% would recommend community services.
- All service lines achieved 76% or above for patients/carer's stating they were extremely likely to recommend the Trust's services.
- Mental Health Services – 86% would recommend mental health services.
- Significant variance across the services in the numbers extremely likely to recommend the Trust– between 33% (CAMH and Specialist services) and 74% (Secondary care services)
- Small numbers stating they were extremely unlikely to recommend.

**Mental Health Services**




**Community Services**




## NICE

There has been little change from last month, although we continue to monitor any new guidance. The Quality Improvement Team have started distributing the guidance out to BDU's for them to assess applicability. However, progress regarding NICE will be limited because of the CQC pressures on both QIAT and BDU's.

## Safeguarding Children

- Throughout quarter 2 there has been evidence of strong partnership and multi-agency working with the local safeguarding children boards and other agencies to complete a number of audits reviewing cases involving neglect, harmful sexual behaviour and children who have been in custody. The findings of the audits have been incorporated into the safeguarding children training to ensure that the lessons learnt are shared in a timely manner.
- There has been a review of the current training material and the Named Nurse along with support from Learning and Development have completed a workforce plan for 2018 to ensure that the Trust has a well-informed, skilled and knowledgeable workforce where training is accessible in a number of forms and incorporated into the upcoming mandatory training days. Alongside this a workforce development plan for PREVENT training has been produced to meet the requirement of 85% compliance by March 2018 (as set by NHS England). Hotspot areas have been contacted and additional training has been organised. This plan has been discussed and agreed with the Regional PREVENT Coordinator.
- The safeguarding children team have been involved in providing reports and chronologies to a number of potential Serious Case Reviews. The team have also supported practitioners to attend Lesson Learnt and Practitioner events to support the learning into the organisation.
- Additional Child Sexual Exploitation and Domestic Abuse training has been delivered to the Learning Disability services following a theme which had emerged from a number of Datix and advice calls.
- Following a recent child death the Assistant Director of Nursing and the Named Nurse have recently attended a CAMHS development session to provide information about the child death process, an explanation of the Serious Case Review process and the internal processes. This event was well received and described as 'helpful' by the Practice Governance Coach.

## Safeguarding Adults

• Three members of the team were nominated at the Trust awards ceremony, with 2 runner up awards.
The safeguarding Adults team have:
• been involved in Supporting staff through complex self-neglect cases, chairing the meetings and supporting process,
• included as part of the safeguarding forum external speakers including representatives from family Support, domestic abuse, advocacy services and the national centre for domestic violence
• have co facilitated the domestic abuse / CSE training for learning disability team.
• Have provided chronology information in a timely manner to the Safeguarding Adult Boards to support potential Safeguarding Adult Reviews in Kirklees and Calderdale
• Have facilitated a presentation on the Forensic learning lessons event
• Contributed to the safeguarding week

## CQC

**CQC inspection**
Since April 2017, the CQC have implemented a new assessment framework. As a result, there will be a more targeted approach to inspection way inspections are conducted with less comprehensive inspections. The CQC will undertake an annual announced well-led review and this will involve CQC speaking with senior members of our organisation. In addition, at least one of our core services will be inspected each year. They are likely to target those services that previously received a 'requires improvement' rating and these visits will be unannounced.

On 14th November 2017 we received a Provider Information Request (PIR), with 144 requests for information. The PIR is made 20-24 weeks prior to our well-led review date and we have three weeks until 5pm on the 5th December 2017 to respond. During the 12-24 week period prior to our well-led review we can expect CQC to carry out at least one unannounced visit to our core services. Therefore, the earliest date the unannounced visit(s) could occur is 6th February 2018 and the earliest the well-led inspection could take place is 3rd April 2018.

In the interim period, our existing CQC inspection action plan will be updated and completed and further areas for development will be identified and addressed.

CQC Re inspection MUST/SHOULD Do action plan – progress report October 2017
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%) | 5 (33%) |
| Green | 3 (37.5%) | 5 (33%) |
| 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.
• Half of the 'must do' actions have either been completed or will be within agreed timeframes.
• The majority of 'should do' actions (66%) have either been completed or are on track to be done within the given timescales.
• The red 'must do' action is about the access to psychological therapies within community mental health services for adults. A desktop quality monitoring review found that serious concerns remain around this issue.
• There are now three amber/red rated 'must do's whereby timescales for completed actions have not been met. The first 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. The second issue remains around waiting times within the CAMHS services and the other is in relation to staff supervision difficulties in one Calderdale acute mental health unit although this situation is improving.
• The amber/red 'should do's relate to staff appraisals and ILS training within our Forensics service. Whilst improvements remain ongoing, again there is concern that the actions will not be delivered within the agreed timeframes. The use of lone working devices continues to be an issue within CAMHS and the Trust wide 'should do' regarding supervision is still an issue (see above) although again improvements are being made but actions have not been completed within the given timescales.

**Monitoring of actions against our CQC action plan by the CQC**
• We continue to submit our monthly action plan progress updates to CQC.
• We review core service progress updates as part of the monthly Clinical Governance Group agenda.
• 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.

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 | Oct-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% | 96.0% | 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% | 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% | 97.2% | 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% | 94.7% | 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% | 99.8% | 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% | 69.1% | 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% | 49.06% | 51.25% | 51.95% | 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% | 80.90% | 82.78% | 87.74% | 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% | 99.31% | 99.01% | 99.52% | 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% | 92.3% | 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% | 80.7% | 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% | 8.4% | 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 | Oct-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 | 22 | 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 | 3 | 2 | 7 | N/A | |
| Number of detentions under the Mental Health Act | Improving Care | Safe | SR/CH | *TBC* | 167 | 174 | 156 | 168 | 212 | | | 221 | | | Due Dec 17 | 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 | Oct-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% | 96.9% | 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% | 99.7% | *90.7%* | 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% | 90.9% | *90.9%* | 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 continues to perform well against the vast majority of NHSI metrics

• 7 day follow up indicator has dropped below threshold for the month of October. This relates to 7 patients discharged out of 133 that were not followed up within the 7 day timeframe. 5 of those that breached were followed up but outside 7 day window, 2 that breached were due to being unable to engage with service user.

• Within the IAPT people moving to recovery indicator the rate achieved is 51.95%, which is marginally above threshold. Work progresses against the action plans to improve IAPT performance in both Barnsley and Kirklees. Performance for each service for the month of October based on the primary IAPT minimum dataset submissions is: Barnsley 55.38%, Kirklees 50% (Greater Huddersfield 45.13%, North Kirklees 52.83%) - for Kirklees the service continue to achieve the 50% threshold overall but with under performance in Greater Huddersfield. Since the dip in August, remedial work on the data has taken place and more robust data quality check and analysis are now in place. For Barnsley, the 50% threshold has now been maintained since August 17. Progress on the action plan continues and this is reviewed and agreed in conjunction with the commissioner.

• Whilst below target data completeness priority metrics for mental health improved from 60.1% to 69.1% in October. Focus has previously been on collecting this information for patients on the care programme in line with the public sector agreement indicator – the collection for all service users is now an area of focus

• Total beds days of Children and Younger People aged under 18 decreased to 21 days in September and remained at s similar level of 22 days in October. 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. This issue does have an impact on total Trust bed availability and therefore the use of out of area bed placements.

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:**

**Barnsley Hospital intermediate care wards – transition to new model**

In September 2017, wards 4 and 5 intermediate care (IC) wards at Mount Vernon Hospital were transferred to wards 35 and 36 at Barnsley Hospital in preparation for the transition to the new IC model in Barnsley. From 1st December 2017, the inpatient element (called the 'Transition Ward') of the intermediate care service will transfer from SWYPT and be run by Barnsley Hospital NHS Foundation Trust. This is in line with the new model of care being implemented by Barnsley's Alliance Management Team.
With this in mind and following liaison with the Care Quality Commission (CQC), new patients will not be admitted to the one ward (ward 35, which is the only ward now occupied) during the last two weeks of November. This is to ensure there is a safe transition to the new model with as little disruption as possible. During this time, intermediate care beds in care homes will be used as required, with contingency arrangements in place should they be needed.
Close lines of communication have been established between each party in the Alliance and CQC to ensure any risks that emerge during the transition are managed quickly and effectively.

**Mental Health**

The BDU has reviewed and refocused its Data Quality action plan and work continues at team and service line level to improve our performance in this area. Progress against this plan will be monitored at Service Line and BDU Management meetings

- A dip in gatekept admissions has been noted in this month's report. Barnsley has maintained 100% gatekeeping for some time and this variance is therefore causing concern. The Team manager is investigating this with an expectation that remedial action will be taken to reinstate 100% compliance.
- SWYPFT hosts the South Yorkshire Liaison and Diversion scheme and is receiving positive feedback in relation to this from the national and regional team. 2 additional posts, funded by BMBC have been secured to support work to develop a Vulnerable Persons Hub in Barnsley. Close partnership working with the Council, the Police and Safer Neighbourhood teams have been instrumental in securing the investment
- The Improving Access to Psychological Therapy (IAPT) service has met all 3 KPIs in October. Progress against the improvement plan and trajectories is positive. The first draft of the national Intensive Support Team (IST) report has been received by the service to be checked for accuracy. A response has been sent to the IST in respect of this.
- Action plan being finalised to address patient flow challenges in community mental health services/teams.

**Calderdale & Kirklees BDU:**

- Works to showers on The Dales has meant a two bedroom reduction for past 6-8 weeks. This work was completed on Friday 17th November. There has been some spikes in in-patient acute admissions, mainly males, however, improved bed availability, discharges and some delayed transfer of care (DTOC) reductions has reduced out of area use in the acute pathway.
- Psychiatric Intensive Care Unit (PICU) use and need remains high, especially female PICU.
- DTOC in older adults in Calderdale and in adults have been subject to a great deal of activity and focus. It is now picked up in Greater Huddersfield and Calderdale Better Care Fund reporting and council and clinical commissioning group (CCG) colleagues are providing additional focus and capacity to all DTOC issues including those in mental health services. Some Batter Care Fund (BCF) monies in Kirklees and Calderdale are identified for mental health activity. We are working up proposals in both areas.
- Perinatal Mental health service continues to recruit to remaining vacancies. The workforce is nearly complete with the process of recruiting final members of staff underway. The service will open to referrals as from December.
- Improving Access to Psychological Therapies (IAPT) Kirklees/G Huddersfield. An NHS England Intensive Support Team 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 and this is likely to take place in December. The review team are making contact with the CCG and Trust to confirm data that is required. The teams are undertaking weekly reviews of performance based on an agreed action plan with commissioners concerning access targets to treatment and this focus has had a very positive impact on performance and Octobers figures, although not finalised yet, are good. Access is at around 17.4% against a 16.8 % target and Recovery is now at 55% against a 50% target.
- The business delivery unit (BDU) clinical leads are working to resolve medical staffing gaps. We have 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. Some vacancies will need to be filled temporarily with locums in order to accommodate capacity in Perinatal service, for instance.

**Forensics BDU:**

• Service Review – this work is continuing nationally. Further stakeholder event was held 13th November. Whilst West Yorkshire technically do not need a reduction in overall bed capacity, the configuration of the beds is an issue in order to ensure all service users are catered for within the STP footprint. Our proposal for an LD Community Team across West Yorkshire was submitted. Further meeting arranged to pursue implementation by April 2018. Further focus being placed on strengthening relationships across the W.Yorkshire STP.
• Forensic CAMHs – Work around the implementation of the regional Forensic CAMHs (FCAMH) service is progressing well and the implementation is being negotiated with NHSE. Work around the implementation of Secure Stairs in Adel Beck is progressing well. We are awaiting further information re the roll out across the secure estate.
• 25 Hours Activity - Significant improvements made in the delivery of 25 hours meaningful activity have continued. The service will continue to monitor this to ensure that improvements are embedded..
• Staff Development - The BDU has progressed discussions re supporting a development programme for Band 3's.
• Nursing Times Award – FCAMHs/LCH won the national award for Partnership Working.
• 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. A recovery plan has been provided. The MOJ indicate that this situation may continue for some time. We are continuing to monitor this and its impact on service users.
• Appraisal Figures, Information Governance and Cardio Pulmonary Resuscitation (CPR) training are key hotspots. Managers are working hard to reach the targets required. Additional CPR training sessions have been identified.
• Occupancy – further slight drop to 85% overall.

**Specialist BDU:**

**Specialist Services**

Year to date (YTD) sickness rates have generally increased. Only Wakefield CAMHS is now within target. A major contributor to overall levels is a small number of staff on long term sickness. All are being proactively managed in accordance with sickness procedures with some additional management support/training now being offered by Human Resource colleagues. However, the recent increase is due to bouts of short-term sickness – essentially anxiety/stress related. Again this is being managed in accordance with procedure and further promotion of health and wellbeing supports is being undertaken

The position in relation to appraisals (Band 5 and Band 6) has significant improved and specialist services is compliant with the agreed target.

**CAMHS**

Further consultation is being undertaken with regard to development of a proposal to establish all-age psychiatric liaison teams in Barnsley, Calderdale, Kirklees and Wakefield. This will ensure compliance with the ambitions of the Five Year Forward View strategy and Core 24 agenda.

It has been recently announced that the West Yorkshire and Harrogate STP will receive £13m funding for a new CAMHS inpatient unit (Leeds Community Hospitals Trust). This investment will complement the new models of care work regarding improved crisis response within specialist child and adolescent mental health services. As part of this work 3 care navigators will shortly be appointed across the STP area to strengthen inpatient admission/discharge processes.

The CAMHS waiting list initiative has, at the end October 17, enabled 192 children/young people to receive more timely support and be removed from the waiting list. The initiative has increased staffing to secure additional bank/agency capacity for a 6 month period (September 17 to March 18). In total it is expected that 400 children/young people will be able supported by the initiative.

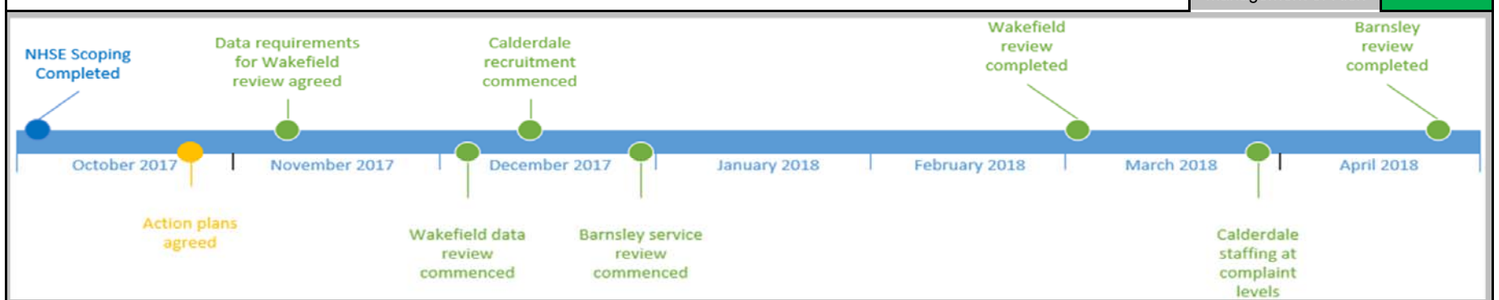
**Learning Disability**

Local reporting identifies significant improvement with regard to waiting times. However, urgent intensive support response times in Barnsley dipped below target in October 17. This is not expected to be a recurrent problem.

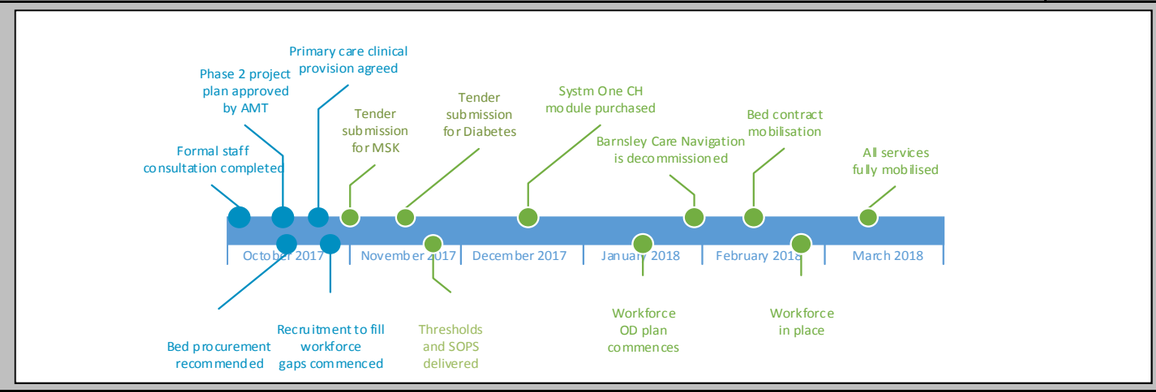
**Wakefield BDU:**

- A Good Practice visit has taken place to the Memory Service in Wakefield with extremely positive results and particular comment on the excellent values and approach of the team.
- Increased scrutiny of requests for Out of Area (OOA) placement, with a problem solving approach to alternative solutions is to be piloted in the Business Delivery Unit (BDU). The Acute General Manger is leading on this with the support of the OOA Project Board to ensure there is a robust and defensible decision making process in place
- An increase in managing aggression and violence (MAV) incidents is noted in the report. Debriefs with the MAV team are undertaken following each incident to ensure that any lessons are learned. Analysis of any trends or themes takes place at the BDU Clinical Governance and Service Line meetings.

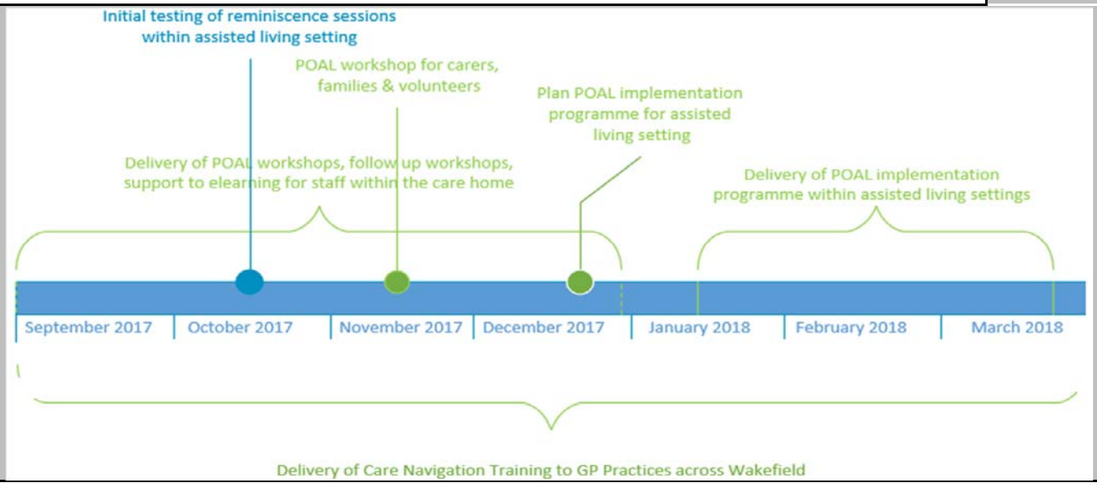
Summary:
• The new framework for reporting on progress made with Trust priority programmes continues this month.
• Reporting is monthly for those programmes that are identified in the two groups of 'major transformation' and 'significant improvement'. Priority programmes not in these two groups are reported bi-monthly on the IPR and are noted accordingly.
Priority highlights in this report include:
• Flow and out of area beds - Pressures continue with this priority through October. Urgent work linked to intensive home based treatment, progress has been made toward resourcing the personality disorder project and it is hoped that project activity can commence in December to impact positively on the performance of this priority. Additional programme management support is being secured to help bolster this priority. Progress and risk is rated as Red due to continued upwards trend in out of area beds
• Older Peoples Transformation - Production of the community workforce modelling has been delayed for this priority and although a revised plan is in place the project is rated as Yellow as the business case will not be submitted as planned in November (actions will not be delivered to agreed timescales/project tolerances)
• Leadership management - a range of workstreams/key deliverables have progressed to agreed timescales in this priority. This programme is still on track and a revised implementation plan with extension to some work-streams is in place.
• Forensic Community CAMHS - Work continues to progress well since award of the contract as lead provider to SWYPFT by NHS England. Partners include Humber, TEWV and Sheffield children's hospital. Discussions continue with partners on the forensic CAMHS model and progress on the implementation of the model is to revised plan.
• Perinatal mental health - New service launched but some delays in recruitment to medical posts has raised risk to this priority to yellow

| 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.<br>Establishment of a benefits realisation framework to support the 3 year evaluation of the project. | **Wakefield**<br>• Recruitment to clinical posts continues.<br>• Wakefield Clinical Commissioning Group (CCG) have commissioned a review of Psychiatric Liaison Service and a task and finish group has been established.<br>• P&I supporting the service, working in partnership with Wakefield CCG (WCCG) and Mid Yorkshire Hospitals Trust (MYHT), to review data requirements.<br>• A review of the first six months of implementation has been requested by NHS England and a response is being prepared identifying current progress, risks, and issues for submission in November.<br>**Calderdale**<br>• Steps taken, in conjunction with Calderdale CCG support, to bid for an early release of wave 2 part funding to support the recruitment of two posts.<br>**Barnsley** | 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:<br>Co-produce an integrated recovery development plan<br>Test new approaches to recovery, developing from what we learn in order to maximise effectiveness and impact<br>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 on the Integrated Performance Report (IPR). 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 IPR. 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 (EMT). | 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 Accountable Care Organisation (ACO). | Discussed quarterly at Strategic Board and monthly updates to EMT | Overall Priority Performance | N/A |
| New models of care and vanguards<br><br>Barnsley Intermediate Care, Respiratory, Diabetes and MSK | Work with partners to introduce new models of Care across SWYPFT footprint<br><br>Barnsley Intermediate Care, Respiratory, Diabetes and Musculo-Skeletal service. | **MSK -** this service has recently been the subject of a tender exercise.<br>**Respiratory Services -** As part of the Alliance agreement all providers are working jointly on the development and implementation of a new model for the service, with BHNFT leading the process. Implementation is on target.<br><br>**Intermediate Care -** Following relocation of the two wards at Mount Vernon (MV) to Barnsley Hospital mobilisation of the new model continues with the aim of going live on December 1st. Staff consultation has taken place and there are a number of staff remaining at risk of redundancy. | 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 NMOC implementation group (and AMT as appropriate) on a monthly basis. Other risks are being managed internally by services as part of BAU. | Management of Risk | |

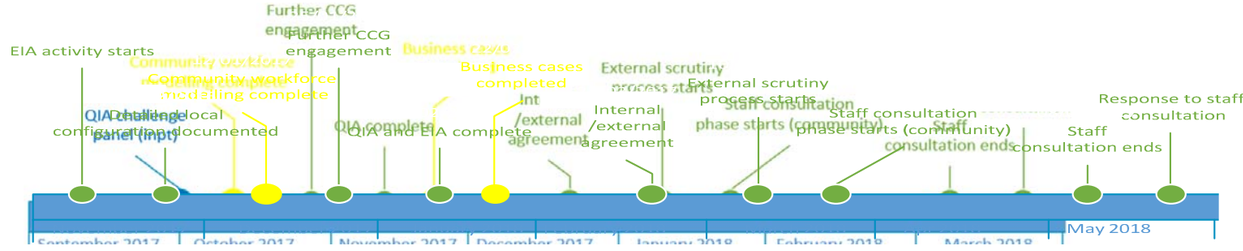


| | | | | |
|---|---|---|---|---|
| New models of care and vanguards<br><br>Wakefield - Care Home Vanguard and Public Health as part of Connecting Care Vanguard<br>Calderdale - Prevention and Supporting Self Management Vanguard | Work with partners to introduce new models of Care across SWYPFT footprint<br><br>Wakefield - care home vanguard and public health<br>Calderdale - Prevention and Supporting Self Management Vanguard | Wakefield<br>•Portrait of a Life (POAL) as part of Wakefield Care Home Vanguard: training and support session on life story work and person centred care interventions provided to 9 of 13 care homes for Wave 2 2017/2018. Project is on track and meeting KPIs.<br>• Wakefield Connecting Care: Work is being undertaken to align SWYPFT involvement in new models of care.<br>• Care Navigation: The role out across Wakefield GPs is on plan. Directory of Services redesigned and working well. Extracting data from the GP systems had been problematic, resulting in data not reflecting output correctly. CCG investigating improvement to coding. It is anticipated that this contract will not continue after March 2018.<br>• Public Health – Live Well Wakefield service, led by Nova, is performing well and meeting all KPI's. Feedback from commissioners has been very positive and the partnership with Nova is working well.<br>A partnership bid for the provision of social prescribing in Wakefield for the next three years is under development, deadline date for submission is 21/11/17.<br>Calderdale.<br>Although not funded by Vanguard, Recovery College Calderdale has been involved with the Vanguard Prevention and Supporting Self-Management work and has been cited by CCCG as providing a useful addition to self-management in Calderdale. The college Principal now appointed and working closely with a range of partners across Calderdale.<br>A single plan for Calderdale is under development. Work continues to develop an integrated community service offer through implementation of five localities by April 2017. | Progress Against Plan | |
| | | Risks are managed by the Vanguard projects which report into the Vanguard PMO (Wakefield) and Vanguard Board (Calderdale) on a monthly basis - there are no significant risks to date. | Management of Risk | |

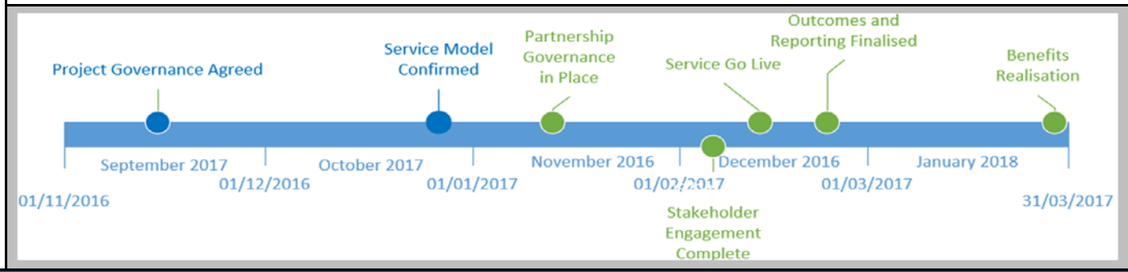


## IMPROVING CARE

### Strategic Priority Three: Quality Counts, Safety First

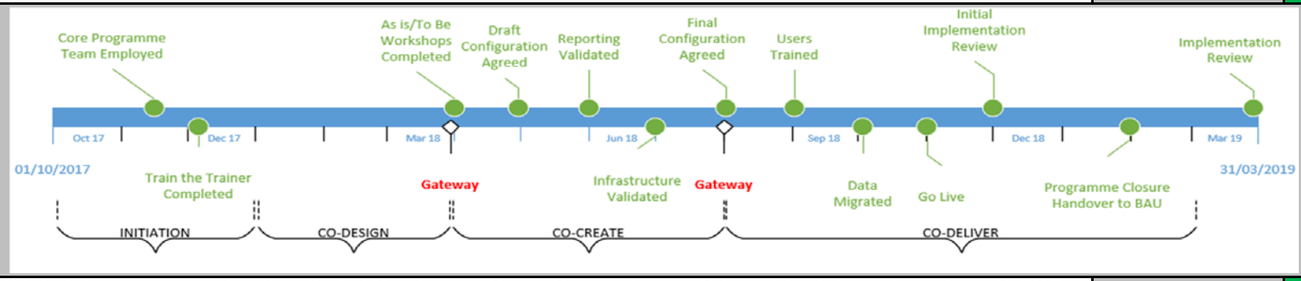
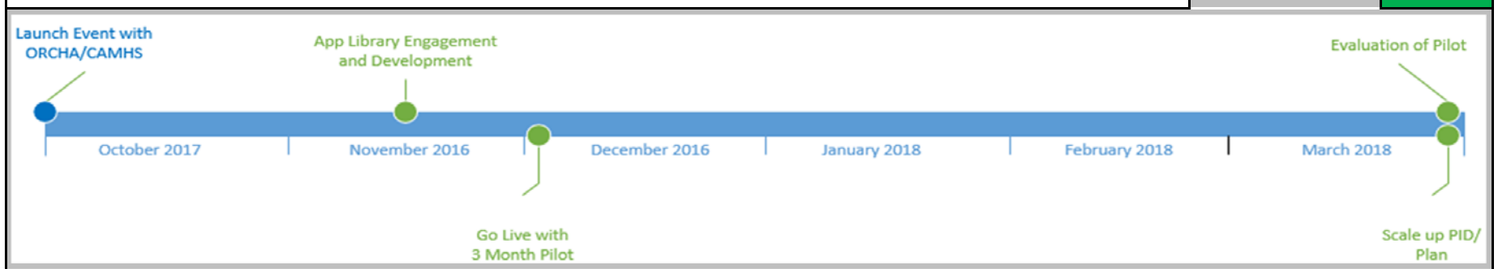
| | | | | |
|---|---|---|---|---|
| Patient Safety | Continue to implement the patient safety strategy including:<br>Measuring and monitoring patient safety framework awareness & use in practice<br>Establish a sustainable resource to support the roll out and continuing support for safety huddles.<br>Develop a process and resources for considering human factors within incident review<br>'So what'… acting on learning from feedback | This priority is updated in the Quality section of this integrated performance report | | |
| Older Peoples Services Transformation | Co-produce, develop and agree a new model of care for Older people with mental health difficulties that improves outcomes, experience and efficiency.<br>To effectively implement this model and demonstrate the impact. | • Production of the community workforce modelling has been delayed. The revised plan involves workforce challenge events being held in early December with completion in the new Year.<br>• Positive progress has been made around involving current inpatient service users/carers and a tablet based questionnaire is ready for inpatient wards to complete from November.<br>• Good progress has also been made to develop the benefits framework and a draft dashboard is in development – 1st draft in November.<br>• A QIA panel meeting is being scheduled for December to review both the community and inpatient business case.<br>• Further work is scheduled on the Equality Impact Assessment and a plan is now in place to establish these by January 2018.<br>• Meeting conducted with commissioners to discuss potential ward options. Further engagement to take place with local authorities.<br>• Work ongoing to pull together the proposed configurations of the community model in each locality.<br>• Progress made to agree adherence and variation to the model across the Trust. Next steps will be to document the agreed configurations in each locality - which will also be shared with local partners and will have scope to evolve.<br>New timescales for draft business case is end Jan 2018. | Progress Against Plan | |
| | | Workforce modelling has been delayed. There is new plan in place to establish a workforce model for community by end December. The ongoing risk of slippage in the project timescale due to limited capacity across the project and across the Business Delivery Units (BDU) remains. | 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 (Sustainability and Transformation Plan ) STP- yet to be developed. | • Work continues to finalise the detail for this priority<br>• The integrated change team are supporting this work and meetings with the clinical lead for this priority are programmed for November 2017 | Progress Against Plan | |
| | | No known risks at this time | Management of Risk | |
| | | Implementation plan will be developed once the scope for this priority is clear. | | |
| 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 and implemented<br>• Full scale launch planned for December 2017 with events in each locality between November 2017 and January 2018. Standard Operating Procedure (SOP) and pathway/internet materials to be reviewed and finalised prior to formal launch.<br>• Additional GP engagement is being planned for early 2018.<br>• Recruitment of remaining posts continues<br>• National team visit conducted on 5 October - awaiting formal feedback.<br>• Performance reporting to central team continues<br>• External communications campaign to accompany launch events ongoing<br>• Multi-agency Networks now established in all localities<br>•Essential training module to be established by end of 2017. | Progress Against Plan | |
| | | • Delay in recruitment to medical posts<br>• If Long term sustainable funding isn't received at the end of the NHS England funded phase, or full funding from each locality isn't agreed there could be a risk to the continuation of the service.<br>• Achievement of performance targets – although early signs are reassuring it remains unknown whether the target of 730 cases will be met. Mitigating actions are being taken forward to ensure as many people as possible access the service. | 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.<br>SWYPFT is a Partner in this contract together with Leeds and York Partnership NHS Foundation Trust and Bradford District Care NHS Foundation Trust<br>Funding has been secured though STP NMoC work stream | • Initial draft business case to NHSE was produced on 4 August 2017.<br>• 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.<br>• Work continues in scoping the extent and role of Trust in this priority programme | 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.<br>• 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<br>Eating Disorders*<br>(* 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 work stream<br>• Work near completion on the role of SWYPFT in the service<br>• Governance arrangements now complete<br>• Planning sessions have been arranged through November to clarify the implementation aspects for SWYPFT | 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 this priority programme progresses well since award of the contract as lead provider by NHS England<br>Specific achievements in line with plan include:<br>• Discussions continue with partners on the proposed forensic CAMHS model and progress on the implementation of the model is to revised plan<br>• Final amendments made to the implementation plan and supportive narrative prior to submission to NHSE.<br>• Formal letters to partners, draft Memorandum of Upstanding (MoU) between partners issued<br>• Recruitment to Single Point of Access (SPA) roles is finalised<br>• SWYPFT Governance for the project established through transformation board<br>• Themed task and finish groups meeting commenced in the areas of: Communications and Marketing; SPA/Assessments/Pathways; Safeguarding and Risk/ Quality and Governance; Workforce/Training; Transitions, and Data/Performance and KPIs | Progress Against Plan | |
| | | • There are currently no high level risks identified in this project.<br>• 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 | Actions achieved for this priority programme within agreed timescale:<br>• Values into Behaviours - shared and roll-out planned<br>• Learning Needs Analysis - completed<br>• Leadership and management framework – leaders/managers expectations obtained<br>• Corporate Leadership and management offer – costed<br>• SWYPFT Leadership and management programmes - implemented<br>• Moving Forward programme - launched<br><br>Revised implementation plan with extension to agreed timescales now in place:<br>• Middle Ground 5: first run of the programme has been deferred slightly to early 2018, rather than the original planned commencement in late 2017. Development is on track with proposals planned to be presented to EMT by end of November.<br>• TRIO development programme: Arising from the Learning Needs Analysis, the BDUs are now wanting to refocus the development on action-orientated learning rather than a more formal development programme, as originally intended. The Leadership and Management Framework will be presented to EMT in November with project still on track for roll-out of a revised programme in Q4.<br>• Maximising Potential: development (workshops and pilot) is ahead of schedule. Launch of the programme is linked to the launch of the new streamlined appraisal process, which is due early in Q1 2018.<br>All other work-streams / key deliverables progressing as per agreed timescales. | Overall Priority Performance | |

| | | | | |
|---|---|---|---|---|
| Change and quality improvement | Develop and agree Quality Strategy which includes the Integrated Change Framework | A draft quality strategy has been produced and shared. Further work is required and this is planned to be completed for the revised Quality Strategy to be presented to Trust Board in December 2017. | Overall Priority Performance | |
| 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 IPR. 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.<br>This is part of the West Yorkshire STP work stream for acute inpatient shared bed base and development of Psychiatric Intensive Care Units (PICU).<br>By March 2018 the Trust will have a shared bed base across West Yorkshire. | • Pressures continued on the Out of area (OOA) system through October 2017, despite the additional beds being in use at Fieldhead.<br>• In October, senior led weekly phone calls commenced to focus on people that have stayed in beds longer than anticipated.<br>• The OOA project board has commissioned urgent work linked to intensive home based treatment, which will involve a peer review of recent admissions to establish whether any of the admissions were avoidable and what we can put in place to stop such admissions in the future.<br>• Progress has been made toward resourcing the personality disorder project and it is hoped that project activity can commence in December. | 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. This risk moved off trajectory briefly but there is remedial activity ongoing now to reduce impact, which will be monitored closely. Risk still rated as Red | Management of Risk | |
| | | A graphical timeline of the key milestones identified to end of March 2018 will be developed. Planned activity for future reporting includes<br>• Peer review of admissions (both from a community and IHBT perspective). Further planning of IHBT strand will follow.<br>• Undertake an Intensive Home Based Treatment workforce analysis<br>• Weekly review of people identified as having challenges to discharge has started. Activity on repeat admissions to commence.<br>• Review senior medical decision-making around out of hours admissions<br>• Review out of hours bed management functions<br>• Commence Personality Disorder (PD) pathway activity. | | |
| 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.<br>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 Finance and Contracts section of this integrated performance report | | |
| Financial sustainability and CIP | Develop and deliver Cost Improvement Programme (CIP). | This priority is updated in the Finance and Contracts section of this integrated performance report | | |

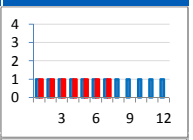
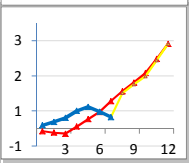
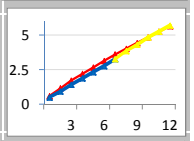
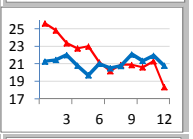
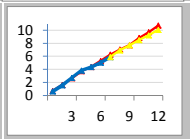
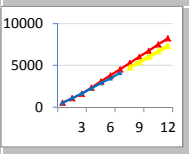
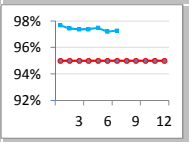
## Strategic Priority Six: Digital by Default

| | | | | |
|---|---|---|---|---|
| Clinical record system | Plan and deliver a new clinical record system which supports high quality care | • System demos continue: Kendray on the 20th November, all 25 spaces booked; Fox View Hub on 4th December, all 25 spaces booked<br>• 14 out of 15 team positions filled<br>• Contract detail being finalised, Change Control Notification drawn up and papers drafted for EMT<br>• Engagement with individuals, management teams and groups continues including a well received 2 hour session on how the system will support care plans led by Deputy Director of Nursing | Progress Against Plan | |
| | | High level risks being captured for analysis, reporting and management in project risk register and Datix where appropriate<br>Initial risk register drafted | Management of Risk | |
| | |  | | |
| Digital health | Improve access to digital health opportunities.<br>Identify our approach to supporting digital health developments.<br>Increase digital clinical practice. | • The digital i-hub challenge has generated interest in digital health and particularly the use of e-consultation which is being explored along with IM&T colleagues<br>• One of our clinical teams is taking up the beta development of the Digital skills practitioner training with mHabitat in Leeds- we will review how beneficial this has been and possible further involvement<br>• Monthly targeted horizon scanning for digital developments is in place<br>• Orcha pilot- remains in the co-design phase-engagement with staff and service users regarding the look and feel of the microsite, including marketing materials. | Progress Against Plan | |
| | | The co-design and reach of the pilot has been extended Trust wide and we are currently engaging with CAMHS teams in all locality areas regarding joining the pilot. | 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 7 months to the end of October 2017. The individual I & E margin rating remains at 2 and Distance from plan rating has moved from 1 to 2 as a result of the in-month deficit. |  |
| 2 | Normalised Surplus (inc STF) | £0.3m | £2.4m | October 2017 finance performance excluding STF is a deficit of £151k. This is below plan due to ongoing out of area bed costs and reduced income. Due the deficit month 7 STF income has not been achieved. Achievement of the full year control total represents a significant challenge. A financial recovery plan is being developed. |  |
| 3 | Agency Cap | £3.3m | £5.7m | Agency expenditure in October 2017 is higher than previous months at £515k. This exceeds the in month cap but remains under the agency cap year to date. The forecast exceeds the cap by 1% given schemes to improve access times and an increase in medical vacancies. |  |
| 4 | Cash | £20.5m | £20.8m | The cash position has improved in month bringing the Trust slightly ahead of its plan (£0.3m above plan). Outstanding debts continue to be chased as part of Working Capital Management. |  |
| 5 | Capital | £5.9m | £10.1m | The majority of spend to date relates to the Non Secure wards on the Fieldhead site with the first phase of wards opening in September 2017. The year end forecast is currently under review with the aim of reducing spend given the I & E risk. |  |
| 6 | Delivery of CIP | £4.1m | £7.3m | Year to date CIP delivery is £430k behind plan. The forecast position is £0.9m below plan. |  |
| 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

The new contract for Smoke Free Services in Sheffield commenced on 1 October 2017 and implementation of the new model of service delivery continues. Following contract award SWYPFT met with Doncaster Commissioners on 14 November 2017 regarding the mobilisation plan for the new Smoke Free Services model to commence 1 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 to commence 1 April 2018. SWYPFT met with Commissioners on 16 November 2017 in relation to the Exit Plan. Work continues on the mobilisation of contracts for the Regional Community Forensic CAMHS Service and implementation of Secure Stairs within the Forensics Secure Estate. In Barnsley, work continues with the transition of the new model of service delivery for Intermediate Care Services and implementation of the revised delivery model for Respiratory Services.

### CQUIN

CQUIN for Quarter 2 submissions across main contracts are in the process of being finalised with CCGs.

### Contracting Issues - Barnsley

Key strategic work areas in Barnsley continue across Intermediate care, Respiratory, MSK and Diabetes services. Contract awards for MSK and Diabetes Services are expected in December 2017 for contract commencement 1 April 2018. Following formal notice that Care Navigation Services in Barnsley would be decommissioned from 31st January 2018 work continues in implementing the Exit Plan. Formal notice has also been received from Bassetlaw CCG that the Care Navigation Service is to be decommissioned with effect from 1st November 2018. An Exit Plan will be put in place to ensure a smooth closure and identify actions to mitigate risk.

### 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 work streams 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

The current priority areas of work related to Kirklees CCGs contracts include IAPT services and expansion to Long Term Conditions and the reconfiguration of adult mental health rehabilitation services. Commissioning of sustainable specialist ASD Services for Adults remains a priority.

### Contracting Issues - Wakefield

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

### Contracting Issues - Forensics

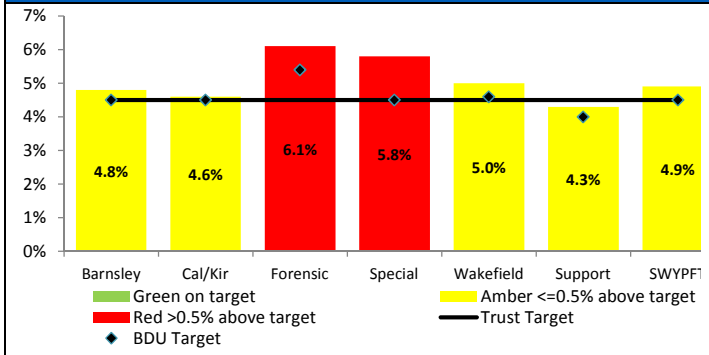
Following successful award of the Lead Provider role for the Yorkshire & Humber delivery of Community Forensic CAMHs services work continues on mobilisation. A bid to NHSE to support the implementation of Secure Stairs within the Forensics Secure Estate was confirmed successful and work has commenced with NHSE regarding mobilisation and contracting arrangements.

### Contracting Issues - Other

The new contract for Smoke Free Services in Sheffield commenced on 1 October 2017 and implementation of the new model of service delivery continues. Following contract award SWYPFT met with Doncaster Commissioners on 14 November 2017 regarding the mobilisation plan for the new Smoke Free Services model to commence 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. SWYPFT met with Commissioners and Park Healthcare on 16 November 2017 in relation to the Exit Plan.

# Human Resources Performance Dashboard - October 2017

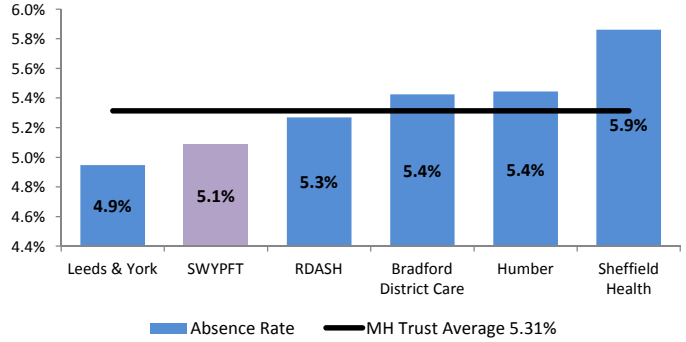
## Sickness Absence




**Current Absence Position - October 2017**

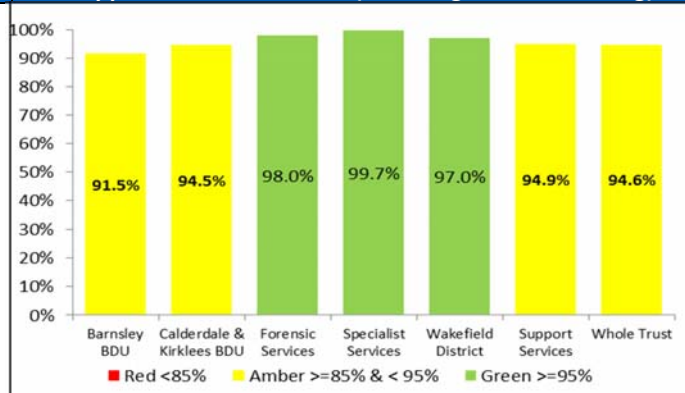
| | Barn | Cal/Kir | Fore | Spec | Wake | Supp | SWYPFT |
|---|---|---|---|---|---|---|---|
| Rate | 5.1% | 5.1% | 7.1% | 6.1% | 4.3% | 4.2% | 5.2% |
| Trend | ↑ | ↓ | ↑ | ↑ | ↑ | ↓ | ↑ |

The Trust YTD absence levels in October 2017 (chart above) were above the overall 4.5% target at 4.9%.
The YTD cost of sickness absence is £3,463,610. If the Trust had met its target this would have been £3,161,511 saving £302,100.



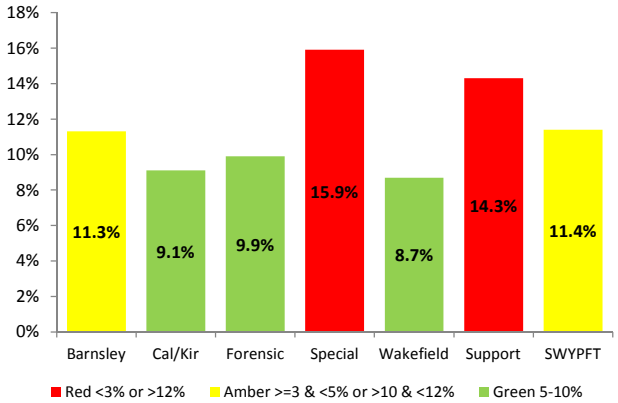

The above chart shows the YTD absence levels in MH/LD Trusts in our region for 12 months from March 2016 to April 2017.
During this time the Trust's absence rate was 5.09% which is below the regional average of 5.31%.

## Appraisal Data - All Staff (including Medical staffing)

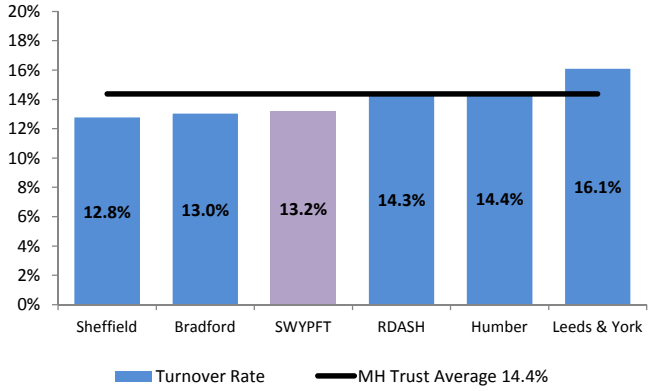



The above chart shows the appraisal rates for all staff for the Trust to the end of October 2017, this data was refreshed in November to include the separate appraisal process for medical staff.
The appraisal target is 95% and over. For staff at Band 6 and above, all appraisals should be completed by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

## Turnover and Stability Rate Benchmark



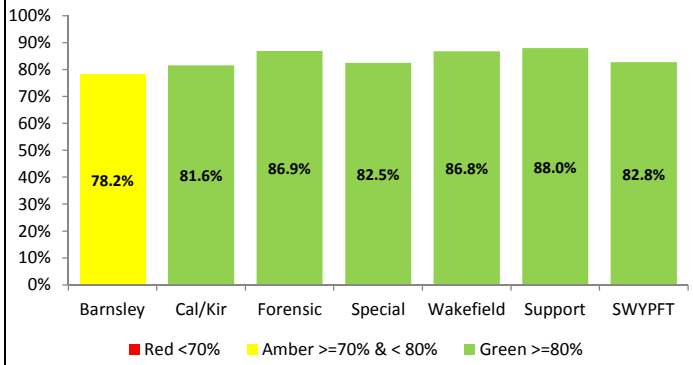

This chart shows the YTD turnover levels up to the end of October 2017.
Turnover figures may look out of line with the average across the Trust but this is because of the small amount of data; the figures will level out over the new reporting year.
*Specialist Services figure excludes the transfer out of Supported Living (Barnsley)




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 October 2017. The Trust continues to achieve its 80% target for fire lecture training and only one area has failed to reach the target in October.

# Workforce - Performance Wall

## Trust Performance Wall

| Month | Objective | CQC Domain | Owner | Threshold | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sickness (YTD) | Improving Resources | Well Led | AD | <=4.4% | 4.8% | 4.9% | 5.0% | 5.1% | 5.1% | 4.8% | 4.7% | 4.7% | 4.8% | 4.9% | 4.9% | 4.9% |
| Sickness (Monthly) | Improving Resources | Well Led | AD | <=4.4% | 5.2% | 5.8% | 6.1% | 5.8% | 5.3% | 4.8% | 4.6% | 4.8% | 5.0% | 5.2% | 4.9% | 5.2% |
| Appraisals (Band 6 and above) 1 | Improving Resources | Well Led | AD | >=95% | 89.8% | 93.2% | 93.7% | 94.4% | 94.9% | 5.2% | 17.60% | 61.30% | 80.90% | 89.00% | 91.00% | 92.70% |
| Appraisals (Band 5 and below) | Improving Resources | Well Led | AD | >=95% | 84.9% | 89.0% | 91.4% | 92.8% | 93.6% | 1.9% | 5.30% | 18.40% | 31.10% | 46.20% | 75.80% | 82.70% |
| Aggression Management | Improving Care | Well Led | AD | >=80% | 78.8% | 78.4% | 77.6% | 77.2% | 76.6% | 76.4% | 75.6% | 78.1% | 76.6% | 77.0% | 77.6% | 76.4% |
| Cardiopulmonary Resuscitation | Improving Care | Well Led | AD | >=80% by 31/3/17 | 66.9% | 69.7% | 72.8% | 73.8% | 73.9% | 75.2% | 75.3% | 74.7% | 73.1% | 71.9% | 73.4% | 72.8% |
| Clinical Risk | Improving Care | Well Led | AD | >=80% by 31/3/17 | 45.1% | 53.5% | 55.3% | 60.4% | 62.2% | 64.8% | 65.3% | 69.1% | 74.6% | 77.3% | 79.2% | 80.7% |
| Equality and Diversity | Improving Health | Well Led | AD | >=80% | 89.4% | 90.1% | 89.0% | 89.4% | 88.2% | 87.3% | 86.6% | 86.0% | 86.6% | 87.1% | 85.7% | 85.4% |
| Fire Safety | Improving Care | Well Led | AD | >=80% | 82.9% | 85.5% | 84.0% | 82.9% | 82.7% | 81.5% | 82.0% | 81.5% | 81.8% | 82.6% | 82.8% | 82.8% |
| Food Safety | Improving Care | Well Led | AD | >=80% | 82.9% | 83.9% | 82.9% | 82.6% | 82.1% | 82.6% | 81.2% | 80.3% | 79.1% | 79.2% | 77.0% | 76.2% |
| Infection Control and Hand Hygiene | Improving Care | Well Led | AD | >=80% | 81.9% | 83.8% | 83.6% | 83.6% | 83.4% | 83.0% | 83.5% | 84.0% | 83.7% | 83.6% | 82.3% | 81.8% |
| Information Governance | Improving Care | Well Led | AD | >=95% | 85.9% | 86.5% | 91.9% | 95.2% | 96.1% | 92.0% | 91.7% | 91.3% | 90.4% | 89.1% | 88.3% | 86.2% |
| Moving and Handling | Improving Resources | Well Led | AD | >=80% | 78.1% | 78.8% | 80.5% | 81.9% | 81.7% | 81.1% | 77.3% | 78.8% | 79.3% | 79.3% | 79.3% | 80.7% |
| 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% | 88.9% |
| 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% | 83.4% |
| No of staff receiving supervision within policy guidance | Quality & Experience | Well Led | | *TBC* | | | | | 39.5% | | | | | | | |
| Safeguarding Adults | Improving Care | Well Led | AD | >=80% | 88.6% | 89.5% | 89.7% | 89.4% | 89.1% | 88.5% | 88.0% | 86.7% | 86.2% | 86.0% | 86.3% | 86.3% |
| Safeguarding Children | Improving Care | Well Led | AD | >=80% | 87.0% | 87.8% | 87.6% | 87.0% | 85.6% | 85.5% | 84.8% | 83.6% | 84.3% | 84.7% | 84.8% | 84.1% |
| Sainsbury's clinical risk assessment tool | Improving Care | Well Led | AD | >=80% | 93.8% | 94.8% | 95.1% | 94.7% | 93.7% | 93.3% | 91.2% | 91.7% | 93.2% | 94.2% | 94.2% | 92.9% |
| Bank Cost | Improving Resources | Well Led | AD | - | £458k | £477k | £505k | £493k | £722k | £398k | £457k | £579k | £576k | £518k | £614k | £545k |
| Agency Cost | Improving Resources | Effective | AD | - | £753k | £885k | £662k | £729k | £833k | £501k | £426k | £500k | £457k | £446k | £435k | £515k |
| Overtime Costs | Improving Resources | Effective | AD | - | £14k | £26k | £19k | £15k | £12k | £16k | £13k | £9k | £9k | £12k | £12k | £7k |
| Additional Hours Costs | Improving Resources | Effective | AD | - | £41k | £47k | £41k | £48k | £53k | £56k | £36k | £48k | £44k | £38k | £45k | £44k |
| Sickness Cost (Monthly) | Improving Resources | Effective | AD | - | £511k | £565k | £592k | £527k | £561k | £476k | £504k | £487k | £511k | £527k | £485k | £539k |
| Business Miles | Improving Resources | Effective | AD | - | 330k | 316k | 284k | 287k | 273k | 289k | 245k | 285k | £299k | 267k | 283k | 291k |

## Workforce - Performance Wall cont.…

1 - this does not include data for medical staffing.

**Notes:**

Green Compliance Status:
• Mental Health Act – 83.4% 1.8% increase on last month. Trust is currently developing eLearning refresher courses for MCA training. This will provide the resource for the refresher compliance requirement, and also for non-registered clinical staff as new starters in the coming years. Registered clinical staff who are new starters will be offered a face to face classroom training
• Mental Capacity Act - 89% 1.4% increase on last month. The Trust is currently developing eLearning refresher courses for MCA training. This will provide the resource for the refresher compliance requirement in the coming years. Registered clinical staff who are new starters will be offered face to face classroom training. An e-learning introduction to MCA course is active and available for non-registered clinical physical health staff.
• Equality and Diversity - 85.4%%
• Fire Safety - 82.8% no change on last month. The new 95% compliance requirement for ward based staff is monitored at service level
• Infection Control and Hand Hygiene – 81.8%
• Safeguarding Adults - 86.3%
• Safeguarding Children - 84.1% additional work has been undertaken by the safeguarding team to target 'hotspot' areas and this has seen an increase in uptake for mandatory courses. Additional workforce planning is being carried out to ensure compliance with the upcoming review of the intercollegiate document (2018).
• Sainsbury's Tool – 93%%
• Clinical Risk – 80.7% moved from amber to green compliance this month with a 1.5% increase. 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
• Moving and Handling – 80.65% moved from amber to green compliance this month with a 1.3% increase

Amber Compliance Status:
• Food Safety – 76.2% 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

• Data Security Awareness Level 1 (formally IG) – 86.2% a 2% decline on last month.
• Aggression Management – 76.4% a 1.2% decline on last month. The MAV team continue to put on extra training sessions to the ones already scheduled to meet demand. 50+ new starters joined the trust in recent months and these are predominately ward based and need 4 day teamwork physical intervention courses. The Aggression Management/Physical Interventions is at 86.7% compliance (Forensic services at 90.1%). De-escalation and Breakaway training for clinical staff is amber in all areas. Non clinical staff personal safety and breakaway courses are red across the trust. This combination of factors contributes to the sub 80% overall rating. The Mav team are currently gathering data regarding attrition and DNAs.

• Cardio Pulmonary Resuscitation – 72.8% a ½% decline from last month. The Team have considered how to address issues of low compliance, and have introduced a number of initiatives, including working with colleagues in the Managing Aggression and Violence (MAV) Team to combine training with three pilot sessions planned for December 2017. This will lessen 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 at 31st October 2017

## Workforce - Performance Wall cont.…

**Sickness**
• The Trusts year to date position is 4.9%, which continues to be above the Trusts threshold.
• Only Barnsley BDU saw a decrease in the monthly sickness position during October 17. Forensic BDU reported the highest level of sickness during the month (7.1%), which increases their year to date position to 6.1%. Forensic and Specialist Service (5.8%) BDUs continue to report the highest year to date sickness levels.
• BDUs continue to focus on long term sickness and the recent staffing summit identified some further potential areas which are being explored that may assist with reducing sickness absence.
• Inpatient areas sickness rates are an area for focus and a Health and Wellbeing Trainer has been appointed to focus on supporting staff in these areas.
• A system of immediate referral into Occupational Health using ERostering has been developed for absence due to MSK and Stress.
• A coordinated system for reasonable adjustments or redeployment for staff is being finalised to support people to remain at work
• Further training support is being rolled for managers on wellbeing and effective absence management.
• The Trust has introduced a fast track facility for episodes of sickness related to musculoskeletal and stress management.
• Pilots are taking place in Wakefield and Forensic BDUs to deep dive into the absences.
• Workshops have been established for managers to assist with the management and sickness review process with a focus on wellbeing and attendance.

# Publication Summary

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

**Department of Health**

2017/18 data security and protection requirements
This document sets out what all health and care organisations will be expected to do to demonstrate that they are putting into practice the ten data security standards recommended by the National Data Guardian.

Click here for link to guidance

**Department of Health**

Guidance for the implementation of changes to police powers and places of safety provisions in the Mental Health Act 1983
This guidance, produced in partnership with the Home Office, outlines changes to police powers and new guidance on appropriate places of safety for people experiencing a mental health crisis. The changes will be coming into force on 11 December 2017.

Click here for link to guidance

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

Direct access audiology waiting times: August 2017

Mixed sex accommodation breaches: September 2017

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

Out of area placements in mental health services: August 2017

NHS Improvement provider bulletin: 18 October 2017 - provided instruction relating to corporate service benchmarking collection

NHS sickness absence rates: April 2017 to June 2017

NHS workforce statistics: July 2017

Diagnostic imaging dataset: June 2017

NHS Improvement provider bulletin: 25 October 2017 - support for how to evaluate learning from deaths policies;  Launch of Mental Health patient safety initiative.  Commencement of amendments to Mental Health Act.  Improving patient flow in Community Health services.

Review of children and young people's mental health services: phase one report, Care Quality Commission

Diagnostic imaging dataset: October 2017

NHS Improvement provider bulletin: 1 November 2017

Children and young people's health services monthly statistics, England - July 2017, experimental statistics

Provisional monthly Hospital Episode Statistics for admitted patient care, outpatients and accident and emergency data - April 2017 to September 2017

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

Monthly hospital activity data for September 2017

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

Delayed transfers of care for September 2017

Diagnostics waiting times and activity for September 2017

# Publication Summary

Children and young people with an eating disorder access and waiting times - experimental statistics, Q2 2017/18

NHS Improvement provider bulletin: 8 November 2017

Mental health community teams activity: quarter ending September 2017

Performance of the NHS provider sector for the month ended 30 September 2017, NHS Improvement

CQC community mental health survey: 2017

Mental health services monthly statistics: final August, provisional September 2017

Out of area placements in mental health services: September 2017

Direct access audiology waiting times: September 2017

Mixed sex accommodation breaches: October 2017

# Appendix 1 - Finance Report

South West Yorkshire Partnership NHS Foundation Trust

# Finance Report

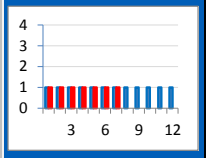
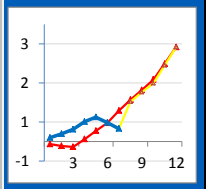
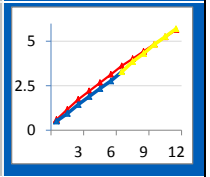
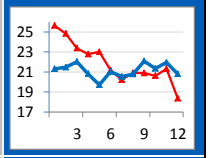
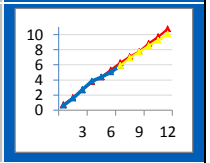
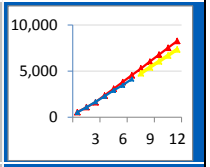
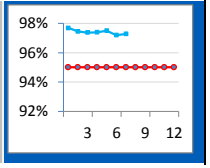
## Month 7 (2017 / 18)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

# Contents

# 1.0 Executive Summary / Key Performance Indicators

| Performance Indicator | | Year to Date | Forecast | Narrative | Trend |
|---|---|---|---|---|---|
| 1 | NHS Improvement Finance Rating | 1 | 1 | The NHS Improvement financial and use of resources risk rating is maintained at 1 for the 7 months to the end of October 2017. The individual I & E margin rating remains at 2 and Distance from plan rating has moved from 1 to 2 as a result of the in-month deficit. |  |
| 2 | Normalised Surplus (inc STF) | £0.3m | £2.4m | October 2017 finance performance excluding STF is a deficit of £151k. This is below plan due to ongoing out of area bed costs and reduced income. Due the deficit month 7 STF income has not been achieved. Achievement of the full year control total represents a significant challenge. A financial recovery plan is being developed. |  |
| 3 | Agency Cap | £3.3m | £5.7m | Agency expenditure in October 2017 is higher than previous months at £515k. This exceeds the in month cap but remains under the agency cap year to date. The forecast exceeds the cap by 1% given schemes to improve access times and an increase in medical vacancies. |  |
| 4 | Cash | £20.5m | £20.8m | The cash position has improved in month bringing the Trust slightly ahead of its plan (£0.3m above plan). Outstanding debts continue to be chased as part of Working Capital Management. |  |
| 5 | Capital | £5.9m | £10.1m | The majority of spend to date relates to the Non Secure wards on the Fieldhead site with the first phase of wards opening in September 2017. The year end forecast is currently under review with the aim of reducing spend given the I & E risk. |  |
| 6 | Delivery of CIP | £4.1m | £7.3m | Year to date CIP delivery is £430k behind plan. The forecast position is £0.9m below plan. |  |
| 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 7 | |
|---|---|---|---|---|---|---|
| Area | Weight | Metric | Score | Risk Rating | Score | Risk Rating |
| Financial Sustainability | 20% | Capital Service Capacity | 2.9 | 1 | 3.2 | 1 |
| | 20% | Liquidity (Days) | 15.9 | 1 | 12.7 | 1 |
| Financial Efficiency | 20% | I & E Margin | 0.3% | 2 | 0.6% | 2 |
| Financial Controls | 20% | Distance from Financial Plan | -0.4% | 2 | 0.0% | 1 |
| | 20% | Agency Spend | -9.2% | 1 | -10.8% | 1 |
| **Weighted Average - Financial Sustainability Risk Rating** | | | | 1 | | 1 |

**Impact**

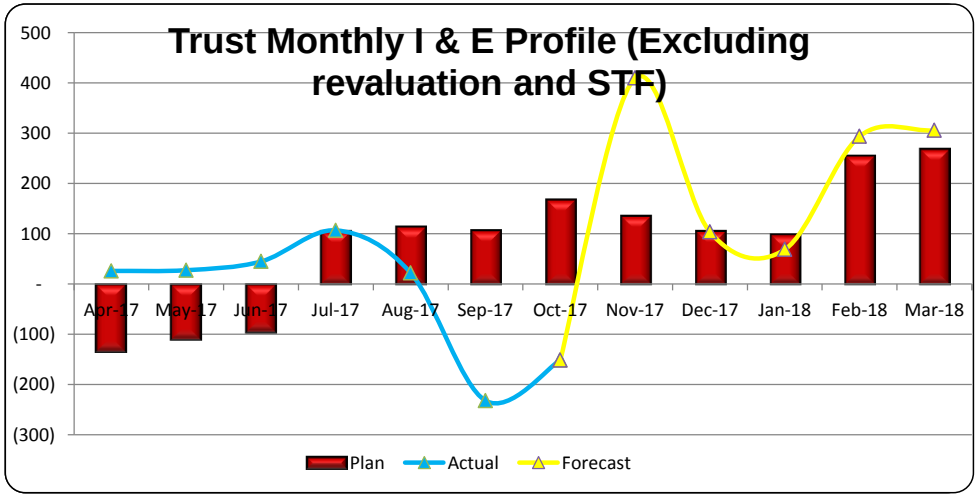
The current risk rating is 1 which is the highest possible score. The I & E margin is rated at 2, this needs to be greater than 1% to achieve a rating of 1. The Distance from Financial Plan has moved from a rating of 1 to 2 at month 7 due to the year to date position now being behind plan.

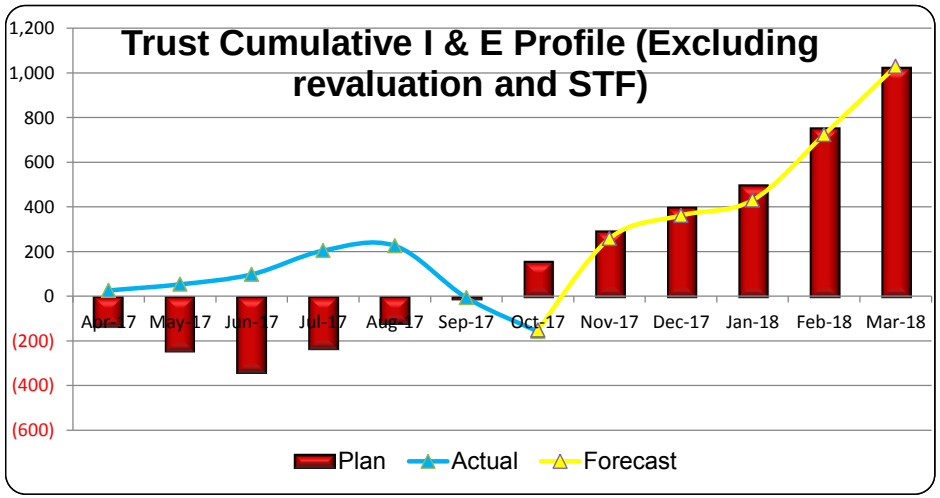
**Definitions**

**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 | Actual worked | Variance | | This Month Budget | This Month Actual | This Month Variance | Description | Year to Date Budget | Year to Date Actual | Year to Date Variance | Annual Budget | Forecast Outturn | Forecast Variance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| WTE | WTE | WTE | % | £k | £k | £k | | £k | £k | £k | £k | £k | £k |
| | | | | | | | | | | | | | |
| | | | | 17,628 | 17,534 | (94) | Clinical Revenue | 120,668 | 119,949 | (720) | 206,378 | 203,193 | (3,184) |
| | | | | **17,628** | **17,534** | **(94)** | **Total Clinical Revenue** | **120,668** | **119,949** | **(720)** | **206,378** | **203,193** | **(3,184)** |
| | | | | 1,185 | 1,146 | (39) | Other Operating Revenue | 8,010 | 8,007 | (3) | 13,516 | 13,365 | (150) |
| | | | | **18,814** | **18,680** | **(134)** | **Total Revenue** | **128,678** | **127,956** | **(722)** | **219,893** | **216,559** | **(3,335)** |
| | | | | | | | | | | | | | |
| 4,254 | 4,129 | (125) | 2.9% | (14,331) | (13,889) | 443 | Pay Costs | (99,581) | (97,097) | 2,484 | (170,259) | (166,654) | 3,605 |
| | | | | (3,754) | (4,292) | (538) | Non Pay Costs | (24,031) | (25,409) | (1,378) | (41,072) | (43,891) | (2,818) |
| | | | | 146 | 82 | (64) | Provisions | 416 | (100) | (515) | 1,313 | 4,176 | 2,864 |
| **4,254** | **4,129** | **(125)** | **2.9%** | **(17,939)** | **(18,098)** | **(159)** | **Total Operating Expenses** | **(123,197)** | **(122,605)** | **591** | **(210,018)** | **(206,368)** | **3,650** |
| | | | | | | | | | | | | | |
| **4,254** | **4,129** | **(125)** | **2.9%** | **875** | **582** | **(293)** | **EBITDA** | **5,481** | **5,350** | **(131)** | **9,875** | **10,191** | **316** |
| | | | | (427) | (453) | (25) | Depreciation | (3,369) | (3,543) | (174) | (5,500) | (5,798) | (298) |
| | | | | (283) | (284) | (1) | PDC Paid | (1,982) | (1,987) | (6) | (3,397) | (3,407) | (10) |
| | | | | 4 | 3 | (0) | Interest Received | 26 | 22 | (4) | 45 | 37 | (8) |
| **4,254** | **4,129** | **(125)** | **2.9%** | **168** | **(151)** | **(320)** | **Normalised Surplus / (Deficit) Excl.STF** | **157** | **(158)** | **(315)** | **1,023** | **1,023** | **0** |
| | | | | 139 | 0 | (139) | STF | 627 | 488 | (139) | 1,394 | 1,394 | 0 |
| **4,254** | **4,129** | **(125)** | **2.9%** | **307** | **(151)** | **(459)** | **Normalised Surplus / (Deficit) Incl SFT** | **784** | **330** | **(454)** | **2,417** | **2,417** | **0** |
| | | | | | | | | | | | | | |
| | | | | 0 | 0 | 0 | Revaluation of Assets | 0 | 0 | 0 | 0 | 0 | 0 |
| **4,254** | **4,129** | **(125)** | **2.9%** | **307** | **(151)** | **(459)** | **Surplus / (Deficit)** | **784** | **330** | **(454)** | **2,417** | **2,417** | **0** |



# Income & Expenditure Position 2017 / 2018

Month 7 represents the second in-month deficit of the financial year and results in an overall pre STF deficit for the period April to October 2017. Under these conditions delivery of the Trust financial control total remains extremely challenging.

**Month 7**

The October position is a pre STF deficit of £151k. The normalised year to date position is a pre STF deficit of £158k and a surplus of £330k including quarter 1 and 2 STF funding. This is £454k behind 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 second in-month deficit position. STF income for quarter 1 and 2 has been achieved however the month 7 position is lower than plan therefore the STF income for month 7 is reported as unachieved.

**Income**

Provision continues to be made for under achievement of CQUIN income of £420k in line with NHS Improvement guidance. The Trust has agreed income for the operation of Intermediate Care prior to the implementation of the new model of care in December.

**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 in October is the highest reported this year at £515k due to an increase in medical vacancies and schemes to improve access times. For the first time this year agency spend exceeds the in month cap, year to date agency expenditure remains within cap (9% below). Bank expenditure which peaked in September has returned to levels in line with previous months.

**Non Pay Expenditure**

October out of area bed spend was the highest of the year at £365k, taking the cumulative overspend to £1,350k. 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, 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.

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. The net risk to achieving the position given known risks and upsides is in excess of £1m.

Agency expenditure is forecast £50k (1%) higher than the cap.

# 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 has traditionally been little variation to plan.

The budget values are reconciled against signed and agreed contracts with any movement highlighted. The month 7 position includes additional income from Barnsley CCG relating to LIFT property costs and shown by an increase in those costs in month. The contract variation is currently being finalised for this but the financial values have been agreed and therefore have been included.

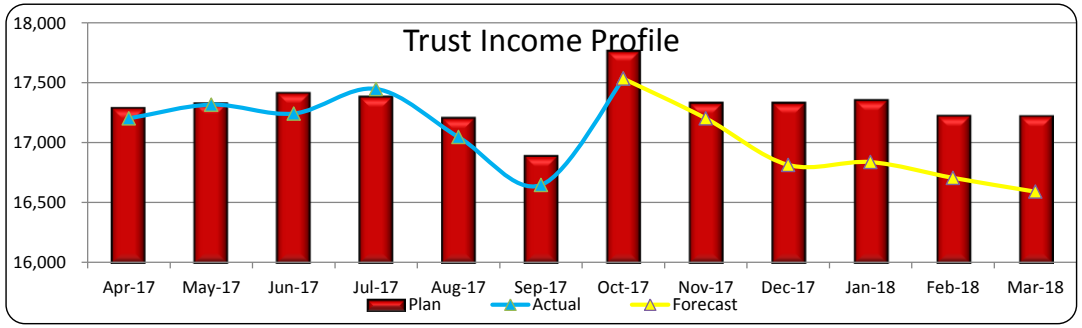
The main variance relates to income reduction and risk in commissioned services in Barnsley. This includes, as the largest, changes in service provision for Intermediate Care within the Barnsley area but also includes changes in Care Navigation services.

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 | | | | Variance Headlines | | |
|---|---|---|---|---|---|---|---|
| | Budget | Actual | Variance | | CQUIN | Other | Total |
| | £k | £k | £k | | £k | £k | £k |
| CCG | 64,206 | 63,823 | (382) | | (420) | 38 | (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 | 37,163 | 37,008 | (155) | | 0 | (155) | (155) |
| **Total** | **120,668** | **119,949** | **(720)** | **0** | **(420)** | **(299)** | **(720)** |

| | Forecast | | | Variance Headlines | | |
|---|---|---|---|---|---|---|
| Budget | Actual | Variance | | CQUIN | Other | Total |
| £k | £k | £k | | £k | £k | £k |
| 151,253 | 150,248 | (1,005) | | (856) | (149) | (1,005) |
| 23,333 | 23,333 | (0) | | 0 | (0) | (0) |
| 13,712 | 11,373 | (2,339) | | 0 | (2,339) | (2,339) |
| 4,923 | 4,764 | (159) | | | (159) | (159) |
| 6,909 | 6,909 | (0) | | 0 | (0) | (0) |
| 6,248 | 6,567 | 319 | | 0 | 319 | 319 |
| **206,378** | **203,193** | **(3,184)** | | **(856)** | **(2,329)** | **(3,184)** |




| CQUIN Risk | YTD | Forecast |
|---|---|---|
| Wellbeing Improvement | 0 | 136 |
| STP Reserve | 420 | 720 |
| **Total** | **420** | **856** |

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

Additional income recognised for the period of April to October in relation to reimbursement of LIFT property costs (reflected as increased expenditure in month as well).

Additional income agreed with Barnsley CCG, above that included in previous months, for reimbursement of costs associated with the ongoing provision of Intermediate Care services prior to the introduction of the new model of care in December 2017. This covers the direct costs only for July, August and September with additional income recovery being discussed with the commissioner and alliance.

CQUIN risk has been recognised within the year to date and forecast position until confirmation is received from NHS Improvement that this is available.

# 2.1 Pay Information

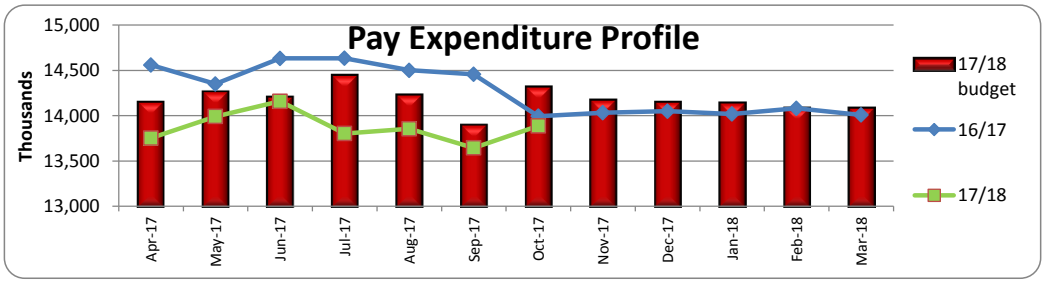
Our workforce is our greatest asset and one in which we continue to invest in ensuring that we have the right workforce in place to deliver safe and quality services. In total workforce spend accounts for circa 75% of total Trust expenditure.

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 | 12,791 | | | | | | **89,967** |
| **Bank & Locum** | 411 | 472 | 620 | 505 | 558 | 701 | 583 | | | | | | **3,850** |
| **Agency** | 501 | 426 | 500 | 457 | 446 | 435 | 515 | | | | | | **3,279** |
| **Total** | **13,752** | **13,992** | **14,161** | **13,804** | **13,854** | **13,645** | **13,889** | **0** | **0** | **0** | **0** | **0** | **97,097** |
| 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% | 4.2% | | | | | | 4.0% |
| Agency as % | 3.6% | 3.0% | 3.5% | 3.3% | 3.2% | 3.2% | 3.7% | | | | | | 3.4% |

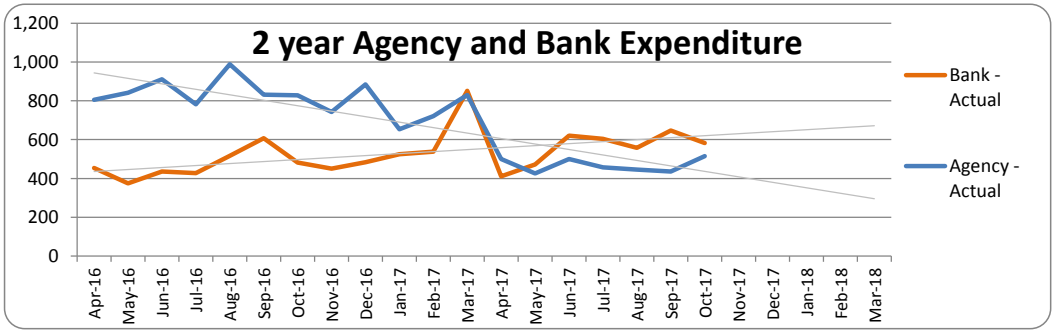
**Year to Date expenditure - by staff group**

| | Substantive £k | Temp £k | Agency £k | Total £k |
|---|---|---|---|---|
| Medical | 10,565 | 212 | 1,506 | 12,283 |
| Nursing Registered | 31,430 | 1,373 | 349 | 33,152 |
| Nursing Unregistered | 10,404 | 1,638 | 766 | 12,807 |
| Other | 22,600 | 228 | 625 | 23,453 |
| Admin | 14,968 | 399 | 33 | 15,401 |
| **Total** | **89,967** | **3,850** | **3,279** | **97,097** |




**October WTE Analysis**

| | Budgeted | Contracted | Bank | Agency | Variance |
|---|---|---|---|---|---|
| Medical | 212 | 175 | 2 | 18 | (17) |
| Qualified Nursing | 1,443 | 1,297 | 52 | 13 | (81) |
| Unqualified Nursing | 685 | 645 | 94 | 40 | 95 |
| Other Clinical | 835 | 768 | 7 | 11 | (49) |
| A & C | 850 | 752 | 27 | 1 | (69) |
| Other | 337 | 302 | 6 | 4 | (25) |
| Staff Vacancy Factor | (107) | 0 | 0 | 0 | 107 |
| **Total** | **4,254** | **3,940** | **189** | **87** | **(38)** |




**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 not forecast to decline further this year, bank usage is forecast 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.

Substantive pay dipped in September due to a one off adjustment to recognise pay costs no longer expected to be charged. As a pass through cost this was offset by a corresponding change in income.

# 2.1 Agency Expenditure Focus

**Agency Spend in October has breached the NHS Improvement agency cap.**

**Spend in October is £44k higher 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 weekly NHSI agency return was expanded in October to also include collection of bank information.

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 2 wte individually approved to the end of November.

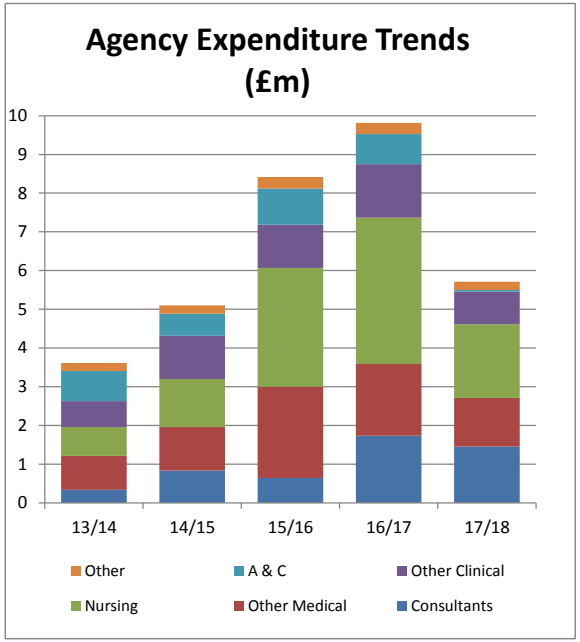
* Reduction in the hourly rate paid. In particular this relates to qualified nursing staff who are now all paid within the NHS Improvement capped rates. 15 out of 20 medical locums continue to be paid higher than the NHSI caps. These have been individually approved by the Trust Medical Director and are reported weekly to NHSI.

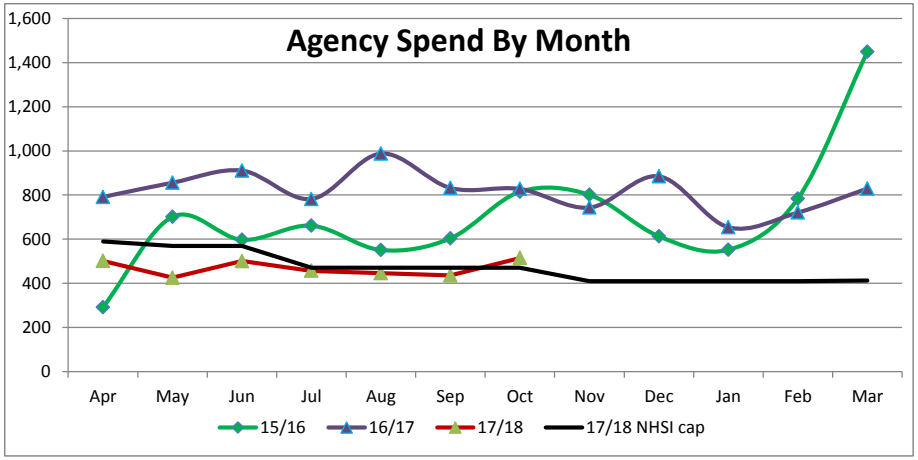
For the first time this year, in month agency spend has breached the agency cap (by £44k) and is forecast to be higher than cap for the remainder of the year. The forecast outturn at October is £50k (1%) above cap.

Increases relate to medical and other clinical expenditure. The increase in medical agency is to cover new vacancies, gaps in the junior medical rotas and extension of cover resulting from delays in, or unsuccessful, recruitment. The increase in other clinical agency is mainly relating to additional staff for CAMHS waiting lists.

Agency Admin & Clerical have been authorised within the Kirklees IAPT service until the end of November. Zero reliance continues throughout the rest of the Trust.

Across all agency categories spend has reduced on 2016 / 2017. YTD has reduced by £2.7m (45%).



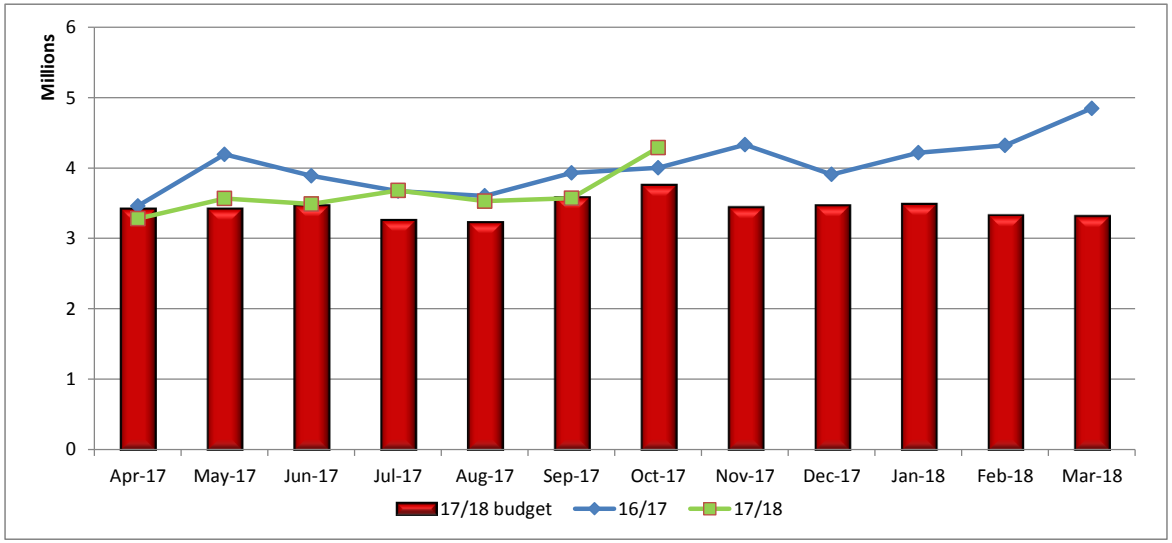
# 2.1 Non Pay Expenditure

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

The Trust is forecasting to spend considerably less on non pay compared to last year. For the year to date this is £1.3m less than the same period in 2016 / 2017. This is driven by a number of key areas which are highlighted below. Excluding the impact of out of area and drugs a saving against plan of £444k 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 | 4,292 | | | | | | **25,409** |
| **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 | 1,769 | 2,046 | (277) |
| Drugs | 1,752 | 2,363 | (611) |
| Healthcare subcontracting | 2,050 | 3,261 | (1,210) |
| Hotel Services | 1,219 | 1,045 | 173 |
| Office Supplies | 2,464 | 2,402 | 62 |
| Other Costs | 2,681 | 2,400 | 280 |
| Property Costs | 4,045 | 4,006 | 39 |
| Service Level Agreements | 3,507 | 3,569 | (62) |
| Training & Education | 420 | 442 | (22) |
| Travel & Subsistence | 2,547 | 2,287 | 260 |
| Utilities | 683 | 664 | 19 |
| Vehicle Costs | 894 | 923 | (29) |
| **Total** | **24,031** | **25,409** | **(1,378)** |
| **Total Excl OOA and Drugs** | **20,229** | **19,785** | **444** |




**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 significant financial pressure. The changes to the supply of drugs to the Trust is now embedded and actions are progressing to identify savings opportunities. Drugs expenditure analysis has also highlighted the impact that changes in drugs prices (for example increase in drug costs due to concessions applied to two widely prescribed drugs) which is adding additional cost.

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.

# 2.1 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 (£)**

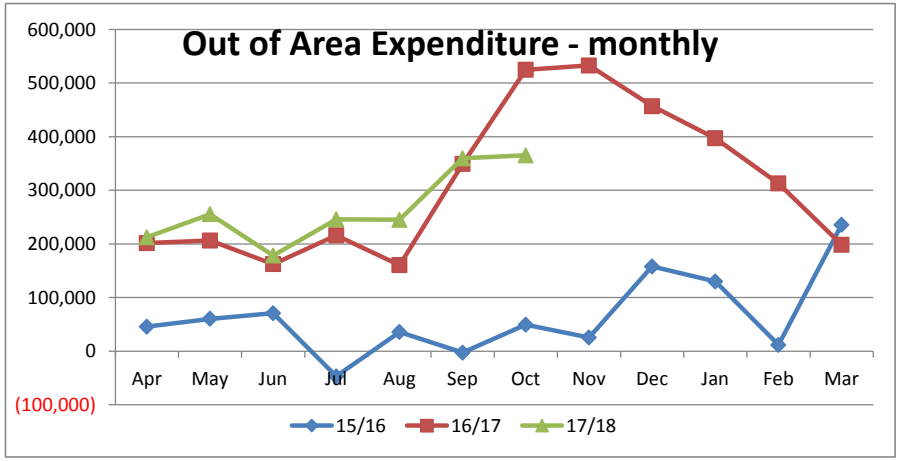
| | Apr £000 | May £000 | Jun £000 | Jul £000 | Aug £000 | Sep £000 | Oct £000 | Nov £000 | Dec £000 | Jan £000 | Feb £000 | Mar £000 | Total £000 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 15/16 | 46 | 60 | 71 | (47) | 36 | (3) | 49 | 25 | 158 | 130 | 12 | 236 | **772** |
| 16/17 | 202 | 206 | 162 | 216 | 160 | 349 | 525 | 533 | 457 | 397 | 313 | 198 | **3,718** |
| 17/18 | 212 | 255 | 178 | 246 | 245 | 359 | 365 | | | | | | **1,861** |

**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 | 477 | | | | | | **2,532** |

**Bed Day Information 2017 / 2018 (by category)**

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PICU | 198 | 176 | 168 | 169 | 213 | 217 | 239 | | | | | | **1,380** |
| Acute | 84 | 170 | 85 | 178 | 148 | 182 | 207 | | | | | | **1,054** |
| Gender | 0 | 0 | 0 | 0 | 30 | 30 | 31 | | | | | | **91** |




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 since Quarter 2. High demand is being observed across the Trust and also nationally.

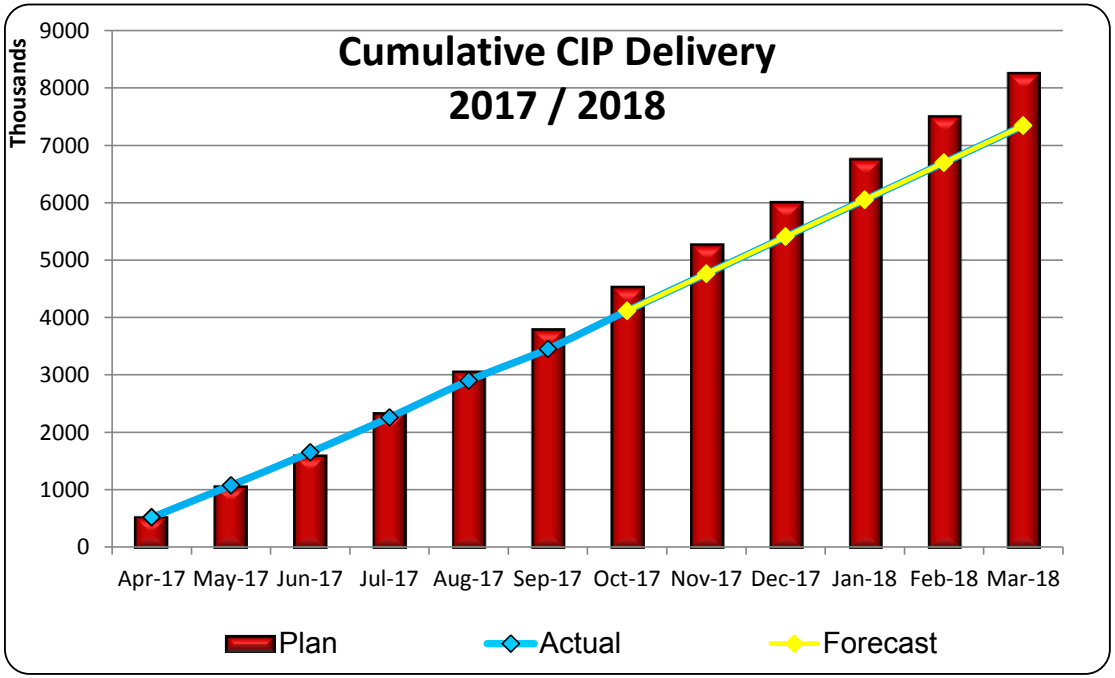
Demand, and expenditure, has increased again and October is the highest month for the year to date. Work continues through the Project Board to ensure that this is minimised. Future costs are forecast to reduced as a result of these actions being taken including exploration of additional bed capacity internally and by working collectively within the STP.

The year to date overspend, for the activity covered in this section of the report, is £1.35m.

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 | 4,546 | 8,262 |
| Delivery as originally planned | 401 | 809 | 1,272 | 1,769 | 2,261 | 2,744 | 3,288 | 3,792 | 4,296 | 4,800 | 5,304 | 5,808 | 3,288 | 5,808 |
| Mitigations - Recurrent & Non-Recurrent | 116 | 266 | 378 | 490 | 639 | 708 | 829 | 971 | 1,112 | 1,253 | 1,394 | 1,535 | 829 | 1,535 |
| Total Delivery | **516** | **1,075** | **1,650** | **2,259** | **2,900** | **3,452** | **4,117** | **4,762** | **5,407** | **6,053** | **6,698** | **7,343** | **4,117** | **7,343** |
| Variance | (20) | 1 | 40 | (82) | (172) | (357) | (430) | (521) | (613) | (715) | (817) | (919) | (430) | (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 £4.1m to date. This is £430k behind plan. The majority (78%) has been delivered in line with original savings plans.

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.

As part of the Trust Annual Planning process for 2018 / 2019 work continues on the identification of recurrent savings. If progress is made in Qtr 4 this will be reported accordingly.

# 3.0 Balance Sheet 2017 / 2018

| | 2016 / 2017 £k | Plan (YTD) £k | Actual (YTD) £k | Note |
|---|---|---|---|---|
| Non-Current (Fixed) Assets | 111,199 | 114,722 | 113,548 | 1 |
| **Current Assets** | | | | |
| Inventories & Work in Progress | 166 | 215 | 166 | |
| NHS Trade Receivables (Debtors | 2,138 | 2,599 | 2,205 | 2 |
| Other Receivables (Debtors) | 8,289 | 7,074 | 8,295 | 3 |
| Cash and Cash Equivalents | 26,373 | 20,211 | 20,539 | 4 |
| **Total Current Assets** | **36,966** | **30,099** | **31,204** | |
| **Current Liabilities** | | | | |
| Trade Payables (Creditors) | (7,213) | (6,334) | (5,042) | 5 |
| Capital Payables (Creditors) | (1,157) | (752) | (665) | 5 |
| Accruals | (9,912) | (11,190) | (10,891) | 6 |
| Deferred Income | (754) | (950) | (662) | |
| **Total Current Liabilities** | **(19,036)** | **(19,226)** | **(17,261)** | |
| **Net Current Assets/Liabilities** | **17,929** | **10,873** | **13,943** | |
| **Total Assets less Current Liabilities** | **129,128** | **125,595** | **127,492** | |
| Provisions for Liabilities | (7,550) | (5,763) | (7,110) | |
| **Total Net Assets/(Liabilities)** | **121,578** | **119,832** | **120,382** | |
| Taxpayers' Equity | | | | |
| Public Dividend Capital | 43,665 | 43,665 | 43,665 | |
| Revaluation Reserve | 18,766 | 18,413 | 18,303 | |
| Other Reserves | 5,220 | 5,220 | 5,220 | |
| Income & Expenditure Reserve | 53,928 | 52,534 | 53,194 | 7 |
| **Total Taxpayers' Equity** | **121,578** | **119,832** | **120,382** | |

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 15. This is lower than plan due to impairments actioned in year relating to Mount Vernon and the lower than plan capital programme.

2. NHS debts remain lower than plan and continue to be actively chased. A focus on debtors has been included on page 14 which highlights some of the outstanding hotspots.

3. Other debtors remain higher than planned. Non-NHS Debtors have reduced in month and continue to be chased for payment. Accrued Income has increased by £1m in month, this totals £4.5m of which £2m is with Barnsley CCG. (Following receipt of Purchase Orders the majority have now been invoiced)

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 18.

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

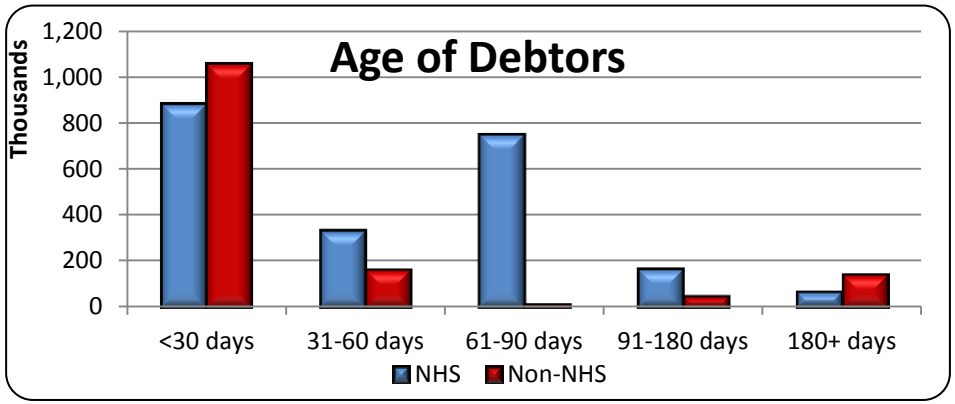
6. Accruals remain slightly lower than planned.

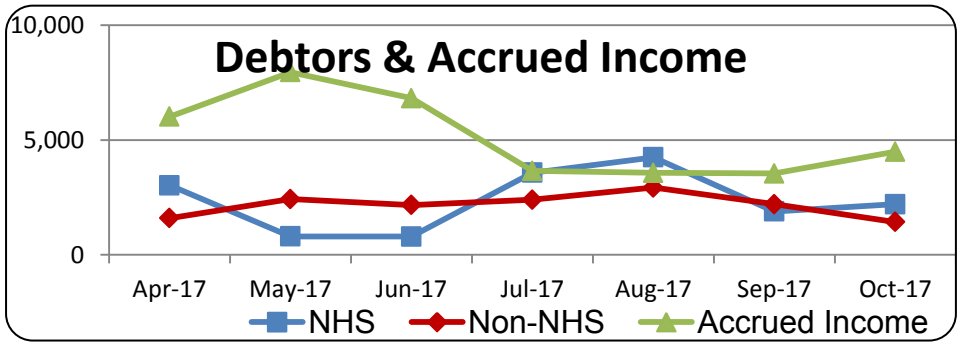
7. This reserve represents year to date surplus plus reserves brought forward.

# 3.0 Debtors

**Debtor management forms a key part of the Trust cash management process.**

**Debtors have reduced further in month from £4.1m to £3.6m.**




The Trust have continued to proactively chase all outstanding debts as part of its cash management process.

The intention of this review and dialogue with outstanding debtors is to reduce the length of time taken to receive cash payment and also identify, and resolve, any issues at the earliest possible opportunity.

This review is undertaken alongside an assessment of accrued income. This ensures that invoices are being raised in a timely fashion. Based upon values this will either be monthly or quarterly in arrears.

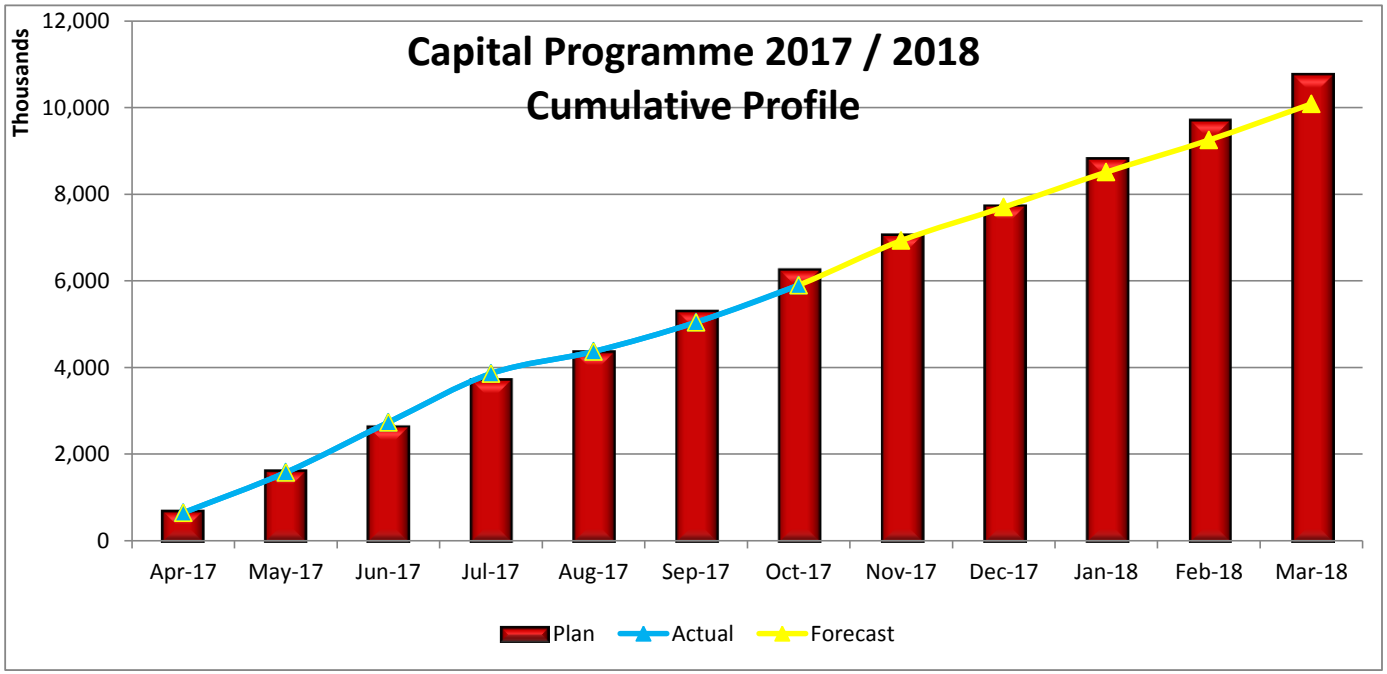
The majority of outstanding debtors, as at the end of October 2017, are less 60 days (67%). Debts older than 180 days have increased to £214k.
Of these NHS debtors account for £69k. (increase from £64k last month).
Non NHS has increased from £125k to £145k and makes up 10% of the total Non NHS debt value (30% based on volume)
Of the 260 individual non NHS debts, 68 (£76k) relates to staff payments and 66 (£1.2m) relates to Local Authorities.

The in year profile of debtors is shown to the left. Accrued income has been added for context with invoices continuing to be raised in a timely manner. The largest element of accrued income relates to expectations of STF income (£418k) and CQUIN achievement in Quarter 2 (£434k)

The graph shows that debtors increased as invoices were raised at the end of Quarter 1. These have subsequently been paid and invoices are being issued on a rolling programme.

# 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 | 1,019 | 608 | (411) | 1,486 | (72) | 3 |
| Equipment Replacement | 44 | 44 | 51 | 6 | 59 | 15 | |
| IM&T | 2,121 | 1,036 | 524 | (512) | 1,289 | (832) | 4 |
| **Major Capital Schemes** | | | | | | | |
| Fieldhead Non Secure | 7,030 | 4,177 | 4,757 | 580 | 7,290 | 260 | 2 |
| VAT Refunds | 0 | 0 | (37) | (37) | (37) | (37) | |
| **TOTALS** | **10,753** | **6,277** | **5,902** | **(375)** | **10,086** | **(667)** | 1 |




**The forecast spend position is currently under review. Schemes may be deferred to protect the Trust cash position.**

**Capital Expenditure 2017 / 2018**

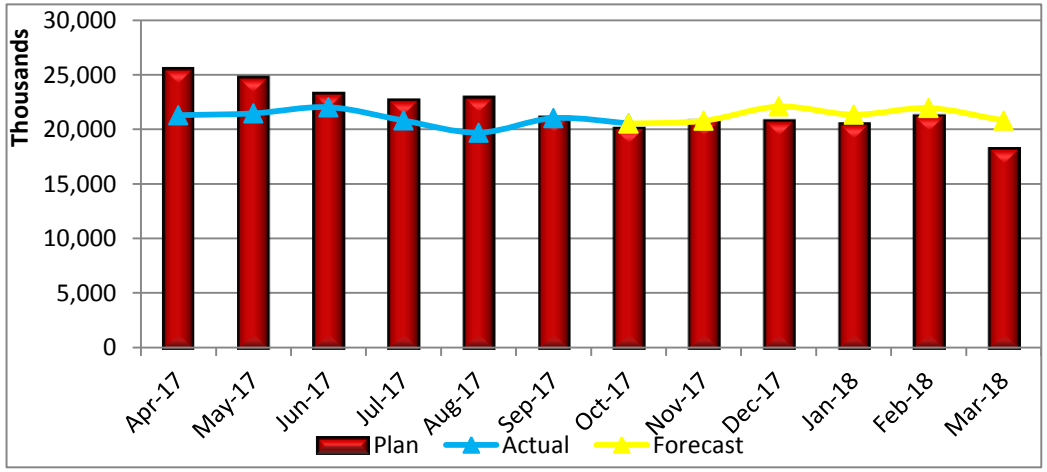
1. The year to date position is £375k lower than plan (6%). Excluding the benefit arising from successful VAT recovery agreed with HMRC this is £412k lower than plan.

2. An updated expenditure profile is being validated for the next phase of the non-secure project. A number of additional cost pressures have been identified as part of the next phase demolition process.

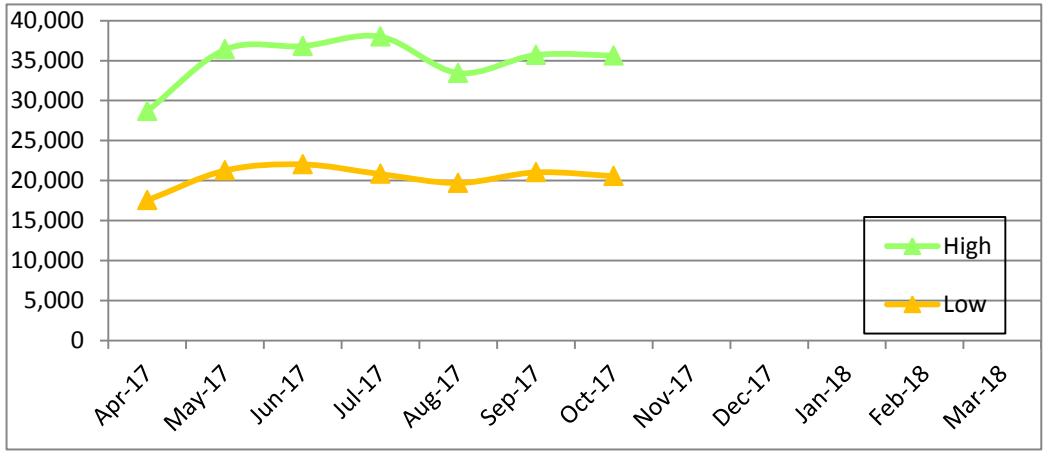
3. Minor works are being re-proritised to support additional new works required to vacate Mount Vernon.

4. IM & T forecast has been reduced to reflect the current programme. This is primarily timing associated with the change in Clinical Record

# 3.2 Cash Flow & Cash Flow Forecast 2017 / 2018




| | Plan £k | Actual £k | Variance £k |
|---|---|---|---|
| Opening Balance | 25,495 | 26,373 | |
| Closing Balance | 20,211 | 20,539 | 328 |




**Action continued in October which has resulted in a slightly above plan position.**

Focus has continued on cash and in particular chasing of outstanding debtors. Debtors have reduced again and the team continue to look at best practice to improve further.

A detailed reconciliation of working capital compared to plan is presented on page 17.

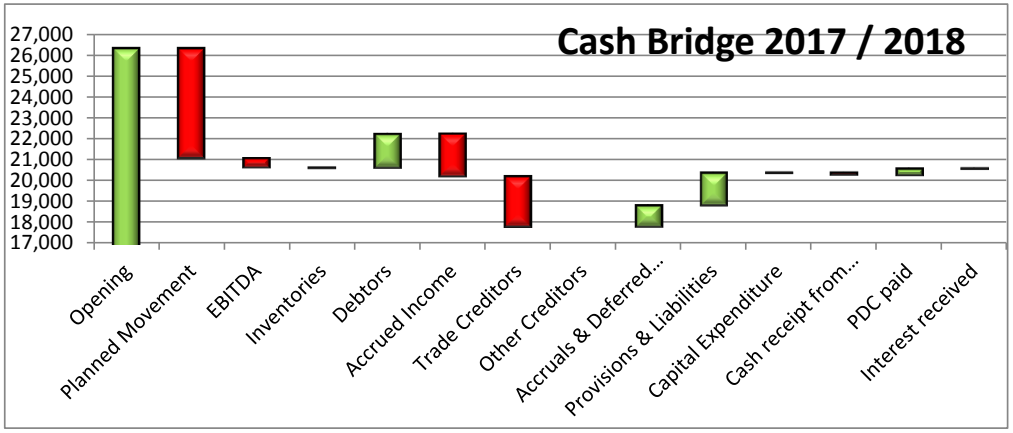
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

| | |
|---|---|
| The highest balance is: | £35.6m |
| The lowest balance is: | £20.5m |

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) | 6,232 | 5,780 | (452) | 5 |
| *Movement in working capital:* | | | | |
| Inventories & Work in Progress | 0 | 0 | 0 | |
| Receivables (Debtors) | (1,000) | 641 | 1,641 | 2 |
| Accrued Income / Prepayments | (419) | (2,482) | (2,063) | 6 |
| Trade Payables (Creditors) | 0 | (2,407) | (2,407) | 7 |
| Other Payables (Creditors) | 0 | 0 | 0 | |
| Accruals & Deferred income | (150) | 887 | 1,037 | 3 |
| Provisions & Liabilities | (2,000) | (440) | 1,560 | |
| *Movement in LT Receivables:* | | | | |
| Capital expenditure & capital creditors | (6,277) | (6,394) | (117) | |
| Cash receipts from asset sales | 0 | 309 | 309 | 4 |
| PDC Dividends paid | (1,698) | (1,751) | (53) | |
| PDC Dividends received | | | 0 | |
| Interest (paid)/ received | 28 | 22 | (6) | |
| **Closing Balances** | **20,211** | **20,539** | **327** | |




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 continues to pursue 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 lower than planned.

6. Accrued income continues to be higher than plan. The majority of this relates to NHS Barnsley CCG (£2m). Purchase orders have now been received for the majority and invoices raised.

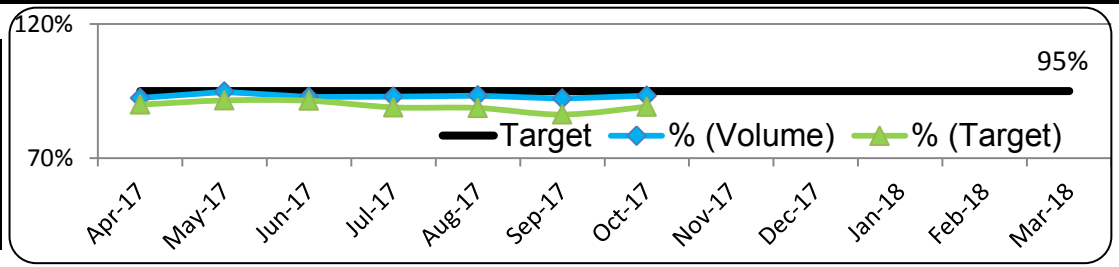
7. Creditors are lower than planned. Invoices are paid in line with the Trust Better Payment Practice Code.

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

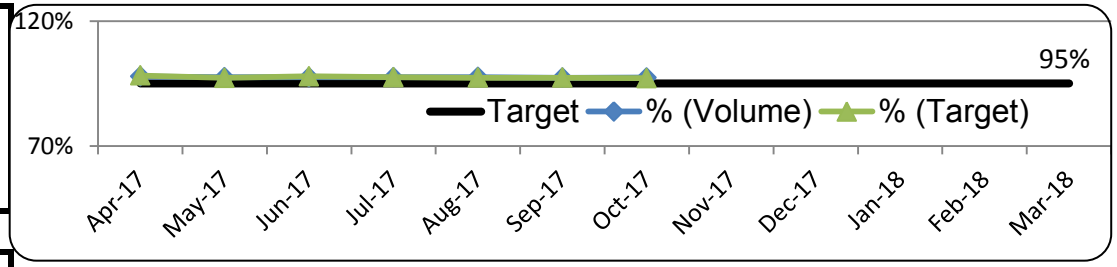
# 4.0 Better Payment Practice Code

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.

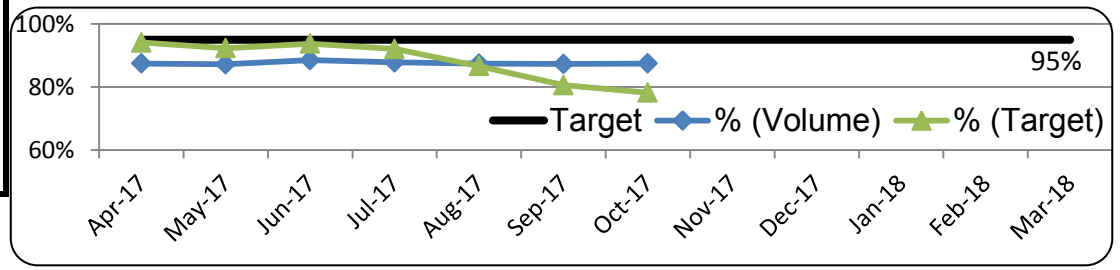
| NHS | Number % | Value % |
|---|---|---|
| Year to September 2017 | 92% | 86% |
| Year to October 2017 | 93% | 89% |




| Non NHS | Number % | Value % |
|---|---|---|
| Year to September 2017 | 97% | 97% |
| Year to October 2017 | 97% | 97% |




| Local Suppliers (10 days) | Number % | Value % |
|---|---|---|
| Year to September 2017 | 87% | 81% |
| Year to October 2017 | 87% | 78% |



# 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 (£) |
|---|---|---|---|---|---|
| 04/10/2017 | Property Rental | Calderdale | Calderdale and Huddersfield NHS Foundation Trust | 3049190 | 212,218.24 |
| 08/09/2017 | Drugs FP10´s | Trustwide | Bradford Teaching Hospitals NHS FT | 3046445 | 103,379.37 |
| 19/09/2017 | Drugs FP10´s | Trustwide | NHSBSA Prescription Pricing Division | 3047655 | 64,607.66 |
| 04/10/2017 | Property Rental | Barnsley | Community Health Partnerships | 3049342 | 63,616.28 |
| 17/10/2017 | Property Rental | Kirklees | Kirklees Council | 3050742 | 61,633.50 |
| 04/10/2017 | Staff Recharge | Forensics | Wakefield MDC | 3049262 | 60,604.29 |
| 04/10/2017 | Property Rental | Barnsley | Community Health Partnerships | 3049347 | 52,563.49 |
| 04/10/2017 | Property Rental | Barnsley | Community Health Partnerships | 3049340 | 52,563.49 |
| 04/10/2017 | Property Rental | Barnsley | Community Health Partnerships | 3049336 | 52,563.49 |
| 12/09/2017 | Staff Recharge | Trustwide | Leeds and York Partnership NHS FT | 3046883 | 49,234.29 |
| 13/10/2017 | CNST contributions | Trustwide | NHS Litigation Authority | 3050346 | 47,580.80 |
| 04/10/2017 | Property Rental | Barnsley | Community Health Partnerships | 3049321 | 40,526.51 |
| 10/08/2017 | Clinical SLA | Barnsley | Barnsley Hospital NHS Foundation Trust | 3046966 | 38,646.00 |
| 10/08/2017 | Clinical SLA | Barnsley | Barnsley Hospital NHS Foundation Trust | 3046964 | 38,014.00 |
| 19/10/2017 | Property Rental | Barnsley | Community Health Partnerships | 3050981 | 32,445.04 |
| 19/10/2017 | Property Rental | Barnsley | Community Health Partnerships | 3050990 | 32,445.04 |
| 19/10/2017 | Property Rental | Barnsley | Community Health Partnerships | 3050979 | 32,445.04 |
| 19/10/2017 | Property Rental | Barnsley | Community Health Partnerships | 3050980 | 32,445.04 |
| 03/10/2017 | Property Rental | Kirklees | Mid Yorkshire Hospitals NHS Trust | 3048907 | 31,010.07 |
| 04/10/2017 | Property Rental | Barnsley | Community Health Partnerships | 3049286 | 30,146.59 |
| 04/10/2017 | Staff Recharge | Wakefield | Wakefield MDC | 3049265 | 28,444.82 |
| 04/10/2017 | Property Rental | Barnsley | Community Health Partnerships | 3049310 | 25,219.75 |
| 04/10/2017 | Property Rental | Barnsley | Community Health Partnerships | 3049313 | 25,219.75 |
| 04/10/2017 | Property Rental | Barnsley | Community Health Partnerships | 3049312 | 25,219.75 |

# 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 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 |
|---|---|---|---|---|---|---|---|---|---|---|
| Sickness (YTD) | Resources | Well Led | AD | <=4.5% | 4.40% | 4.50% | 4.60% | 4.70% | 4.80% | 4.80% |
| Sickness (Monthly) | Resources | Well Led | AD | <=4.5% | 4.50% | 4.60% | 5.00% | 5.20% | 5.30% | 5.10% |
| Appraisals (Band 6 and above) | Resources | Well Led | AD | >=95% | 24.00% | 70.30% | 82.70% | 84.60% | 86.10% | 87.50% |
| Appraisals (Band 5 and below) | Resources | Well Led | AD | >=95% | 8.20% | 25.00% | 39.90% | 50.30% | 70.70% | 75.60% |
| Aggression Management | Quality & Experience | Well Led | AD | >=80% | 71.90% | 81.70% | 78.40% | 80.00% | 78.40% | 77.80% |
| Cardiopulmonary Resuscitation | Health & Wellbeing | Well Led | AD | >=80% | 79.10% | 78.20% | 78.00% | 74.70% | 76.40% | 74.40% |
| Clinical Risk | Quality & Experience | Well Led | AD | >=80% | 74.70% | 79.10% | 82.70% | 84.30% | 86.60% | 88.80% |
| Equality and Diversity | Resources | Well Led | AD | >=80% | 88.50% | 89.00% | 89.70% | 89.70% | 88.90% | 88.60% |
| Fire Safety | Health & Wellbeing | Well Led | AD | >=80% | 80.80% | 79.80% | 78.30% | 77.20% | 77.00% | 78.20% |
| Food Safety | Health & Wellbeing | Well Led | AD | >=80% | 76.10% | 73.30% | 69.30% | 67.10% | 63.30% | 65.00% |
| Infection Control and Hand Hygiene | Quality & Experience | Well Led | AD | >=80% | 87.10% | 87.10% | 85.50% | 84.50% | 81.60% | 81.70% |
| Information Governance | Resources | Well Led | AD | >=95% | 89.80% | 89.60% | 88.00% | 85.40% | 84.30% | 82.40% |
| Moving and Handling | Resources | Well Led | AD | >=80% | 81.90% | 82.30% | 82.70% | 82.60% | 82.50% | 82.10% |
| Safeguarding Adults | Health & Wellbeing | Well Led | AD | >=80% | 89.30% | 86.50% | 86.90% | 85.60% | 85.80% | 87.60% |
| Safeguarding Children | Health & Wellbeing | Well Led | AD | >=80% | 86.50% | 86.50% | 86.10% | 85.80% | 85.60% | 85.00% |
| Sainsbury's clinical risk assessment tool | Quality & Experience | Well Led | AD | >=80% | 94.60% | 93.90% | 94.90% | 96.00% | 95.50% | 94.90% |
| Mental Capacity Act/DOLS | Quality & Experience | Well Led | AD | >=80% | 56.90% | 64.30% | 73.60% | 76.50% | 79.40% | 82.10% |
| Mental Health Act | Quality & Experience | Well Led | AD | >=80% | 41.20% | 55.60% | 64.10% | 68.00% | 71.80% | 74.00% |
| Agency Cost | Resources | Effective | AD | | £109k | £118k | £109k | £84k | £71k | £101k |
| Overtime Costs | Resources | Effective | AD | | £3k | £4k | £2k | £3k | £3k | £2k |
| Additional Hours Costs | Resources | Effective | AD | | £20k | £21k | £22k | £21k | £21k | £25k |
| Sickness Cost (Monthly) | Resources | Effective | AD | | £136k | £136k | £159k | £164k | £167k | £168k |
| Vacancies (Non-Medical) (WTE) | Resources | Well Led | AD | | 108 | 113.58 | 111.16 | 110.21 | 108.86 | 106.64 |
| Business Miles | Resources | Effective | AD | | 91k | 97k | 104k | 96k | 98k | 106k |

## Calderdale and Kirklees District

| Month | Objective | CQC Domain | Owner | Threshold | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 |
|---|---|---|---|---|---|---|---|---|---|---|
| Sickness (YTD) | Resources | Well Led | AD | <=4.5% | 4.20% | 4.30% | 4.40% | 4.50% | 4.50% | 4.60% |
| Sickness (Monthly) | Resources | Well Led | AD | <=4.5% | 4.20% | 4.50% | 4.50% | 5.10% | 4.60% | 5.10% |
| Appraisals (Band 6 and above) | Resources | Well Led | AD | >=95% | 14.90% | 52.80% | 81.20% | 89.10% | 92.60% | 93.70% |
| Appraisals (Band 5 and below) | Resources | Well Led | AD | >=95% | 2.50% | 8.60% | 21.70% | 40.50% | 78.00% | 84.50% |
| Aggression Management | Quality & Experience | Well Led | AD | >=80% | 72.30% | 73.90% | 74.20% | 75.90% | 77.40% | 75.80% |
| Cardiopulmonary Resuscitation | Health & Wellbeing | Well Led | AD | >=80% | 75.40% | 77.30% | 72.80% | 70.10% | 70.90% | 72.40% |
| Clinical Risk | Quality & Experience | Well Led | AD | >=80% | 71.30% | 73.10% | 79.20% | 80.60% | 81.30% | 79.90% |
| Equality and Diversity | Resources | Well Led | AD | >=80% | 84.50% | 82.00% | 82.50% | 83.00% | 82.00% | 81.10% |
| Fire Safety | Health & Wellbeing | Well Led | AD | >=80% | 80.50% | 79.40% | 82.70% | 84.40% | 84.00% | 81.60% |
| Food Safety | Health & Wellbeing | Well Led | AD | >=80% | 78.30% | 79.20% | 77.70% | 80.90% | 79.60% | 76.30% |
| Infection Control and Hand Hygiene | Quality & Experience | Well Led | | >=80% | 78.80% | 80.20% | 79.90% | 80.50% | 80.50% | 81.70% |
| Information Governance | Resources | Well Led | AD | >=95% | 92.60% | 90.70% | 91.00% | 90.80% | 90.40% | 87.40% |
| Moving and Handling | Resources | Well Led | AD | >=80% | 76.10% | 76.00% | 75.40% | 74.00% | 76.00% | 75.60% |
| Safeguarding Adults | Health & Wellbeing | Well Led | AD | >=80% | 86.80% | 85.40% | 83.00% | 82.80% | 82.90% | 81.70% |
| Safeguarding Children | Health & Wellbeing | Well Led | AD | >=80% | 82.80% | 80.60% | 78.90% | 78.00% | 79.00% | 79.00% |
| Sainsbury's clinical risk assessment tool | Quality & Experience | Well Led | AD | >=80% | 93.30% | 93.30% | 95.60% | 95.40% | 95.70% | 93.80% |
| Mental Capacity Act/DOLS | Quality & Experience | Well Led | AD | >=80% | 75.40% | 83.30% | 88.10% | 89.50% | 90.60% | 90.90% |
| Mental Health Act | Quality & Experience | Well Led | AD | >=80% | 67.10% | 77.60% | 84.00% | 85.00% | 86.30% | 88.20% |
| Agency Cost | Resources | Effective | AD | | £61k | £79k | £58k | £84k | £65k | £101k |
| Overtime Costs | Resources | Effective | AD | | £3k | £1k | £2k | £2k | £6k | £2k |
| Additional Hours Costs | Resources | Effective | AD | | £-2k | £2k | £3k | £0k | £1k | £0k |
| Sickness Cost (Monthly) | Resources | Effective | AD | | £91k | £97k | £98k | £117k | £103k | £122k |
| Vacancies (Non-Medical) (WTE) | Resources | Well Led | AD | | 75.52 | 71.45 | 80.1 | 88 | 89.58 | 72.68 |
| Business Miles | Resources | Effective | AD | | 58k | 68k | 69k | 54k | 68k | 68k |

## Appendix - 2 - Workforce - Performance Wall cont....

### Forensic Services

| Month | Objective | CQC Domain | Owner | Threshold | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 |
|---|---|---|---|---|---|---|---|---|---|---|
| Sickness (YTD) | Resources | Well Led | AD | <=5.4% | 6.20% | 5.90% | 5.70% | 5.80% | 5.80% | 6.1% |
| Sickness (Monthly) | Resources | Well Led | AD | <=5.4% | 5.50% | 5.10% | 5.40% | 6.20% | 5.70% | 7.1% |
| Appraisals (Band 6 and above) | Resources | Well Led | AD | >=95% | 21.20% | 63.30% | 93.20% | 93.50% | 93.50% | 96.2% |
| Appraisals (Band 5 and below) | Resources | Well Led | AD | >=95% | 7.40% | 29.60% | 39.30% | 45.00% | 70.40% | 84.0% |
| Aggression Management | Quality & Experience | Well Led | AD | >=80% | 85.30% | 87.40% | 84.30% | 82.30% | 84.10% | 84.3% |
| Cardiopulmonary Resuscitation | Health & Wellbeing | Well Led | AD | >=80% | 74.00% | 73.30% | 75.10% | 77.60% | 77.40% | 73.50% |
| Clinical Risk | Quality & Experience | Well Led | AD | >=80% | 65.00% | 71.00% | 73.50% | 75.60% | 75.30% | 79.90% |
| Equality and Diversity | Resources | Well Led | AD | >=80% | 86.60% | 85.90% | 87.70% | 87.70% | 84.20% | 86.20% |
| Fire Safety | Health & Wellbeing | Well Led | AD | >=80% | 83.40% | 86.20% | 86.20% | 84.20% | 86.70% | 86.90% |
| Food Safety | Health & Wellbeing | Well Led | AD | >=80% | 88.30% | 88.80% | 90.00% | 90.00% | 87.20% | 85.10% |
| Infection Control and Hand Hygiene | Quality & Experience | Well Led | AD | >=80% | 84.90% | 86.70% | 87.70% | 86.70% | 85.70% | 86.00% |
| Information Governance | Resources | Well Led | AD | >=95% | 92.70% | 92.30% | 91.40% | 88.40% | 88.80% | 89.3% |
| Moving and Handling | Resources | Well Led | AD | >=80% | 82.90% | 84.10% | 85.20% | 85.20% | 85.00% | 86.70% |
| Safeguarding Adults | Health & Wellbeing | Well Led | AD | >=80% | 91.70% | 90.50% | 90.60% | 89.90% | 88.80% | 89.50% |
| Safeguarding Children | Health & Wellbeing | Well Led | AD | >=80% | 87.90% | 85.70% | 84.00% | 86.20% | 84.50% | 84.00% |
| Sainsbury's clinical risk assessment tool | Quality & Experience | Well Led | AD | >=80% | 51.70% | 64.50% | 70.00% | 70.00% | 69.00% | 70.4% |
| Mental Capacity Act/DOLS | Quality & Experience | Well Led | AD | >=80% | 70.70% | 84.10% | 85.40% | 90.40% | 89.30% | 91.00% |
| Mental Health Act | Quality & Experience | Well Led | AD | >=80% | 61.90% | 77.50% | 79.30% | 86.00% | 82.50% | 84.50% |
| Agency Cost | Resources | Effective | AD | | £54k | £46k | £43k | £51k | £68k | £60k |
| Overtime Costs | Resources | Effective | AD | | £0k | | £0k | £6k | £0k | |
| Additional Hours Costs | Resources | Effective | AD | | £2k | £4k | £3k | £3k | £5k | £2k |
| Sickness Cost (Monthly) | Resources | Effective | AD | | £51k | £47k | £48k | £55k | £50k | £65k |
| Vacancies (Non-Medical) (WTE) | Resources | Well Led | AD | | 47.49 | 48.04 | 55.16 | 48.61 | 40.43 | 37.35 |
| Business Miles | Resources | Effective | AD | | 5k | 5k | 5k | 6k | 9k | 8k |

### Specialist Services

| Month | Objective | CQC Domain | Owner | Threshold | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 |
|---|---|---|---|---|---|---|---|---|---|---|
| Sickness (YTD) | Resources | Well Led | AD | <=4.5% | 5.90% | 5.70% | 5.60% | 5.60% | 5.70% | 5.80% |
| Sickness (Monthly) | Resources | Well Led | AD | <=4.5% | 6.10% | 5.30% | 5.50% | 5.50% | 6.20% | 6.20% |
| Appraisals (Band 6 and above) | Resources | Well Led | AD | >=95% | 9.40% | 36.30% | 57.70% | 82.70% | 87.80% | 92.50% |
| Appraisals (Band 5 and below) | Resources | Well Led | AD | >=95% | 1.80% | 15.60% | 26.30% | 46.20% | 66.40% | 79.30% |
| Aggression Management | Quality & Experience | Well Led | AD | >=80% | 75.20% | 77.40% | 75.60% | 75.60% | 74.20% | 74.30% |
| Cardiopulmonary Resuscitation | Health & Wellbeing | Well Led | AD | >=80% | 69.20% | 68.20% | 64.60% | 68.10% | 74.60% | 76.30% |
| Clinical Risk | Quality & Experience | Well Led | AD | >=80% | 46.50% | 52.40% | 63.20% | 72.50% | 78.80% | 83.20% |
| Equality and Diversity | Resources | Well Led | AD | >=80% | 84.80% | 83.20% | 84.40% | 87.30% | 85.60% | 85.30% |
| Fire Safety | Health & Wellbeing | Well Led | AD | >=80% | 80.20% | 80.00% | 83.40% | 81.10% | 81.10% | 82.50% |
| Food Safety | Health & Wellbeing | Well Led | AD | >=80% | 56.50% | 56.50% | 56.50% | 58.30% | 66.70% | 76.90% |
| Infection Control and Hand Hygiene | Quality & Experience | Well Led | AD | >=80% | 83.30% | 82.10% | 83.80% | 83.90% | 83.30% | 81.50% |
| Information Governance | Resources | Well Led | AD | >=95% | 91.50% | 92.30% | 90.80% | 91.30% | 91.30% | 87.30% |
| Moving and Handling | Resources | Well Led | AD | >=80% | 75.80% | 76.50% | 80.10% | 80.90% | 78.90% | 78.20% |
| Safeguarding Adults | Health & Wellbeing | Well Led | AD | >=80% | 82.40% | 83.60% | 82.30% | 83.30% | 86.20% | 85.30% |
| Safeguarding Children | Health & Wellbeing | Well Led | AD | >=80% | 85.20% | 86.30% | 85.70% | 86.10% | 87.00% | 86.70% |
| Sainsbury's clinical risk assessment tool | Quality & Experience | Well Led | AD | >=80% | 86.90% | 88.90% | 88.50% | 92.10% | 92.80% | 91.60% |
| Mental Capacity Act/DOLS | Quality & Experience | Well Led | AD | >=80% | 62.70% | 75.90% | 79.60% | 86.50% | 90.10% | 91.70% |
| Mental Health Act | Quality & Experience | Well Led | AD | >=80% | 57.80% | 71.40% | 73.00% | 81.40% | 83.70% | 86.10% |
| Agency Cost | Resources | Effective | AD | | £167k | £169k | £163k | £156k | £147k | £181k |
| Overtime Costs | Resources | Effective | AD | | £3k | £1k | £2k | | £0k | £0k |
| Additional Hours Costs | Resources | Effective | AD | | £4k | £4k | £4k | £2k | £2k | £1k |
| Sickness Cost (Monthly) | Resources | Effective | AD | | £75k | £58k | £60k | £63k | £70k | £69k |
| Vacancies (Non-Medical) (WTE) | Resources | Well Led | AD | | 51.56 | 52.4 | 55.96 | 41.72 | 44.58 | 51.71 |
| Business Miles | Resources | Effective | AD | | 33k | 38k | 47k | 39k | 43k | 34k |

## Appendix 2 - Workforce - Performance Wall cont....

### Support Services

| Month | Objective | CQC Domain | Owner | Threshold | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 |
|---|---|---|---|---|---|---|---|---|---|---|
| Sickness (YTD) | Resources | Well Led | AD | <=4.0% | 4.30% | 4.30% | 4.40% | 4.40% | 4.20% | 4.30% |
| Sickness (Monthly) | Resources | Well Led | AD | <=4.0% | 4.30% | 4.40% | 4.50% | 4.30% | 3.50% | 4.20% |
| Appraisals (Band 6 and above) | Resources | Well Led | AD | >=95% | 17.40% | 83.00% | 97.80% | 98.90% | 95.20% | 97.10% |
| Appraisals (Band 5 and below) | Resources | Well Led | AD | >=95% | 1.10% | 5.20% | 15.20% | 37.60% | 83.60% | 89.80% |
| Aggression Management | Quality & Experience | Well Led | AD | >=80% | 73.00% | 71.30% | 68.40% | 68.20% | 68.80% | 63.40% |
| Cardiopulmonary Resuscitation | Health & Wellbeing | Well Led | AD | >=80% | 86.80% | 82.90% | 79.30% | 62.10% | 61.30% | 65.50% |
| Clinical Risk | Quality & Experience | Well Led | AD | >=80% | 16.70% | 28.60% | 0.00% | 0.00% | 0.00% | 0.00% |
| Equality and Diversity | Resources | Well Led | AD | >=80% | 86.40% | 86.50% | 86.70% | 86.60% | 84.00% | 83.90% |
| Fire Safety | Health & Wellbeing | Well Led | AD | >=80% | 87.10% | 84.80% | 82.40% | 88.30% | 89.30% | 88.00% |
| Food Safety | Health & Wellbeing | Well Led | AD | >=80% | 98.30% | 96.70% | 97.60% | 97.50% | 99.10% | 94.90% |
| Infection Control and Hand Hygiene | Quality & Experience | Well Led | AD | >=80% | 86.00% | 85.70% | 84.70% | 85.50% | 83.90% | 81.20% |
| Information Governance | Resources | Well Led | AD | >=95% | 93.40% | 92.90% | 91.70% | 91.40% | 90.30% | 88.60% |
| Moving and Handling | Resources | Well Led | AD | >=80% | 72.60% | 78.90% | 79.60% | 81.30% | 81.30% | 88.50% |
| Safeguarding Adults | Health & Wellbeing | Well Led | AD | >=80% | 89.80% | 89.50% | 88.50% | 89.10% | 89.20% | 88.00% |
| Safeguarding Children | Health & Wellbeing | Well Led | AD | >=80% | 86.60% | 82.50% | 89.80% | 91.70% | 92.90% | 91.60% |
| Sainsbury's clinical risk assessment tool | Quality & Experience | Well Led | AD | >=80% | 20.00% | 33.30% | 0.00% | 0.00% | 0.00% | 0.00% |
| Mental Capacity Act/DOLS | Quality & Experience | Well Led | AD | >=80% | 94.80% | 97.40% | 98.10% | 98.50% | 98.20% | 97.90% |
| Mental Health Act | Quality & Experience | Well Led | AD | >=80% | 53.10% | 64.40% | 68.20% | 78.40% | 93.80% | 75.00% |
| Agency Cost | Resources | Effective | AD | | £5k | £10k | £0k | £-3k | £0k | £12k |
| Overtime Costs | Resources | Effective | AD | | | £3k | £1k | £0k | £0k | £1k |
| Additional Hours Costs | Resources | Effective | AD | | £8k | £13k | £10k | £9k | £12k | £11k |
| Sickness Cost (Monthly) | Resources | Effective | AD | | £77k | £76k | £74k | £70k | £57k | £73k |
| Vacancies (Non-Medical) (WTE) | Resources | Well Led | AD | | 43.12 | 40.07 | 41.18 | 37.56 | 54.11 | 59.23 |
| Business Miles | Resources | Effective | AD | | 29k | 39k | 38k | 34k | 28k | 36k |

### Wakefield District

| Month | Objective | CQC Domain | Owner | Threshold | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 |
|---|---|---|---|---|---|---|---|---|---|---|
| Sickness (YTD) | Resources | Well Led | AD | <=4.6% | 4.70% | 5.00% | 5.20% | 5.30% | 5.20% | 5.00% |
| Sickness (Monthly) | Resources | Well Led | AD | <=4.6% | 4.50% | 5.50% | 5.80% | 5.90% | 4.30% | 4.30% |
| Appraisals (Band 6 and above) | Resources | Well Led | AD | >=95% | 16.10% | 63.10% | 82.40% | 95.10% | 97.20% | 97.20% |
| Appraisals (Band 5 and below) | Resources | Well Led | AD | >=95% | 11.80% | 36.20% | 48.80% | 65.80% | 84.20% | 88.70% |
| Aggression Management | Quality & Experience | Well Led | AD | >=80% | 80.40% | 80.80% | 80.10% | 79.40% | 82.00% | 81.90% |
| Cardiopulmonary Resuscitation | Health & Wellbeing | Well Led | AD | >=80% | 69.70% | 66.00% | 64.50% | 66.20% | 66.00% | 65.80% |
| Clinical Risk | Quality & Experience | Well Led | AD | >=80% | 61.50% | 65.00% | 68.20% | 69.00% | 70.30% | 72.90% |
| Equality and Diversity | Resources | Well Led | AD | >=80% | 86.80% | 86.50% | 86.80% | 87.50% | 87.40% | 86.60% |
| Fire Safety | Health & Wellbeing | Well Led | AD | >=80% | 80.90% | 82.50% | 83.60% | 85.80% | 85.10% | 86.80% |
| Food Safety | Health & Wellbeing | Well Led | AD | >=80% | 75.00% | 72.90% | 71.20% | 71.30% | 69.20% | 69.90% |
| Infection Control and Hand Hygiene | Quality & Experience | Well Led | AD | >=80% | 77.10% | 79.30% | 81.10% | 80.90% | 81.10% | 80.30% |
| Information Governance | Resources | Well Led | AD | >=95% | 92.30% | 93.50% | 92.90% | 91.70% | 89.50% | 87.30% |
| Moving and Handling | Resources | Well Led | AD | >=80% | 71.30% | 71.50% | 71.00% | 69.90% | 68.70% | 70.30% |
| Safeguarding Adults | Health & Wellbeing | Well Led | AD | >=80% | 85.30% | 85.60% | 87.20% | 88.10% | 87.30% | 87.00% |
| Safeguarding Children | Health & Wellbeing | Well Led | AD | >=80% | 77.40% | 78.70% | 80.00% | 81.10% | 79.40% | 77.10% |
| Sainsbury's clinical risk assessment tool | Quality & Experience | Well Led | AD | >=80% | 92.50% | 93.40% | 93.40% | 94.10% | 93.80% | 92.60% |
| Mental Capacity Act/DOLS | Quality & Experience | Well Led | AD | >=80% | 59.10% | 73.10% | 73.70% | 83.70% | 84.30% | 86.00% |
| Mental Health Act | Quality & Experience | Well Led | AD | >=80% | 49.70% | 66.90% | 67.20% | 78.40% | 79.00% | 81.10% |
| Agency Cost | Resources | Effective | AD | | £31k | £77k | £83k | £74k | £84k | £60k |
| Overtime Costs | Resources | Effective | AD | | £4k | | £1k | £3k | £4k | £2k |
| Additional Hours Costs | Resources | Effective | AD | | £4k | £4k | £2k | £2k | £4k | £4k |
| Sickness Cost (Monthly) | Resources | Effective | AD | | £46k | £58k | £56k | £58k | £39k | £43k |
| Vacancies (Non-Medical) (WTE) | Resources | Well Led | AD | | 48.56 | 43.91 | 45.19 | 45.35 | 43.73 | 50.39 |
| Business Miles | Resources | Effective | AD | | 29k | 38k | 37k | 38k | 37k | 41k |

# 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 19 December 2017
# Agenda item 6.2

| | |
|---|---|
| **Title:** | **Finance Report Month 8 2017/18** |
| **Paper prepared by:** | Director of Finance |
| **Purpose:** | To advise the Trust Board of the financial performance in month 8 and the year-to-date |
| **Mission/values:** | Use of resources |
| **Any background papers/ previously considered by:** | Regular Finance report provided as part of the Integrated Performance Report |
| **Executive summary:** | ➢ The November financial close is complete and as such the finance report is being provided separately at the December Board as the IPR will not be fully available until after the Trust Board has taken place.<br>➢ Reported pre-STF surplus of £0.4m generated in November. Excluding the one-off final insurance settlement there is an underlying net deficit of £0.1m.<br>➢ Cumulatively there is now a pre STF surplus of £235k which is £58k below plan. As such Q3 STF income is not recognised in our accounts.<br>➢ In-month out of area bed costs were £277k meaning the year-to-date overspend is now in excess of £1.5m.<br>➢ Agency costs of £531k were the highest of any month this year and were £120k above the lower value agency cap in November. Year-to-date costs are now £3.8m which is a 43% reduction compared to the same period last year and £0.2m below the cap<br>➢ CIP delivery of £4.8m is £458k adverse to plan<br>➢ Pay costs were broadly in line with previous month and £0.2m lower than plan<br>➢ Achievement of the year-end control pre STF total of £1.02m total remains a significant challenge given the variances associated with out of area beds and reduced income.<br>➢ Cash is slightly ahead of plan at £20.9m with lower than plan capital expenditure and continued focus on working capital management<br><br>**Risk Appetite**<br><br>This paper needs to be considered in line with the Trust risk appetite statement which aims for financial risk of 4-6. Any implications on clinical risk must also be taken into account. The current financial performance and forecast is not within the Trust risk appetite. |
| **Recommendation:** | **The Trust Board is asked to REVIEW the Month 8 Finance Report and COMMENT accordingly.** |
| **Private session:** | Not applicable. |

South West Yorkshire Partnership NHS Foundation Trust

# Finance Report

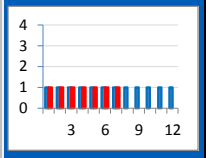
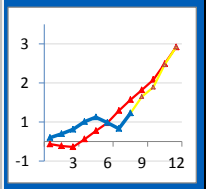
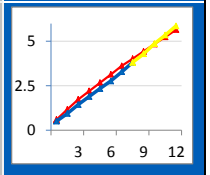
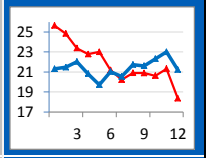
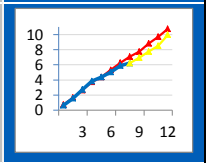
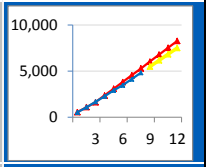
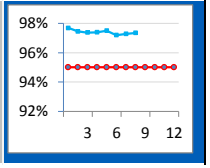
## Month 8 (2017 / 18)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

# Contents

## 1.0 Executive Summary / Key Performance Indicators

| Performance Indicator | | Year to Date | Forecast | Narrative | Trend |
|---|---|---|---|---|---|
| 1 | NHS Improvement Finance Rating | 1 | 1 | The NHS Improvement financial and use of resources risk rating is maintained at 1 for the 8 months to the end of November 2017. The individual I & E margin and Distance from plan rating remains at 2. |  |
| 2 | Normalised Surplus (inc STF) | £0.7m | £2.4m | November 2017 finance performance excluding STF is a surplus of £0.4m. Excluding a one-off £0.5m insurance settlement the underlying position was a £0.1m deficit. STF income of £0.3m has not been acheived to date in Q3. Achievement of the full year control total remains a significant challenge. |  |
| 3 | Agency Cap | £3.8m | £5.9m | Agency expenditure in November 2017 is higher than previous months at £531k. This exceeds the in month cap but remains under the agency cap year to date. The forecast exceeds the cap by 4% given schemes to improve access times and an increase in medical vacancies. |  |
| 4 | Cash | £21.7m | £21.2m | The cash position has improved in month bringing the Trust ahead of its plan (£0.8m above plan). Outstanding debts continue to be chased as part of Working Capital Management. |  |
| 5 | Capital | £6.2m | £10m | The majority of spend to date relates to the Non Secure wards on the Fieldhead site with the first phase of wards opening in September 2017. The year end forecast is currently under review with the aim of reducing spend given the I & E risk. |  |
| 6 | Delivery of CIP | £4.8m | £7.5m | Year to date CIP delivery is £468k behind plan. The forecast position is £0.8m below plan. |  |
| 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

# 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 has provided an updated Single Oversight Framework for 2018 / 2019 and beyond. There is limited impact on the finance rating.

| | | | Actual Performance | | Plan - Month 8 | |
|---|---|---|---|---|---|---|
| Area | Weight | Metric | Score | Risk Rating | Score | Risk Rating |
| Financial Sustainability | 20% | Capital Service Capacity | 3.1 | 1 | 3.2 | 1 |
| | 20% | Liquidity (Days) | 16.7 | 1 | 12.7 | 1 |
| Financial Efficiency | 20% | I & E Margin | 0.5% | 2 | 0.7% | 2 |
| Financial Controls | 20% | Distance from Financial Plan | -0.2% | 2 | 0.0% | 1 |
| | 20% | Agency Spend | -5.2% | 1 | -8.5% | 1 |
| **Weighted Average - Financial Sustainability Risk Rating** | | | | 1 | | 1 |

**Impact**

The current risk rating is 1 which is the highest possible score. The I & E margin is rated at 2, this needs to be greater than 1% to achieve a rating of 1. The distance from Financial Plan moved to a rating of 2 in month 7 and remains so at month 8 due to the year to date position being behind plan.

**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.

# 1.2 NHS Financial Context

| Provider Type | Plan £m | Forecast £m | Variance £m | Deficit Providers |
|---|---|---|---|---|
| Acute | (1,013) | (1,339) | (326) | 88 |
| Ambulance | (4) | (4) | 0 | 5 |
| Community | 29 | 25 | (4) | 5 |
| Mental Health | 138 | 118 | (20) | 8 |
| Specialist | 19 | 16 | (3) | 5 |
| **Total - Deficit** | **(831)** | **(1,184)** | **(353)** | **111** |
| Adjustments | (108) | (44) | 64 | |
| Uncommitted STF | 443 | 605 | 162 | |
| **Adjusted Deficit** | **(496)** | **(623)** | **(127)** | |

NHS Improvement published Quarter 2 Performance of the NHS Provider Sector 17th November 2017. This summarises operational and financial performance of the sector.

Operationally, the position remains extremely challenging with demand for hospital services continuing to increase. In turn this impacts on performance of key operational standards and additional costs in trying to address these challenges.

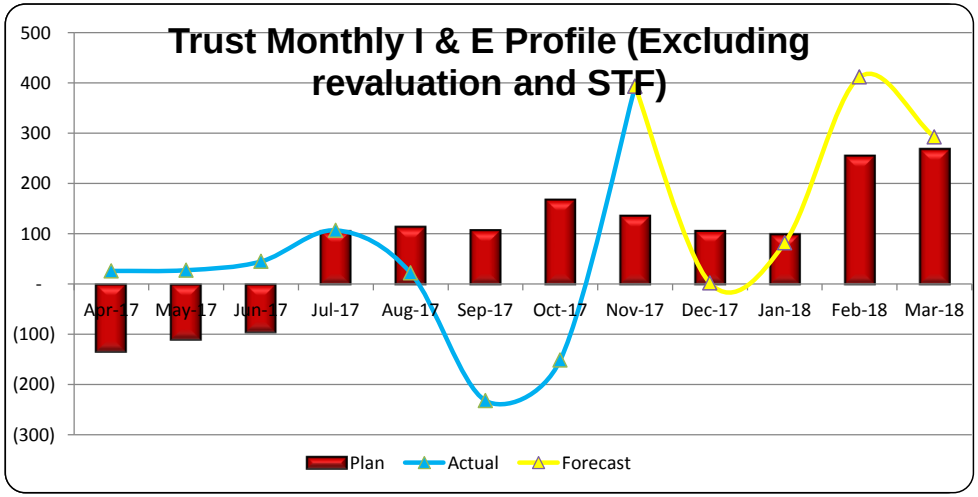
Financially pressures continue to be experienced across the sector with 87 (out of 230) providers not achieving their planned year to date Quarter 2 financial positions. (67 at Qtr 1)

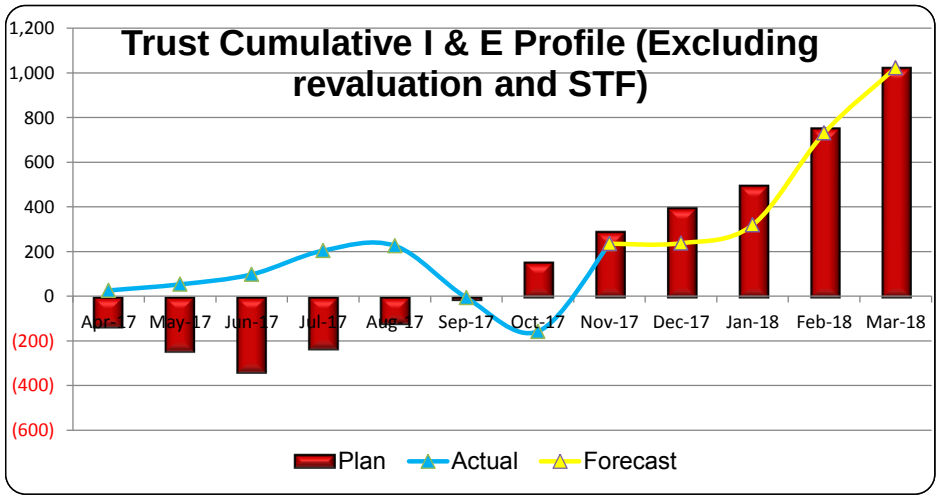
As noted above the sector forecast deficit for the year is £623m. This is £127m below plan and an increase of £100m from reported Quarter 1 forecast. The year to date position is a reported deficit of £1.1bn which is £142m below plan (Quarter 1 was broadly in line with plan) and demonstrates the level of improvement forecast during the second half of the year.

5 Trusts account for £120m of the variance to plan. (26 Trusts have a variance greater than £5m from plan)

# 2.0 Income & Expenditure Position 2017 / 2018

| Budget Staff | Actual worked | Variance | | This Month Budget | This Month Actual | This Month Variance | Description | Year to Date Budget | Year to Date Actual | Year to Date Variance | Annual Budget | Forecast Outturn | Forecast Variance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **WTE** | **WTE** | **WTE** | **%** | **£k** | **£k** | **£k** | | **£k** | **£k** | **£k** | **£k** | **£k** | **£k** |
| | | | | 17,330 | 17,083 | (248) | Clinical Revenue | 137,999 | 137,032 | (967) | 206,605 | 203,515 | (3,090) |
| | | | | **17,330** | **17,083** | **(248)** | **Total Clinical Revenue** | **137,999** | **137,032** | **(967)** | **206,605** | **203,515** | **(3,090)** |
| | | | | 1,244 | 1,227 | (17) | Other Operating Revenue | 9,254 | 9,234 | (20) | 13,630 | 13,543 | (88) |
| | | | | **18,575** | **18,310** | **(265)** | **Total Revenue** | **147,252** | **146,266** | **(987)** | **220,235** | **217,057** | **(3,178)** |
| 4,240 | 4,132 | (108) | 2.5% | (14,118) | (13,876) | 242 | Pay Costs | (113,700) | (110,973) | 2,727 | (169,918) | (166,424) | 3,494 |
| | | | | (3,519) | (3,829) | (310) | Non Pay Costs | (27,550) | (29,238) | (1,688) | (41,165) | (43,534) | (2,369) |
| | | | | (94) | 516 | 611 | Provisions | 321 | 417 | 95 | 723 | 3,085 | 2,362 |
| **4,240** | **4,132** | **(108)** | **2.5%** | **(17,732)** | **(17,188)** | **543** | **Total Operating Expenses** | **(140,928)** | **(139,794)** | **1,135** | **(210,360)** | **(206,874)** | **3,487** |
| **4,240** | **4,132** | **(108)** | **2.5%** | **843** | **1,122** | **279** | **EBITDA** | **6,324** | **6,472** | **148** | **9,875** | **10,183** | **308** |
| | | | | (427) | (453) | (25) | Depreciation | (3,796) | (3,995) | (199) | (5,500) | (5,798) | (298) |
| | | | | (283) | (284) | (1) | PDC Paid | (2,265) | (2,271) | (7) | (3,397) | (3,407) | (10) |
| | | | | 4 | 8 | 4 | Interest Received | 30 | 30 | 0 | 45 | 44 | (1) |
| **4,240** | **4,132** | **(108)** | **2.5%** | **136** | **393** | **257** | **Normalised Surplus / (Deficit) Excl.STF** | **294** | **235** | **(58)** | **1,023** | **1,023** | **0** |
| | | | | 139 | 0 | (139) | STF | 766 | 488 | (278) | 1,394 | 1,394 | 0 |
| **4,240** | **4,132** | **(108)** | **2.5%** | **275** | **393** | **118** | **Normalised Surplus / (Deficit) Incl SFT** | **1,060** | **723** | **(336)** | **2,417** | **2,417** | **0** |
| | | | | 0 | 0 | 0 | Revaluation of Assets | 0 | 0 | 0 | 0 | 0 | 0 |
| **4,240** | **4,132** | **(108)** | **2.5%** | **275** | **393** | **118** | **Surplus / (Deficit)** | **1,060** | **723** | **(336)** | **2,417** | **2,417** | **0** |



# Income & Expenditure Position 2017 / 2018

November 2017 financial performance is a surplus of £393k. Excluding the receipt of Insurance monies this is an underlying deficit of £101k.

**Month 8**

The November position is a pre STF surplus of £393k. The normalised year to date position is a pre STF surplus of £235k and a surplus of £723k including quarter 1 and 2 STF funding. This is £336k behind plan. The key headlines are below:

In month, a £0.5m insurance settlement relating to a fire was received and masks the continuation of previous trends with underspends in pay offset by overspends on out of area beds and below plan CIP acheivement. Excluding the insuance setttlement a £0.1m deficit was recorded, the third consecutive month of a deficit. STF income for quarter 1 and 2 was achieved however the Quarter 3 position to date is lower than plan and as such is reported as unachieved.

**Income**

Provision continues to be made for under achievement of CQUIN income of £480k in line with NHS Improvement guidance. The other significant variance to plan in month continues to be the level of income for the operation of Intermediate Care prior to the implementation of the new model of care in December 2017.

**Pay Expenditure**

The Trust continues to run with a number of vacancies and utilises temporary (both internal bank and external agency) staff to meet clinical and service requirements. The most significant pay savings year to date are within Nursing, Medical and Psychology. Agency expenditure in November is the highest reported this year at £531k due to an increase in medical vacancies and schemes to improve access times. Agency spend continues to exceed the in month cap although due to performance earlier in the year the year to date agency expenditure position remains within cap (5% below).

**Non Pay Expenditure**

November out of area bed spend has reduced from the peak in September and October, taking the cumulative overspend to £1,560k. 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, 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.

Agency expenditure is forecast to end the year £203k (4%) higher than the cap, which is an increase of £158k compared to last month.

# 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 6) The majority of Trust income is secured through block contracts and therefore there has traditionally been little variation to plan.

The budget values are reconciled against signed and agreed contracts with any movement highlighted. There has been no movement in budgets in month 8.

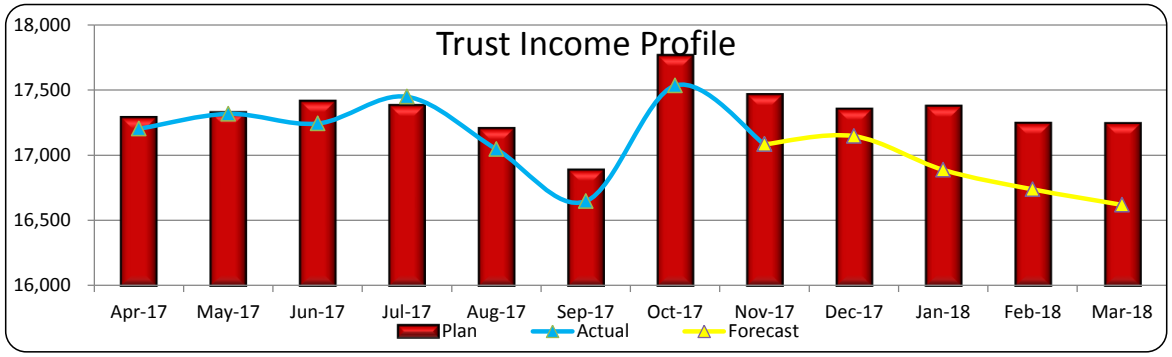
The main variance relates to income reduction and risk in commissioned services in Barnsley. This includes changes in service provision for Intermediate Care within the Barnsley area and de-commissioning of Care Navigation services.

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. As at the end of November 2017 Quarter 2 was yet to be finalised within commissioners.

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

| Commissioner | Year to Date | | | | Variance Headlines | | |
|---|---|---|---|---|---|---|---|
| | Budget | Actual | Variance | | CQUIN | Other | Total |
| | £k | £k | £k | | £k | £k | £k |
| CCG | 101,971 | 101,383 | (589) | | (480) | (108) | (589) |
| Specialist Commissioner | 15,555 | 15,555 | 0 | | 0 | 0 | 0 |
| Alliance | 8,386 | 7,786 | (600) | | 0 | (600) | (600) |
| Local Authority | 3,234 | 3,218 | (16) | | | (16) | (16) |
| Partnership | 4,586 | 4,542 | (44) | | 0 | (44) | (44) |
| Other | 4,266 | 4,548 | 282 | | 0 | 282 | 282 |
| **Total** | **137,999** | **137,032** | **(967)** | **0** | **(480)** | **(487)** | **(967)** |

| | Forecast | | | Variance Headlines | | |
|---|---|---|---|---|---|---|
| | Budget | Actual | Variance | CQUIN | Other | Total |
| | £k | £k | £k | £k | £k | £k |
| CCG | 151,464 | 150,423 | (1,041) | (856) | (185) | (1,041) |
| Specialist Commissioner | 23,333 | 23,333 | 0 | 0 | 0 | 0 |
| Alliance | 13,712 | 11,394 | (2,318) | 0 | (2,318) | (2,318) |
| Local Authority | 4,970 | 4,923 | (47) | | (47) | (47) |
| Partnership | 6,879 | 6,849 | (30) | 0 | (30) | (30) |
| Other | 6,248 | 6,594 | 346 | 0 | 346 | 346 |
| **Total** | **206,605** | **203,515** | **(3,090)** | **(856)** | **(2,235)** | **(3,090)** |




| CQUIN Risk | YTD | Forecast |
|---|---|---|
| Wellbeing Improvement | 0 | 136 |
| STP Reserve | 480 | 720 |
| **Total** | **480** | **856** |

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

Income from Barnsley CCG for reimbursement of costs associated with the ongoing provision of Intermediate Care services prior to the introduction of the new model of care in December 2017 have been agreed for the cost of service provision up to October 2017.

CQUIN risk has been recognised within the year to date and forecast position until confirmation is received from NHS Improvement that it is available.

# 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.

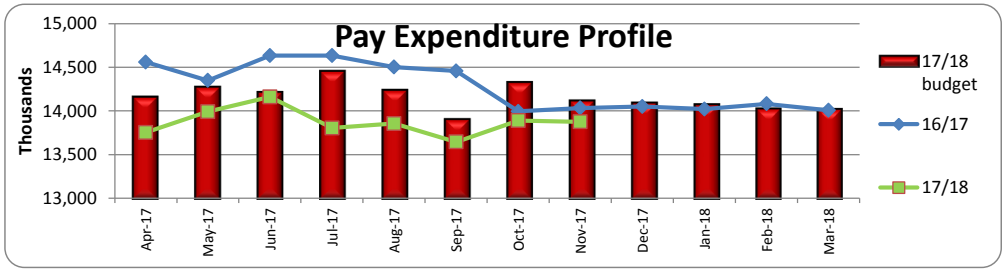
The Trust workforce strategy continues to be developed but current expenditure patterns highlight the usage of temporary staff (through either internal sources such as Trust bank or through external agencies). Actions are focussed on providing the most cost effective workforce solution to meet the service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

Total Pay costs in November were very similar to October.

| | 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 | 12,791 | 12,771 | | | | | **102,737** |
| **Bank & Locum** | 411 | 472 | 620 | 505 | 558 | 701 | 583 | 575 | | | | | **4,425** |
| **Agency** | 501 | 426 | 500 | 457 | 446 | 435 | 515 | 531 | | | | | **3,810** |
| **Total** | **13,752** | **13,992** | **14,161** | **13,804** | **13,854** | **13,645** | **13,889** | **13,876** | **0** | **0** | **0** | **0** | **110,973** |
| 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% | 4.2% | 4.1% | | | | | 4.0% |
| Agency as % | 3.6% | 3.0% | 3.5% | 3.3% | 3.2% | 3.2% | 3.7% | 3.8% | | | | | 3.4% |

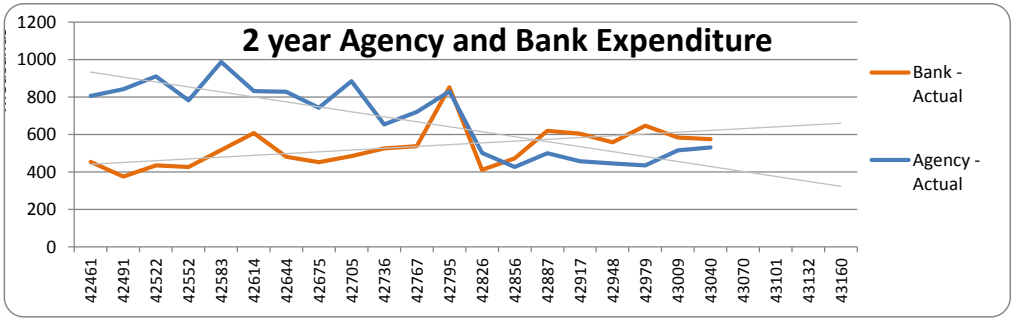
**Year to Date expenditure - by staff group**

| | Substantive £k | Temp £k | Agency £k | Total £k |
|---|---|---|---|---|
| Medical | 12,011 | 254 | 1,802 | 14,067 |
| Nursing Registered | 35,864 | 1,580 | 402 | 37,846 |
| Nursing | 11,878 | 1,880 | 858 | 14,616 |
| Other | 25,915 | 260 | 709 | 26,883 |
| Admin | 17,069 | 452 | 39 | 17,560 |
| **Total** | **102,737** | **4,425** | **3,810** | **110,973** |




**November WTE Analysis**

| | Budgeted | Contracted | Bank | Agency | Variance |
|---|---|---|---|---|---|
| Medical | 212 | 171 | 2 | 21 | (18) |
| Qualified Nursing | 1,443 | 1,305 | 56 | 12 | (70) |
| Unqualified Nursing | 680 | 647 | 87 | 33 | 86 |
| Other Clinical | 835 | 779 | 7 | 9 | (41) |
| A & C | 850 | 752 | 26 | 2 | (70) |
| Other | 326 | 298 | 6 | 3 | (20) |
| Staff Vacancy Factor | (107) | 0 | 0 | 0 | 107 |
| **Total** | **4,240** | **3,951** | **184** | **79** | **(26)** |




**Key Messages**

Both 2016/17 and 2017/18 have seen an increased focus on reducing agency staffing. The graph above shows the downward trend in the use of agency staffing until September when it increased as a result of increased Agency Medical usage. 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 not forecast to decline further this year, bank usage is forecast 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.

Substantive pay dipped in September due to a one off adjustment to recognise pay costs no longer expected to be charged. As a pass through cost this was offset by a corresponding change in income.

# 2.1 Agency Expenditure Focus

**Agency Spend is forecast to breach the NHS Improvement agency cap for the remainder of the year**

**Spend in November is £120k higher 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 weekly NHSI agency return was expanded in October to also include collection of bank information.

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 2 wte individually approved to the end of November.

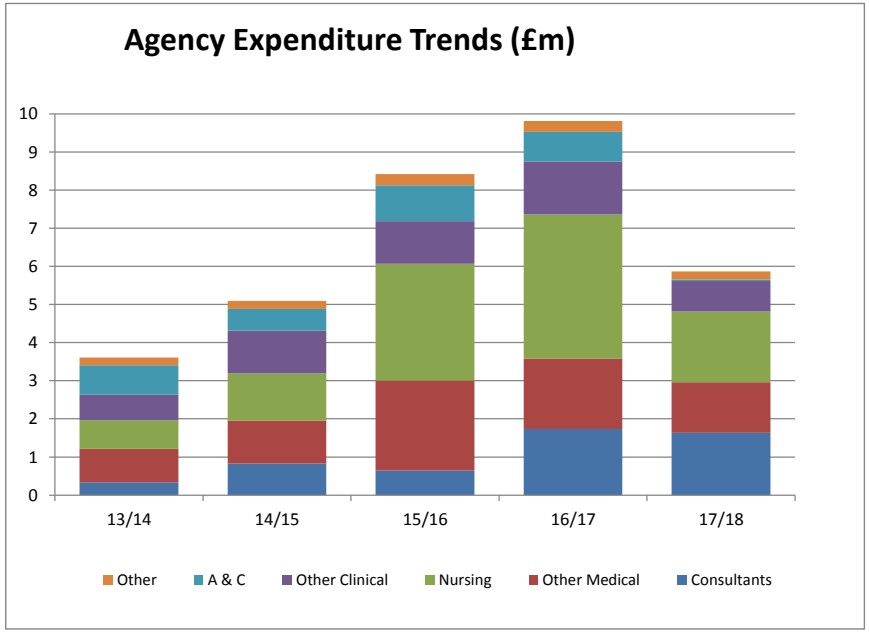
* Reduction in the hourly rate paid. In particular this relates to qualified nursing staff who are now all paid within the NHS Improvement capped rates. 18 out of 20 medical locums continue to be paid higher than the NHSI caps. These have been individually approved by the Trust Medical Director and are reported weekly to NHSI.

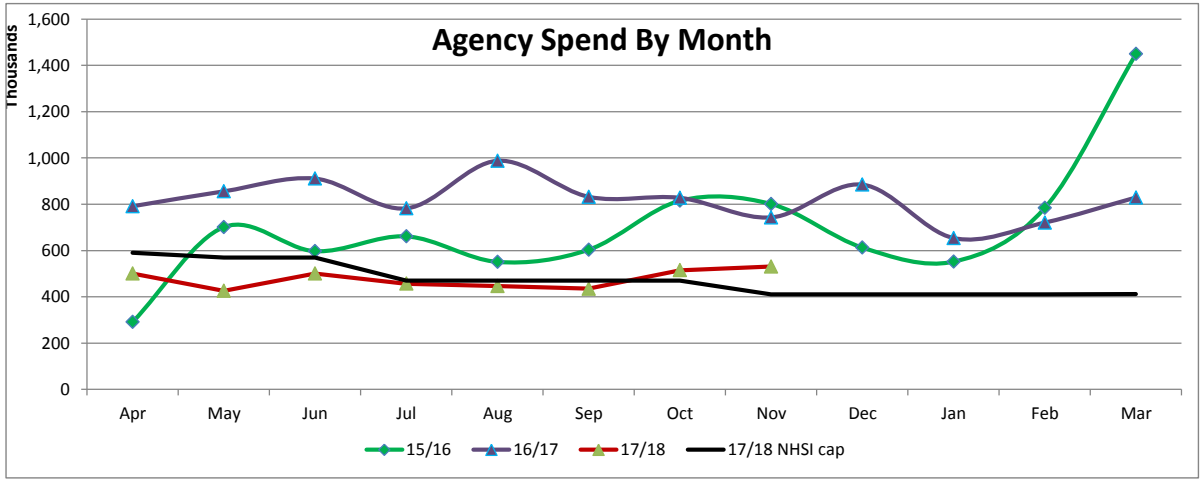
In November the in month agency cap reduced to £410k, for the second month running agency spend has breached the agency cap (by £120k) and is forecast to be higher than cap for the remainder of the year.The forecast outturn at November is £203k (4%) above cap.

Increases relate to medical and other clinical expenditure. The increase in medical agency is to cover new vacancies, gaps in the junior medical rotas and extension of cover resulting from delays in, or unsuccessful, recruitment. The increase in other clinical agency is mainly relating to additional staff for CAMHS waiting lists.

Agency Admin & Clerical have been authorised within the Kirklees IAPT service until the end of November. Zero reliance continues throughout the rest of the Trust.

Across all agency categories spend has reduced on 2016 / 2017. YTD has reduced by £2.9m (43%).



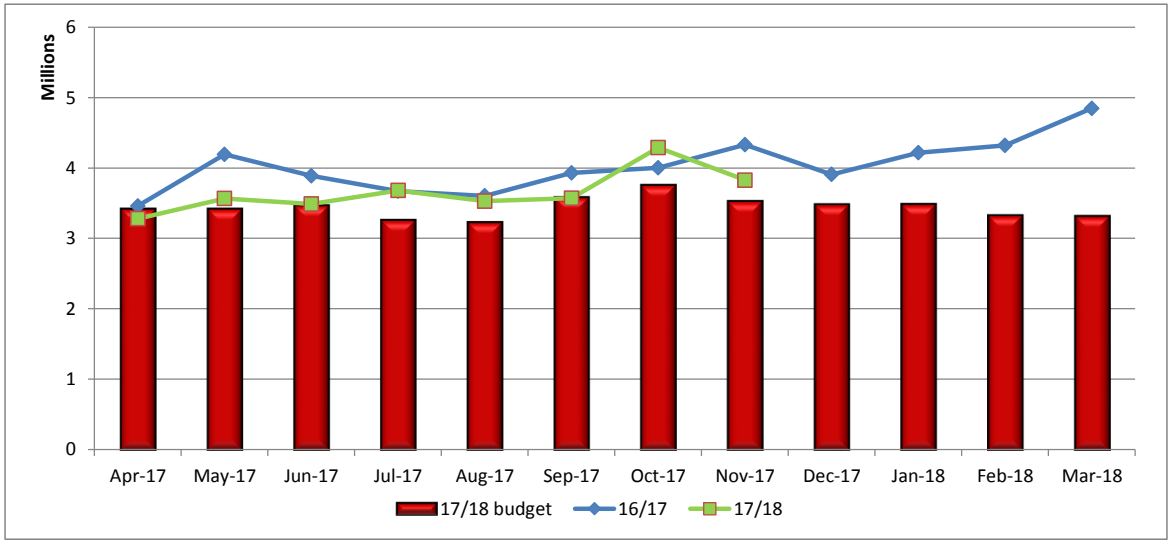
# 2.1 Non Pay Expenditure

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 £1.8m 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 £375k 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 | 4,292 | 3,829 | | | | | **29,238** |
| **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 | 2,055 | 2,342 | (287) |
| Drugs | 2,002 | 2,698 | (696) |
| Healthcare subcontracting | 2,340 | 3,707 | (1,368) |
| Hotel Services | 1,390 | 1,192 | 198 |
| Office Supplies | 2,824 | 2,920 | (96) |
| Other Costs | 3,050 | 2,798 | 251 |
| Property Costs | 4,615 | 4,644 | (29) |
| Service Level Agreements | 4,018 | 4,048 | (30) |
| Training & Education | 487 | 483 | 3 |
| Travel & Subsistence | 2,915 | 2,574 | 340 |
| Utilities | 829 | 772 | 56 |
| Vehicle Costs | 1,026 | 1,059 | (33) |
| **Total** | **27,550** | **29,238** | **(1,688)** |
| **Total Excl OOA and Drugs** | **23,208** | **22,832** | **375** |




**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 significant financial pressure. The changes to the supply of drugs to the Trust are now embedded and actions are commencing to identify savings opportunities. Drugs expenditure analysis has also highlighted the impact that changes in drugs prices (for example increase in drug costs due to concessions applied to two widely prescribed drugs) which is adding additional cost.

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.

# 2.1 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 (£)**

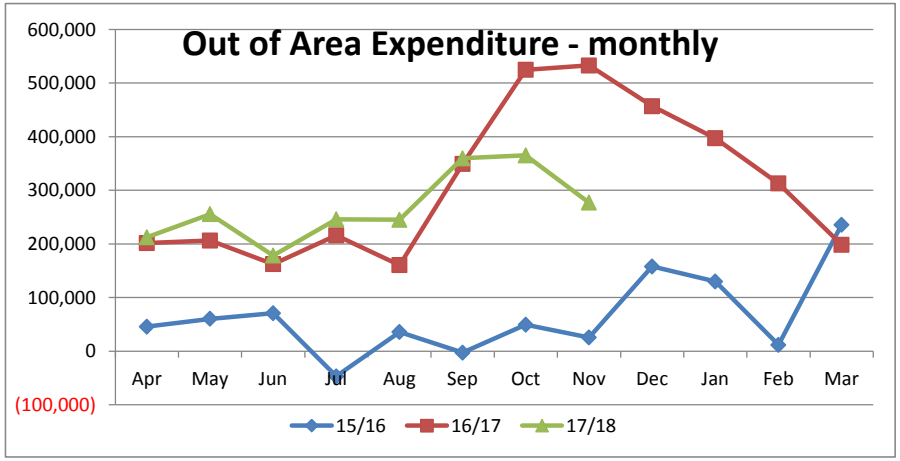
| | Apr £000 | May £000 | Jun £000 | Jul £000 | Aug £000 | Sep £000 | Oct £000 | Nov £000 | Dec £000 | Jan £000 | Feb £000 | Mar £000 | Total £000 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 15/16 | 46 | 60 | 71 | (47) | 36 | (3) | 49 | 25 | 158 | 130 | 12 | 236 | **772** |
| 16/17 | 202 | 206 | 162 | 216 | 160 | 349 | 525 | 533 | 457 | 397 | 313 | 198 | **3,718** |
| 17/18 | 212 | 255 | 178 | 246 | 245 | 359 | 365 | 277 | | | | | **2,138** |

**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 | 477 | 437 | | | | | **2,969** |

**Bed Day Information 2017 / 2018 (by category)**

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PICU | 198 | 176 | 168 | 169 | 213 | 217 | 239 | 318 | | | | | **1,698** |
| Acute | 84 | 170 | 85 | 178 | 148 | 182 | 207 | 118 | | | | | **1,172** |
| Gender | 0 | 0 | 0 | 0 | 30 | 30 | 31 | 1 | | | | | **92** |



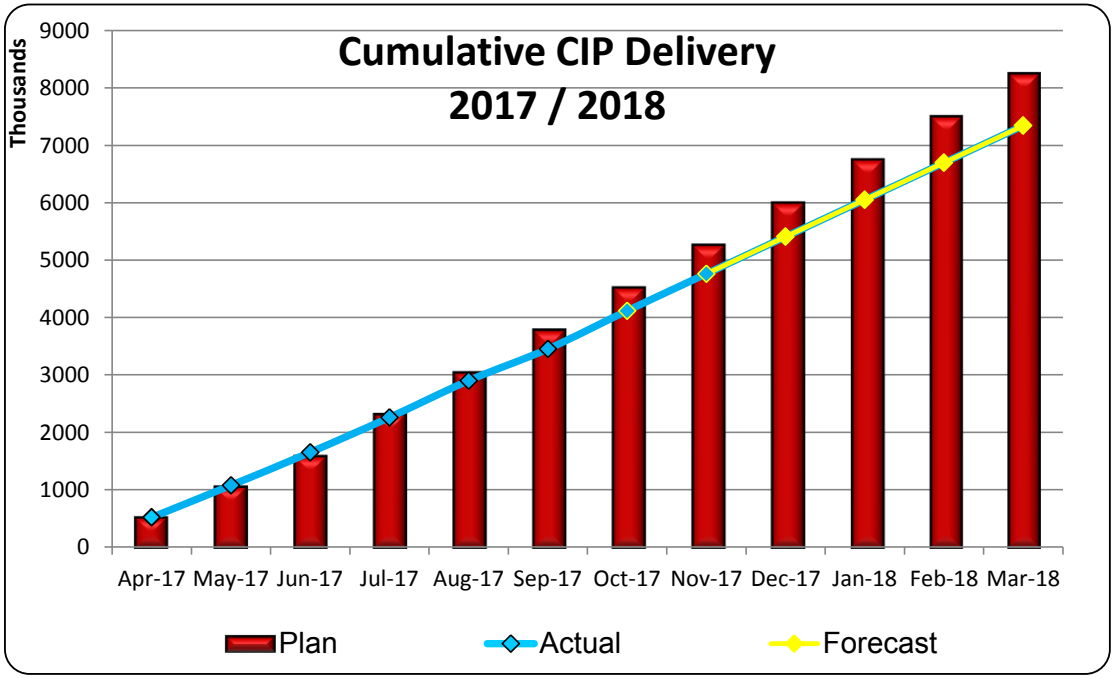

Expenditure on Out of Area placements increased significantly during 2016 / 2017 but through continued action usage did reduce in Quarter 4. This trend continued in Quarter 1 2017 / 2018 but has increased since Quarter 2. High demand is being observed across the Trust and also nationally.

Overall out of area demand continues to be high. Whilst November activity is lower than October it remained higher than the previous months. Actions continue and alternatives to out of area placements are being explored. This is led by the Project Board.

The year to date overspend, for the activity covered in this section of the report, is £1.56m.

# 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 | 5,283 | 8,262 |
| Delivery as originally planned | 401 | 809 | 1,272 | 1,769 | 2,261 | 2,744 | 3,286 | 3,821 | 4,331 | 4,841 | 5,351 | 5,861 | 3,821 | 5,861 |
| Mitigations - Recurrent & Non-Recurrent | 116 | 266 | 378 | 490 | 639 | 708 | 829 | 994 | 1,155 | 1,315 | 1,475 | 1,635 | 994 | 1,635 |
| Total Delivery | **516** | **1,075** | **1,650** | **2,259** | **2,900** | **3,452** | **4,115** | **4,815** | **5,485** | **6,156** | **6,826** | **7,496** | **4,815** | **7,496** |
| Variance | (20) | 1 | 40 | (82) | (172) | (357) | (431) | (468) | (535) | (612) | (689) | (766) | (468) | (766) |




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 £4.8m to date. This is £468k behind plan. The majority (79%) has been delivered in line with original savings plans.

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.

As part of the Trust Annual Planning process for 2018 / 2019 work continues on the identification of recurrent savings. If progress is made in Qtr 4 this will be reported accordingly.

# 3.0 Balance Sheet 2017 / 2018

| | 2016 / 2017 £k | Plan (YTD) £k | Actual (YTD) £k | Note |
|---|---|---|---|---|
| Non-Current (Fixed) Assets | 111,199 | 115,075 | 113,409 | 1 |
| **Current Assets** | | | | |
| Inventories & Work in Progress | 166 | 215 | 166 | |
| NHS Trade Receivables (Debtors | 2,138 | 1,999 | 1,934 | 2 |
| Other Receivables (Debtors) | 8,289 | 7,241 | 7,419 | 3 |
| Cash and Cash Equivalents | 26,373 | 20,899 | 21,721 | 4 |
| **Total Current Assets** | **36,966** | **30,354** | **31,240** | |
| **Current Liabilities** | | | | |
| Trade Payables (Creditors) | (7,213) | (6,234) | (4,749) | 5 |
| Capital Payables (Creditors) | (1,157) | (752) | (745) | 5 |
| Accruals | (9,912) | (11,623) | (10,867) | 6 |
| Deferred Income | (754) | (950) | (661) | |
| **Total Current Liabilities** | **(19,036)** | **(19,559)** | **(17,022)** | |
| **Net Current Assets/Liabilities** | **17,929** | **10,795** | **14,218** | |
| **Total Assets less Current Liabilities** | **129,128** | **125,870** | **127,626** | |
| Provisions for Liabilities | (7,550) | (5,763) | (6,851) | |
| **Total Net Assets/(Liabilities)** | **121,578** | **120,107** | **120,775** | |
| Taxpayers' Equity | | | | |
| Public Dividend Capital | 43,665 | 43,665 | 43,665 | |
| Revaluation Reserve | 18,766 | 18,413 | 18,303 | |
| Other Reserves | 5,220 | 5,220 | 5,220 | |
| Income & Expenditure Reserve | 53,928 | 52,809 | 53,587 | 7 |
| **Total Taxpayers' Equity** | **121,578** | **120,107** | **120,775** | |

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 16. This is lower than plan due to impairments actioned in year relating to Mount Vernon and the lower than plan capital programme.

2. NHS debts remain slightly lower than plan and continue to be actively chased. A focus on debtors has been included on page 15 which highlights some of the outstanding hotspots.

3. Other debtors are slightly higher than planned. Non-NHS Debtors continue to be chased for payment.

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 18.

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

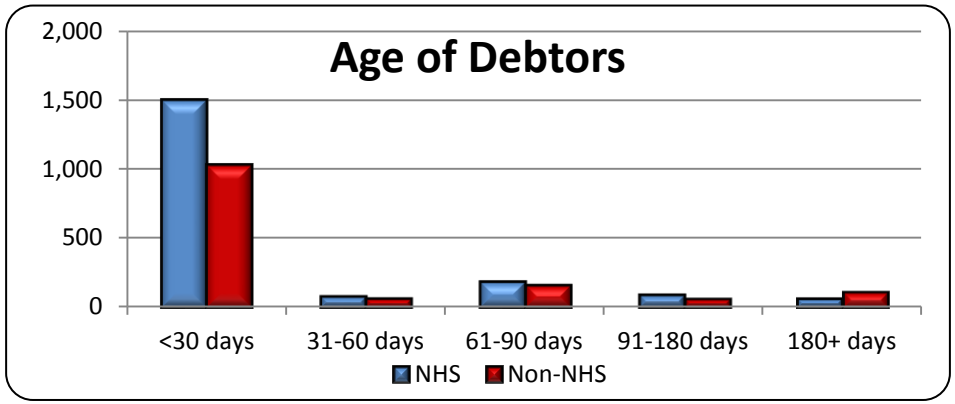
6. Accruals remain slightly lower than planned.

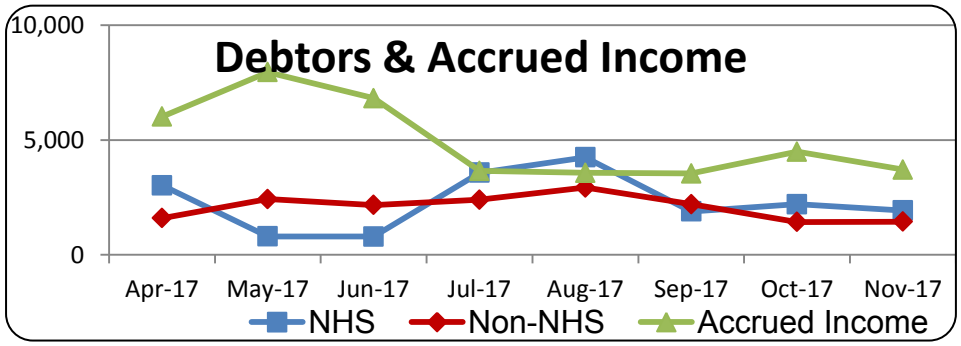
7. This reserve represents year to date surplus plus reserves brought forward.

# 3.0 Debtors

**Debtor management forms a key part of the Trust cash management process.**

**Debtors have reduced further in month from £3.6m to £3.4m.**




The Trust has continued to proactively chase all outstanding debts as part of its cash management process.

The intention of this review and dialogue with outstanding debtors is to reduce the length of time taken to receive cash payment and also identify, and resolve, any issues at the earliest possible opportunity.

This review is undertaken alongside an assessment of accrued income. This ensures that invoices are being raised in a timely fashion. Based upon values this will either be monthly or quarterly in arrears.

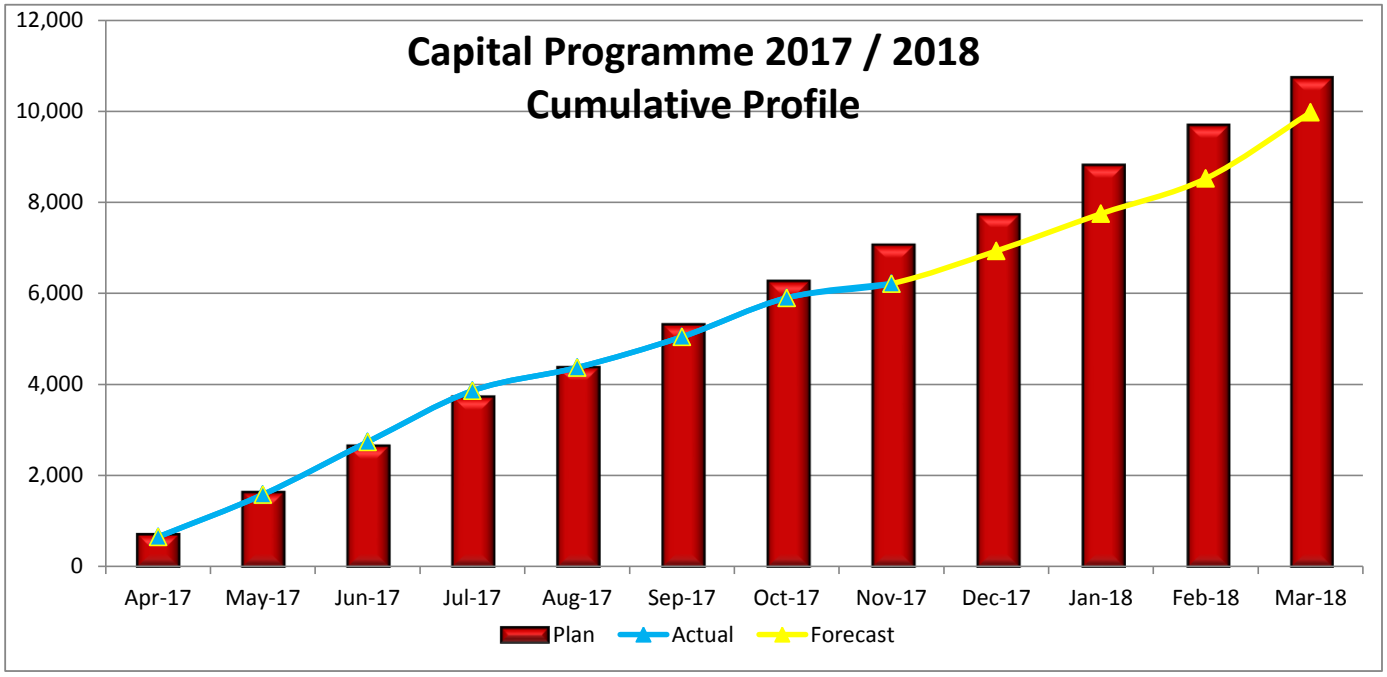
The majority of outstanding debtors, as at the end of November 2017, are less 60 days (79%). Debts older than 180 days have reduced to £180k.
Of these NHS debtors account for £67k. (broadly the same as last month).
Non NHS have reduced to £114k from £145k and makes up 8% of the total Non NHS debt value

The in year profile of debtors is shown to the left. Accrued income has been added for context with invoices continuing to be raised in a timely manner. CQUIN accruals account for £471k of this.

The graph shows that debtors increased as invoices were raised at the end of Quarter 1. These have subsequently been paid and invoices are being issued on a rolling programme.

# 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 | 1,095 | 728 | (367) | 1,432 | (126) | 3 |
| Equipment Replacement | 44 | 44 | 58 | 14 | 58 | 14 | |
| IM&T | 2,121 | 1,201 | 576 | (625) | 1,236 | (885) | 4 |
| **Major Capital Schemes** | | | | | | | |
| Fieldhead Non Secure | 7,030 | 4,734 | 4,892 | 158 | 7,290 | 260 | 2 |
| VAT Refunds | 0 | 0 | (40) | (40) | (40) | (40) | |
| **TOTALS** | **10,753** | **7,074** | **6,214** | **(860)** | **9,976** | **(777)** | 1 |




**The capital programme has been revised to reflect a lower spend. Schemes have been deferred to protect the Trust cash position.**

**Capital Expenditure 2017 / 2018**

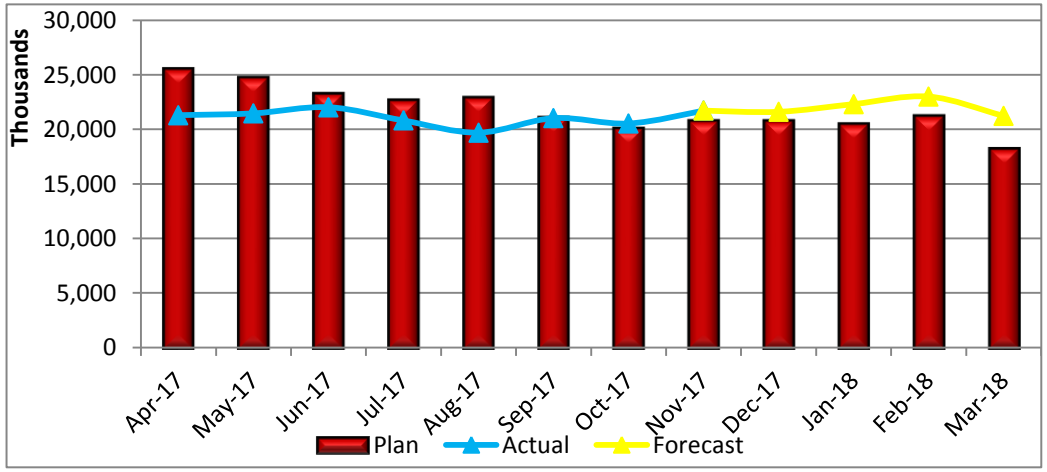
1. The year to date position is £860k lower than plan (12%). Excluding the benefit arising from successful VAT recovery agreed with HMRC this is £900k lower than plan.

2. Fieldhead Non Secure is expected to spend more than plan due to levels of obstructions found during the demolition.

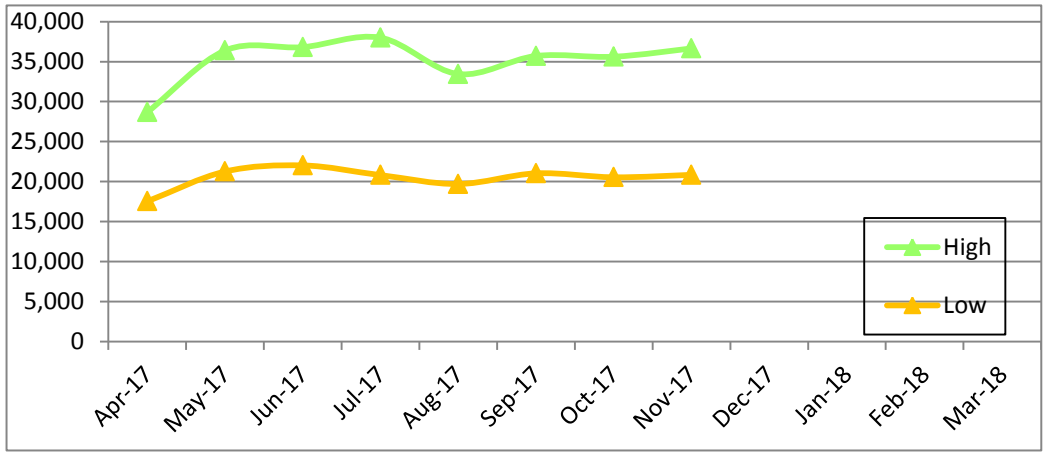
3. Minor works has been revised to reflect a lower spend to protect the Trust cash position.

4. IM & T forecast has been reduced to reflect the current programme. This is primarily timing associated with the change in Clinical Record System.

# 3.2 Cash Flow & Cash Flow Forecast 2017 / 2018




| | Plan £k | Actual £k | Variance £k |
|---|---|---|---|
| Opening Balance | 25,495 | 26,373 | |
| Closing Balance | 20,899 | 21,721 | 822 |




**Cash is above plan, due to continued action and the receipt of £0.5m insurance monies.**

Focus has continued on cash and in particular chasing of outstanding debtors. Debtors have reduced again and the team continue to look at best practice to improve further.

A detailed reconciliation of working capital compared to plan is presented on page 18.

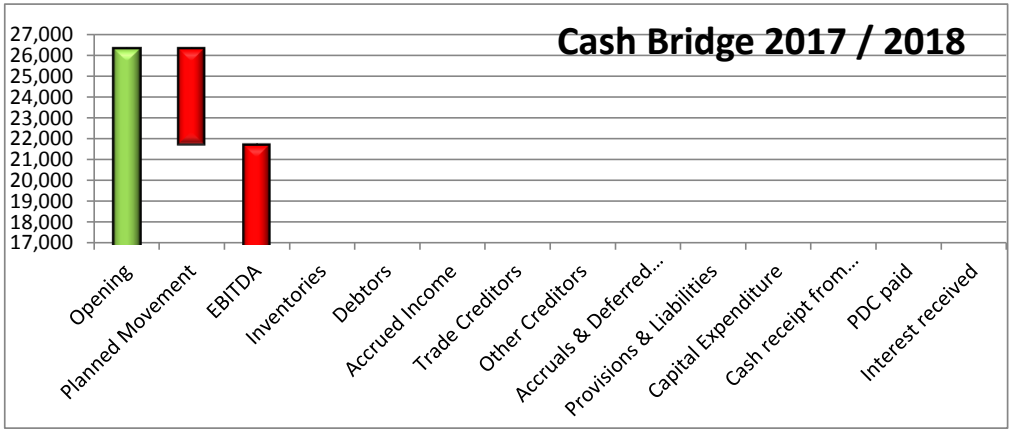
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

| | |
|---|---|
| The highest balance is: | £36.7m |
| The lowest balance is: | £20.8m |

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

# 3.3 Reconciliation of Cashflow to Cashflow Plan

| | Plan £k | Actual £k | Variance £k | Note |
|---|---|---|---|---|
| **Opening Balances** | **25,495** | **26,373** | 878 | 1 |
| Surplus (Exc. non-cash items & revaluation) | 7,231 | #VALUE! | #VALUE! | 5 |
| *Movement in working capital:* | | | | |
| Inventories & Work in Progress | 0 | 0 | 0 | |
| Receivables (Debtors) | (400) | 875 | 1,275 | 2 |
| Accrued Income / Prepayments | (586) | (1,570) | (984) | 6 |
| Trade Payables (Creditors) | 0 | (2,984) | (2,984) | 7 |
| Other Payables (Creditors) | 0 | 0 | 0 | |
| Accruals & Deferred income | (100) | 862 | 962 | 3 |
| Provisions & Liabilities | (2,000) | (699) | 1,301 | |
| *Movement in LT Receivables:* | | | | |
| Capital expenditure & capital creditors | (7,075) | (6,627) | 448 | |
| Cash receipts from asset sales | 0 | 309 | 309 | 4 |
| PDC Dividends paid | (1,698) | (1,751) | (53) | |
| PDC Dividends received | | | 0 | |
| Interest (paid)/ received | 32 | 30 | (2) | |
| **Closing Balances** | **20,899** | **#VALUE!** | **#VALUE!** | |




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 continues to pursue old and high value debts.

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 lower than planned.

6. Accrued income continues to be higher than plan. This is expected to reduce as we approach the end of quarter 3.

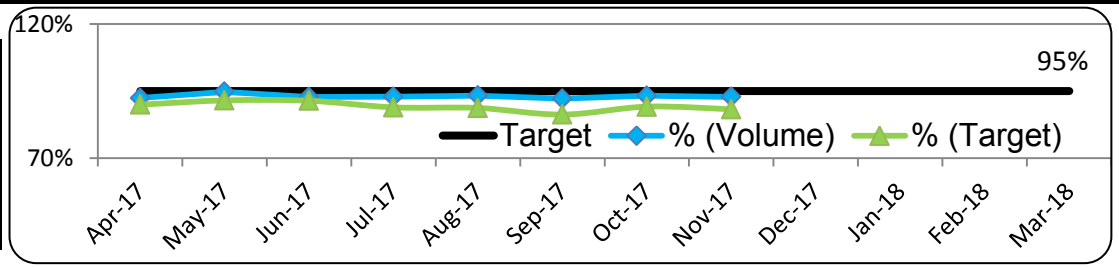
7. Creditors are lower than planned. Invoices are paid in line with the Trust Better Payment Practice Code.

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

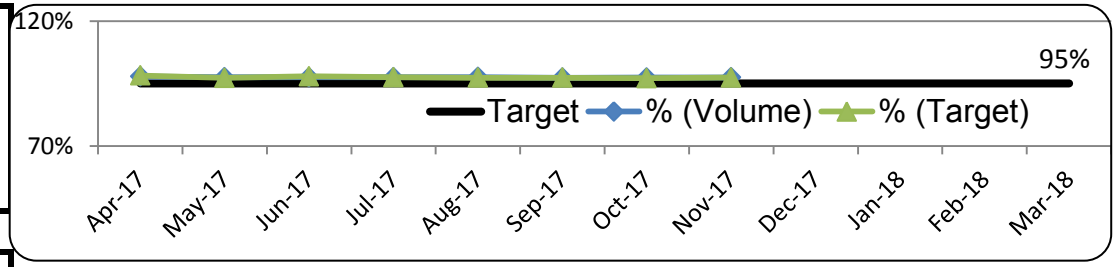
# 4.0 Better Payment Practice Code

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.

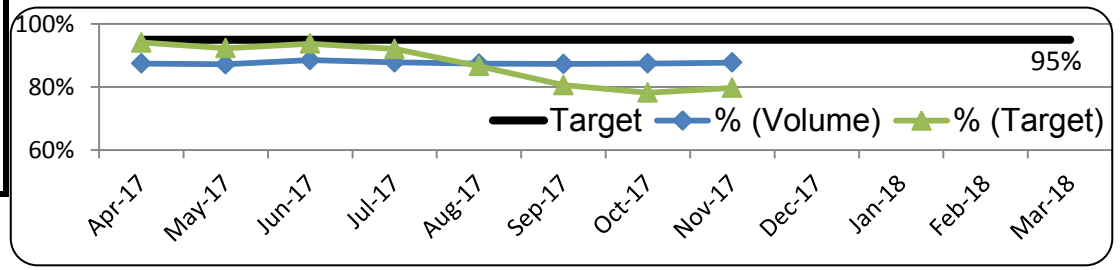
| NHS | Number % | Value % |
|---|---|---|
| Year to October 2017 | 93% | 89% |
| Year to November 2017 | 93% | 88% |




| Non NHS | Number % | Value % |
|---|---|---|
| Year to October 2017 | 97% | 97% |
| Year to November 2017 | 97% | 97% |




| Local Suppliers (10 days) | Number % | Value % |
|---|---|---|
| Year to October 2017 | 87% | 78% |
| Year to November 2017 | 88% | 80% |



# 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 (£) |
|---|---|---|---|---|---|
| 18-Sep-17 | Drugs FP10´s | Trustwide | Bradford Teaching Hospitals NHS FT | 3047482 | 153,433 |
| 26-Sep-17 | Drugs FP10´s | Trustwide | Mid Yorkshire Hospitals NHS Trust | 3048319 | 105,205 |
| 03-Nov-17 | Property Rental | Barnsley | Community Health Partnerships | 3052766 | 102,624 |
| 26-Oct-17 | Drugs FP10´s | Trustwide | NHSBSA Prescription Pricing Division | 3051633 | 55,083 |
| 25-Oct-17 | Staff Recharge | Trustwide | Leeds and York Partnership NHS FT | 3051416 | 49,489 |
| 13-Nov-17 | CNST contributions | Trustwide | NHS Litigation Authority | 3053561 | 47,581 |
| 15-Nov-17 | Property Rental | Barnsley | Community Health Partnerships | 3053830 | 38,934 |
| 06-Nov-17 | Property Rental | Barnsley | Community Health Partnerships | 3052857 | 32,445 |
| 06-Nov-17 | Property Rental | Barnsley | Community Health Partnerships | 3052861 | 32,445 |
| 06-Nov-17 | Property Rental | Barnsley | Community Health Partnerships | 3052859 | 32,445 |
| 01-Nov-17 | Property Rental | Kirklees | Mid Yorkshire Hospitals NHS Trust | 3052333 | 31,010 |
| 08-Nov-17 | Rates | Barnsley | Barnsley Metropolitan Borough Council | 3053250 | 29,964 |
| 15-Nov-17 | Property Rental | Barnsley | Community Health Partnerships | 3053835 | 28,820 |
| 06-Nov-17 | Property Rental | Barnsley | Community Health Partnerships | 3052859 | 26,218 |
| 06-Nov-17 | Property Rental | Barnsley | Community Health Partnerships | 3052857 | 26,218 |
| 06-Nov-17 | Property Rental | Barnsley | Community Health Partnerships | 3052861 | 26,218 |

# 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.

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 19 December 2017
# Agenda item 6.3

| | |
|---|---|
| **Title:** | **Serious Incident report Quarter 2 2017/18** |
| **Paper prepared by:** | Director of Nursing and Quality |
| **Purpose:** | This report provides information in relation to incidents in Quarter 2 and more detailed information in relation to serious incidents.<br>The Board is asked to note the plans to recover the timeliness of 60 day reports over the next 5 months and to consider the report and feedback from the Clinical Governance & Clinical Safety Committee.<br>The Board is also asked to note that:<br>➢ The report provides important data to support our ongoing work in relation to our new "learning from deaths" policy and our commitment to the zero suicide philosophy described in the West Yorkshire and Harrogate Suicide Prevention Strategy.<br>➢ The Smoke Free Policy Review Group is considering the intended and unintended consequences of the policy and impact on incident reporting |
| **Mission/values:** | ➢ We are respectful, honest, open and transparent<br>➢ We are always improving<br>➢ We know that families and carers matter |
| **Any background papers/ previously considered by:** | Previous quarterly reports which have been submitted to Trust Board. The annual incident report which was submitted to Trust Board in July 2017.<br>The "Our Learning Journey Reports" |
| **Executive summary:** | ➢ This report is produced by the patient safety support team and shows the data for incidents. Detailed Quarterly reports have been produced and shared with each BDU; this is available at service line level.<br>➢ The actions from incidents are managed at BDU level. The patient safety support team produces information on completion of action plans from serious incidents and these are monitored through the operational managers group.<br>➢ This report has overall figures for incident reporting – Trust reporting is up following a slight downwards trend in the previous two quarters. Q2 had 3,048 incidents which is higher than the previous two quarters.<br>➢ Around 89% of incidents are graded as "low" or "no harm" showing a positive culture of proactive risk management.<br>➢ Physical aggression/threat (no physical contact) by patient was the most reported category, as per three of the five quarters shown in the report. Physical aggression continues to be the highest reported incident. Staff report this can be linked to individual services users and there is also evidence that some incidents are linked to the Trust's current smoking policy. This is being examined in more detail, with figures/information from Datix given to the group that has been set up to consider changes to the |

| | |
|---|---|
| | policy.<br>➢ There have been no 'Never Events' reported in the Trust during Q2, the last Never event reported was in 2010/11.<br>➢ The total number of serious incidents reported through STEIS in Q2 is 18. This is similar to the 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 11. Serious incidents have included fires, information governance, and medication errors and the breadth in the type of incidents has been greater. The highest category of serious incident is Suicide (incl apparent) -community team care –current episode (9). This is slightly higher than previous quarters<br>➢ The category of apparent suicide at point of reporting is similar in the rolling previous 4 quarters -, 7, 8, 8, and 11. Due to this quarter this is 34 in total, which is close to the level of estimated cases based on National Confidential Inquiry numbers and our population - 32/33.<br>➢ 12 investigations have been submitted to the Commissioner during the quarter and 21 have been closed by Commissioners.<br>➢ Many reports are outside the 60 day target, all of these have agreed extensions with Commissioners. The team have noted an increase in the complexity of investigations and steps are being made to reduce backlog of reports by increasing capacity of internal and external investigators. From September 2017 we would expect to see the overdue reports reduce in the next five months, if demand remains the same. We have the support of Commissioners in completing a quality report above a timely report. However we remain alert to the needs of family and carers to achieve closure. This balance is managed by the team.<br>➢ Within the report are some examples of learning from specialist advisors and workstream for the highest reported incidents.<br>➢ There is also a brief update and link for the National Confidential Inquiry into Suicide and Homicide by people with Mental illness annual report 2017.<br>➢ **This report was scrutinised by the Clinical Governance and Clinical Safety Committee meeting held on the 14th November 2017.**<br>➢ Feedback from the CGCS was positive in terms of the insight the report provides into patient safety.<br>➢ It was identified that it is difficult to trend or draw any firm conclusions when comparing data from one quarter to the next due to relatively small numbers. More important lessons are derived from the SI reports following RCA investigations.<br>➢ The Committee was assured that robust systems and processes for the reporting and investigation of incidents remain in place. The importance of the dissemination of the learning lessons report was also noted.<br>➢ The Committee also noted the importance of the weekly risk panel where all amber and red incidents are reviewed.<br>**Risk appetite**<br>➢ Risk identified –the trust continues to have a good governance system of reporting and investigating incidents including serious incidents. |

| | |
|---|---|
| | ➢ This report covers assurance for compliance risk for health and safety legislation and compliance with CQC standards for incident reporting. This meets the risk appetite –low and the risk target 1-3.<br>➢ The clinical risk –risk to service user/public safety and risk to staff safety which is again low risk appetite and a risk target of 1-3.<br>The incident management process supports the drive to reduce harm and learn from incidents to reduce risk and prevent recurrence in the future. |
| **Recommendation:** | **Trust Board are asked to NOTE the quarterly report on incident management and the assurance given by the Clinical Governance and Clinical Safety Committee.** |

South West Yorkshire Partnership NHS Foundation Trust

# TRUSTWIDE INCIDENT MANAGEMENT SUMMARY REPORT

## QUARTERLY REPORT FOR THE PERIOD 1 JULY 2017 – 30 SEPTEMBER 2017

## (QUARTER 2)

This summary report has been prepared by the Patient Safety Support Team to bring together Trustwide information on incident activity during Quarter 2 17/18 (1 July 2017 to 30 September 2017), including reported serious incidents.

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

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

## 1 UPDATES FROM THE PATIENT SAFETY SUPPORT TEAM

### 1.1 INCIDENT REPORTING AND DATIXWEB UPDATES

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

when a death is reported. The Patient Safety Support Team have also used this as an opportunity to review other sections of the form to improve the quality of data collected to help with decision making, investigation, learning and audit.

Changes include:

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

- Following the introduction of new mortality fields on Datix in April 2017 and ongoing review of data, it is often not clear from the record if the family or carer or clinician/manager have any concerns about the care we have given. As such the fields below have been added to Datixweb to prompt for this information.

- Specialist Advisor Datix guidance has been produced by the team and circulated following an action from an SI. The guidance can also be found on the intranet.

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

## 1.2 WORK IN PROGRESS FOR IMPLEMENTATION IN QUARTER 3 17/18

- Development and implementation of Security Incident Reporting System (SIRS) on Datixweb in conjunction with the Security Team. Data to be collected and used locally.

- The Learning from Healthcare deaths policy in place from 1 October 2017.

- Development of the Inquest and claims module on Datix web

## 1.3 CHANGES IN SERVICES IN QUARTER 2 17/18

- Changes have been made to Datix to reflect the new core and enhanced teams in Kirklees and Calderdale BDU following transformation.

## 1.4 INCIDENT ANALYSIS AND TRAINING REQUESTS FROM BDU'S

During Quarter 2, the Patient Safety Support Team has received the following requests for analysis of incident data and training:

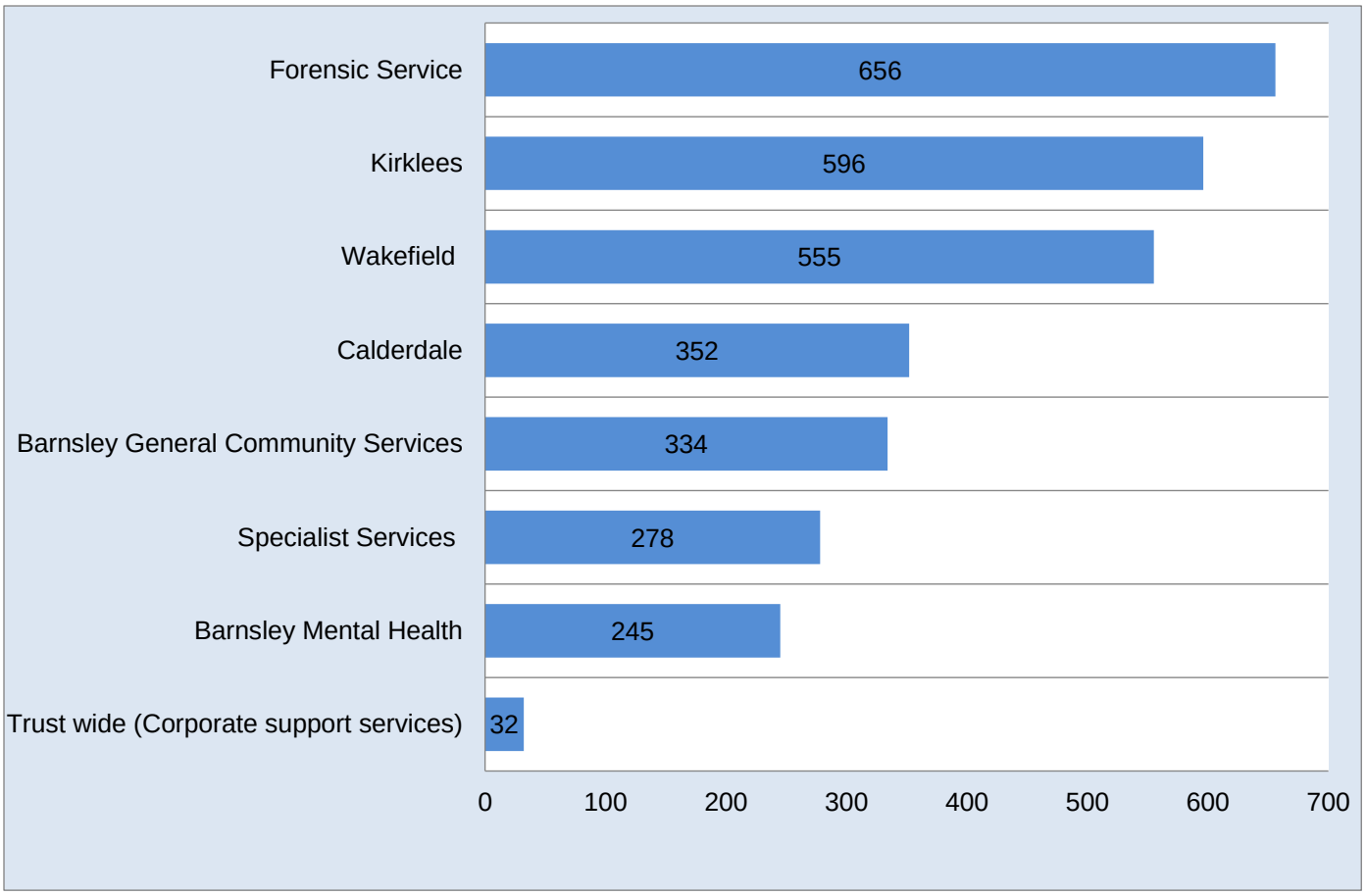
| BDU | Quarter 2 17/18 |
|---|---|
| Kirklees and Calderdale BDU | No requests. |
| Wakefield BDU | No requests. |
| Barnsley BDU | Request for report to be produced in relation to pressure ulcer incidents from April 2017. |
| Forensic BDU | No requests. |
| Specialist Services BDU | Further request for Datix training for Practice Governance Coaches in CAMHS (Kirklees and Calderdale). |
| Trustwide (corporate) | Request for report for outstanding SI actions.<br><br>Request for report in relation to breach of smoke free policy incidents from 01 Dec 2005 to 31 Aug 2017 (Quality Team)<br><br>Request for a report in relation to CAMHS IG incidents previous 4 quarters (Information Governance) |

## 1.5 FREEDOM OF INFORMATION REQUESTS RECEIVED WITHIN QUARTER 2

| Request Reference | Information Requested |
|---|---|
| FOI1688 | 1) Please state the number of assaults that were conducted by:<br>a) Patient on staff<br>b) Patient on patient<br>c) Staff on patient<br>d) Staff on staff<br><br>Recorded at hospitals and other premises of your mental health trust/board in each of the following financial years.<br>i) 2012/13<br>ii) 2013/14<br>iii) 2014/15<br>iv) 2015/16<br>v) 2016/17<br><br>2) Please provide, for each assault, a description of each assault and details of where the assault took place (e.g. in a secure unit/in a consultation room/hospital ward), if possible under the cost limit set out by the FOIA. |
| FOI1722 | The information requested is as follows and relates to mental health service users:<br><br>1. Use of physical restraint<br>For 2015/16 and 2016/17, please provide the following information:<br><br>a) The total number of incidents of physical restraint<br>b) The total number of incidents of face down physical restraint<br>c) The total number of incidents where police were involved in physically restraining a patient<br><br>2. Impact of physical restraint<br>For 2015/16 and 2016/17, please provide the following information:<br><br>a) The total number of incidents of physical restraint which resulted in injury<br>b) The total number of incidents of physical restraint which resulted in death |
| FOI1727 | How many non-fatal suicide attempts were there in the trust in (a) 2014/15, (b) 2015/16 and (c) 2016/17. |

| | |
|---|---|
| FOI1741 | 3. How many injuries were recorded as having occurred to patients as a result of physical restraint in your mental health trust in each of the following years: 2016/17; 2015/16; 2014/15; 2013/14?<br><br>4. How many injuries were recorded as having occurred to staff as a result of physical restraint in your mental health trust in each of the following years: 2016/17; 2015/16; 2014/15; 2013/14? |
| FOI1767 | 1) Please state the number allegations of theft of hospital drugs by staff members that have been investigated by the trust in each of the last three financial years (2014-15, 2015- 2016, 2016-2017)? |

## 2. INCIDENTS REPORTED TRUSTWIDE WITHIN THE QUARTER BY BDU




## 2.1 TRUSTWIDE COMPARATIVE DATA 01 JULY 2016 TO 30 SEPTEMBER 2017 (ROLLING YEAR)

| | Q2 16/17 | Q3 16/17 | Q4 16/17 | Q1 17/18 | Q2 17/18 |
|---|---|---|---|---|---|
| Total Incidents Reported | 3349 | 3242 | 2910 | 2790 | 3048 |
| Total Number of Green (No Harm) Incidents Reported | 2008 | 1891 | 1772 | 1700 | 1881 |
| Total Number of Green (Low Harm) Incidents Reported | 943 | 975 | 813 | 776 | 844 |
| Total Number of Yellow (Moderate) Incidents Reported | 307 | 282 | 237 | 232 | 232 |
| Total Number of Amber Incidents Reported | 73 | 70 | 71 | 55 | 59 |
| Total Number of Red Incidents Reported | 18 | 24 | 17 | 27 | 32 |
| Most Reported Category of Incident | Breach of Smoke Free Policy | Physical aggression/threat (no physical contact): by patient | Physical violence (contact made) against staff by patient | Physical aggression/threat (no physical contact): by patient | Physical violence (contact made) against staff by patient |
| Team who reported most signifcant number of incidents | Ward 18, Priestley Unit | Elmdale Inpatient Services Ward | Elmdale Inpatient Services Ward | Elmdale Inpatient Services Ward | Ward 18, Priestley Unit |
| How many "Lessons Learnt were extracted from the incidents reported within the quarter (note more than one "Lessons Learnt" can be selected. Not all incidents will have included Lessons Learnt) | 860 | 703 | 728 | 554 | 716 |
| Most Frequent Lessons Learned Theme is | Physical healthcare | Physical healthcare | Physical healthcare | Physical healthcare | Physical healthcare |

In section 2.1 there have been 32 red incidents reported. This data is live data at the point of producing the report. The incident may be initially graded red for a number of reasons. An example would be a death (for healthcare deaths we have been encouraging staff to report on Datix) but we later find out this is natural causes or not been involved with Trust services for over six months so not this may be re-graded and not reported on STEIS, this can take some

time to get this information. A case may be red but reported through the Commissioner onto STEIS e.g. multi-agency Serious Case Review.

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

| | Barnsley Mental Health | Barnsley General Community | Calderdale | Kirklees | Wakefield | Forensic Service | Specialist Services | Trustwide (Corporate support services) | Total |
|---|---|---|---|---|---|---|---|---|---|
| Green (no harm) | 165 | 199 | 187 | 339 | 316 | 504 | 154 | 17 | 1881 |
| Green | 58 | 89 | 125 | 207 | 169 | 116 | 69 | 11 | 844 |
| Yellow | 12 | 9 | 27 | 35 | 59 | 35 | 53 | 2 | 232 |
| Amber | 3 | 37 | 7 | 6 | 3 | 1 | 0 | 2 | 59 |
| Red | 7 | 0 | 6 | 9 | 8 | 0 | 2 | 0 | 32 |
| Total | 245 | 334 | 352 | 596 | 555 | 656 | 278 | 32 | 3048 |

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

| | Barnsley Mental Health | Barnsley General Community | Calderdale | Kirklees | Wakefield | Forensic Service | Specialist Services | Trustwide (Corporate support services) | Total |
|---|---|---|---|---|---|---|---|---|---|
| Violence and Aggression | 56 | 15 | 91 | 170 | 167 | 268 | 109 | 2 | 878 |
| Care Pathway, Clinical and Pressure Ulcer Incidents | 16 | 216 | 15 | 36 | 37 | 4 | 22 | 0 | 346 |
| Legislation and Policy | 5 | 0 | 38 | 67 | 65 | 157 | 2 | 2 | 336 |
| Self Harm | 31 | 1 | 59 | 74 | 54 | 18 | 3 | 0 | 240 |
| Medication | 25 | 20 | 28 | 37 | 26 | 55 | 24 | 0 | 215 |
| Health and Safety (including fire) | 19 | 9 | 11 | 35 | 35 | 47 | 26 | 9 | 191 |
| Slips, Trips and Falls | 16 | 30 | 31 | 36 | 39 | 11 | 4 | 4 | 171 |
| Death (including suspected suicide) | 28 | 2 | 22 | 29 | 44 | 0 | 8 | 1 | 134 |
| Security Breaches | 12 | 8 | 5 | 15 | 19 | 45 | 15 | 1 | 120 |
| All Other Incidents | 4 | 4 | 15 | 28 | 20 | 29 | 11 | 2 | 113 |
| Missing/absent service users | 11 | 1 | 18 | 33 | 20 | 9 | 0 | 0 | 92 |
| Information Governance Incidents | 4 | 14 | 4 | 7 | 7 | 3 | 17 | 8 | 64 |
| Safeguarding Adults | 6 | 5 | 6 | 11 | 9 | 4 | 23 | 0 | 64 |
| IT Related Issues | 4 | 7 | 6 | 8 | 8 | 2 | 4 | 3 | 42 |
| Safeguarding Children | 8 | 1 | 3 | 9 | 5 | 0 | 10 | 0 | 36 |
| Infection Prevention/Control | 0 | 1 | 0 | 1 | 0 | 4 | 0 | 0 | 6 |
| Total | 245 | 334 | 352 | 596 | 555 | 656 | 278 | 32 | 3048 |

## 3. LEARNING IDENTIFIED BY SPECIALIST ADVISORS

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

**Fire Safety**

We have continued to deliver annual fire training (face to face or e-learning where applicable) and have continued to achieve the target of 80% Trustwide. Following recent fire related incidents, EMT have increased the target for staff at work on in patient areas (clinical, non-clinical and support staff) to 95%.

Although targets have been achieved, it is evident that some staff have been completing e-learning where they do not meet the criteria in the training policy.

Face to face fire training this year has been updated to include the learning outcomes arising from the Trinity 2 fire, where occupants were evacuated safely, but there was a total loss of the ward as a result of the fire.

**Safeguarding**

Attendance at the regional Yorkshire and Humber Prevent forum provided the Prevent lead for the Trust information regarding the changes to the current training packages including the changes to the training compliance target. Consequently a workforce plan has been produced to ensure that the Trust achieves the 85% compliance target by March 2018. Additionally information was provided around the current National and Local risks. This information was shared in a timely manner at the Safeguarding Strategic subgroup and has been added to information delivered as part of the training package.

Attendance by the safeguarding adult and children team members at the NHS England Child Sexual Exploitation (CSE) subgroup, local strategic and operational CSE subgroups has ensured that up to date CSE information is shared across all services to keep children and vulnerable adults safe.

The safeguarding Adult and Children link professional forums continue to be well attended and raise awareness around the safeguarding agenda including Domestic Abuse, Honour Based Violence, Forced Marriage and Neglect.

The safeguarding children team are currently providing support to services within the Barnsley BDU in regards to a possibly SEND inspection. The team have provided information about the process, what information may be requested and safeguarding supervision sessions have been arranged.

The safeguarding team have attended the launch of the Female Genital Mutilation (FGM) Strategy meeting in Wakefield. This information will be incorporated into the Trust FGM guidance.

**Medicines Management/Pharmacy**

**Common contributory factors**

**Documentation**

Staff are reminded to check the administration chart prior to administering medicines on wards in clinics or in the community. Check a dose hasn't already been given or been changed or discontinued. **Even if you think you know – check**.

**Interruptions**

This is a common cause of errors at all stages of the medicines management process; prescribing, dispensing and administration.

Interruptions can come from colleagues, telephones, services users or visitors, breaking off to get equipment.

**Discuss at team meetings strategies to reduce interruptions during medicines management processes** for example segregating dispensing and checking areas, a medicines administration tabard or do not disturb badge.

**Missed doses**

Recent incidents include service users missing vital medicines, including insulin, following transfer to another ward, hospital or team. Liaise with the receiving team to check they have supplies. **Remember if you transfer a person transfer their medicines.**

**Medicines reconciliation on admission**

Recent incidents have occurred leading to prescribing errors when medicines reconciliation has not been complete. This has led to missed medicines and medicines prescribed when discontinued.

Summary care records, whilst useful may not be up to date if prescriptions have been written very recently or the service user has been advised to stop a medication.

**Remember to use more than one source of information and where possible consult the service user or carer.**

**Wrong person**

There have been recent reports of incidents of administration, dispensing and prescribing medicines for the wrong person. These can occur if there are similar names, drop down menus are used on electronic prescribing or dispensing systems, looking after more than one person in the same home, not completing the full identity check.

**Remember to check at least three details, name, date of birth and address. Ask the person to give you their details rather than asking them to confirm details you give them.**

## Good practice

### Depot reminders

Inpatient wards in the Forensic BDU have introduced pictorial reminder cards to clip to prescriptions charts for service users prescribed depot antipsychotic medication to reduce missed doses.

### Lithium

Serious harm was prevented in Calderdale by the quick recognition of lithium toxicity and subsequent discovery that the service user was receiving lithium from two sources.

### Introducing the Safe Medicines Practice Group

This is a multi-disciplinary group whose remit is to review incidents reported via the Datix system. The group looks at common themes, medications and systems involved in reports. The group is a subgroup of the Drug and Therapeutics subcommittee.
For further information contact Kate Dewhirst, Medicines Safety Officer.
Kate.dewhirst@swyt.nhs.uk

### Patient Safety Support Team

Messages to BDU's

Managers are reminded to ensure that when they review incidents that they update the incident form with the outcome for the patient e.g. if the patient has attended A&E following an incident, please state any treatment that was required, any injuries sustained and length of stay etc. This helps to determine the level of harm to the patient and also prevents delays with reporting to the National Reporting and Learning System.

Can all managers please remember to approve contacts, when search matching contacts and link the correct contact to the incident form rather than creating duplicate contacts. When filling out the contact details on the incident form, could managers please ensure that they provide much information as possible and include, Date of Birth and Rio/SystemOne number.

When reviewing a death of a service user, could all managers/reporters please ensure that they complete the death of a service user fields. A recent audit has highlighted that these fields are not being completed by reporters/managers, where a death has occurred to a service user.

When grading an incident, it is always better to grade the severity of the incident higher, if unsure what the severity of the incident is. Once the incident has been submitted, the reviewing manager will review the incident and re-grade if necessary.

Can we also remind all staff, that when grading an incident it is important, to consider **the potential for harm** that may occur as well as **actual harm** from the incident. A link to grading guidance can be found on the intranet under FAQs and can also be accessed by clicking on the link below: http://nww.swyt.nhs.uk/incident-reporting/Pages/Frequently-asked-questions.aspx (click on Further guidance on using risk grading matrix.doc).

Bluelight alerts have been created to provide a way to share urgent learning quickly across the Trust. If you have urgent safety or learning information that needs to be shared across the Trust urgently, please discuss the information you want to share with your managers to firstly

agree if a Bluelight is the appropriate route for circulation, then follow the process on the intranet http://nww.swyt.nhs.uk/learning-from-experiences/Pages/Bluelight-alerts.aspx

**National Confidential Inquiry into Suicide and Homicide by people with Mental illness annual report 2017.**

The annual report was launched in October 2017.

The 2017 Annual Report provides the latest figures (from 2005 to 2015) on suicide, homicide, and sudden unexplained deaths and makes recommendations for clinical practice to improve safety in mental health care. Key messages include:

- Suicide by mental health in-patients continues to fall but the longstanding downward trend has slowed. There is an average of 114 suicides by in-patients in the UK per year.
- Similar falls are also apparent in other specific patient groups, including patients recently discharged from hospital and patients who were non-adherent with drug treatment in the month before death. These downward trends have occurred despite more patients being treated by mental health services.
- However, the first week post-discharge period remains a time of particularly high risk and we continue to recommend all patients are followed up within 3 days of discharge from in-patient care.
- Figures we have presented this year for less common diagnoses highlight the need for vigilance in these groups - the number of suicides in patients with a diagnosis of eating disorder, autism spectrum disorder or dementia have risen; although this rise may reflect increasing diagnoses.
- Although opiates remain the main type of drug taken in fatal overdose in the UK, the number of opiate deaths continues to fall in England, Scotland and Wales. Safer prescribing in primary and secondary care remains crucial.
- Most patients convicted of homicide also have a history of alcohol or drug misuse, between 88% in England and 100% in Northern Ireland. That it is unusual for mental health patients to commit homicide unless these is a co-existing problem of substance misuse is an important message in combatting stigma.
- In England, of the 641 homicides by patients, 218 had a primary diagnosis of schizophrenia. Of these, 34% of patients with schizophrenia were convicted of murder and 41% sent to prison – raising concerns about patients with severe mental illness being sent to prison rather than hospital following conviction for homicide.

Link for report, infographic and video

| Clinical messages | |
|---|---|
| **In-patient care** | There should be a renewed emphasis on suicide prevention on in-patient wards, with the aim of re-establishing the previous rate of decrease in in-patient suicide. This could include: (a) measures to improve the physical environment, e.g. removing low-lying ligature points, (b) ensuring care plans are in place during agreed leave, (c) measures to reduce leaving the ward without agreement, e.g. improvements to ward milieu, better monitoring of ward access and exit points, and observation protocols. |
| **Post-discharge care** | Services should build on the recent fall in suicide following discharge from<br>in-patient care: this remains a time of particularly high risk. This should include:<br>(a) patient follow-up within 3 days of hospital discharge, (b) care plans in place on discharge from hospital to community, (c) ending 'out of area treatments' (OATs) for acutely ill patients. National clinical guidelines have been developed with reference to NCISH findings (e.g. NICE guideline on transition between in-patient and community care settings3). |
| **Diagnostic groups** | Services should be aware of the potential suicide risk in patients with a diagnosis of an eating disorder, ASD or dementia, and this should be part of<br>a comprehensive assessment. Mental health staff should have access to specialist support in these conditions. |
| **Reducing suicide by opiate overdose** | Clinicians and pharmacists should be aware of the potential risks of opiate and opiate-containing analgesics. Safer prescribing in primary and secondary care remains crucial, particularly for patients with long-term pain, a group at high suicide risk. This should include prescribing only short-term supplies and enquiring about opiate-containing painkillers kept at home. |
| **Alcohol and drug misuse** | A greater focus on alcohol and drug misuse is required as a key component of risk management in mental health care, with specialist substance misuse and mental health services working closely together as reflected in published guidance. |
| **Patient homicides and courts** | Our findings raise concern about patients with severe mental illness being sent to prison rather than hospital following conviction for homicide.<br>Further investigation of the appropriateness of these decisions should now be undertaken by health and justice agencies. |

## 3.1 PROGRAMMES OF WORK FOR HIGHEST REPORTED INCIDENTS

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

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

A group has recently been set up to discuss the policy and the consequences intended and unintended of the policy.

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

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

- **Sign up to safety –** A number of targets have been set around reducing harm from restrictive intervention (originating **incident**). For incidents of restraints the aim is to reduce the frequency (use of) of prone restraint and the duration of prone restraints. Training has been updated and rolled out. The results are positive to date.
- **Safewards-** This work is within the patient safety strategy. A number of units are using the tools available and sharing practice across the Trust.
- **Safety Huddles –**again this sits under the patient safety strategy and some wards have chosen to have their huddles on reducing violence and aggression incidents. Chantry ward has received their silver award from the academy for achieving a stretch target for a number of days without an incident.
- **Significant event analysis (SEA)-** Work has taken place between patient safety support team, management of violence and aggression team and health and safety to pilot use a tool focusing on human factors following an incident of violence and aggression that has resulted in a Riddor reportable incident. The first incidents have been reviewed using this tool. The value of this will be reviewed in three months after introduction through plan, do study act cycle.
- **Staff wellbeing –** a campaign has been launched to ensure the support available to staff is known across the Trust.
- **Trust Action Group** – meets 6 weekly to review V&A across the trust. Robust representation from BDU's and other stakeholders. Amongst objectives includes incident analysis, aims to identify and analyse trends and report on training activity.
- **Training –** MAV team are working with the team who provide Basic Life Support to develop a pilot project aimed at utilising the RAMPPS model to provide staff with scenario and simulation based training looking at managing physical complications during Reducing Restrictive Physical Interventions such as restraint. It is anticipated this will better equip staff to deal with emergency situations.
- **Contemporary Practice –** MAV policy is currently under review and following consultation it is going to be renamed Reducing Restrictive Physical Interventions, Policy, Procedures and Guidance.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

## TRUST WIDE SERIOUS INCIDENT (SI) REPORT FOR QUARTER 2 2017/18 (DATA AS AT 3 OCT 2017)

*The SI figures given in different reports can vary slightly. This report is based on the date the SIs were reported to the CCG via the Department of Health Strategic Executive Information system (StEIS).*

### 1. Never Events

Never Events is a list (Department of Health) of serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

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

| Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|
| 0 | 0 | | |

### 2. Serious Incidents reported to the Commissioners

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

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

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

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

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

**Table 3 Serious Incidents reported by team types and BDU during Q2 2017/18**

| | Barnsley MH&SMS | Barnsley General Community | Calderdale | Kirklees | Wakefield | Total |
|---|---|---|---|---|---|---|
| Early Intervention Service (Insight) - Calderdale | 0 | 0 | 2 | 0 | 0 | **2** |
| Intensive Home Based Treatment Team (IHBTT) - Barnsley | 2 | 0 | 0 | 0 | 0 | **2** |
| Intensive Home Based Treatment Team (Kirklees) | 0 | 0 | 0 | 2 | 0 | **2** |
| Clark Ward - Barnsley | 1 | 0 | 0 | 0 | 0 | **1** |
| CMHT West (OPS), Wakefield | 0 | 0 | 0 | 0 | 1 | **1** |
| Core Team East - Wakefield | 0 | 0 | 0 | 0 | 1 | **1** |
| Early Intervention Service - Barnsley | 1 | 0 | 0 | 0 | 0 | **1** |
| Early Intervention Service (Insight) - Kirklees | 0 | 0 | 0 | 1 | 0 | **1** |
| Enhanced Team East - Wakefield | 0 | 0 | 0 | 0 | 1 | **1** |
| Intensive Home Based Treatment Team (IHBTT) - Wakefield | 0 | 0 | 0 | 0 | 1 | **1** |
| Kendray Enhanced Team, Barnsley | 1 | 0 | 0 | 0 | 0 | **1** |
| Neighbourhood Team - Central (Barnsley) | 0 | 1 | 0 | 0 | 0 | **1** |
| Psychology Services - Kirklees (Adult) | 0 | 0 | 0 | 1 | 0 | **1** |
| Single Point of Access, (Calderdale) | 0 | 0 | 1 | 0 | 0 | **1** |
| Ward 18, Priestley Unit | 0 | 0 | 0 | 1 | 0 | **1** |
| **Total** | **5** | **1** | **3** | **5** | **4** | **18** |

All serious incidents are subject to a manager's review within 48 hours of reporting. This is to enable any themes/trends /issues to be identified early and as close to services as possible.

**Table 4 Serious Incidents reported by incident category and BDU during Q2 2017/18**

| | Barnsley Mental Health | Barnsley General Community | Calderdale | Kirklees | Wakefield | Total |
|---|---|---|---|---|---|---|
| Suicide (incl apparent) - community team care - current episode | 4 | 0 | 1 | 2 | 2 | **9** |
| Suicide (incl apparent) - community team care - discharged | 0 | 0 | 0 | 0 | 2 | **2** |
| Administration/supply of medication from a clinical area | 1 | 0 | 0 | 0 | 0 | **1** |
| Death - cause of death unknown/ unexplained/ awaiting confirmation | 0 | 0 | 0 | 1 | 0 | **1** |
| Fire / Fire alarm related incidents | 0 | 0 | 0 | 1 | 0 | **1** |
| Information disclosed in error | 0 | 0 | 1 | 0 | 0 | **1** |
| Self harm (actual harm) with suicidal intent | 0 | 0 | 0 | 1 | 0 | **1** |
| Physical violence (contact made) against other by patient | 0 | 0 | 1 | 0 | 0 | **1** |
| Pressure Ulcer - grade 3 | 0 | 1 | 0 | 0 | 0 | **1** |
| Total | 5 | 1 | 3 | 5 | 4 | **18** |

The highest category of serious incidents during Quarter 2 (Table 4) related to apparent suicide of current service users in contact with community teams. Table 5 shows the method used.

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

| | Barnsley Mental Health | Calderdale | Kirklees | Wakefield | Total |
|---|---|---|---|---|---|
| Hanging - self injury | 2 | 0 | 2 | 1 | **5** |
| Method unknown - self injury | 1 | 0 | 0 | 1 | **2** |
| Jumping from height | 0 | 1 | 0 | 0 | **1** |
| Prescription medication - self poisoning | 1 | 0 | 0 | 0 | **1** |
| Other - self poisoning | 0 | 0 | 0 | 1 | **1** |
| Over the counter medication - self poisoning | 0 | 0 | | 1 | **1** |
| **Total** | **4** | **1** | **2** | **4** | **11** |

The most common method of suicide is hanging in England (43%), self-poisoning (25% and jumping/multiple injuries (15%). The Trust data for quarter 2 is small in numbers but includes these methods.

## 3. Suspected Suicide reported to the Commissioners

The National Confidential Inquiry (NCI) figures **October 2017** indicate that:

- Based on an average of the suicides recorded in the general population per 100,000 population by STP footprint area of residence (average rate 2013-2015) there are approximately 9.9 (West Yorkshire STP) and 10.0 (South Yorkshire & Bassetlaw) .
- On average during 2005-2015 patient suicides accounted for 27% of the general population suicide figures (13,576 deaths i.e. the individual had been in contact with mental health services in the 12 months prior to death.) This represents an average of 1,234 patient suicides per year, though the number has fallen each year since 2012.

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

**Table 6 BDU populations and average suicide rates**

| District | Population ONS – population estimates Mid 2016 | General population suicide rate (NCI) 9.9(West Yorkshire STP) & 10.0 (South Yorkshire and Bassetlaw) per 100,000 | Patient suicide rate (27% general pop) (NCI) |
|---|---|---|---|
| **Barnsley** | 241,218 | 24 | 6-7 |
| **Calderdale** | 209,770 | 21 | 5-6 |
| **Kirklees** | 437,047 | 43 | 11-12 |
| **Wakefield** | 336,834 | 33 | 9 |
| **Trust wide** | 1,224,869 | 121 | 32-33 |

*ONS – Office of National Statistics mid 2016 population estimate*
*NCI – National Confidential Inquiry into Suicide and Homicide by people with Mental Illness*

**Table 7 Apparent Suicides reported on STEIS between 01/010/16 – 30/09/17 by Quarter and geographical area**

| | Barnsley Mental Health | Calderdale | Kirklees | Wakefield | Forensic Service | Specialist Services | **Total** |
|---|---|---|---|---|---|---|---|
| 16/17 Q3 | 3 | 0 | 2 | 2 | 0 | 0 | **7** |
| 16/17 Q4 | 1 | 0 | 3 | 1 | 1 | 2 | **8** |
| 17/18 Q1 | 0 | 1 | 4 | 2 | 1 | 0 | **8** |
| 17/18 Q2 | 4 | 1 | 2 | 4 | 0 | 0 | **11** |
| **Total** | **8** | **2** | **11** | **9** | **2** | **2** | **34** |

The rolling 4 quarter data (Table 7) (by reported date) shows that the Trust is slightly above the expected number of suicides based on the National Confidential Inquiry figures (Table 6) for a population the size of the Trust and patient suicide rate (27%). This figure (34) includes apparent suicides occurring in specialist services (CAMHS and Forensics). Calderdale is below the expected number for their respective geographical areas, Kirklees and Wakefield have the expected number.

Barnsley is slightly above. The specialist services deaths are not allocated to a BDU. Caution is advised with these comparisons due to the sensitivity of the figures if just one or two more incidents occur, and because the figures are not weighted by characteristics such as age, gender or socio-economic status. The financial quarters are also based upon when it was reported as a Serious Incident, not when it occurred (see Appendix 1 for further information).

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

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

## Performance Management of Serious incidents

- **12** SI Investigation Reports have been completed this quarter and sent to the Commissioners
- **21** SI reports have been closed by the Commissioners during the quarter
- There are currently **29** open SI investigations taking place across the Trust (as at 03/10/17) see Table 8 and further breakdown in Table 9.

**Table 8 Current position on open SI investigations as at 03/10/17**

| | **Barnsley Mental Health** | **Calderdale** | **Kirklees** | **Wakefield** | **Forensic Service** | **Specialist Services** | Total |
|---|---|---|---|---|---|---|---|
| IG investigation - panel being established | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| Lead Investigator being allocated | 1 | 2 | 2 | 2 | 0 | 0 | 7 |
| Investigation panel being established | 2 | 0 | 2 | 0 | 0 | 0 | 4 |
| Investigation within 60 working days and on track | 1 | 0 | 1 | 0 | 0 | 0 | 2 |
| Investigation within 60 working days but off track | 1 | 0 | 0 | 1 | 1 | 0 | 3 |
| Investigation report over 60 working days but extension agreed | 1 | 2 | 4 | 1 | 0 | 0 | 8* |
| Investigation report over 60 working days, no extension agreed | 0 | 0 | 2 | 0 | 0 | 1 | 3* |
| Investigation report over 60 working days, no extension agreed and further info/clarification requested by director | 0 | 0 | 0 | 0 | 1 | 0 | 1* |
| **Total** | **6** | **5** | **11** | **4** | **2** | **1** | **29** |

In Table 8, some of the SIs are marked with an asterisk. This is where investigations are ongoing but the investigation has passed the standard 60 working day timeframe. Further breakdown of these is shown in Table 9. Of these 12, one SI investigation was put on hold due to an ongoing police investigation. Another incident had been completed but further information was requested by directors in the approval process.

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

| | Barnsley MH | Calderdale | Kirklees | Forensic Service | Specialist Services | Total |
|---|---|---|---|---|---|---|
| 91-180 days since reported on STEIS | 1 | 2 | 4 | 1 | 0 | **8** |
| 181-270 days since reported on STEIS | 0 | 0 | 2 | 0 | 1 | **3** |
| 270-360 days since reported on STEIS | 0 | 0 | 0 | 1 | 0 | **1** |
| Total | **1** | **2** | **6** | **2** | **1** | **12** |

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

In summary, 17 are within timescales at differing stages and twelve are overdue.

As shown in Table 9, there are 12 reports that are more than 60 working days since the incident was reported on STEIS. The investigations are expected to be delivered within the next month. The reasons for delays varying but relate to issues such as complexity, staff availability to conduct interviews and investigation allocation delays due to capacity. Some of the investigations have involved a number of organisations and this further adds to the complexity.

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

## 4. SI Action Plans

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

## 5. Updates on other SIs

**Independent Reviews** (DOH guidance HSG (94)27)

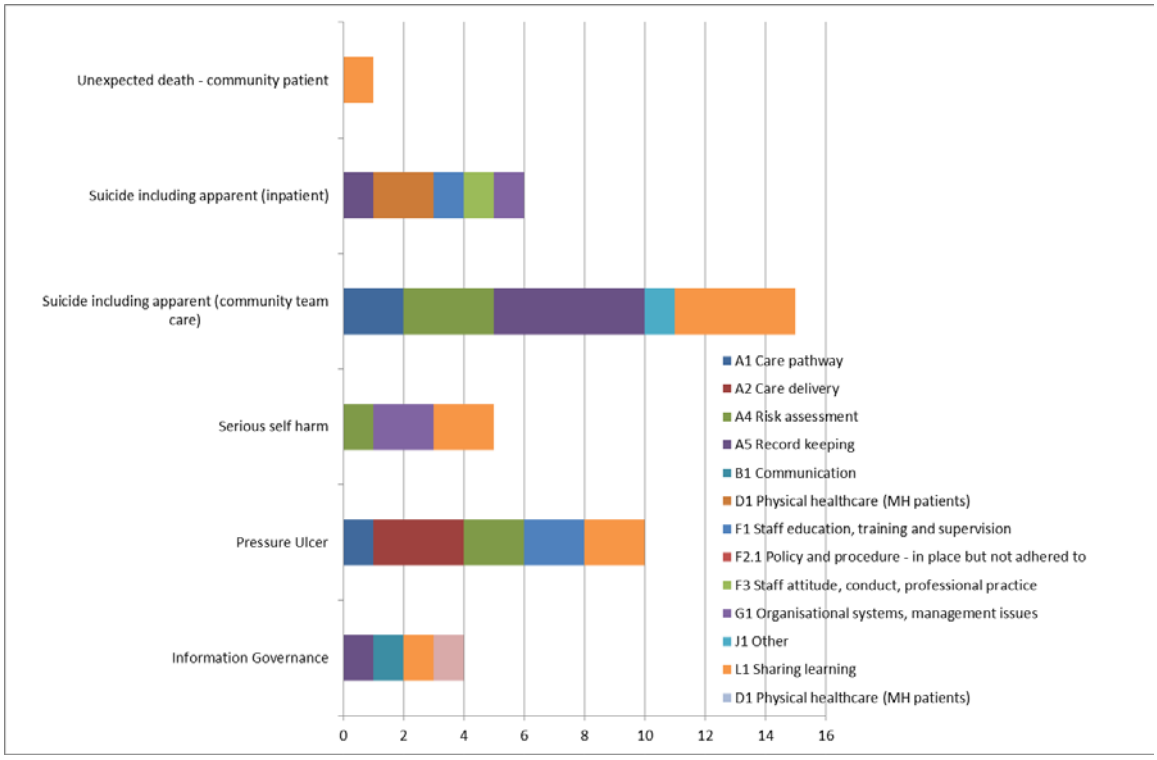
The independent review process has been completed in relation to the Kirklees cases listed below. The review was level C which is mainly desktop with some interviews. The investigation reports were published in January 2015. NHS England also requested the investigations covered the learning outcomes from 3 previous Kirklees homicides that took place in 2007/8. There are two reports **2010/9926 & 2011/11502** still open to the Local Area Team  The commissioners have agreed to close the action plan, and it has been sent to the Local Area Team requesting closure.

## 6. Serious Incident themes

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

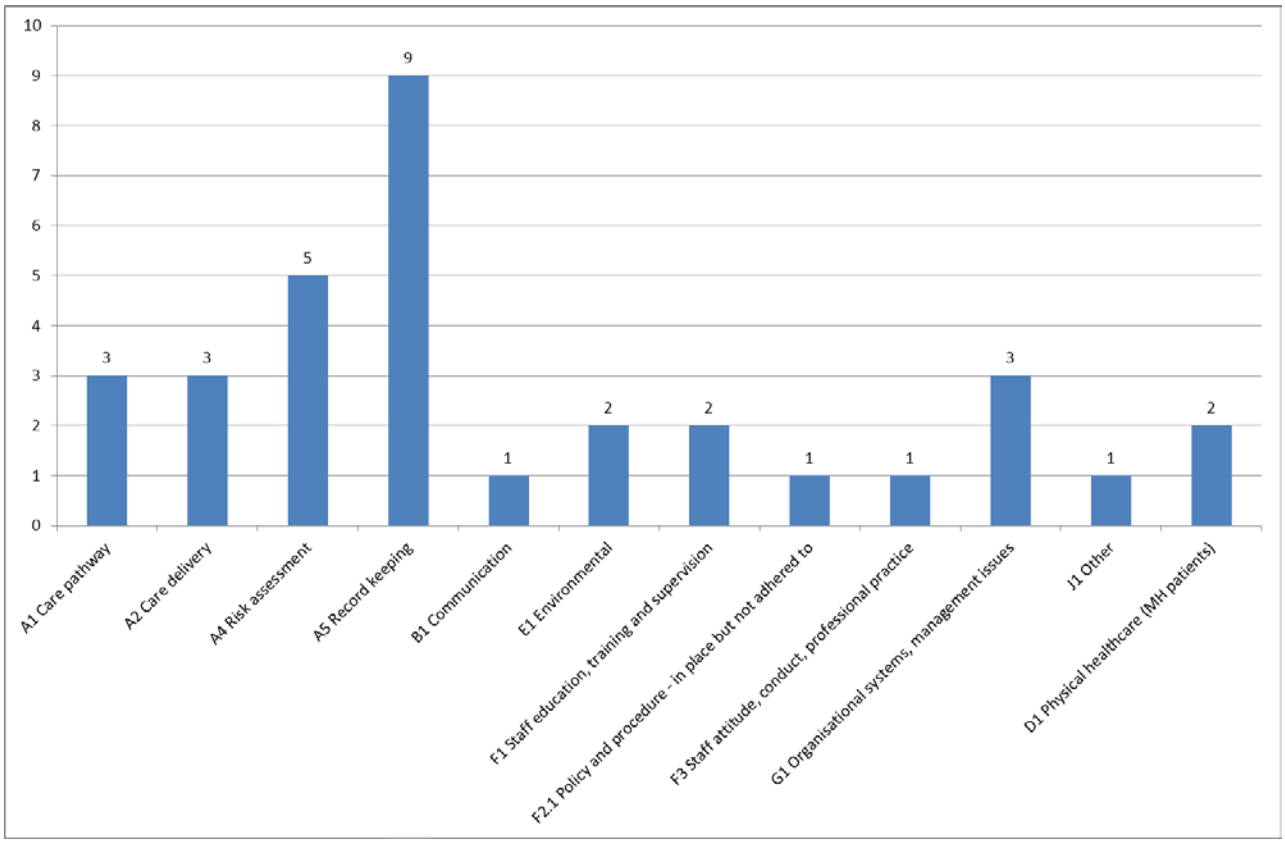
During Quarter 2, the number of investigations completed and sent to the commissioners was 14, which is an increase on the previous quarter (8). Twelve of these SI investigations had an action plan. There were 43 separate recommendations made to improve the system or process to prevent recurrence.

**Graph 1 Quarter 2 2017/18 Completed SI Investigation reports – Recommendations by theme and serious incident type**




Suicide including apparent (community team care) incidents had the largest number of recommendations, which correlates with the number of investigations sent to the commissioners in the quarter (4).  The top themes this quarter are – record keeping and risk assessment and Care pathway, care delivery and organisation system and management issues all coming at 3rd for top 3 themes

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




Many actions take some time to implement. These are monitored through the operational managers group and BDU governance groups.

Sharing learning is an action the patient safety support team have added to action plans; eleven action plans included this as a specific action. This is to support learning being shared across the teams, service, BDU, Trust and wider health economy.

Within this quarter:-

- A number of individual teams have taken time to share and discuss the learning from particular incidents
- The incidents were shared in the team, service line and BDU
- The trust wide alert system on Datix has been used to share newly identified safety issues quickly.
- There were a number of actions linked to the need to improve clinical records, these included clarity re paper light system as records were not available, codes on observations sheet were not clear. The need to ensure care plans, crisis and contingency plans were up to date. The need to record next of kin details
- A numbers of actions liked to risk assessments around the completion –this is an issue for a particular professional group, accurate recording. Plans were put in place to audit this within the team involved.
- A recurring theme is staff not meeting requirements of clinical policies.
- One unit has hosted a emergency response exercise as a method of learning.

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

**Patient Safety Support Team**

**Updated 30/10/17**

**Appendix 1**

**Serious incident definition and reporting information**

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

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

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

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

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

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

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

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

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

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 19 December 2017
# Agenda item 6.1

| | |
|---|---|
| **Title:** | **Single Oversight Framework** |
| **Paper prepared by:** | Director of Finance and Resources |
| **Purpose:** | To provide the Board with details of recently announced changes to the Single Oversight Framework and where they are applicable to the Trust. |
| **Mission/values/objectives** | All Trust objectives |
| **Any background papers/ previously considered by:** | ➢ Integrated Performance Report (IPR) is reviewed at the Trust Board each month<br>➢ Single Oversight Framework details were provided to the Trust Board in 2016 ahead of its introduction |
| **Executive summary:** | NHS Improvement's Single Oversight Framework (SOF) was introduced for provider trusts from October 2016. A recent consultation exercise has resulted in a number of changes to the SOF. The vast majority of the SOF remains the same as current. The attached NHS Providers report includes greater detail on the changes.<br>The most notable changes that apply to the Trust are as follows:<br>➢ Within Use of Resources the Finance and use of resources score" is re-labelled as "finance score"<br>➢ A new metric is being introduced in relation to out of area bed placements. It will be focused on the reduction of inappropriate adult mental health out-of-area placements as standard for mental health providers. This is a new national priority to eliminate inappropriate out-of-area placements by 2021.<br>➢ With regard to Data Quality Maturity Index (DQMI) – the Mental Health Services Data Set (MHSDS) data score replaces previous standards for submitting priority and identifier metrics to MHSDS. This is driven by the fact the original measure of complete and valid metrics in the monthly MHSDS submissions are not supported by NHS Digital.<br>➢ Changes to triggers of potential support needs regarding quality of care. A CQC rating of inadequate or requires improvement in the overall rating or against any of the safe, effective, caring or responsive key questions could trigger the need for support<br>➢ The metric for Patients requiring acute care who received a gatekeeping assessment as standard for mental health providers has been removed.<br>➢ The most notable change to the Trust is the introduction of the metric in relation to out of area bed placements and will be reported to Trust Board through the Integrated Performance Report (IPR). |

| | |
|---|---|
| **Recommendation:** | **Trust Board is asked to NOTE the forthcoming changes to the Single Oversight Framework which will be reported on via the Integrated Performance Report (IPR).** |
| **Private session:** | Not applicable |

13 November 2017

on the day BRIEFING

NHS Providers

# NHS IMPROVEMENT SINGLE OVERSIGHT FRAMEWORK UPDATE RESPONSE – ON THE DAY BRIEFING

Today NHS Improvement (NHSI) has published the updated Single Oversight Framework (SOF) and its response to a recent feedback exercise on updates to the SOF. NHS Providers submitted a response to the exercise, which was informed by feedback from members and can be found on our website. This briefing summarises the specific metric changes under each SOF theme, followed by a summary of the feedback from respondents and NHSI's response, where this has been provided.

If you have any questions about this briefing or our work on regulation more generally please contact Ella Jackson, policy advisor (regulation), Ella.Jackson@nhsproviders.org

## SUMMARY OF CHANGES TO THE SINGLE OVERSIGHT FRAMEWORK

The first version of the single oversight framework (SOF) was published in September 2016. In light of recent developments and to reflect learning from the framework's first year of operation, NHSI conducted this feedback exercise on making some changes to the SOF, including:

- Changes to improve the structure and presentation of the document, updating the introductory sections and summarising key information more succinctly
- Introducing a separate section outlining the five key themes of the SOF and summarising under each theme what would trigger consideration of a support need
- Changes to some of the metrics that NHSI uses to assess providers' performance under the SOF themes and the indications that trigger consideration of a potential support need (including removing some metrics and adding new ones). Of note is the addition of a new standard on the reduction of inappropriate adult mental health out-of-area placements as standard for mental health providers
- Making clear under all themes that in addition to specific triggers, other material concerns arising from intelligence gathered by or provided to NHSI could trigger consideration of a support need
- Making explicit that providers are expected to notify NHSI of significant actual or prospective changes in performance or risk outside routine monitoring.

NHSI did not propose any changes to the underlying framework itself – i.e. there will be no changes to the five themes, NHSI's approach to monitoring, how support needs are identified, and how providers are segmented.

During NHSI's feedback exercise we welcomed the changes to improve the structure, format and presentation of the SOF document which is now clearer and easier to read. However we have highlighted

the need for further clarity and detail around NHSI's support offer and the decision-making process around segmentation. We also highlighted concerns around some of the additional metrics being proposed, particularly around the mental health out of area placements. Although we support the ambition to reduce inappropriate adult mental health out of area placements, which is in line with the policy priorities of the Five year forward view for mental health, this new metric is likely to be a cause for concern and contention for providers that are not yet part of a new mental health care model which gives them control over the commissioning budget.

Overall we are pleased to see that NHSI is delivering on its commitment to review the SOF, but would encourage NHSI to establish a regular review of the SOF and to evaluate its impact, in the same way that Monitor undertook a yearly consultation on its risk assessment framework. We also note more broadly that it continues to be difficult to separate the framework from the wider policy context, continued financial pressure and the reality of greater grip and control from the centre. In addition to this, given the current direction of travel of Sustainability and Transformation Partnerships (STPs) and Accountable Care Systems (ACSs), NHSI will need to continue to work closely with providers and other national bodies to ensure the new framework develops alongside STPs and ACSs, as well as the development of new models of care, and the emerging organisational structures needed to support these new approaches.

## CHANGES BY THEME

Please find below an overview of the metric changes under each SOF theme.

| Quality of care | | |
|---|---|---|
| *Added* | *Removed* | *Amended* |
| E.coli bacteraemia bloodstream infection (BSI) rates to quality indicators | Aggressive cost reduction plans metric from list of quality indicators | |
| Medticillin-sensitive Staphylococcus aureus (MSSA) rates to quality indicators | Hospital standardised mortality ratio-weekend (DFI) from list of quality indicators for acute providers | |
| | Emergency readmission rates from list of quality indicators for acute providers | |
| | | Change to triggers of potential support needs regarding quality of care: CQC rating of 'inadequate' or 'requires improvement' in overall rating, or against any of the safe, effective, caring or responsive key questions. |
| **Finance and use of resources** | | |
| *Added* | *Removed* | *Amended* |
| Reference to the new Use of Resources (UoR) framework, with | | |

| | | |
|---|---|---|
| explanation of how UoR assessments will be used under the SOF | | |
| 'Finance and use of resources score' is re-labelled as 'finance score' | | |
| Operational performance | | |
| *Added* | *Removed* | *Amended* |
| Dementia assessment and referral standards for acute providers | Patients requiring acute care who received a gatekeeping assessment as standard for mental health providers | Where relevant, NHSI will use performance against the national standard rather than the Sustainability and Transformation Fund (STF) trajectories as the trigger of potential support needs in relation to operational performance standards |
| Reduction of inappropriate adult mental health out-of-area placements as standard for mental health providers | | Ambulance response time standards (updated to reflect the new standards, indicators and measures that have been introduced for ambulance providers through the Ambulance Response Programme) |
| Data Quality Maturity Index (DQMI) – Mental Health Services Data Set (MHSDS) Data score replaces previous standards for submitting 'priority' and 'identifier' metrics to MHSDS | | |
| Strategic change | | |
| *Added* | *Removed* | *Amended* |
| NHSI will review the assessment of system-wide leadership in relevant sustainability and transformation partnership (STP) ratings when considering providers' performance under this theme. | | |
| Leadership and improvement capability | | |
| *Added* | *Removed* | *Amended* |
| Reference to NHS Improvement and CQC's new, fully joint well-led framework and guidance on developmental reviews | | |

# SUMMARY OF FEEDBACK AND NHSI RESPONSE

## Quality of care

**Feedback:** Concerns were raised in response to the original proposal to move to using only the overall CQC rating as the main trigger to consider potential support needs under the quality of care theme. We recognised the rationale behind the proposed change to the CQC rating trigger under the quality of care theme from an 'inadequate' or 'requires improvement' rating against any of the safe, effective, caring or responsive key questions to a rating of 'inadequate' or 'requires improvement' in an overall rating. However, we urged NHSI to ensure there is a clear understanding of what sits underneath the overall rating so that support is tailored appropriately to individual providers

**NHSI response:** The SOF has reverted to listing ratings of 'inadequate' or 'requires improvement' in both the overall CQC rating and those for the individual themes acting as triggers to consider a potential support need under the quality of care theme.

## Finances and use of resources

**Feedback:** Respondents to the feedback exercise felt NHSI's proposals clearly explained how the new UoR assessments will inform SOF monitoring and its assessment of providers' support needs under the finance and use of resources theme. We welcomed the re-labelling of the previous 'finance and use of resources score' as 'finance score' to reduce potential for confusion with the Use of resources assessment ratings. Requests for clarity on the UoR assessment process were made by respondents and some also suggested that the UoR key lines of enquiry (KLOE) would require further development for mental health services. We believe that NHSI should have revisited how UoR aligns with the financial special measures regime.

**NHSI response:** NHSI and CQC have now published the UoR assessment framework, summary of responses to the consultation on the assessment framework, and a brief guide for acute non-specialist trusts on UoR assessments. Currently, the availability and quality of productivity metrics for non-acute trusts are not sufficient to support a robust UoR assessment. NHSI is undertaking a programme of work to understand the productivity of community, mental health and ambulance trusts. The emerging metrics and benchmarking in these areas will be available to providers via the Model Hospital portal, in due course.

## Operational performance

**Feedback:** We raised concerns that including both the STF trajectories and absolute performance as triggers around A&E performance was confusing. Respondents also suggested that reporting against STF trajectories should apply to other relevant operational performance indicators, in addition to A&E. There was a request for clarity on when formal monitoring of performance under the new ambulance response targets will start, and around how delayed transfers of care (DToCs) will be measured.

Some respondents noted that only a few metrics apply to community trusts and that the SOF could better reflect the requirements on mental health, community and ambulance sectors. Specific concerns were raised about the indicators and standards use to measure the performance of mental health providers,

including data quality; the requirement for local interpretation within the national definition; urban/rural population differences; the extent to which reducing out-of-area placements is within the control of providers, and how locally agreed trajectories for this metric will be agreed.

NHSI response: Consideration of support needs should be based on absolute performance. Failure to meet any of the absolute national standards - including A&E waiting times - for more than two months will trigger consideration of a provider's support needs. Where providers have an agreed trajectory for improvement toward any national standard, progress against this will be taken into account when determining whether they have an actual underlying support need. However, as all providers are expected to meet national standards, it is appropriate to consider what support may be required if performance consistently falls below this level.

There will be a transition period until April 2018 to allow all providers to implement the new ambulance response targets requirements. During this period providers will be expected to demonstrate progress towards full implementation of the new standards, following an agreed plan and trajectory. From April 2018, failure to meet the standards will trigger consideration of a provider's support needs in this area. NHSI will consider introducing DToCs as an indicator or standard in future updates of the SOF.

The out-of-area indicator is already a key indicator for clinical commissioning groups (CCGs) and addressing this issue requires a joined-up approach. The Department of Health has published guidance on what counts as an adult acute out-of-area placement. STP mental health leads, supported by NHS England and NHSI regional teams, are developing STP and provider-level baselines and trajectories for eliminating out-of-area placements.

## Strategic change

While NHSI is developing its work on the governance and oversight of STPs and accountable care systems, we believe further work is necessary to clarify how NHSI intends to measure the contribution of individual providers to local systems as currently the strategic change theme is underdeveloped.

## Use of information beyond routine monitoring

Feedback: Respondents made requests for clarity on what may be considered 'other material concerns' arising from intelligence gathered by or made available to NHSI. Clarity was also sought on when providers are expected to notify NHSI of significant actual or prospective changes in performance or risk outside routine monitoring. We also urged NHSI to adopt a formal consultation approach where any changes to the SOF are proposed, in a similar way to Monitor's approach when it proposed changes to its risk assessment framework.

NHSI response: It is not possible to specify what would suggest new, material concerns in each case, as such information would be considered in the context of NHSI's wider knowledge of the provider and its circumstances. However any such information should be discussed openly with the provider to determine its relevance and significance. Examples of the types of circumstances where NHSI would expect providers to notify it of significant actual or prospective changes in performance or risk outside routine monitoring have been provided in the updated SOF.


Contact: Ella Jackson, Policy Advisor (Regulation) ella.jackson@nhsproviders.org

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 19 December 2017
# Agenda item 6.2

| | |
|---|---|
| **Title:** | **NHS Constitution** |
| **Paper prepared by:** | Company Secretary |
| **Purpose:** | To provide assurance to Trust Board that the Trust meets the rights and pledges set out in the NHS Constitution in relation to patients and staff, and that it is mindful of the commitments in the NHS Constitution in delivering, planning and developing its services. |
| **Mission/values:** | Meeting the rights and pledges in the NHS Constitution supports the Trust to adhere to its mission and values. |
| **Any background papers/ previously considered by:** | NHS Constitution January 2009 and papers to Trust Board in March 2010, September 2011, September 2012, June 2013, September 2014, September 2015 and December 2016. A full copy of the NHS Constitution can be found on the Department of Health website at:<br>https://www.gov.uk/government/publications/the-nhs-constitution-for-england.<br>The attached assurance document was reviewed and updated as appropriate by the Executive Management Team. |
| **Executive summary:** | The NHS Constitution was published in January 2009, following an extensive public consultation during 2008. It established the principles and values for the NHS in England and set out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieving, together with responsibilities which the public, patients and staff owe to one another to ensure the NHS operates fairly and effectively. All NHS bodies and private and third sector providers supplying NHS services are required, by law, to take account of the NHS Constitution in their decisions and actions. The NHS Constitution also applies to public health services, which are now the responsibility of local authorities.<br>The Government has committed to renewing the NHS Constitution every ten years with the full involvement of patients who use the NHS, the public who fund it and the staff who work in it. The first review took place in early 2012 and a further review was undertaken following the publication of the second Francis Report, which was published in March 2013.<br>In July 2015, the Constitution was updated to reflect a limited package of changes. These included:<br>➢ reflecting recommendations made by Sir Robert Francis QC in his Inquiry Report on Mid- Staffordshire NHS Foundation Trust;<br>➢ incorporating a series of fundamental standards, below which |

| | |
|---|---|
| | standards of care should never fall;<br>➢ highlighting the importance of transparency and accountability within the NHS;<br>➢ giving greater prominence to mental health, through reflecting a parity of esteem between mental and physical health problems; and<br>➢ making reference to the Armed Forces Covenant.<br>The Trust meets the rights and pledges of the NHS Constitution. There are elements of the Constitution that refer to consultation and involvement with service users. The Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care; however, there will be occasions when the nature of an individual's illness makes this inappropriate.<br><br>**Risk appetite**<br>The delivery of the NHS Constitution rights and pledges supports the Trust's endeavours to provide high quality and equitable services, improving the Trust's reputation in line with the Trust's Risk Appetite Statement. |
| **Recommendation:** | **Trust Board is asked to APPROVE the paper, which demonstrates how the Trust is meeting the requirements of the Constitution.** |
| **Private session:** | Not applicable. |

South West Yorkshire Partnership NHS Foundation Trust

# The NHS Constitution – patients and the public
## How the Trust meets its obligations
## Trust Board 19 December 2017

| Heading | Compliance | Evidence | Lead |
|---|---|---|---|
| **Access to health services – rights** | | | |
| ➢ R1 You have the right to receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament. | Yes | Core services are commissioned by clinical commissioning groups covering the areas the Trust covers in Barnsley, Calderdale, Kirklees and Wakefield local authority areas, and NHS England (via the Specialist Commissioning Team). Annual contracts and service specifications are evidenced through annual contract negotiations. | Director of finance and resources |
| ➢ R2 You have the right to access NHS services. You will not be refused access on unreasonable grounds. | Yes | The Trust has contracts in place for its services with commissioners and endeavours to provide access to services within its available resources. The Trust's complaints and contracting processes would identify any instances where the Trust has not met or is perceived not to have met this right. | Director of finance and resources |
| ➢ R3 You have the right to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences. | Yes | The Trust has contracts in place for its services with commissioners and endeavours to provide access to services within its available resources. The Trust's complaints and contracting processes would identify any instances where the Trust has not met or is perceived not to have met this right. | Director of finance and resources |
| ➢ R4 You have the right to expect your local NHS to assess the health requirements of your community and to commission and put in place the services to meet those needs as considered necessary and, in the case of public health services commissioned by local authorities, to take steps to improve the health of the local community. | Yes | The Trust does assess the health needs of the local community in the development of its operational and strategic plans and, as part of the development of its transformation programme, is working with commissioners, stakeholders, service users and carers, and local people to transform its services and develop new models and pathways of care that meet people's needs. The Trust has also embarked on a major health intelligence project, which will include further assessment of local health needs in relation to modelling future service provision. The Trust is a member of the local Health and Wellbeing Boards who have a statutory duty to do this. | Director of Strategy |
| ➢ R5 You have the right, in certain circumstances, to go to other European Economic Area countries or Switzerland | N/A | | |

| Heading | Compliance | Evidence | Lead |
|---|---|---|---|
| for treatment which would be available to you through your NHS commissioner. | | | |
| ➢ R6 You have the right not to be unlawfully discriminated against in the provision of NHS services including on the grounds of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. | Yes | The Trust complies with appropriate legislation relating to discrimination and has an Equality First Strategy in place with the prime aims of respecting and valuing difference and promoting a fairer organisation.<br>The Trust has committed to implementing the NHS Workforce Race Equality Standards (WRES) in accordance with the NHS Standard Contract.<br>The Trust Board established an Equality and Inclusion Forum, which identified four priorities for 2017/2018, including supporting staff and supporting service users into employment.<br>The Trust established a Black, Asian, and minority ethnic (BAME) staff network in 2017/2018 and is also establishing a staff disability network.<br>The Trust uses an Equality Impact Assessment to evaluate the effect of its strategies and policies on its service users and the communities it serves and publishes these on its website.<br>The Trust is implementing the Equality Delivery System 2 (EDS2) and Trust Board has recently agreed for each of the four EDS2 goals to focus on one key outcome in each area as assessed by service users and staff. | Director of nursing and quality |
| ➢ R7 You have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution. | Yes | The Trust does provides some services subject to waiting times as outlined in the Handbook to the NHS Constitution which are reported monthly to the Trust Board under the national metrics in the Integrated Performance Report:<br>➢ patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral;<br>➢ a maximum 7 day wait for follow-up after discharge from psychiatric in-patient care for people under adult mental illness specialties on Care Programme Approach.<br>➢ a new right for patients to start consultant-led non-emergency treatment within a maximum of 18 weeks of a GP referral and for the NHS to take all reasonable steps to offer a range of alternatives if this is not possible | |
| **Access to health services – pledges** | | | |
| ➢ P1 The NHS commits to provide convenient, easy access to services within the waiting times set out in the Handbook to the Constitution. | Yes<br>? | As part of its contracts with commissioners, the Trust is required to report on local waiting times in relation to improving access to psychological therapies (IAPT) and psychological therapies, referral and treatment times in relation to the Barnsley BDU musculoskeletal service. The Trust meets the required timescale. The Trust is meeting national targets for access to IAPT and when there is an issue in terms of meeting any local targets action plans are | Director of Finance & Resources/ Director of Nursing & Quality |

| Heading | Compliance | Evidence | Lead |
|---|---|---|---|
| | | put in place to address<br>Access is one of the Trust's quality priorities set out in its Quality Accounts and performance is monitored and reported on a quarterly basis.<br>The Trust has local Commissioning for Quality and Innovation (CQUIN) targets in relation to waiting times for mental health services, which are monitored and reported on a monthly basis. | |
| ➢ P2 The NHS commits to make decisions in a clear and transparent way so that patients and the public can understand how services are planned and delivered. | Yes | The Board meets in public and papers and minutes for public Trust Board meetings are published on the Trust's website.<br>The Trust holds an annual members' meeting and regular public events throughout the year.<br>The Trust has a Members' Council in place comprising elected public and staff governors and stakeholder representatives. Meetings are held in public and papers and minutes are published on the Trust's website.<br>The Trust's Communication, Engagement and Involvement Strategy outlines its approach to involvement and engagement. Service users and carers are involved in planning and designing Trust services, including the transformational service change programme.<br>The Trust's services have individual service user groups.<br>A description of the Trust's service offer is available on its website. | Director of finance and resources / Company secretary |
| ➢ P3 The NHS commits to make the transition as smooth as possible when you are referred between services, and to put you, your family and carers at the centre of decisions that affect you or them. | Yes | The Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care; however, there will be occasions when the nature of an individual's illness may make this inappropriate.<br>Care planning is a priority area for the Trust 2017/2018.<br>The Trust has improved systems and processes to ensure that all service users have a care plan in place and that they know who is responsible for their care. The Care Programme Approach (CPA) and standard care standards demonstrate the Trust's commitment to put service users at the centre of care planning.<br>Service user and their carers' perceptions of the Trust are regularly reviewed through national and local surveys.<br>The Trust is committed to system wide improvement of services and interagency protocols through the Sustainability and Transformation Plans (STPs) and local partnership arrangements. | District Directors / Director of nursing and quality |
| **Quality of care and environment – rights** | | | |
| ➢ R8 You have the right to be treated with a professional standard of care, by | Yes | The Trust has in place strong and robust processes for the employment, appraisal and re-validation of medical staff. | Director of nursing and |

| Heading | Compliance | Evidence | Lead |
|---|---|---|---|
| appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality. | | The Trust ensures all appropriate staff are registered with the Health and Care Professions Council (HCPC).<br>The Trust endeavours to use bank staff where appropriate. In circumstances, where it has to use agency staff, these are from approved suppliers to ensure the quality, skills and experience of staffing is maintained.<br>The Trust has an e-rostering system for all inpatient areas with agreed establishment levels for qualified and unregistered staff.<br>The Trust is registered with no conditions with the Care Quality Commission.<br>The Trust is licensed by Monitor with no conditions and continues to comply with licencing requirements.<br>The Trust is compliant with relevant National Institute for Health and Care Excellence (NICE) guidelines.<br>The Trust has a robust system in place to undertake appropriate employment checks for all its staff.<br>The Trust has an ongoing Continuous Professional Development approach.<br>A Human Resources and Workforce Development Strategy, including mandatory training plan, is in place.<br>The Trust's Patient Safety Strategy brings all aspects of patient safety together in one document.<br>The Trust has an unannounced visits programme in place supported by the 15-Steps Challenge programme involving staff, service user and carer volunteers.<br>Safe staffing reports is included within the monthly Integrated Performance Report. | quality / Director HR, OD and estates / Medical director |
| ➢ R9 You have the right to be cared for in a clean, safe, secure and suitable environment. | Yes | The Trust has an Estates Strategy to support and meet the needs of services. Development of the Estates Strategy included a detailed six-facet survey of Trust estate. The Trust is compliant with Fire and OHS legislation.<br>In light of the Grenfell fire, a review was undertaken of all inpatient areas and these were shown to be fully compliant.<br>The latest round of Patient-led assessments of the care environment (PLACE) visits of the Trust continue to result in a positive outcome.<br>Infection prevention and control advisers and specialist advisers in place with regular programme of audits in place. | Director HR, OD and estates / District Directors |
| ➢ R10 You have the right to receive suitable and nutritious food and | Yes | The Trust's approach is based on the key areas included in the Department of Health Food Standards in relation to nutritional care, healthier eating for | Director HR, OD and |

| Heading | Compliance | Evidence | Lead |
|---|---|---|---|
| hydration to sustain good health and wellbeing. | | the whole hospital community and sustainable procurement of food and catering services. In all areas, the Trust works with its dieticians to create a balanced nutritional and healthy menu to cover the Trust's diverse patient base and also cooks to request for special diets. Work is continuing with procurement to raise awareness of the standards and the role the Trust plays with suppliers. Nursing and medical staff are also aware of their role within the process. These processes are capture within the Trusts Food Policy which was updated to include the latest guidelines including new guidance on allergens. | estates |
| ➢ R11 You have the right to expect NHS bodies to monitor, and make efforts to improve continuously, the quality of the healthcare they commission or provide. This includes improvements to the safety, effectiveness and experience of services. | Yes | The Trust publishes an annual Quality Account describing performance against key quality priorities and plan for imrprovement<br>The Trust's performance management processes includes summary statistics on service activity data to enable comparisons of Trust outcomes with the 'what good looks like' and health needs assessment intelligence to support local decision-making to ensure continuous improvement.<br>The Trust Board and its Committees receive performance and other reports. Trust Board reports are publicly available on the Trust's website.<br>The Trust has a transformational service change programme in place with an ongoing programme of engagement and involvement. Dedicated website pages supported by two-year operational and three-year strategic plans to our regulator.<br>Trust's own programme of visits to all in-patient locations and a range of community teams registered with the Care Quality Commission where compliance with essential standards is reviewed. Supported by 15 Steps Challenge.<br>The Trust continues to work towards the delivery of the action plan agreed with the Care Quality Commission following unannounced visits and has processes in place to learn from the outcome of previous visits to the Trust.<br>The Trust has a programme of PLACE visits undertaken annually, which continue to achieve positive results. | Director of finance and resources / Director of nursing and quality |
| **Quality of care and environment – pledges** | | | |
| ➢ P4 The NHS commits to identify and share best practice in quality of care and treatments. | Yes | The Trust has a leadership and clinical management structure, including Practice Governance Coaches whose role is to ensure best practice is being followed and effective clinical governance is maintained and developed.<br>The Trust has quality improvement and patient safety strategies with implementation plans in place and formal systems in place to share good | Executive Management Team |

| Heading | Compliance | Evidence | Lead |
|---|---|---|---|
| | | practice through the Quality Improvement Group.<br>Accreditation for Trust services, such as ECT, memory services in Barnsley, Calderdale and Wakefield, and secure services peer review undertaken annually.<br>Francis values into action group reviewed actions arising out of the Francis Report at Director-level.<br>Living our values and values into excellence introduced in 2014 for staff.<br>Trust unannounced visits programme in place.<br>Clinical network for forensic services with providers as part of Allied Health Services Network members and the West Yorkshire Sustainability and Transformation Plan (STP).<br>Annual staff Excellence Awards which celebrate the difference that our staff and teams make to the lives of local people.<br>(also see R11) | |
| **Nationally approved treatments, drugs and programmes – rights** | | | |
| ➢ R12 You have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if you doctor says they are clinically appropriate for you. | Yes | The Trust is compliant with relevant NICE guidelines.<br>The Trust has a policy and procedures in place with timelines to implement NICE guidance.<br>The Trust has a robust procedure in place for the approval and oversight of medical treatments within the Drug and Therapeutic Subcommittee. | Director of nursing and quality / Medical director |
| ➢ R13 You have the right to expect local decisions on funding of other drugs and treatments to be made rationally following proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain the decision to you. | N/A | | |
| ➢ R14 You have the right to receive vaccinations that the Joint Committee on Vaccinations and Immunisation recommends that you should receive under an NHS-provided national immunisation programme. | N/A | The Trust is commissioned by NHS England to provide school age children (5-19) vaccination and immunisation programme including flu.<br>A comprehensive service for immunisation and vaccination to the 0-19 population of Barnsley is delivered by BMBC Public Health following re-commissioning arrangements October 2016. The Trust, in partnership, upholds the principles, values pledges and responsibilities as a significant partner in providing sign-posting arrangements and every contact counts capability in demonstrating partnership working. Pharmacy support continues to be provided by the Trust. | District Director |

| Heading | Compliance | Evidence | Lead |
|---|---|---|---|
| **Nationally approved treatments, drugs and programmes – pledges** | | | |
| ➢ P5 The NHS commits to provide screening programmes as recommended by the UK National Screening Committee. | N/A | Where appropriate, all national screening programmes are in place and managed through the Screening Advisory Committee for South Yorkshire in respect of screening services provided by Barnsley BDU. | District Director |
| **Respect, consent and confidentiality – rights** | | | |
| ➢ R15 You have the right to be treated with dignity and respect, in accordance with your human rights. | Yes | Staff work to professional codes of conduct, Trust policies and CPA standards.<br>The Trust's Equality and Diversity Policy sets out how the Trust accords to an individual's human rights.<br>Living our values and values into excellence were introduced in 2014 for staff.<br>The Trust has values based recruitment and induction programme.<br>The Trust has a strong pastoral care function to support service users and their carers, and staff.<br>The Trust has a contractual duty of candour and has arrangements in place to ensure it meets the extended legal duties of candour introduced by the Care Quality Commission. Regular reporting has been established at BDU, Executive Management Team and Board level. | District Directors / Medical director / Director of nursing and quality |
| ➢ R16 You have the right to be protected from abuse and neglect, and care and treatment that is degrading. | Yes | The Trust has a robust policy and arrangements in place through its approaches to safeguarding vulnerable adults and children and is an active member of local safeguarding boards at director-level. | Director of nursing and quality / District Directors |
| ➢ R17 You have the right to accept or refuse treatment that is offered to you, and not be given any physical examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf, or the treatment must be in your best interests. (NB different rules apply for patients detained in hospital or on supervised community treatment under the Mental | Yes | The Trust has a Consent Policy in place.<br>The Trust has clear policies, procedures and guidance in place for the administration of the Mental Health Act (MHA), Mental Capacity Act (MCA) and for Deprivation of Liberty Standards.<br>The Trust works in partnership with advocacy services provided by local authorities to provide support for service users and carers.<br>The Trust's complaints processes would identify any instances where the Trust has not met or is perceived not to have met this right.<br>The Trust introduced an updated training plan for MHA / MCA compliance and is meeting revised targets. | Medical director / Director of nursing and quality |

| Heading | Compliance | Evidence | Lead |
|---|---|---|---|
| Health Act 1983.) | | | |
| ➢ R18 You have the right to be given information about the test and treatment options available to you, what they involve and their risks and benefits. | Yes | The Trust has medicine information leaflets including translation into other languages if required and utilises information available from NHS Choices.<br>Service user information leaflets, which set out service user rights.<br>Service users are given copies of their care plans.<br>Service users and carers are part of developing Trust approach to care planning.<br>Ongoing engagement with service users and carers, particularly around CPA.<br>The Trust meets the Accessible Information Standard | Medical director / Director of nursing and quality |
| ➢ R19 You have the right of access to your own health records and to have any factual inaccuracies corrected. | Yes | The Trust has a Patient Identifiable Information Policy – service user access and a Freedom of Information Policy.<br>The Trust complies with requirements of Information Governance Toolkit, CQC registration and Monitor's licence conditions. | Director of finance and resources / Director of nursing and quality |
| ➢ R20 You have the right to privacy and confidentiality and to expect the NHS to keep your confidential information safe and secure | Yes | Trust meets Department of Health privacy and dignity guidance and has made a declaration of compliance to Monitor and to service users regarding elimination of mixed sex accommodation.<br>The Trust has a confidentiality and data protection policy and has systems and processes in place regarding access to and transfer of personally identifiable data. The Trust complies with the requirements of the Information Governance Toolkit and Department of Health requirements to train staff in this area. When breaches do occur they are thoroughly investigated with learning identified and notification to the Information Commissioner where appropriate. | Director of nursing and quality<br>Director of finance and resources |
| ➢ R21 You have the right to be informed about how your information is used. | Yes | The Trust has a confidentiality and data protection policy and has systems and processes in place regarding access to and transfer of personally identifiable data. The Trust complies with the requirements of the Information Governance Toolkit and Department of Health requirements to train staff in this area. | Director of finance and resources / Director of nursing and quality |
| ➢ R22 You have the right to request that your confidential information is not used beyond your own care and treatment and to have your objections considered and, where you wishes cannot be | Yes | Patient Identifiable Information Policy – service user access.<br>Freedom of Information Policy.<br>The Trust has a confidentiality and data protection policy and has systems and processes in place regarding access to and transfer of personally identifiable data. The Trust complies with the requirements of the | Director of finance and resources / Director of nursing and |

| Heading | Compliance | Evidence | Lead |
|---|---|---|---|
| followed, to be told the reasons, including the legal basis. | | Information Governance Toolkit and Department of Health requirements to train staff in this area. | quality |
| **Respect, consent and confidentiality – pledges** | | | |
| ➢ P6 The NHS commits to ensure those involved in your care and treatment have access to your health information so they can care for you safely and effectively. | Yes | The Trust has two main clinical information systems, RiO and SystmOne, across its business delivery units. The Trust is also working with partners to ensure interoperability between systems, such as those used by local authorities, to make accessing information on care easier for staff working in integrated teams. Information sharing protocols in place with partners as appropriate. | Director of finance and resources |
| ➢ P7 The NHS commits that, if you are admitted to hospital, you will not have to share sleeping accommodation with patients of the opposite sex, except where appropriate, in line with details set out in the Handbook to the NHS Constitution. | Yes | The Trust is able to make a declaration that it complies with the national standard in relation to Eliminating Mixed Sex Accommodation. | Director of nursing and quality |
| ➢ P8 The NHS commits to anonymise the information collected during the course of your treatment and use it to support research and improve care for others. | Yes | The Trust has a confidentiality and data protection policy and has systems and processes in place regarding access to and transfer of personally identifiable data. The Trust complies with the requirements of the Information Governance Toolkit and Department of Health requirements to train staff in this area. When breaches do occur they are thoroughly investigated with learning identified and notification to the Commissioner where appropriate.<br>The Trust has robust governance arrangements in place to cover its research and development work. | Director of finance and resources |
| ➢ P9 The NHS commits, where identifiable information is used, to give you the chance to object wherever possible. | Yes | As above (see P8). | Director of finance and resources |
| ➢ P10 The NHS commits to inform you of research studies in which you may eligible to participate. | Yes | The Trust has an in house research and development department that manages, facilitates and governs all research to ensure it reflects services and the geographical area the Trust serves. Support is available to staff, patients/service users and carers who would like to become more involved in research as well as those who are established researchers. Advice and information is available on NHS research approval, ethics, the research passport, letters of access, training and funding opportunities, patient/service user and carer involvement in research and dissemination. | Medical director |

| Heading | Compliance | Evidence | Lead |
|---|---|---|---|
| ➢ P11 The NHS commits to share with you any letters sent between clinicians about your care. | Yes | All service users have access to their clinical records (Patient Identifiable Information Policy – service user access).<br>Service users are offered a copy of their care plan and are able to receive a copy of any correspondence between clinicians about them unless there is a specific risk identified to their physical and/or mental wellbeing. | Director of nursing and quality / Director of finance and resources / District Directors |
| **Informed choices – rights** | | | |
| ➢ R23 You have the right to choose your GP practice and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons. | N/A | | |
| ➢ R24 You have the right to express a preference for using a particular doctor within your GP practice and for the practice to try to comply. | N/A | | |
| ➢ R25 You have the right to transparent, accessible and comparable data on the quality of local healthcare providers, and on outcomes, as compared to others nationally. | N/A | | |
| ➢ R26 You have the right to make choices about the services commissioned by NHS bodies and to information to support these choices. The options available to you will develop over time and depend on your individual needs. | N/A | | |
| **Informed choices – pledges** | | | |
| ➢ P12 The NHS commits to inform you about the healthcare services available to you, locally and nationally. | Yes | Information is available on the Trust's website and in information leaflets. The Trust's service offer by district is available on its website, which provides individual service information on services offered and teams.<br>The Trust is compliant with Accessible Information Standards and has implemented Easy Read options for commonly accessed documents. | Director of nursing and quality / District Directors |
| ➢ P13 The NHS commits to offer you | Yes | Information available on Trust's website, in information leaflets and the | District |

| Heading | Compliance | Evidence | Lead |
|---|---|---|---|
| easily accessible, reliable and relevant information in a form you can understand and support to use it. This will enable you to participate fully in your own healthcare decisions and to support you in making choices. This will include information on the quality of clinical services where there is robust and accurate information available. | | Trust's Quality Accounts.<br>The Trust's service offer by district is available on its website, which provides individual service information on services offered and teams.<br>Information on mental health conditions is included on the Trust's website.<br>Service user survey findings are displayed on wards and units.<br>Feedback mechanisms are in place for service users and their carers, including 'real time' collection of customer experience feedback.<br>Advocacy information is available on wards and in patient information.<br>The Trust is compliant with Accessible Information Standards and has implemented Easy Read options for commonly accessed documents. | Directors / Director of nursing and quality |
| **Involvement in your healthcare and in the NHS – rights** | | | |
| ➢ R27 You have the right to be involved in planning and making decisions about your health and care with your care provider or providers, including your end of life care, and to be given information and support to enable you to do this. Where appropriate, this right includes your family and carers. This includes being given the chance to manage your own care and treatment, if appropriate. | Yes | As above (see R18, P12, P13).<br>The Trust offers and has available interpreter services either face-to-face or by telephone.<br>An agreed end-of-life care pathway in Barnsley involving all agencies involved in end-of-life care is in place. | District Directors / Director of nursing and quality |
| ➢ R28 You have the right to an open and transparent relationship with the organisation providing your care. You must be told about any safety incident relating to your care which, in the opinion of a healthcare professional, has caused, or could still cause, significant harm or death. You must be given the facts, an apology, and any reasonable support you need. | Yes | The Trust has a Duty of Candour policy in place supported by robust processes for complaints and redress.<br>The Trust monitors compliance with the policy which is reviewed by the Clinical Governance and Clinical Safety Committee and Board. | Director of nursing and quality |
| ➢ R29 You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those | Yes | Patients, services users and their carers can be involved in the Trust through the Members' Council, Trust membership and volunteering.<br>Communication, Engagement and Involvement Strategy in place.<br>The Trust is continuing to ensure service users and carer groups to ensure all teams and wards will have the ability to involve, listen and respond to feedback from people who use Trust services at all levels of the | Director of nursing and quality |

| Heading | Compliance | Evidence | Lead |
|---|---|---|---|
| services are provided, and in the decisions to be made affecting the operation of those services. | | organisation.<br>Trust service users/carers on local partnership boards.<br>Information provided to local HealthWatch.<br>There is a programme of public engagement events in place involving service users and carers regarding Trust plans and the transformational change programme. | |
| **Involvement in your healthcare and in the NHS – pledges** | | | |
| ➢ P14 The NHS commits to provide you with the information and support you need to influence and scrutinise the planning and delivery of NHS services. | Yes | As above (see P2, P3, R29). | Director of nursing and quality |
| ➢ P15 The NHS commits to work in partnership with you, your family, carers and representatives. | Yes | As above (see P2, P3). | District Directors / Director of nursing and quality |
| ➢ P16 The NHS commits to involve you in discussions about planning your care and to offer you a written record of what is agreed if you want one. | Yes | Service users are offered a copy of their care plan. Care Plans are coproduced with service users wherever possible.<br>The Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care; however, there will be occasions when the nature of an individual's illness makes this inappropriate. | District Directors / Director of nursing and quality / Medical director |
| ➢ P17 The NHS commits to encourage and welcome feedback on your health and care experiences and use this to improve services. | Yes | The Trust welcomes feedback from service users and carers and actively encourages people to comment on its services. The Trust uses this information to inform service development and improvement.<br>The Trust is working towards real time service user feedback through the Friends and Family service user test.<br>Service user surveys are undertaken as part of commissioner-agreed CQUINs across all BDUs.<br>Public engagement events held throughout the year.<br>Feedback facility on the Trust's website.<br>Feedback is provided through the Customer Services Team, which is reported to Trust Board quarterly and annually. | Director of nursing and quality |
| **Complaints and redress – rights** | | | |
| ➢ R30 You have the right to have any complaint you make about NHS | Yes | Customer Services Policy and Customer Service Team structure with quarterly reports to Trust Board. | Director of nursing and |

| Heading | Compliance | Evidence | Lead |
|---|---|---|---|
| services acknowledged within three working days and to have it properly investigated. | | Performance measures in place. Complaints acknowledged within three working days and investigated appropriately. | quality |
| ➢ R31 You have the right to discuss the manner in which the complaint is to be handled, and to know the period within which the investigation is likely to be completed and the response sent. | Yes | As above.<br>The Trust encourages face to face meetings to discuss complaints as the first act of resolution. Formal complaints always involve the offer of a further face to face meeting.. | Director of nursing and quality |
| ➢ R32 You have the right to be kept informed of the progress and to know the outcome of any investigation into your complaint, including an explanation of the conclusions and confirmation that any action needed in consequence of the complaint has been taken or is proposed to be taken. | Yes | Customer Services Policy and Customer Service Team structure.<br>All responses are shared with complainants and personally signed by the Chief Executive including actions to be taken as a result.<br>Learnings are discussed by the Trust Board. | Director of nursing and quality |
| ➢ R33 You have the right to take your complaint to the independent Parliamentary and Health Service Ombudsman or Local Government Ombudsman if you are not satisfied with the way your complaint has been dealt with by the NHS. | Yes | This is referenced in all correspondence around complaints. Everything possible is done to prevent this. During the last year 10 complaints have been referred to the Ombudsman, 4 have not been upheld, 2 have been partly upheld/upheld. This is also reflected in the Customer Services Policy and Customer Service Team structure. | Director of nursing and quality |
| ➢ R34 You have the right to make a claim for judicial review if you think you have been directly affected by an unlawful act or decision of an NHS body or local authority. | Yes | Customer Services Policy and information on Trust websites. | Director of nursing and quality |
| ➢ R35 You have the right to compensation where you have been harmed by negligent treatment. | Yes | Claims Management Policy. | Director of nursing and quality |
| **Complaints and redress – pledges** | | | |
| ➢ P18 The NHS commits to ensure you are treated with courtesy and you receive appropriate support throughout the handling of a complaint and the fact that you have complained will not | Yes | Customer Services Policy and Customer Service Team structure. | Director of nursing and quality |

| Heading | Compliance | Evidence | Lead |
|---|---|---|---|
| adversely affect your future treatment. | | | |
| ➢ P19 The NHS commits to ensure that, when mistakes happen or if you are harmed while receiving health care, you receive an appropriate explanation and apology, delivered with sensitivity and recognition of the trauma you have experienced, and know that lessons will be learned to help avoid a similar incident occurring again. | Yes | The Trust has robust processes in place to investigate and learn from its mistakes and to share lessons across services and districts.<br>Arrangements in place to ensure the Trust and its staff meet the Trust's Duty of Candour responsibilities. | Director of nursing and quality |
| ➢ P20 The NHS commits to ensure that the organisation learns lessons from complaints and claims and uses these to improve NHS services. | Yes | The Trust has robust processes in place to investigate and learn from its mistakes and to share lessons across services and districts.<br>Quality Improvement Group established to share learning between and across BDUs.<br>Learning lessons reports are reviewed by the Clinical Governance and Clinical Safety Committee.<br>Post investigation meetings are held at a local level. | Director of nursing and quality / Medical director |

The NHS Constitution also sets out nine responsibilities of patients and the public.

- Please recognise that you can make a significant contribution to your own, and your family's, good health and well-being, and take some personal responsibility for it.
- Please register with a GP practice – the main point of access to NHS care as commissioned by NHS bodies.
- Please treat NHS staff and other patients with respect and recognise that violence or the causing nuisance or disturbance on NHS premises could result in prosecution. You should recognise that abusive and violent behaviour could result in you being refused access to NHS services.
- Please provide accurate information about your health, condition and status.
- Please keep appointments, or cancel within reasonable time. Receiving treatment within the maximum waiting times may be compromised unless you do.
- Please follow the course of treatment which you have agreed, and talk to your clinician if you find this difficult.
- Please participate in important public health programmes such as vaccination.
- Please ensure that those closest to you are aware of your wishes about organ donation.
- You should give feedback – both positive and negative – about your experience and the treatment and care you have received, including any adverse reactions you may have had. You can often provide feedback anonymously and giving feedback will not affect adversely your care or how you are treated. If a family member or someone you are a carer for is a patient and unable to provide feedback, you are encouraged to give feedback about their experiences on their behalf. Feedback will help to improve NHS services for all.

**The NHS Constitution – staff**
**How the Trust meets its obligations**
**Trust Board 19 December 2017**

| Heading | Compliance | Evidence | Lead |
|---|---|---|---|
| **The rights are there to help ensure staff:** | | | |
| ➢ have a good working environment with flexible working opportunities, consistent with the needs of patients and with the way that people live their lives; | Yes | Workforce strategy agreed which includes workforce development, and staff engagement and wellbeing as key priority areas<br>HR policies and procedures on annual leave, sickness absence, flexible working, carer leave, adoption rights and benefits, age retirement, equal opportunities in employment, job share, paternity leave, maternity leave, special leave, stress, etc. Also Harassment and Bullying Policy and Grievance Policy and Procedures in place.<br>Friends and Family Test for staff.<br>Wellbeing survey/national staff survey.<br>Occupational health policy and service in place including Musculoskeletal and staff counselling services.<br>Values-based recruitment, induction and appraisal policies in place. | Director HR, OD and estates |
| ➢ have a fair pay and contract framework; | Yes | Workforce strategy agreed by the Trust Board<br>Trust pay structure based on Agenda for Change and Trust follows guidance issued by National Pay Bodies as appropriate.<br>HR Policies and Procedures as above.<br>Workforce Strategy sets out Trust approach to pay.<br>Support to the concept of Living Wage.<br>Gender pay audit to be completed for 2017/18 | Director HR, OD and estates |
| ➢ can be involved and represented in the workplace; | Yes | Workforce strategy agreed by the Trust Board includes staff engagement as key priority area<br>Disciplinary Policy and Procedures.<br>Grievance Policy and Procedures<br>Set out in the Social Partnership Agreement between the Trust and staff side organisations.<br>Staff engagement strategy.<br>Staff engagement events.<br>Annual staff survey.<br>BAME and Disability Staff Networks established | Director HR, OD and estates |
| ➢ have healthy and safe working conditions and an environment free from harassment, bullying or violence; | Yes | HR policies and procedures.<br>Staff survey.<br>Health and Safety Policy. | Director HR, OD and estates |

| Heading | Compliance | Evidence | Lead |
|---|---|---|---|
| | | Health and Safety Steering Group.<br>Health and Safety annual audit and work programme.<br>Occupational health service.<br>Risk assessments of workplace.<br>Managing Aggression and Violence lead in place with supporting Management of Violence and Aggression Trust Action Group (MAV TAG). | |
| ➢ are treated fairly, equally and free from discrimination; | Yes | HR policies and procedures.<br>Equality and Inclusion Forum, which is a forum of the Trust Board in place.<br>Trust staff are required to undertake mandatory equality training.<br>Equality networks, annual workforce equality impact assessment.<br>Equality impact assessment of all policies and procedures<br>BAME and Disability staff networks established<br>WRES and EDS2 action plans agreed | Director HR, OD and estates |
| ➢ can, in certain circumstances, take a complaint about their employer to an Employment Tribunal; | Yes | Disciplinary and Grievance Policies and Procedures.<br>Trust staff advised of their rights following disciplinary action. | Director HR, OD and estates |
| ➢ can raise any concern with their employer, whether it is about safety, malpractice or other risk, in the public interest. | Yes | HR Policies and Procedures.<br>Information given to staff and Trust welcome events include information for staff.<br>Whistleblowing Policy.<br>Whistleblowing report taken to Clinical Governance & Clinical Safety Committee every 6 months.<br>Raising concerns leaflet widely available.<br>Network of Freedom to Speak Up Guardian established<br>Intranet site for staff on raising concerns in place. | Director HR, OD and estates |

The NHS Constitution also sets out seven staff pledges, which, although not legally binding, represent a commitment by the NHS to provide high-quality working environments for staff.

- The NHS commits to provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability.
- The NHS commits to provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.
- The NHS commits to provide all staff with personal development, access to appropriate training for their jobs and line management support to enable them to fulfil their potential.
- The NHS commits to provide support and opportunities for staff to maintain their health, well-being and safety.

- The NHS commits to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.
- The NHS commits to have a process for staff to raise an internal grievance.
- The NHS commits to support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice, or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Public Interest Disclosure Act 1998.

The NHS Constitution also sets out six existing legal duties that staff must observe. (This list is not meant to be exhaustive.)

- To accept professional accountability and maintain the standards of professional practice as set by the appropriate regulatory body applicable to your profession or role.
- To take reasonable care of health and safety at work for you, your team and others, and to co-operate with employers to ensure compliance with health and safety requirements.
- To act in accordance with the express and implied terms of your contract of employment.
- Not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation.
- To protect the confidentiality of personal information that you hold unless to do so would put anyone at risk of significant harm.
- To be honest and truthful in applying for a job and in carrying out that job.

The Constitution also sets out how staff should play their part in ensuring the success of the NHS.

- You should aim to provide all patients with safe care, and to do all you can to protect patients from avoidable harm.
- You should follow all guidance, standards and codes relevant to your role, subject to any more specific requirements of your employers.
- You should aim to maintain the highest standards of care and service, treating every individual with compassion, dignity and respect, taking responsibility not only for the care you personally provide, but also for your wider contribution to the aims of your team and the NHS as a whole.
- You should aim to find alternative sources of care or assistance for patients, when you are unable to provide this (including for those patients who are not receiving basic care to meet their needs).
- You should aim to take up training and development opportunities provided over and above those legally required of your post.
- You should aim to play your part in sustainably improving services by working in partnership with patients, the public and communities.
- You should aim to raise any genuine concern you may have about a risk, malpractice or wrongdoing at work, (such as a risk to patient safety, fraud or breaches of patient confidentiality), which may affect patients, the public, other staff, or the organisation itself at the earliest reasonable opportunity.
- You should aim to involve patients, their families, carers or representatives fully in decisions about prevention, diagnosis and their individual care and treatment.
- You should aim to be open with patients, their families, carers or representatives, including if anything goes wrong; welcoming and listening to feedback and addressing concerns promptly and in a spirit of co-operation.
- You should contribute to a climate where the truth can be heard and the reporting of, and learning from, errors is encouraged and colleagues are supported where errors are made.
- You should aim to view the services you provide from the standpoint of a patient, and involve patients, their families and carers in the services you provide, working with them, their communities and other organisations, and making it clear who is responsible for their care.
- You should aim to take every appropriate opportunity to encourage and support patients and colleagues improve their health and wellbeing.

- You should aim to contribute towards providing fair and equitable services for all and play your part, wherever possible, in helping to reduce inequalities in experience, access and outcomes between differing groups or sections of society requiring health care.
- You should aim to inform patients about the use of their confidential information and to record their objections, consent or dissent.
- You should aim to provide access to a patient's information to other relevant professionals, always doing so securely, and only where there is a legal and appropriate basis to do so.

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 19 December 2017

## Agenda item 6.3 – Receipt of public minutes of partnership boards

### Wakefield Health and Wellbeing Board

| | |
|---|---|
| **Date** | 23 November 2017 |
| **Member** | Rob Webster/Sean Rayner |
| **Items discussed** | ➢ Financial strategy update<br>➢ Safe & Health Futures for Children<br>➢ Health Housing and Estates<br>➢ Winter Plan<br>➢ Strategic development for urgent and emergency care services for the Wakefield district |
| **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 |

### Kirklees Health and Wellbeing Board

| | |
|---|---|
| **Date** | 14 December 2017 |
| **Invited Observer** | Rob Webster/Karen Taylor |
| **Items discussed** | ➢ Kirklees Safeguarding Adults Board 2016/17 Annual Report<br>➢ Children & Adolescents Mental Health Service (CAMHS) Local Transformation Plan Refresh<br>➢ Pharmaceutical Needs Assessment Post Consultation<br>➢ Proposals for integrated governance arrangements for commissioning Health and Social Care in Kirklees |
| **Minutes** | Papers and draft minutes (when available): https://democracy.kirklees.gov.uk/mgCommitteeDetails.aspx?ID=159 |

### Calderdale Health and Wellbeing Board

| | |
|---|---|
| **Date** | Next meeting scheduled for 21 December 2017 |
| **Non-Voting Member** | Dr Adrian Berry/Karen Taylor |
| **Items discussed** | ➢ To be confirmed |
| **Minutes** | Papers and draft minutes (when available): https://www.calderdale.gov.uk/council/councillors/councilmeetings/agendas-detail.jsp?meeting=24531 |

### Barnsley Health and Wellbeing Board

| | |
|---|---|
| **Date** | Next meeting scheduled for 30 January 2018 |
| **Member** | Rob Webster/Sean Rayner |
| **Items discussed** | ➢ To be confirmed. |
| **Minutes** | Papers and draft minutes (when available): http://barnsleymbc.moderngov.co.uk/mgCommitteeDetails.aspx?ID=143 |

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

| | |
|---|---|
| **Date** | To be confirmed (last update from meeting 5 September 2017) |
| **Attendee** | Rob Webster |
| **Items discussed** | ➢ To be confirmed. |
| **Papers** | Not yet available. |

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 19 December 2017

## Agenda item 7 – Assurance from Trust Board Committees

### Clinical Governance & Clinical Safety Committee

| | |
|---|---|
| **Date** | 14 November 2017 |
| **Presented by** | Charlotte Dyson |
| **Key items to raise at Trust Board** | ➢ Strategic risk<br>➢ Demand for resources<br>➢ Waiting lists and improvement plan<br>➢ Child and Adolescent Mental Health Service (CAMHS) update<br>➢ Safeguarding Adults annual report<br>➢ Safeguarding Children's annual report<br>➢ Ligature annual report<br>➢ Patient Safety annual report (attached)<br>➢ Positive outcome of (Patient Led Assessment of the Care Environment) PLACE |

### Mental Health Act Committee

| | |
|---|---|
| **Date** | 21 November 2017 |
| **Presented by** | Chris Jones |
| **Key items to raise at Trust Board** | ➢ New requirements for Section 135/136 capacity/demand.<br>➢ Section 49 workforce capacity.<br>➢ Outliers in relation to patient transfers, particularly in Dewsbury.<br>➢ Poor response rate to the Community Treatment Order audit.<br>➢ How to manage response in relation to recurrent themes from the Care Quality Commission visits and the BDU response to action plans. |

South West Yorkshire Partnership NHS Foundation Trust

# Trust Board 19 December 2017
# Agenda item 8

| | |
|---|---|
| **Title:** | **Use of Trust seal** |
| **Paper prepared by:** | Company Secretary |
| **Purpose:** | The Trust's Standing Orders, which are part of the Trust's Constitution, require a report to be made to Trust Board on the use of the Trust's seal every quarter. The Trust's Constitution and its Standing Orders are pivotal for the governance of the Trust, providing the framework within which the Trust and its officers conduct its business. Effective and relevant Standing Orders provide a framework that assists the identification and management of risk. This report also enables the Trust to comply with its own Standing Orders. |
| **Mission/values:** | The paper ensures that the Trust meets its governance and regulatory requirements. |
| **Any background papers/ previously considered by:** | Quarterly reports to Trust Board. |
| **Executive summary:** | The Trust's Standing Orders require that the Seal of the Trust is not fixed to any documents unless the sealing has been authorised by a resolution of Trust Board, or a committee thereof, or where Trust Board had delegated its powers. The Trust's Scheme of Delegation implied by Standing Orders delegates such powers to the Chair, Chief Executive and Director of Finance of the Trust. The Chief Executive is required to report all sealing to Trust Board, taken from the Register of Sealing maintained by the Chief Executive.<br>The seal has been used three (3) times since the report to Trust Board in October 2017 in respect of the following:<br>➢ Contract for lot one Tobacco Control Service – Stop Smoking Service (adult 18+) in the community between the Trust and Sheffield Council.<br>➢ Deed of variation for the development of land at Saville Park, Castleford.<br>➢ Lease for Unit 33, Grange Lane Industrial Estate, Barnsley between the Barnsley Council and the Trust. |
| **Recommendation:** | **Trust Board is asked to NOTE use of the Trust's seal since the last report in October 2017.** |
| **Private session:** | Not applicable. |

NHS
South West Yorkshire Partnership
NHS Foundation Trust

# Trust Board annual work programme 2017-18

| Agenda item/issue | Apr | June | July | Sept | Oct | Dec | Jan | Mar |
|---|---|---|---|---|---|---|---|---|
| **Standing items** | | | | | | | | |
| Declaration of interest | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ |
| Minutes of previous meeting | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ |
| Chair and Chief Executive's report | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ |
| Integrated performance report | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ |
| Assurance from Trust Board committees | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ |
| Receipt of minutes of partnership boards | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ | ✘ |
| **Quarterly items** | | | | | | | | |
| Assurance framework and risk register | ✘ | | ✘ | | ✘ | | ✘ | |
| Customer services quarterly report | ✘ | | ✘ | | ✘ | | ✘ | |
| Guardian of safe work hours *(from July 2017)* | | | ✘ | | ✘ | | ✘ | |
| Serious incidents quarterly report | | ✘ | | ✘ | | ✘ | | ✘ |
| Use of Trust Seal | | ✘ | | ✘ | | ✘ | | ✘ |
| 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. |