South West Yorkshire Partnership NHS Foundation Trust

Trust Board (performance and monitoring)
Tuesday 27 March 2018 at 9.30am
Rooms 3&4, Laura Mitchell, Great Albion Street, Halifax HX1 1YR

AGENDA

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
1.	9.30	**Welcome, introductions and apologies**	Chair	**Verbal item**		To receive
2.		**Declarations of interest**	Chair	**Paper**		To receive
3.		**Minutes and matters arising from previous Trust Board meeting held 30 January 2018**	Chair	**Paper**	10	To approve
4.	9.40	**Service User Story**	District Director Forensic, Specialist, Calderdale & Kirklees	**Verbal item**	5	To receive
5.	9.45	**Chair and Chief Executive's remarks**	Chair Chief Executive	**Verbal item and paper**	5	To receive
6.	9.50	**Performance reports**				
		6.1 Integrated performance report month 11 2017/18	Director of Finance & Resource and Director of Nursing & Quality	**Paper**	20	To receive
		6.2 Serious incident report quarter 3 2017/18	Director of Nursing & Quality	**Paper**	10	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
		6.3 NHS staff survey	Director of Human Resources, Organisational Development & Estates	**Paper**	10	To receive
7.	10.30	**Operational plan 2018/19**	Director of Finance & Resource	**Paper**	15	To receive
8.	10.45	**Business developments**				
		8.1 South Yorkshire and Bassetlaw Integrated Care System (formerly STP) update	Director of Strategy	**Verbal item**	5	To receive
		8.2 West Yorkshire and Harrogate Health and Care Partnership (formerly STP) and local integrated care partnerships update	Director of Strategy	**Paper**	5	To receive
	10.55	*Break*			*15*	
9.	11.10	**Strategies and policies**				
		9.1 Quality Strategy	Director of Nursing & Quality	**Paper**	15	To approve
		9.2 Update to the Trust Board declaration and register of fit and proper persons, interests and independence policy	Director of Finance & Resource	**Paper**		To approve
10.	11.25	**Governance matters**				

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
		10.1 Appointment of Responsible Officer for Medical Revalidation	Director of Human Resources, Organisational Development & Estates	**Paper**	5	To approve
		10.2 Eliminating mixed sex accommodation (EMSA) declaration	Director of Nursing & Quality	**Paper**	5	To approve
		10.3 Information Governance toolkit	Director of Finance & Resource	**Paper**	5	To receive
		10.4 Review of Risk Appetite Statement	Director of Finance & Resource	**Paper**	5	To receive
11.	11.45	**Receipt of public minutes of partnership boards**	Chair	**Paper**	5	To receive
12.	11.50	**Assurance and receipt of minutes from Trust Board Committees** - Clinical Governance and Clinical Safety Committee 6 February 2018 - Nominations Committee 22 February 2018 - Mental Health Act Committee 6 March 2018 - Equality and Inclusion Forum 6 March 2018 - Remuneration and Terms of Service Committee 26 March 2018	Chair of Committee	**Paper**	5	To receive
13.	11.55	**Use of Trust seal**	Company Secretary	**Paper**		To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
14.	11.55	**Trust Board Work Programme 2018/19**	Chair	**Paper**	5	To receive
15.		**Date of next meeting** The next public meeting of Trust Board will be held on Tuesday 24 April 2018 in the Boardroom at Kendray in Barnsley.				

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 March 2018
Agenda item 2

Title:	**Trust Board declaration of interests, including fit and proper persons declaration**
Paper prepared by:	Company Secretary on behalf of the Chief Executive
Purpose:	To ensure the Trust continues to meet the NHS rules of Corporate Governance, the Combined Code on Corporate Governance, Monitor's Code of Governance and the Trust's own Constitution in relation to openness and transparency.
Mission/values:	The mission and values of the Trust reflect the need for the Trust to be open and act with probity. The Declaration of Interests and independence process and the fit and proper person declaration undertaken annually support this.
Any background papers/ previously considered by:	Previous annual declaration of interest papers to the Trust Board. Policy for Trust Board declaration and register of fit and proper persons, independence, interests, gifts and hospitality approved by Trust Board in March 2015. A revised policy is within a separate paper on the Trust Board agenda for approval. The 2015 policy remains fit for purpose, with minor amendments to align it to the staff Standards of Business Conduct Policy (conflict of interest policy) updated to align NHS England guidance and model policy.
Executive summary:	**Declaration of interests** The Trust's Constitution and the NHS rules on corporate governance, the Combined Code of Corporate Governance, and Monitor/NHS Improvement require Trust Board to receive and consider the details held for the Chair of the Trust and each Director, whether Non-Executive or Executive, in a Register of Interests. During the year, if any such Declaration should change, the Chair and Directors are required to notify the Company Secretary so that the Register can be amended and such amendments reported to Trust Board. Trust Board receives assurance that there is no conflict of interest in the administration of its business through the annual declaration exercise and the requirement for the Chair and Directors to consider and declare any interests at each meeting. As part of this process, Trust Board considers any potential risk or conflict of interests. If any should arise, they are recorded in the minutes of the meeting. There are no legal implications arising from the paper; however, the requirement for the Chair and Directors of the Trust to declare interests is part of the Trust's Constitution.

	Non-Executive Director declaration of independence Monitor's Code of Governance and guidance issued to Foundation Trusts in respect of annual reports requires the Trust to identify in its annual report all Non-Executive Directors it considers to be independent in character and judgement and whether there are any relationships or circumstances which are likely to affect, or could appear to affect, the Director's judgement. This Trust considers all its Non-Executive Directors to be independent and the Chair and all Non-Executive Directors have signed a declaration to this effect. **Fit and proper person requirement** There is a requirement for members of Boards of providers of NHS services to make a declaration against the fit and proper person requirement for directors set out in the new fundamental standard regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which came into force on 1 April 2015. Within the new regulations, the duty of candour and the fit and proper person requirements for Directors came into force earlier for NHS bodies on 1 October 2014. Although the requirement is in relation to new Director appointments, Trust Board took the decision to ask existing Directors to make a declaration as part of the annual declaration of interests exercise. All Directors have signed the declaration stating they meet the fit and proper person requirements. The Company Secretary is responsible for administering the process on behalf of the Chief Executive of the Trust. The declared interests of the Chair and Directors are reported in the annual report and the register of interests is published on the Trust's website. In February 2017, NHS England released new guidance on Managing Conflicts of Interest in the NHS including a model policy which took effect from 1 June 2017. The Standards of Business Conduct Policy (conflict of interest policy) for staff was updated to align with the model policy and approved by Trust Board in October 2017. A revised version of the Policy for Trust Board declaration and register of fit and proper persons, independence, interests, gifts and hospitality is included in a separate paper on the Trust Board agenda for approval. The Policy approved by Trust Board in March 2015 remains fit for purpose, with minor amendments to align it to the staff policy. **Risk appetite** The mission and values of the Trust reflect the need for the Trust to be open and act with probity. The Declaration of Interests and independence process and the fit and proper person declaration undertaken annually support this.
Recommendation:	**Trust Board is asked to CONSIDER the attached summary,**

	particularly in terms of any risk presented to the Trust as a result of a Director's declaration, and, subject to any comment, amendment or other action, to formally NOTE the details in the minutes of this meeting.
Private session:	Not applicable

South West Yorkshire Partnership NHS Foundation Trust

Trust Board – Declaration of Interests
27 March 2018

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

The following declarations of interest were made by Directors:

Name	Declaration
Chair	
MONAGHAN, Angela Chair	Spouse - Strategic Director at Bradford Metropolitan District Council. Spouse - Director of the National Association for Neighbourhood Management.
Non-Executive Directors	
CAMPBELL, Laurence Non-Executive Director	Director, Trustee and Treasurer, Kirklees Citizens' Advice Bureau and Law Centre, includes NHS complaints advocacy for Kirklees Council.
COURT, Rachel Non-Executive Director	Director and Chair, Leek United Building Society. Chair, Invesco Perpetual Life Ltd. Director, Invesco UK Ltd. Director, Leek United Financial Services Ltd Chair, PRISM Governor, Calderdale College Magistrate Chair, NHS Pension Board
DYSON, Charlotte Non-Executive Director	Independent Marketing Consultant, Beyondmc. Lay Chair, Leeds Teaching Hospitals NHS Trust Advisory Appointments Committee for consultants (occasional). Lay member, Leeds Teaching Hospitals NHS Trust Clinical Excellence Awards Committee (CEA). Lay member, Bradford Teaching Hospitals NHS Trust Clinical Excellence Awards (CEA) Lay member, Advisory Committee Clinical Excellence Awards, Yorkshire and Humber Sub-Committee. Lay member, Royal College of Surgeons of Edinburgh, MRSC Part B OSCE.
JONES, Chris Non-Executive Director	Director and part owner, Chris Jones Consultancy Ltd. Interim Chief Executive Officer at Bradford College.
QUAIL, Kate Non-Executive Director	Owner / Director of The Lunniagh Partnership Ltd, Health and Care Consultancy.

Name	Declaration
Chief Executive	
WEBSTER, Rob Chief Executive	Independent Chair of Panel for assessing clinical commissioning group learning disability commissioning (NHS England). Visiting Professor, Leeds Beckett University. Honorary Fellow, Queen's Nursing Institute. Honorary Fellow, Royal College of General Practitioners.. Lead Chief Executive, West Yorkshire and Harrogate Health and Care Partnership (Sustainability and Transformation Plan). Member of Bercow Review Panel, Royal College of Speech and Language Therapists (RCSLT).
Executive Directors	
BERRY, Dr Adrian Medical Director (to 31 March 2018)	No interests declared.
BREEDON, Tim Director of Nursing and Quality	No interests declared.
BROOKS, Mark Director of Finance and Resources	No interests declared.
DAVIS, Alan Director Human Resources, Organisational Development and Estates	Spouse – Managing Director, NHS North West Leadership Academy
THIYAGESH, Dr Subha Medical Director (from 19 April 2018)	No interests declared.
Other* Directors (non-voting)	
HARRIS, Carol District Director – Forensic, Specialist, Calderdale and Kirklees	Spouse - Engineering Company has contracts with NHS providers including Mid Yorkshire Hospitals NHS Trust.
HENRY, Kate Director of Marketing, Communication and Engagement	No interests declared.
RAYNER, Sean District Director – Barnsley and Wakefield	No interests declared.
TAYLOR, Karen Director of Delivery	No interests declared.
YASMEEN, Salma Director of Strategy	Board member, PRISM charity in Bradford.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Trust Board meeting held on 30 January 2018
Conference Room, Kendray Hospital, Barnsley

Present:	Angela Monaghan	Chair
	Charlotte Dyson	Deputy Chair
	Rachel Court	Non-Executive Director
	Kate Quail	Non-Executive Director
	Dr Adrian Berry	Medical Director
	Tim Breedon	Director of Nursing and Quality
	Alan Davis	Director of Human Resources, Organisational Development and Estates
	Mark Brooks	Director of Finance and Resources
	Rob Webster	Chief Executive
Apologies:	Members	
	Laurence Campbell	Non-Executive Director
	Chris Jones	Non-Executive Director
	Other	
	Karen Taylor	Director of Delivery
In attendance:	Carol Harris	District Director - Forensics and Specialist Services, Calderdale and Kirklees
	Kate Henry	Director of Marketing, Communications and Engagement
	Sean Rayner	District Director - Barnsley and Wakefield
	Salma Yasmeen	Director of Strategy
	Emma Jones	Company Secretary (author)

TB/18/01 Welcome, introduction and apologies (agenda item 1)

The Chair, Angela Monaghan (AM) welcomed everyone to the meeting. The apologies above were noted.

AM informed the Board of the sad news of the passing of Bob Mortimer, public governor for Kirklees. Bob was a member of the Members' Council Coordination Group, Members' Council Quality Group, and was a regular attendee at Trust Board meetings held in public. Those in attendance observed a minute's silence in memory of Bob Mortimer. AM advised she would send a condolence letter on behalf of the Members' Council to Bob's family.

TB/18/02 Declaration of interests (agenda item 2)

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

TB/18/03 Minutes and matters arising from previous Trust Board meeting held on 19 December 2017 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 19 December 2017 as a true and accurate record. The matter arising from 19 December 2017 was noted.

TB/18/04 Chair and Chief Executive's remarks (attached) and Service User Story (agenda item 4)

Chair's remarks

AM advised that this year's Members' Council election would commence with nominations open from 2 February 2018. There were five public seats and five staff seats available for election in this year's process. The election will be run by the Electoral Reform Services (ERS) on behalf of the Trust with information available on the Trust's website.

Chief Executive's remarks

Rob Webster (RW) commented after every Trust Board meeting there is an Extended Executive Management Team (EMT) of senior managers across the organisation to cascade information throughout the organisation including The Brief. RW highlighted the following:

- The Brief is one of the main ways that communications are delivered throughout the Trust. It connects us to people in the organisation and the communications team has been reviewing the effectiveness of internal communications. Kate Henry (KH) said the review of effectiveness was first conducted in 2015. In December 2017, there was another increase in the number of staff who felt they were kept up to date (88% compared to 57% in 2015) and improvements in how the Trust communicates with them (76% compared to 45% in 2015). The review provided some areas to focus on. Overall, the results were positive and important when we are going into even more challenging times and periods of change.
- The recent case of a doctor outside of the Trust who was convicted of manslaughter where the doctor's reflections from supervision were considered as part of the case. This had sparked controversy with significant commentary, including from the Secretary of State. For this Trust, conversations with our medical committee around Duty of Candour, openness and medical fitness will consider any issues. Dr Adrian Berry (ABe) commented that this has been raised through the medial appraisers forum and this case would influence how doctors record their reflections. The requirement to record reflections comes from the General Medical Council (GMC). AM commented that if there was an opportunity to go back to the GMC regarding doctors' reflections we should do that. Charlotte Dyson (CD) asked if Duty of Candour was embedded in the organisation. ABe advised that incident reporting on Datix now records how Duty of Candour has been enacted so reports can be produced to confirm that it has been done. CD asked if there was a role for staff Freedom to Speak Up Guardians (FTSUG). Alan Davis (AGD) advised that the FTSUG was a six month pilot and he had met with the FTSUGs last week as part of the review. Most contacts are in relation to harassment and bullying. The next phase of development will be in relation to promoting cultural change. CD commented that she would like to understand the themes and how they may impact the workforce strategy. AGD advised that a paper on FTSUGs would go to the Executive Management Team (EMT) and an update to the Clinical Governance and Clinical Safety Committee as part of the whistleblowing report.
- The Trust is playing a supportive role in relation to winter pressures at acute hospitals with daily calls and four levels of escalation in place. We continue to deliver on majority of targets, however PICU beds remain under pressure. AM and Tim Breedon (TB) commented that they had received positive feedback on the support the Trust is providing to other organisations. Increased awareness of the role the Trust plays within the acute system is also apparent.
- Annual Planning guidance is due imminently and may require a refresh of 2018/19 plans that were submitted in December 2016 as part of a two year plan requirement.
- There was a successful judicial review against the development of Accountable Care Organisation contracts. This was on the basis that a move away from "payment by results" needed consultation and that did not take place.

The Board recognised the hard work that staff are putting in during challenging times and periods of change.

Service User story

The Trust Board heard a service user story. Carol Harris (CH) advised that she had the permission of the service user and their partner to share this story to support learning and she would provide them with feedback following the Trust Board meeting discussions.

The Trust Board heard of a couple that had recently lost a child, the subsequent impact of this traumatic event and the involvement of mental health services due to low mood and suicidal ideation. The story covered referral to the Intensive Home Based Treatment Team and the service users experience and involvement with the team.

The service user felt that they did not have the support they needed and later required admission to inpatient services where they initially made good progress and were discharged early. However, whilst on leave from the inpatient ward, the service users' needs became more complex. The medical team believed that symptoms of emotionally unstable personality disorder were present and following an MDT review, a decision was made to detail the service user under the Mental Health Act and requirement of support and supervision available on a Psychiatric Intensive Care Unit (PICU).

At the time of admission to PICU, there were no beds available locally and the service user was transferred to a unit over 60 miles from her home which made it difficult for family to visit and for the service user to have involvement with her local team. A location closer to home was sought, a like for like placement was found and the decision made to move the service user. The service user was moved, however was only given a short amount of notice regarding the move which caused suffering. The couple fed back to the team that because of this, had they been consulted, it is likely that they would have declined the move.

Further assessments were completed and, 10 months since her initial admission, the service user was assessed and transferred to an appropriate placement to receive psychological care. Throughout this time, the service user's partner felt that there was a lack of support and clarification of the plan and they wrote to their MP to outline their concerns including:

- A placement outside of the local area meant family struggled to visit
- The impact upon the wider family was not considered and support during this difficult 10 month period did not meet the needs of the service user or their family
- A transfer from one PICU to another was made based purely on the assumption that this was a request from the service user / carer
- They were not informed of the planned transfer until 30 minutes before it took place
- They did not know who was responsible for the service user's care and who to contact, they didn't feel that professionals engaged in a meaningful way

CH outlined that the Trust has done to ensure this doesn't happen again:

- Defined the role of the care coordinator, patient flow manager and patient flow clinical lead
- Mapped out clear roles and responsibilities for staff involved
- Mapped out the process for communication (including that with service users, carers and out of area inpatient teams) when a service user is transferred out of area
- Discussion in Partnership Board highlighted that there was more that could have been done much earlier to support the couple. The death of their son was a crucial time for them.

- Ideally the service user would not have been transferred to a PICU out of area.
- We need a clear pathway for people with emotionally unstable personality disorder.

Rachel Court (RC) asked about how the couple feels about it now. CH advised that they are grateful that the Trust has learnt from the episode and that their story was coming to Trust Board. RC asked what action would be taken in response to the service user feeling like she wasn't being listened to. CH advised that this was an area of focus, as well as ensuring the appropriate care pathways are in place.

RW commented that there was also some work to do with commissioners about what role the Trust could play as part of a child death processes. Kate Quail (KQ) added that there was also a role for support of carers of children that have some complex care conditions across the system. CH advised that the Health and Wellbeing Board should be looking at bereavement services.

The Board asked to pass on their thanks to the couple for sharing their story.

It was RESOLVED to NOTE the Chair's remarks, content of the Chief Executive's report, and Service User Story.

TB/18/05 Business developments (agenda item 5)

West Yorkshire and Harrogate Health and Care Partnership (formally STP) update (agenda item 5.1)

Salma Yasmeen (SY) reported that the West Yorkshire and Harrogate Health and Care Partnership (WYHHCP) continue to play a role in developing sustainable services for the future and highlighted the following:

- Moving towards formalising the partnership arrangements and stabilising work over 12-18 months.
- A draft Memorandum of Understanding (MoU) will be considered in the private session of the Board to formalise the relationship of mutual accountability and responsibility about what happens across West Yorkshire.
- A series of engagement events are taking place including one for Non-Executive Directors and Governors in relation to the West Yorkshire Mental Health Services Collaborative (WYMHSC).
- In relation to Mental Health workstreams, there are several that the Trust was leading on, or partners in, including:
  - the launch of the Suicide Strategy.
  - funding for new Child and Adolescent Mental Health Services (CAMHS) inpatient unit.
  - Out of area beds in each of the places and vision across West Yorkshire with a workshop to be held in Wakefield.
  - Perinatal services
- Calderdale is working towards integrated care with a proposal for discussion in the private session.
- Wakefield have a proposal in relation to end of life care for discussion in the private session.

RW commented that the WYHHCP were developing a document that sets out progress over the last year in relation to cancer, diabetes, working with communities, and next steps which should be published in the next few weeks, including in accessible forms.

CD asked about how areas such as developing workforce strategy could be incorporated into the worksteams. RW advised that there was a workforce plan for the WYHHCP. NHS England had oversight for this but has created partnerships locally called Local Workforce Advisory Boards [LWAB] which sit with provider representatives and some commissioning representatives. AGD commented that where shared services would benefit, some arrangements were already in place and there were links with universities.

AM asked if the voluntary and community sectors were included in decision making. RW advised that the System Leadership Executive Group includes representation from the voluntary sector. Each of the work programmes has a place for voluntary sector and within each of the six places the voluntary sector has a key role to play. SY commented that positive feedback was received from engagement events. Healthwatch have created videos around changing conversation within communities and the carers workstream is also a part of this.

It was RESOLVED to:

- **NOTE the update provided; and**
- **CONFIRM support for the WYHHCP programmes.**

South Yorkshire and Bassetlaw Accountable Care System update (agenda item 5.2)
AGD reported that the South Yorkshire and Bassetlaw Accountable Care System (SYBACS) was still in developmental phase and highlighted the following:

- SYBACS agenda for 2018/19 was to review governance arrangements and impact of regulation.
- SYBACS recognise that 2017/18 had so many priorities that there was a danger that there was a lack of focus.
- In April 2019, SYBACS would be responsible for control totals.
- Workforce was seen as a barrier to transformation, noting the history of the working together programme.
- Work is taking place on how they engage with patients and public on the ACS and also any service change.
- The acute service review will require a systematic approach that is robust with strong clinical engagement and consultation with the public to identify the key areas of particular pressure in the service.
- The ACS have produced an early report (called 1A) and about to publish a second (called 1B) which sets out the system and key priorities for the hospital services review.

RW commented that the SYBACS were looking to implement a single set of performance indicators. As part of the Health and Care Working Together, the Trust would be held to account by SYBACS rather than regulators so it will be important to keep a focus on what those indicators will be.

CD asked what the Trust's relationship was like with other mental health providers in the SYBACS. Sean Rayner (SR) advised that there was not a formal arrangement, however historically there had always been good working relationships with the mental health providers and there were mental health workstreams within the SYBACS. Recently the South Yorkshire group was unsuccessful with perinatal bid as it was not a joint bid. Kate Quail (KQ) asked if Learning Disabilities was part of the mental health workstreams. SR advised that it was part of SYBACS workstreams, although not specifically noted. RW commented that it was being discussed as part of the WYHHCP workstreams. CH commented that the Trust was looking at long term placement for learning disabilities and

also assessment and treatment within mental health services, with Barnsley still a part of the discussions as they are within the Trust services and footprint.

AM commented that she understood that a commissioning review would be taking place and it would be good for the Board to have an understanding of the process. AGD advised that it had not been part of partnership board discussions to date.

It was RESOLVED to NOTE the update from the SYB STP Collaborative Partnership Board.

TB/18/06 Risk and assurance (agenda item 6)

TB/18/06a Corporate/organisational risk register (agenda item 6.1)

Emma Jones (EJ) reported that the Corporate/Organisational Risk Register (ORR) was reviewed by the Executive Management Team (EMT), aligned to the Trust's priorities for 2017/18. Risks are aligned to Committees to provide further assurance on the risks and controls. The ORR currently contains nine 15+ risks. There were 16 changes to risks in the last quarter, with six closed and seven new entries as corporate/organisational level risks.

The Board discussed the following risks:

- Risk ID 812: Risk that Trust's sustainability will be adversely impacted by the creation of local place based solutions which change clinical pathways and financial flows. For example ACO implementation.
  Rationale for change of consequence score from a 5 down to a 3 given ongoing discussions. It was discussed that the risk had been discussed at Audit Committee and the rationale was that we see the creations of the Accountable Care Organisations (ACOs) as a positive move and we need to focus on how the Trust plays an active role.
- Risk ID 1151: Risk of being unable to recruit qualified clinical staff due to national shortages which could impact on the safety and quality of current services and future development.
  Whether the likelihood should be scored 5 and further detail is needed in relation to controls and mitigating actions. AGD advised in relation to control measures he was confident that they were in place, however others could be added such as physician associates and that the Trust was currently part of a pilot programme. RW commented that the Trust was able to fill gaps in rotas for senior doctors however it was at a cost which is why the Trust was looking at working with other organisations. ABe commented that it was not consistent with some areas more difficult to recruit to. TB commented that the impact of the early retirement also needed to be understood.
- Risk ID 1212: Risk that the amount of tendering activity taking place has a negative impact on staff morale which leads to sub-optimal performance and increased staff turnover.
  Tendering activity, with 15% staff turnover in Barnsley taking account of TUPE transfers there is a concern people are unsettled by uncertainty. The Board need to be assured that there are a reasonable set of mitigations in place.
- Risk 1213: Risk that the sub-optimal transition from Rio to SystmOne will result in significant loss or ineffective use of data resulting in the inability share information and produce reports.
  Should be amber not yellow for target. SY commented that there was a specific risk register in relation to the Clinical Records System programme which was moving towards co-design phase and there were currently significant controls in place.

The Board discussed the difference in the Trust's Risk Appetite and the target scores of some risks. MB commented that the Audit Committee had been discussing the current Risk Appetite Statement and it would be an item for discussion at the Trust Board strategic session in February 2018.

The Board discussed the heat map and supported the new proposal. AM suggested that a total/average risk score over time could be incorporated to see if the overall level of risk is increasing or decreasing.

Action: Mark Brooks / Emma Jones

It was RESOLVED to NOTE the key risks for the organisation subject to any changes / additions arising from papers discussed at the Board meeting around performance, compliance and governance.

TB/18/06b Assurance framework (agenda item 6.2)

Mark Brooks (MB) reported that the review of the assurance framework by the Executive Management Team (EMT) followed a similar process to the review of the Corporate/Organisational Risk Register. The key change this quarter was in relation to strategic risk 3.1 - Deterioration in financial performance leading to unsustainable organisation and insufficient cash to deliver capital programme. The RAG rating for this risk has moved from a yellow to amber as there is not currently a plan in place which balances financial performance in 2018/19. With two amber and two yellow RAG rated strategic risks within strategic objective 3 - Improving resources (operational excellence, digital by default), the overall rating has been left as yellow however it could also be considered amber. The identified gaps, controls and actions have been reviewed.

RW commented that through conversations at Trust Board and strategy development it was important to continue to use the assurance framework as a reference, as well as when the Trust Board work programme is set for 2018/19, to ensure reports address the strategic objectives and risks.

It was RESOLVED to NOTE the controls and assurances against the Trust's strategic objectives for Quarter 3 2017/18.

TB/18/07 Performance reports (agenda item 7)

TB/18/07a Integrated performance report month 9 2017/18 including finance (agenda item 7.1)

TB highlighted the following on the summary dashboard:

- Children and young people on adult wards – these are only ever used when no CAMHS beds are available and are considered the "least worst" option for the service user, with appropriate safeguarding in place.
- Out of area beds (OOAB) – there are positive moves in acute, a continued hot spot in PICU, awaiting Care Quality Commission (CQC) response in relation to a temporary measure proposal. RW commented that the OOAB position is reviewed by services daily and by the Operational Management Group (OMG) and Executive Management Group (EMT) weekly. Overall seeing continued management and decrease in number of OOAB in January 2018, which is credit to staff and significant work.
- Safer staffing - rates maintained through the use of the professional guidance tool.
- Mental Health Act/Mental Capacity Act mandatory training - sustained progress made against the completion of training.

- Delayed transfers of care - slight deterioration in delayed transfers of care performance, however still within target.

TB highlighted the following in relation to Quality:

- Compliments and Complaints - Complaints process is under review and compliments received are showing an increase.
- Medicine omissions - performance sustained in Quarter 3 and some areas are scoring well below national levels.
- Incidents - the number of incidents reported shows a positive reporting culture, there was an increase in Quarter 3 around moderate / severe incidents which needs review.
- Prone restraint - levels of prone restraints with duration of 3 minutes or less have worsened.
- Safety first - the learning from deaths dashboard will be included in the quarterly incident report.
- Managing Aggression and Violence (MAV) - joint training has taken place with positive feedback from staff.
- CQC visit to Ward 18 - visit in relation to CQC safe domain, positive verbal feedback has been received to date.

CD asked if transformation of services was having an impact on serious incidents. TB advised that this was a key line of enquiry of incidents and the risk panel looks at these on a weekly basis.

CD asked why the Improving Access to Psychological Therapies (IAPT) year-end forecast was RAG rated as red although current performance is green. TB advised that this would be reviewed.

CD asked for a progress update in relation to Information Governance (IG) mandatory training. MB advised that there was a new online training module to be completed which is different to previous years and took longer to complete. Many staff were due to complete this in Quarter 4 with weekly updates and focus to achieve the target. Currently it is slightly below where we were in previous years, but there is commitment in place to achieve.

KQ asked if there was a link between the increase in falls and use of bank staff. TB commented that this was a potential line of enquiry, but it does look as though the increase may be linked as staff may not have completed assessments in the timeliest manner. RW commented that it was an area for the Trust to aspire to be a leader. TB commented that it is one of the areas within the revised Quality Strategy that could be linked to the overall Trust Strategy.

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

- IAPT – the team has sustained the improvement in its performance and has continued to meet all key performance indicators. Work continues in line with the action plan and the service is working closely with the commissioners to achieve closure of the Contract Performance Notice.
- The Exchange Recovery College – a local bid was successful around first aid mental health training.
- Easicup – will be hosted in Barnsley with a range of teams participating from across Europe.

SR highlighted in relation to Locality - Wakefield that work continues with commissioners to address the needs of a service user who is from out of the area and remains an inpatient in PICU. This has been escalated nationally to seek resolution.

CH highlighted in relation to Locality - Kirklees that the National IAPT support team noted a £1.5m investment shortfall across the two commissioners in Kirklees. Despite the level of funding, a lot of positive feedback was received, including that they were impressed by the level of activity and good practice.

CH highlighted in relation to Locality - Forensics that the national review continues, with the West Yorkshire team looking at care pathways and distribution of resources.

CH highlighted in relation to Locality - Specialist services that they were an outlier in terms of sickness absence and were trying to proactively manage this with Human Resources colleagues.

SY highlighted the following in relation to Priorities/Transformation:

- Clinical Records System - has moved to co-design phase.
- Older Peoples' Transformation - presented the clinical model to the partnership board and community and inpatient workforce workshops have been held.
- ORCHA pilot with young people - continuing and will evaluate the impact.
- Out of Area Beds - the impact of work has been outlined previously

MB highlighted the following in relation to Finance/Contracts:

- £0.6m pre STF and £1.5m surplus year to date, £0.5m from recognition of the CQUIN risk reserve and a similar amount from the final insurance settlement.
- Risk is that the underlying position in recent months has been a net deficit and there are no further planned one-off upsides.
- Out of Area Beds overspend of £1.7m which is slightly improved position in-month. January 2018 has been better in number of days reduced, however it does not always manifest in cost due to transport, complexity of care, and type of bed required.
- Agency spend in December 2017 was lower than previous months at £430k. This exceeds the in-month cap but cumulative agency expenditure remains below the cap.
- Total pay costs lower than previous months, due to Intermediate Care transfer.
- £22m cash due to timing of capital expenditure and disposal proceeds.

RW commented that a consistent message in relation to reducing non-pay spend has been reinforced and the actions staff have taken to reduce this is noteworthy. If it is possible to continue to push upsides around Out of Area Beds and manage any contract risks the Trust may be able to achieve its target. AM noted that the Trust Board have had substantial input and discussion in relation to finance, including monthly sessions with the Executive Management Team (EMT).

AGD highlighted the following in relation to Workforce:

- Appraisals – a new appraisal process will be rolled out across the Trust.
- Turnover - the Trust has taken part in an NHS Improvement support programme. Hotspot areas in relation to retention of staff include CAMHS and Learning Disabilities. These data would be combined with staff survey results to provide some targeted support.
- Flu vaccination - target reached.

- IG mandatory training - continued to be an area of focus.

It was RESOLVED to NOTE the Integrated Performance Report.

TB/18/07b Customer services report quarter 3 2017/18 (agenda item 7.2)
TB highlighted the following:

- Fortnightly report goes to the business development units (BDUs) with a quarterly report to Trust Board.
- 33 fewer formal complaints than in the previous quarter.
- Will be moving away from a Customer Services report and more towards a fuller patient experience report in 2018/19, including lessons learned.
- Customer Services Policy will be updated.

KQ commented that currently if the comments, concerns and complaints were amalgamated, it would outweigh the compliments and the reviews on NHS Choices may be incorrectly aligned to locations rather than localities. TB commented that the way matters are raised needs to reviewed as part of the update to the Customer Services Policy. To be looked at as part of the policy review.

Action: Tim Breedon

RC asked if complaints in relation to staff attitude were ever reviewed collectively over a longer period of time to see if any themes are identified, rather than on an individual basis. TB advised that they were reviewed and addressed on an individual basis rather than theme based, however could be reviewed as part of the annual planning process.

Action: Tim Breedon

RW asked if the two cases upheld by the Ombudsman would be complete within the timeframe. TB confirmed that they would and there will be lessons learned as a result of the process.

It was RESOLVED to NOTE the feedback received through Customer Services in Quarter 3 of financial year 2017/18.

TB/18/08 Strategies and policies (agenda item 8)

TB/18/08a Trust Strategy refresh (agenda item 8.1)
SY reported that the Trust's overall Strategy document had been co-produced over last 12 months, with the update finalised at the strategic Trust Board session in November 2017. Final small amendments may be needed to formatting and the foreword. The Equality Impact Assessment (EIA) also required formal sign off, with a review to take place annually on each of the programmes within the Strategy.

Action: Salma Yasmeen

Due to the nature of the changing external and internal context the Trust's Strategy would require periodic review.

It was RESOLVED to APPROVE the Trust Strategy refresh.

TB/18/08b Digital Strategy (agenda item 8.2)
KH reported that the updated Digital Strategy included the merger of the Information Management and Technology Strategy. Both were developed with a significant amount of

engagement. The update retained the four goals from the original Digital Strategy with the addition of six aims. Many of the aims relate to Information Management and Technology and also cover clinical safety and risk, learning, and development. The Strategy will be delivered through the annual digital delivery plan. An update will be provided to the Executive Management Team bi-monthly and Trust Board twice-yearly, in line with the current reporting of the previous Information Management and Technology Strategy.

CD commented that it would be interesting to understand if the Trust was a digital leader, noting that the Clinical Governance and Clinical Safety Committee would receive updates on delivery of the new Clinical Records System through the transformation/priorities programme and Audit Committee in relation to any risks around implementation. SY commented that the digital components would come through transformation board. KH commented that NHS Digital was developing a digital inclusion guide and the Trust would be involved. The Trust is also taking part in the national NHS Wi-Fi programme, which would be rolled out across the Trust.

MB highlighted that affordability needed to be a consideration with areas to be prioritised across the organisation. The Wi-Fi implementation would be funded through the national NHS programme, however funding of the ongoing costs will be the responsibility of the Trust. RW commented that there was a willingness and commitment from a number of staff to embrace this, building on the work we have already done to date on agile working. It was important to continue to be honest around capacity and finances needed to support this work.

RW asked if the Equality Impact Assessment (EIA) had been reviewed. MB confirmed it had.

Action: Mark Brooks / Kate Henry

It was RESOLVED to APPROVE the updated Digital Strategy.

TB/18/08c Treasury Management Strategy and Policy (agenda item 8.3)

MB reported that the updated strategy and policy included only minor amendments. The update had been reviewed by the Audit Committee who supported its approval by Trust Board in line with the requirements of the Scheme of Delegation. It was recommended that the strategy and policy be reviewed every two years instead of annually going forward.

It was RESOLVED to APPROVE the updated Treasury Management Strategy and that it be updated every two years instead of annually.

TB/18/09 Governance items (agenda item 9)

TB/18/09a Safe Working Hours Doctors in Training report - Quarter 2 2017/18 (agenda item 9.1)

ABe reported that the original purpose of the reporting requirement was to assure Board that the new contract was implemented, compliant, and that people were not working in excess of the contract. It also notes the impact of the ability to recruit nationally, leaving significant gaps and use of agency staff.

CD asked if the independent guardian needed to raise an issue, who they would raise it with? ABe advised that if it was an education matter it would be raised with the Associate Medical Director for training, and if it was an employment issue it would be raised with the Medical Director.

It was RESOLVED to NOTE the report and feedback from the independent guardian.

TB/18/09b Internal meetings' governance framework update (agenda item 9.2)
EJ reported that the internal meetings' governance framework document had been updated to reflect changes that have taken place in the last year, including reflecting the disbanding of the time-limited IM&T Forum. It was also recommended that the Trust Board now formally disband the time-limited Estates Forum. The Estates Forum was established by the Board to provide assurance on the implementation of the Estates Strategy, however it had not needed to meet within the last year. It was therefore recommended that it be disbanded with formal reporting to be put in place through the Executive Management Team (EMT) monthly and Trust Board six-monthly.

TB commented that in light of work around the annual review of committees and reports to the Audit Committee there may be some changes to how some of the committees operate and a further review may be needed.

It was RESOLVED to:

- **RECEIVE the update to the internal meetings' governance framework; and**
- **AGREE that the Estates Forum be formally disbanded, with reporting put in place through EMT (monthly) and Trust Board (six monthly).**

TB/18/09c Guidance for reserving matters to private session of the Trust Board (agenda item 9.3)
EJ reported within NHS Providers' and NHS Leadership Academy's guidance in relation to good governance it recommends that when determining which matters should be reserved for private consideration, the Trust should consider whether the information to be discussed would be exempt from disclosure under the Freedom of Information (FOI) Act 2000. A guidance document had been created to support the Chair when determining what matters should be reserved for discussion in a private session on Trust Board, outlining the FOI Act exemptions most likely to apply to information considered by the Trust Board as a point of reference.

AM added that it was always the Trust Board's intent to discuss as much in public as possible, unless there were specific reasons prohibiting this. In relation to section 36 of the FOI Act, this is a requirement which applies to FOI requests received and may not specifically apply to Trust Board discussions. In relation to section 38, matters of health and safety would be discussed in public, however there may be personal data and confidentiality considerations.

It was RESOLVED to APPROVE the guidelines for reserving matters to a private session of Trust Board and evaluate after 12 months through Audit Committee.

TB/18/09d Board development programme (agenda item 9.4)
AM advised that part of leadership and management development also included Board development to ensure the Board was operating effectively. The last formal session on Board development took place in January 2016. Future options include the use of an external facilitator to help identify the Board's further development needs. It was suggested that Board development could take place at a future strategic session of the Board. AM to take forward.

Action: Angela Monaghan

TB/18/10 Receipt of minutes of partnership boards (agenda item 10)

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

- Wakefield Health and Wellbeing Board 25 January 2018.

TB/18/11 Assurance from Trust Board committees (agenda item 11)

Audit Committee 9 January 2018

RC provided an update on behalf of Laurence Campbell (LC), Chair of the Audit Committee who highlighted the following:

- Risks from the corporate/organisational risk register aligned to the Audit Committee were discussed today.
- SystmOne continued oversight needed to understand any associated risks.
- Treasury Management Strategy and Policy update supported for approval by Trust Board was approved today.

In addition to the above, MB highlighted the following:

- A General Data Protection Regulation (GDPR) session took place prior to the Audit Committee meeting for Directors and Non-Executive Directors and he will ensure those that could not be in attendance were fully briefed.

Action: Mark Brooks

- A joint internal audit with Barnsley CCG relating to a procurement tender has taken place with the results provided to the Audit Committee.

TB/18/12 Trust Board work programme 2017/18 (agenda item 12)

AM advised that the draft work programme for 2018/19 would come to the next Trust Board meeting.

TB/18/13 Date of next meeting (agenda item 13)

The next meeting of Trust Board in public will be held on Tuesday 27 March 2018, Rooms 3 & 4, Laura Mitchell, Halifax.

TB/18/14 Review of meeting (agenda item 14)

The Board agreed to discuss this during the private session of Trust Board.

Signed: **Date:**

South West Yorkshire Partnership NHS Foundation Trust

TRUST BOARD 30 JANUARY 2018 – ACTION POINTS ARISING FROM THE MEETING

Actions from 30 January 2018

Min reference	Action	Lead	Timescale	Progress
TB/18/06a Corporate/organisational risk register	The Board discussed the heat map and supported the new proposal. AM suggested that a total/average risk score over time could be incorporated to see if the overall level of risk is increasing or decreasing.	MB / EJ		
TB/18/07b Customer services report quarter 3 2017/18	KQ commented that currently if the comments, concerns and complaints were you amalgamated, it would outweigh the compliments and the reviews on NHS Choices may be incorrectly aligned to locations rather than localities. TB commented that the way matters are raised needs to reviewed as part of the update to the Customer Services Policy. be looked at as part of the policy review.	TB		
TB/18/07b Customer services report quarter 3 2017/18	RC asked if complaints in relation to staff attitude were every reviewed collectively over a longer period of time to see if any themes are identified, rather than on an individual basis. TB advised that they were reviewed and addressed on an individual basis rather than theme based, however could be reviewed as part of the annual planning process.	TB		
TB/18/08a Trust Strategy refresh	SY reported that the Trust's overall Strategy document had been co-produced over last 12 months, with the update finalised at the strategic Trust Board session in November 2017. Final small amendments may be needed to formatting and the foreword. The Equality Impact Assessment (EIA) also required formal sign off, with a review to take place annually on each of the programmes within the Strategy.	SY		
TB/18/08b Digital Strategy	RW asked if the Equality Impact Assessment (EIA) had been reviewed. MB advised that the EIA was	MB / KH		

Min reference	Action	Lead	Timescale	Progress
	done on the original two strategies and an update would take place.			
TB/18/09b Internal meetings' governance framework update	It was RESOLVED to: RECEIVE the update to the internal meetings' governance framework; and AGREE that the Estates Forum be formally disbanded, with reporting put in place through EMT (monthly) and Trust Board (six monthly).	AGD		
TB/18/09c Guidance for reserving matters to private session of the Trust Board	It was RESOLVED to APPROVE the guidelines for reserving matters to a private session of Trust Board and evaluate after 12 months through Audit Committee.	MB		Added to the forward plan for the Audit Committee in January 2019.
TB/18/09d Board development programme	AM advised that part of leadership and management development also included Board development to ensure the Board was operating effectively. The last formal session on Board development took place in January 2016. Future options include the use of an external facilitator to help identify the Board's further development needs. It was suggested that Board development could take place at a future strategic session of the Board. AM to take forward.	AM		
TB/18/11 Assurance from Trust Board committees	A General Data Protection Regulation (GDPR) session took place prior to the Audit Committee meeting for Directors and Non-Executive Directors and he will ensure those that could not be in attendance were fully briefed.	MB		Presentation circulate to all Board members.

Outstanding actions from 31 October 2017

Min reference	Action	Lead	Timescale	Progress
TB/17/86c Strategic overview of business and	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	SY	April 2018	

Min reference	Action	Lead	Timescale	Progress
associated risks	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.			

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 March 2018
Agenda item 5

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 outlines the current context, one 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 also includes *The Brief* that goes to all staff and will be supplemented by a verbal update.
Executive summary:	*The Brief* sets out the overall context that we are working within. There are areas of emphasis to draw the attention of the Board: • **There were no announcements within the Spring Budget statement that impact upon the NHS.** This is in line with expectations, though there is an increasing political debate about sustainable future funding. • **Speculation continues about the potential for a new three year deal for NHS staff.** The negotiations on this have not yet concluded, though it is widely reported that staff will be offered a front-loaded deal that may be worth over 6% over 3 years, in return for a day of annual leave. Our work on retaining staff continues, with support from NHS Improvement. The Board report on the Staff Survey outcomes and links to the workforce plan is a relevant consideration here. • **Details of the social care green paper are emerging, with the Secretary of State for Health setting out principles that will govern the future of social care for older people.** The response has focused on the ongoing pressures on social care budgets across the country, with the Local Government Association requesting a "down payment" to help meet the reported £2bn of pressures by 2020. • **The NHS and social care system continues to be under significant pressures with national figures showing the worst performance against the A&E 4 hour target since it was introduced.** This masks the fact that in February 2018, 30,000 more patients were seen within four hours than the previous February. This shows the increased demand, exacerbated by flu

	and severe weather. • **Severe weather continues to affect the country, leading to additional pressure.** This is playing out in South West Yorkshire, with staff responding well to the issues we face, implementing business continuity processes as required. • **We continue to play a role in national policy and lobbying, including the *All Party Parliamentary Group into Arts and Health*** http://www.artshealthandwellbeing.org.uk/appg-inquiry/ **and the *Bercow 10 years on* report into speech and language therapy from the Royal College of Speech & Language Therapists/I-Can charity** http://www.bercow10yearson.com/wp-content/uploads/2018/03/337644-ICAN-Bercow-Report-WEB.pdf We are progressing the programme to ensure that the Arts and Health work is embedded in the West Yorkshire & Harrogate Health and Care Partnership, with a strong lead from Calderdale. This builds on Creative Minds strong presence. • **The role of collaboration and joined up services in the future of health and care continues.** This is demonstrated by the publication of the *Next Steps* document in West Yorkshire & Harrogate and progress in South Yorkshire. Weekly communications son the significant progress being made in each area is shared with Board members. These are covered on the agenda, alongside developments in our local places. • **Business planning guidance has been issued, with associated contract variations to be signed by March 23rd.** This is covered in the Board papers and we are making good progress with partners. There is a requirement that each Clinical Commissioning Group must meet the Mental Health Investment Standard, and we are working to ensure that this is the case. Pressures on acute beds continues to be the biggest area of risk for the system. • **The Care Quality Commission [CQC] have now begun visits and have been into the organisation inspecting core services, with more than half now covered.** This is in advance of the Well Led Review. Prior to this, a focused safety report into Ward 18 at the Priory Unit was published and showed the unit was good for safety. The CQC has witnessed the extra efforts that staff have made during the cold weather and are again inspecting us during the toughest of times. • **We have launched #allofusimprove – our programme of support for change across the Trust.** This is linked to the Director of Strategy's role and the creation of change frameworks and networks. These are reflected in the Quality Strategy • **We continue to celebrate success and thank staff as part of #NHS70.** Over 600 nominations have been received by staff for staff to recognise them as an "NHS Superstar". Board members are invited to peruse the nominations here http://www.southwestyorkshire.nhs.uk/superstar/meet/

	• **Congratulations to Creative Minds, named organisation of the year at the Disability Sport Yorkshire Awards**. This is a fantastic accolade and highlights the sporting elements of our linked charity.
Recommendation:	**Trust Board is asked to NOTE the Chief Executive's report.**
Private session:	Not applicable.

NHS
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NHS Foundation Trust

The Brief

1 March 2018

Monthly briefing for staff, including feedback from Trust Board and executive management team (EMT) meetings

With **all of us** in mind.

Our mission and values

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

To achieve our mission we have a strong set of values:

- We put people first and in the centre and know that families and carers matter
- We're respectful, honest, open and transparent
- We constantly improve and aim to be outstanding so that we're relevant today and ready for tomorrow

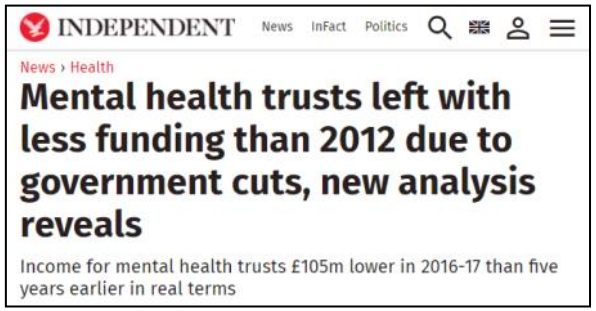
Tracy Brabin MP visits
Trust services, including CAMHS

With **all of us** in mind.

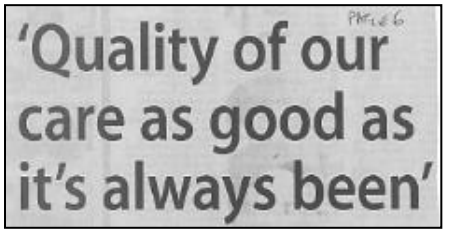
What's happening externally

National and local news

2018/19 planning guidance out



RCP analysis of mental health funding



CEO letter in Barnsley Chronicle

West Yorkshire STP publish 'Next steps'

South Yorkshire STP publish 2nd hospital services report

With **all of us** in mind.

What's happening internally

Safety and quality

CQC well-led review (9-11 Apr)

- Unannounced visits to services will take place – possibly to those that had 'must do' actions in the last inspection
- They will also follow up on our 'should do' actions - please make sure you're aware of progress made in your service
- Find out more on the intranet and don't forget to share all the things you're proud of with the CQC

Incidents

- **1,102** incidents reported in Jan:
  - 985 were rated green (no/low harm)
  - 109 were rated yellow or amber
  - 8 were rated as red
- 4 serious incidents reported in Jan – 3 apparent suicides and a grade 3 pressure ulcer

With **all of us** in mind.

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What's happening internally

Performance (Jan)

- **117%** overall safer staffing fill rate
- **100%** average fill rate of registered nurses, **95%** on days, **105%** on nights
- **97%** of people would recommend our community services and **85%** our mental health services
- **51%** of people completing IAPT treatment and moving to recovery
- **268** out of area bed days
- **2** young people admitted to adult wards
- **7** confidentiality breaches

Confidentiality breaches

These relate to information disclosed in error, being faxed or posted to the wrong person or place.

89% of staff were up to date on data security training at the end of Jan – our target is 95%.

With **all of us** in mind.

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What's happening internally

Staffing

- January's sickness absence rate was 5.9%, we're at 5.2% so far this year – our target is 4.5%
- Nominations for staff governor elections close on 2 March and voting opens on 26 March – take part in electing your staff group representative
- Our annual staff listening events are being held in May – one in each of our districts. Come along to hear from our chief exec and share your views. Keep an eye out for dates and more info in The Headlines.

Hundreds of staff have been nominated by a colleague, service user or carer – find out who and read comments on the intranet.

With **all of us** in mind.

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What's happening internally

Month 10 finances (Jan)

- We now have a year to date surplus of £635k – we need to achieve a £1m surplus by the end of March, which will be a real challenge
- We spent £465k on agency – we're expecting to go 4% over our cap set by NHS Improvement
- We've saved £6.2m so far this year in cost improvement initiatives, £0.6m less than planned
- We have an NHS Improvement financial risk rating of 1 – the highest possible out of 4

Thanks for your continued work to help control spend. We will only achieve our control total (and get an extra £0.5m) if we keep going.

With **all of us** in mind.

What's happening internally

Infrastructure

Clinical record system

- Co-design workshops with service representatives are now taking place
- Email if you want to join our change champion network: crsprogramme@swyt.nhs.uk
- Read more by clicking the SystmOne bookmark on the intranet homepage

Unity Centre

- Ground works are now underway and some steel frames are up
- The roof will go up after Easter
- We're trying to keep disruption to a minimum – thanks for your patience

With **all of us** in mind.

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What's happening internally

Service change

- Thank you to all staff, clinical and non-clinical, for helping to keep services up and running during recent bad weather
- We're working to TUPE transfer diabetes service staff to Barnsley Hospital from 1 Apr
- Barnsley Council's procurement of intermediate care independent sector beds started on 26 Feb
- Low and medium secure services had an annual Quality Network for Forensic Mental Health Services review on 23/24 Jan – verbal feedback was positive and we expect the full report back by the end of March

Mental health inpatient wards

Bed occupancy levels remain high and we're keeping a strong focus on out of area beds. There's lots of activity underway to maintain optimum patient flow – thanks for everyone's efforts.

With **all of us** in mind.

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Focus on:

Improving quality

Together, all of us can improve. We need to be ready for tomorrow because we want to be outstanding and we want everyone to reach their potential.

We must get from where we are to where we want to be. We want to improve care, improve health and improve our use of resources. We'll share - and learn from - what each other is doing.

You can do something to make a difference. If you see something that can be improved, take action. It doesn't matter what role you're in, there's support available.

Focusing on three areas of quality (Darzi's definition):

- Patient safety
- Effectiveness
- Experience of care

Get involved:

- Read fortnightly case studies
- Share your improvements
- Discuss in teams

With **all of us** in mind.

Take home messages

NHS
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Maintaining quality is a priority - #allofusimprove focuses on safety, effectiveness and experience

We welcome the CQC coming to review our services again – read more on the intranet

It's nearly the end of the financial year – make sure your mandatory training is up to date

Financially, we've still got a way to go if we're to meet our required year-end surplus

Get involved in your Trust – vote for a Governor, put forward a superstar, attend a listening event

Thank you for keeping going during what has been a tough winter

What do you think about The Brief?
comms@swyt.nhs.uk

With **all of us** in mind.

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Trust Board 27 March 2018
Agenda item 6.1

Title:	**Integrated Performance Report**
Paper prepared by:	Director of Finance & Resource and Director of Quality & Nursing
Purpose:	To provide the Board with the Integrated Performance Report (IPR) for February 2018.
Mission/values/objectives	All Trust objectives
Any background papers/ previously considered by:	• IPR is reviewed at Trust Board each month • IPR is reviewed at Executive Management Team Meeting on a monthly basis
Executive summary:	**Quality** • CQC inspecting core services during March – a range of visits have taken place to inpatient wards and community services. • 122 data information requests received following the visits with more anticipated. • Safer Staffing - Overall fill rates for all inpatient areas remain above 90%; Overall fill rates of 117.5% in February • All safeguarding staff providing Prevent Training – over 90% of staff have attended • 360 Assurance have undertaken an internal audit of our mortality process – the report is awaited • Infection Prevention Control Surveillance - 3 cases of C difficile to date and all deemed unavoidable. • Incident reporting levels remain within range however the serious incident levels are subject to review • An increase in falls linked to one service user in medium secure. Investigations and harm minimisation in place **NHSI Indicators** • The Trust continues to perform well against the vast majority of nationally reported measures • Improving Access to Psychological Therapies – proportion of people moving to recovery for the month of February is currently just over the 50% threshold but is yet to be finalised. It is anticipated that the threshold of 50% will be maintained • The total number of bed days used by Children and Younger People in Adult wards has reduced to 28 during the month and relates to 1 service user admitted to the Horizon centre in November 2017 who remains an inpatient. **Locality** • Within Barnsley we are working with our partners on the development of new model of care for stroke services • New Musculo Skeletal (MSK) service is on track to go live from April • High pressures on many inpatient wards given occupancy acuity levels • Increased focus being applied to the recording of supervision

	• A CQC visit in conjunction with Prison Inspectorate has taken place in Wetherby. Very positive feedback regarding level of service, support to prison personnel and integrated working with Leeds Community Health. • On call in CAMHs remains a key concern for staff. Developmental work continues with regard to an all-age psychiatric liaison team model with the intention of ensuring safer and more sustainable 24/7 crisis resolution delivery **Priority Programmes** • The mental health clinical record system programme is now in the co-design phase of the project and is on track with key milestones. • Business case for Older Peoples Service Transformation is progressing and work continues with the community workforce model to ensure new roles are an integral part of the model design • Action plans are in place for the flow and out of area beds project to reduce immediate out of area expenditure and sustainability plans are being developed to reduce people being placed out of area. **Finance** • Pre-STF surplus of £0.6m generated in February driven by a gain on disposal of £350k, pay savings and an agree to refund some bespoke care costs • Cumulatively there is now a pre STF surplus of £1.2m, which is ahead of plan, largely through non-recurrent means • In-month out of area bed costs were the highest of the year at £373k meaning the year-to-date overspend is now in excess of £1.9m. • Agency costs also increased to £563k in the month with increasing acuity on inpatient wards a key factor. Year to date agency costs are 41% lower than last year and remain a little below our cap. • CIP delivery of £6.8m is £0.7m lower than plan • Achievement of the year-end control pre STF total of £1.02m is more likely given the benefits from the gain on disposal of the former Castleford & Normanton District Hospital • Cash is ahead of plan at £25.5m due to the timing of capital expenditure and asset disposal receipts. It will reduce by the end of the year. **Workforce** • Sickness absence has reduced slightly to 5.8% in February taking the cumulative level of absence to 5.3%, which remains higher than the target of 4.5% • Information Governance training compliance is 95.7% and is now therefore above the 95% threshold.
	Trust Board is asked to NOTE the Integrated Performance Report and comment accordingly.
Private session:	Not applicable

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Integrated Performance Report

Strategic Overview

February 2018

With **all of us** in mind.

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Introduction

Please find the Trust's Integrated Performance Report (IPR) for Febaruary 2018. An owner is identified for each key metric and the report aligns 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. This single report 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, meet the requirements of our regulators and provide 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 on these changes was taken to the December Board, 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 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
- 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.

This dashboard is a summary of key metrics identified and agreed by the Trust Board to measure performance against Trust objectives. They are deliberately focussed on those metrics viewed as key priorities.

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	2	2	2	2		2
CQC Quality Regulations (compliance breach)		Green	Green	Green	Green	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	2	2	1		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%	98.2%	98.2%	97.2%	*95.0%*		4
% clients in settled accommodation		*60%*	82.2%	82.5%	82.2%	81.8%	81.7%	80.8%	80.7%	80.5%	80.4%	80.1%	80.4%		4
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks [1]		*TBA*	80.3%			87.5%			86.8%			Due April 18			
Out of area beds [2]		<=100 Green, 101 -199 Amber, >=200 Red	286	357	242	341	362	424	467	412	407	268	613		1
IAPT – proportion of people completing treatment and moving to recovery		50%	45.6%	49.4%	56.4%	52.4%	49.1%	51.3%	53.3%	54.1%	54.5%	*50.7%*	*50.6%*		4
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%	86%	85%	85%	85%		85%
Friends and Family Test - Community		98%	97%	99%	98%	95%	99%	99%	97%	98%	100%	97%	97%		98%
Patient safety incidents involving moderate or severe harm or death (Degree of harm subject to change as more information becomes available) [6]		N/A	18	22	32	29	28	25	29	34	28	34	39		N/A
Safer staff fill rates		90%	110%	111%	103%	112.6%	109%	111.8%	112.9%	115.7%	113.4%	117.1%	117.5%		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	12	7	7	10		
% people dying in a place of their choosing [4]			Reporting established from Sept 17					82.6%	90.9%	88.6%	87.5%	94.3%	84.4%		
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	£856k	£136k	£136k	£136k		£185k
Surplus		In line with Plan	£26k	£53k	£95k	£204k	£226k	£6k	£158k	£235k	£551k	£635k	£1186K		£1120k
Agency spend		In line with Plan	£501k	£426k	£500k	£457k	£446k	£435k	£515k	£531k	£430k	£465k	£563K		£6m
CIP delivery		£1074k	£472k	£1024k	£1643k	£2306k	£2950k	£3452k	£4117k	£4815k	£5442k	£6157k	£6816k		£7.5m
Sickness absence		4.5%	4.8%	4.7%	4.7%	4.8%	4.9%	4.9%	4.9%	5.0%	5.1%	5.2%	5.3%		5.2%
Mental Health Act training		>=80%	51.2%	56.9%	70.5%	75.0%	80.3%	81.6%	83.4%	84.7%	86.6%	86.4%	86.0%		85%
Mental Capacity Act Training		>=80%	64.9%	69.6%	78.0%	82.5%	86.1%	87.6%	88.9%	90.3%	91.1%	91.0%	91.1%		90%

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.
6- Further information is provided under Quality Headlines. Data is extracted from a live system, and correct at the time of reporting. The degree of harm is initially recorded based on the potential level of harm, and is subject to change as further information becomes available e.g. when actual injuries or cause of death are confirmed.

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 Integrated Performance Report.

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:

Quality
• CQC inspecting core services during March – a range of visits have taken place to inpatient wards and community services.
• 122 data information requests received following the visits with more anticipated.
• Safer Staffing - Overall fill rates for all inpatient areas remain above 90%; Overall fill rates of 117.5% in February
• All safeguarding staff providing Prevent Training – over 90% of staff have attended
• 360 Assurance have undertaken an internal audit of our mortality process – the report is awaited
• Infection Prevention Control Surveillance - 3 cases of C difficile to date and all deemed unavoidable.
• Incident reporting levels remain within range however the serious incident levels are subject to review
• An increase in falls linked to one service user in medium secure. Investigations and harm minimisation in place

NHSI Indicators
• The Trust continues to perform well against the vast majority of nationally reported measures
• Improving Access to Psychological Therapies – proportion of people moving to recovery for the month of February is currently just over the 50% threshold but is yet to be finalised. It is anticipated that the threshold of 50% will be maintained
• The total number of bed days used by Children and Younger People in Adult wards has reduced to 28 during the month and relates to 1 service user admitted to the Horizon centre in November 2017 who remains an inpatient.

Locality
• Within Barnsley we are working with our partners on the development of new model of care for stroke services
• New Musculo Skeletal (MSK) service is on track to go live from April
• High pressures on many inpatient wards given occupancy acuity levels
• Increased focus being applied to the recording of supervision
• A CQC visit in conjunction with Prison Inspectorate has taken place in Wetherby. Very positive feedback regarding level of service, support to prison personnel and integrated working with Leeds Community Health.
• On call in CAMHs remains a key concern for staff. Developmental work continues with regard to an all-age psychiatric liaison team model with the intention of ensuring safer and more sustainable 24/7 crisis resolution delivery

Priority Programmes
• The mental health clinical record system programme is now in the co-design phase of the project and is on track with key milestones.
• Business case for Older Peoples Service Transformation is progressing and work continues with the community workforce model to ensure new roles are an integral part of the model design
• Action plans are in place for the flow and out of area beds project to reduce immediate out of area expenditure and sustainability plans are being developed to reduce people being placed out of area.

Finance
• Pre-STF surplus of £0.6m generated in February driven by a gain on disposal of £350k, pay savings and an agree to refund some bespoke care costs
• Cumulatively there is now a pre STF surplus of £1.2m, which is ahead of plan, largely through non-recurrent means
• In-month out of area bed costs were the highest of the year at £373k meaning the year-to-date overspend is now in excess of £1.9m.
• Agency costs also increased to £563k in the month with increasing acuity on inpatient wards a key factor. Year to date agency costs are 41% lower than last year and remain a little below our cap.
• CIP delivery of £6.8m is £0.7m lower than plan
• Achievement of the year-end control pre STF total of £1.02m is more likely given the benefits from the gain on disposal of the former Castleford & Normanton District Hospital
• Cash is ahead of plan at £25.5m due to the timing of capital expenditure and asset disposal receipts. It will reduce by the end of the year.

Workforce
• Sickness absence has reduced slightly to 5.8% in February taking the cumulative level of absence to 5.3%, which remains higher than the target of 4.5%
• Information Governance training compliance is 95.7% and is now therefore above the 95% threshold.

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	Nov-17	Dec-17	Jan-18	Feb-18	Q1 17/18	Q2 17/18	Q3 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	0	0	0	0	1	0	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	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	13% 7/56	9% 4/43	17% 13/76	18% 13/72	19.8% 43/217	18.2% 38/208	7.7% 13/168	4
Service User Experience	Friends and Family Test - Mental Healtl	Improving Health	Caring	TB	85%	72%	71%	71%		85%	82%	86%	89%	79%	85%	86%	86%	85%	85%	85%	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%	100%	97%	97%	98%	98%	98%	4
Quality	Total number of reported incidents	Improving Care	Safety Domain	TB	N/A	3509	3405	3293	2946	848	1023	978	1083	1084	897	995	993	969	1120	1113	2849	3064	2957	N/A
	Total number of patient safety incidents resulting in Moderate harm. (Degree of harm subject to change as more information becomes available)9	Improving Care	Safety Domain	TB						15	16	26	20	24	14	21	20	17	26	31	57	58	58	
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available)9	Improving Care	Safety Domain	TB	N/A	10	19	19	20	1	0	2	3	1	4	1	5	3	2	3	3	8	9	N/A
	Total number of patient safety incidents resulting in death harm. (Degree of harm subject to change as more information becomes available)	Improving Care	Safety Domain	TB	N/A	73	79	73	84	2	6	4	6	3	7	7	9	8	6	5	12	16	24	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%	15.3%	16.7%	20.8%	20.6%	18.2%	24.3%	16.5%	3
	Safer staff fill rates	Improving Care	Safety Domain	TB	90%					110%	111%	103%	112.6%	109%	111.8%	112.9%	115.7%	113.4%	117.1%	117.5%	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%	101%	96.6%	99.9%	97.6%	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	26	29	45	29	82	92	71	N/A
	Number of pressure ulcers (avoidable)2	Improving Care	Safety Domain	TB	0	1	4	3	2	0	1	1	0	1	0	1	1	0	2	0	2	1	2	3
	Complaints closed within 40 days	Improving Health	Responsive	TB	80%				28% 11/39	10% 2/20	24% 6/25	0% 0/18	10% 2/20	11% 2/18	17% 2/12	0% 0/18	19% 4/20	0% 0/5	28%	8% 2/26	12.7% 8/63	12% 6/50	9.3% 4/43	1
	Referral to treatment times	Improving Health	Responsive	KT/SR/CH	TBC	KPI under development																		
	Un-outcomed appointments6	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%	2.7%	2.5%	2.5%	2.4%	4.3%	3.3%	2.5%	N/A
	Number of Information Governance breaches3	Improving Health	Effective	MB	<=8	36	25	29	36	9	12	12	6	10	6	5	12	7	7	10	33	22	24	
	Staff FFT survey - % staff recommending the Trust as a place to receive care anc treatment	Improving Health	Caring	AD	80%	N/A	79.26%	N/A	80%	N/A											74%	75%	N/A	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	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	33	59	20	23	81	113	148	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	0	0	0	0	0	4
	Number of Duty of Candour applicable incidents4	Improving Health	Caring	TB	N/A	73	86	83	86	244									Due March 18	Due April 18	154			N/A
	Duty of Candour - Number of Stage One exceptions4	Improving Health	Caring	TB	N/A	Reporting established from Oct 16		0	2	2	0	2	3	1	4	3	3	3			4	8	9	N/A
	Duty of Candour - Number of Stage One breaches4	Improving Health	Caring	TB	0	Reporting established from Oct 16		0	1	3											1		2	3
	% Service users on CPA given or offered a copy of their care plan	Improving Care	Caring	KT/SR/CH	80%	85.6%	85.0%	83.0%	85.2%	85.2%	85.0%	85.5%	85.0%	85.3%	85.6%	81.4%	85.4%	85.0%	85.2%	85.1%	85.2%	85.6%	85.0%	4
	% of prone restraint with duration of 3 minutes or less8	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%	69%	82%	70%	80.6%	75%	80%	77%	4
	Delayed Transfers of Care10	Improving Care	Effective	KT/SR/CH	7.5% 3.5% from Sept 17	2.2%	2.6%	3.1%	2.7%	1.9%	1.7%	1.1%	1.7%	2.8%	2.8%	2.70%	2.4%	2.9%	3.9%	3.4%	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	Improving Care	Well Led	KT/SR/CH	80%	39.5% (March 17)				59.3%			61.0%			64.7%			81.7% 11		59.3%	61.0%	64.7%	4
	Number of Falls (inpatients)	Improving Care	Safety Domain	TB	TBC	162	158	136	95	38	52	49	39	54	46	41	43	66	40	75	139	139	150	
	Number of restraint incidents	Improving Care	Safety Domain	TB	N/A	Data not avail				104	140	101	144	159	121	134	132	176	204	186	345	424	442	N/A

** 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.

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 on bands 5 and above (excluding medics) 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.

9 - Incidents may be subject to re-grading as more information becomes available.

10 - In the 2017/18 mandate to NHS England, the Department of Health set a target for delayed transfers to be reduced to no more than 3.5 per cent of all hospital bed days by September 2017. The Trusts contracts have not been varied to reflect this, however the Trust now monitors performance against 3.5%.

11 - The figures reported for February 18 are as at 15th March 2018 for the period 01/01/18 - 15/03/18.

Quality Headlines

During 2017/18 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 April 18 - data is currently being reviewed and validated.

• 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. The customer service team maintain central oversight and management of the complaints process with 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 set 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. In light of the service developments the 40 day target has been suspended until 1st April 2018, when additional targets will also be included to demonstrate performance of the complaints management process.

• Number of pressure ulcers (attributable) - The number of pressure ulcers developing in patients on the Trust caseload has increased to 45 during the month of January. The increase is linked to the number of vulnerable patients under the care of the Trust during this period and an increase in the number of outbreaks of diarrhoea and vomiting infections in care homes which would contributed to the breakdown of the skin. Also ill health due to viral infections in community, where the vulnerable are less mobile, developed chest infections and more likely to spend longer periods of time is bed. January has been a challenging period for all community teams.

• % of prone restraint with duration of 3 minutes or less - The number of restraint incidents occurring over 3 minutes during February 17 has decreased compared to last month and is now reporting over the 80% threshold at 80.6% This relates to 6 incidents out of 31 being for 3 minutes or more. All had cogent reasons for restraint. 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%.

• Number of restraint incidents - January 2018 had seen a spike in reported incidents. On review of the data, 46% of the incidents were attributed to 3 wards: horizon (learning disability), Walton (psychiatric intensive care unit) and priory 2 (adults acute mental health). 9 individuals accounted for 84 of the incidents or 40% of the total. These individuals all have positive behaviour support plans in place or in the process of having one created. February 2018 data shows a reduction in incidents during the period and continues to be monitored.

• NHS Safety Thermometer - Medicines Omissions – This only relates to Inpatient areas in Calderdale, Kirklees and Wakefield. SWYPFT has been focusing on reducing medication omissions on in-patient areas for the past 3.5 years. The Mental Health Safety Thermometer's national data has shown that the trust has been an outlier when benchmarked to other mental health/combined trusts. The national average for medication omissions on in-patient units is currently at 16%, SWYPFT has been around the 24% mark, however there has been a concerted effort to identify specific medication omissions in given clinical scenarios over the past year. At Quarter 3 the average for SWYPFT was 16.5%. February 2018 position has decreased slightly to 20.6. Analysis of the data has been undertaken and has found the adult wards have shown an improvement but the older peoples wards have shown a deterioration across all worsened. This appears to be linked to the acuity levels on the wards and the response to winter pressures. The biggest reason for medicine omissions remains refusal by the service user.

• Duty of Candour - Number of Stage One breaches - 3 breaches reported to end January 2018. This relates to one in the Kirklees BDU where a verbal apology was given on day 14 and the service user declined a letter of apology from the Trust. 2 in the Wakefield BDU - 1 related to a patient who fell on Stanley ward and 1 related to Older People CMHT where the apology took place outside the required timeframe. The guidance for duty of candour stipulates that apology should be made within 10 days.

• Number of Falls (inpatients) - reported falls in February has increased to 75. Forensic BDU have seen the largest increase of incidents this month and this is attributed to one service user (23 fall incidents) who is currently under a lot of medical investigations to identify the root cause. The increase in falls relates to one person. There is a robust harm minimisation plan in place to increase observations and support the person's physical health. The plan also includes a series of physical health investigations and liaison with Specialist Advisors. The service plans to undertake a peer review of this case. Appropriate interventions are being undertaken by staff involved in the care of this individual to reduce risk.

• Friends and Family Test - Community - the Trust have set a local stretch target of 98% for this indicator. This has been set based on historic performance. The Trust regularly reports above this level and benchmarks well with comparable organisations. The slight drop below this level during February 2018 relates to receipt of a high number of returns from the Children's Immunisation Team, where a couple of respondents stated they were unlikely to recommend due to their injection being painful.

Safety First

Summary of Incidents during 2017/18

	Q1 17/18	Q2 17/18	Q3 17/18	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Total
Green no harm	1765	1893	1774	537	625	603	662	670	561	607	587	580	665	633	6730
Green	782	854	824	228	286	268	317	295	242	271	264	289	337	344	3141
Yellow	226	229	262	66	86	74	77	88	64	85	102	75	86	101	904
Amber	57	59	63	14	18	25	18	25	16	21	28	14	23	29	231
Red (should not be compared with SIs)	19	29	34	3	8	8	9	6	14	11	12	11	9	6	97
Total	**2849**	**3064**	**2957**	848	1023	978	1083	1084	897	995	993	969	1120	1113	11103

** incidents may be subject to re-grading as more information becomes available*

• Incident reporting levels have been checked and remain within the expected range.
• Degree of harm and severity are both subject to change as incidents are reviewed and outcomes are established.
• Reporting of deaths as red incidents in line with the Learning from Healthcare Deaths may increase the number of red incidents whilst causes of death/circumstances are clarified.
• All serious incidents are investigated using 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.
See http://nww.swyt.nhs.uk/incident-reporting/Pages/Patient-safety-and-incident-reports.aspx
• Risk panel remains in operation and scans for themes that require further investigation. Operational Management Group continues to receive a monthly report.
• No never events reported in Feb 2018

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.

Summary of Serious Incidents (SI) by category 2017/18

	Q1	Q2	Q3	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Total
Administration/supply of medication from a clinical area	**0**	**1**	**1**	0	0	0	1	0	0	0	1	0	0	0	2
Death - cause of death unknown/ unexplained/ awaiting confirmation	**0**	**1**	**0**	0	0	0	0	0	1	0	0	0	0	0	1
Death - confirmed related to substance misuse (drug and/or alcohol)	**1**	**0**	**1**	1	0	0	0	0	0	0	1	0	0	0	2
Fire / Fire alarm related incidents	**1**	**1**	**0**	0	0	1	1	0	0	0	0	0	0	0	2
Formal patient absent without leave	**0**	**0**	**1**	0	0	0	0	0	0	0	1	0	0	0	1
Illegal Acts	**1**	**0**	**0**	1	0	0	0	0	0	0	0	0	0	0	1
Informal patient absent without leave	**0**	**0**	**1**	0	0	0	0	0	0	0	0	1	0	0	1
Information disclosed in error	**1**	**1**	**2**	0	1	0	0	0	1	0	2	0	0	0	4
Self harm (actual harm)	**2**	**0**	**0**	0	1	1	0	0	0	0	0	0	0	0	2
Self harm (actual harm) with suicidal intent	**0**	**0**	**0**	0	0	0	0	0	0	0	0	0	0	1	1
Suicide (incl apparent) - community team care - current episode	**4**	**10**	**13**	1	1	2	5	2	3	4	4	5	2	3	32
Suicide (incl apparent) - community team care - discharged	**0**	**2**	**2**	0	0	0	1	0	1	1	0	1	0	0	4
Suicide (incl apparent) - inpatient care - current episode	**0**	**0**	**1**	0	0	0	0	0	0	0	1	0	1	0	2
Vehicle Incident	**1**	**0**	**0**	0	0	1	0	0	0	0	0	0	0	0	1
Homicide by patient	**1**	**0**	**0**	0	0	1	0	0	0	0	0	0	0	0	1
Physical violence (contact made) against other by patient	**1**	**1**	**1**	0	0	1	0	0	1	1	0	0	0	0	3
Pressure Ulcer - grade 3	**1**	**1**	**3**	0	0	1	1	0	0	1	1	1	1	0	6
Physical/sexual violence by other	**1**	**0**	**0**	0	0	1	0	0	0	0	0	0	0	0	1
Total	**15**	**18**	**26**	3	3	9	9	2	7	7	11	8	4	4	67

Mortality

• The Trust's Learning from Healthcare Deaths information is now reported through the quarterly incident reporting process. Reports are available on the Trust website when approved by Trust Board. These include learning to date. Mortality is being reviewed and learning identified through different processes:
Serious incidents and service level investigations – learning will be shared in Our Learning Journey report for 2017/18
Structured Judgement Record Reviews – 8 cases have been completed for Q1 and Q2 cases. Due to small numbers to date, it is difficult to identify any themes. Of note, in 5 of the 8 cases, the overall care was rated as good (4) or excellent (1). The learning from healthcare deaths report includes examples of areas for improving practice identified by the reviewers, and also good practice examples. These will be developed into themes as more reviews are completed. See the following link for further information http://www.southwestyorkshire.nhs.uk/about-us/performance/learning-from-deaths/

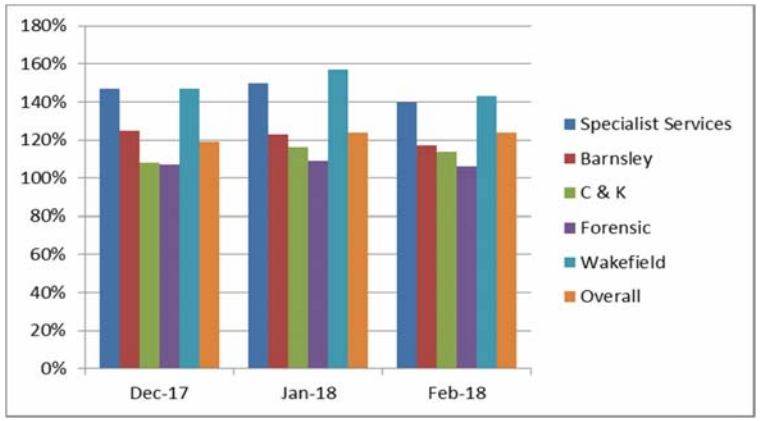
• Internal audit are undertaking a review of our mortality process – the report is due at the end of February 2018
• A review of the Learning from Healthcare Deaths policy will be done to take into account feedback from the audit findings. Any comments on the policy are welcomed to feed into the review process via risk@swyt.nhs.uk
• 360 Assurance have undertaken an internal audit of our mortality review process . Our process received significant assurance.

Safer Staffing

Overall Fill Rates: 117.5%
Registered fill rate: (day + night) 97.6%
Non Registered fill rate: (day + night) 137.8%

Overall fill rates for staff for the all inpatient areas remain above 90%.

BDU Fill rates - Nov 17 - Feb 18



Unit	Dec-17	Jan-18	Feb-18
Specialist Services	147%	150%	140%
Barnsley	125%	123%	117%
C & K	108%	116%	114%
Forensic	107%	109%	106%
Wakefield	147%	157%	143%
Overall	119%	124%	124%

The figures (%) for February 2018
Registered Staff:
Days 90.8 (decrease of 4.0 on January)
Nights 104.4 (decrease of 0.4 on January)

Registered average fill rate:
Days and nights 97.6 (decrease of 2.2 on January)

Non Registered Staff
Days 133.0 (increase of 1.8 on January)
Nights 142.6 (increase of 4.9 on January)

Non Registered average fill rate:
Days and nights 137.8 (increase of 4.9 on January)

Overall average fill rate all staff: 117.5 (increase of 0.4 on January)

Overall fill rates for staff for the all inpatient areas remain at 90%

Safer Staffing cont…

Summary

For the sixth consecutive month, no ward fell below a 90% overall fill rate in February. Of the 30 inpatient areas listed 20 (66%) achieved greater than 100%. Indeed of these 20 areas, 9 achieved greater than 120%.
Registered On Days (Trust Total 90.8%)
There has been an increase in the number of wards that have failed to achieve 80% registered nurses, four wards in all (13.2%) compared to two (6.6%) in January. Chippendale has increased to 74% (+12.0%), Priestley has decreased to 69.6% (- 23.4%) which can be attributed to sickness and supporting other areas within their BDU, Chantry Unit has increased 78.6% (+3.6%) and Ward 19 has decreased to 78.2% (-7.5%)
Registered On Nights (Trust Total 104.8%) There are various interventions we consider when 80% is not achieved, including altering the skill mix to cover registered staff shortfalls with non-registered staff, moving peripatetic staff onto that area, block booking bank/agency staff if it is an ongoing issue and if necessary, supporting the areas with a staffing continuity escalation plan.
The number of wards which are achieving 100% and above fill rate on nights remained at 70% (21 wards) for the second consecutive month. No ward fell below the 80% registered nurse threshold which is a decrease of one.
Average Fill Rates for Barnsley BDU decreased by 6% to 117%. Calderdale and Kirklees BDU were 114%, a decrease of 2%. Forensic BDU were 106% with a decrease of 3%. Wakefield BDU were 143% with a decrease of 14%. Specialist services were 140% with a decrease of 10%.
Despite the achievement and above of expected fill rates, significant pressures remain on inpatient wards due to demands arising from acuity of service user population. This is particularly apparent in PICU in Wakefield where additional duties such as special observations and 2 staff to 1 service user observations are being used. Measures have been taken to support the ward team with bank, agency and off ward staff during this period.

Centralised values-based staff recruitment continues. Most recent assessment centre resulted in job offers to 8 x band 5 staff nurses and 36 x bank band 2tnt health care assistant posts.

Recent analysis of additional ward duties has shown a significant demand placed on wards over and above usual staffing establishments. These additional duties were for clinical reasons only and requested in response to increased clinical acuity and demands on staff. Additional duties included special observations of service users, escorting inside and outside of ward, seclusion, special needs and enhanced care packages.

Information Governance

There were 10 confidentially breaches reported during February 18. Each incident is being investigated and corrective actions will be taken where required. A breakdown of the incidents can be seen below:
• 9 incidents of data being disclosed in error, largely due to documents being emailed or posted to the wrong address.
• 1 incident of sensitive personal data being lost from a vehicle that had collected confidential waste from a Trust site.

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.
- Improving physical healthcare to reduce premature mortality in people with severe mental illness (PSMI)
  - o Part a is reliant upon the result of national audit data which will be available in Q4. All elements of a record being audited need to achieve the standard, if all not achieved, this results in a fail for the whole record.
  - o Part b – results for Q4 achievement dependant on local audit reviewing success of sharing and exchanging information. Audit will be across multiple organisations, SWYPT process robust but cannot guarantee others will be.
- Risky Behaviours – the Trust had reported some under performance in Q2 against national thresholds. There has been a significant amount of work linked to these indicators, the guidance is ambiguous. Further work has been undertaken on reviewing the specific cases that did not meet the Q2 requirements. For the West, the Trust had found mitigating evidence meaning that the indicator had been achieved and this has now been agreed with the commissioner which reduced the loss of income. Q3 position was achieved across the board and Q4 is forecast to achieve.
- A&E Attendance for people with Mental Health problems – The Trust has actioned as much as possible, Q4 results are dependent upon achieving a 20% reduction in attendances compared to 16/17 baseline.

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.

NHSI has confirmed the 0.5% CQUIN risk reserve can now be recognised. The full year forecast is for a £185k shortfall in achievement. The Trust will be undertaking the Q4 submission at the end of April.

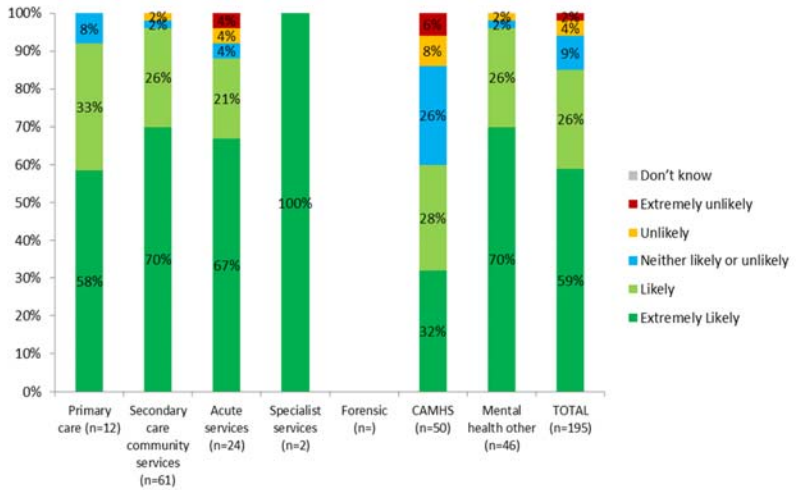
As the national CQUIN indicators are part of a two year scheme, work is taking place to prepare for the 18/19 requirements which are an extension of 17/18 requirements.

Patient Experience

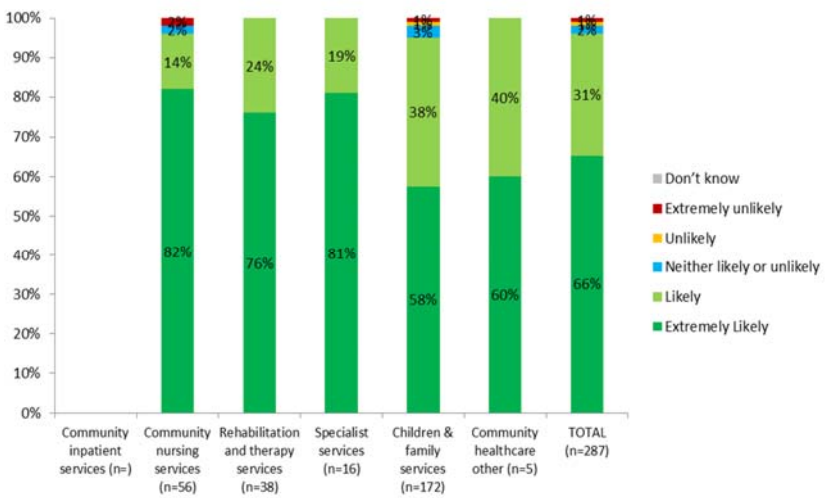
Friends and family test shows

- Community Services – 97% would recommend community services.
- Mental Health Services – 85% would recommend mental health services.
- Significant variance across the services in the numbers extremely likely to recommend the Trust – between 32% (CAMHs) and 100% (Specialist services)
- Small numbers stating they were extremely unlikely to recommend.

Mental Health Services



Community Services



Care Quality Commission (CQC)

CQC action plan – CQC – rating Green
The majority of the actions from previous CQC visits are now complete although a few outstanding areas remain as outlined in previous IPR updates. We are in the process of having some of our core services re-visited and as a result will be developing a new action plan to meet any 'must' and 'should' do's identified from these visits.

CQC Inspection 2018 visits
CQC commenced their inspections of our core services on Tuesday 6th March. These visits initially focussed on our inpatient wards for working age adults with mental health problems and PICUs, the Horizon Centre and several of our wards within our Forensics service. These visits typically lasted for three days. However, CQC had to return to Forensics for a further two days because of the weather implications and they returned to undertake a further two day visit to our Wakefield inpatient mental health wards and PICU on Wednesday 14th March. We also received three day visits to our CAMHS services, Community Learning Disabilities and Community Adult Mental Health Teams which commenced from Tuesday 12th March. Our Forensic CAMHS team was also visited during this period. We are not expecting any further core service visits at this time but CQC may return at any time if they wish to act on any new information or collect further evidence from their initial visits.

CQC reporting arrangements
When we held our recent engagement meeting with CQC, they explained that there will be some changes to the way reports are completed following core service inspection visits. The core service visit reports will now be included within the well-led review report that we should receive within three months of our well-led review. Core services will get individual ratings which are then aggregated and influence the well-led rating. In the interim period teams that have been visited will receive a brief summary of the CQC initial findings. Our inpatient mental health wards and the Horizon Centre team have already received this CQC feedback from their visits which included positive findings and areas for improvement. We are advising that teams keep a record of any comments from this feedback for future reference as we will be given the opportunity to challenge any factual accuracy comments when we receive our core service and well-led inspection reports.

Additional data requests
We are receiving additional data information requests following the core service visits. When we met with CQC at our engagement meeting they explained that additional data requests should be kept to a minimum as most of the information required should have been obtained during the core service visit. So far CQC have made 122 data information requests following the current visits. As yet we have not received any requests for additional information following the visits to our Community Learning Disabilities and Community Adult Mental Health Teams and are anticipating these may be made within the next week.

Well-led review
In preparation for our well-led review a number of service user and carer engagement events have now been conducted. We have also been making arrangements for the well-led interviews that will be taking place as part of the well-led review. We have submitted information to the CQC about the key individuals who will be attending these interviews and they have confirmed they are satisfied with these proposals. We are in the process of confirming the interview schedule details with the relevant individuals identified.

Registration activity
We continue to keep CQC notified about any planned changes to our services that may impact on our registration. We recently paid a small fine to the CQC as a result of a fixed penalty notice being issued. This is in relation to a registration condition whereby providers' services must be run from specified locations. It was not issued in relation to the quality of care being provided.

General
The Trust was included in the recent CQC publication 'Driving improvement'. We were referenced as an organisation that had demonstrated significant improvements recently in quality and safety.

A CQC focussed inspection of Ward 18 in December 2017 found that:
All patients were protected from potential harm and abuse. Patients' individual needs were met through timely risk assessments that were reviewed and updated regularly. The service had enough staff with the right training and support to deliver safe care and treatment. Regular assessment of environmental risk ensured facilities and equipment were safe for patients and staff. The ward complied with the Department of Health's national guidance on eliminating mixed-sex accommodation. Both men and women had separate corridors and bathroom facilities. The ward also had separate lounges for men and women.

We recently paid a small fine to the CQC as a result of a fixed penalty notice being issued. This is in relation to a registration condition whereby providers' services must be run from specified locations. It was not issued in relation to the quality of care being provided.

Safeguarding

• All staff in the safeguarding team are now delivering Prevent training. Extra training sessions being facilitated throughout the organisation to enable more practitioners to attend and the target has been met; over 90% of staff have attended the training. The team continue to deliver to individual teams trust wide. The team have promoted the prevent e-learning package to further support the workforce.
• Safeguarding adult's forum and safeguarding children's forum have been merged to further embed the think family agenda into practice.
• The team are continuing to work working towards achieving the "Domestic abuse Quality assurance mark" this will be a trust wide project.
• Safeguarding conference has been set up SWYPFT safeguarding team, at Fieldhead on 9th April , this is an all-day event with external speakers, focusing on CSE, human trafficking, FGM/Honour based violence and radicalisation.
• Safeguarding team have been looking at the option of offering mandatory training via webinar, a demonstration was attended by acting named nurse

Safeguarding Children

• Safeguarding advisor is contributing to an LLR in Wakefield
• Acting named nurse is involved with WDSCB suicide review
• Continued multi-agency working, safeguarding nurse advisor has completed a CSE/Gangs Audit for Calderdale.
• The safeguarding children nurse advisor attended a practitioner event that was arranged following a SCR, in response

Safeguarding Adults

• Multi-agency working, continues with Kirklees, they have appointed a safeguarding consultant, his role is to work with CMHTs to ensure that processes are followed when carry out section 42 enquiries. This has had a positive impact and he is working well with team managers.
• A part time seconded practitioner is in post to support the safeguarding adult's specialist advisor.
• Management of violence and aggression team (MAV) are now part of the directorate and working alongside the safeguarding team.
• In response to concerns raised by the CQC in relation to seclusion and reducing restrictive Interventions, MAV team and safeguarding, together with the practice governance coach carried out an investigation. They reviewed all seclusion data against RiO records and Datix for Stanley ward for 2018 and found that staff were utilising appropriately and applying least restrictive practice.
• Specialist advisor for safeguarding adults is currently leading on a Serious Investigation and contributing to a Safeguarding Adult Review and a Domestic Homicide Review

Infection Prevention Control (IPC)

Surveillance- 0- MRSA Bacteraemia and 0 MSSA Bacteraemia
3 cases of C diff to date (Barnsley BDU) all presented at PIR group (post infection review) and deemed unavoidable (presently trajectory of 6 for BBDU).
3 E.coli bacteraemia.
SWYFT are dedicated to the reduction of E.coli bacteraemia and have committed the CCGs Health and Social Care economy reduction plans (lead by the CCGs).

Annual IPC Action Plan has progressed well and is on track to achieve all but one objective. One objective is rated as red (not achieved and Annual Audit Plan- progressing well), no areas at risk of non-completion. The annual antibiotic audit has been cancelled for this year (2017/18) and this decision was agreed by the Drugs & Therapeutics Committee on 6 February 2018. The committee assessed the risk in terms of doing the audit verses additional pressure on the pharmacy team and decided to defer the audit until November 2018.

Initial baseline assessment of the NICE Sepsis: recognition and diagnosis and early management has been undertaken, the early outcomes show that the organisation need to undertake a concentrated piece of work to improve compliance. Work on early earning score, recognition and awareness of Sepsis.

Annual audit programme as bee completed, carrying the same not achieved objective. Draft annual audit programme has been produce, this programme has been reduced by 25% over the last 3 years. However this is still systematic and independent examination the high priority IPC compliance.

Mandatory IPC and Hand Hygiene Training is maintaining at above 80%

The Infection Prevention and Control (IPC) team are updating many policies and procedures at the moment, ensuring that the document are up to date.

IPC team are working with intermediate care (care homes) Quality Impact Assessment and visiting represented homes and assessing from IPC perspective.

The combined IPC task and finish group meeting, met for the first time on 13th March, quoracy has improved and the meeting was positive.

There is still reduced capacity within the team, (there is 1 IPC nurse vacant), we have recruited to the vacant post, person will start 30th April.

Managing Aggression and Violence

In a recent national Freedom of Information request undertaken by UNISON and the Health Service Journal SWYPFT were identified as having the one of the biggest reductions in assaults on staff. Actions behind this reduction include initiatives to reduce conflict and containment and restrictive physical interventions; evidence-based training for staff in managing violence and aggression; assessment, formulation and management of risk and positive behaviour support plans.

Guardian of Safe Working - Quarterly report Q3 (Oct – Dec 2017)

High Level Data

Number of doctors in training (total):	47
Amount of time available in job plan for Guardian to do the role:	1 Programmed Activity (PA)
Admin support provided to the Guardian:	Ad hoc
Amount of job-planned time for educational supervisors:	0.125 PAs per Trainee

Distribution of Trainee Doctors within SWYPFT

Poor recruitment to core training posts in Psychiatry has led to a number of gaps with 2 out of the 7 Wakefield posts vacant, 5 out of 10 posts on the Calderdale and Kirklees Core Training Scheme and 1 of the 4 posts in Barnsley.

Exception reports (with regard to working hours)

There have only been a few exception reports completed in SWYPFT since the introduction of the new contract and none during this period.

Fines

There have been none within this reporting period.

Work schedule reviews

There were no reviews required but the Calderdale and Kirklees rotas are under review due to concerns raised both informally and in previous exception reports.

Rota gaps and cover arrangements

The rota gaps page refers to medics. As such we are extending the medical bank, which is going live on e-roster in April. This will assist in understanding trends and hotspots as well as helping to fill gaps. Medics are encouraged to join the bank when they begin and again before leaving the trust

Gaps by rota October/November/December 17					
Rota	Number (%) of rota gaps	Number (%) covered by trainees	Number (%) covered by agency / external	Number (%) covered by other trust staff / Medical Bank	Number (%) vacant
Barnsley 1st	32 (18%)	6 (19%)	6 (19%)	20 (62%)	0
Calderdale 1st	54 (29%)	15 (28%)	15 (28%)	16 (30%)	8 (14%)
Kirklees 1st	21 (23%)	18 (86%)	0	3 (14%)	0
Wakefield 1st	13 (7%)	3 (23%)	1 (8%)	7 (54%)	2 (15%)
Total 1st	120 (19%)	42 (38%)	22 (18%)	46 (38%)	10 (8%)
Wakefield 2nd	0	0	0	0	0

There continue to be a number of trainee vacancies across the trust which in turn places greater pressure on those in post. As a result of these vacancies there are gaps on the rota. The lack of staff means that the remaining trainees cannot be expected to do all the extra shifts. The following table details rota gaps by area and how these have been covered. Due to the number of gaps, it has been necessary to use agency or external staff on a number of occasions. In addition, there were 10 shifts where it was not possible to obtain junior doctor cover. All of these were between 5-9.15pm and some were for a shorter period of time whilst the covering doctor travelled to the site (total 27.5 hours). No weekend or overnight shifts were uncovered.

Guardian of Safe Working - Quarterly report Q3 (Oct – Dec 2017) cont…

Costs of Rota Cover November/December '17						
1st On-Call Rotas	Shifts (Hours) Covered by Trainees	Cost of Shifts Covered by Trainees	Shifts (Hours) Covered by Bank	Cost of Shifts Covered by Bank	Shifts (Hours) Covered by Agency	Cost of Shifts Covered by Agency
Barnsley	2 (16)*	£560*	0	0	0	0
Calderdale	8 (26.5)	£1,277	10 (122)	£4,287	14(138)	£6,988
Kirklees	11 (184)	£5,040	2 (40)	£1,400	0	0
Wakefield	3 (28)	£1,496	5 (61)	£2,143	1 (12)	£528
Total	24 (255)	£8,373	17 (223)	£7,831	15 (151)	£7,047

*The majority of shifts in Barnsley (13) were covered by Specialty Doctors who were paid according to their individual terms and conditions.

Issues and Actions

Recruitment – vacancies remain an ongoing national issue. There are a number of initiatives that the trust is involved through royal college, pilot Physician Associate role to address this.

Management of rota gaps – Trust bank for medical staff is live and has been used to cover a number of vacant shifts. Employment of locum doctors is likely to be required despite some progress.

Calderdale rota - In the short term the main action has been to employ locum doctors to cover gaps. Options to change the rota remain under review. A further meeting to look at progress on the developments is being arranged.

Education and support – Guardian will work closely with the new Associate Medical Director for Postgraduate Medical Education to develop a more robust system to support clinical supervisors and monitor the educational aspects of the new contract and through induction sessions for new trainees on use of Exception Reporting.

IT system – decision has been made to move from DRS to Allocate.

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. This table has been revised to reflect the changes to the framework introduced during 2017/18.
• 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 - Operational Performance

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	Nov-17	Dec-17	Jan-18	Feb-18	Q1 17/18	Q2 17/18	Q3 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%	94.6%	*94.5%*	98.1%	99.1%	98.3%	96.8%	95.0%	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%	100%	100%	100%	100%	99.7%	100.0%	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%	95.3%	97.9%	100%	100%	98.5%	96.6%	96.9%	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%	98.2%	98.2%	97.1%	*95.0%*	97.6%	95.5%	96.9%	4	
Data Quality Maturity Index [4]	Improving Health	Responsive	SR/CH	95%	Reporting from Nov 17.							98.0%			Due April 18								4	
Out of area bed days [4]					Reporting from April 17.				286	357	242	341	362	424	467	412	407	268	613	885	1127	1286		
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%	49.1%	51.3%	53.3%	54.1%	54.2%	50.9%	*50.6%*	50.1%	49.2%	53.8%	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%	87.68%	91.57%	90.5%	*90.6%*	*90.6%*	81.9%	81.1%	89.8%	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%	99.51%	99.44%	100%	*99.7%*	*99.6%*	99.5%	99.4%	99.6%	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%	81.2%	94.1%	89.5%	92.3%	89.2%	84.4%	89.5%	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%	80.4%	80.4%	80.1%	80.4%	82.2%	80.8%	80.2%	4	
% clients in employment	Improving Health	Responsive	SR/CH	*10%*	Reporting developed from Sept 16		8.3%	8.8%	9.3%	8.8%	9.0%	9.3%	9.3%	8.7%	8.4%	8.4%	8.4%	9.0%	8.4%	9.0%	8.7%	8.6%	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 (reporting available June 18)											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	Nov-17	Dec-17	Jan-18	Feb-18	Q1 17/18	Q2 17/18	Q3 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	2	38	38	28	4	108	62	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	1	2	2	1	2	7	6	N/A	
Number of detentions under the Mental Health Act	Improving Care	Safe	SR/CH	*TBC*	167	174	156	168	212			221			186			Due April 18		212	221	186	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%			15.1%					10.8%	13.6%	15.1%	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	Nov-17	Dec-17	Jan-18	Feb-18	Q1 17/18	Q2 17/18	Q3 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%	96.5%	97.9%	98.1%	*97.8%*	*Due end March 18*	98.7%	97.1%	98.4%	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%	99.9%	99.8%	99.8%	*99.8%*	*Due end March 18*	99.7%	99.8%	*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%	91.0%	90.9%	90.9%	90.9%	*90.5%*	89.3%	90.3%	*90.8%*	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 due to the transition to MHSDS v2. Data flow monthly from May 17 onwards.
4 - This indicator was introduced from November 2017 as part of the revised NHSI Single Oversight Framework operational metrics. It measure the proportion of valid and complete data items from the MHSDS:
- *ethnic category*
- *general medical practice code (patient registration)*
- *NHS number*
- *organisation code (code of commissioner)*
- *person stated gender code*
- *postcode of usual address*

As this is a revised indicator, the initial focus (until April 2018) will be ensuring providers understand their current score and, where the standard is not being reached, have a clear plan for improving data quality. During 2018/19, failure to meet the standard (95%) will trigger consideration of a provider's support needs in this area.
5 - Out of area bed days - progress in line with agreed trajectory for elimination of inappropriate adult acute out of area placements no later than 2021. The process for agreeing trajectories toward eliminating acute mental health out-of-area placements (OAPs) is being jointly led by the NHS England and NHS Improvement regional teams during October to December 2017 - this has now been extended to April 2018. Sustainability and transformation partnership (STP) mental health leads, supported by regional teams, are working with their clinical commissioning groups and mental health providers during this period to develop both STP and provider level baselines and trajectories. The January 2018 submission will be taken as an agreed baseline position.

Areas of concern/to note:
• The Trust continues to perform well against the vast majority of NHS Improvement metrics
• Within the Improving Access to Psychological Therapies people moving to recovery indicator shows that the threshold has been met though only by a close margin. This is a provisional figure, the final figure will be available at the end of the month and it is anticipated that this will show further improvement on the 50% threshold.
• Out of area beds days has seen a spike in February 2018. This is attributed to acuity levels and increased demand in both acute and PICU services.
• Total beds days of Children and Younger People aged under 18 reduced to 28 days in February and relates to the admission of one 17 year old at the end of November to the Horizon centre who remains an inpatient .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 Care Quality Commission (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. In addition, the Trusts operational management group have recently signed off a new standard operating procedure for admitting young people to adult wards which has now been put into operation.
• 7 day follow up - this figure is currently being finalised for Feb 18, however, performance is expected to remain above 95%.

This section of the report is to be developed during 2017/18 and populated with key performance issues or highlights as reported by each business delivery unit (BDU).

Barnsley BDU:

Mental Health

• Improved access to Psychological Therapies (IAPT) has sustained its improved performance, meeting all KPIs again in February.
• Work is well underway to prepare for the upcoming IAPT tender process – an internal project team is meeting regularly to work on a new clinical model and compile organisational and corporate information likely to be required for the bid.
• The Memory Service achieved a rating of Excellent from MSNAP. The team have been asked to present at a regional network meeting as a result of this rating and commendations from Memory Services National Accreditation Programme (MSNAP).
• Work continues to implement changes in line with the Transformation Action Plan in Community Mental Health Services– this is monitored by the business delivery unit management meeting to ensure that progress is being made and that the District Director is fully sighted on this. In addition, work is underway with colleagues in Barnsley Metropolitan Borough Council to clarify the statutory responsibilities of the social care staff within the integrated teams in preparation for their return to direct management by the Council.
• An atypical variance in delayed transfers of care on the wards has been noted in February. The patient flow manager is working with Performance and Information colleagues to understand this as it is significant increase on previous months.
• An action plan is in place in the Acute Service line to address recording of supervision which appears to be low in comparison to other areas. The Quality and Governance Lead is giving focus to this work as a priority.
• Negotiations continue with the clinical commissioning group (CCG) to address the waiting lists in Psychology in the Community Service Line. Significant improvements have been made by the service through the implementation of a revised clinical pathway, skill mixing of the staff team and streamlining the service offer to maximise use of our resources. The CCG has acknowledged this work and its positive impact.

General Community

• We have undertaken some deep dip sample audits in terms of short term sickness absence management which confirm compliance with policy and we continue to monitor this closely
• A plan is in place to address the recording of Supervision which appears to be low in comparison on some lines from a data recording perspective - we are addressing this,
• The cardiovascular disease work stream has commenced. This involves our heart failure service and the wider End of Life team. Pathways and activity will be reviewed as part of this process.
• Stroke Services – locally we are working with our partner Barnsley Hospitals NHS Foundation Trust to ensure a local service whilst waiting for the publication of the Hospital Services Review and the Sustainability and transformation partnerships Hyper Acute Stroke Unit work.
• Performance related to the percentage of people dying where they are choosing is a testament to our End of Life team and the education programmes and support they give to Primary Care and other professionals and agencies.
• We are contributing substantially to Barnsley Health and Care Together Board activities e.g. development of Neighbourhood Clinical model.
• The Barnsley Assisted Living Review has commenced involving commissioners and multiple providers, with the aim of improving the customer experience and driving significant system efficiencies. Our Community Equipment Service is a significant component in this review.
• Following sucessful retender of the Musculo Skeletal service, the service has undertaken work to remodel and review skill mix, which will ensure that the increased activity thresholds will be achieved.

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Calderdale & Kirklees BDU:

Key Issues

• Meeting with Calderdale and Kirklees Local Authorities and Clinical Commissioning Groups (CCG) to consider options for developing Business cases for access to Better Care Funds (BCF). Focus on two projects which are within the improved better care fund (iBCF) offer.

1. Additional 7 day support to all wards to focus on support for early discharge and delayed transfers of care (DTOC). To be a link to housing, benefits and at home rapid support on discharge. Both Local Authorities are supportive. Costed model now shared with both councils.
2. To develop the older adult Intermediate Support Team (IST) model in Calderdale, which reflects the older adult transformation model.

• Delayed Transfers of Care (DTOC) - Monthly figures have been scrutinised at CCG level as a reduction target has been set against iBCF investment. Number of DTOC days in Calderdale reduced in February against the January performance.
• NHSi IST diagnostic review draft document of IAPT has been sent to Trust and CCG for comments and checking. Due to be returned in first week April. Trust continues to meet CCG to develop realistic key performance indicators (KPIs) against current and future CCG funding intentions.
• Adult Acute ward pressures were particularly high with for example, 5 one to one levels on Ward 18 in February to March. To assist all the acute wards and Ward 18, community staff were moved to wards for 3 days along with staff from Enfield Down.
• During the snow period, community staff also attended wards to reinforce staffing whilst awaiting ward staff to arrive into work.

Strengths

• IG target achieved for business delivery unity (BDU).
• Improved and sustained performance across all service lines for KPIs.
• Sickness levels remain a challenge with reports of high flu levels over 2-3 waves. Absence management is positive in spite of an upturn in absences.
• Mandatory training figures are very positive.
• Supervision levels are green.

Challenges

• Medical staffing vacancies and recruitment. Recruitment is underway in consultant roles but gaps will remain for trainee posts until rotation in August.
• Occupancy levels (high above 95%) and continue to be monitored closely.
• Adult bed capacity/Out of Area (OOA) has deteriorated with excess OOA Acute beds in use.

Areas of Focus

• Admissions and discharge flow in acute adults services.
• Reduction of sickness in hotspots.
• Continue to improve performance in service area hotspots.
• Recruitment to medical posts.

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Forensic BDU:

Medium and Low Secure

• Both Medium and Low Secure hosted the Quality Network for Forensic Mental Health Services in January. The process occurs annually and is a supportive and developmental peer review. The draft report is largely positive with no surprises.
• CQC visit - Overall the informal feedback has been positive. The CQC noted that the Trust had plans to address the areas of improvement in relation to the locks, observation windows and emergency response to Newhaven and Ryburn.
• There has been a noted increase in falls relating to one service user in medium secure. Investigations and harm minimisation plan in place.
• National service review continues. Recent management changes in NHS England have led to a 'pause' in proceedings to ensure the work is in line with the national initiatives.
• SWYPFT approached recently to develop a proposal for a Forensic Learning Disability Community service and have been informed this has been successful. The funding mechanism for this service is not yet confirmed.
• Sickness levels are currently high in Forensic CAMHs and contingency plans are in place for safe delivery of the service. Return to work plans now in place for some staff who have been on long term sick.
• Implementation of the region wide Forensic Service has operationalised and the Partnership Board established. There has been a steady flow of referrals so far which is predicted to increase once the communication strategy is implemented.
• A CQC visit in conjunction with Prison Inspectorate has taken place in Wetherby. Very positive feedback regarding level of service, support to prison personnel and integrated working with Leeds Community Health.

Forensic CAMHS

• Funding of the Wakefield community team is threatened pending review and transformation. Work is ongoing and the focus has been to work up an alternative offer.
• Sickness levels are currently very high in this team and contingency plans are in place for safe delivery of the service. Return to work plans now in place for some staff who have been on long term sick.
• Implementation of the region wide Forensic Service has operationalised and the Partnership Board established. There has been a steady flow of referrals so far which is predicted to increase once the communication strategy is implemented.
• CQC visit in conjunction with Prison Inspectorate. Extremely positive feedback regarding level of service, support to prison personnel and integrated working with Leeds Community Health.

Specialist BDU:

Specialist Services

• Mandatory training performance has improved significantly. Only food safety remains below target and actions are underway to review and address this.

Child and Adolescent Mental Health Services (CAMHS)

• Sickness rates in Wakefield have reduced but the rates in Calderdale and Kirklees and Barnsley have increased. The overall sickness in CAMHS has remained relatively constant, although this is above target at 5%. Work is planned with the organisational development and health and well-being teams.
• The recent CQC inspection highlighted positives in the feedback from children and families and in the professional and supportive attitudes of staff. Some real strength in multi-disciplinary team working were also evident. Waiting lists/times for treatment remain an area for improvement. There is still a significant number of children and young people waiting over 6 months for treatment in Wakefield and Barnsley and the CQC noted the impact on staff morale. The clinical governance clinical safety committee continue to monitor CAMHS on behalf of the Trust board.
• On call remains a key concern for staff. Developmental work continues with regard to an all-age psychiatric liaison team model with the intention of ensuring safer and more sustainable 24/7 crisis resolution delivery. In the short-term an adjustment to on-call arrangements is being developed to reduce individual/service impact.
• The service review of Wakefield CAMHS and Forensic CAMHS (Wakefield) is being progressed. The intention is to clarify the proposed model by the end of April 2018

Learning Disability

• Sickness rates have improved throughout the year but remain a concern at 7.0% (year to date)
• The CQC inspection noted staff within learning disability community teams to be caring and knowledgeable. The improvement work in ensuring risk assessments were easily accessible and up to date was also acknowledged. STOMP and the AAA and bowel screening initiatives were positively referenced as was the transformation work in establishing multi-disciplinary intensive support teams.
• Staff concerns in relation to the Wakefield hub (Drury Lane) were also identified by the CQC. Work is already underway with the estates team and operational managers to improve the working arrangements.
• The CQC noted many positive areas of practice in learning disability inpatient services and this was supported by feedback from patients and carers. The team are reviewing the arrangements for access to the female lounge and access to the facilities to make a hot drink as these were raised as concerns. Patients raised concerns about the food so a meeting with the catering manager will be facilitated so that opportunities for improvement can be explored.
• Capital programme work will commence on Horizon in the first quarter of 2018/19. This will remove any environmental limitations to full occupancy – allowing the more proactive marketing of the 2 spot purchasing beds. Discussions have started with Leeds and Bradford to work towards a shared assessment and treatment provision.
• A bid has been submitted to NHS England to host an operational delivery network for learning disability and autism across the Yorkshire and Humber region. The network will ensure clinicians are engaged in developing and sustaining new care models.

This section of the report is to be developed during 2017/18 and populated with key performance issues or highlights as reported by each business delivery unit (BDU).

Wakefield BDU:

• The acute service line continues to experience high demand and staffing pressures. Staff are being used flexibly across the wards. Due to the particular presentation and risk of service users on the wards at this time, additional staff are usually required to provide levels of observation.
• Use of out of area beds (Acute and Psychiatric intensive care unit) for Wakefield service users continues to reduce.
• Collaborative care planning meetings have been introduced in the Business Delivery Unit (BDU). These focus on a service user with complex needs who require a comprehensive risk management and care plan to enable their discharge from the wards. These service users may have been on the ward for some time. These meetings have representatives from inpatients, community teams, social care and any external agencies involved with the care of the service user to ensure a holistic approach that fully supports a safe discharge from hospital and transition home. The meetings are evaluating well and support safe transitions out of hospital for patients who may have some residual risk, but can be supported back into their own community.
• Focus is being given to recording of supervision. Uptake of supervision within the BDU has increased significantly, but recording has been inconsistent. The Quality and Governance Leads are addressing this with staff.
• The Engaged Leader Programme for Band 7 managers across the Wakefield business delivery unit commenced this month. The first session focussed on personal resilience, their leadership behaviours when under stress and how this reflected in their interactions with their teams. Evaluation was extremely positive and attendance from the invited group was 100%.

Summary of progress highlights for the Trusts priority programmes for February 2018 include:

Flow and out of area beds:
• The pressures on Out of Area bed usage reached unprecedented levels in February 2018 and the work to safely reduce these pressures is an ongoing operational priority.
• Work is focussing on the root causes for the differing pressures in each of our localities that is resulting in the number of admissions for acute and PICU beds and the length of time people are spending on our wards.
• Each area is developing a local sustainability plan to say how their locality specific problems will be addressed.
• An action plan for change is in place which covers: work to reduce the Out of Area expenditure by the end of March 2018; a sustainability plan to reduce people being placed Out of Area in an acute bed, and a sustainability plan to reduce people being placed Out of Area in a Psychiatric Intensive Care Unit (PICU) bed.

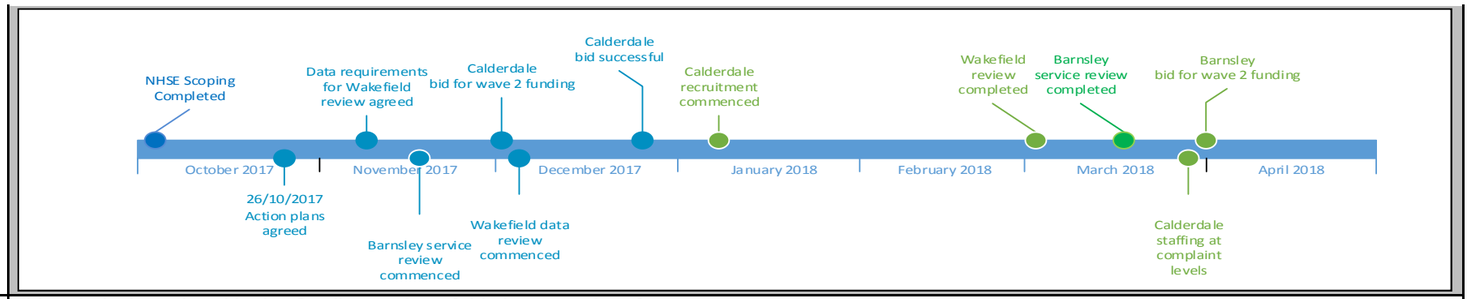
Clinical Record System
• The clinical record system programme is now well into the co-design phase of the project and is on track with key milestones.
• Data migration option appraisal plans are moving ahead
• Training approach has been drafted, co-produced with Learning and Development input and the master implementation schedule has been developed across all workstreams

Older Peoples Transformation
• Draft business cases for the community and inpatient models have been shared across project groups and steering groups and are currently ongoing refinement prior to sign off
• Business cases will be presented to the trusts Executive Management Team (EMT) in May and work is ongoing to define the community workforce model in more detail. Work continues to finalise the workforce across the models
• Quality impact for the community model is now in place

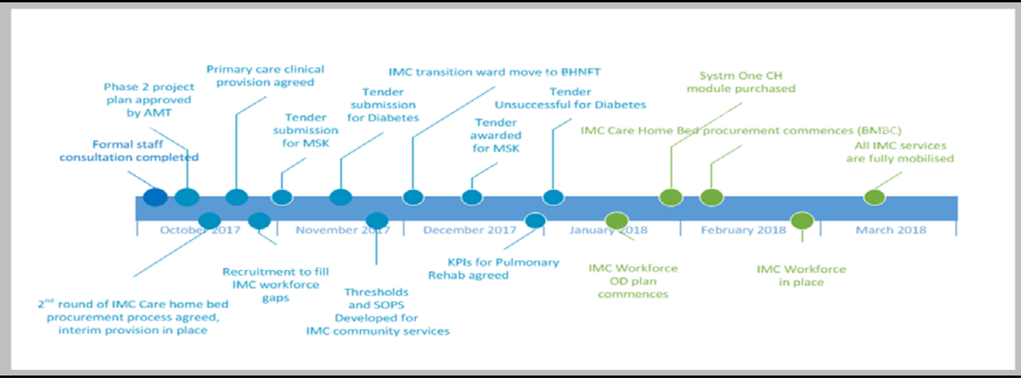
Community Forensic Child and Adolescent Mental Health service (CAMHs)
This programme is continuing to plan and was on track with a soft launch and commencement of accepting referrals through the Single Point of Access (SPA) in February. Formal launch will be conducted later in the year.

Perinatal Mental Health
This priority programme has now gone live and the project handed over to operational management.

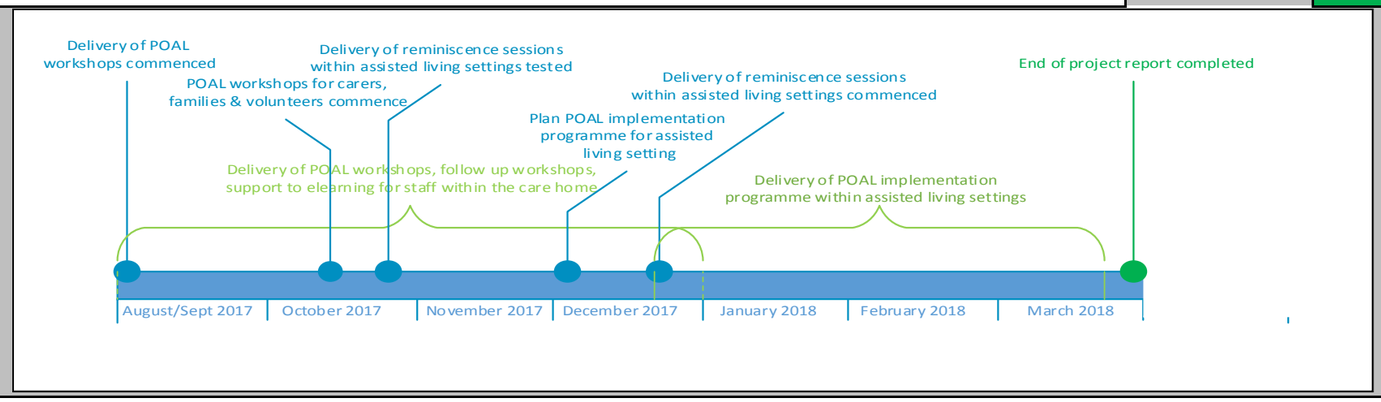
Priority	Scope	Update	Area	RAG
IMPROVING HEALTH				
Strategic Priority One: People First				
Enhancing Liaison Services	Transition to a new framework for liaison services. Identification of where current gaps in provision are and support development of plans for appropriate liaison services to support commissioner intentions to work towards CORE 24 compliance by 2020. Establishment of a benefits realisation framework to support the 3 year evaluation of the project.	**Wakefield** • Recruitment - All staff now in post • Gathering data as requested for evaluation. • Review meeting set up to look at progress against key performance indicators (KPIs) **Calderdale** • Bid for an early release of wave 2 part funding to support the recruitment of two posts has been successfully secured. **Barnsley** • The clinical commissioning group (CCG) are supportive of a Wave 2 bid for Core 24 monies and steps are being taken by the service to support this.	Progress Against Plan	
		Risks are being managed and mitigated within the individual services	Management of Risk	

				
Improving People's Experience and Equalities	A structured approach to ensuring that we collect and act on patient experience feedback building upon our current strong foundations. We have identified five objectives for improvement during 2017/2018, including a programme to formally connect with other priority objectives.	This priority is updated in the Quality section of this integrated performance report		
Recovery based approaches	Further develop a range of innovative initiatives which promote recovery focused approaches in order to meet the Trust mission, including: Co-produce an integrated recovery development plan Test new approaches to recovery, developing from what we learn in order to maximise effectiveness and impact Continue to build, support and sustain recovery work which has already been undertaken or is already planned	• Work continues in line with the milestone plan as agreed by the Transformation Board. • Progress includes work on the alignment of the work of Altogether Better, Creative Minds, the Mental Health Museum, Recovery Colleges and Spirit in Mind through a workshop and subsequent development plan. • Evaluation methods for recovery based approaches are being further developed through a community of practice. This work is linked to the Trust approach to measuring impact on individuals and communities in line with the Trust mission • Work continues to build, support and sustain recovery work which has already been undertaken. This includes the development of a Recovery College business plan which focuses on sustaining and developing the five recovery colleges.	Overall Priority Performance	
Physical/Mental Health	Improve the physical health of people with mental health difficulties and the mental health of people with physical health difficulties	Activity on physical health continues to be delivered as part of CQUIN. See the quality section of the integrated performance report for more information.	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) so no direct update required in this section of the integrated performance report (IPR)		
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 so no direct update required in this section of the integrated performance report (IPR)		

New models of care and vanguards Barnsley Intermediate Care, Respiratory, Diabetes and MSK	Work with partners to introduce new models of Care across SWYPFT footprint Barnsley Intermediate Care, Respiratory, Diabetes and Musculo-Skeletal service.	**MSK** Mobilisation is on track. **Pulmonary Rehabilitation - 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. KPIs, Quality Indicators and data flows have been amended without negotiation and will be raised at the Alliance Management Team (AMT). **Diabetes** Formal consultation with staff has commenced with regards to TUPE of staff to Barnsley Hospitals NHS Foundation Trust on 31st March. **Intermediate Care** • Mobilisation of the new model continues with key workstreams linked to keep performance indicators (KPIs), Information Management and Technology and assessment processes progressing. • Mobilisation within community continues, recruitment to the staffing model and skill mix commenced. • Interim solution in place for the Independent Sector Care Home beds which is being mobilised, Barnsley Metropolitan Borough Council have commenced the procurement process.	Progress Against Plan	
		The Partnership Intermediate Care Mobilisation Team meeting manages the risks and has produced a risk log on behalf of the Alliance which reports to Barnsley Accountable Care Organisation (ACO) New Models of Care (NMoC) implementation group (and AMT as appropriate) on a monthly basis. Other risks are being managed internally by services as part of business as usual.	Management of Risk	

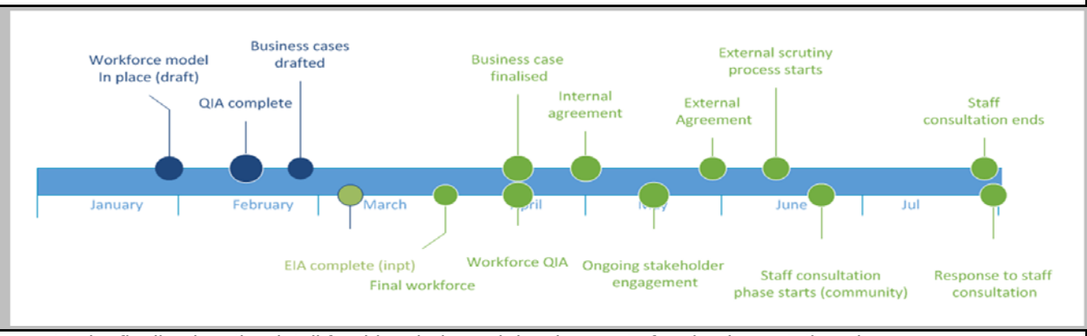


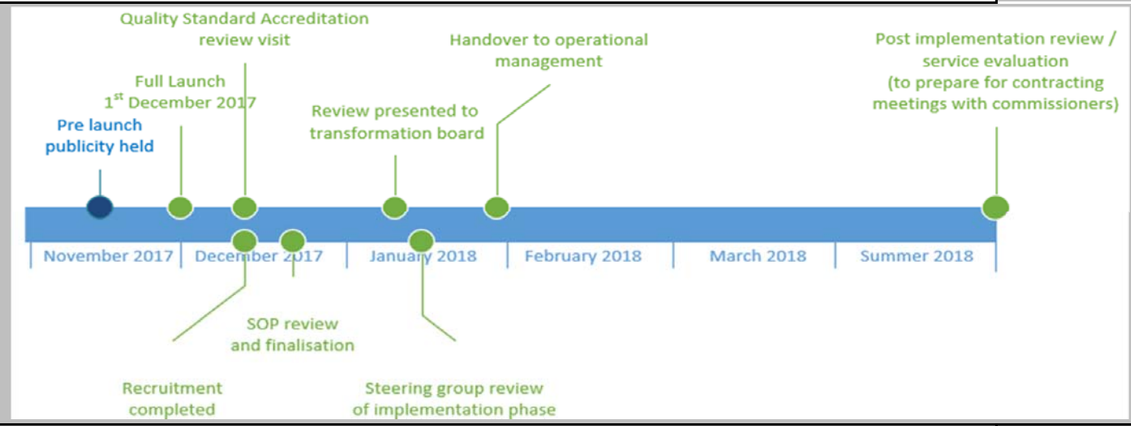
New models of care and vanguards Wakefield - Care Home Vanguard and Public Health as part of Connecting Care Vanguard Calderdale - Prevention and Supporting Self Management Vanguard	Work with partners to introduce new models of Care across SWYPFT footprint Wakefield - care home vanguard and public health Calderdale - Prevention and Supporting Self Management Vanguard	**Wakefield** • 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 12 of 13 care homes for Wave 2 2017/2018 and to one assisted living facility. Project is on track and meeting KPIs. • Wakefield Connecting Care: Work is being undertaken to align SWYPFT involvement in new models of care. Steps are being taken to move to a single leadership model for Connecting Care, Mid Yorkshire NHS Hospitals Trust (MYHT) and Adult Social Care, Wakefield Metropolitan District Council (WMDC). • Care Navigation: The role out across Wakefield GP's 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 are investigating improvement to coding. • Public Health – Live Well Wakefield service, led by Nova, is performing well and meeting all KPIs. Feedback from commissioners has been very positive and the partnership with Nova is working well. • A partnership bid for the provision of social prescribing in Wakefield for the next three years is under development. **Calderdale.** • A single plan for Calderdale is under development. Work continues to develop an integrated community service offer through implementation of five localities by April 2018.	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	



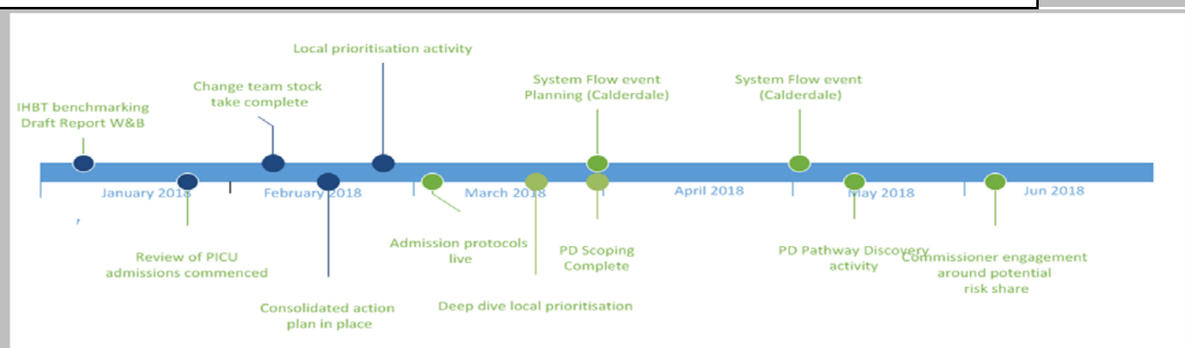
IMPROVING CARE

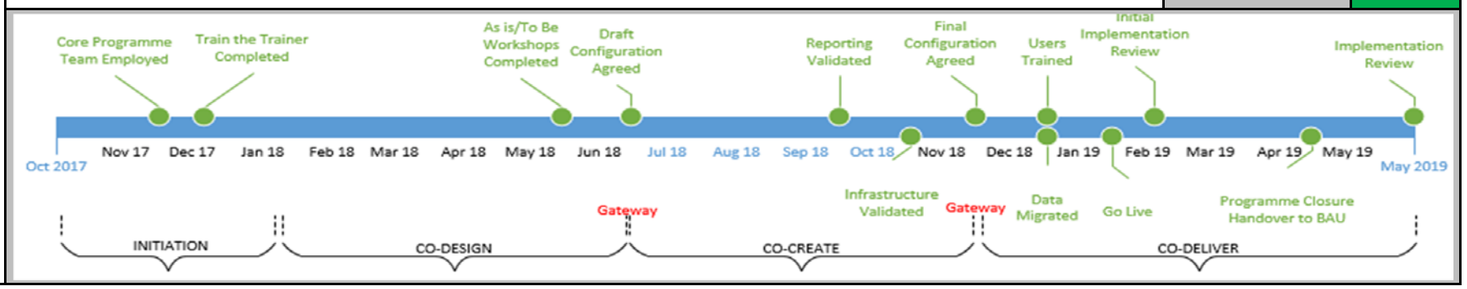
Strategic Priority Three: Quality Counts, Safety First

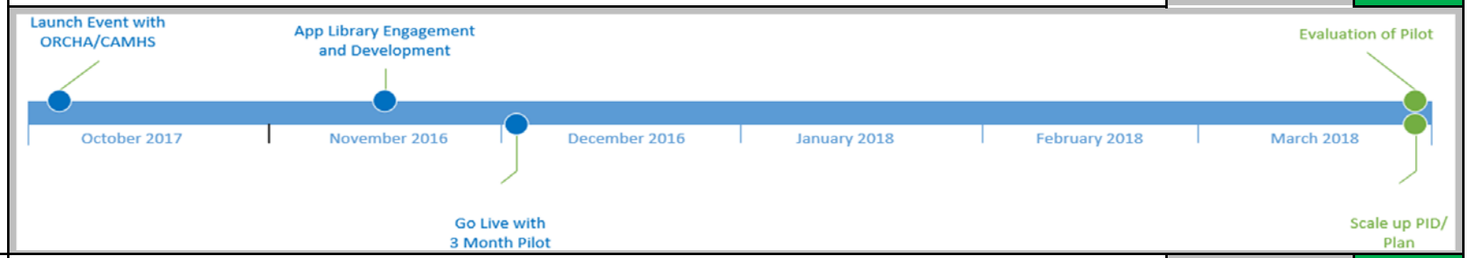
Patient Safety	Continue to implement the patient safety strategy including: Measuring and monitoring patient safety framework awareness and use in practice; establish a sustainable resource to support the roll out and continuing support for safety huddles; develop a process and resources for considering human factors within incident review 'So what'… acting on learning from feedback.	This priority is updated in the Quality section of this integrated performance report		
Older 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. To effectively implement this model and demonstrate the impact.	• Business cases will be presented to EMT in May and work is ongoing to define the community workforce model in more detail to ensure new roles are an integral part of the model design. • Quality Impact Assessment (QIA) for community model now in place - agreed to hold an overall quality assurance process for the workforce model when completed. • Equality Impact Assessment (EIA) for community model in place and agreed, EIA for inpatient model undergoing further refinement. • Outline engagement plan now in place for coming months and formal consultation readiness has been reviewed.	Progress Against Plan	
		The complexity of the differing workforce models already in place across the Trust remains a challenge though project team has undertaken extensive, comprehensive levels of rigour to unpick and understand this with a view to bringing a transformational model to this stage and activity is still ongoing to ensure that we get this right. The ongoing risk of slippage in the project timescale due to limited capacity across the project and across the business delivery units (BDUs) 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 has yet to be finalised on the detail for this priority and development of an implementation plan.	Progress Against Plan	
		No known risks identified at this time.	Management of Risk	
		Implementation plan will be developed once the scope for this priority is clearer.		

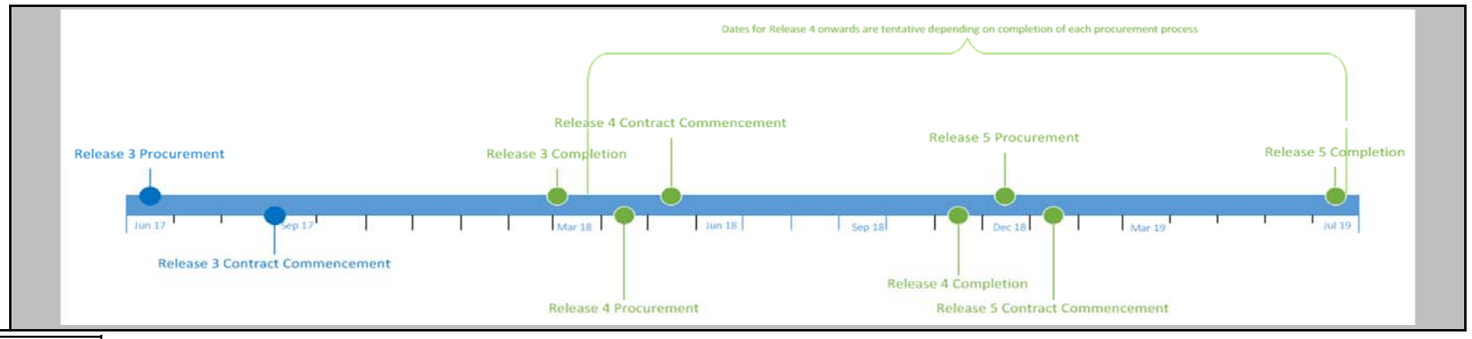
Perinatal mental health	To implement the new service within the Trust. To evaluate the impact in terms of outcomes, experience and use of resources	• This priority programme has now gone live and has been handed over to operational management. • A project closure report will be presented to the March meeting of the Transformation Board. • A post implementation review will then be conducted 12 months after hand over	Progress Against Plan	
		Any residual risks will be reported here in March following the project closure report.	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. This new care model (NMoC) aims to develop streamlined standard pathways for community intensive services with the aims of reducing the need for, and the length of, inpatient stays, and to ensure children and young people are cared for in West Yorkshire and do not need to travel out of area unnecessarily. SWYPFT is a Partner in this contract together with Leeds and York Partnership NHS Foundation Trust and Bradford District Care NHS Foundation Trust Funding has been secured though STP NMoC work stream	• Work in this project is focussing on delivering services differently for children's admissions to prevent them from being miles away from home, trying to keep them local and out of hospital whenever possible. This is through use of locally placed beds and home based treatment teams in local areas. • Project is two year pilot • SWYPFT contribution to the business case continues.	Progress Against Plan	
		Risk management has yet to commence for this priority as part of the planning phase for this new model of care.	Management of Risk	
		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.	Progress Against Plan	
		A workshop of providers and commissioners has been held and identified actions will take the project to the next phase of this work	Management of Risk	
		Discussions continue regarding links between this work and locked rehabilitation.		
West Yorkshire work – Suicide prevention	Leading West Yorkshire STP wide work on zero suicides	This priority is updated in the Quality section of this integrated performance report		
West Yorkshire work Eating Disorders	Eating Disorders- Provision of community treatment services for eating disorders across West Yorkshire lead by Leeds and York Partnership NHS Foundation	• Work in this priority is focused on supporting the Leeds and York Partnership NHS Foundation Trust as lead provider in the provision of a West Yorkshire wide new model for community treatment services for adults with eating disorders. • The adult eating disorders service, called the Eating Disorders West Yorkshire and Harrogate Network (EDWYHN) has SWYPFT as a partner as part of the West Yorkshire STP. • Funding has been secured though STP NMoC work stream • Work continues on the role of SWYPFT in the service • Planning sessions are ongoing to confirm the implementation aspects for SWYPFT	Progress Against Plan	
		Any implementation risks are with Leeds and do not transfer to us	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 progresses well on this priority programme. • Confirmation was received that the implementation plan for the Yorkshire and Humber region is signed off by NHS England. • On track with soft launch and commencement of accepting referrals through the single point of access (SPA) at end of February • Work of the themed SWYPFT groups for this project is nearing conclusion of their work as the project nears implementation of the SPA. • Workforce has now finalised for each of the partners in the provision of this service	Progress Against Plan	
		• There are currently no high level risks identified in this project. • Risk sharing agreements are being developed for the partnership	Management of Risk	
				
Strategic Priority Four: Compassionate Leadership				
Leadership development	Leadership and management strategy which includes development of an integrated change network	This priority programme is updated bi-monthly and the next update is due in March. Details of the last update include: • Values into Behaviours - shared and roll-out planned after launch in Q1 2018; incorporated into revised Appraisal • Learning Needs Analysis - completed • Leadership and management framework – leaders/managers expectations obtained and incorporated • Corporate Leadership and management offer – developed further and costed • SWYPFT Leadership and management programmes – shared via Workforce Planning workshops; implemented and collaborative programmes with Bradford District Care Trust and Leeds and York Partnership Trusts agreed • Moving Forward programme – launched Revised implementation plan with extension to agreed timescales now in place: • Middle Ground 5: first run (pilot) confirmed for February and March 2018 and first run of the programme agreed for 2018. Revisions agreed and redesign underway. • TRIO development programme: Review of needs completed as part of Workforce Planning workshops within 2018/2019 Business Planning • Maximising Potential: Funding via 'In Place Leadership Fund secured; 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 in Q1 2018. All other work-streams/key deliverables are progressing as per agreed timescales.	Overall Priority Performance	

Change and quality improvement	Develop and agree Quality Strategy which includes the Integrated Change Framework	Further work has been undertaken on the quality strategy which is due to be presented into the Executive Management Team on 18th January 2018. This strategy includes how the Trust assures quality as well as how we improve quality. The Integrated Change Framework is aligned and integrated with this strategic approach.	Overall Priority Performance	
Membership	Develop an approach to membership which maximises the impact of members in key activities	• Membership project group is ongoing and working in line with a thorough implementation plan • Communication plan is being developed. • Progress is on target against the revised plan hence RAG rating of green. Implementation actions are across two years - 2017/2018 and 2018/2019 • No identified risks are of concern for this priority	Overall Priority Performance	
IMPROVING USE OF RESOURCES				
Strategic Priority Five: Operational Excellence				
Flow and out of area beds	Improve flow and reduce/eliminate use of out of area beds so that everyone is in the right bed including their own. This is part of the West Yorkshire STP work stream for acute inpatient shared bed base and development of Psychiatric Intensive Care Units (PICU).	• Out of area placements reached unprecedented high levels through February 2018. Over 200 out of area bed days were used in each of the weeks ending 23rd Feb and 2 Mar. • Safely reducing pressures is an operational priority and the pressures are still severe. • Analysis shows that the trust has different priorities in each locality linked to the number of admissions for acute and PICU beds, and the length of time people are spending on our wards. Work has identified how pressures differ in each locality and we are focusing in on the root causes. This will enable us to undertake activity that will have the biggest impact. • We have undertaken a comprehensive review of bed demand to understand the different pressures in each of our localities. This will add to the body of knowledge guiding our corrective and sustainability activity. Each area is developing a sustainability plan to say how their locality specific problems will be addressed. These will cover pathway issues and will strengthen the community offer, support in a crisis, gate keeping, patient flow and risk taking on discharge. • Our bed management protocol has been updated to promote and support a challenging and problem solving approach before admissions and an out of area placement. This includes assertive use of IHBT, enhanced coordination of patient flow across our estates and senior level clinical input in risk taking. This is awaiting sign off. • A patient flow event, sponsored by the Academic Health Science Network is scheduled for 1 May 2018. It will include a range of stakeholders and focus on the issues that lead to hospital bed use in that locality. • A process to use West Yorkshire STP Trust beds is in place and work continues to develop a systemic shared bed base	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 has increased. This risk has moved off trajectory with recent pressures on the system.	Management of Risk	
				

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. Sickness absence performance is in the Summary section of the integrated performance report (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 integrated performance report (IPR).	Overall Priority Performance	
CQUIN	Deliver Trust CQUINS	This priority is updated in the Quality 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	• Data migration option appraisal reviewed – all records to be migrated in first data cut, then review • Clinical Record System for Mental Health Clinical Safety Design Group membership agreed, Mike Doyle to chair • First SystmOne Change Reference Group established • Training approach drafted, co-produced with Learning and Development • Master schedule developed across all workstreams • Clinical record system performance & information analyst working with Bradford on read code analysis	Progress Against Plan	
		Risks identified: • In the event of not knowing the full list of services, sites and users, there will be a risk of missing a service, site, and user, which will result in reverting back to paper for SystmOne • In the event of staff not being trained there will be a risk of staff unable to access the Clinical Records System Programme which will result in lack of visibility of the shared record • In the event of not having enough server resources for report production there will be a risk of a financial impact to provide such resources • In the event of the complexities of the programme being ineffectively managed, there will be a risk of ineffective decision making which will result in the time delays, work redone and loss of confidence in the programme • In the event of sub-optimal transition from Rio to SystmOne there will be a risk of resulting in significant loss or ineffective use of data which will result in inability to capture data, produce report and share information • In the event of the number of Rio users being in the excess of the assumed 3500 licenses there is a risk of a financial impact to provide access to all the users of the system	Management of Risk	
				

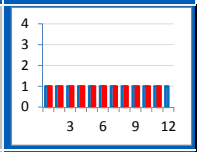
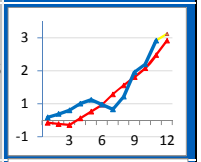
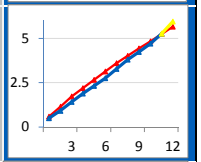
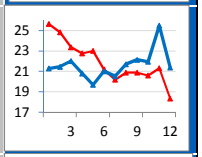
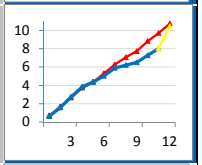
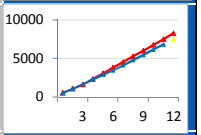
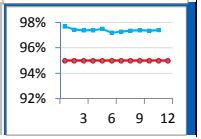
Digital health	Improve access to digital health opportunities. Identify our approach to supporting digital health developments. Increase digital clinical practice.	The ORCHA pilot was launched in December 2017 for three months and is ongoing. 65 clinicians have been issued with a license to prescribe/recommend apps to the people they are working with. Data shows that 16 people have activated their license, and 5 apps have been recommended to individuals. There has also been 394 visits to the website, whereby people will have downloaded apps independently themselves. There is ongoing engagement and communication with clinicians to support them to use the app library.	Progress Against Plan	
		The project has now been extended to all teams in each of the business delivery units. Many of the clinicians do not have a smart phone (and there is no available budget) which would enable people to be more agile with the use of the platform. Staff are using laptops, and/or providing a leaflet with new appointment letters to enable young people to look for themselves from their own mobile phones or devices. This could mean there are more downloads than prescriptions (no issue therefore risk is still rated as green), however this may affect staff usage of the platform. In other organisations staff are using personal smartphones to use the platform- there is no personal usage cost as all prescription texts are paid for by the platform, and no personal data is stored on the handset. The project team will explore this option with the management team/information governance/policy with the review for scale up following the three month pilot.	Management of Risk	
				
Data driven improvements and innovation	Increase the accessibility of good quality, easy to use data which informs improvement.	• A suite of analytical reports are now available for the Working Age Adult Acute pathway. This includes trend and benchmarking reporting and will continue to be developed on an ongoing basis • A number of engagement activities have taken place to try and increase uptake and usage of reports - this includes messages being circulated via established Trust communication routes, demos of products at Trust Operational Management Group, one to one sessions with key stakeholders • Release 3 of the Business Intelligence Programme is underway with support from an external supplier - this is a six month release focussed on supporting Neighbourhood Nursing Services in Barnsley - expected delivery is late March 2018 • Preparation is taking place for the procurement for the next release • Delivery could be impacted due to involvement of staff in clinical record system implementation (reference as a risk below)	Progress Against Plan	
		Key risks identified are: • Engagement with Business Intelligence across the Trust - more work needs to be done on engagement if the value of the work is to be realised; work is taking place with Trust Communications team to improve this • Implementation of SystmOne for Mental Health - may have a resource impact on Business Intelligence Programme due to involvement of staff in workstreams; work will be required to integrate SystmOne Mental Health data into Data Warehouse	Management of Risk	



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 Finance Rating	1	1	The NHS Improvement financial and use of resources risk rating is maintained at 1 for the 11 months to the end of February 2018.	
2	Normalised Surplus (inc STF)	£2.4m	£2.6m	February 2018 finance performance excluding STF is a surplus of £0.6m. Including STF this is a surplus of £0.7m. This includes the gain from the sales of two properties and other one-off measures. The cumulative surplus excluding STF is now £1.2m, including STF the surplus is £2.4m.	
3	Agency Cap	£5.3m	£6m	Agency expenditure in February 2018 is the highest YTD at £563k, this exceeds the in-month cap by 37%. For the first time this year cumulative agency expenditure is above the cap by 0.4%. The forecast exceeds the cap by 5% given schemes to improve access times, an increase in medical vacancies and bespoke packages of care.	
4	Cash	£25.5m	£21.4m	The Trust cash position is £4.2m above plan in February with continued focus on working capital management and lower than plan capital expenditure. Two properties planned for sale in 2018/19 have been sold in February resulting in the cash increase. The forecast cash position is also higher than plan.	
5	Capital	£8m	£10.4m	Capital Expenditure is forecast to be £0.3m lower than plan. This includes an additional £0.35m for rollout of the Trustwide WiFi network which has been funded separately as a national project.	
6	Delivery of CIP	£6.8m	£7.5m	Year to date CIP delivery is £0.7m 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

Contracting - Trust Board

Contracting Issues - General

SWYPFT was successfully awarded the contract for the provision of school vaccinations in Barnsley following a competitive procurement exercise. Work continues in relation to mobilisation of a number of contracts commencing 1 April 2018: Barnsley Musculo Skeletal (MSK), Doncaster Smoke Free, Wakefield Tuberculosis (TB), Regional Community Forensic CAMHs Services and Secure Stairs within the Forensics Secure Estate. Work continues on implementation of the Exit Plans from Smoke Free services in Rotherham and Community Diabetes Services in Barnsley. Implementation of a range of Winter Pressures initiatives continues. Following publication of the 2018/19 Annual Planning Guidance, work continues to confirm commissioning intentions and plans for investment in the Mental Health Investment Standard (MHIS) seeking clarity on how additional funds provided to CCGs for specific investment in priority areas; including delivery of the MHIS and Transforming Care for People with Learning Disabilities will be invested. Meetings have been held with all CCGs. Contract variations relating to 2018/19 need to be agreed by 23rd March 2018.

Commissioning for Quality and Innovation (CQUIN)

Barnsley and West Commissioners have confirmed full achievement of Q3 CQUINs. Final confirmation from NHSE regarding Forensic services for Q3 required.

Contracting Issues - Barnsley

Key strategic work areas in Barnsley continue across Intermediate care, Respiratory, MSK, Diabetes and Stroke services. Key priorities include mobilisation of the new MSK service and implementation of the exit from Diabetes services which transfer to Barnsley Hospitals NHS Foundation Trust on 1 April 2018. The Alliance Agreement and underlying Service Contracts have been agreed.

Contracting Issues - Calderdale

Key priorities relate to a sustainable 24/7 crisis resolution service and pressures within Psychology services. A specialist ASD Service for Adults will be enhanced in 2018/19. 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. A specialist ASD Service for Adults will be enhanced in 2018/19.

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. Mobilisation continues in relation to the new contract for the provision of TB services commencing 1 April 2018.

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 at Adel Beck was confirmed successful and work is ongoing with NHSE regarding mobilisation and contracting arrangements.

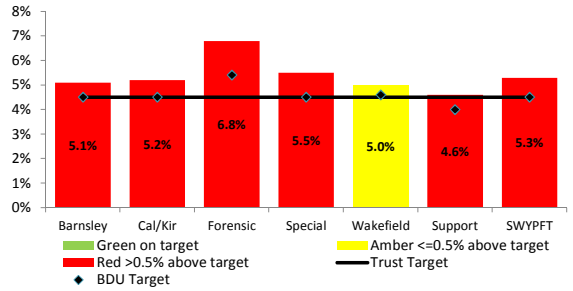
Contracting Issues - Other

Meetings with Doncaster Commissioners continues regarding the mobilisation plan for the new Smoke Free Services model to commence 1 April 2018. Work continues on implementation of the exit from Smoke Free services in Rotherham. A contract extension for three years for the continued provision of Smoke Free Services in Wakefield has been agreed.

Workforce

Human Resources Performance Dashboard - February 2018

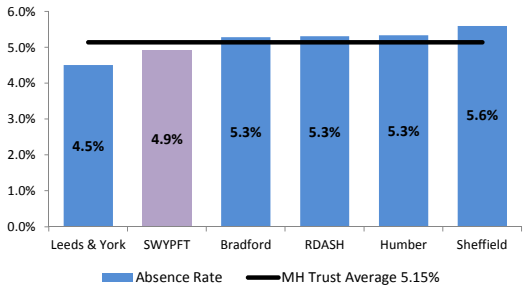
Sickness Absence



Current Absence Position and Change from Previous Month - February 2018

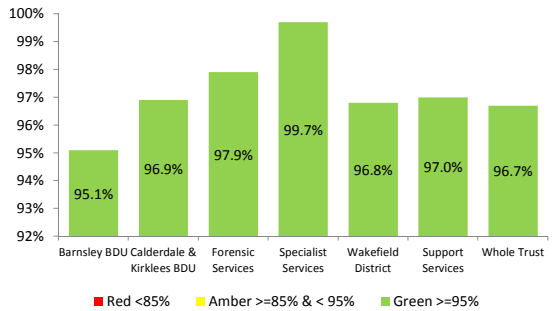
	Barn	Cal/Kir	Fore	Spec	Wake	Supp	SWYPFT
Rate	5.8%	5.1%	6.8%	6.4%	7.7%	5.4%	5.9%
Change	↓	↓	↓	↑	↓	↓	↓

The Trust YTD absence levels in February 2018 (chart above) were above the overall 4.5% target at 5.3%.
The YTD cost of sickness absence is £5,762,693. If the Trust had met its target this would have been £4,939,451 saving £823,242.



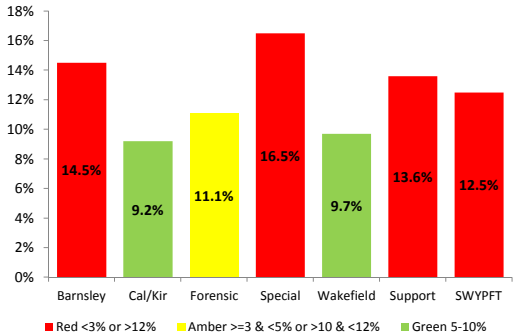
The above chart shows the YTD absence levels in MH/LD Trusts in our region for the period April 2017 to August 2017.
During this time the Trust's absence rate was 4.93% which is below the regional average of 5.15%.

Appraisal Data - All Staff

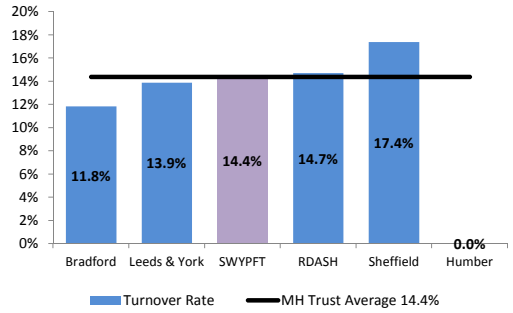


The above chart shows the appraisal rates for all staff for the Trust to the end of February 2018.
The appraisal target is 95% and over. For staff at Band 6 and above, all appraisals should be completed by the end of June and Band 5 and below, by end of September in each financial year.

Turnover and Stability Rate Benchmark

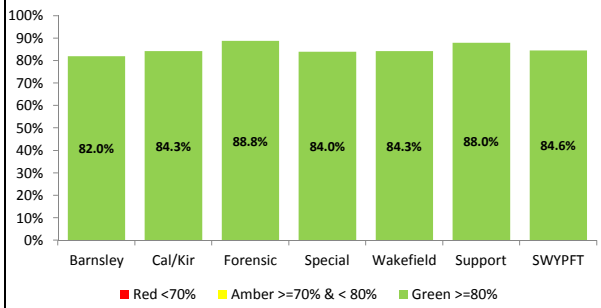


This chart shows the YTD turnover levels up to the end of February 2018.
*The turnover data excludes recently TUPE'd services
• The Trust is now part of the NHSI Retention Support Programme and a Retention Plan has been agreed by the EMT.
• In Barnsley there has been a large number of retirements in addition to the redundancies related to service decommissioning/transfer/tendering which accounts for over 30% of the reasons why staff have left.
• Specialist Service again just over 25% have left for either retirement or termination of contracts.



This chart shows turnover rates in MH Trusts in the region for the 12 months ending in September 2017. The turnover rate shows the percentage of staff leaving the organisation during the period.
SWYPFT figures exclude decommissioned service changes.
This is calculated as: leavers/average headcount.
Figures for Humber are not available.

Fire Training Attendance



The chart shows the YTD fire lecture figures to the end of February 2018. The Trust continues to achieve its 80% target for fire lecture training.

Workforce - Performance Wall

Trust Performance Wall

Month	Objective	CQC Domain	Owner	Threshold	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Sickness (YTD)	Improving Resources	Well Led	AD	<=4.4%	5.1%	5.1%	4.8%	4.7%	4.7%	4.8%	4.9%	4.9%	4.9%	5.0%	5.1%	5.2%	5.3%
Sickness (Monthly)	Improving Resources	Well Led	AD	<=4.4%	5.8%	5.3%	4.8%	4.6%	4.8%	5.0%	5.2%	5.0%	5.2%	5.6%	5.7%	6.1%	5.8%
Appraisals (Band 6 and above) 1	Improving Resources	Well Led	AD	>=95%	94.4%	94.9%	5.2%	17.6%	61.3%	80.9%	89.0%	91.0%	92.7%	97.6%	98.1%	97.9%	97.8%
Appraisals (Band 5 and below)	Improving Resources	Well Led	AD	>=95%	92.8%	93.6%	1.9%	5.3%	18.4%	31.1%	46.2%	75.8%	82.7%	95.5%	95.7%	95.9%	95.9%
Aggression Management	Improving Care	Well Led	AD	>=80%	77.2%	76.6%	76.4%	75.6%	78.1%	76.6%	77.0%	77.6%	76.4%	79.0%	78.0%	77.9%	78.2%
Cardiopulmonary Resuscitation	Improving Care	Well Led	AD	>=80% by 31/3/17	73.8%	73.9%	75.2%	75.3%	74.7%	73.1%	71.9%	73.4%	72.8%	75.4%	76.6%	77.0%	78.5%
Clinical Risk	Improving Care	Well Led	AD	>=80% by 31/3/17	60.4%	62.2%	64.8%	65.3%	69.1%	74.6%	77.3%	79.2%	80.7%	82.3%	82.5%	83.8%	85.3%
Equality and Diversity	Improving Health	Well Led	AD	>=80%	89.4%	88.2%	87.3%	86.6%	86.0%	86.6%	87.1%	85.7%	85.4%	87.0%	86.9%	88.3%	88.9%
Fire Safety	Improving Care	Well Led	AD	>=80%	82.9%	82.7%	81.5%	82.0%	81.5%	81.8%	82.6%	82.8%	82.8%	83.3%	82.4%	83.8%	84.6%
Food Safety	Improving Care	Well Led	AD	>=80%	82.6%	82.1%	82.6%	81.2%	80.3%	79.1%	79.2%	77.0%	76.2%	78.4%	78.6%	79.3%	77.8%
Infection Control and Hand Hygiene	Improving Care	Well Led	AD	>=80%	83.6%	83.4%	83.0%	83.5%	84.0%	83.7%	83.6%	82.3%	81.8%	83.2%	83.2%	85.0%	86.5%
Information Governance	Improving Care	Well Led	AD	>=95%	95.2%	96.1%	92.0%	91.7%	91.3%	90.4%	89.1%	88.3%	86.2%	85.9%	83.8%	89.2%	95.7%
Moving and Handling	Improving Resources	Well Led	AD	>=80%	81.9%	81.7%	81.1%	77.3%	78.8%	79.3%	79.3%	79.3%	80.7%	81.6%	81.9%	84.1%	85.4%
Mental Capacity Act/DOLS	Improving Care	Well Led	AD	>=80% by 31/3/17	53.1%	64.1%	64.9%	69.6%	78.0%	82.5%	86.1%	87.6%	88.9%	90.3%	91.1%	91.0%	91.1%
Mental Health Act	Improving Care	Well Led	AD	>=80% by 31/3/17	30.5%	47.9%	51.2%	56.9%	70.5%	75.0%	80.3%	81.6%	83.4%	84.7%	86.6%	86.4%	86.0%
No of staff receiving supervision within policy guidance	Quality & Experience	Well Led		>=80%	39.5%		59.3%			61.0%			64.7%			81.7%	
Safeguarding Adults	Improving Care	Well Led	AD	>=80%	89.4%	89.1%	88.5%	88.0%	86.7%	86.2%	86.0%	86.3%	86.3%	87.4%	87.8%	89.0%	89.8%
Safeguarding Children	Improving Care	Well Led	AD	>=80%	87.0%	85.6%	85.5%	84.8%	83.6%	84.3%	84.7%	84.8%	84.1%	85.4%	85.1%	86.7%	87.5%
Sainsbury's clinical risk assessment tool	Improving Care	Well Led	AD	>=80%	94.7%	93.7%	93.3%	91.2%	91.7%	93.2%	94.2%	94.2%	92.9%	93.4%	93.3%	93.8%	94.3%
Bank Cost	Improving Resources	Well Led	AD	-	£493k	£722k	£398k	£457k	£579k	£576k	£518k	£614k	£545k	£534k	£534k	£604k	£655k
Agency Cost	Improving Resources	Effective	AD	-	£729k	£833k	£501k	£426k	£500k	£457k	£446k	£435k	£515k	£531k	£430k	£465k	£563k
Overtime Costs	Improving Resources	Effective	AD	-	£15k	£12k	£16k	£13k	£9k	£9k	£12k	£12k	£7k	£10k	£8k	£11k	£13k
Additional Hours Costs	Improving Resources	Effective	AD	-	£48k	£53k	£56k	£36k	£48k	£44k	£38k	£45k	£44k	£50k	£39k	£34k	£24k
Sickness Cost (Monthly)	Improving Resources	Effective	AD	-	£527k	£561k	£476k	£504k	£487k	£493k	£527k	£499k	£547k	£550k	£589k	£627k	£518k
Business Miles	Improving Resources	Effective	AD	-	287k	273k	289k	245k	285k	299k	267k	283k	291k	265k	305k	271k	275k

1 - this does not include data for medical staffing.

Workforce - Performance Wall cont.…

Notes:

This period has seen most mandatory training subjects either maintain or increase compliance percentages; the only exception to this is Food Safety.
Data Security Awareness has moved from amber to green

Green Compliance Status:
• Mental Health Act (MHA) – 86% no significant change in compliance from last month. The Trust has begun work developing MHA e-learning courses to meet the refresher compliance requirement in the coming years. New registered clinical staff will be required to attend face to face classroom training to meet their initial competency requirement. There will be the option for non-registered clinical staff to attend face to face classroom training or completing an e-learning course
• Mental Capacity Act (MCA) – 91.1% no significant change in compliance from last month. The Trust has developed e-learning refresher courses. This now provides the resource for the refresher compliance requirement. New registered clinical staff will be required to attend face to face classroom training to meet their initial competency requirement. There will be the option for non-registered clinical staff to attend face to face classroom training or complete the e-learning course
• Equality and Diversity – 88.9% continues to increase each month
• Fire Safety – 84.6% 1% increase on last month. The 95% compliance requirement for ward based staff is monitored at service level. A particular hot spot of low compliance is Barnsley BDU Mental Health Acute Care with 78.3% however, compliance has increased by 13.5% in the previous 2 months
• Infection Control and Hand Hygiene – 86.5% 1.5% increase on last month
• Safeguarding Adults – 89.8% nearly 1% increase on last month
• Safeguarding Children – 87.5% nearly 1% increase on last month. Additional work has been undertaken by the safeguarding team to target 'hotspot' areas
• Sainsbury's Tool – 94.3% ½% increase on last month
• Clinical Risk – 85.3% ½% increase on last month. As well as the e-learning provision, bespoke face to face training has been facilitated for a number of services, giving the opportunity for a collective learning experience through sharing knowledge and exploring scenarios
• Data Security Awareness Level 1 (formally IG) – 95.7% 5.5% increase on last month, moving from amber compliance to green
• Moving and Handling – 85.4% 1.5% increase on last month. This figure may be compromised by the suspension of training in Barnsley BDU due to the closure of the training room at Priory Day unit; an alternative venue has been agreed but requires some minor works. This should be completed by the end of April with training resuming in the BDU in early May. Alternative training dates have been offered at Fieldhead in order to offset some of the loss however travel may be an issue for some staff.

Amber Compliance Status:
• Food Safety – 78.8% 1.5% 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
• Aggression Management – 78.2% Slight increase from last month at end of February. The MAV team continue to put on extra training sessions to the ones already scheduled to meet demand. The Aggression Management/Physical Interventions is at 87% compliance (Forensic services at 89.7%). The performance for this training as at 13th March was 79%.
The sub 80% overall rating is compromised by 72.7% Personal Safety and Breakaway-Non Clinical, and 75.2% De-esc and Breakaway-Clinical. This is currently being reviewed for initiatives to improve the overall compliance data
Workforce Development have given a compliance percentage at today's date of 78.8%
• Cardio Pulmonary Resuscitation (CPR) – 78.5% this is the fourth consecutive month that CPR compliance has increased (5% over last 4 months) The Team have introduced a number of initiatives to continue to improve compliance – CPR training (ILS) is now incorporated in the Aggression Management/Physical Interventions training. To avoid staff going out of compliance with their ILS training until their renewal date is aligned with their MAV renewal date, the Resuscitation team are providing additional interim ILS training to cover this period. Performance for this training as at 13th March was 80%

Red Compliance Status:
Sickness
• The Trust's year to date position is 5.3%, which continues to be above the Trust's threshold.
• 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.
• The Trust has launched the new Middleground Programme focused on creating Health Teams.
• Staff counselling is now fully recruited to and waiting times have reduced significantly.

Publication Summary

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

NHS England

Choice in mental health care

This guidance provides advice for commissioners, GPs and providers on how to implement patients' legal rights to choose their care provider and the team they see for their mental health care.
Click here for link to guidance

NHS England

Technical guidance for refreshing NHS plans for 2018/19

This document details the operational planning technical guidance annexes that support the submission of commissioner and provider templates. It should be read in conjunction with the guidance which sets out the expectations for commissioners and providers in updating their operational plans for 2018/19.
Click here for link to technical guidance

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

Quarterly performance of the NHS provider sector: quarter 3 2017/18 - NHS Improvement

Bed availability and occupancy: quarter 3, 2017–18

Psychological therapies: reports on the use of IAPT services, England: November 2017 final

NHS outcomes framework indicators: February 2018 release

NHS Improvement update: January/February 2018 - inlcudes resources to assist with delivering a lean management system, and resources to assist with safe sustainable and productive staffing.

NHS Improvement provider bulletin: 21 February 2018 - includes 2016/17 reference cost benchmarking tools, Estates and facilities alert for the reporting of defects and failures

NHS Improvement provider bulletin: 28 February 2018 - includes an article on cyber security and updated requirements for quality reports

NHS Improvement provider bulletin: 7 March 2018 - includes information on the NHS70 Parliamentary Awards nominations and invited Mental health trusts to apply for the chance to win a 'feel good' garden.

NHS Improvement provider bulletin: 14 March 2018 - includes access to a Delayed transfers of care improvement tool, link to resources to support the implementation of General Data Protection Regulation which comes into effect from 25th May 2018,

Annual report on the use of Improving Access to Psychological Therapies services in England: further analyses on 2016-17

Cost effectiveness methodology for vaccination programmes: consultation - Department of health consultation - This consultation seeks views on the recommendations set out by the Cost-Effectiveness Methodology for Vaccination Programmes and Procurement group on whether the methodology for appraising cost effectiveness of vaccination programmes should change. The consultation closes on 21 May 2018.

Healthcare workforce experimental statistics: September 2017

NHS workforce provisional statistics: November 2017

Publication Summary

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

NHS sickness absence rates: October 2017

Vaccine update: issue 275, February 2018

NHS combined performance summary - Department of Health and Social Care

Data on written complaints in the NHS, experimental statistics: quarter 3, 2017-18

Monthly hospital activity data: January 2018

Early intervention in psychosis access and waiting time statistics: January 2018

Diagnostics waiting times and activity statistical report: January 2018

Delayed transfers of care: January 2018

Care Quality Commission report on the review of children and young people's mental health services

Friends and family test data: January 2018

Provisional monthly hospital episode statistics for admitted patient care, outpatients and accident and emergency data: April 2017 to January 2018

Community services statistics for children, young people and adults, England, experimental statistics: November 2017

South West Yorkshire Partnership NHS Foundation Trust

Finance Report

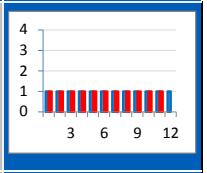
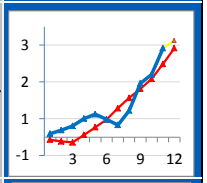
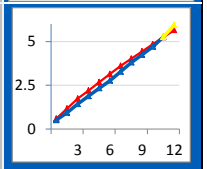
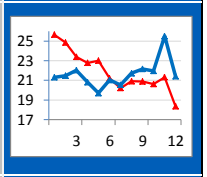
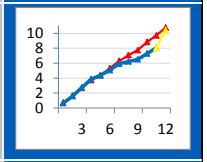
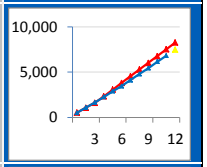
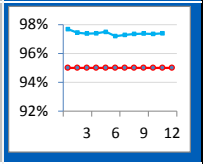
Month 11 (2017/18) Appendix 1

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

Contents

1.0 Executive Summary / Key Performance Indicators

	Performance Indicator	Year to Date	Forecast	Narrative	Trend
1	NHS Improvement Finance Rating	1	1	The NHS Improvement financial and use of resources risk rating is maintained at 1 for the 11 months to the end of February 2018.	
2	Normalised Surplus (inc STF)	£2.4m	£2.6m	February 2018 finance performance excluding STF is a surplus of £0.6m. Including STF this is a surplus of £0.7m. This includes the gain from the sales of two properties and other one-off measures. The cumulative surplus excluding STF is now £1.2m, including STF the surplus is £2.4m.	
3	Agency Cap	£5.3m	£6m	Agency expenditure in February 2018 is the highest YTD at £563k, this exceeds the in-month cap by 37%. For the first time this year cumulative agency expenditure is above the cap by 0.4%. The forecast exceeds the cap by 5% given schemes to improve access times, an increase in medical vacancies and bespoke packages of care.	
4	Cash	£25.5m	£21.4m	The Trust cash position is £4.2m above plan in February with continued focus on working capital management and lower than plan capital expenditure. Two properties planned for sale in 2018/19 have been sold in February resulting in the cash increase. The forecast cash position is also higher than plan.	
5	Capital	£8m	£10.4m	Capital Expenditure is forecast to be £0.3m lower than plan. This includes an additional £0.35m for rollout of the Trustwide WiFi network which has been funded separately as a national project.	
6	Delivery of CIP	£6.8m	£7.5m	Year to date CIP delivery is £0.7m 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%	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 has provided an updated Single Oversight Framework for 2018 / 2019 and beyond. There is limited impact on the finance rating.

			Actual Performance		Plan - Month 11	
Area	Weight	Metric	Score	Risk Rating	Score	Risk Rating
Financial Sustainability	20%	Capital Service Capacity	3.4	1	3.3	1
	20%	Liquidity (Days)	22.7	1	12.0	1
Financial Efficiency	20%	I & E Margin	1.2%	1	1.0%	2
Financial Controls	20%	Distance from Financial Plan	0.2%	1	0.0%	1
	20%	Agency Spend	0.4%	2	-3.6%	1
Weighted Average - Financial Sustainability Risk Rating				1		1

Impact

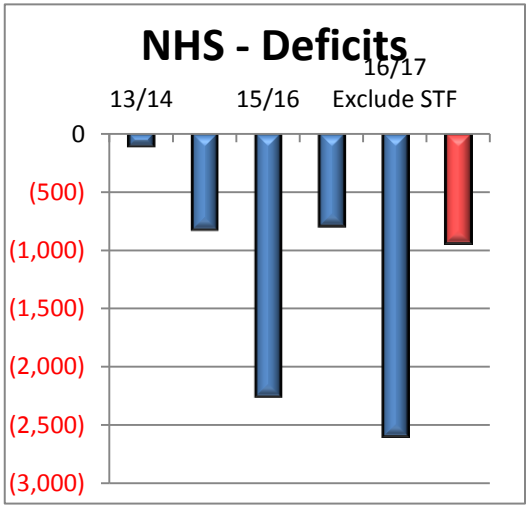
The current overall risk rating is 1 which is the highest possible score. The Trust's I & E Margin has exceeded 1% at month 11 reducing the risk rating from 2 to 1. The agency spend risk rating has increased from 1 to 2, month 11 is the first month that year to date agency spend has exceeded plan.

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	Variance - Q2 £m	Movement £m
Acute	(1,015)	(1,922)	(907)	99	(1,339)	(583)
Ambulance	(4)	9	13	5	(4)	13
Community	28	24	(4)	5	25	(1)
Mental Health	125	103	(22)	10	118	(15)
Specialist	19	92	73	5	16	76
Total - Deficit	**(847)**	**(1,694)**	**(847)**	**124**	**(1,184)**	**(510)**
Adjustments	(92)	(15)	77		(44)	29
Uncommitted STF	443	778	335		605	173
Adjusted Deficit	**(496)**	**(931)**	**(435)**		**(623)**	**(308)**



NHS Improvement published Quarter 3 performance of the NHS Provider Sector 21st February 2018.

This summarises operational and financial performance for the period of April 2017 to December 2017.

Operational pressures being experienced within the NHS have been widely publicised. At a summary level, rising demand for services, high levels of bed occupancy (including the effects experienced from delays in transfer of care) and continued workforce issues meant that the NHS National Emergency Pressures panel advised Trusts to prioritise emergency activity over non-urgent inpatient elective care.

This has had a direct significant impact on the financial performance of the provider sector primarily within acute providers. As such the overall financial position has deteriorated from £623m deficit forecast in Q2 to £931m at Q3 (movement of £308m). The majority of this financial decline is within a minority of providers. Current CCG overspends are forecast at £471m.

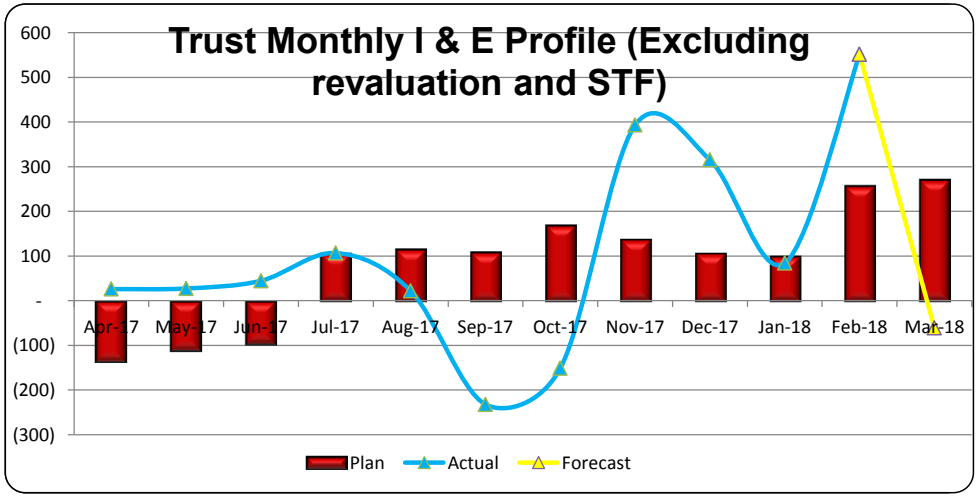
This position includes approximately 70% of the additional £337m given to the NHS in the November 2017 budget. It also includes £569m in Sustainability and Transformation (STF) funding.

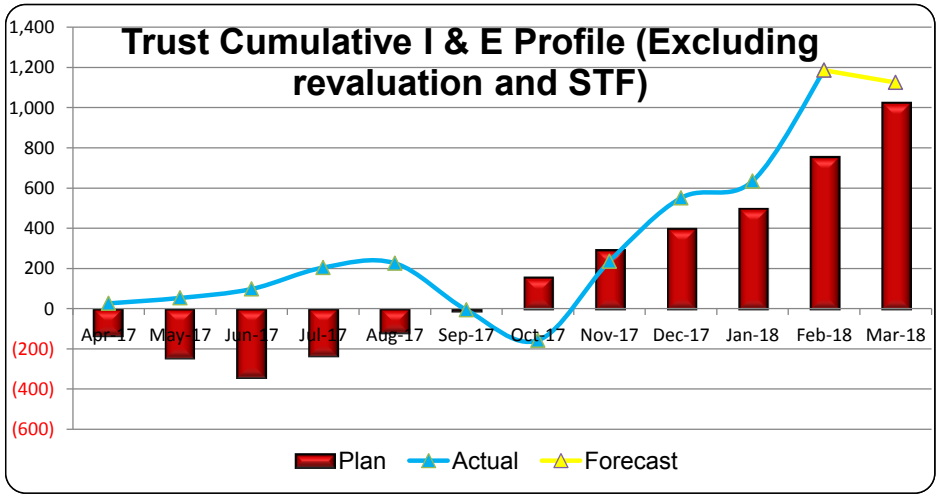
Overall 139 Trusts (59%) reported a deficit at Q3, an increase of 4 from the same period in 16/17.

As a result of this many Trusts are not delivering against their targets and control totals. At Q3 nearly £800m remained uncommitted which will be passed into the sector through the STF incentive and bonus scheme.

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**
				17,222	16,922	(300)	Clinical Revenue	189,783	188,212	(1,571)	206,967	204,792	(2,175)
				17,222	**16,922**	**(300)**	**Total Clinical Revenue**	**189,783**	**188,212**	**(1,571)**	**206,967**	**204,792**	**(2,175)**
				1,058	1,280	222	Other Operating Revenue	12,815	12,899	85	13,994	14,183	189
				18,280	**18,202**	**(77)**	**Total Revenue**	**202,598**	**201,112**	**(1,486)**	**220,961**	**218,975**	**(1,986)**
4,255	4,096	(159)	3.7%	(14,163)	(13,781)	382	Pay Costs	(156,291)	(152,171)	4,120	(170,454)	(166,205)	4,249
				(3,232)	(3,552)	(320)	Non Pay Costs	(37,897)	(39,745)	(1,848)	(41,238)	(44,054)	(2,817)
				76	424	348	Provisions	491	441	(49)	606	1,617	1,011
4,255	**4,096**	**(159)**	**3.7%**	**(17,319)**	**(16,909)**	**410**	**Total Operating Expenses**	**(193,697)**	**(191,474)**	**2,223**	**(211,086)**	**(208,643)**	**2,443**
4,255	**4,096**	**(159)**	**3.7%**	**960**	**1,293**	**333**	**EBITDA**	**8,901**	**9,637**	**736**	**9,875**	**10,332**	**457**
				(426)	(466)	(40)	Depreciation	(5,074)	(5,384)	(310)	(5,500)	(5,861)	(361)
				(283)	(284)	(1)	PDC Paid	(3,114)	(3,123)	(9)	(3,397)	(3,407)	(10)
				4	8	4	Interest Received	41	56	14	45	61	16
4,255	**4,096**	**(159)**	**3.7%**	**255**	**551**	**296**	**Normalised Surplus / (Deficit) Excl.STF**	**754**	**1,186**	**432**	**1,023**	**1,125**	**102**
				163	163	0	STF	1,232	1,232	0	1,394	1,496	102
4,255	**4,096**	**(159)**	**3.7%**	**418**	**714**	**296**	**Normalised Surplus / (Deficit) Incl SFT**	**1,986**	**2,418**	**432**	**2,417**	**2,621**	**204**
				0	0	0	Revaluation of Assets	0	(908)	(908)	0	(908)	(908)
4,255	**4,096**	**(159)**	**3.7%**	**418**	**714**	**296**	**Surplus / (Deficit)**	**1,986**	**1,510**	**(476)**	**2,417**	**1,713**	**(704)**





Income & Expenditure Position 2017 / 2018

Gains on disposal of two Trust properties have enabled the Trust to report an in month surplus of £296k. This contributes to an improved forecast position although significant operational and financial pressures remain.

Month 11

The February position is a pre STF surplus of £551k. The normalised year to date position is a pre STF surplus of £1,186k and a post STF surplus of £2,418k. This is £432k ahead of plan. The key headlines are below.

Month 11 includes gains from the disposal of CNDH and Bridwell properties of £353k. Excluding this gain the year to date position would be £79k ahead of plan. It also includes income from Kirklees CCG related to a besp[eoke package of care. Month 11 is similar to the trend throughout the year with underspends on pay and non clinical non pay areas such as travel and office costs being offset by out of area bed costs and income lower than plan. Shortfalls within the Trust CIP programme continue to be met within the overall bottom line position ensuring that the year to date position remains ahead of plan.

Income

Income for the year to date is £1.6m lower than plan with the full breakdown on page 8. This is primarily due to changes in commissioned services with the majority of income received as per agreed contracts.

National Winter Pressures funding has been received. For the Trust this totals £0.2m and additional expenditure is being incurred within the BDUs to meet its targets and requirements.

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 February has increased as forecast with increases focused within inpatient services. The level of spend in month was 37% over the cap limit of £410k. Cumulatively agency expenditure has exceeded the cap for the first time this year by 0.4% (£19k).

Non Pay Expenditure

February out of area bed spend was £373k, this is the highest monthly spend this year and nearly double the January expenditure amount. The cumulative overspend is now £1.9m. 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. Excluding out of area beds and drugs costs non-pay is showing a £0.8m saving.

Forecast

The current forecast is reported as £1,125k which is £102k better than plan. This is recognition of the gain of disposal of properties recorded in month 11 which is then partially offset by continued, and increased, pressures in Out of Area bed usage.

Other significant risks including CIP delivery, reduced service provision and CQUIN delivery have been considered within this position.

Agency expenditure is forecast to end the year £291k (5%) 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 6). The majority of Trust income is secured through block contracts and therefore there has traditionally been little variation to plan.

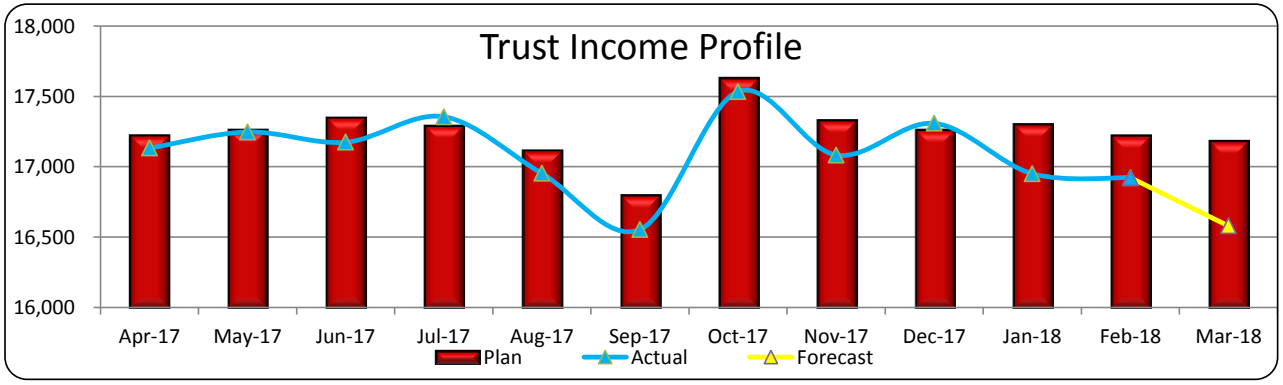
The budget values are reconciled against signed and agreed contracts with any movement highlighted.

The year to date and forecast variances are shown below. This highlights the most significant variance relates to changes in income relating to Intermediate Care. Delivery of this service has changed in year and forms part of our ongoing Alliance / Accountable Care system arrangement.

Ahead of year end a review is being undertaken to ensure that all invoices have been raised. This also assesses risk of recovery of this income.

Commissioner	Year to Date Budget £k	Actual £k	Variance £k		Variance Headlines CQUIN £k	Other £k	Total £k
CCG	139,278	139,104	(174)		(18)	(156)	(174)
Specialist Commissioner	21,388	21,388	(0)		0	(0)	(0)
Alliance	12,380	10,568	(1,812)		0	(1,812)	(1,812)
Local Authority	4,536	4,441	(95)			(95)	(95)
Partnership	6,305	6,305	0		0	0	0
Other	5,895	6,405	510		0	510	510
Total	**189,783**	**188,212**	**(1,571)**	**0**	**(18)**	**(1,552)**	**(1,571)**

	Forecast Budget £k	Actual £k	Variance £k	Variance Headlines CQUIN £k	Other £k	Total £k
CCG	151,611	151,248	(363)	(154)	(209)	(363)
Specialist Commissioner	23,333	23,333	(0)	0	(0)	(0)
Alliance	13,712	11,470	(2,241)	0	(2,241)	(2,241)
Local Authority	4,970	4,855	(115)		(115)	(115)
Partnership	6,879	6,879	0	0	0	0
Other	6,463	7,006	544	0	544	544
Total	**206,967**	**204,792**	**(2,175)**	**(154)**	**(2,021)**	**(2,175)**



CQUIN Risk - Summary	YTD	Forecast
Wellbeing Improvement	0	136
Ill Health by Risky behaviour	18	18
STP Reserve	0	0
Total	**18**	**154**

2.1 Pay Information

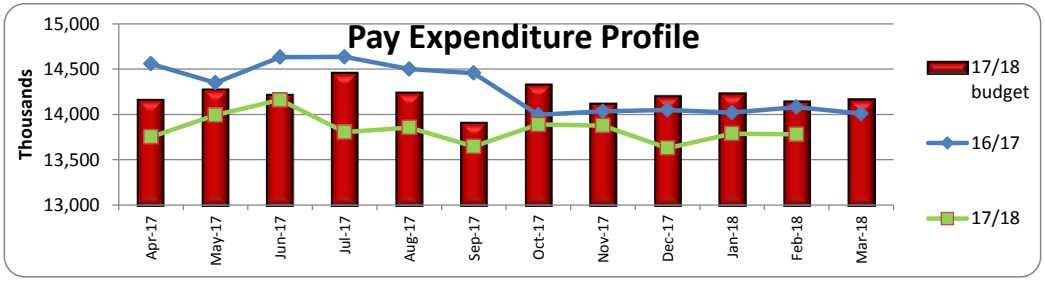
Our workforce is our greatest asset and one in which we continue to invest in ensuring that we have the right workforce in place to deliver safe and quality services. In total workforce spend accounts for circa 75% of total Trust expenditure.

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	12,771	12,616	12,688	12,491		**140,532**
Bank & Locum	411	472	620	505	558	701	583	575	583	635	727		**6,370**
Agency	501	426	500	457	446	435	515	531	430	465	563		**5,269**
Total	**13,752**	**13,992**	**14,161**	**13,804**	**13,854**	**13,645**	**13,889**	**13,876**	**13,629**	**13,788**	**13,781**	**0**	**152,171**
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%	4.3%	4.6%	5.3%		4.2%
Agency as %	3.6%	3.0%	3.5%	3.3%	3.2%	3.2%	3.7%	3.8%	3.2%	3.4%	4.1%		3.5%

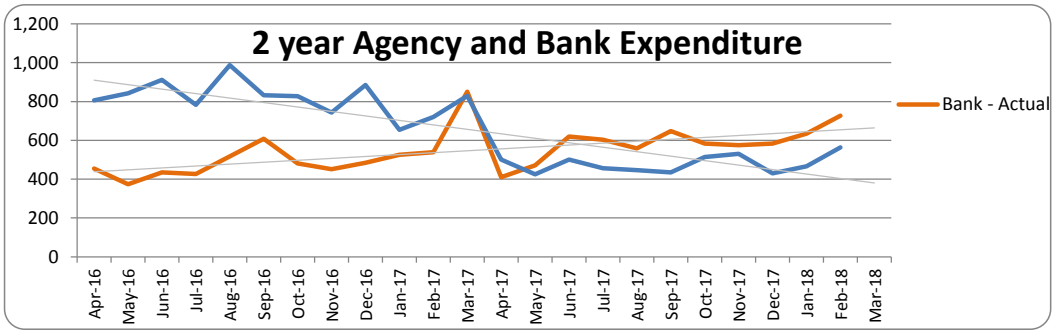
Year to Date expenditure - by staff group

	Substantive £k	Temp £k	Agency £k	Total £k
Medical	16,353	410	2,496	19,258
Nursing Registered	49,013	2,204	572	51,788
Nursing Unregistered	16,028	2,812	1,231	20,071
Other	35,750	373	921	37,044
Admin	23,344	616	50	24,010
Total	**140,488**	**6,414**	**5,269**	**152,171**



February WTE Analysis

	Budgeted	Contracted	Bank	Agency	Variance
Medical	212	170	3	20	(19)
Qualified Nursing	1,436	1,272	62	14	(87)
Unqualified Nursing	695	605	119	46	75
Other Clinical	850	773	9	10	(59)
A & C	839	755	26	2	(56)
Other	337	290	6	2	(39)
Staff Vacancy Factor	(113)	0	0	0	113
Total	**4,255**	**3,864**	**225**	**94**	**(72)**



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 2017 when it increased as a result of additional Agency Medical usage to cover vacancies and initiatives to improve access in some services. The recent increased expenditure on Bank and Agency is driven by increases in medical and nursing spend and are forecast to reach levels last seen in 2016/17. Some agency staff have moved to bank posts and a more moderate increase in month on month bank usage can be seen.

The WTE Analysis table above presents the budgeted WTE across staffing categories and demonstrates that whilst overall agency and bank usage are covering a significant proportion of gaps in services particularly in nursing, the actual staffing profile is currently altered from plan with the use of temporary staff.

2.1 Agency Expenditure Focus

The NHS Improvement agency cap is forecast to be breached by 5%

February spend is the highest during 2017/18; March spend is forecast at levels last seen in 2016/17

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

The financial implications, alongside clinical and other considerations, continues to be a high priority area for the Trust. We acknowledge that agency and other temporary staff have an important role to play within our overall workforce strategy but this must fit within the overall context of ensuring the best possible use of resources and providing a cost effective strategy.

The Trust had experienced increased levels of agency spend rising from £3.6.m in 2013 / 2014 to £9.8m in 2016 / 2017. This increase was across all staffing groups.

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

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

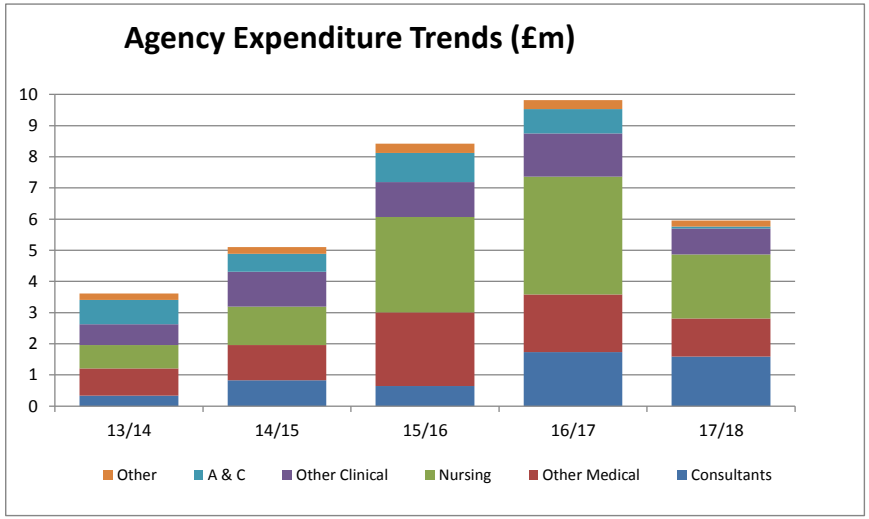
* Reduction in the number of agency staff used - this is especially evident within the Admin & Clerical category where the Trust currently has 2 wte individually approved to the end of February.

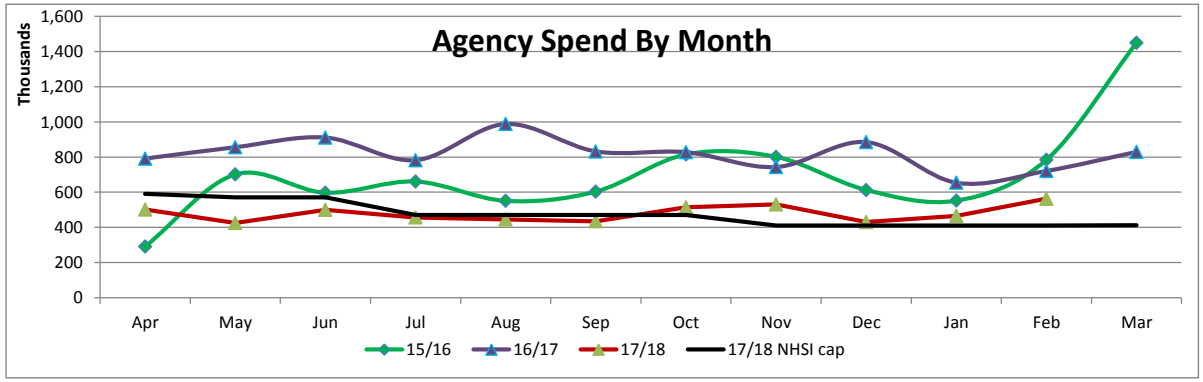
* Reduction in the hourly rate paid. In particular this relates to qualified nursing staff who are now all paid within the NHS Improvement capped rates. 16 out of 20 medical locums continue to be paid higher than the NHSI caps. These have been individually approved by the Trust Medical Director and are reported weekly to NHSI.

Agency expenditure in February is £563k, the highest monthly expenditure in 2017/18. This breaches the agency cap (£410k) for the fifth month and agency spend is forecast to be higher than cap for the remainder of the year. The forecast outturn at February is £291k (5%) above cap.

Medical agency is forecast to increase towards year end; the majority of these posts are covering vacancies. Nursing agency is also forecast to increase in response to increasing acuity levels across several inpatient units and also to support a bespoke package in Forensic BDU. This increase will take expenditure levels to those not seen since 2016/17.

Across all agency categories spend has reduced on 2016 / 2017. YTD has reduced by £3.9m (39%).





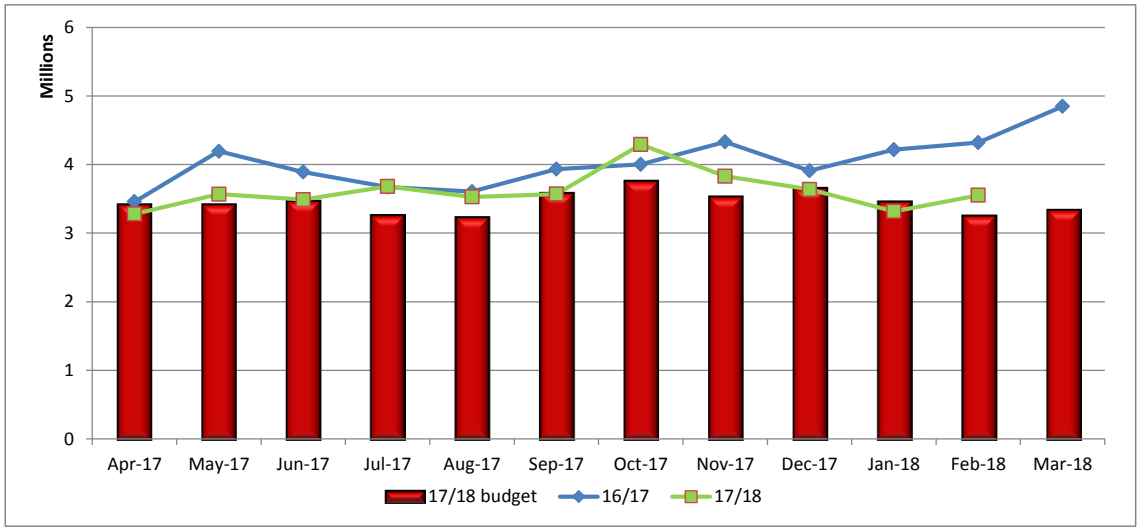
2.1 Non Pay Expenditure

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 £3.8m 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 £782k 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	3,637	3,318	3,552		**39,745**
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	2,753	3,066	(313)
Drugs	2,775	3,539	(764)
Healthcare subcontracting	3,208	5,074	(1,866)
Hotel Services	1,909	1,613	297
Office Supplies	3,911	4,083	(172)
Other Costs	4,063	3,643	419
Property Costs	6,217	6,274	(57)
Service Level Agreements	5,527	5,534	(7)
Training & Education	735	787	(52)
Travel & Subsistence	4,015	3,564	451
Utilities	1,374	1,161	213
Vehicle Costs	1,410	1,406	4
Total	**37,897**	**39,745**	**(1,848)**
Total Excl OOA and Drugs	**31,914**	**31,132**	**782**



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.

Underspends on Utilities includes a refund on rates relating to properties being disposed.

Central funding of Microsoft licences has ceased 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. Wherever possible service users are placed within the Trust footprint.

This analysis excluded activity relating to Locked Rehab in Barnsley.

Out of Area Expenditure Trend (£)

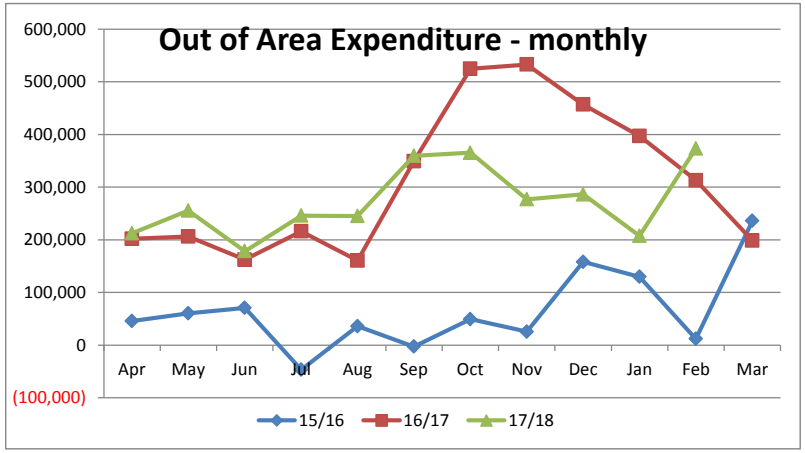
	Apr £000	May £000	Jun £000	Jul £000	Aug £000	Sep £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	Mar £000	Total £000
15/16	46	60	71	(47)	36	(3)	49	25	158	130	12	236	**772**
16/17	202	206	162	216	160	349	525	533	457	397	313	198	**3,718**
17/18	212	255	178	246	245	359	365	277	286	208	373		**3,005**

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	367	253	351	373	427	479	434	414	276	631		**4,287**

Bed Day Information 2017 / 2018 (by category)

PICU	199	168	168	169	195	216	239	314	216	153	245		**2,282**
Acute	83	192	85	182	148	181	209	119	168	92	358		**1,817**
Gender	0	7	0	0	30	30	31	1	30	31	28		**188**



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 increased again during Quarter 2, the main factor being high demand observed across the Trust and also nationally. Early indications showed a pilot led by the Trust Project Board to reduce out of area placements (starting December) was effective with out of area bed days reducing steadily.

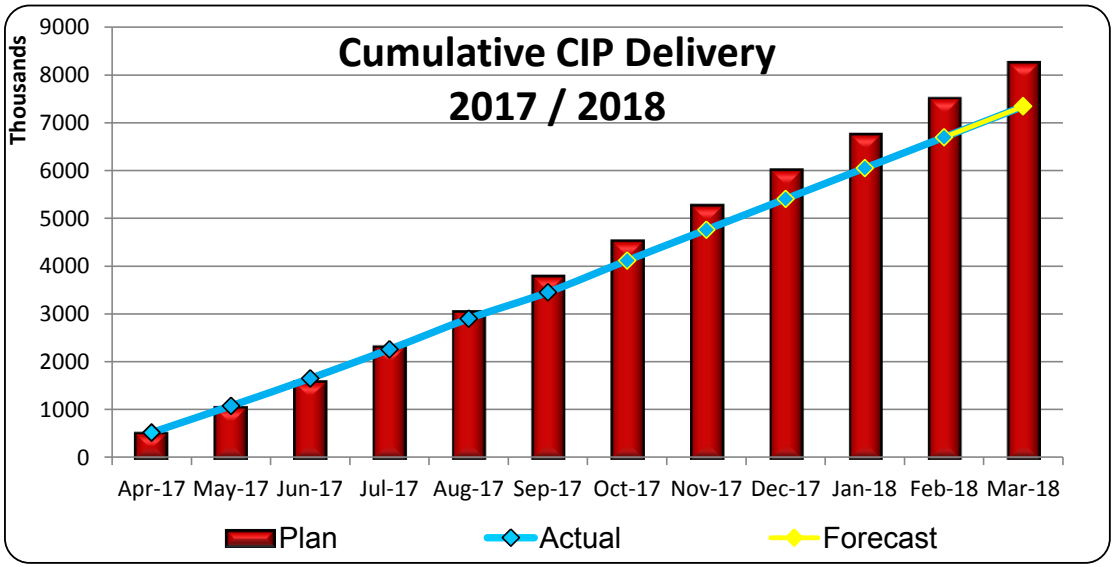
In February there has been unprecedented demand for services requiring 631 out of area bed days, the forecast has been updated to reflect the increased usage.

The year to date overspend, for the activity covered in this section of the report, is £1.9m.

During February 2017 the Trust has had up to 11 PICU patients out of area due to the level of acuity. Teams are working hard to provide safe, alternative options to acute admission.

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	7,515	8,262
Delivery as originally planned	401	809	1,272	1,769	2,261	2,744	3,286	3,821	4,330	4,889	5,398	5,907	5,398	5,907
Mitigations - Recurrent & Non-Recurrent	116	266	378	490	639	706	829	974	1,117	1,267	1,418	1,568	1,418	1,568
Total Delivery	**516**	**1,075**	**1,650**	**2,259**	**2,900**	**3,450**	**4,115**	**4,794**	**5,447**	**6,157**	**6,816**	**7,475**	**6,816**	**7,475**
Variance	(20)	1	40	(82)	(173)	(359)	(431)	(489)	(574)	(611)	(699)	(787)	(699)	(787)



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 £6.8m to date. This is £0.7m behind plan. The majority (79%) has been delivered in line with original savings plans.

The shortfall in schemes identified continues to be managed within the Trust overall financial position. Additional savings schemes have been identified for 2018 / 2019. Outline schemes to deliver further savings are also in development.

3.0 Balance Sheet 2017 / 2018

	2016 / 2017 £k	Plan (YTD) £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	111,199	114,919	115,335	1
Current Assets				
Inventories & Work in Progress	166	215	166	
NHS Trade Receivables (Debtors	2,138	1,999	1,746	2
Other Receivables (Debtors)	8,289	6,992	8,429	3
Cash and Cash Equivalents	26,373	21,320	25,494	4
Total Current Assets	**36,966**	**30,526**	**35,834**	
Current Liabilities				
Trade Payables (Creditors)	(7,213)	(6,034)	(6,341)	5
Capital Payables (Creditors)	(1,157)	(752)	(866)	5
Accruals	(9,912)	(12,372)	(10,748)	6
Deferred Income	(754)	(950)	(789)	
Total Current Liabilities	**(19,036)**	**(20,108)**	**(18,744)**	
Net Current Assets/Liabilities	**17,929**	**10,418**	**17,090**	
Total Assets less Current Liabilities	**129,128**	**125,337**	**132,425**	
Provisions for Liabilities	(7,550)	(5,763)	(6,291)	
Total Net Assets/(Liabilities)	**121,578**	**119,574**	**126,135**	
Taxpayers' Equity				
Public Dividend Capital	43,665	43,665	44,015	
Revaluation Reserve	18,766	18,413	22,445	
Other Reserves	5,220	5,220	5,220	
Income & Expenditure Reserve	53,928	52,276	54,454	7
Total Taxpayers' Equity	**121,578**	**119,574**	**126,135**	

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. Year to date spend is less than plan. The main increase in value relates to the impact of the annual revaluation exercise.

2. NHS debts remain slightly lower than plan. Accrued income is being reviewed to ensure all appropriate invoices are raised.

3. Other debtors are higher than planned. Accrued income is £4.8m including £1.4m with Barnsley CCG and £0.8m relating to STF income.

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.

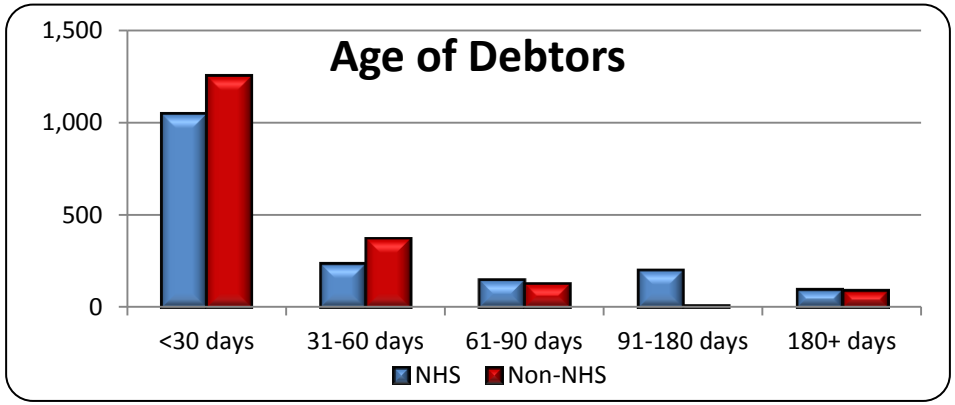
6. Accruals remain slightly lower than planned.

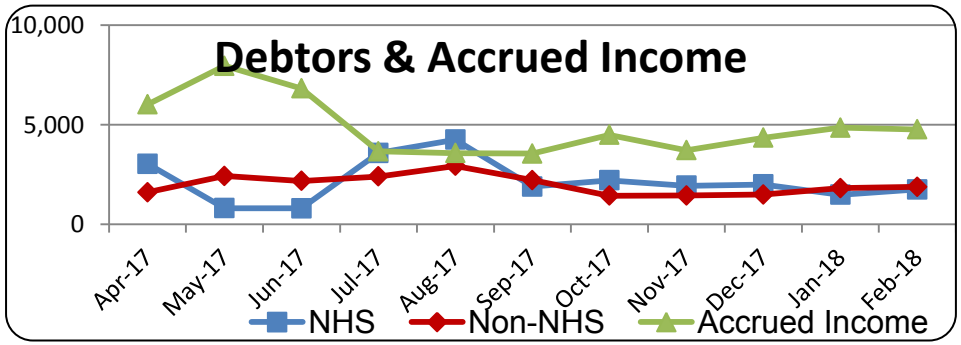
7. This reserve represents year to date surplus plus reserves brought forward.

3.0 Debtors

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

Debtors remain at a low level although accrued income has increased. Actions are focussed to ensure values are agreed and invoiced.





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 February 2018, are less than 60 days (81%). Debts older than 180 days have reduced from £223k to £193k.

All outstanding debts have been reviewed to ensure that a recovery plan is in place. This includes discussions with other organisations to ensure we understand the reason for non-payment and therefore can take appropriate steps to resolve.

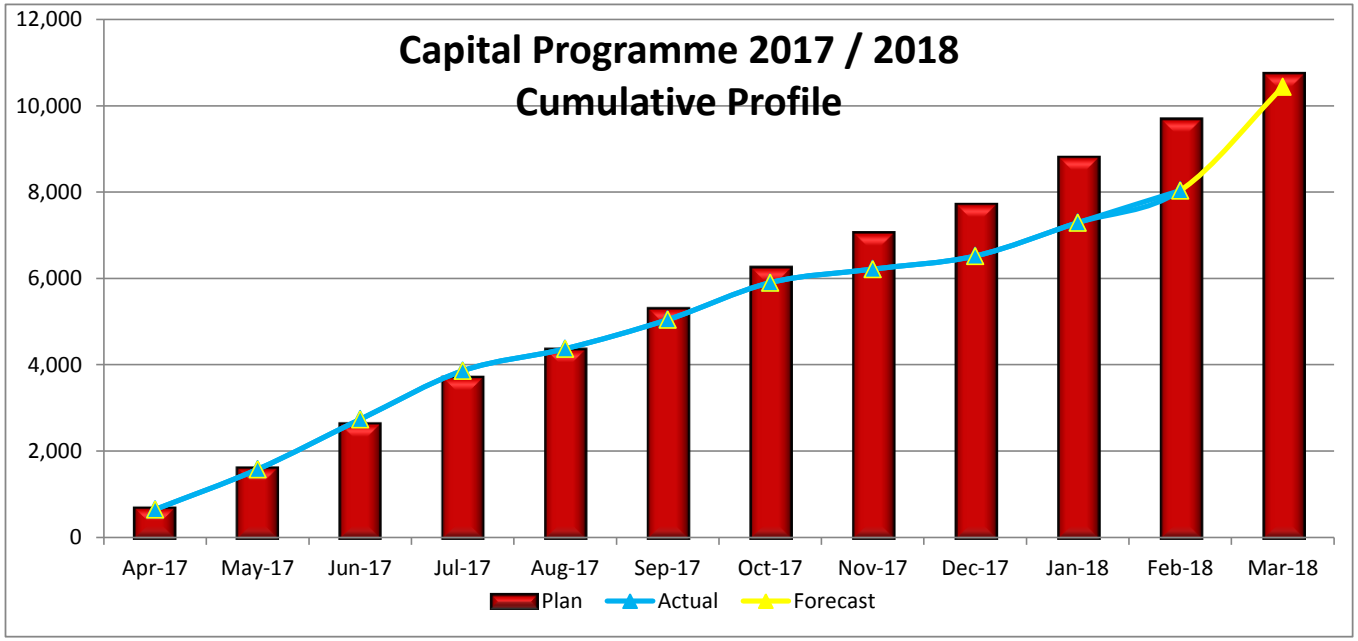
The in year profile of debtors is shown to the left. Accrued income has been added for context with invoices continuing to be raised in a timely manner.

Accrued income remains higher than planned primarily due to STP income and outstanding contract variations with main CCG commissioners. These are actively seeking resolution prior to 31st March 2018.

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	1,322	1,055	(267)	1,499	(58)	3
Equipment Replacement	44	44	58	14	58	14	
IM&T	2,121	1,876	966	(910)	1,673	(448)	4
Major Capital Schemes							
Fieldhead Non Secure	7,030	6,465	6,043	(422)	7,290	260	2
VAT Refunds	0	0	(86)	(86)	(86)	(86)	
TOTALS	**10,753**	**9,707**	**8,036**	**(1,671)**	**10,435**	**(318)**	1

Additional funding has been secured to support Trustwide WiFi access. This will be operational by 31st March 2018.



Capital Expenditure 2017 / 2018

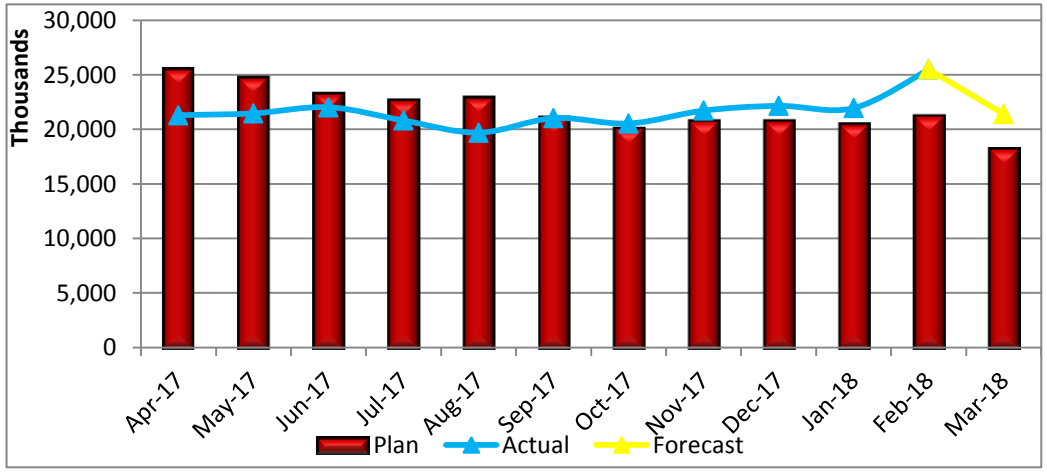
1. The year to date position is £1.7m lower than plan (17%). Forecast spend is £10.4m which includes an additional £0.35m relating to a new Trustwide wifi project.

2. Construction of the Unity Centre continues with phase 4 (Nostell Ward) with the outline structure in place. The impact of recent inclement weather is currently being reviewed.

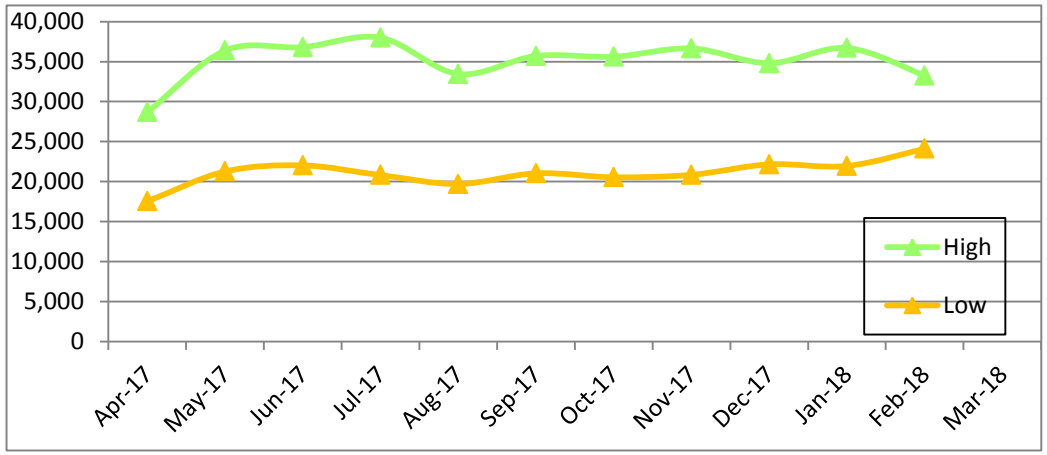
3. Minor works continue to be reviewed against Trust priorities. The plan for 18/19 is yet to be finalised.

4. Spend includes an additional £0.35m for rollout of the Trustwide WiFi network. This is enabled by new national funding.

3.2 Cash Flow & Cash Flow Forecast 2017 / 2018



	Plan £k	Actual £k	Variance £k
Opening Balance	25,495	26,373	
Closing Balance	21,320	25,494	4,174



Cash is £4.2m ahead of plan. Two properties, originally planned for sale in 2018 / 2019, have been sold in February 2018.

Two properties have been sold in month resulting in the cash increase. This is due to decrease in month 12 due to the payment of PDC.

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

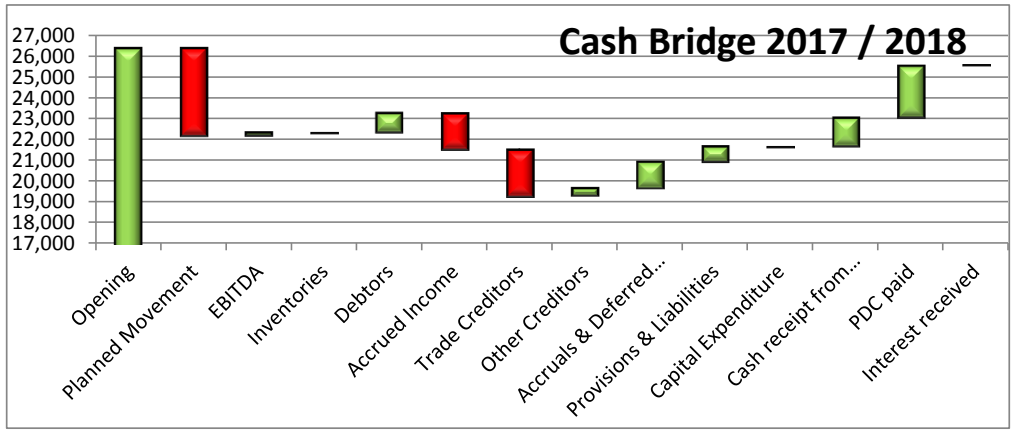
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is:	£33.2m
The lowest balance is:	£24.1m

This reflects cash balances built up from historical surpluses.

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)	10,324	10,458	134	
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	(400)	536	936	2
Accrued Income / Prepayments	(337)	(2,051)	(1,714)	5
Trade Payables (Creditors)	0	(2,244)	(2,244)	6
Other Payables (Creditors)	0	350	350	
Accruals & Deferred income	(400)	872	1,272	3
Provisions & Liabilities	(2,000)	(1,259)	741	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(9,708)	(8,328)	1,380	
Cash receipts from asset sales	0	2,483	2,483	4
PDC Dividends paid	(1,698)	(1,751)	(53)	
PDC Dividends received			0	
Interest (paid)/ received	44	56	12	
Closing Balances	**21,320**	**25,494**	**4,174**	



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. The team continue to focus action in pursuing old and high value debts.

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

4. Trust assets (Birdwell & CNDH) have been sold in February 2018. These were originally planned for cash receipts to be during 2018 / 2019.

Factors which decrease the cash position against plan:

5. Accrued income continues to be higher than plan. The STF outstanding for Q3 is expected to be paid 12th March 2018.

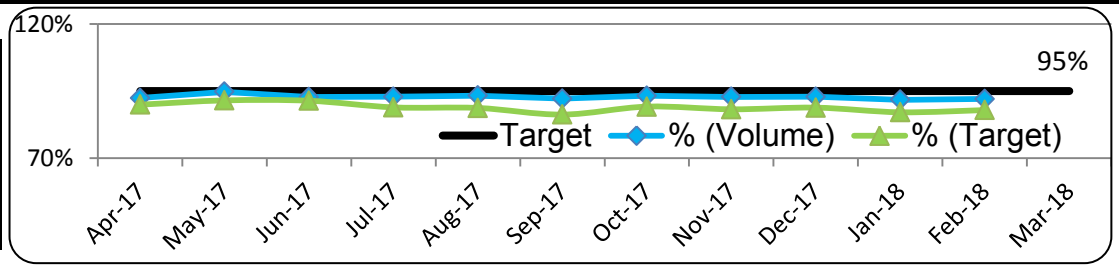
6. Creditors are lower than planned. Invoices are paid in line with the Trust Better Payment Practice Code.

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

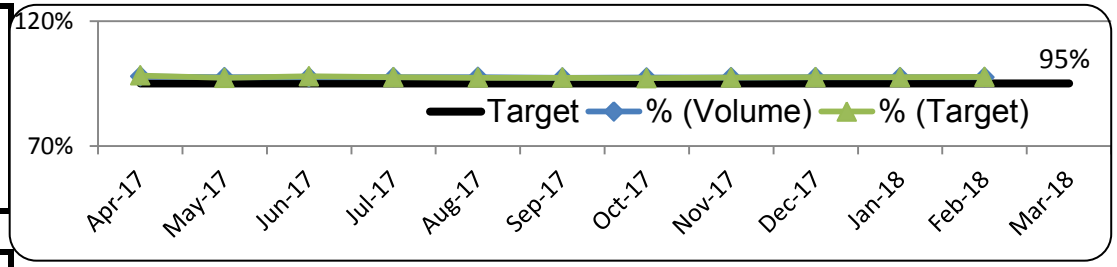
4.0 Better Payment Practice Code

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.

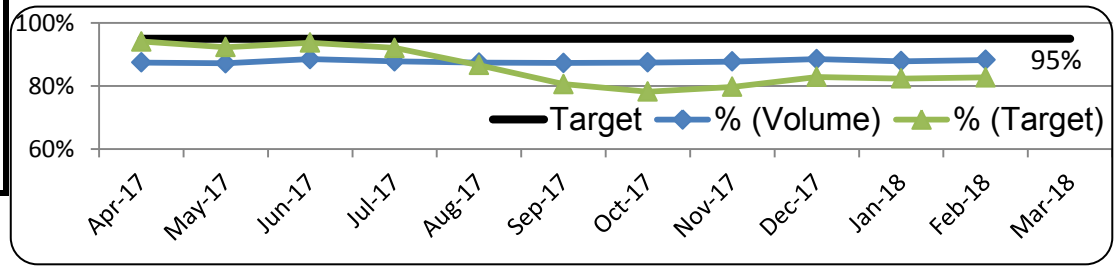
NHS	Number %	Value %
Year to January 2018	92%	87%
Year to February 2018	92%	88%



Non NHS	Number %	Value %
Year to January 2018	97%	98%
Year to February 2018	98%	98%



Local Suppliers (10 days)	Number %	Value %
Year to January 2018	88%	82%
Year to February 2018	88%	83%



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 (£)
02-Feb-18	Property Rental	Calderdale	Calderdale and Huddersfield NHS Foundation	3061780	219,053
02-Feb-18	Property Rental	Barnsley	Barnsley Metropolitan Borough Council	3061841	138,598
23-Feb-18	Staff Recharge	Wakefield	Wakefield MDC	3063787	60,468
25-Jan-18	Drugs FP10's	Trustwide	NHSBSA Prescription Pricing Division	3060940	53,044
05-Feb-18	Staff Recharge	Trustwide	Leeds and York Partnership NHS FT	3061904	49,001
08-Feb-18	Property Rental	Barnsley	Community Health Partnerships	3062450	32,445
02-Feb-18	Maintenance SLA	Trustwide	Mid Yorkshire Hospitals NHS Trust	3061866	31,010

4.2 Glossary

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 2 - Workforce - Performance Wall

Barnsley District

Month	Objective	CQC Domain	Owner	Threshold	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.7%	4.8%	4.9%	5.0%	5.1%	5.1%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	5.2%	5.2%	5.9%	5.9%	5.5%	5.9%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	86.1%	87.5%	95.4%	96.9%	96.6%	96.6%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	70.7%	75.6%	94.5%	94.5%	94.5%	94.3%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	78.4%	77.8%	79.1%	77.6%	77.4%	77.5%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	76.4%	74.4%	75.8%	78.8%	77.2%	78.7%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	86.6%	88.8%	88.1%	87.4%	87.4%	88.0%
Equality and Diversity	Resources	Well Led	AD	>=80%	88.9%	88.6%	89.1%	89.3%	91.0%	92.4%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	77.0%	78.2%	77.5%	77.4%	81.0%	82.0%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	63.3%	65.0%	62.6%	62.5%	66.4%	62.9%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	81.6%	81.7%	82.2%	81.7%	84.4%	85.2%
Information Governance	Resources	Well Led	AD	>=95%	84.3%	82.4%	83.4%	82.3%	88.4%	95.9%
Moving and Handling	Resources	Well Led	AD	>=80%	82.5%	82.1%	82.7%	81.8%	84.0%	84.7%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	85.8%	87.6%	87.6%	87.5%	88.0%	88.7%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	85.6%	85.0%	85.6%	84.5%	85.8%	86.7%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	95.5%	94.9%	95.3%	94.5%	94.0%	94.3%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	79.4%	82.1%	83.6%	84.4%	84.3%	84.2%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	71.8%	74.0%	74.3%	78.1%	78.6%	77.8%
Agency Cost	Resources	Effective	AD		£71k	£101k	£68k	£68k	£105k	£104k
Overtime Costs	Resources	Effective	AD		£3k	£2k	£4k	£3k	£4k	£3k
Additional Hours Costs	Resources	Effective	AD		£21k	£25k	£29k	£19k	£17k	£11k
Sickness Cost (Monthly)	Resources	Effective	AD		£162k	£170k	£174k	£182k	£163k	£150k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		108.86	106.64	111.36	158.63	191.9	166.28
Business Miles	Resources	Effective	AD		98k	106k	89k	107k	101k	90k

Calderdale and Kirklees District

Month	Objective	CQC Domain	Owner	Threshold	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.6%	4.7%	4.8%	4.9%	5.1%	5.2%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	4.8%	5.3%	5.7%	5.8%	6.7%	6.3%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	92.6%	93.7%	97.6%	97.9%	97.9%	97.9%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	78.0%	84.5%	95.2%	95.6%	95.8%	96.0%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	77.4%	75.8%	78.9%	76.8%	76.0%	77.6%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	70.9%	72.4%	74.3%	72.9%	73.1%	75.1%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	81.3%	79.9%	81.7%	82.4%	84.2%	87.5%
Equality and Diversity	Resources	Well Led	AD	>=80%	82.0%	81.1%	84.1%	83.9%	86.9%	86.8%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	84.0%	81.6%	81.4%	80.7%	83.4%	84.3%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	79.6%	76.3%	81.1%	82.4%	83.3%	80.3%
Infection Control and Hand Hygiene	Quality & Experience	Well Led		>=80%	80.5%	81.7%	83.1%	82.7%	85.2%	86.5%
Information Governance	Resources	Well Led	AD	>=95%	90.4%	87.4%	85.0%	84.9%	94.1%	98.5%
Moving and Handling	Resources	Well Led	AD	>=80%	76.0%	75.6%	77.8%	79.3%	83.0%	84.1%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	82.9%	81.7%	84.5%	85.5%	86.8%	89.8%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	79.0%	79.0%	79.6%	78.5%	82.4%	84.5%
Sainsbury's clinical risk assessment	Quality & Experience	Well Led	AD	>=80%	95.7%	93.8%	94.1%	94.0%	95.1%	95.6%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	90.6%	90.9%	92.6%	92.9%	92.7%	93.1%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	86.3%	88.2%	89.6%	90.4%	90.2%	90.5%
Agency Cost	Resources	Effective	AD		£65k	£101k	£139k	£92k	£108k	£131k
Overtime Costs	Resources	Effective	AD		£6k	£2k	£6k	£5k	£2k	£8k
Additional Hours Costs	Resources	Effective	AD		£1k	£0k	£3k	£2k	£1k	£1k
Sickness Cost (Monthly)	Resources	Effective	AD		£109k	£128k	£127k	£137k	£164k	£134k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		89.58	72.68	66.03	62.96	62.78	67.83
Business Miles	Resources	Effective	AD		68k	68k	56k	64k	65k	69k

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

Forensic Services

Month	Objective	CQC Domain	Owner	Threshold	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Sickness (YTD)	Resources	Well Led	AD	<=5.4%	5.9%	6.1%	6.3%	6.4%	6.6%	6.8%
Sickness (Monthly)	Resources	Well Led	AD	<=5.4%	6.2%	7.3%	7.6%	7.4%	8.4%	8.4%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	93.5%	96.2%	98.7%	98.7%	98.7%	98.7%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	70.4%	84.0%	97.8%	97.7%	97.7%	97.7%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	84.1%	84.3%	85.5%	85.7%	86.3%	84.9%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	77.4%	73.5%	76.5%	79.4%	80.4%	82.1%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	75.3%	79.9%	83.2%	82.9%	86.0%	86.9%
Equality and Diversity	Resources	Well Led	AD	>=80%	84.2%	86.2%	87.6%	87.1%	88.4%	88.8%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	86.7%	86.9%	89.0%	90.4%	91.8%	88.8%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	87.2%	85.1%	87.1%	86.0%	84.7%	87.3%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	85.7%	86.0%	87.3%	85.4%	86.5%	89.2%
Information Governance	Resources	Well Led	AD	>=95%	88.8%	89.3%	90.3%	87.2%	89.8%	95.6%
Moving and Handling	Resources	Well Led	AD	>=80%	85.0%	86.7%	88.0%	87.5%	88.9%	89.0%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	88.8%	89.5%	89.0%	89.0%	91.8%	89.7%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	84.5%	84.0%	85.6%	87.1%	87.4%	86.6%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	69.0%	70.4%	76.9%	77.8%	100.0%	94.7%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	89.3%	91.0%	92.1%	92.6%	92.0%	92.2%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	82.5%	84.5%	84.4%	86.5%	85.7%	85.5%
Agency Cost	Resources	Effective	AD		£68k	£60k	£47k	£30k	£26k	£36k
Overtime Costs	Resources	Effective	AD		£0k		£0k	£0k	£0k	£0k
Additional Hours Costs	Resources	Effective	AD		£5k	£2k	£1k	£1k	£3k	£1k
Sickness Cost (Monthly)	Resources	Effective	AD		£56k	£67k	£71k	£72k	£82k	£72k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		40.43	37.35	35.35	36.55	42.11	45.72
Business Miles	Resources	Effective	AD		9k	8k	7k	12k	8k	6k

Specialist Services

Month	Objective	CQC Domain	Owner	Threshold	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	5.8%	5.8%	5.6%	5.7%	5.7%	5.5%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	6.4%	5.9%	4.7%	5.7%	5.8%	4.2%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	87.8%	92.5%	99.5%	99.5%	99.4%	99.4%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	66.4%	79.3%	100.0%	100.0%	100.0%	100.0%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	74.2%	74.3%	76.3%	74.4%	71.9%	71.4%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	74.6%	76.3%	78.1%	76.1%	80.1%	83.8%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	78.8%	83.2%	85.7%	85.2%	85.6%	84.7%
Equality and Diversity	Resources	Well Led	AD	>=80%	85.6%	85.3%	87.1%	86.5%	84.4%	85.6%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	81.1%	82.5%	84.9%	80.4%	79.7%	84.0%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	66.7%	76.9%	70.8%	73.9%	75.0%	69.2%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	83.3%	81.5%	83.5%	82.3%	84.7%	87.7%
Information Governance	Resources	Well Led	AD	>=95%	91.3%	87.3%	85.3%	82.7%	85.7%	95.3%
Moving and Handling	Resources	Well Led	AD	>=80%	78.9%	78.2%	79.9%	79.9%	81.1%	84.7%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	86.2%	85.3%	87.8%	88.2%	87.0%	88.9%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	87.0%	86.7%	86.6%	86.5%	87.5%	87.3%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	92.8%	91.6%	91.9%	91.6%	91.0%	91.6%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	90.1%	91.7%	92.8%	93.6%	92.9%	92.0%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	83.7%	86.1%	87.3%	88.4%	87.1%	85.5%
Agency Cost	Resources	Effective	AD		£147k	£181k	£196k	£148k	£153k	£174k
Overtime Costs	Resources	Effective	AD		£0k	£0k	£0k		£5k	£0k
Additional Hours Costs	Resources	Effective	AD		£2k	£1k	£2k	£1k	£3k	£1k
Sickness Cost (Monthly)	Resources	Effective	AD		£71k	£64k	£50k	£63k	£63k	£37k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		44.58	51.71	39.29	52.42	54	50.8
Business Miles	Resources	Effective	AD		43k	34k	44k	46k	37k	35k

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

Support Services

Month	Objective	CQC Domain	Owner	Threshold	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Sickness (YTD)	Resources	Well Led	AD	<=4.0%	4.3%	4.3%	4.3%	4.4%	4.5%	4.6%
Sickness (Monthly)	Resources	Well Led	AD	<=4.0%	3.9%	4.3%	4.6%	4.9%	5.6%	5.2%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	95.2%	97.1%	98.0%	98.0%	98.0%	98.0%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	83.6%	89.8%	95.4%	95.8%	96.6%	96.6%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	68.8%	63.4%	69.4%	69.8%	72.6%	74.9%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	61.3%	65.5%	85.7%	82.1%	96.3%	96.3%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Equality and Diversity	Resources	Well Led	AD	>=80%	84.0%	83.9%	87.0%	87.0%	87.5%	88.1%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	89.3%	88.0%	89.5%	86.6%	87.0%	88.0%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	99.1%	94.9%	99.1%	100.0%	100.0%	98.1%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	83.9%	81.2%	83.8%	85.4%	85.6%	87.0%
Information Governance	Resources	Well Led	AD	>=95%	90.3%	88.6%	86.7%	81.4%	88.2%	93.3%
Moving and Handling	Resources	Well Led	AD	>=80%	81.3%	88.5%	87.8%	89.0%	90.4%	90.9%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	89.2%	88.0%	89.1%	88.4%	91.1%	91.8%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	92.9%	91.6%	94.7%	95.0%	96.1%	95.9%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	0.0%	0.0%	100.0%	100.0%	100.0%	100.0%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	98.2%	97.9%	97.9%	98.6%	98.8%	98.9%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	93.8%	75.0%	86.7%	86.2%	92.3%	88.9%
Agency Cost	Resources	Effective	AD		£0k	£12k	£5k	£4k	£1k	£5k
Overtime Costs	Resources	Effective	AD		£0k	£1k	£0k	£1k	£1k	£1k
Additional Hours Costs	Resources	Effective	AD		£12k	£11k	£13k	£13k	£8k	£9k
Sickness Cost (Monthly)	Resources	Effective	AD		£64k	£75k	£74k	£78k	£90k	£75k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		54.11	59.23	58.15	62.71	57.42	60.97
Business Miles	Resources	Effective	AD		28k	36k	36k	38k	26k	36k

Wakefield District

Month	Objective	CQC Domain	Owner	Threshold	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Sickness (YTD)	Resources	Well Led	AD	<=4.6%	5.1%	5.0%	5.0%	5.0%	5.0%	5.0%
Sickness (Monthly)	Resources	Well Led	AD	<=4.6%	4.2%	4.1%	4.9%	4.9%	5.6%	4.7%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	97.2%	97.2%	99.4%	99.4%	98.9%	98.3%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	84.2%	88.7%	94.4%	94.4%	94.4%	95.4%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	82.0%	81.9%	83.5%	83.5%	83.9%	82.5%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	66.0%	65.8%	72.0%	75.7%	77.4%	75.4%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	70.3%	72.9%	74.3%	75.6%	76.3%	77.6%
Equality and Diversity	Resources	Well Led	AD	>=80%	87.4%	86.6%	86.5%	85.9%	88.0%	87.9%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	85.1%	86.8%	86.7%	87.6%	83.4%	84.3%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	69.2%	69.9%	72.7%	71.8%	70.9%	68.6%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	81.1%	80.3%	81.2%	83.4%	84.4%	85.3%
Information Governance	Resources	Well Led	AD	>=95%	89.5%	87.3%	89.6%	87.4%	86.7%	93.8%
Moving and Handling	Resources	Well Led	AD	>=80%	68.7%	70.3%	71.5%	73.1%	74.5%	78.1%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	87.3%	87.0%	87.8%	90.5%	91.8%	90.2%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	79.4%	77.1%	79.5%	80.6%	80.8%	83.2%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	93.8%	92.6%	92.9%	93.7%	92.9%	93.7%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	84.3%	86.0%	88.2%	90.5%	90.3%	91.5%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	79.0%	81.1%	83.9%	86.5%	86.5%	86.4%
Agency Cost	Resources	Effective	AD		£84k	£60k	£76k	£90k	£73k	£114k
Overtime Costs	Resources	Effective	AD		£4k	£2k			£0k	£1k
Additional Hours Costs	Resources	Effective	AD		£4k	£4k	£3k	£3k	£4k	£1k
Sickness Cost (Monthly)	Resources	Effective	AD		£38k	£43k	£54k	£57k	£64k	£50k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		43.73	50.39	48.33	45	55.2	62.34
Business Miles	Resources	Effective	AD		37k	41k	31k	37k	33k	38k

Glossary

ADHD	Attention deficit hyperactivity disorder
AQP	Any Qualified Provider
ASD	Autism spectrum disorder
AWA	Adults of Working Age
AWOL	Absent Without Leave
B/C/K/W	Barnsley, Calderdale, Kirklees, Wakefield
BDU	Business Delivery Unit
C&K	Calderdale & Kirklees
C. Diff	Clostridium difficile
CAMHS	Child and Adolescent Mental Health Services
CAPA	Choice and Partnership Approach
CCG	Clinical Commissioning Group
CGCSC	Clinical Governance Clinical Safety Committee
CIP	Cost Improvement Programme
CPA	Care Programme Approach
CPPP	Care Packages and Pathways Project
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CROM	Clinician Rated Outcome Measure
CRS	Crisis Resolution Service
CTLD	Community Team Learning Disability
DoC	Duty of Candour
DoV	Deed of Variation
DoC	Duty of Candour
DQ	Data Quality
DTOC	Delayed Transfers of Care
EIA	Equality Impact Assessment
EIP/EIS	Early Intervention in Psychosis Service
EMT	Executive Management Team
FOI	Freedom of Information
FOT	Forecast Outturn
FT	Foundation Trust
FYFV	Five Year Forward View

HEE	Health Education England
HONOS	Health of the Nation Outcome Scales
HR	Human Resources
HSJ	Health Service Journal
HSCIC	Health and Social Care Information Centre
HV	Health Visiting
IAPT	Improving Access to Psychological Therapies
ICD10	International Statistical Classification of Diseases and Related Health Problems
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 27 March 2018
Agenda item 6.2

Title:	**Serious incident report Quarter 3 2017/18 (including Learning from healthcare deaths Quarter 2 2017/8)**
Paper prepared by:	Director of Nursing and Quality
Purpose:	This report provides information in relation to incidents in Quarter 3 and more detailed information in relation to serious incidents. Also to provide assurance that learning from healthcare deaths arrangements are in place and to provide cumulative data for Quarters 1& 2 that require publication on the Trust website.
Mission/values:	➢ We are respectful, honest, open and transparent ➢ We put the person first and in the centre ➢ We are always improving
Any background papers/ previously considered by:	Previous quarterly reports which have been submitted to Board and Clinical Governance and Clinical Safety Committee. The annual incident report is considered by Board in June. The Board has also received papers about the introduction of the national requirement for learning from healthcare deaths and approved the corresponding policy.
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 Business Delivery Unit. Data are also available at service line level. ➢ The actions from incidents are managed at Business Delivery Unit 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. ➢ This report has overall figures for incident reporting. Q3 had 2,948 incidents similar to the levels in the previous two quarters. ➢ Almost 87% of incidents are graded as “low” or “no harm” showing a positive culture of risk management (the more green incidents reported mean action taken proactively at an early stage before harm occurs). ➢ “Physical violence (contact made) against staff by patient” was the most reported category, as per the three of the five quarters shown in the report. ➢ “Physical aggression” continues to be the highest reported incident type. Staff report this can be linked to individual services users but also say some incidents are linked to the trusts current smoking policy. This is being examined in more detail and figures/information from Datix have been given to the group that has been set up to consider the issues and actions. ➢ There have been no ‘Never Events’ reported in the Trust during Q3, the last Never Event reported was in 2010/11. ➢ The total number of serious incidents reported through Strategic Executive Information System (STEIS) in Q3 (27), is higher than the previous two quarters which had 18 and 15 serious incidents. This year the number of

	serious incidents is higher than the previous year at this stage by 19 and likely to be about the same as 15/16 but much less than 14/15.Incidents have included fires, information governance, and medication error and the breadth of incidents has been wider than previously. The highest category of serious incident is "Suicide (including apparent suicide) - community team care – current episode" (13). This is slightly higher than previous quarters. ➢ The category of apparent suicide at point of reporting is higher in the rolling last 4 quarters -, 8, 4, 12, and 16. Due to this quarter this is now at 40 in total and over level of estimated cases based on National Confidential Inquiry numbers and our population - 32/33. ➢ We are implementing our Trustwide suicide prevention strategy, which includes conducting a deep dive analysis on hotspot areas and targeting clinical teams and service user groups where there is concern (e.g. CAMHS). ➢ We have taken the lead on the West Yorkshire and Harrogate Health Care Partnership 5-year suicide prevention strategy, which has adopted an evidence-based approach to suicide prevention and zero suicide philosophy for targeted areas and hotspots. ➢ 11 investigations have been submitted to the Commissioner during the quarter and 12 previous serious incidents have been closed by Commissioners. ➢ A number of reports are outside the 60 day target, all of these have agreed extensions with Commissioners. The complexity of investigations have contributed to delays. Steps are being taken to reduce the backlog although demand has remained very high in terms of frequency of serious incidents and complexity. ➢ Within the report are some examples of learning from specialist advisors and workstreams for the highest reported incidents. ➢ New and innovative ways of learning from incidents are being explored. **Learning from healthcare deaths** ➢ Scrutiny of healthcare deaths has been high on the government's agenda for some time, reports such as Francis report and the Mazar's report into Southern Healthcare has intensified this. ➢ Trusts must report and publish data from quarter 3 2017/18 onwards. ➢ The report provides figures on deaths and the number that have been reviewed. ➢ From April 2017 to September 2017 the Trust started reviewing all deaths reported on Datix using an incremental approach. ➢ The new policy on learning from deaths will result in more deaths being in scope for review from 1 October 2017. ➢ The Trust has adopted the three levels of scrutiny suggested in the National Quality Board guidance: o Death Certification o Case record review, through Structured Judgment Record Review o Investigation – that could be service level, serious incident reported on STEIS or other review e.g. Learning Disability Mortality Review (LeDeR), safeguarding. ➢ The total number of deaths reported on SWYPFT clinical systems where

	there has been system activity within 180 days of death, where the service user had had any form of contact with NHS services = 646 ➢ Total number of deaths reported on Datix by staff between 1/4/17 – 30/09/2017 (by reported date, not date of death) NB: Date range of Datix reported deaths is July - - September 2017 =168 ➢ Total reviewed =168 ➢ Total in scope as described in report =23 ➢ Learning from quarter one and two Structured Judgement Record Reviews /Investigations is included in the report. **This report was scrutinised by the Clinical Governance and Clinical Safety Committee meeting held on the 6 February 2018** ➢ The Committee was positive in terms of the insight the report provides into patient safety and also received the apparent suicides report which informed the discussion and scrutiny. ➢ It was identified that it is difficult to draw any firm conclusions or trends when comparing data from one quarter to the next due to relatively small numbers. More concrete lessons are derived from the Serious Incident reports following Route Cause Analysis investigations. ➢ The position regarding Kirklees apparent suicide levels was of concern and further assurance was requested through a themed review. ➢ The Committee noted the future work in respect of learning from deaths and recognised the increased demand upon the Patient Safety Team, and asked for this to be monitored closely. ➢ The Committee noted that the change in reporting scope in relation to learning from deaths policy during Q1 18/19 may well have a significant impact upon the future figures. ➢ The Committee was assured that robust systems and processes for the reporting and investigation of incidents remain in place. ➢ The Committee also noted the importance of the weekly risk panel where all amber and red incidents are reviewed. ➢ The learning section of the report has been enhanced and more frequent, easily accessible ways to share learning from incidents will be introduced from April 2018. **Risk appetite** ➢ Risk identified –the trust continues to have a good governance system of reporting and investigating incidents including serious incidents and of reporting, analysing and investigating healthcare deaths. ➢ 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. ➢ 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. ➢ Financial or commercial risks -Reputational risks, negative impact on perceptions of service users, staff, commissioners. Risk appetite Cautious/Moderate 4-6

	The incident management process supports the drive to reduce harm and learn from incidents to reduce risk and prevent recurrence in the future. For learning from healthcare deaths Trust has developed Datix and worked with performance and information to ensure information is available. A policy has been developed which meets current national requirements. Training to review records has been provided. The outcome which is now the important aspect continues to be developed.
Recommendation:	**Trust Board is asked to NOTE the quarterly report on incident management, including Learning from healthcare deaths Q2 data, and the ASSURANCE and FURTHER ACTION REQUIRED by the Clinical Governance and Clinical Safety Committee.**
Private session:	Not applicable.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

TRUSTWIDE INCIDENT MANAGEMENT SUMMARY REPORT FOR QUARTERLY REPORT FOR THE PERIOD 1 OCTOBER 2017 – 31 DECEMBER 2017

INCORPORATING

THE LEARNING FROM HEALTHCARE DEATHS 2017/18 REPORT FOR THE PERIOD 1ST APRIL 2017 – 30TH SEPTEMBER 2017

This summary report has been prepared by the Patient Safety Support Team to bring together Trustwide information on incident activity during Quarter 3 17/18 (1 October 2017 to 31 December 2017) including reported serious incidents.

Please note that figures within this report may vary 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

- 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 have been added to Datixweb to prompt for this information.

- The Learning from Healthcare deaths policy in place from 1 October 2017. The policy can be found on the intranet here.

- 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.

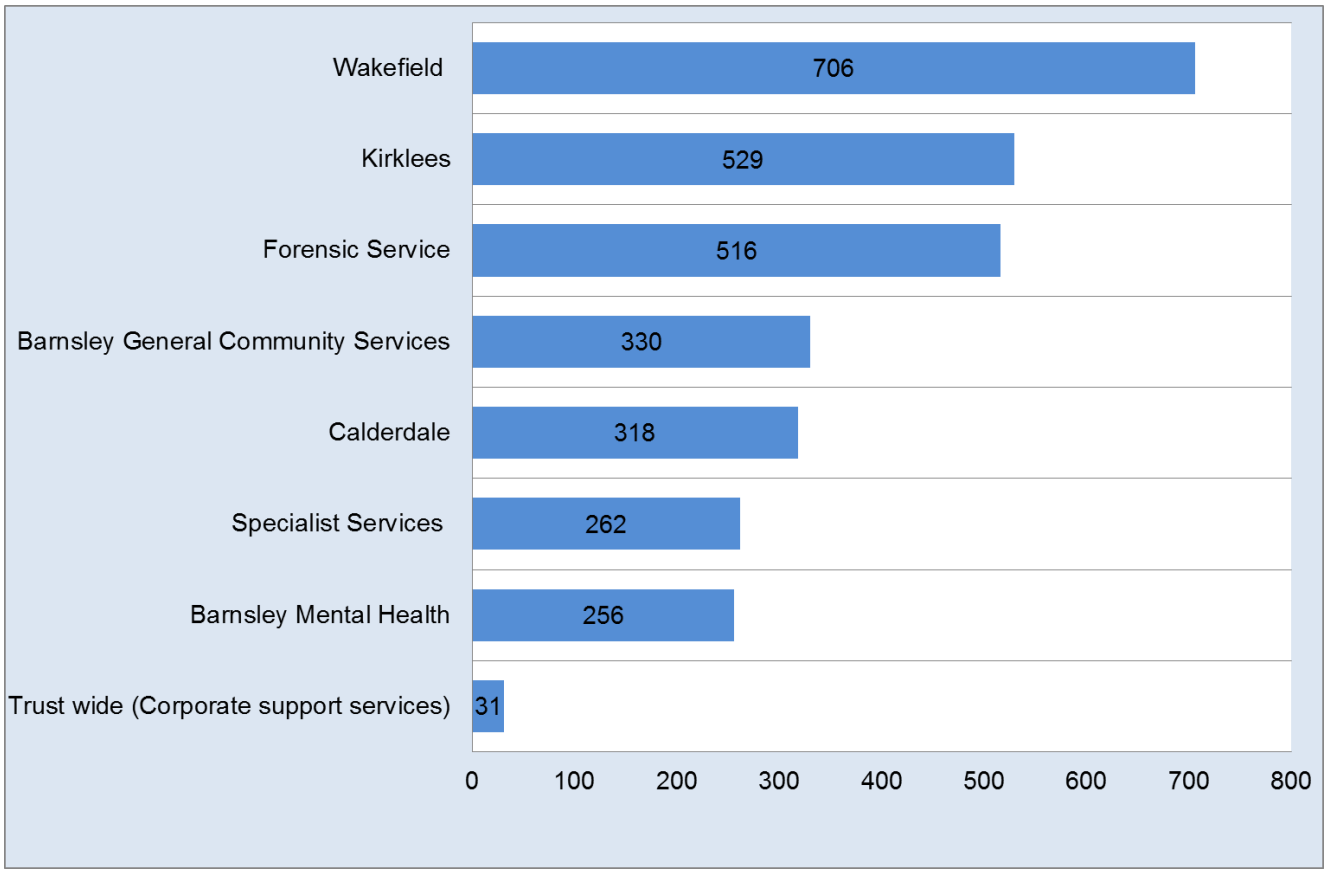
Managers should contact the patient safety support team on 01924 316180 or Datix@swyt.nhs.uk for advice as needed.

1.5 FREEDOM OF INFORMATION REQUESTS RECEIVED WITHIN QUARTER 3

Request Reference	Information Requested
FOI1765	The number of Serious Incidents reported by the Trust between 1 January 2016 and 31 December 2016. If possible, a description of each of these incidents, including what harm was caused to a patient as a result of the incident.

FOI1801	Please provide in the table below information about aggression and violence incidents for the financial years April 2014 – March 2015, April 2015 – March 2016, April 2016 – March 2017. Please note all non-physical assaults would include all incidents of aggression and violence that did not result in physical contact i.e. verbal, racial abuse etc. PSST responded to the following: Total number of incidents reported in each year in your risk management system, April 2014 – March 2017.
FOI1838	1) How many incidents of harm caused by Restrictive Interventions were recorded in mental health units in your Trust in the year 2016/17? 2) How many staff in mental health units in your Trust were assaulted by patients whilst attempting/following the use of Restrictive Interventions in the year 2016/17? 3) How many staff in mental health units in your Trust were injured whilst attempting/ following the use of Restrictive Interventions in the year 2016/17?

2. INCIDENTS REPORTED TRUSTWIDE WITHIN THE QUARTER BY BDU



2.1 TRUSTWIDE COMPARATIVE DATA 1 OCTOBER 2016 TO 31 DECEMBER 2017 (ROLLING YEAR)

	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
Total Incidents Reported	3242	2910	2790	3048	2948
Total Number of Green (No Harm) Incidents Reported	1891	1772	1700	1881	1759
Total Number of Green (Low Harm) Incidents Reported	975	813	776	844	814
Total Number of Yellow (Moderate) Incidents Reported	282	237	232	232	276
Total Number of Amber Incidents Reported	70	71	55	59	63
Total Number of Red Incidents Reported	24	17	27	32	36
Most Reported Category of Incident	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	Physical violence (contact made) against staff by patient
Team who reported most significant number of incidents	Elmdale Inpatient Services Ward	Elmdale Inpatient Services Ward	Elmdale Inpatient Services Ward	Ward 18, Priestley Unit	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)	703	728	554	716	541
Most Frequent Lessons Learned Theme is	Physical healthcare	Physical healthcare	Physical healthcare	Physical healthcare	Physical healthcare

In section 2.1 there have been 36 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)	172	200	157	300	366	396	153	15	1759
Green	55	94	119	159	212	89	74	12	814
Yellow	22	9	34	39	114	27	28	3	276
Amber	5	26	2	13	8	4	4	1	63
Red	2	1	6	18	6	0	3	0	36
Total	256	330	318	529	706	516	262	31	2948

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

	Barnsley Mental Health	Barnsley General Community Services	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Trust wide (Corporate support services)	Total
Security Breaches	9	1	4	9	17	34	11	4	89
Health and Safety (including fire)	25	13	18	33	48	29	29	12	207
Infection Prevention/Control	0	4	1	2	0	1	2	1	11
Slips, Trips and Falls	16	31	19	28	67	9	5	2	177
Missing/absent service users	11	1	18	33	12	2	0	0	77
Care Pathway, Clinical and Pressure Ulcer Incidents	8	194	12	28	31	6	15	0	294
Information Governance Incidents	3	19	8	11	4	5	12	6	68
IT Related Issues	8	3	3	6	12	6	12	1	51
Safeguarding Children	6	0	9	7	6	5	15	0	48
Safeguarding Adults	9	5	4	13	17	6	19	0	73
Medication	21	39	22	38	38	45	14	0	217
Legislation and Policy	9	0	10	68	57	95	2	0	241
Self Harm	67	0	41	67	102	11	8	0	296
Death (including suspected suicide)	7	3	11	28	22	0	10	0	81
Violence and Aggression	47	9	125	137	242	230	99	2	891
All Other Incidents	10	8	13	21	31	32	9	3	127
Total	256	330	318	529	706	516	262	31	2948

3. LEARNING

Specialist Advisors are 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

Fire Training is still exceeding the minimum target of 80% Trustwide (this includes staff who have completed the e-learning fire safety refresher). The target for "ward based" staff is 95%.

Also the eligibility for e-learning in the Training and Fire Policies is that;

E-learning is not applicable for staff directly involved in the evacuation of patients.

E-learners must have done the face to face session in the previous 12 month period.

Musculoskeletal Health

A Bluelight Alert was published by the Musculoskeletal Health Specialist Advisor in relation to wheelchair safety.

It has been brought to the attention of the Musculoskeletal Health (Moving and Handling) team that wheelchairs are being used to transport individuals without footplates. Footplates have been removed from wheelchairs for transfer of patients and are lost.

There is a potential risk to wheelchair users safety associated with the use of wheelchairs without footplates. This presents a risk of entrapment of users' feet, a risk of the user falling from the wheelchair when travelling and also a postural risk to the user from sliding in the wheelchair adopting a slouched, seated position.

To all staff using wheelchairs to transport individuals;
• footplates should always be used when transporting individuals to avoid potential for injury
• if footplates or any part of a wheelchair is broken or missing it should be immediately taken out of service and logged with Facilities for repair http://nww.swyt.nhs.uk/medical-devices/Pages/Reporting-faults-and-repairs.aspx

Safeguarding

There have been several updates to the safeguarding team to further improve cohesion, knowledge and support to the workforce. From January 2018 changes have been made to the safeguarding duty advice team to enable the cross fertilisation of the teams skills (mental health, adult nursing, social work, health visiting and midwifery) and further embed the 'think family' model to improve the quality of care our service users receive.

Bluelight Alerts

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 to 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

The Bluelight alerts that have already been circulated are available on the intranet and below:

Bluelight alert 6 9 March 2018- Wax paper medication pots

Greenlight alerts

Greenlight alerts have been created to provide a way to share important information and learning related to medication safety.

These are available on the intranet

Our annual learning report is available on the intranet and we are currently looking at new and innovative ways to improve sharing of information and learning from incidents and serious incidents (e.g. monthly clinical risk report

4. UPDATE ON 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 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 as described below:

- **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 (see table below) and 2017 data is currently being finalised.

Area	Target	Baseline period	% reduction from baseline	End period
Medicine omissions	To reduce unintended missed doses by 25% by 2018	2015/16 Q3	on track	31/05/2018
Pressure ulcers	To reduce the frequency of new pressure ulcers that are attributable to SWYPFT care and avoidable by 50% by 2018	2015	on track	31/12/2018
Falls	To reduce the frequency of falls by inpatients by 15% by 2018	2014	on track	31/12/2017
Falls	To reduce the frequency of inpatient falls resulting in moderate/severe harm or death by 10% by 2018	2014	on track	31/12/2017
Prone Restraint	To reduce the frequency (use of) of prone restraint by 30% by 2018	2015 part year average	on track	31/12/2018

- **Safewards-** This work is within the patient safety strategy. Most mental health and LD units are using the tools available and good practice is shared across the Trust and through MAV training.

- **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 of violence and aggression.

- **Significant event analysis (SEA) -** Work continues 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. Nine reviews have now been conducted using the tool. A review meeting will be held to reflect on how the tool has worked in practice. Feedback so far has been positive.

- **Staff wellbeing –** #allofus campaign launched.

- **MAV Trust Action Group** – The group meets 6 weekly to review Violence and Aggression 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. Development of the use of Statistical Process Control (SPC) charts.

- **Training –** MAV team are working with the team who provide Basic Life Support to develop a pilot project aimed at utilising the Recognising and Assessing Medical Problems in Psychiatric Services (RAMPPS) model to provide staff with scenario and simulation based training looking at managing physical complications during restrictive physical interventions such as restraint. It is anticipated this will better equip staff to deal with emergency situations.

5 TRUST WIDE SERIOUS INCIDENT (SI) REPORT FOR QUARTER 3 2017/18 (DATA AS AT 3 JAN 2018)

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	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 National Patient Safety Agency (NPSA) definition of severe harm)
- a scenario that prevents, or threatens to prevent, a provider organisation's ability to continue to deliver health care services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment. IT failure or incidents in population programmes like screening and immunisation where harm potentially may extend to a larger population
- allegations of abuse
- adverse media coverage or public concern for the organisation or the wider NHS
- one of the core set of *Never Events.*

During Quarter 3 2017/18 there have been 27 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 (27) 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	15
Quarter 2	27	24	23	13	18
Quarter 3	31	30	15	15	27
Quarter 4	29	21	20	24	
Totals	**101**	**106**	**76**	**65**	

The trend suggests that we will have more SIs than 16/17, about the same as 15/16 but much less than 14/15.

Table 3 Serious Incidents reported by team types and BDU during Q3 2017/18

	Barnsley Mental Health	Barnsley General Community Services	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Total
Acute Inpatients (Adult)	0	0	0	2	0	0	0	**2**
Child and Adolescent Mental Health Services, Wakefield	0	0	0	0	0	0	2	**2**
CMHT's (OPS)	0	0	0	2	0	0	0	**2**
Core pathway	1	0	1	3	0	0	0	**5**
Crisis/IHBTT (Adult)	0	0	0	2	0	0	0	**2**
District Nursing	0	4	0	0	0	0	0	**4**
Enhanced Pathway	0	0	0	2	2	0	0	**4**
Forensic CAMHS Services	0	0	0	0	0	1	0	**1**
Inpatient Service (OPS)	0	0	0	1	0	0	0	**1**
Liaison Services	0	0	0	0	1	0	0	**1**
Single Point of Access (SPA)	0	0	0	3	0	0	0	**3**
Total	**1**	**4**	**1**	**15**	**3**	**1**	**2**	**27**

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 Q3 2017/18

	Barnsley Mental Health	Barnsley General Community Services	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Total
Administration/supply of medication from a clinical area	0	1	0	0	0	0	0	**1**
Death - confirmed related to substance misuse (drug and/or alcohol)	0	0	0	1	0	0	0	**1**
Formal patient absent without leave	0	0	0	1	0	0	0	**1**
Informal patient absent without leave	0	0	0	1	0	0	0	**1**
Information disclosed in error	0	0	0	1	0	1	0	**2**
Self harm (actual harm) with suicidal intent	0	0	0	1	0	0	0	**1**
Suicide (incl apparent) - community team care - current episode	1	0	1	7	2	0	2	**13**
Suicide (incl apparent) - community team care - discharged	0	0	0	1	1	0	0	**2**
Suicide (incl apparent) - inpatient care - current episode	0	0	0	1	0	0	0	**1**
Physical violence (contact made) against other by patient	0	0	0	1	0	0	0	**1**
Pressure Ulcer - grade 3	0	3	0	0	0	0	0	**3**
Total	**1**	**4**	**1**	**15**	**3**	**1**	**2**	**27**

The highest category of serious incidents during Quarter 3 (Table 4) related to apparent suicide of current service users in contact with community teams. Table 5 shows the method used. Ongoing 'Deep Dive' review into SIs in Kirklees to see if any themes or systemic issues evident.

Table 4 Apparent Suicides reported on STEIS between 01/10/17 – 31/12/17 by Sub-category

	Barnsley Mental Health	Calderdale	Kirklees	Wakefield	Specialist Services	Total
Hanging - self injury	1	0	6	2	2	**11**
Other - self poisoning	0	1	2	0	0	**3**
Prescription medication - self poisoning	0	0	1	1	0	**2**
Total	**1**	**1**	**9**	**3**	**2**	**16**

The most common method of suicide in England is hanging (43%), self-poisoning (25%) and jumping/multiple injuries (15%). The Trust data for quarter 3 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) expected suicides in our area.
- 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 5 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 6 Apparent Suicides reported on STEIS between 01/01/17 – 31/12/17 by Quarter and geographical area

	Barnsley Mental Health	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Total
Quarter 4 16/17	1	0	3	1	1	2	**8**
Quarter 1 17/18	0	1	3	0	0	0	**4**
Quarter 2 17/18	4	1	3	0	0	0	**12**
Quarter 3 17/18	1	1	9	0	0	2	**16**

Total	6	3	18	1	1	4	**40**

The rolling 4 quarter data (Table 7) (by reported date) shows that the Trust is 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 (40) includes apparent suicides occurring in specialist services (CAMHS and Forensics). Calderdale is below the expected number for their respective geographical areas, Kirklees is above and Wakefield is well below the expected number.

Barnsley is as expected. 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.

We are implementing our Trustwide suicide prevention strategy, which includes conducting a deep dive analysis on hotspot areas and targeting clinical teams and specific service user groups (e.g. CAMHS).

We have taken the lead on the West Yorkshire and Harrogate Health Care Partnership 5-year suicide prevention strategy, which has adopted an evidence-based approach to suicide prevention and zero suicide philosophy for targeted areas and hotspots. A number of key objectives have been identified including using an evidence based approach and a zero suicide philosophy to reduce the number of suicides, working on real-time data with our partner agencies, enhancing services for those bereaved by suicide and providing training for mental health and non-mental health partners across West Yorkshire and Harrogate.

4. Performance Management of Serious incidents

- **11** SI Investigation Reports have been completed this quarter and sent to the Commissioners
- **12** SI reports have been closed by the Commissioners during the quarter
- There are currently **45** open SI investigations taking place across the Trust (as at 3/1/18) see Table 8 and further breakdown in Table 9.

Table 7 Current position on open SI investigations as at 3/1/18

	Barnsley Mental Health	Barnsley General Community Services	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Total
IG investigation - panel being established	0	0	0	1	0	1	0	2
Lead Investigator being allocated	1	0	1	6	2	0	1	11
Investigation panel being established	0	0	0	3	0	0	0	3
Investigation within 60 working days and on track	0	3	0	1	1	0	1	6
Investigation within 60 working days but off track	0	0	0	*1	0	0	0	1
Investigation report over 60 working days but extension agreed	4	0	2	6	2	1	0	***15**
Investigation report over 60 working days, no extension agreed	0	0	0	2	0	0	0	***2**
Investigation sign off process - on track	1	0	0	0	0	0	1	2
Investigation not being led by Patient Safety Support Team	0	1	0	1	0	0	0	2
Investigation being led by external investigator	0	0	0	1	0	0	0	1
Total	**6**	**4**	**3**	**22**	**5**	**2**	**3**	**45**

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.

Table 8 Breakdown of SI investigations that are over the original timescales

Commissioner extension (one extension is usually agreed for a further 20 working days)		Barnsley MH	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services - CAMHS	Total
Red	Investigation has required 2 or more extensions from commissioners beyond 60 working days.	3	1	5	1	0	1	**11**
Amber	Investigation has required 1 extension from commissioners beyond 60 working days.	2	1	2	1	1	0	**7**
total		**5**	**2**	**7**	**2**	**1**	**1**	**18**

In summary, 27 are within timescales at differing stages and 18 are overdue.

Table 9b Breakdown of SI investigations over 60 working day timescale in each quarter 2017/18 compared with the total number of investigations underway at that time

	Quarter 1 2017/18	Quarter 2 2017/18	Quarter 3 2017/18
Serious Incident investigations over 60 working days timeframe	8	12	18
Total number of ongoing SI investigations	27	29	45

As shown in Table 9, there are 18 reports that are more than 60 working days since the incident was reported on the Strategic Executive Information system (StEIS). Serious Incident Investigations are monitored through the weekly patient safety support team investigators meeting, and through the weekly clinical risk panel. 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.

5. 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

6. 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.

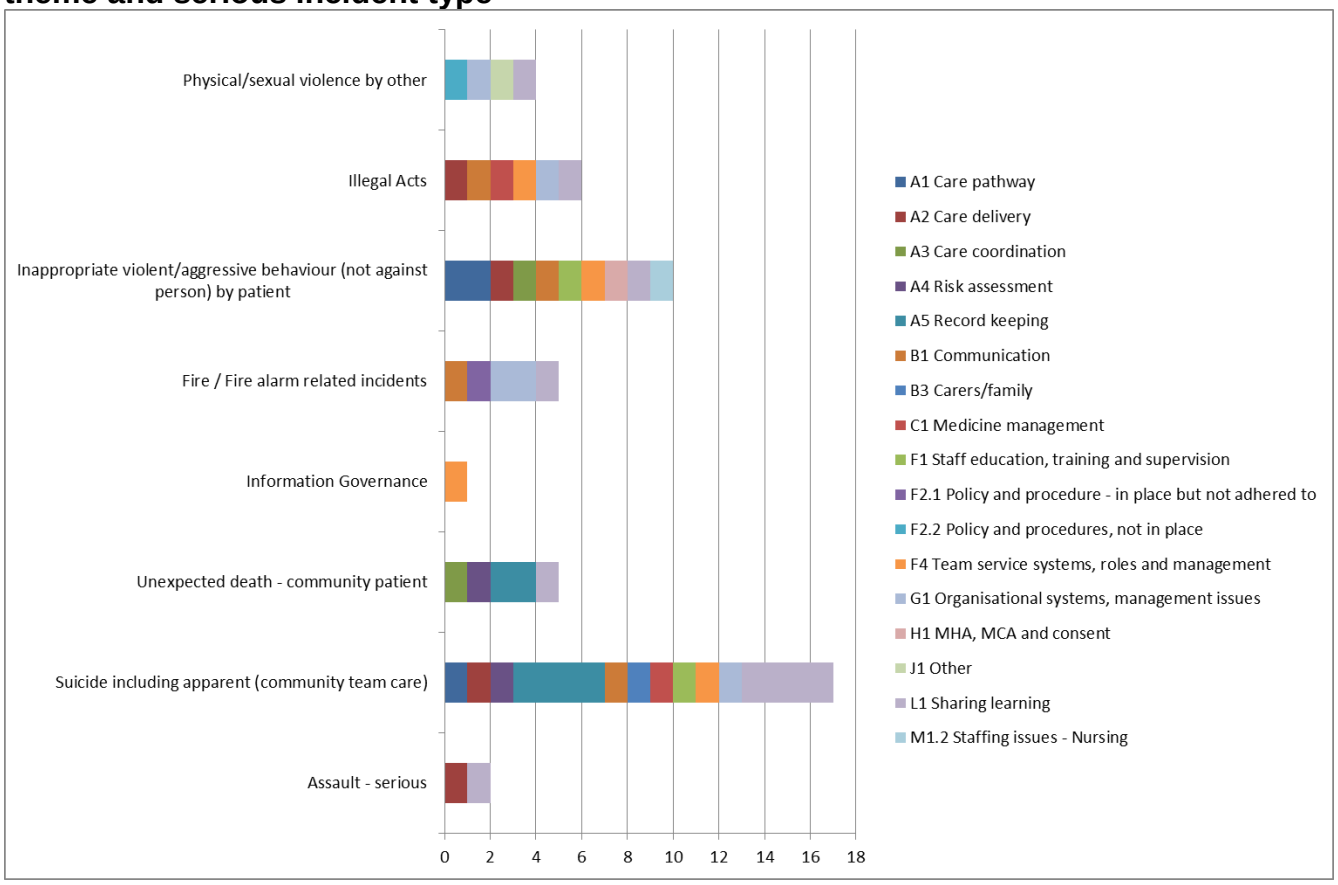
7. Serious Incident themes

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

During Quarter 3, the number of investigations completed and sent to the commissioners was 11, which is a decrease on the previous quarter (14). This has been affected primarily by the number of serious incident investigations being carried by the lead investigators, which impacts on completion of individual cases. 11 of these SI investigations had an action plan. There were 50 separate recommendations made to improve the system or process to prevent recurrence**.**

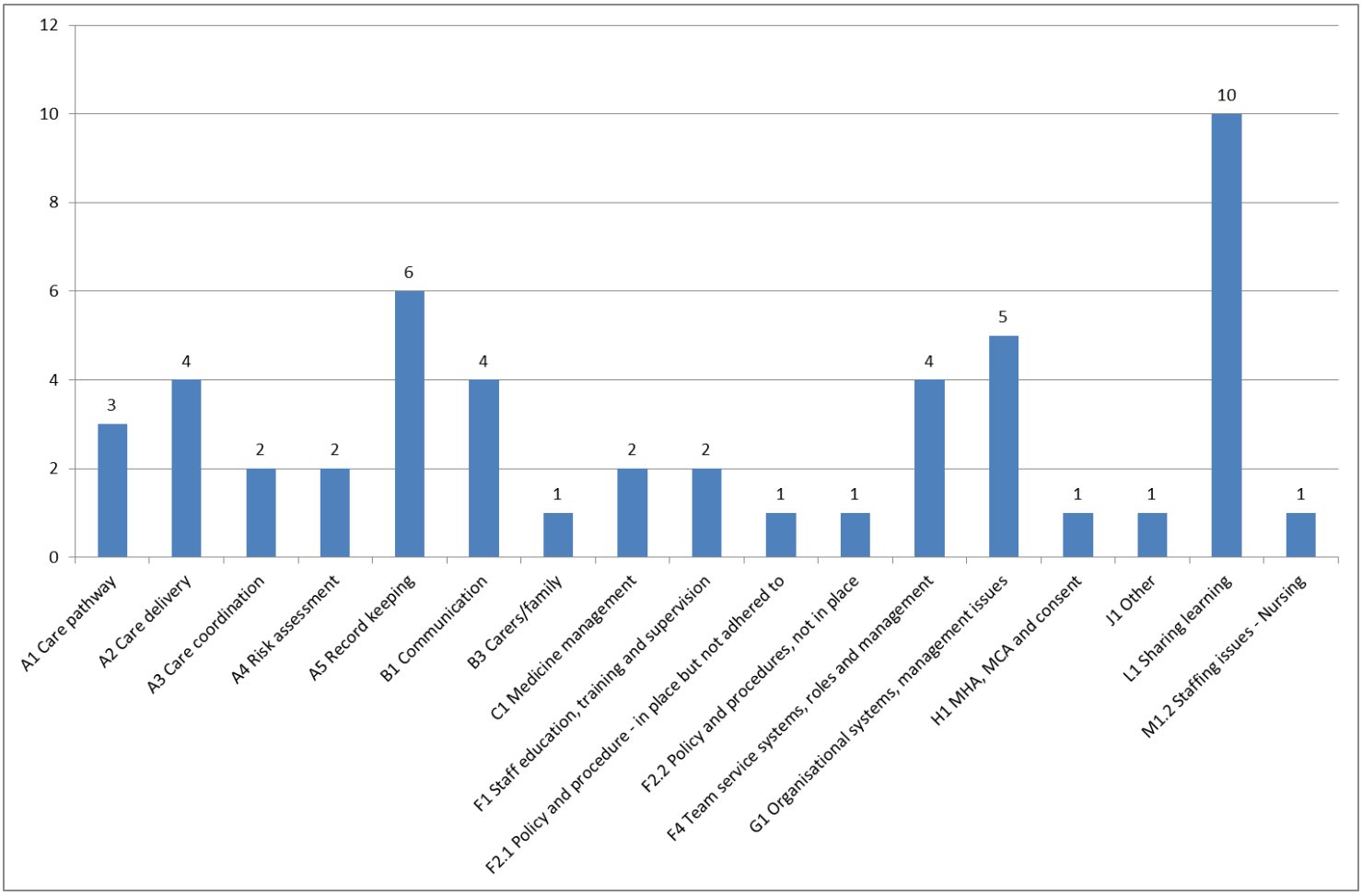
Details of the 11 serious incidents completed and sent to commissioners during Quarter 3 are available in Appendix 2. This includes a summary of the incident, the team and BDU, type of incident, learning identified through the serious incident investigation process, and recommendations for improvement.

Graph 1 Quarter 3 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. The top themes this quarter are – 'record keeping', 'organisation systems and management issues' being the top 2 themes and 'team service systems, roles and management', 'care delivery' and 'communication' all coming at joint 3rd themes.

Graph 2 Quarter 3 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. In the period 1/4/17 and 31/12/17, there were 46 serious incident investigations completed and sent to commissioners, generating 184 recommendations. 86.4% of these have been completed (149) or are not yet due (10). A further 25 (13.6%) recommendations are overdue for completion. These are shared via Operational Management Group on a monthly basis and this is a much improved position.

Sharing learning is an action the patient safety support team have added to action plans; ten 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.

Learning 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 an 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 19/01/18

6 Learning from healthcare deaths: The right thing to do

Annual Cumulative Report 2017/18

Report period: 1/4/2017 – 30/9/17

Introduction

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

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

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

This report is the Trust's second report on healthcare deaths. This will be an incremental development over time and ongoing feedback and suggestions about this development would be useful.

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

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

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

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

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

Scope

The Trust has systems that identify and capture the known deaths of its service users on its electronic patient administration system (PAS) and on its Datix system where the death requires reporting.

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

Of note, the total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of date of death has been recalculated because of a technical error with the data warehouse. This has now been resolved.

Whilst this work was being developed, and to introduce the process in a manageable way, from April 2017 to September 2017 the Trust started reviewing all deaths reported on Datix, using an incremental approach and to date has subjected the following to further review:

- All inpatient deaths or where they had been discharged in last 30 days
- Learning Disability Mortality Review (LeDeR) deaths in scope. All deaths were reviewed but then excluded deaths that took place in acute trusts as they would be undertaking the review and linking with SWYPFT if required. We still ensured all deaths had been reported to the LeDeR programme.
- Existing Serious Incident Framework – deaths requiring reporting through this system on STEIS
- Deaths subjected to service level investigation
- Any death where there were family, clinical or governance concerns that did not meet any of the above
- A case where we were not the main provider at the time of death but worked with the acute Trust
- Other processes such as serious case review

From 1 October 2017, Trust staff must report deaths where there are concerns from family, clinical staff or through governance processes and where the Trust is the main provider of care, reporting these deaths on Datix within 24 hours of being informed and providing the cause of death where known.

Each reported death will then be reviewed in line with the three levels of scrutiny the Trust has adopted. These are as suggested in the National Quality Board guidance:

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

This scope is further developed in the policy: Learning from healthcare deaths – the right thing to do. This is being followed for deaths reported from 1 October 2017 onwards.

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

The dashboard on the following pages presents the Trust's reporting for 2017/18 to the end of Quarter 2.

Of note, the total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of date of death has been recalculated because of a technical error with the data warehouse. This has now been resolved and the number has changed from 967 to 730 for Quarter 1 2017/18.

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

Table 1: Total Summary Information 2017/18

	Quarter 1 2017/18	Quarter 2 2017/18	Quarter 3 2017/18	Quarter 4 2017/18
Total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of date of death	730	646		
Total number of deaths reported on Datix by staff (by reported date, not date of death)	158	168		
Total number of deaths reviewed	158	168		
Total Number of deaths reported on Datix that were in scope (see scope criteria above)	26	23		
Total Number of deaths not in the Trust scope (where the Trust was not the lead provider of care; and there were no concerns raised about care provided)	132	145		

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

Total Number of Deaths reviewed	Mental Health Community	Mental Health Inpatient	General Community	General Community Inpatient	Specialist Services Learning Disability	Specialist Services CAMHS	Specialist Services ADHD	Forensic
Q1	Q1	Q1	Q1	Q1	Q1	Q1	Q1	Q1
158	**143**	**3**	**0**	**7**	**4**	**0**	**1**	**0**
Q2	Q2	Q2	Q2	Q2	Q2	Q2	Q2	Q2
168	**157**	**3**	**0**	**0**	**8**	**0**	**0**	**0**
Q3	Q3	Q3	Q3	Q3	Q3	Q3	Q3	Q3
0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Q4	Q4	Q4	Q4	Q4	Q4	Q4	Q4	Q4
0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
YTD	YTD	YTD	YTD	YTD	YTD	YTD	YTD	YTD
326	**300**	**6**	**0**	**7**	**12**	**0**	**1**	**0**

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

Total Number of Deaths in scope	Total Number of In-Patient Deaths	Total Number of Deaths Reviewed in Line with SI Framework***	Total Number of Deaths (other investigation)***	Total number of deaths subject to Structured Judgement Record Review**	Total number of deaths that were certified*
Q1	Q1	Q1	Q1	Q1	Q1
26	**10**	**10**	**1**	**4**	**11**
Q2	Q2	Q2	Q2	Q2	Q2
22	**3**	**12**	**3**	**6**	**1**
Q3	Q3	Q3	Q3	Q3	Q3
0	**0**	**0**	**0**	**0**	**0**
Q4	Q4	Q4	Q4	Q4	Q4
0	**0**	**0**	**0**	**0**	**0**
YTD	YTD	YTD	YTD	YTD	YTD
48	**13**	**22**	**4**	**10**	**12**

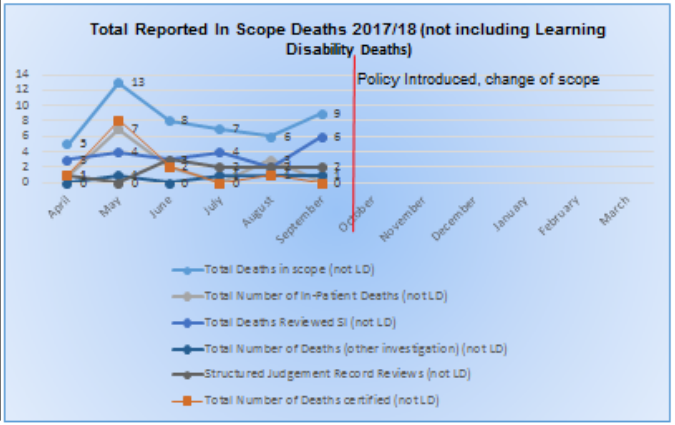
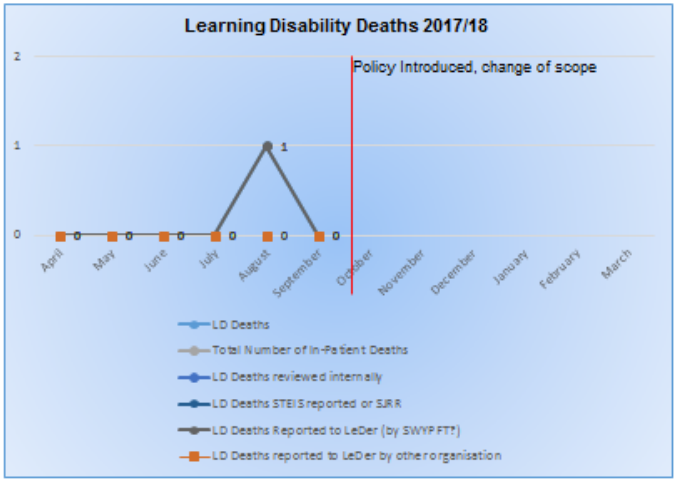


Table 4: Summary of total number of Learning Disability deaths which were in scope

Total Number of Learning Disability Deaths in scope	Total Number of In-Patient Deaths	Total Number of Deaths Reviewed internally	Total Number of Deaths Reviewed in Line with SI Framework* or Structured Judgement Record Review**	Total number of deaths reported through LeDer (By SWYPFT)**	Total number of deaths reported through LeDer (By other organisation)**
Q1	Q1	Q1	Q1	Q1	Q1
0	**0**	**0**	**0**	**0**	**0**
Q2	Q2	Q2	Q2	Q2	Q2
1	**0**	**0**	**0**	**1**	**0**
Q3	Q3	Q3	Q3	Q3	Q3
0	**0**	**0**	**0**	**0**	**0**
Q4	Q4	Q4	Q4	Q4	Q4
0	**0**	**0**	**0**	**0**	**0**
YTD	YTD	YTD	YTD	YTD	YTD
1	**0**	**0**	**0**	**1**	**0**



Learning from Structured Judgment Record Reviews and Investigations

This section contains a summary of learning identified from reviews and investigations that have been completed so far from Quarters 1 and 2 2017/18. Further learning will be added as these are completed.

1) Learning from Serious Incident Investigations

Of the 23 deaths reported from 1st April to 30th September 2017 resulting in serious incident investigations (11 Qu 1 including 1 serious case review, 12 Qu 2), ten investigations have been completed at the date of reporting (15/01/18). The remaining investigations are underway and any learning identified will be added to this report at the conclusion of the investigation process.

The ten completed Serious Incident investigations resulted in 22 recommendations being made. Analysis of these recommendations has identified five emerging themes. The top theme is consistent with that identified in the 2016/17 Incident Management Annual report. The themes are:

Recommendation theme	Number of recommendations	Number of reports this has appeared
Care pathway	1	1
Care delivery	1	1
Risk assessment	3	2
Record keeping	7	4
Communication	1	1
Carers/families	1	1
Medication Management	2	2
Staff education, training and supervision	1	1
Policy and procedure in place but not adhered to	1	1
Policy and procedure not in place	1	1
Team service, systems, roles and a management	2	2
Organisational systems, management	1	1

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

Of the 10 Structured Judgment Record Reviews that were commissioned during Quarters 1 and 2 2017/18, 8 Structured Judgment Record Reviews (SJRR) have been completed. The reviewers give a rating for the Assessment of Care Overall. The ratings given for quarters 1 and 2 are below:

Assessment of Care Overall:

	Poor care	Adequate care	Good care	Excellent care	Pending completion	Total
17/18 Q1	1	1	1	1	0	4
17/18 Q2	0	1	3	0	2	6
Total	**1**	**2**	**4**	**1**	**2**	**10**

Further discussion with the coroner is taking place in relation to the case with an overall rating of poor care. Following this, further review of the care will take place.

Areas to consider for improving practice

Due to the small number of completed structured judgement record reviews, it is difficult to identify any themes. However below are some examples of areas for improving practice identified by the reviewers. These will be added to as more reviews are completed:

- The person was at risk of falls and died as a result of a fall at home. There was no evidence of using the skills of the whole team in mitigating risk e.g. Occupational Therapy assessment.
- Convening best interest case conference or strategy meeting to discuss service user's capacity would be valuable. Robust plan to further review their capacity in the community would also be useful.
- The severity of a service user's condition by different practitioners and services was underestimated. There appeared to be a relative lack of knowledge across different services that a man presenting in his mid-50's with severe treatment-resistant anxiety symptoms is likely to have a depressive illness of moderate to severe intensity. When reviewed by a senior practitioner, the severity was immediately noted who did a robust and well-recorded assessment. A senior review (or by someone having a higher level of training and awareness) earlier on in the episode of illness is likely to have identified the severity and risks at an earlier stage.
- Ensuring that when specific treatments cannot be provided, that this is documented clearly and explained. In this example, it appeared to lead to the service user being pre-occupied with a pathway that was not available until the point of death.

Summary of areas for learning from SJRR in Quarters 1 and 2 2017/18

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

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

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

"Advocacy contacted on his behalf."

"Overall the patient was cared for and time being taken to engage with her….There was a multidisciplinary approach throughout involving specialist advisors for assessment and advice."

"When a fall occurred they were being observed constantly. Changes to presentation were discussed with the multidisciplinary team and the family."

"The family were involved in the resuscitation decision. A palliative approach was taken following difficulty swallowing and deterioration in physical health."

"From the care record there is evidence of structured risk assessments appertaining to the community aspect of care prior to admission. These were carried out by staff who had a good therapeutic working knowledge and relationship with the patient… close working relationships and coordination between the community and inpatient teams was evident."

The risk triggers were identified and the plan was adhered to resulting in an informal admission to the ward. This was in a timely manner and did not escalate to a formal admission under the mental health act.

"Discharge was being planned from an early stage in the admission with the patient being actively involved in her care

arrangements…The ward team were able to facilitate escorted home leave then worked with the community teams to increase the time spent at home. Good feedback from each visit is documented and provided a basis to inform the MDT of each stage to discharge."

Additional data

The Structure Judgment Record Review template captures data about the quality of care of different phase of care. The ratings given so far for each phase of care are given below:

Risk assessment:

	Poor care	Adequate care	Good care	Excellent care	Pending completion	Total
17/18 Q1	1	2	0	1	0	4
17/18 Q2	0	2	1	1	2	6
Total						

Allocation/ Initial Review

	Poor care	Adequate care	Good care	Excellent care	Pending completion	Total
17/18 Q1	0	2	1	1	0	4
17/18 Q2	0	2	1	1	2	6
Total	**0**	**4**	**2**	**2**	**2**	**10**

On-going Care

	Poor care	Adequate care	Good care	Excellent care	Pending completion	Total
17/18 Q1	1	1	0	2	0	4
17/18 Q2	0	2	1	1	2	6
Total	**1**	**3**	**1**	**3**	**2**	**10**

Care During Admissions (where applicable)

	Poor care	Adequate care	Good care	Excellent care	Not applicable	Pending completion	Total
17/18 Q1	0	1	0	2	1	0	4
17/18 Q2	1	0	1	0	2	2	6
Total	**1**	**1**	**1**	**2**	**3**	**2**	**10**

Follow-up Management / Discharge

	Poor care	Adequate care	Good care	Excellent care	Pending completion	Total
17/18 Q1	1	1	1	1	0	4
17/18 Q2	0	1	2	1	2	6
Total	**1**	**2**	**3**	**2**	**2**	**10**

Quality of the patient record in enabling good quality of care to be provided:

	Poor quality	Adequate quality	Good quality	Excellent quality	Pending completion	Total
17/18 Q1	0	2	1	1	0	4
17/18 Q2	0	0	4	0	2	6
Total	**0**	**2**	**5**	**1**	**2**	**10**

Action

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

3) Learning from other Investigations

a) Service level investigations

There were 2 service level investigations completed for deaths 1st April to 30th to the 30th September 2017

Areas identified for improvement:-

- Need to check details on system at the time of taking a verbal referral e.g. GP details and address of patient.
- Although teams have systems and processes there are times when an individual staff member has not taken responsibility for tasks allocated to them and care delivered was not provided as planned.

b) Learning disability reviews

Feedback from the Learning Disabilities Review programme has been limited to date. The interim national report for 2016/7 tells us that 521 deaths that are eligible for review have been notified to the LeDeR programme from 1st January 2016- 30th May 2017. Priority is being given to themed reviews of death of young people aged 18-24 years and people from black and minority ethnic background.

They have identified key challenges to be:-

- 45% have not yet been allocated to a reviewer.
- A small proportion of trained reviewers are 'active' in reviewing deaths 27%.
- A majority of reviewers are from nursing and care backgrounds, and better representation of medical professions is required.

The Trust reviewers tell us that in Yorkshire and Humber there have been over 200 notifications since the programme started and there is a backlog in reviews being undertaken.

Main findings

- 50% of deaths are due to aspiration pneumonia
  - Contributing factors are:- Behavioural risk factors, Medication and Seizures, poor oral health, post sedation and post dentistry aspiration

Learning is not available at Trust or locality level to date.

Next Steps

- Continue to use the Structured Judgment Record Review for analysis of themes.
- Develop experience in the use of Structured Judgment Record Review.
- Continue to theme recommendations arising from Serious Incident investigations.
- Further detailed information on learning will be provided to the Clinical Mortality and Improvement Group.
- Review learning from deaths policy and reporting based on pilot and findings to date

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 27 March 2018
Agenda item 6.3

Title:	**NHS Staff Survey results 2017: Highlight report on final results**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates
Purpose:	The Trust's Workforce Strategy sets out 3 key strategic workstreams: ➢ Workforce Development ➢ Staff Wellbeing and Engagement ➢ Leadership and Management Development These are built on a foundation of Values Based Human Resource Management and Equality and Diversity. The Strategy also sets out an extensive range of key performance indicators (KPIs) which includes feedback from the NHS Staff Survey. The purpose of this paper is to provide the Trust Board with a summary of the final 2017 NHS Staff Survey results for the organisation. The paper also provides an update on–the Workforce Strategy 2017/2018 action plan.
Mission/values:	The NHS Staff Survey provides direct measures of staff views on whether the organisation lives its values and is meeting its mission.
Any background papers/ previously considered by:	The Trust Board approved the Workforce Strategy in 2017 and the NHS Staff Results are part of a comprehensive set of KPIs within it. The Board received an embargoed copy of the high level interim results.
Executive summary:	The Trust recognised that an important part of the Workforce Strategy is continuous improvement and to support this on-going feedback from staff is vital. The NHS Staff Survey is one mechanism to get the views of staff and the Trust decided this year to send it to every member of staff rather than a sample. The Trust uses Quality Health (one of the nationally approved contractors) to undertake the NHS Staff Survey on its behalf and 1888 completed surveys were received. The official NHS staff survey results were released on the 6 March 2018. http://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2017-Results/ These include key indicators, the national benchmarking data and a drill down of the results. The results present a mixed picture overall. A more detailed analysis of the results is being undertaken to assess whether actions are required across the Trust or targeted interventions are needed for certain staff groups or areas of service, and this will be reviewed at the Remuneration and Terms of Service Committee. The key highlights are: 1. **Results compared to the national average** *1.1 Results better than average:* ➢ Quality of non-mandatory training, learning and development ➢ Trust taking positive action on health and wellbeing ➢ Satisfaction with flexible working opportunities

- Numbers of staff working extra hours
- Reporting physical violence at work
- Reporting harassment and bullying at work

1.2 Results worse than average:

- Witnessing errors, near misses or incident that could hurt staff
- Bullying and harassment from service users/carers
- Staff motivation at work
- Effective team working
- Effective use of patient/service user experience feedback
- Staff feeling unwell due to work related stress

2. Changes since the 2016 survey

2.1 ***Positive changes:***

- Satisfaction with opportunities for flexible working
- Feeling safe in raising concerns about unsafe clinical practice

2.2 ***Negative changes:***

- Satisfaction with the quality of work and care delivered
- Satisfaction with the amount of responsibility
- Trust acts fairly with regard to career progression/promotion

3. Workforce Strategy Outcome Measures: NHS Staff Survey

The Trust Board approved the Workforce Strategy in March 2017. The Strategy included a detailed set of outcome measures based on the NHSI Culture and Leadership Programme. The metrics in the NHSI programme drew heavily from the NHS Staff Survey.

The 2017 NHS Survey was undertaken after only 6 months from the Trust Board approving the Workforce Strategy and therefore is too early to gauge an accurate picture of the strategy's impact. However, it does:

- Set a baseline to measure progress for future
- Provide areas where we need to target further actions
- Help to continuously improve and refine agreed actions
- Informs the 18/19 Workforce Strategy Action plan

Attached in appendix 1 are the NHS Staff Survey relevant Key Findings broken down by the Workforce Strategy strategic goals.

4. Actions from the 2017/2018 Workforce Strategy Action Plan

Since the 2016 NHS Staff Survey there has been a range of actions within the 2017/2018 Workforce Strategy action plan. These include:

- Workplace health and well-being. Further investment in the Occupational health team to provide additional support for staff.

Health and well-being roadshows have been delivered across the Trust, yoga sessions, menopause group, support for staff to lose weight etc. Staff can access in-house counselling service, mindfulness training and staff retreats. A communications strategy has been agreed to actively promote health and well-being support available to staff including a well-being magazine, messages to staff etc. Well-being at work survey administered in 2017 with 1900 responses.

- Prevention and management of violence and aggression in the workplace. 'Safewards' continues to be rolled out across in patient areas. The Trust is committed to the 'Sign up to Safety' initiative and has set 3 year targets to reduce the use of prone restraint and to reduce harm as a consequence of restraint. Work is taking place to conduct debriefing focussing on RIDDOR cases. A revised Management of Violence and Aggression Policy, renamed 'Reducing Restrictive Interventions Policy' is being agreed.
- Errors, near misses and incidents. The Trust's Patient Safety Strategy action plan is being implemented.
- Workforce planning workshops delivered across the BDUs as part of the annual planning process.
- Development of a values into behaviours framework.
- A revised leadership and management development framework was agreed.
- Development of a BAME staff network and a Staff Disability network.
- Promotion of the Freedom to Speak up Guardian role.

5. **Further developments already planned in 2018/19 relevant to survey feedback**

A revised appraisal process, supported by training is being implemented in 2018. The learning and development team is using the NHS Staff Survey feedback to inform the development and implementation of the revised appraisal system.

'Middleground' which is a communication and engagement programme will run in 2018 and the proposal is to focus on developing healthy and productive teams. The programme will address ways on increasing staff engagement, promoting health at work and encouraging positive behaviours.

The Well-being at Work survey will be used to target advice and support to service areas and teams with a follow up support package. Significant activity has taken place in the last 12 months to promote the Trust's well-being services including physiotherapy and moving and handling advice. Further actions will be agreed at the Well-being at Work Partnership Group to target advice and support.

Training for leaders and colleagues on improving workplace well-being, resilience and engagement will be offered. The Trust has

	commissioned a train the trainer programme from Robertson Cooper to support the delivery of this programme. The Leadership and Management development offer will be promoted in 2018. A clinical network has been established to support the reduction of harassment, bullying or abuse. The network will review the staff survey feedback to agree further actions. Proposal for Health and Wellbeing champion in each BDU/Directorate is being developed. **6. Conclusion** The NHS Staff Survey provides extremely important feedback on colleague's experience of work. A more detailed analysis of the results will be undertaken to assess what actions are required across the Trust or targeted interventions are needed for certain staff groups or areas of service. This will go into the Remuneration and Terms of Service Committee. **Risk Appetite** The NHS Staff Survey is one source of feedback from staff on what we do well as an employer and where we can get better. The Remuneration and Terms of Service Committee will monitor overall workforce risks in line with the Trust's Risk Appetite statement.
Recommendation:	**Trust Board is asked to NOTE the report and the high level actions and next steps.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

National Staff Survey 2017: Highlight report on the Trust's results with national benchmarking data

1. Introduction

The Trust's Workforce Strategy sets out 3 key strategic work streams: Workforce Development; Staff Wellbeing and Engagement: and Leadership and Management Development. These are built on a foundation of Valued Based Human Resource Management and Equality and Diversity. The Strategy also sets out an extensive range of key performance indicators (KPIs) which includes feedback from the NHS Staff Survey.

Between October and December 2017 the annual National NHS Survey was distributed to all staff in the Trust. The aim of the survey is to gather information to enable NHS organisations to improve the working lives of staff and consequently provide better care for service users and their carers.

The Trust decided to send the 2017 survey to all staff to enable the results to be meaningfully presented by Service as well as at an organisational level. In previous years the Trust surveyed a sample of staff receiving between 400-600 responses and this year there were 1888 completed surveys.

The information below summarises the results from the Trust's NHS Staff Survey report published on the 6th March 2018. The Trust's report compares the organisation results with 29 combined community, mental health and learning disability NHS providers. The Trust's response rate was 44%, the average for the comparison group of 29 Trusts was 45%.

The report summarises key results and action already taken and planned.

2. Staff Wellbeing and Engagement

A key workstream of the Workforce Strategy is Staff Wellbeing and Engagement. It's proven that staff wellbeing and engagement have a link to productivity and employee relations. To support a culture of wellbeing the Trust has being working in partnership with Robertson Copper who are a team of business psychologists who specialise in wellbeing. They have developed a model for creating a culture of wellbeing known as ASSET. The model looks at the key aspects of working life that affect staff wellbeing and engagement these are known as the 6 essentials which are:

- Resources and communications
- Control
- Balanced workload
- Job security and change
- Work relationships
- Job conditions

The 6 essentials provide a framework to enable the Trust to identify measure and develop the areas to achieve the organisation's goals. The NHS Staff results helps to gain further insight into Staff Wellbeing and Engagement and are part of the KPIs within the Workforce Strategy. The initial results below will be matched against the "6 essentials" as part of the Trust's approach to continuous learning and development.

3. SWYPFT results

3.1 Results better than average

Appraisals and support for development

Quality of non-mandatory training, learning and development scale summary score 4.09, average 4.06.

Working patterns

Are you satisfied with opportunities for flexible working, 62%, national average 58%.

Percentage of staff working extra hours 68%, national average 71%.

Health and well-being

Does your organisation take positive action on health and well-being, scale summary score 3.76, average 3.70.

Violence, aggression, harassment, bullying and abuse

The last time you experienced physical violence at work, did you or a colleague report it? Yes 92%, national average 88%

The last time you experienced harassment, bullying or abuse at work from patients, relatives or the public, did you or a colleague report it? Yes 30%, national average 26%.

The last time you experienced harassment, bullying or abuse at work from staff, did you or a colleague report it? Yes 62%, national average 57%.

3.2 Results worse than average, negative results

Your job

Staff motivation at work scale summary score 3.79, national average 3.93.

Effective team working scale summary score 3.77, national average 3.85.

Errors and Incidents

Percentage of staff witnessing harmful errors, near misses or incidents in last month 26%, national average 23%.

Health and well-being

Percentage of staff feeling unwell due to work related stress in the last 12 months 41%, national average 40%.

Violence, aggression, harassment, bullying and abuse

In the last 12 months have you personally experienced harassment, bullying or abuse from patients, service users, relatives? Yes 30%, national average 26%.

In the last 12 months have you personally experienced physical violence from patients, service users, relatives? Yes 17%, national average 14%.

Service user feedback

Effective use of patient/service user feedback, scale summary score 3.58, national average 3.69.

4. Changes since the 2016 survey

4.1 Positive changes:

Your Job

I am satisfied with the opportunities for flexible working 62%, increased by 6%.

Raising Concerns

Staff confidence and security in reporting unsafe clinical practice scale summary score 3.71, increased from 3.60.

4.2 Negative changes:

Your Job

Staff satisfaction with the quality of work and care they are able to deliver scale summary score 3.83, the Trust score has worsened from 3.99 in 2016.

Staff satisfaction with level of responsibility and involvement scale summary score 3.84, the Trust score has worsened from 3.90 in 2016.

Equal Opportunities

Percentage of staff believing the organisation provides equal opportunities for career progression or promotion 86%, the Trust score has worsened from 90% in 2016.

5. Actions from the Workforce Strategy 2017/2018 action plan since the 2016 survey

Since the 2016 NHS Staff Survey there has been a range of actions. These include:

- Workplace health and well-being. Further investment in the Occupational health team to provide additional support for staff. Health and well-being roadshows have been delivered across the Trust, yoga sessions, menopause group, support for staff to lose weight etc. Staff can access in-house counselling service, mindfulness training and staff retreats. A communications strategy has been agreed to actively promote health and well-being support available to staff including a well-being magazine, messages to staff etc. Well-being at work survey administered in 2017 with 1900 responses.
- Prevention and management of violence and aggression in the workplace. 'Safewards' continues to be rolled out across in patient areas. The Trust is committed to the 'Sign up to Safety' initiative and has set 3 year targets to reduce the use of prone restraint and to reduce harm as a consequence of restraint. Work is taking place to conduct debriefing focussing on RIDDOR cases. A revised Management of Violence and Aggression Policy, renamed 'Reducing Restrictive Interventions Policy' is being agreed.
- Errors, near misses and incidents. The Trust's Patient Safety Strategy action plan is being implemented.
- Workforce planning workshops delivered across the BDUs as part of the annual planning process.
- Development of a values into behaviours framework.
- A revised leadership and management development framework was agreed.
- Development of a BAME staff network and a Staff Disability network
- Promotion of the Freedom to Speak up Guardian role.

6. Further developments planned in 2018/19 relevant to survey feedback

A revised appraisal process, supported by training is being implemented in 2018. The learning and development team is using the NHS Staff Survey feedback to inform the development and implementation of the revised appraisal system.

'Middleground' which is a communication and engagement programme will run in 2018 and the proposal is to focus on developing healthy and productive teams. The

programme will address ways on increasing staff engagement, promoting health at work and encouraging positive behaviours.

The Well-being at Work survey will be used to target advice and support to service areas and teams with a follow up support package. Significant activity has taken place in the last 12 months to promote the Trust's well-being services including physiotherapy and moving and handling advice. Further actions will be agreed at the Well-being at Work Partnership Group to target advice and support.

Training for leaders and colleagues on improving workplace well-being, resilience and engagement will be offered. The Trust has commissioned a train the trainer programme from Robertson Cooper to support the delivery of this programme.

The Leadership and Management development offer will be promoted in 2018.

A clinical network has been established to support the reduction of harassment, bullying or abuse. The network will review the staff survey feedback to agree further actions. Proposal for Health and Wellbeing champion in each BDU/Directorate is being developed.

7. Conclusion

The NHS Staff Survey provides extremely important feedback on colleague's experience of work. A more detailed analysis of the results will be undertaken to assess whether actions are required across the Trust or targeted interventions are needed for certain staff groups or areas of service. An action plan will be then be developed.

Appendix 1

Workforce Strategy Outcome Measures: NHS Survey Key Performance Indicators

Workforce Strategy Strategic Goals	NHS Staff Survey: Key Performance Indicators Identified in the Workforce Strategy	Comments/Actions
Workforce Development	Appraisal and Support • 91% of staff appraised in the last 12 months **Average** • Quality of Appraisal **Average** • Quality of learning and Development **Better than Average** Job Satisfaction • Staff recommending as a place to work or receive treatment **Average** • 72% of staff felt able to contribute towards improvement at work **Average** • Staff satisfaction with level of responsibility **Average** • Effective team working **Below Average** • Staff satisfaction with resources and support **Average** • Staff satisfaction with quality of work and care they are able to deliver **Average** • 89% of staff felt that their role makes a difference to patients and service users **Average**	New Streamlined Value Based Appraisal Operational from 1st April 2018 Specialist Services was a hotspot in this area and focused support identified
Staff Wellbeing and Engagement	• 41% of staff felt unwell due to work related stress in the last 12 months **Below Average** • 52% of staff attended work in the last 3 months feeling unwell because they felt pressure from their Manager, Colleagues or themselves **Average** • Trust and managers interested in and action on health and wellbeing **Better than Average** • 62% staff felt satisfied with the opportunities for flexible working **Better than Average** • 68% of staff work extra hours **Better than Average** • Staff motivation at work **Below Average**	Continue support through rapid referral to Occupational Health now in place Managing Staff Wellbeing and Attendance programme for managers implemented All of Us Health and Wellbeing brand launched

	• 17% of staff experienced physical violence from patients, relatives or the public in the last 12 months Below Average • 2% of staff experienced physical violence from staff in the last 12 months **Average** • 92% of staff/colleagues reported recent experience of violence Better than Average • 30% of staff experienced harassment, bullying or abuse from patient, relatives or the public in the last 12 months **Average** • 19% of staff experienced harassment, bullying or abuse from staff in the last 12 months **Better than Average** • 62% of staff/colleagues reported most recent experience of harassment, bullying or abuse **Better than Average**	48% of staff from Forensic experienced physical violence from service users, relatives or the public. A clinical network has been established to address this issue. Forensic Services report the highest level of violence, harassment and bullying and the highest level of reporting New approach to Harassment and Bullying being developed with the Staff Side and Staff Networks. Middleground programme will cover creating healthy teams which will include tackling harassment and bullying
Leadership and Management Development	• Recognition and value by managers and the Trust **Average** • 34% reporting good communications between senior managers and staff **Average** • Support immediate managers **Average**	New leadership and management development framework launched
Equality and Diversity	Equality and Diversity • 11% experienced discrimination at work in the last 12 months **Average** • 86% of staff believe the Trust provides equal opportunities for career progression or promotion Below Average	Trust part of pilot for Building Inclusive Leadership Moving forward programme launched for BAME staff Staff disability network launched

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board 27 March 2018
Agenda item 7

Title:	Operational Plan 2018/19
Paper prepared by:	Director of Finance and Resources
Purpose:	The purpose of this paper is to provide an update to the Trust Board of the current status of the financial plan for 2018/19 and ensure Board requirements can be met in order to submit the final plan to NHS Improvement by the end of April
Mission/values:	Use of resources
Any background papers/ previously considered by:	Regular plan updates regularly provided to the Trust Board Specific session held at EMT on January 18th attended by a number of Board members, with the papers circulated to all Additional session to discuss the control total held on January 25th
Executive summary:	➢ The draft operating plan was submitted to NHS Improvement (NHSI) on March 8th in line with what was agreed at the previous Trust Board. ➢ Contract variation negotiations are progressing with each commissioner ➢ The Trust has requested a reduction in control total of c£3m. This is challenging but achievable based on the work carried out to date and would mean a cost improvement programme of 4.6% ➢ The Trust did not accept its control total of £374k surplus in the draft plan submission. ➢ The West Yorkshire and Harrogate Health and Care Partnership (formerly the STP) has submitted an expression of interest to become an Integrated Care System (ICS). This will potentially mean working to a single control total across West Yorkshire ➢ The full plan needs to be submitted to NHSI by April 30th. It will therefore be presented in full at the April Board meeting. In order to ensure the plan is ready for Board approval the following actions will take place: - Any comments on the draft narrative need to be provided to the Director of Finance by April 6th to enable a final draft to be completed. - Work will continue on the financial plan, with a particular focus on signing off and agreeing any recommended changes and concluding progress against potential upsides - Feedback from NHS Improvement, when received, needs to be taken into account - Completion of the contract variation process - Improve understanding of requirements for the W. Yorkshire and Harrogate Health and Care Partnership becoming an ICS and the impact this has on the Trust - Completion of Quality Impact Assessment process to the satisfaction of EMT and the Board.
Recommendation:	**It is recommended that the Trust Board NOTES this update and provides feedback**
Private session:	Not applicable

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Operating Plan Update

Introduction

The purpose of this paper is to provide the Trust Board with the status of the operating and financial plan for 2018/19 and to advise on the next steps to enable completion in time for the NHS Improvement (NHSI) deadline for submission of April 30th.

Draft Plan Submission

The draft plan was submitted on March 8th in line with NHSI deadlines. This included an update to the narrative that was submitted in December 2016 and March 2017 as well as finance and workforce schedules. As previously agreed at the Trust Board a letter has been written to the regulator asking for a reduction in control total of c£3m to reflect lost contribution from decommissioned and tendered services, as well as other pressures. To date we have not had a response to this request. A copy of the draft plan submission has been provided to all Trust Board members.

The plan will be finalised following the successful conclusion of contract updates for 2018/19 and considering any feedback from NHS Improvement.

Contract Negotiations

The Trust signed two year contracts covering 2017/18 and 2018/19. Following the additional funding made available to the NHS in the Autumn Budget, there is a requirement to vary contracts in 2018/19 and agree revised targets. The Trust is discussing these contract variations with each of its commissioners based on the recent planning guidance. Commissioning intentions have been received and the Trust has responded to them. Planning guidance stated contract variations should be signed by March 23rd. At this point good progress has been made, but there are further points to clarify on a number of the contracts prior to signature. The Trust Board will be kept up-to-date of progress being made towards final agreement.

Financial Plan

The Trust has written to NHS Improvement requesting a reduction in control total. The control total required by NHS Improvement is £0.4m before the allocation of any Provider Sustainability Funds (PSF). The PSF is the new name for the sustainability element of the Sustainability and Transformation Funding. If a change in control total is not agreed and the Trust does not accept the NHSI proposed plan surplus it will not be eligible to receive £1.9m of PSF.

The Board has been well briefed on the level of cost improvement required to deliver this control total, which is in excess of 6%. This requirement is in excess of the CIP agreed at the time that control totals were conditionally accepted. At that time, the risks associated with potential decommissioning and tendering were included in our initial agreement of the control total.

The Trust has requested a reduction in control total of c£3m. This is very challenging but achievable based on the work carried out to date and would mean a cost improvement programme of 4.6%. Schemes have been identified that will deliver a good proportion of this, with further potential upsides of £2.7m being worked on to cover the gap. Countering this further risk of £2.4m has also been identified. Overall, there is an improvement on the £6.1m deficit position presented to the Trust Board in January.

West Yorkshire STP

The West Yorkshire and Harrogate Health and Care Partnership [formerly the STP] has submitted an expression of interest in becoming an Integrated Care System (ICS). There are a number of advantages to this that have been presented to the Board at previous sessions. This includes greater access and control over sustainability and transformation funds; and better alignment of regulation, commissioning and provision. Discussions are at an early stage but one consequence of becoming an ICS is that we would expect to see a "system wide" control total. The discussions around how this operates continue and may have a material impact on our control total. Trusts will be required to accept and achieve their current or revised control totals; or mechanisms will need to be identified to enable the system to remain in balance within the overall control total.

Collaboration, transparency and openness around West Yorkshire and Harrogate's finance community has increased in recent times. The conversations around control totals are being held in a context where people are looking to share solutions and take a system wide view. The Board will be updated on the development of control totals as parallel discussions continue.

Next Steps

The full plan needs to be submitted to NHSI by April 30th. It will therefore be presented in full at the April Board meeting. In order to ensure the plan is ready for Board approval the following actions will take place:

- Any comments on the draft narrative need to be provided to the Director of Finance by April 6th to enable a final draft to be completed.
- Work will continue on the financial plan, with a particular focus on signing off and agreeing any recommended changes and concluding progress against potential upsides
- Feedback from NHS Improvement, when received, needs to be taken into account
- Completion of the contract variation process.
- Improve understanding of requirements for the West Yorkshire & Harrogate HCP becoming an ICS and the impact this has on the Trust.
- Completion of Quality Impact Assessment (QIA) process to the satisfaction of EMT and the Board.

Recommendation

It is recommended that the Trust Board notes this update and the next steps in the development of the plan.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 March 2018
Agenda item 8.2

Title:	**West Yorkshire and Harrogate Health and Care Partnership update - 'Our Next Steps to Better Health and Care for Everyone' document**
Paper prepared by:	Director of Strategy
Purpose:	The purpose of this paper is to provide Trust Board with a summary of the *'Next Steps to Better Health and Care for Everyone'* document that sets out the priorities and plans for the West Yorkshire and Harrogate Health and Care Partnership (WYHHCP).
Mission/values/objectives	The development of joined up care through place-based plans are central to the **Trust's strategy**. As such it is supportive of our mission, particularly to **help people to live well in their communities.** The development of strategic partnerships **support the achievement of the Trust's strategic objectives** – to **improve health** and wellbeing through an enhanced focus on prevention and early intervention, **improve quality** and experience through more integrated ways of working and **improve the use of resources** across the whole system. **The way in which the Trust approaches strategic developments and partnerships must be in accordance with our values**. The approach is in line with our values - being **relevant today and ready for tomorrow**. The Next Steps document outlines the priorities and plans for the WY&H HCP. The partnership is critical in ensuring the sustainability of Trust services.
Any background papers/ previously considered by:	Updates and focused strategic discussions on placed-based plans including the WYHHCP have formed part of most recent Trust Board meetings, including January Trust Board and February Strategic Board.
Executive summary:	**Background** Led by the Trusts Chief Executive, Rob Webster, WYHCP was formed in 2016 as one of 44 Sustainability and Transformation Plans (STPs), in response to the *NHS Five Year Forward View*. It brings together all health and care organisations in six places: Bradford District and Craven, Calderdale, Harrogate & Rural District, Kirklees, Leeds and Wakefield. **Summary 'Our Next Steps to Better Health and Care for Everyone'** WYHHCP has published 'Our Next Steps to Better Health and Care for Everyone'. The document describes the progress made since the

	publication of the initial plan in November 2016, and sets out the progress made over the last sixteen months and how the partnership will improve health and care for the 2.6 million people living across the area in 2018 and beyond. The report positions the Partnership in a way that would allow the development of a new Memorandum of Understanding between the partners; an improved financial strategy; and the potential to become an "Integrated Care System" with more freedom and autonomy from the centre. **Risk Appetite** Supporting the development of strategic partnerships and place-based plans that enhance the Trusts sustainability are within the Trust's risk appetite. Risks to the Trust services in each place will need to be reviewed and managed as the partnerships develop to ensure that they do not have a negative impact upon services, clinical and financial flows.
Recommendation:	**Trust Board is asked to NOTE the contents of the 'Our Next Steps to Better Health and Care for Everyone' document and progress made by the WYHHCP; and to NOTE that the Board would be engaged in any further developments in shared arrangements.**
Private session:	Not applicable.

West Yorkshire and Harrogate Health and Care Partnership update

'Our Next Steps for Better Health and Care for Everyone in West Yorkshire and Harrogate'

South West Yorkshire Partnership NHS Foundation - Trust Board

27th March 2018

Introduction

West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) has published 'Our Next Steps to Better Health and Care for Everyone'. The document describes the progress made since the publication of the initial WY&H plan in November 2016, and sets out how the partnership will improve health and care for the 2.6 million people living across the area in 2018 and beyond.

West Yorkshire and Harrogate Health and Care Partnership - Background

Led by the Trusts Chief Executive, Rob Webster, West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs), in response to the *NHS Five Year Forward View*. It brings together all health and care organisations in six places: Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

The West Yorkshire and Harrogate Health and Care Partnership emphasises the importance of place-based plans where majority of the work happens in each of the six places (Bradford, Calderdale, Harrogate, Kirklees, Leeds and Wakefield). These build on existing partnerships, relationships and health and wellbeing strategies.

Collaboration is emphasised at WY&H level when it is better to provide services over a larger footprint; there is benefit in doing the work once and where 'wicked' problems can be solved collaboratively.

The next steps document focuses on the progress being made on national and regional priorities including, Cancer, Mental Health, Primary and Community care, to name a few. The document describes how the partnership will continue to work together on the 'triple aim' of the Five Year Forward View, which is all about improving the health of people; providing better care; and financial sustainability.

Summary Next Steps Document

A significant amount of work has been progressed since the draft plan was published in 2016. The WY&H HCP has developed and matured over the past sixteen months. Programmes of work have further developed into clear plans for delivery and begun to deliver in important areas including:

- Refined and further developed programmes of work into clear plans for delivery.
- Begun to deliver on a number of important areas, including cancer and mental health.
- Built capacity into programmes through alignment of staff, namely from NHS England and clinical commissioning groups with the support of council colleagues and community organisations.
- Developed governance and partnership working arrangements that facilitate more collaborative working at a local place level and across the West Yorkshire and Harrogate area. Examples of this include the way hospitals and mental health providers are working together and the establishment of the Joint Committee of the 11 Clinical Commissioning Groups (CCG).
- Attracted over £45m of additional national funding to support transformation, such as cancer, mental health and diabetes.
- Continue to have meaningful conversations and effective engagement with communities – both at a West Yorkshire and Harrogate level and in each of the six places that make up the partnership.

Relevance for the Trust

The next steps document is an important document that provides the regional strategic context, plans and priorities that are an integral part of the Trusts strategic and operational plans.

Trust Board Recommendation

1) **To note the contents of the 'Our Next Steps to Better Health and Care for Everyone' document and progress made by the West Yorkshire and Harrogate Health and Care Partnership.**

Our next steps to better health and care for everyone

January 2018

Executive Summary

West Yorkshire and Harrogate
Health and Care Partnership

The West Yorkshire and Harrogate Health and Care Partnership is made up of organisations working closely together to plan health and care services across the area.

This includes:

Care providers

Airedale NHS Foundation Trust

Bradford District Care NHS Foundation Trust

Bradford Teaching Hospitals NHS Foundation Trust

Calderdale and Huddersfield NHS Foundation Trust

Harrogate and District NHS Foundation Trust

Leeds Community Healthcare NHS Trust

Leeds and York Partnership NHS Foundation Trust

Leeds Teaching Hospitals NHS Trust

Locala Community Partnerships

The Mid Yorkshire Hospitals NHS Trust

South West Yorkshire Partnership NHS Foundation Trust

Tees, Esk and Wear Valleys NHS Foundation Trust

Yorkshire Ambulance Service NHS Trust

Clinical commissioning groups (CCGs)

NHS Airedale, Wharfedale and Craven CCG
NHS Bradford City CCG
NHS Bradford Districts CCG
NHS Calderdale CCG
NHS Greater Huddersfield CCG
NHS Harrogate and Rural District CCG
NHS Leeds North CCG*
NHS Leeds South and East CCG*
NHS Leeds West CCG*
NHS North Kirklees CCG
NHS Wakefield CCG

Other organisations involved

Voluntary and community partners
NHS England
NHS Improvement
Public Health England
Health Education England
Healthwatch
GP Federations working in our local areas

Local councils

Bradford District Council
Calderdale Council
Craven District Council
Harrogate Borough Council
Kirklees Council
Leeds City Council
North Yorkshire County Council
Wakefield Council

*In April 2018 the number of clinical commissioning groups will reduce to nine when the three Leeds clinical commissioning groups come together.

Foreword

This executive summary describes the progress made and our next steps for improving health and services across the West Yorkshire and Harrogate Health and Care Partnership.

In November 2016 we published draft proposals for our Sustainability and Transformation Partnership. We described how we will work together on the **'triple aim'** of the Forward View: to improve the health of people; provide better care; and ensure financial sustainability.

Since this point we have taken forward a significant amount of work and our partnership has grown and matured:

- We have refined and further developed our programmes into clear plans for delivery.
- We have begun to deliver improvement in a number of important areas.
- We have built capacity into programmes through alignment of staff currently working in our system.
- We have developed governance and partnership working arrangements that facilitate closer working at local place level and across the West Yorkshire and Harrogate area.
- We have attracted over £45m of national funding to support changes in areas like cancer, mental health and diabetes so we can move quickly on our priorities; and
- We continue to have meaningful conversations and effective engagement with communities – both at West Yorkshire and Harrogate level and in each of the places that make up our partnership (see page 5).

Performance and finances are stressed in many organisations within West Yorkshire & Harrogate. **Staff are working incredibly hard to deliver care and improve care in the most trying of circumstances.**

This summary provides an overview on how we are working to deliver high quality and sustainable services into the future. This means working in all our communities to tackle the root cause of the issues – whether loneliness, poverty, poor housing or disjointed and complicated services. We can only do this by working together and by being clear about the choices we need to make now and in the future.

As a frontline Chief Executive I see the reality of the fantastic innovation that exists alongside the pressures in services. I have been formally appointed to the role of Partnership Leader for West Yorkshire and Harrogate. It is a privilege to continue to work with leaders across our area to build on the strong foundations we have put in place.

Rob Webster
Lead Chief Executive, West Yorkshire and Harrogate Health and Care Partnership

Our vision

In your neighbourhood and community 01

Health and social care will work together to **support your social, physical and mental health**

Your carers will **be supported** too

And where safe to do so **you will be supported to self-care**

02 In your local area

Care will be delivered locally, managed locally and planned locally

You will be seen as **equal partners** and encouraged to **support one another**

Community groups and local teams including your GP will **work with you**

You know better what **you and your community needs**

You are at the centre of everything we do

You will have the best start in life so you can live and age well.

We will work with you to deal with the issues that affect your health and wellbeing in your communities, whether it's loneliness or learning disability; housing or mental health; childhood obesity or air quality – **together we can make things better with you.**

Across West Yorkshire and Harrogate (WY&H) 03

We will plan care across WY&H. E.g. sharing good practice, staff skills and buildings

Our hospitals will work together so you have the best treatment possible

We will make the best use of all the expertise and staff skills available to us

We will work across the area on issues like **mental health, cancer, stroke and urgent care**

Our partnership is not a new organisation. It is a new way of working for the 2.6million people who live in Bradford District and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

NHS services, councils, voluntary and community organisations will work together to improve your health and wellbeing.

Technology

We want to use the **latest technology** to give you the best health recovery possible.

We also want to use **equipment to help you** safely manage your health.

This includes using technology to let you **make GP appointments** and to **help you stay safe at home.**

Money

We aim to **spend as much of the local health and care pound as possible** in local places.

And that **we talk to you** and community representatives on how best to do this.

Our partnership staff

Our workforce is our best asset.

We will **develop and train** them to **give you the best care possible.**

If we don't, we will lose them and they are too important to us all.

Our plans

We will always ask you for your views.

You are welcome to **get involved.**

www.wyhpartnership.co.uk
01924 317659
westyorkshire.stp@nhs.net
@WYHpartnership

Summary

1 **We aim to deliver improvements in the quality and value for money of care** we provide, working through nine programmes and six enabling workstreams:

National priorities

- Cancer services
- Urgent and emergency care
- Mental health
- Maternity
- Primary and community care

West Yorkshire and Harrogate priorities

- Stroke care
- Preventing ill health
- Improving planned care and reducing variation
- Hospitals working together

Enablers

- Best practice and innovation
- Workforce
- Digital ways of working
- Harnessing the power of communities
- Capital and estates
- Business intelligence

2 Change needs to happen as close to people as possible, **putting the person at the centre of what we do.** This is why local relationships are the basis of our plans.

3 **The way we work:**

- **50 neighbourhoods** bringing social, physical and mental health care closer together and **seven local health and care partnerships** coming together to deliver care in **six places** where council and NHS commissioners plan and pay for services together.
- Supported by 1 association of acute hospitals and 1 group of mental health providers in **1 health and care system.**

4 **We are committed to meaningful conversations with staff and communities** and we will continue to engage people in the design, development and delivery of our plans.

5 **Housing, employment and access to green spaces can have the biggest impact on health.** Local government has a key role to play and health research is helping us to target those people at risk.

6 £45m

We have brought in **over £45million extra funding through partnership working** – and aim to attract more.

7 **We will invest in the development and skills of our workforce** to enable them to provide the best possible care. We have produced a plan to achieve this which also covers recruitment and retention.

8 The financial challenge we face is the biggest in a generation. **Our response is around getting the best value from every pound.** We will also be very open about the choices we have to make to live within our means.

9 Over the past fourteen months our partnership has made major strides towards **working together to improve health and care.**

10 **What will this all mean for you:**

- Places will be **healthy.**
- If you have long term health conditions you will be **supported to manage them yourself.**
- If you have multiple health conditions, there will be **a team supporting your physical, social and mental health needs.**
- **Hospitals will work closely together** to give you the best care possible.
- All **healthcare will be planned and paid** for once.
- **You can get involved** in the development of plans.

This information is available in alternative formats, for example large print, Braille, EasyRead and community languages. For more information contact:

01924 317659

NHS Wakefield CCG
White Rose House
West Parade
Wakefield
WF1 1LT

westyorkshire.stp@nhs.net

www.wyhpartnership.co.uk

@WYHpartnership

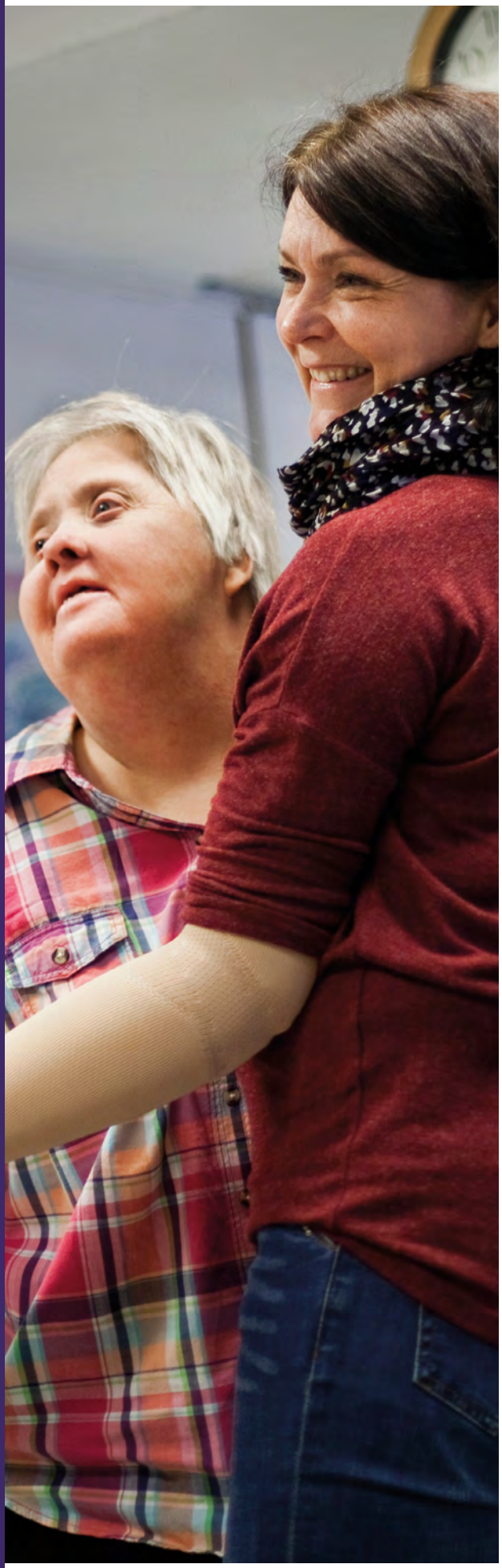
A partnership made up of the NHS, local councils, care providers, Healthwatch and community organisations.

January 2018

West Yorkshire and Harrogate
Health and Care Partnership

Our next steps to better health and care for everyone

January 2018



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Leeds Teaching Hospitals NHS Trust

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South West Yorkshire Partnership NHS Foundation Trust

Tees, Esk and Wear Valleys NHS Foundation Trust

Yorkshire Ambulance Service NHS Trust

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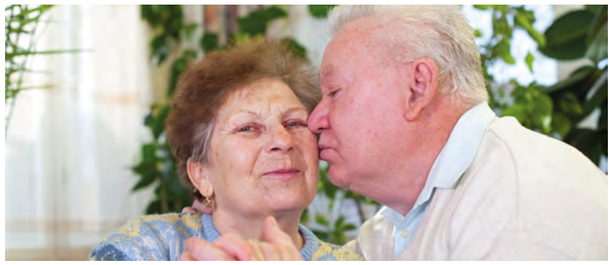
NHS Leeds South and East CCG*
NHS Leeds West CCG*
NHS North Kirklees CCG
NHS Wakefield CCG

Other organisations involved

Voluntary and community partners
NHS England
NHS Improvement
Public Health England
Health Education England
Healthwatch
GP Federations working in our local areas



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Since this point we have taken forward a significant amount of work and our partnership has grown and matured:

- We have refined and further developed our programmes into clear plans for delivery.
- We have begun to deliver improvement in a number of important areas.
- We have built capacity into programmes through alignment of staff currently working in our system.
- We have developed governance and partnership working arrangements that facilitate closer working at local place level and across the West Yorkshire and Harrogate area.
- We have attracted over £45m of national funding to support changes in areas like cancer, mental health and diabetes so we can move quickly on our priorities; and
- We continue to have meaningful conversations and effective engagement with communities – both at West Yorkshire and Harrogate level and in each of the places that make up our partnership (see page 5).

Performance and finances are stressed in many organisations within West Yorkshire & Harrogate. **Staff are working incredibly hard to deliver care and improve care in the most trying of circumstances.**

This publication provides an update on how we are working to deliver high quality and sustainable services into the future. This means working in all our communities to tackle the root cause of the issues – whether loneliness, poverty, poor housing or disjointed and complicated services. We can only do this by working together and by being clear about the choices we need to make now and in the future.

As a frontline Chief Executive I see the reality of the fantastic innovation that exists alongside the pressures in services. I have been formally appointed to the role of Partnership Leader for West Yorkshire and Harrogate. It is a privilege to continue to work with leaders across our area to build on the strong foundations we have put in place.

Rob Webster
Lead Chief Executive, West Yorkshire and Harrogate Health and Care Partnership

Introduction

The purpose of our West Yorkshire and Harrogate Health and Care Partnership is to deliver the best possible health and care for everyone living in the area.

We serve a diverse range of communities and recognise that they have different needs which require different services that meet their needs.

West Yorkshire and Harrogate is the **second largest health and care partnership in the country. 2.6 million people live here.** We have strong and vibrant communities and diverse population groups.

We have a **health care budget of over £5 billion.**

There are six places that make up the partnership:

Bradford District and Craven
Calderdale
Harrogate & Rural District
Kirklees
Leeds
Wakefield

There are nine West Yorkshire and Harrogate priority programmes:

- Preventing ill health
- Primary and community services, which covers a wide range of services including your local GP, pharmacies, social care services and local charities.
- Mental health
- Stroke
- Cancer
- Urgent and emergency care
- Hospitals working together
- Planned care and reducing variation
- Maternity

These local plans and our nine priorities make up the West Yorkshire and Harrogate Health Care Partnership Plan.

200,000 people
at risk of type II diabetes

Across our area we have so much to be proud of but we also need to address some significant health challenges. For example people are living longer with complex health care needs; **we have higher than average obesity levels, and over 200,000 people are at risk of type II diabetes.**

We all agree that working more closely together is the only way we can tackle these challenges and achieve our ambitions.

It is the only way we can genuinely put people, rather than organisations, at the centre of what we do. It is also the only way we can maximise the benefit of sharing the expertise and resources we have, including money, buildings and staff, **to achieve a greater focus on preventing ill health and reducing health inequalities.**

Over the past fourteen months our partnership has made major strides towards working together. You can see examples of this through:

- The structures we have put in place to support joint working.
- The way we have prioritised partnership working.
- The backing and support we have given to our priority programmes, including cancer and stroke, so that we can deliver change at pace.
- Our commitment to engaging with local communities and tackling inequalities.
- Our commitment to developing a joint financial strategy rather than competing organisational plans.
- Our conversations with people and communities who both provide and receive health care across our area.
- The new relationships we are building with national organisations, such as NHS England and NHS Improvement, who work closely with the partnership.

We benefit from strong partnership working in each of the six places (see page 5) that make up our partnership. This work is centred on our **Health and Wellbeing Boards.** These partnerships of councillors and NHS leaders are very important.

We remain steadfast in our thinking that change and improvement needs to happen as close to people as possible, putting the person at the centre of what we do, and that is why these local relationships are so important to us. This is a genuinely new approach to partnerships - built from the bottom up.

We believe in people, and the power that many have to improve their own health.

We also believe in the power of our local council partners and voluntary and community organisations, and the huge contribution they make to understand what really makes communities healthy.

The financial challenge we face is the biggest in a generation. Funding will grow by £0.4bn in the next five years to 2020-21, but this is significantly lower than the long term average growth by successive governments.

Demands on our resources are growing faster than those available; as a result the local health and social care system is under increasing financial pressure.

The right response is about refocusing our investment so that we are putting the available resources to their best possible use. But it will also mean that we will have difficult choices to make to live within our financial means. **It's very important that we are honest with everyone** about these choices – communicating things that we need to improve and letting you know why and when we need to save money; and being clear where service redesign will lead to better health for people.

An easy read version of this publication has been produced. **This is available on our website here.**

You can also **watch our British Sign Language films here.**

Our vision (see page 10)

- Places will be healthy - you'll have the best start in life, so you can live and age well.
- If you have long term health conditions you will be supported to self-care. This will include peer support and technology, for everything from telemedicine (where you can talk to your GP or a nurse via SKYPE, where it is safe to do so), carephones and fall detectors, to virtual communities of support from people like you.
- If you have multiple health conditions, your GP with a bigger team and social services will work together. This will involve you, your family and carers, the NHS, social care and voluntary and community organisations.
- If you need hospital care, it will usually mean going to your local hospital, which works closely with others to give you the best care possible.
- Local hospitals will be supported by centres of excellence for cancer, stroke, mental health which will deliver world class care and push the boundaries of research and innovation.
- All of this will be planned and paid for once, with councils and the NHS working together and removing the barriers created by planning and paying for services separately.
- Communities and staff will be involved in the design, delivery and assurance of services so that everyone truly owns their health care.

This publication has been produced for staff, stakeholders, public and communities so everyone is aware of the work we're doing and the progress we're making. You can **watch this short film here** to find out more about our partnership.

Summary

1 **We aim to deliver improvements in the quality and value for money of care** we provide, working through nine programmes and six enabling workstreams:

National priorities

- Cancer services
- Urgent and emergency care
- Mental health
- Maternity
- Primary and community care

West Yorkshire and Harrogate priorities

- Stroke care
- Preventing ill health
- Improving planned care and reducing variation
- Hospitals working together

Enablers

- Best practice and innovation
- Workforce
- Digital ways of working
- Harnessing the power of communities
- Capital and estates
- Business intelligence

2 Change needs to happen as close to people as possible, **putting the person at the centre of what we do.** This is why local relationships are the basis of our plans.

3 **The way we work:**

- **50 neighbourhoods** bringing social, physical and mental health care closer together and **seven local health and care partnerships** coming together to deliver care in **six places** where council and NHS commissioners plan and pay for services together.
- Supported by 1 association of acute hospitals and 1 group of mental health providers in **1 health and care system.**

4 **We are committed to meaningful conversations with staff and communities** and we will continue to engage people in the design, development and delivery of our plans.

5 **Housing, employment and access to green spaces can have the biggest impact on health.** Local government has a key role to play and health research is helping us to target those people at risk.

6 £45m

We have brought in **over £45million extra funding through partnership working** – and aim to attract more.

7 **We will invest in the development and skills of our workforce** to enable them to provide the best possible care. We have produced a plan to achieve this which also covers recruitment and retention.

8 The financial challenge we face is the biggest in a generation. **Our response is around getting the best value from every pound.** We will also be very open about the choices we have to make to live within our means.

9 Over the past fourteen months our partnership has made major strides towards **working together to improve health and care.**

10 **What will this all mean for you:**

- Places will be **healthy.**
- If you have long term health conditions you will be **supported to manage them yourself.**
- If you have multiple health conditions, there will be **a team supporting your physical, social and mental health needs.**
- **Hospitals will work closely together** to give you the best care possible.
- All **healthcare will be planned and paid** for once.
- **You can get involved** in the development of plans.

Our vision

Our partnership is not a new organisation. It is a new way of working for the 2.6million people who live in Bradford District and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

NHS services, councils, voluntary and community organisations will work together to improve your health and wellbeing.

Technology

We want to use the **latest technology** to give you the best health recovery possible.

We also want to use **equipment to help you** safely manage your health.

This includes using technology to let you **make GP appointments** and to **help you stay safe at home.**

Money

We aim to **spend as much of the local health and care pound as possible** in local places.

And that **we talk to you** and community representatives on how best to do this.

Our partnership staff

Our workforce is our best asset.

We will **develop and train** them to **give you the best care possible.**

If we don't, we will lose them and they are too important to us all.

Our plans

We will always ask you for your views.

You are welcome to **get involved.**

www.wyhpartnership.co.uk
01924 317659
westyorkshire.stp@nhs.net
@WYHpartnership

Our approach to delivering services

We believe firmly in the principle that services should be delivered as close as possible to people in their own homes and communities, where safe and effective.

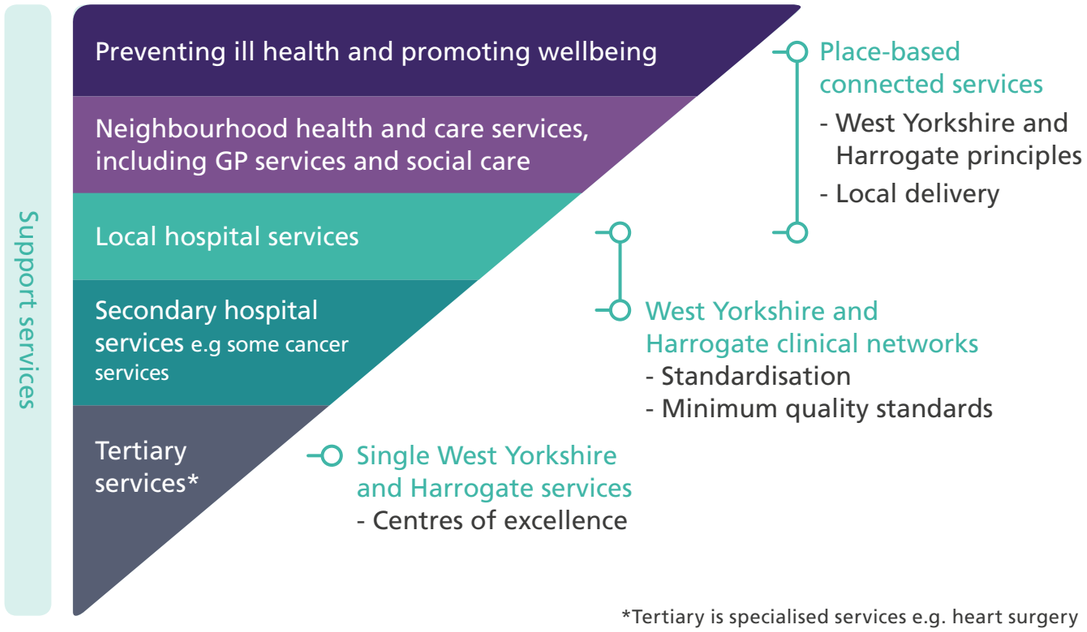
Wherever possible, services will be provided in your local neighbourhood. Only when the safety, quality and cost-effectiveness of care are improved by providing it at a greater scale will services be delivered elsewhere.

Neighbourhood health and care services

Health and care services will be tailored to meet the needs of people living in a neighbourhood of around 30-50,000 people.

They will be delivered through the Primary Care Networks model, an innovative approach to strengthening and redesigning primary care. It brings together a range of health and social care professionals from GP surgeries, mental health, community, hospital, social care and the voluntary sector to provide personalised and preventative care for local people. The model will also help neighbourhood services work together with hospitals and social care.

West Yorkshire and Harrogate service delivery model



*Tertiary is specialised services e.g. heart surgery

Local hospital services

Delivery of local hospital services will be planned based on the needs of each of our six local places (see page 5) and they will be operated and managed locally by each hospital. They will be designed to work seamlessly with services because people will often move between primary (such as GPs and dentists), community and hospital services. To avoid unnecessary differences between our six local places and **to further improve quality and the cost of care, groups of health care professionals will work together in clinical networks across West Yorkshire and Harrogate.**

Secondary hospital services (e.g. some cancer services)

Some hospital services need to be planned and delivered for larger areas and populations to be safe and effective (see page 5). For example those that deliver some cancer care. Although operational management will remain the responsibility of the hospitals, **clinical networks made up of consultants, GPs and other health and care professionals will ensure a common approach across West Yorkshire and Haorrgate, for example by agreeing shared clinical standards and procedures.**

Clinical research and education will also be managed once for West Yorkshire and Harrogate.

In some cases, this may lead to closer working between two or more hospitals to deliver services by sharing staff, buildings, and the latest technology.

Tertiary (or specialised) hospital services

The most complex services, such as heart surgery, will be planned, operated and managed as single services for West Yorkshire and Harrogate. Clinicians, for example **specialist consultants and nurses, from different hospitals will be brought together as a single team** to make the most of their skills, expertise and equipment.

This will improve care and support high quality research and education.

In some cases this may mean reducing the number of sites delivering the more complex care, such as high risk surgery, whilst other parts, for example outpatients, diagnostics and day surgery, will remain as local as possible.

Support services

The clinical and care services which look after people, are supported by a wide range of essential services. These include clinical support services (for example medicines and lab testing) and corporate support services (for example buildings, equipment and information technology).

Taking a common approach to these services across **West Yorkshire and Harrogate will enable different organisations and services to work together more easily.** This may be achieved through networks, partnerships between organisations or other ways of working.

working together
more easily

Working in partnership with communities

We know that not only hospitals and doctors keep people well; a person's life choices, where they live, and family support are also very important.

Working alongside our communities is an important part of our partnership - seeing the people we serve as assets and partners. The role of councillors, council staff, voluntary community organisations and many others is essential if we are to improve the health of our communities. We want a changed relationship with people, built on trust and empowerment, where the benefits of self-care, early help and preventing ill health can flourish.

A big part of this is asking and listening to the views of people and acting with them to deliver improvement.

There is a wealth of expertise across West Yorkshire and Harrogate and our communities are better placed than us to know what they need and to make positive change happen in their neighbourhoods. Our partnership seeks to be in the right relationship with communities and provide support that does not displace or diminish community power.

We have good leadership from the voluntary sector, and we are attracting support from Healthwatch, Nurture Development, National Voices and unpaid carers organisations to help us to think about our next steps. This is as important as getting future NHS and care staffing in place

We are committed to working with people who have experience of what can make services better. **For example in our stroke engagement work in 2017, 75% of 900 people who responded had either experienced a stroke, or cared for someone who had had one.**

75%
of 900 people

Watch this film where Soo Nevison from Community Action Bradford and District talks about the importance of working with voluntary and community organisations.

In Leeds, the local health and care plan is rooted in a community approach guided by political and public engagement.

All 99 councillors, voluntary organisations and communities have been involved in the ongoing conversation about health care plans. It has become clear that bringing people together in communities, to discuss housing and employment issues alongside health is an approach that has a natural fit for neighbourhoods and people.

Community conversations

We are committed to meaningful conversations with people on the right issues at the right time.

We believe that this approach informs the ambitions of our partnership - to work in an open and transparent way with everyone. **You can read about some of the work that has taken place over the past three years here.**

We have published our engagement and consultation timeline – setting out our plans to engage on the West Yorkshire and Harrogate priorities and each of the six local places (see page 5). **You can find them here.** Our communication and engagement plan is available **here.**

Local Healthwatch organisations have also supported engagement with people across a number of the West Yorkshire and Harrogate priorities in the last 18 months. From urgent care and stroke to health optimisation, which is all about promoting a healthy lifestyle to prevent as much ill-health as possible. Working with Healthwatch and our voluntary and community partners helps us to make sure we keep people's views at the heart of discussions.

Watch this film

Nichola Esmond, Director of Wakefield **Healthwatch talks here about the importance of engaging with communities** across West Yorkshire and Harrogate.

You can get involved in health and care in many ways, by becoming a member of your local NHS foundation trust, joining a clinical commissioning group public patient involvement group, public patient Involvement Panel, your council engagement work, volunteering with a charity or becoming a member of Healthwatch.

You can also contact us with any questions you may have. Our contact details are on the back cover.

Watch this film to find out about what we mean by working differently together, for the better. Featuring: Thea Stein, Chief Executive, Leeds Community Healthcare Trust and Andrew Sixsmith, a Leeds GP.

Working in partnership with our staff

Our staff are our most important asset. The views of staff are fundamental to our plans and we continue to engage with them throughout our work.

Most staff engagement, including conversations with GPs, community nurses, social workers, home care workers, council staff etc. takes place at the level of the neighbourhood and local place (see page 5).

For example, in Calderdale and Kirklees, the local plan includes a major reconfiguration of hospital services. The clinical model for these changes was developed with clinical colleagues and all staff. Both clinical and non-clinical, were invited to provide their views and feedback as part of the full formal consultation process.

As we work more closely together, we are seeing clinicians (ie, doctors, nurses and other health and care professionals) leading and driving the work to improve services.

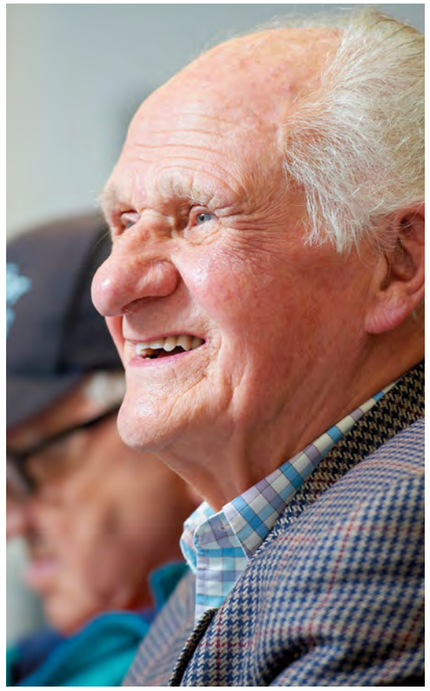
Staff have a wealth of experience and knowledge and often have the best ideas to make positive change happen. For example, Bradford District and Craven have a project between Airedale NHS Foundation Trust and Bradford Teaching Hospitals NHS Foundation Trust that is looking at how care is provided between the two trusts, and the differences in the quality of that care.

The first service to take part is gastroenterology, and staff engagement workshops have already taken place to agree areas of focus going forward.

Building on a history of good medical leadership through our cancer networks, clinicians in primary (community health care), hospital and specialist care are involved at every level in the work of our Cancer Alliance (one of our West Yorkshire and Harrogate priorities). Their experience and expertise help to shape and support the way we do business and secure funding to deliver on our ambitions.

£4.5million
to five care providers

You can see evidence of successful staff engagement in the recent allocation of £4.5 million to five care provider organisations, who are running the first 11 projects seeking funding from our Capacity for System Change Fund here in West Yorkshire and Harrogate.



We are also looking at how we can further improve stroke care and support across West Yorkshire and Harrogate.

This is being carried out with the expertise of leading consultants, other health care professionals and is informed by the engagement work from public feedback in 2017 and a clinical summit held in 2017.

This work includes working with the Academic Health Science Network on preventing and treating atrial fibrillation at scale across the area. Atrial fibrillation causes a fast and erratic heartbeat which is a major factor of stroke.

9 in 10 people
managed by GPs

This work is about detecting and treating people who are at risk of stroke so that around **9 in 10 people with atrial fibrillation are managed by GPs with the best local treatments,** saving lives and delivering efficiencies too. Our engagement work also highlighted the importance of further improving awareness of the signs and symptoms of stroke.

GPs are key partners in both our local place and West Yorkshire and Harrogate priority programmes (see page 5). They are represented in our clinical forum, which meets every month, and is made up of 11 clinical commissioning groups chairs, NHS provider medical directors, nursing leads and allied health professionals.

Council staff are critical in many different ways to help us fulfil our Next Steps vision.

Staff are being engaged in lots of ways. Senior leaders in councils such as CEOs and directors are engaged with how council resources and the influence they have in their local places (see page 5) can be maximised for our shared health outcome improvements. Colleagues in front line services in social care, children's services and public health are core to the conversations we are having on how local partnerships can change and develop practice jointly with NHS staff.

Council staff are discussing and supporting wider sets of initiatives which help recovery and broader wellbeing. This includes ensuring we have effective transport services to and from our hospitals across West Yorkshire, ensuring our air quality improves particularly in towns and cities and ensuring physical activity opportunities are built in to our new and redeveloping housing and public spaces.

Our priorities

Preventing ill health and improving wellbeing

Preventing ill health is at the heart of our partnership and a theme that runs through all of our West Yorkshire and Harrogate priorities. We have built this into the way we work through public health involvement in all our programmes (see page 5).

We know that more needs to be done to prevent ill health. Your life chances are shaped in the early years of life. With an ageing population, helping frail and older people stay healthy and independent, tackling loneliness, and avoiding hospital stays is also important. GPs, community health, mental health, and hospital services, need to work more closely together and in partnership with voluntary community organisations, housing, social care services, care home providers, making better use of technology to support self-care. This will deliver better care for children and adults, including for people with learning disabilities, as we work to promote Independent Living in the community with a wide range of options.

Each of our six local places (see page 5) is focused on preventing ill health, and providing early help and support sooner rather than later. To do this we will develop a new relationship with communities, and promote person-led choice and behaviours that make and keep people well.

For example 'The Born in Bradford' research is helping to unravel the reasons for ill health and bringing new ways of working between communities, health services and the local council to improve child health and wellbeing.

The right home environment is also essential to delivering our partnership ambitions. Housing associations provide 2.5 million homes for more than 5 million people who typically have greater social or health needs than the general population.

Research estimates that the cost to the NHS of poor housing for those over age 55 is £624m per year.

The current housing situation presents a real risk to the health and wellbeing of people, including a person's physical and mental health associated with living in a cold damp house and household income. The right home environment is essential to delivering the NHS and council plans for social care, such as preventing hospital admissions and timely discharge as well as the wellbeing of people who are homeless – who we know are some of the most vulnerable people in our communities.

Another important part of our work is increasing the contribution of our staff to prevent ill health and wellbeing through **'making every contact count'.** This includes health promoting hospitals, tackling smoking, obesity, and heavy drinking. Key to achieving this is how we work as a partnership to influence and prevent ill health with public health colleagues and voluntary community organisations.

We continually look for opportunities to prevent people becoming ill; working together to understand what has a major impact on people's lives, including child poverty.

The right interventions will lead to people making informed lifestyle choices and feeling more in control of their life.

Our ambitions regarding smoking, alcohol and diabetes.

Smoking: We want to see a reduction of 125,000 smokers. Recent figures show we have reduced this to 23,300 fewer people smoking in 2015/2016.

Using recent work by the Healthy London Partnerships on prevention and savings, this reduction will give **£17.1m of healthcare savings over the next five years.** This is good progress overall but masks differences across our area.

£17.1m
of healthcare savings

Alcohol: Tackling alcohol related harm; including those attending hospital, as well as a focus on early prevention are part of our plan.

This requires a joined up approach with all partners and highlights the importance of balancing different people's circumstances and needs.

Focus on early **prevention**

National Diabetes **Prevention Programme**

Diabetes: We are applying the National Diabetes Prevention Programme to **reduce the numbers of people at high risk of becoming diabetic.**

This programme provides education on healthy eating and physical exercise **programmes to support people to lose weight – a key risk factor for type 2 diabetes.** Leeds and Bradford are up and running and the rest of our partnership has signed up.

Reducing health inequalities

There are long standing health inequalities across West Yorkshire and Harrogate. Whether compared to England as a whole or between different neighbourhoods within our area, too many people are dying too early and/or spending more years in ill health. Addressing these inequalities is a partnership priority.

Health inequalities arise for many reasons and cut across all age groups, including before a baby is born. Household income, housing, education, employment, loneliness, and disability can affect people's health. Creating the conditions for people to take control of their lives is central to making progress on health inequalities. To do this requires co-ordinated action by government, local councils, the NHS, community organisations, the private sector and the public. For example, we know that living in poverty has an impact on people's health and behaviours. This is often linked to those conditions most related to health inequalities such as cancer and cardio-vascular disease (such as heart attacks) through smoking, heavy drinking, drug use and being overweight.

We also know that living in an urban area with green spaces has a long-lasting positive impact on people's mental wellbeing. For example **people living in greener neighbourhoods display fewer signs of depression or anxiety.**

Work is taking place across West Yorkshire and Harrogate to help promote environments which support healthy eating communities. This includes local councils reviewing the amount of fast food outlets in any one area and how close they are to schools etc.

Travel incentives for people living in rural communities, including the elderly, and access to green spaces and outdoor activities is important to both physical and mental health.

Affordable healthy eating and physical activity is often determined by where people live and work. There have been repeated messages that investing in preventing ill health can improve health and life expectancy as well as offering significant short, medium and long term savings for the public purse. This requires a refocus on a need for investment by NHS services and local councils working together. As well as recognition that many groups of people have additional needs such as people with a disability or mental illness, minority groups, the homeless, refugees and asylum seekers, the elderly and unpaid carers etc.

We are looking for a new relationship with people in West Yorkshire and Harrogate that recognises that councils and health services alone are not the things that make communities healthy.

International evidence shows how the health of people is mainly determined by socio-economic, environmental and genetic factors **(Health Foundation, 2017).** These factors are hard to influence from within the NHS but partners such as local government, **West Yorkshire Combined Authority,** universities and business can apply significant pressure via a **'Health in All Policies'** approach.

'Inclusive Growth' has emerged as a key factor in local policy discussions and central to this is bringing economic and health strategies closer together.

Evidence shows that opportunities for employment and skills development are factors which can impact on people's health and wellbeing. Public sector partners have a key role to play, **supporting local businesses, alongside the voluntary and community sector,** and exercising their economic and social influence in this important area of work.

Preventing diabetes

There are 226,000 people at risk of diabetes in West Yorkshire and Harrogate. Our aspiration is that 50% of these are offered diabetes prevention support, with a 50% success rate. **We have secured diabetes transformation money of £2.7m to improve care for people across the area** at risk or currently living with this long-term health condition. We have been awarded funds in each of the six local places which make up our health and care partnership (see page 5).

Bradford Healthy Hearts campaign

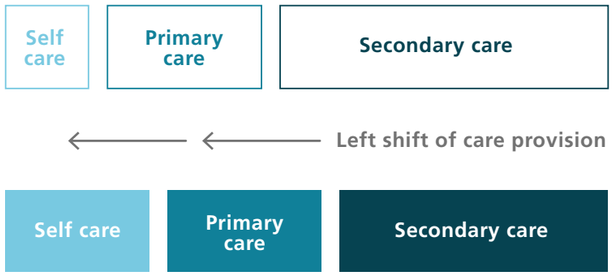
The campaign is supported by wider health and wellbeing initiatives, particularly local self-care programmes and activity relating to **effective management and prevention of diabetes**. As well as preventing cardiovascular disease (CVD) the clinical commissioning groups also ensure that people who do have CVD are supported to manage their symptoms. Our West Yorkshire and Harrogate partnership will help the development of Bradford's CVD prevention and management programme, expanding good practice across the rest of the area through shared learning.

For more information watch this film, in which Corinne Harvey from Public Health England talks about preventing ill health and inequalities.

Primary and community care

Primary and community care includes a wide range of services supporting the health and wellbeing of everyone in the community, including local GPs, pharmacies, community mental health teams and social care.

Primary and community care working together is the cornerstone of our plans (see page 12). The vast majority of care and support is provided in communities. Our vision depends on people being supported to stay well at home (we know this is where people want to be) and in their communities. Primary and community care services have a critical role in making sure this happens. This is the first point of call and people's experience of health care is usually through these services.



There is clear evidence that strong community care can offer better health for people, and more effective management of long term conditions, high levels of public satisfaction, and reduced demand on hospital services.

However we know that GPs and community services have come under increasing pressure in recent years and new investment is needed and some current ways of working need to change. **We need to ensure care is delivered as close to a person's home as possible.**

Fundamental to our plans is the idea of left shift. We want to support people so they can manage their own health and help manage their conditions in their community when they become ill.

Wherever possible we want to move towards self managed care. Some people who have a health condition could potentially take an increasing role in managing their condition alongside health professionals, and are often more motivated when they are given the chance to share their experience with others in the same situation.

We also need to reduce the deterioration with high level care needs, long term health conditions and disabilities to become less reliant on hospital and emergency services, where safe to do so. Having care closer to home and looking at the whole person's needs is a priority to us.

Our primary and community care delivery plan will set out the work we are doing. It will be published in the next few months on our website. It includes the following elements:

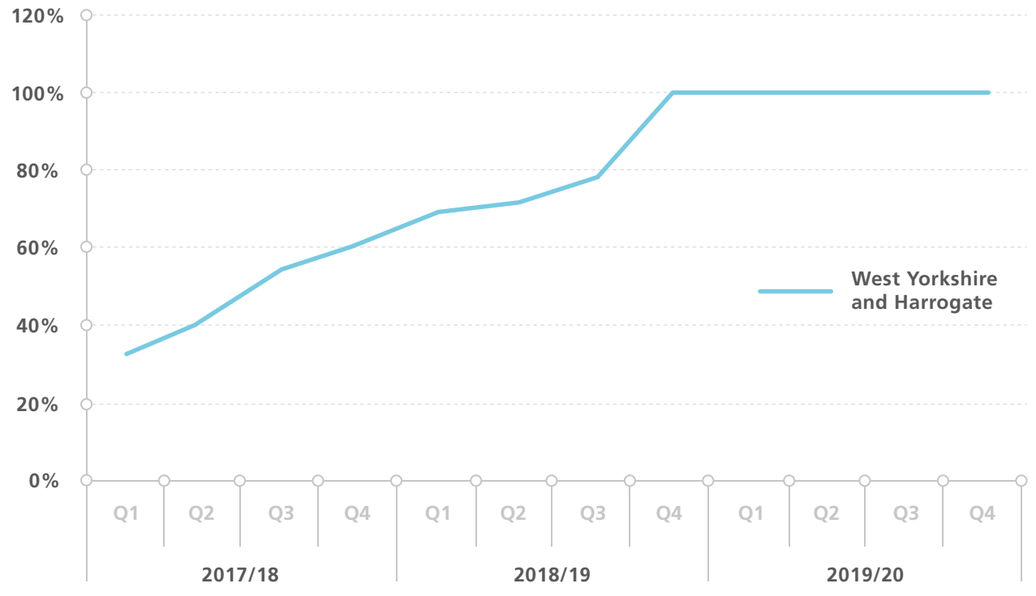
Better access to GP services

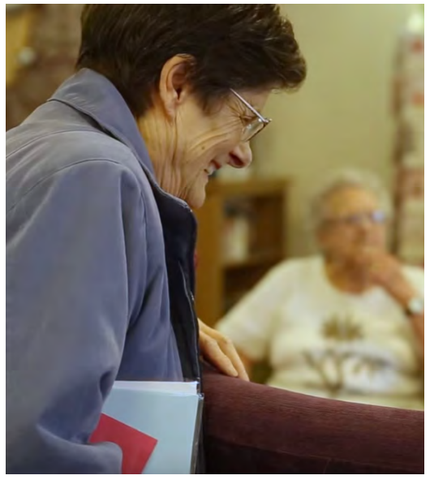
In line with the General Practice Forward View ambitions, we are working to provide more convenient, consistent and fair access to GP services, whilst making sure people with urgent care needs receive a timely response in the most appropriate way.

We know that services are not as convenient for some people as we would like them to be and that they would like to receive services on evenings and weekends.

Our ambition is to **extend opening hours so that 50% of people have more choice** by March 2018. We want to extend this way of working across West Yorkshire and Harrogate by March 2019. We are making good progress with this. Clinical commissioning groups, who buy health services, have plans in place to deliver 50% uptake by March 2018.

% of population receiving some level of extended access





New ways of working

In each of the six places (see page 5) new ways of working are being developed.

30,000 - 50,000
people covered

These involve groups of GPs and other care providers; including dentists and ophthalmologists (specialist in medical and surgical eye disease), **working closely together in networks covering populations of 30,000-50,000 people.**

These networks support various services working together, including community nursing and community mental health services. This way of working will become the norm over the next three years.

Watch this film about social prescribing – which tells you all about a project in Leeds.

Health in our care homes

Working well with independent providers, for example care homes, is very important when managing the current pressures in health care.

We recognise the important role care home providers play in caring for our most frail and vulnerable people.

They are under increasing pressure to recruit staff and deliver quality care that meets the expectations we would want for our families.

Two of the six national *enhanced health in care homes* pilots are in West Yorkshire and Harrogate – these are **Connecting Care Wakefield District and Airedale and Partners.** They are moving away from traditional ways of delivering support in care homes towards care that is more centred on people's needs, and those of their families and care home staff. This way of working can only be achieved through a partnership which aims to provide continuity of care for people, timely medicines reviews, hydration and nutrition support which is all about reducing the risks of malnutrition and dehydration while people receive care and treatment, and referral to out-of-hours services and urgent care.

These pilots have helped develop a strong approach to co-ordinated care which includes people having access to the right health care services in the place of their choosing and reducing unnecessary visits to hospitals, admissions, and length of stay.

Other work outside of the pilots is taking place, for example 'QUEST' in Calderdale. Calderdale clinical commissioning groups and Calderdale Council have invested in telehealth and telecare solutions, benefitting up to 1,000 people in care homes. Telehealth uses technology to provide services that help in the management of long term health conditions, including chronic obstructive pulmonary disease (COPD), chronic heart failure (CHF), diabetes and epilepsy.

Telehealth helps people to take more control over their own health, with information about their health condition being **monitored regularly to flag up issues before they become 'care critical'.**

committed
to boosting GP numbers

Primary and community care staff

Improved access requires staff working in different ways.

We are committed to boosting GP numbers – in line with the General Practice Forward View and it is clear that our future workforce needs to look different from how it does today, with more practice nurses and others taking the pressure off our GPs, and a wider range of services working as part of the primary and community care offer.

People with high level health and care needs, need teams of professionals working together to focus their combined expertise to achieve improved health and wellbeing for them.

This change in care requires a shift in skill mix to transform services for the better. The West Yorkshire and Harrogate Local Workforce Action Board has recommended that we invest in GPs and meet requirements such as those described in the GP Five Year Forward View.

We will see new teams emerging over time, with an increased role for non-medical staff working alongside medical staff and new roles alongside traditional roles. Some local modelling has been undertaken based on the current workforce challenges and potential transformation in service, suggesting the following to happen by 2021:

- 150 new GPs every year across our area.
- 50 new nurses every year working in GP surgeries or health centres across the area.
- 50 new clinical pharmacists every year, providing care, medication and health promotion in GP surgeries or health centres.
- 50 new advanced allied health professionals every year, including paramedics, emergency care practitioners, physiotherapists and occupational therapists.
- 50 physician associates every year working in GP surgeries.
- Health care support workers working from GP surgeries and health centres.
- 70 new clinical support workers (health care assistants) every year.
- Development of 70 practice clerical support workers every year into public facing roles such as a care navigators.
- 70 mental health therapists.
- Training of 70 existing and new volunteers as community champions, wellbeing ambassadors and experts by experience.

We recognise that as we start to see new teams and models emerge, these numbers are likely to change.

We are making good progress with expanding multidisciplinary primary care (these are teams of doctors, therapists, social workers and community colleagues all working together) and we are in line with our plans for recruitment of clinical pharmacists in general practice.

Significant progress in general practice has been made. We continue to recruit clinical pharmacists into the practice team as part of the NHS England National Scheme.

We are also looking at other long-term solutions including area wide nurse training and development.

GP buildings and digital technology

Making sure our buildings are suitable and fit for modern healthcare is an important part of our plan. Our clinical commissioning groups have local estate plans and digital maps to inform priorities for investment.

To get the full benefit of technology, we also need to look at how all our systems talk and link up to each other.

Investment

Strengthening services in this way will need increased investment. **Between now and 2021 our clinical commissioning groups (CCGs) plan to invest a total of £75million in GP services across the area.** This increase is higher than the growth in total funding available, and reflects the importance of investing in these services to achieve our ambitions. The funding will be used to expand and invest in staff, and support the development of new ways of working.

Urgent and emergency care

We need to rethink the way urgent and emergency care is provided to ensure more options are available away from hospital, ensuring our A&Es are supported by better primary and social care.

Our approach is about making sure the right treatment is received at the right time, and protecting A&E services so that they are there when they are most needed. We also need to think about how other services, such as GP practices, pharmacists, community care and mental health services need to improve, so that people are supported before their needs become urgent.

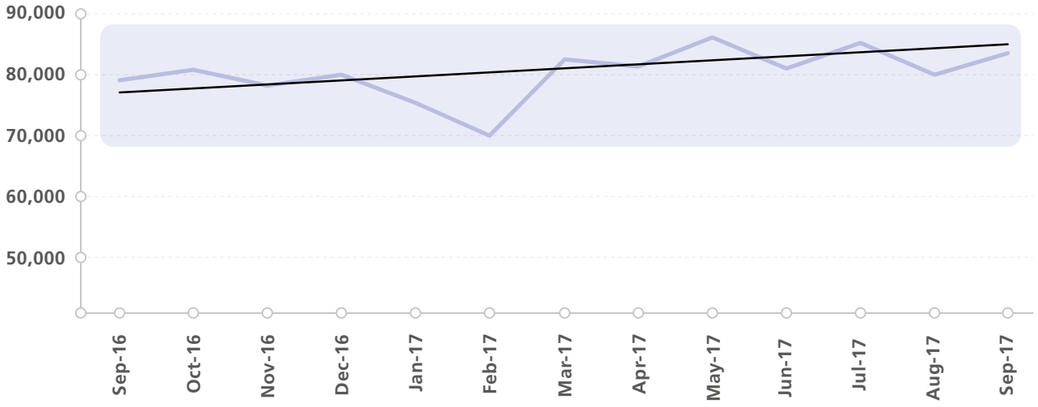
Urgent and emergency care is too often relied on because other services are not there. Our systems are complicated and people can find it hard to navigate their way around especially when they are unwell. People only need to remember three numbers 999,111 and their local surgery.

Recently the number of people attending A&E has been growing at 6.6% per year.

This is higher than the England average, faster than the rate of population growth, and greater than the pressure we would expect from this change. This level of growth is unsustainable within the funding that has been made available to the NHS.

Our partnership working in this area is well established. The West Yorkshire and Harrogate urgent and emergency care national pilot ended in March 2017. Through this programme we developed new ways of working so that NHS 111 call handlers can book appointments into some GP practices. This is being rolled out to another 100 practices in 2017/18.

Total A&E Attendances



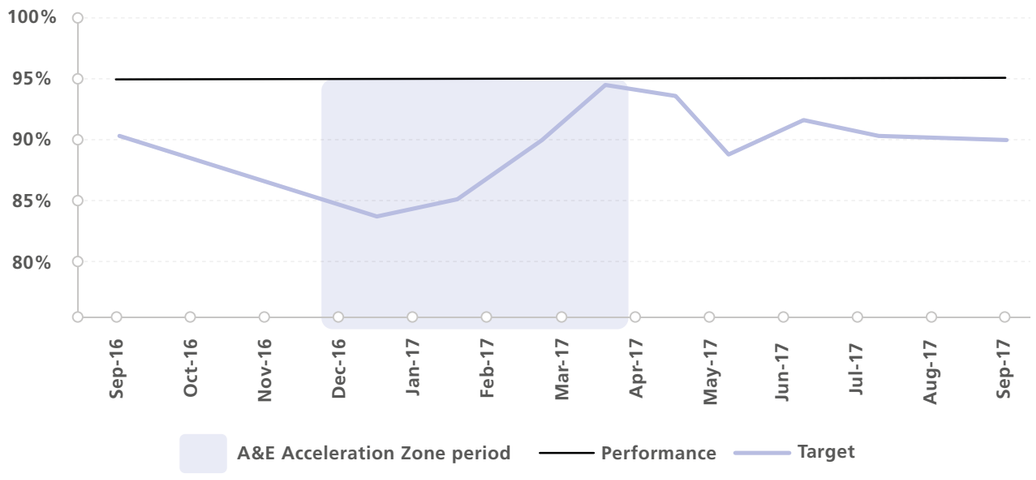
We have established the joint 999/111 Clinical Advice Service within Yorkshire Ambulance Service.

The aim is to increase the number of callers into 111 getting clinical advice on the phone, resulting in fewer people needing to go on to use more acute services. We have also led a joint procurement exercise across nine hospitals to provide the best value regional imaging solution (imaging solutions includes diagnostic equipment) to improve people's experience.

Early in 2017 the A&E acceleration zone programme focused on rapidly improving the way A&E functions to better manage demand. We achieved a 10% improvement in A&E performance in the final four months of 2016-17.

While there is more to be done to sustain this improvement and return to 95% achievement of the four hour A&E standard, we can see clearly what can be achieved through partnership working towards a common goal.

A&E 4 hour wait performance



Our ambitions for urgent and emergency care are highlighted in our milestone document here. This includes:

NHS 111: Roll out of NHS 111 online to cover all of West Yorkshire & Harrogate; increasing clinical contact through NHS 111 calls to 50% by March 2018, and expand direct booking to GP practices from NHS 111.

GP access: Increase extended access so that 100% of people have evening and weekend appointments by March 2019.

Ambulance services: Increase hear, see and treat services, to reduce the need for people being taken to hospital. Treatment starts when our ambulance crew arrive.

Hospital services: Including delivery of the 95% four hour A&E waiting time standard; co-located GP support; consistent adoption of the frailty pathway and SAFER bundle and more trusts having psychiatric liaison in place by October 2018.

Improving hospital to community care: Reducing the rate of delayed transfers of care to a minimum of 3.5%; increasing the number of continuing healthcare assessments in the hospital; and delivering effective discharge consistently across West Yorkshire and Harrogate.

The **Urgent Emergency Care Programme Board** oversees the delivery plan, connecting with the five A&E Delivery Boards across the area. Through our partnership we have begun a process of peer support so that we are sharing and learning what works well.

Dr Adam Sheppard, Chair of the West Yorkshire and Harrogate Urgent Emergency Programme Board explains the importance of people receiving the right care in the right place at the right time in this film.

Direct booking

If a person wants an urgent GP appointment they contact their surgery directly for an appointment during surgery hours. However, information shows that a certain amount of booked GP appointments were not needed and people could have received care elsewhere, for example by speaking to the pharmacist or a nurse. Our work has helped to join this up.

Going forward, people will be able to ring NHS 111 and if NHS 111 agrees that they need to be seen by Primary Care they will be able to book an appointment directly into a suitable service. This may not be their own GP practice but could be an urgent treatment centre or GP extended services. This will save people time by not having to make several phone calls and will also make sure that they are directed to the best place possible to meet their health need. This way of working was developed in partnership with West Yorkshire and Harrogate clinical commissioners and 20 pilot GP practices. The information received so far is that this offered a swifter service to people who would have otherwise attended A&E.

Mental health

There is strong evidence that tackling mental ill health early improves lives.

If you are a man with a severe mental illness in West Yorkshire and Harrogate you are three times more likely to die of circulatory disease (smoking, an unhealthy diet and stress all increase the risk of heart disease; a heart attack or stroke can occur if the circulatory condition is untreated) and you are twice as likely to die of cancer than someone who is mentally well.

This is equally true across a range of other common conditions, and the result of this that your life expectancy is **18.6 years lower**. Our mental health work across West Yorkshire and Harrogate aims to redress this imbalance. We are developing a local service framework for mental health and strong partnership on child and adolescent mental health services, low, medium and secure forensic services, autism and suicide prevention.

Watch this film Nicola Lees, Mental Health Lead for the Health and Care Partnership and Chief Executive of Bradford District Care NHS Foundation Trust, talks about our priorities for mental health services in this film.

Our ambitions include:

40% A 40% reduction in **unnecessary A&E attendance.**

A zero suicide approach to prevention (with an aspiration of **10% reduction in suicides** overall, and a 75% reduction in numbers in mental health settings by 2020-21).

A reduction in Section 136 place of safety episodes both in police and health based places of safety. Section 136 gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder, to a place of safety.

12 Elimination of out of area placements for non-specialist hospital care.

A reduction in waiting times for autism assessment.

To help make sure we meet these ambitions the four organisations (South West Yorkshire Partnership NHS Trust, Leeds and York Partnership NHS Foundation Trust, Bradford District Care NHS Foundation Trust and Leeds Community Healthcare NHS Trust) are working together, alongside clinical commissioning groups (CCGs), to strengthen partnerships and share delivery of specialist and acute mental health services.

Through these closer working arrangements we will share best practice across West Yorkshire and Harrogate, for example reducing out of area placements for non-specialist hospital care over the next 12 months. We are already achieving this in some areas across the partnership.

Our aim is to ensure that people are supported in the least restrictive environment, ideally in a community setting close to home, rather than in hospital.

We are developing a single West Yorkshire and Harrogate operating model for the management of acute mental health inpatient beds and a West Yorkshire and Harrogate commissioning approach for mental health hospital services for 2019-20, which will operate in shadow form in 2018-19.

In the last 12 months we have:

- ✓ Produced and launched West Yorkshire suicide prevention strategy **[available here].**
- ✓ Started the development of new care models for child and adolescent mental health services and adult eating disorders. These models will provide a consistent level of service across the region with more care in the community. This will avoid acute hospital admissions unless absolutely necessary. This will ensure that front line services have greater control over funding.
- ✓ **Successfully secured £13m of capital investment to build a new Children and Adolescent Mental Health Unit in Leeds.**
- ✓ Agreed, and from April 2018 we will implement a co-ordinated bed management approach for acute mental health beds, helping to ensure we stop people having to travel outside of the area for a bed.
- ✓ Developed a new perinatal mental health service which will have staff based in all locations across the area.
- ✓ Successfully secured £800,000 transformation investment to improve mental health liaison services.

Listen to Bev in this film talk about bipolar disorder, mental health stigma and her work in Leeds to support others and the pressure on young carers.

Paul talks on film about Schizophrenia and the impact this has had on his life and how he wants to help others living in Leeds and wider.

Peter explains on **film** how we can help men who contemplate taking their life.

Through our innovative approach to mental health, Wakefield now has mental health navigators within Wakefield District Housing helping people to navigate their way around health and housing services. There is also a new initiative which sees mental health nurses working with police in the Wakefield control room to enable officers to provide a more appropriate response to people who present with mental health issues.

The 'Creative Minds' programme at NHS Foundation Trust was launched in 2011. It has delivered over 250 creative projects in partnership with over 100 community organisations and benefited more than 20,000 people. We were delighted when Creative Minds received the 2014 Health Service Journal Award for Compassionate Care.

In Harrogate we are piloting a project with a local community organisation for people with long term mental health problems with the aim of supporting them back into community life, by reducing reliance on mental health services and working towards employment. Harrogate has also introduced an all age mental health crisis response through single point of contact.

Bradford's crisis care partnership and first response services have received national recognition and they have had no out of area placements for people needing an acute mental health bed in over a year. Being part of the West Yorkshire and Harrogate partnership will help strengthen the work to improve mental health and wellbeing through shared learning across our area.

The service offers mental health crisis support 24 hours a day, seven days a week, to vulnerable people needing urgent crisis support. A single phone number means that people can self-refer.

Getting involved early and signposting to the right service, has reduced demand on the police, ambulance services and A&E departments, and achieved a 50 per cent reduction in people detained under section 136, which gives police the power to take someone to a place of safety.

NHS Greater Huddersfield and North Kirklees Clinical Commissioning Groups and Kirklees Council have worked to improve access to children's mental health services. This included agreeing additional funding for autistic spectrum condition assessments, launching a one-stop-shop phone service for children and young people with emotional and mental health needs, developing a regional eating disorder service and piloting a scheme to provide support to school pupils with autism and mental health needs.

Cancer

Our draft proposals in November 2016 identified cancer as one of our top priorities.

Every week 250 people in West Yorkshire and Harrogate are diagnosed with cancer, and every week 115 people will die as a result of it. There are also significant differences in the chances of surviving cancer, depending on where you live, your gender, your ethnic background and how early your cancer is diagnosed. Screening rates are also generally low across our patch – for example, around 14,000 women eligible for breast cancer screening are not taking up this valuable opportunity. World class facilities , such as the internationally recognised Leeds Cancer Centre, need a world class approach to early detection and prevention if we are to improve people's experience and outcomes. We are placing more emphasis on prevention by tackling lifestyle choices which can impact on cancer, as well as investing in earlier diagnosis, new treatments and better support to help people live well beyond their cancer diagnosis. By doing this, we have a much better chance of reducing the incidence of cancer, of treating it more effectively and of reducing the longer term impact of a cancer diagnosis.

This will also contribute to our wider objectives for reducing the unacceptable differences between the most and least healthy people in the West Yorkshire and Harrogate area.

As part of our commitment to ensuring the voices of all those affected by cancer are listened to, we have worked with people to record their experiences and share their stories. **They're available here.**

We have recently secured £12.4 million of national funding to support work to improve early diagnosis and make more cancers curable through a range of projects. We have also secured £840,000 of additional transformation funding to support people living with and beyond a cancer diagnosis, and in particular to improve access to the four elements of the so-called Recovery Package – a holistic needs assessment and care plan; a treatment summary; a cancer care review and access to health and wellbeing events.

£12.4m
national funding

The focus of our programme is to deliver the best possible outcomes and experience for people affected by cancer, while spending the West Yorkshire and Harrogate pound as effectively as possible through delivering value for money care and treatment.

We will do this through a set of clear ambitions and targets for improvement:

Health and wellbeing

Reduce adult smoking rates from 18.6% to 13%, resulting in around 125,000 fewer smokers and preventing around 11,250 admissions to hospital.

Increase 1 year survival from 69.7% to 75%, equating to around 700 lives per year.

Increase the proportion of cancers diagnosed early (stages 1 and 2) from 40% to 62%, offering 3,000 extra people the chance of curative or life extending treatment.

Watch this film Professor Sean Duffy, Clinical Lead for West Yorkshire and Harrogate Cancer Alliance Board explains how we want to tackle cancer **here.**

Care and quality

Increase the number of patients actively involved in providing feedback and contributing to service improvement over and above the annual national Cancer Patient Experience Survey (CPES).

Improve the patient's care journey to ensure current cancer waiting times standards are met and go further to deliver a '28 day to diagnosis' standard for 95% of people investigated for cancer symptoms.

This could deliver faster diagnosis for around 5,000 people currently diagnosed with cancer through the routine referral to treatment 'pathway'.

Finance and efficiency

Deliver estimated efficiency savings of up to £12 million over 5 years based on lower treatment costs associated with earlier stage diagnosis for many forms of cancer.

We also need to support and increase our workforce so that so that we have the right capacity and skills.

We have provided 35 more places for clinical radiology training.

Plans are also in place for a new bursary scheme in partnership with **Yorkshire Cancer Research** that allows health professionals to enhance their personal development and speed up cancer diagnoses for people. It will support a total of 30 health professionals who have already enrolled on a training course to become a clinical endoscopist or reporting radiographer.

Our cancer work is delivered through a partnership of health, social care, individual patients, support groups and charities called the **West Yorkshire and Harrogate Cancer Alliance.**

The Alliance is responsible, on behalf of the local health and care partnership, for the local delivery of the ambitions and improvements set out in the national cancer strategy.

Our delivery plan sets out in greater detail how we will deliver our objectives across five areas of work:

> Tobacco control
> Patient experience
> Early diagnosis
> Living with and beyond cancer
> High quality services

Read more about them here.

Through the Cancer Alliance Board, we are improving our understanding of the outcomes around how we currently spend money on cancer services.

We will then compare this with what we could potentially achieve if we invested differently.

Our partnership provides the vehicle to work together across these commissioning bodies, and re-prioritise how we spend cancer funding to get the best possible health outcome.

Diagnosing cancer earlier

In West Yorkshire and Harrogate, supported by the Alliance, GPs and hospitals are already working together to test new models of service that help to diagnose cancer earlier. These new models focus on improving diagnosis for patients that GPs find most difficult to place on a specific part of the patient journey.

These are people who have vague but concerning symptoms such as unexplained pain or weight loss. They are part of a **national programme to test new ways of diagnosing cancer** earlier, known as the ACE programme – **Accelerate, Co-ordinate, Evaluate.**

new ways of
diagnosing cancer earlier

Currently, if a person attends their GP with specific symptoms (for example unexplained bleeding) they are referred quickly through a two week wait specific pathway for the relevant investigation or specialist assessment.

For those who have vague but concerning symptoms GPs need to decide which pathway is likely to be the most appropriate (e.g. bowel, stomach, lung) and sometimes these people can be referred from one speciality to another, often experiencing delays in their pathway, until they receive a diagnosis of cancer.

Specialists
together in one place

Airedale hospital has been running a 'best test' project. This established a new electronic referral system from GPs to radiology in order to get triage advice on the most suitable imaging for a patient who presents with vague symptoms. Early findings show that this triage advice is of high value in deciding how best to investigate the patients, helps to get the right first test for people, can result in fewer unnecessary tests to diagnose a cancer and for those who have a normal scan, they are quickly taken off a suspected cancer pathway, avoiding unnecessary visits to hospital and worry. People who are diagnosed with cancer are then able to start their treatment quickly.

In a further phase of national testing, both Leeds and Airedale are looking at how the model of a multidisciplinary diagnostic centre (MDC) - used to great effect in Denmark - could be adapted to work in the NHS. Rather than a patient going back and forth to see different specialists, an **MDC brings all specialists together in one place so that various tests can be done as soon as possible,** and discussed across all specialisms, speeding up waiting times for tests, reducing multiple appointments and a more efficient use of resources.

Although the multidisciplinary diagnostic service test sites have only been operating for less than a year (and with small groups of practices in the case of Leeds) the early results are encouraging.

Through the Alliance partnership we can work with the test sites, sharing learning to assess how these models could be adapted and spread across West Yorkshire and Harrogate to support our ambitions to diagnose more cancers earlier, improve survival and patient experience and make most efficient use of expert resources.

Barbara in this film explains the importance of early diagnosis. **Watch it here.**

Stroke

Stroke is a life changing event and is the third highest single cause of death in the UK.

Evidence shows the care people receive in the first few hours can make a difference to how well they recover. This includes having scans to assess the nature of the stroke and if appropriate receiving clot-busting drugs (thrombolysis) or clot removal (thrombectomy) delivered by specialist staff working in hyper acute stroke units.

You can see why this is important by watching **Malcolm and Sue's story here.**

Geoff also explains the difference community support has made to his recovery **here.**

There are challenges for the health and social care system and most importantly for stroke survivors, their families and carers.

This, alongside an ageing population, with complex health and social care needs, means we have to change if we want to continue to further improve people's quality of life with the resources we have available.

We want to make sure our services are 'fit for the future' and make the most of the skills of our valuable workforce and new technology whilst maximising opportunities to improve quality and outcomes for local people. We also want to ensure that **care across the whole stroke pathway is working effectively** to meet the current and future needs of people.

We have an ambition to eliminate unnecessary variation, improve outcomes for people who experience stroke and to give the best recovery care possible. For example:

Prevention – we need a more consistent approach to preventing stroke across West Yorkshire and Harrogate so that people receive information and advice to make informed decisions about their health. We have agreed an ambition to improve detection and management of Atrial Fibrillation (erratic heartbeat) to 89%. **We estimate that this will prevent 190 strokes over 3 years.**

Variation – depending on where you live, some people have better experience and access to specialist stroke services than others. Work is needed to reduce these differences so that no matter where people live and what time of day they are admitted to hospital, they are able to receive high quality stroke services.

Staff – we want to ensure we make the most of the skills of our valuable workforce so that we can recruit and retain the staff we need to further improve quality and outcomes for people and make sure our services are 'fit for the future'.

Technology – we want to maximise opportunities to further improve the use of technology so that our doctors, consultants and other health care professionals can provide earlier assessment and treatment of people, provide improved access to specialist technology, which we know can save lives.

Stroke rehab and aftercare – improving health outcomes from prevention to specialist treatment to rehabilitation and after care.

Our work has been informed by a programme of engagement – **a summary can be found here.**

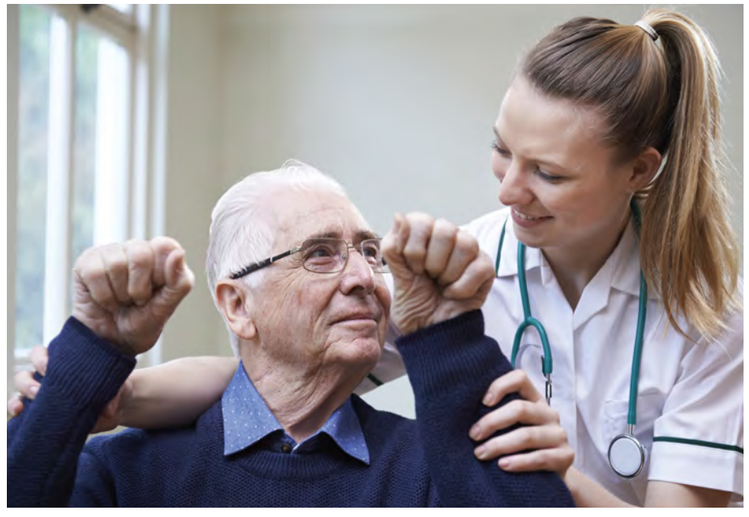
Over 1500 people gave their views via an online survey, outreach sessions with voluntary and community groups, and interviews with people in GP practices, rehabilitation units, stroke wards, and libraries.

Stroke consultants also took part in sessions so that people could hear first-hand about the care and support available from health professionals.

You can read more here.

We are now in the process of working up options for how hyper acute stroke and acute stroke services could be provided across West Yorkshire and Harrogate.

To find out more, **watch this film with Dr Andy Withers,** Chair of the West Yorkshire and Harrogate Stroke Group.



The **work** was also discussed at the Joint Committee of the 11 clinical commissioning groups meeting in November 2017 (held in public) and consultation will follow as appropriate in 2018.

Improving planned care and reducing variation

There is a big opportunity to standardise our commissioning policies and reduce differences for people receiving health care in different places across West Yorkshire and Harrogate.

These differences are often referred to as a 'postcode lottery'. Reducing unnecessary differences helps to ensure that what care people receive is fair and consistent no matter where they live. **We are tackling differences in four key areas:**

Health and wellbeing - We are exploring the potential for supporting healthier choices with people. This is about supporting people to stay healthy so that we give people the best chance of their treatment being effective, and reduce the likelihood of them needing treatment in the future.

Clinical thresholds and policies - Bringing together a consistent set of commissioning policies based on good practice from West Yorkshire and Harrogate CCGs and elsewhere. This includes developing approaches to ensure they can be consistently applied across the area.

Out-patients and follow-up appointments - Each year in the NHS there are 'follow-up' outpatient appointments where people are asked to return to hospital to have their progress checked, to undergo tests, or to get results. Whilst some of these appointments are needed, a large amount could be done differently. We want to re-think how out-patients and follow ups are done. This might mean fewer visits to the hospital, and telephone calls, online services or an appointment at their GP practice could be used instead. **This would free up time for the treatment of new people, and would save people time and money by not having to attend the hospital when they don't really need to.** We are going to develop these new approaches in elective orthopaedics and eye-care services in the first instance, and we will work closely with patients and the public to understand how we can best meet the needs of people living in West Yorkshire and Harrogate.

Prescribing treatments and medicines - By identifying and addressing differences in policy we can reduce the variation in access to medicines across West Yorkshire and Harrogate. We will also take steps to reduce medicines waste for example through the better management of repeat prescriptions. We will work with hospitals to reduce the amount spent on high-cost medicines through switching to drugs of lower cost but equal effectiveness. **Our aim is to develop a consistent approach across all of our clinical commissioning groups by 2020-21. The first set of policies will be agreed at the Joint Committee next year.**

Healthwatch engaged people on follow-up appointments in spring 2017. This led to 502 people completing the survey. You can read this here. The main themes raised were that, people were supportive of being able to have their follow-up appointments in a different way, and most wanted these to be done face-to-face so they were able to ask questions.

Maternity

This is about maternity care and it is about preparing for pregnancy – making sure people have the information and advice to make life choices before getting pregnant so women are in the best health before and after they give birth.

In support of NHS England's National Maternity Review, we have established a West Yorkshire and Harrogate Local Maternity System Board.

The Board's vision for maternity services is based on the needs of women, their partner and their families. It has been developed together with them. Our work is all about developing a culture across maternity care which puts women and their babies at the centre of care, improves choice and personalisation, supports professionals working and learning together and has the safety of women and their babies throughout.

We are:

> Implementing the local vision for improved maternity services to make sure **there is access to services for women, their partners and families, regardless of where they live.**

> Developing perinatal mental health **services to support women,** before, during pregnancy and after birth.

> Ensuring women, their partners and **families can easily access the right care,** in the right place at the right time.

> Making sure that maternity care providers in West Yorkshire and Harrogate work together so that the needs and preferences of women, their partners and families are paramount.

> Putting in place arrangements to support **services to work together effectively.**

> Making sure that women, their partners and **families and local communities are involved in developing and designing maternity care.**

> **Supporting a learning culture** between NHS staff, partners and fostering workforce co-ordination and training.

> **Engaging with children and family services** at local councils.

The number of births was 31,961 in 2015

> The number of all babies born, in 2015, with low birthweight was **8%,**

with a very low birth weight was **1.3%,**

and term babies with a low birth weight was **8%**

> Stillbirth rate for 2013 -15 is **4.9 per 1000**

> **70.6%** of women in 2014/15 were breastfeeding to begin with

> Infant mortality for 2013 to 2015 is **4.5 per 1000**

> Smoking status at time of delivery in 2015/16 was **13.1%**

We believe all women, their partners and their families, should have access to information to help them make decisions about care; and that every woman and baby should be able to receive support centred on their needs and circumstances.

All staff working in maternity should be well supported to deliver care which is centred on women, their partners and families.

They should work in high performing teams, in organisations which are well led, and in cultures which promote innovation, continuous learning and work across professional boundaries.

Watch this film where Carol McKenna, Co-lead for the Maternity Board talks about the **importance of good maternity care.**

Hospitals working together

There are six hospital trusts in West Yorkshire and Harrogate:

> Airedale NHS Foundation Trust

> Bradford Teaching Hospitals NHS Foundation Trust

> Calderdale & Huddersfield NHS Foundation Trust

> Harrogate & District NHS Foundation Trust

> Leeds Teaching Hospitals NHS Trust

> Mid Yorkshire Hospitals NHS Trust

The six trusts have come together as the West Yorkshire Association of Acute Trusts (WYAAT).

The association believes that the health and care challenges and opportunities facing West Yorkshire and Harrogate cannot be solved through each hospital working alone in competition with the others; they require the hospitals to work together to achieve solutions that improve the quality of care, increase the health of people and deliver more efficient services for the whole population.

The way we work together

✓ **Specialist hospital services** delivered through a centres of excellence approach.

✓ **Collaborating to develop clinical networks** and alliances for secondary services which increase resilience while protecting local access for patients.

✓ **Standardisation across all our services** based on common West Yorkshire and Harrogate protocols, procedures and pathways so all patients receive the same high quality of care wherever they are treated.

✓ Workforce planning at scale to create **a highly skilled, capable, resilient and productive workforce** with the capacity to meet patient demand with high quality services.

✓ **High quality and efficient clinical and corporate support functions** by collaborating and sharing services to achieve economies of scale.

The association's current work can be broken down into the following programmes:

Workforce

> Developing West Yorkshire and Harrogate wide medical and nursing 'banks' to provide cost effective temporary staff and reduce the need for expensive agency and medical locum staff.

> Setting up the West Yorkshire Centre of Excellence to provide apprenticeships for all WYAAT trusts.

> Standardisation of workforce polices and processes such as: consultant job planning; common job descriptions and pay banding for the same role in every trust; and a single approach to locally determined terms and conditions.

Support programmes

By bringing together their buying power, the six trusts are often able to negotiate reduced prices for the essential goods and supplies needed to provide services. **This work has already delivered around £500,000 of savings.**

Information management and technology (IM&T) is an essential enabler for every trust's services and the association is discussing the potential for common clinical and business IT systems that talk to one another. The association is also looking to improve the efficiency and effectiveness of the trusts' IM&T services, for instance through common cyber-security software and a shared email solution.

Every trust owns a large number of buildings and the association is working together to increase their efficiency and make best use of all the buildings.

Clinical support programmes

Trusts have approved a business case to establish a shared supply system for medicines. Not only will this increase efficiency and save money, but it will also increase quality by releasing pharmacists' and nurses' **time to look after patients on wards and increase safety by enabling standardisation of medicines across all the WYAAT trusts.**

The WYAAT trusts plus others in Yorkshire and the Humber are putting in place a new IT system (known as a 'Picture Archiving and Communication System', PACS) to help them manage and share radiology imagery. This should be complete in all trusts by the end of 2019. At the same time, the association will be working with doctors and other healthcare staff to standardise processes for diagnostic imaging (such as X-Rays and Magnetic Resonance Imaging) in order to increase quality and improve efficiency. **Together these two programmes will help us cope with the increasing demand for imaging.**

Through the association, the trusts have agreed to form a West Yorkshire and Harrogate Pathology Network to enable their laboratories to work more closely together. This includes putting in place common IT systems to help trusts share testing and reporting of results.

Clinical services programmes

The trusts have agreed that vascular services (diseases of the blood vessels, arteries, veins and circulatory system), both surgery and interventional radiology, should be delivered as a single 'West Yorkshire Vascular Services Network'. Consultants from all trusts will work together as a single team, often providing care in more than one hospital in the network.

Using data from the national 'Getting It Right First Time' programme the trusts are starting work to identify and minimise unwarranted difference in planned surgery, initially focussing on orthopaedic surgery as it is one of the highest volume specialties. **The programme will standardise processes, protocols and pathways across West Yorkshire and Harrogate** to bring all care up to the highest standards of quality and efficiency.

Our staff

Our staff are our most important asset.

Around 70% of the £5billion we spend each year pays for our workforce - over 100,000 people work in health and care in West Yorkshire and Harrogate.

The number of staff has been increasing year on year, but the increasing pressure of work, and the ongoing pay restraint, has made it challenging to recruit and retain enough staff to meet our needs.

Specialties and staff groups, such as emergency medicine; psychiatry; specialist radiology; gastroenterology; microbiology, histopathology have particularly significant challenges.

'What' we need to do is relatively well known and understood. The 'how' we do it, is more challenging. For example, we have heard that:

> **Local employers compete for scarce skills,** often between neighbouring organisations.

> **Voluntary and community workforce is essential** in offering early help and maintaining people's independence.

> Current employment models hinder rather than help employee flexibility.

> There are well known 'supply'/ shortage issues in some professions, yet alternative ways of working are difficult to introduce consistently.

> **Improved primary, community care and social care services are the answer to many challenges,** yet the capacity of this workforce is stretched and employers find it hard to recruit and retain staff.

> **High quality and efficient clinical and corporate support** functions by collaborating and sharing services to achieve economies of scale.

We want West Yorkshire and Harrogate to be a great place to work.

Our Local Workforce Action Board (LWAB) has developed a West Yorkshire and Harrogate workforce plan which **describes the issues and challenges we face and sets out our plans to achieve this.**

Council staff are an important part of our workforce. For example colleagues in front line social care, children's services and public health are core to the conversations we are having on how local partnerships can change and develop to ensure we have effective transport services to and from our hospitals across West Yorkshire, ensuring our air quality improves particularly in towns and cities and ensuring physical activity opportunities are built in to new and redeveloping housing and public spaces. **The strategy includes the following actions:**

Maximising the contribution of the current health and social care workforce

> Improving recruitment and retention in all areas

> Exploiting skills development

> Improving health and wellbeing of the workforce.

Getting more people training for a future career in health and social care

> **Increasing the numbers in training to work in health and social care roles,** specifically focusing on support workers, the registered workforce (nurses, doctors and allied health professionals) and advanced clinical practitioners.

Growing the general practice and community workforce to enable the 'left shift' (see page 22)

> Increasing the numbers, developing new roles and changing the makeup of staff in primary and community care.

Transforming teamwork

> **Strengthening capability** to implement new 'workforce team' models.

Making it easier to work in different places and different organisations

> **Developing flexible employment models** across organisations – including lead employers for some contracts, and new models of employment contracts.

Agreeing and tracking workforce productivity measures

> Including a number of specific targets for productivity measures, **including reductions in sickness absence, bank and agency spend and turnover. We are already seeing reductions in agency spend.**

Strengthening workforce plans

> Ensuring that the workforce issues are built into all of the WY&H work programmes, taking in to account national strategies and priorities.

Establishing a workforce investment plan and fund

> We will develop a comprehensive workforce investment plan and a strategic workforce investment fund. **This will bring together employers, commissioners and national bodies around a sector wide approach.**

> Establishing a 'workforce hub' in partnership with Health Education England.

> This hub would provide the infrastructure for joined up workforce planning and training across WY&H. It will undertake strategic workforce planning, education and development; a point of co-ordination across programmes and each place; and ensure improved workforce information and analysis.

> **Establishing effective workforce infrastructure** in each place.

> **We will strengthen workforce partnerships** that exist in each place.

Unpaid carers

In addition to the paid workforce, we estimate that there are around 260,000 carers in West Yorkshire and Harrogate.

As the population ages, the number of people who become carers is increasing. This, combined with changes in retirement age, means the demographic of unpaid carers across the country is altering too. This will become more complex as the changes in the retirement age means people will be working until much later than is currently the case and therefore juggling work and caring for others longer.

Barbara talks about her husband Paul developing dementia in this **short film.**

Sally talks about her husband Steve's experience of Alzheimer's and their readjustment to life. **Watch it here.**

Across our area there are a significant number of working carers, many of whom struggle to cope with managing their caring responsibilities alongside work. There is also evidence that people who are carers can have poorer health than those who are not. **We aspire to be a place where working carers are recognised and supported to remain in work.**

As a partnership we recognise that unpaid carers are a significant partner in health care.

There is some excellent practice across our area, we need to use the partnership working to share good practice. We are a national exemplar for our carers work, and there are four early priorities for our work:

> Supporting carers in the workforce

> Supporting young people who are carers

> Making sure hospital care is carer friendly

> Identifying carers through primary care.

Fatima Khan-Shah, Lead for Unpaid Carers West Yorkshire and Harrogate Programmes, talks about the **aims of the work here.**

Listen to how Judy and Chris talk about how they care for one another **in this film.**

Digital ways of working

All of our work is supported by technology.

As in everyday life, technology is transforming the way people receive and use services, and the way that organisations connect with each other to deliver joined up care.

Building an effective digital infrastructure

We are working to establish an effective digital infrastructure which enables IT systems and organisations to connect. Our approach is based on the 'anytime, anywhere, any place' philosophy. This will allow health and care professionals to work across public sector buildings.

We have three main programmes of work:

> **A new health and social care network** will replace the separate digital networks that connect buildings to the required IT systems across the area. Procurement will be completed in spring 2018;

> **Funding has been made available to allow all our GP Practices to apply wifi.** This is currently live in Leeds and will be extended to the rest of the area in the next 12 months. **Our ambition is that two thirds of practices will have wifi by March 2018.** This will be free to use by the public, and will help point them to health and care advice.

> We are implementing 'Govroam', which allows people visiting another connected organisation to log on to its wifi using their own username and password. This will realise savings and **make it easier for staff to stay connected.**

There is huge potential for digital technology to support healthier lifestyles, allow people to manage their own healthcare, and enable people to benefit from more fully from health and care services.

We have recently developed a partnership with the Good Things Foundation and mHabitat, focusing on digital inclusion for people with hearing and visual impairments. The project will help to make sure that people receive health services in a way that works better for them.

The pilot is backed with £50,000 of national funding and is part of NHS Digital's widening digital participation programme.

Find out more about using digital technology here
by watching this film here with Dr Jason Broch and Dr Victoria Betton.

We are working to introduce nationally created digital solutions that have proven health and care benefits.

For example, GP practices across West Yorkshire and Harrogate are making good progress towards using Electronic Prescription Services (EPS2). This has benefits for both GPs and patients. For example, prescriptions will go straight to a nominated pharmacist. This is especially helpful for repeat prescriptions. GPs can authorise prescriptions electronically and don't need to be in the building to do this.

Well over 70% of GP practices are already working in this way with more due to come on board soon.

The Leeds Care Record enables the sharing of clinical information between health and care professionals providing direct care to a person. >>

>> The organisations participating are; Leeds Teaching Hospitals, Leeds Community Healthcare NHS Trusts, Leeds and York Partnership NHS Foundation Trust, adult social care, children's services, over 100 GP practices in Leeds, hospices in Leeds and most recently the Yorkshire Ambulance Service 111 service.

It is used by over 5000 health and care professionals and has been shown to improve clinical decision making, helping keep people out of hospital, increase the speed by which patients are discharged from hospital and reduce the time making phone calls between organisations.

Other places are moving along the same route. Calderdale and Huddersfield foundation trust and Bradford Teaching Hospitals foundation trust have recently implemented a class-leading Electronic Patient Record system. This forms the largest deployment of this particular system in Europe. Airedale foundation trust has been using an electronic patient record for several years. Such systems allow a single record of clinical care to be maintained thus support holistic clinical decision making and service scheduling.

Our region hosts 20% of the total number of digital health jobs and we plan to work with our universities, through organizations like the Leeds Academic Health Partnership, to improve that number and to design new and ground breaking innovations that will allow us to tackle the challenges inherent in prevention and early intervention, and to promote an approach rooted in self-management.

An example of this is Leeds adult social care and the clinical commissioning groups working closely with Samsung to trial new wearable devices that will prevent ill health in the frail elderly and people with long term conditions.

Financial strategy

Financial outlook

The funding available for West Yorkshire and Harrogate **health and care services is set to increase to £5.8bn by 2020-21. This represents an overall increase of £0.4bn from 2016-17, a growth rate of 2.2% per year.** This modest increase is significantly lower than the long term average growth that has been invested by successive governments.

Based on current trends and forecast levels of population changes, pay and non-pay inflation, advances in medical technology and rising patient expectations - demands on our resources are growing faster than those available; as a result our local health and social care services are under increasing financial pressure.

We refreshed the financial analysis that was summarised in our November 2016 draft plan to reflect the 2016/17 out-turn financial position and the outcome of the operational planning and contracting process for 2017-18. **This confirmed there is a £1.2bn "gap" between the resources available at 2020/21**.

We will deliver these savings through:

> Delivering care more efficiently – £0.5bn

> Providing the right care to everyone who uses our services – £0.4m

> Projects delivering savings across the area – £0.1bn

> Securing our fair share of sustainability and transformation funding – £0.2bn

Significant financial pressure is evident in 2017/18; a number of NHS organisations within the partnership are no longer forecasting to deliver their financial plans for the year. In simple terms, we are spending more locally than has been allocated to us which is not sustainable. This will make the financial challenge greater in future years, and we are working hard to address this challenge in each of our organisations, in our places and across the partnership.

Whilst the Autumn 2017 Budget provided some welcome and additional resource to the NHS in the years to 2019/20, the overall financial settlement at 2020/21 remained as previously published. It will be critical to ensure that a fair share of the additional resource in 2018/19 is made available to support our services in West Yorkshire and Harrogate, and that we have the discretion to use this to meet local priorities which will include meeting existing demand requirements. **The financial challenge we face is the biggest in a generation.**

Approach to financial delivery

We need to maximise the value from every pound we spend.

Part of the way we will do this is to achieve targets for efficiency savings within each organisation. We will also work collaboratively within each of our places and across the partnership to develop different ways of delivering better services in a more efficient way. We need to avoid focusing simply on delivering financial savings within current models of service provision, and rather consider the totality of funding that is available, and how it might be best used to deliver the best services and care possible.

We are currently developing a single financial strategy for the West Yorkshire and Harrogate partnership.

This aim of the strategy is to set out how we spend the resources we have available on models of service provision that is high quality, deliver excellent care to the local population, and are financially and economically sustainable. It will also set out some of the new and changed arrangements that we will need to move to if we wish to plan for and commission our services differently, particularly in the run-up to the 2018/19 planning and contracting process. Part of the context for this change is that the current arrangements **(known as "Payment by Results")** were introduced into the NHS when there was a concerted effort on the part of government to shorten waiting times in hospitals, encourage more planned surgery being done as day cases rather than staying overnight in hospitals, and also shortening the length of time patients stayed in hospital where they required at least an overnight stay.

This system has been successful, but there is an increasing sense that in the current financial climate of the NHS, it can be a barrier to collaborative working.

We will be reviewing current financial flows and the incentives they create.

This may lead to agreement to a move away from the existing payment system **towards risk-share arrangements, outcome based contracting and how we design incentives that encourage system working.**

Working together to address the difficult choices

The scale of the financial challenge we are facing will require us to make difficult choices in terms of how we prioritise the resource we have available.

It will be critical for us to ensure that we work alongside the public who we serve to ensure that we make the best choices we can. We will act to ensure that these choices are made locally wherever possible, although there will be some instances where we will make decisions that impact on services across West Yorkshire & Harrogate. **In all cases, we will maintain the principles of transparency and honesty.**

We know that, without significant change to the ways in which services are provided to patients, the level of growth in demand for hospital activity and beds over the next four years is not unaffordable. Part of our strategy to address this is about how we invest resources into primary and community services to keep people well, supported and at home.

We will need to review all of our services to ensure that we prioritise those that have the greatest positive impact on people's health and lives. This will include reviewing those clinical interventions which have limited clinical benefit and the medicines that are prescribed by GPs.

We will need to ensure that all of our services are as efficient and effective as they can be. **We will work collaboratively across all organisations in West Yorkshire & Harrogate** to share what works well and will challenge each other constructively where we need to.

Managing NHS resources across the system

Our financial strategy will set out how we are working collaboratively to manage the financial resources available to NHS organisations. This will include how we will plan and commission services, and how we will monitor our combined financial position, taking on greater responsibility as a partnership for system financial management. Discussions are underway about how this would work in practice, and we are developing options alongside our wider partnership strategy work.

These developments are being part of an overall move towards greater local autonomy and control over key financial flexibilities and levers that are currently held nationally by regulators; these include access to transformation funding to support service change and flexibility in how we use this money.

Capital and buildings

As part of the financial plan that was submitted in November 2016, we identified that we had significant capital requirements to ensure that the buildings we operate out of were both fit for purpose and supported the new ways of working identified in the **NHS Five Year Forward View.**

Understanding these capital priorities across West Yorkshire and Harrogate and making these support the clinical service strategy has been an important part of the move nationally towards capital resource that is allocated through the partnership rather than to individual organisations.

We have already been notified that our CAMHS proposal has been supported, and we are hopeful that further funding will be made available in due course.

Transformation funding

Having access to funds available to enable new ways of working is often a key part of service change. **To date we have been successful in securing £45m of transformation funding from national organisations** to support transformation – this is summarised in the table below.

Transformation funding secured through STP	
West Yorkshire Acceleration Zone (2016/17)	£8.6m
West Yorkshire Acceleration Zone (Q1 of 2017/18)	£4.3m
Primary care extended access (2016/17)	£1.7m
Mental Health Liaison (2017/18)	£0.2m
Mental Health Liaison (2018/19)	£0.6m
Diabetes (2017/18)	£2.7m
Cancer (2017/18)	£6.7m
Cancer (2018/19)	£6.8m
CAMHS (capital for a new facility)	£13m
Total	**£45m**

We aim to get to a position where we can secure access to a share of the national transformation funding, based on a greater level of independence so that we can make decisions locally over the priorities we back.

A new health and social care partnership

The West Yorkshire and Harrogate Health and Care Partnership has been created through the authority of the boards and governing bodies of its member organisations.

Each of them remains sovereign and, of course local councils remain directly accountable to their electorates.

Most decisions on how we manage health and care services in each local place will continue to be made by these individual bodies.

The partnership provides a mechanism for joint action and joint decision-making for those issues which are best tackled on a wider scale.

Overall support
through system leadership

At present, the partnership has a series of specific agreements that underpin the way we work:

> **A shared ambition** and five common principles for how we work.

> **An agreement on ways of working,** governance and coordination.

> **A Joint Committee of the 11 Clinicial Commissioning Groups** supported by a Memorandum of Understanding, terms of reference and workplan, agreed by all clinical commissioning groups governing bodies.

> **A Committee in Common of Acute Trusts** (WYAAT) supported by a Memorandum of Understanding, signed by all parties.

> **Mental health trusts** introducing a committee in common supported by a Memorandum of Understanding (to be approved March 2018).

> **Six place based plans** overseen by Health and Wellbeing Boards and associated arrangements.

> **WY&H wide programmes** with clear terms of reference and leadership, agreed by all sovereign Boards.

> **An advisory group of local politicians** coordinated with support from the West Yorkshire Combined Authority.

> **Clinical input from the Clinical Forum**, and Clinical Senates at local level.

> **Overall support through system leadership** executive function with senior responsible officer and team.

Leadership

We have guiding principles that shape everything we do as we build trust and delivery:

> We will be ambitious for the people we serve and the staff we employ.

> The West Yorkshire and Harrogate Health and Care Partnership belongs to commissioners who buy care, providers, councils and NHS.

> We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict.

> We will undertake shared analysis of problems and issues as the basis of taking action.

> We will apply subsidiarity principles (i.e. we make the decision as close to local people as possible) in all that we do – with work taking place at the appropriate level and as near to local as possible.

Our partnership, working with the Canterbury Health Board in New Zealand, has given a strong insight into the importance of collective leadership working towards a shared set of goals.

At the centre of these collective arrangements is our leadership executive group.

The group includes representation from each health and care sector and the six places that make up the partnership. The group is responsible for setting and overseeing the strategic direction, building leadership and collective responsibility for our shared objectives. It has no formal delegated powers.

It works by **building agreement with leaders across health care organisations to drive action around a shared direction of travel.**

Joint decision making

West Yorkshire and Harrogate Joint Committee of the 11 Clinical Commissioning Groups.

Joint Committee of the Commissioning Groups (CCGs)

Over the past 12 months the management structure of these CCGs has changed and there is closer working with the six places that make up our partnership. **The three Bradford District and Craven CCGs, the three Leeds CCGs and the two Kirklees CCGs have each moved to a single management structure.**

A Joint Committee of the clinical commissioning groups has also been established with delegated authority to take decisions collectively.

The joint committee is made up of representatives from each clinical commissioning group and has an independent lay chair and two lay members drawn from the clinical commissioning groups.

The joint committee is underpinned by a memorandum of understanding and a work plan **which you can read here.** The committee meets in public every second month. More information on attendance and how you can get involved is **available here.**

The programme of work is agreed by the clinical commissioning groups together. This currently reflects our partnership priorities for which collective decision making is essential.

The clinical commissioning groups retain their statutory powers and accountability. The joint committee is a sub-committee of the clinical commissioning groups. It only has decision-making responsibilities for the West Yorkshire and Harrogate programme work that have been delegated by the clinical commissioning groups.

West Yorkshire Association of Acute Trusts (WYAAT) Committee in Common

Our hospital trusts have formed a Committee in Common made up of the Chairs and Chief Executives of the six organisations represented. **This Committee in Common provides the vehicle for working together,** and decisions that are taken by the Committee in Common are then approved by each Trust Board.

Mental health services working together

There has been a historically strong partnership working between the five organisations across our area:

- South West Yorkshire Partnership NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Bradford District Care NHS Foundation Trust
- Tees Esk and Wear Valley NHS Trust
- Leeds Community Healthcare NHS Trust.

This close working has been strengthened and reinforced through our partnership approach.

The four Trusts in West Yorkshire are in the process of developing a 'Committee in Common' to strengthen their partnership working and to deliver the priorities set out in this plan.

Local council leadership

We have important and well established relationships with local councils in each of the six places (see page 5) and these relationships continue to strengthen across the West Yorkshire and Harrogate area. We have established an area-wide council leader group which is an important part of our partnership working.

established relationships

Clinical leadership

Clinical leadership is central to all of the work we do.

Clinical leadership is built into each of our work programmes, and our Clinical Forum provides formal clinical advice to all of our programmes.

Governance arrangements

Our partnership includes a range of West Yorkshire and Harrogate **priority programmes** as well as the significant amount of work happening in each of our six local places. **Our way of delivering services reflects this.**

West Yorkshire and Harrogate programme governance

Strong governance and programme management arrangements are built into each of our West Yorkshire and Harrogate-wide programmes (see page 5).

Each programme has a chief executive or clinical commissioning group chief officer and has a structure that builds in clinical and other stakeholder input, representation from each of our six places and each part of the partnership, for example council, voluntary community, NHS.

The next steps for our partnership

Each of our six places (see page 5) are having conversations about what developing stronger local partnerships means for them. **Commissioners and providers are coming together to take responsibility for the cost and quality of care** for an area, for example Bradford District and Craven; Calderdale, Harrogate etc

These new ways of working reflect local priorities and relationships. There are common themes running through them of a greater focus on population health management, integration between providers of **services around the individual's needs, and a focus on care provided in primary and community settings.**

Next steps for developing our partnership

The West Yorkshire and Harrogate Sustainability and Transformation Partnership has evolved in three phases:

Phase 1:
Mobilising and producing draft proposals (May to December 2016)

Phase 2:
Consolidating, building capacity, governance and infrastructure (January to September 2017)

Phase 3:
Mutual accountability, greater ownership of system performance – towards greater autonomy and control (October 17 to April 18).

We are now in the third phase of this evolution.

The System Leadership Executive Group has agreed to refresh and strengthen the partnership's governance and accountability mechanisms and ways of working, and to set out them out in a single memorandum of understanding (MoU).

The new memorandum of understanding will provide a platform for:

> Clarification of effective governance arrangements for partnership level commissioning and the management of risk;

> Maturing provider networks that collaborate to deliver services in places and WY&H level;

> Clinical and managerial leadership of change in major transformation programmes, including national priorities;

> Citizen engagement in development, delivery and assurance;

> Better political ownership or engagement in the agenda; and

> Light touch system management and support of all of the above.

It will provide **a mutual accountability framework that ensures we have collective ownership of delivery,** rather than a hierarchical approach. **We also aim for it to provide the basis for a refreshed relationship with national oversight bodies.**

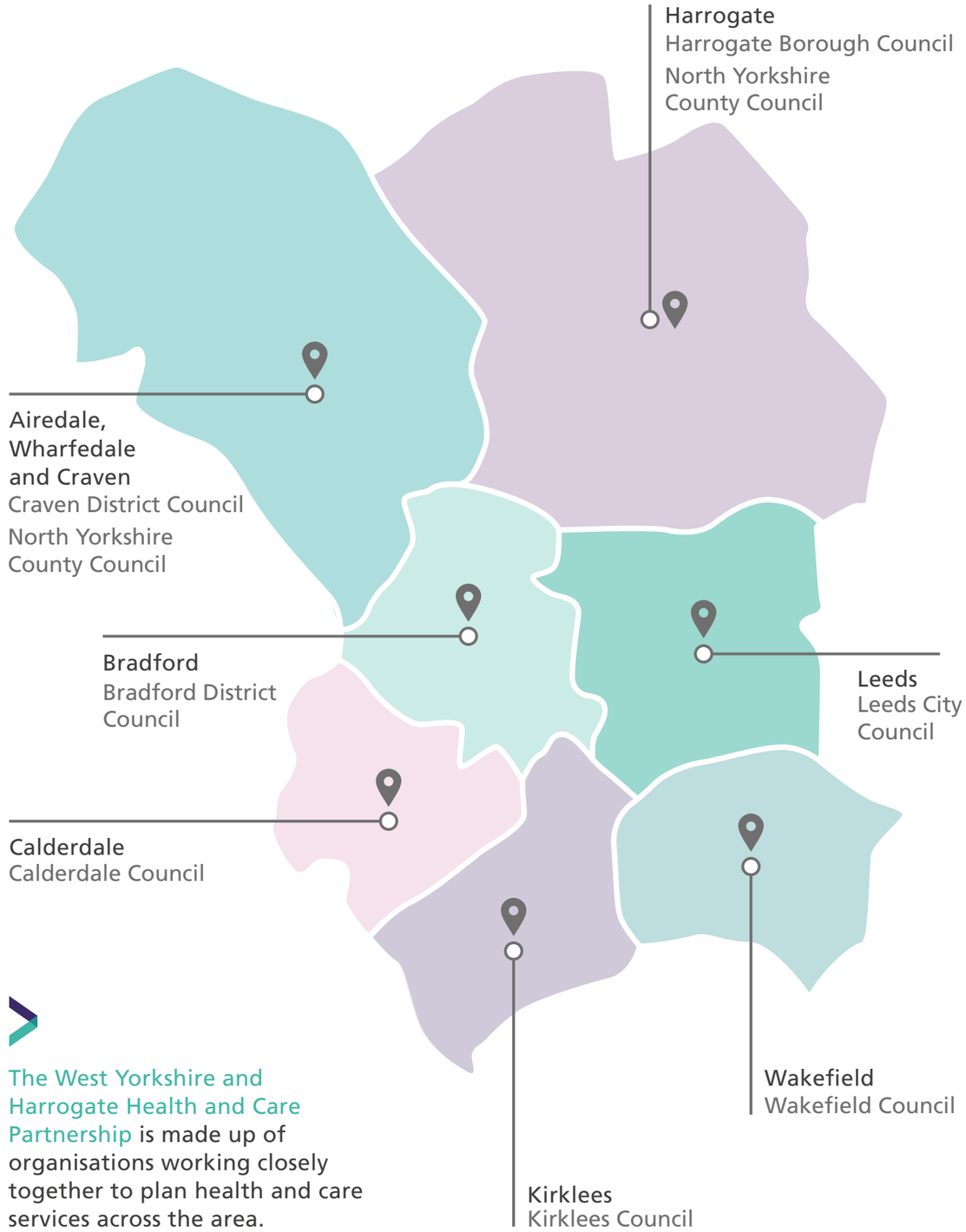
The new governance and accountability arrangements will retain the ethos that **the partnership is a servant of the member organisations** in West Yorkshire and Harrogate and in pursuit of delivering better outcomes for people.

With these new arrangements in place, from April 2018, our partnership will be ready to take on greater responsibility for:

- The planning and design of the West Yorkshire and Harrogate work programmes, and oversee delivery locally
- Managing transformation funding and capital; and
- Oversight and delivery of milestones set out in this plan.

This is the most difficult time in the health and care system for a generation. We are facing unprecedented challenges with limited resources. At the time of writing, we await details of how extra resources should be allocated to the NHS from the Autumn Budget.

Our view is that we should work with Government and the national bodies that regulate us to secure greater autonomy and greater control over our resources and our future. Whatever the label for this, only by having control can we secure any sort of sustainable future.



The West Yorkshire and Harrogate Health and Care Partnership is made up of organisations working closely together to plan health and care services across the area.

This information is available in alternative formats, for example large print, Braille, EasyRead and community languages. For more information contact:

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A partnership made up of the NHS, local councils, care providers, Healthwatch and community organisations.

January 2018

West Yorkshire and Harrogate Health and Care Partnership

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 March 2018
Agenda item 9.1

Title:	**Quality Strategy**
Paper prepared by:	Director of Nursing and Quality
Purpose:	To provide Trust Board a quality strategy for approval.
Mission/values:	We exist to help people reach their potential and live well in their community. To do this we have a strong set of values that mean: ➢ We must put **people first and in the centre** and recognise that **families and carers matter** ➢ We will be **respectful** and h**onest, open and transparent** in our dealings, to build trust and act with integrity ➢ We will constantly **improve and aim to be outstanding** so we can be **relevant today, and ready for tomorrow**. The Quality Strategy is underpinned by all of our values.
Any background papers/ previously considered by:	Previous Quality Strategy that expires April 2018. The Clinical Governance and Clinical Safety Committee have commented on the strategy.
Executive summary:	➢ This quality strategy sets out our commitment to providing high quality care for all while achieving our organisational mission, to help people to reach their potential and live well in their communities. ➢ The strategy spans a three year period, which allows for large scale and cultural change to be achieved. ➢ It sets out what we mean by quality and provides a framework for how we assure and improve quality across the organisation. It also describes our Integrated Change Framework that supports innovation and improvement at all levels. ➢ In development of the strategy we have considered the need to both assure the fundamental standards of care and provide a framework to encourage improvement activity at all levels in the organisation. ➢ When developing the strategic objectives it has been important to strike a balance between; a) Describing our ambition and our immediate goals, b) Ensuring that key elements of supporting strategies have sufficient profile. c) Keeping a simple and concise message ➢ It is important to note that during consultation it became apparent that in order to provide a relevant and concise document, a separate implementation plan is required that describes year on year goals, metrics and clinical leadership. This approach was discussed at Clinical Governance & Clinical Safety Committee

	(CGCS) and agreed that an implementation plan will be developed and added as an appendix. This plan will be reviewed at the next CGCS meeting. ➢ The strategy aligns fully with our commitment to quality improvement that we shared with the Care Quality Commission (CQC) in October 2017. ➢ The strategy aligns with our Integrated Performance Report and quality priorities that we set each year for the quality account. Consultation: The strategy has been shared with the following groups/committee during the consultation process: ➢ Clinical Governance & Clinical Safety Committee ➢ Members council quality sub group ➢ Quality Improvement Group ➢ Clinical Governance group ➢ Service user groups / networks vis BDU partnership leads Changes to the document as a result of (accumulated) feedback: ➢ Equality impact assessment has been added to the strategy ➢ Definition of quality has been strengthened ➢ Quality strategy objectives – these have been reviewed and detail has been removed ➢ A description of how we will deliver the strategy and how we will measure success has been added ➢ The #allofusimprove campaign has been shared with key groups to demonstrate how the strategy will be implemented ➢ Alignment has been made with the IPR and quality priorities for the quality account so as to avoid excessive priorities that staff need to focus on Strategy implementation ➢ A small working group has been established to oversee the implementation of the strategy
Recommendation:	**Trust Board is asked to APPROVE Quality Strategy.**
Private session:	Not applicable.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Quality Strategy

To improve and be outstanding

Version FINAL DRAFT for Trust Board
March 2018

With **all of us** in mind.

Contents

1. Introduction

1.1. Our mission and values

We exist to help people reach their potential and live well in their community. To do this we have a strong set of values that mean:

- We must put people first and in the centre and recognise that families and carers matter
- We will be respectful and honest, open and transparent in our dealings, to build trust and act with integrity
- We will constantly improve and aim to be outstanding so we can be relevant today, and ready for tomorrow.

In 2017/18, our strategic objectives are to:

- Improve people's health and wellbeing
- Improve the quality and experience of all that we do
- Improve our use of resources.

This quality strategy will support the achievement of the organisation's mission and contribute to the delivery of all three strategic objectives. Every aspect of the strategy will be delivered in line with our values.

1.2. Purpose and scope

This quality strategy sets out our commitment to providing high quality care for all while achieving our organisational mission

to help people to reach their potential and live well in their communities

It sets out what we mean by quality and provides a framework for how we assure and improve quality across the organisation. It also describes our Integrated Change Framework that supports innovation and improvement at all levels.

1.3. Background

We publish a Quality Account each year that describes how the Trust is doing against its quality priorities. The Quality Account is an important vehicle for public accountability and broader ownership of how the Trust is delivering high quality services.

Quality is supported by appropriate governance. Currently we have an integrated governance structure (appendix 11.1), with three lines of assurance to ensure escalation of risk, including risk to quality from "ward to board". To effectively assure and improve quality we use the following mechanisms:

- Quality measurement
  - Quality monitoring visits, risk meetings and key governance and operational groups
  - NICE guidance documents in relation to best clinical practice, national and local clinical audits & DATIX dashboards
- Quality assurance
  - Review of a range of intelligence & information through our Integrated Performance reporting system
- Quality monitoring visits
  - Focus on risk and learning and plan to integrate into our quality scheme
- Quality impact assessment framework
  - Formal quality impact assessment process to support change

- Listening and learning
  - Information from incidents, service user feedback, staff feedback, customer services and 'listening' events

Progress in past 2 years

Through the above mechanisms, substantial progress has been made in many areas including;

- Improved quality performance reporting through our new Integrated Performance report
- Refreshed our quality impact assessment process
- Strengthened our governance structures and frameworks to aid ward to board connectivity
- Established a Quality Improvement Group to celebrate achievements and scan the horizon
- Implemented our Patient Safety Strategy
- Reviewed Quality & Governance lead roles
- Listened to our staff to understand how they feel quality could be improved and how they can actively lead improvement work
- Introduced crowdsourcing technology where staff and volunteers can develop ideas share good practice, and engage in driving improvements through innovation and change
- Trained a cohort of staff in quality improvement methodologies and aligned ourselves with the Yorkshire Improvement Academy
- Reorganised our central resources to manage our integrated change programme
- Refreshed and improved the impact of quality monitoring visits.
- Celebrated our achievements through the Trust Excellence Awards and shared best practice, locally, regionally and nationally

For our Quality Account 2017-18, we identified 42 key quality indicators across the five CQC domains of safe, effective, caring, responsive and well-led. At the end of quarter 2 2017, we were on track with 38 (90%) of the indicators with action ongoing and planned to ensure achievement against the remaining four (10%).

The CQC (Care Quality Commission) inspected our services in March 2016 and rated our Trust as Required Improvement. The CQC revisited the Trust in 2017 and rerated us as Good overall with some outstanding ratings. In terms of the broad ratings, the CQC described us as:

Safe	Good
Effective	Good
Caring	Good
Responsive	Requires Improvement
Well-Led	Good

The responsive domain of quality is clearly an area that needs to be improved by the application of this strategy.

2. Context

2.1. Fit with our OD and related strategies

This strategy is clearly integral to the delivery of a number of our existing strategies including:

- *Nursing Strategy*, which supports safe, effective, caring, responsive and well-led nursing practice
- *Communication, Engagement and Involvement Strategy* sets out the framework to ensure service users, carers, staff, stakeholders & local communities have a say in how services are planned and delivered.
- *Equality Strategy* focuses on diversity and health inequalities with the aim of identifying, understanding and reducing inequalities which affect our service users, communities and workforce.
- *Digital Strategy* is an essential enabler to effective communication, engagement and involvement and in delivering modern health and care
- *Membership Strategy and Volunteering policy* set out ways for people to be involved in the organisation and influence how services are developed and delivered.
- *Customer Services Policy* supports seeking the views of people who use our services and responding appropriately to feedback, including when things go wrong.
- *Workforce Strategy* sets out a strategic approach to leadership, management and development to ensure the Trust is well led and has the right people to achieve the strategic direction, deliver the mission and demonstrate the values.
- *Patient Safety Strategy* provides a framework will help us to 'do no harm' and reduce harm to those who use our services and monitor and improve patient safety.
- *Estates and Facilities Strategy* provides a framework for the management and maintenance of the Trusts estates.

This strategy is also fundamental to our *Organisational Development (OD) Strategy* and contains the essential enablers to a successful organisation (structure, strategy, systems, shared values, skills, staff and style).

2.2. Regional and national context

In developing this strategy, we have referenced contemporary evidence and best practice on how to build capacity and improve and sustain quality in NHS organisations from the Kings Fund (Ross and Naylor, 2017), Care Quality Commission (CQC), National Health Service Improvement (NHSi, 2017) and National Quality Board (see 2.5 below).

- NHSi- NHS Improvement (2017). Building capacity and capability for improvement: embedding quality improvement skills in NHS providers. September 2017. London, Publication code: IG 36/17. https://improvement.nhs.uk/resources/embedding-quality-improvement-skills/

- Ross, S. and Naylor, C. (2017). Quality improvement for mental health. King'sfund, London. July 2017.

https://www.kingsfund.org.uk/topics/mental-health?dm_i=21A8%2C4JTPS%2CFLWSXD%2C&search=&page=0

2.3. Local context

In aspiring to be outstanding, the Trust has identified a number of **ambitions** to be achieved by delivering the quality strategy, including;

- Providing support and services to people that they would describe as outstanding and which truly helps them to reach their potential and live well in their community
- Outstanding and the best in we can be where quality is the governing principle:
- Regional centre of excellence for specialist and forensic mental health; and for Learning Disability Services
- A strong partner in mental health service provision across West Yorkshire and South Yorkshire Accountable Care System/Sustainability &Transformation Partnership
- A host or partner in four local accountable care partnerships – Barnsley, Calderdale, Kirklees, Wakefield
- An innovative organisation with coproduction at its heart, building on Creative Minds, Recovery Colleges, MHM and Altogether Better
- In delivering these we will need to be flexible and more responsive to our stakeholders, recognising the local and national context. In particular, we want to see a move in our focus from compliance with external targets to achieve sustainable improvement in safety, effectiveness, experience, responsiveness, efficiency and leadership. This includes taking every opportunity to learn from incidents, complaints, compliments and feedback so we can drive through meaningful change programmes and quality improvements.
- This will mean that we must nurture and train our staff to ensure that they are developed and are working in a learning environment that fosters positive attitudes and a desire to improve
- There are specific improvement goals that we must achieve to demonstrate progress, including
  - Waiting times
  - Physical healthcare for patients with severe mental illness
  - Access times for patients with first episode psychosis
  - Transition pathways from children's to adult mental health services
  - Patient experience and outcomes

2.4. Our quality challenge

Quality must be the organising principle for our services. It is what matters most to people who use services and what motivates and unites everyone working in health and care services. But quality challenges remain, alongside new pressures on staff and finances.

Improving quality, alongside finance, workforce and population pressures
The Trust is committed to delivering the triple aim of improving experience, quality and efficiency.

The quality of care has improved in this organisation during the last two years and we are proud to provide good or outstanding care in most areas. However, services are facing additional pressures from a changing population with more complex needs, changing expectations and unprecedented financial constraint.

Challenges in recruitment and retention remain as we commit to maintain an appropriate workforce ready for new services. Also, when pursuing quality, we must maintain the right balance between assurance and support for improvement.

The regulatory context within which the Trust operates includes a strong focus on the balance between quality, the use of resources and governance.

- **The CQC (Care Quality Commission)** inspected our services in March 2016 and rated our Trust *Requires Improvement*. The CQC revisited the Trust In early 2017 and re-rated the Trust as Good overall with serval outstanding ratings. We aspire to continue our journey towards excellence and to be outstanding
- **NHS Improvement** introduced a new approach to evaluating the financial and governance performance of NHS trusts during 2016. The *Single Oversight Framework* has recognized the challenge to our finances and in particular has highlighted control of spending on agency staff as a significant cause to be addressed.

It is a priority for us to collaborate and learn from our regulators, not just because of the potential regulatory consequences, but because they indicate opportunities to better meet the needs of our service users as effectively and efficiently as possible.

2.5. Our commitment to quality

We know that to provide high quality person centred care we must be a well-led organisation committed to delivering safe, effective, responsive and caring services.
In SWYPFT we define quality as the achievement or surpassing of best practice standards and describe this as a “quality counts, safety first” approach.

To us this means

Safety: people are protected from avoidable harm and abuse. When mistakes occur, lessons will be learned.

Effective: people’s care and treatment achieves good outcomes, promotes a good quality of life, and is based on the best available evidence.

Caring: staff, involve and treat people with compassion, dignity and respect.

Responsive; services respond to people’s needs and choices and enable them to be equal partners in their care.

Well-led: an organisation that communicates well, is open and transparent, works together and in partnership with local people and communities, and is committed to learning and improvement.

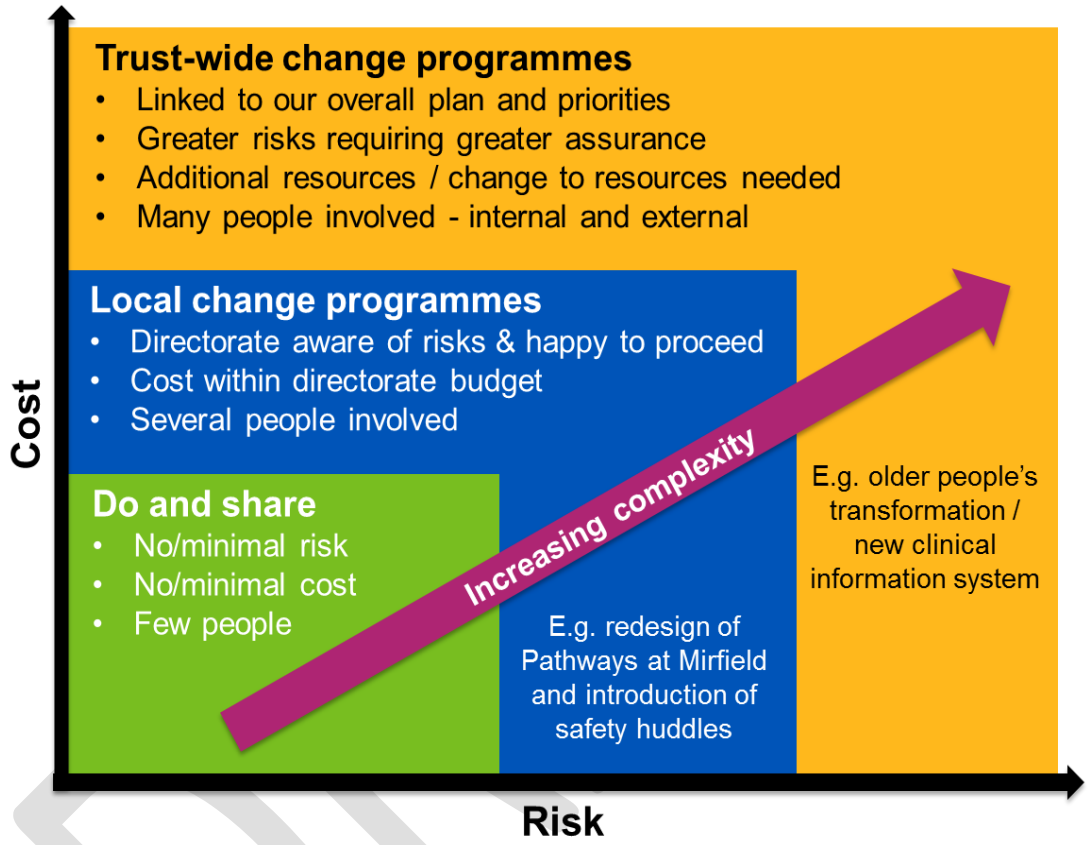
2.6. Our improvement approach

Our method for improving quality needs to:

- Be a simple approach understood by all in the Trust, based on balancing cost, risk and complexity
- Reduce bureaucracy and support decision making closest to our services and service users
- Provide appropriate support and governance for small or large Trust-wide changes

Integrated change framework

The Trust has already developed an *Integrated Change Framework,* which brings together the people and process elements of change in order to ensure that quality improvements are delivered in line with good practice.
We have defined three distinct but overlapping levels of change to reflect individual, service and Trustwide innovations and improvements: 1) 'do and share', 2) 'local change' and, 3) 'trust wide programmes'.

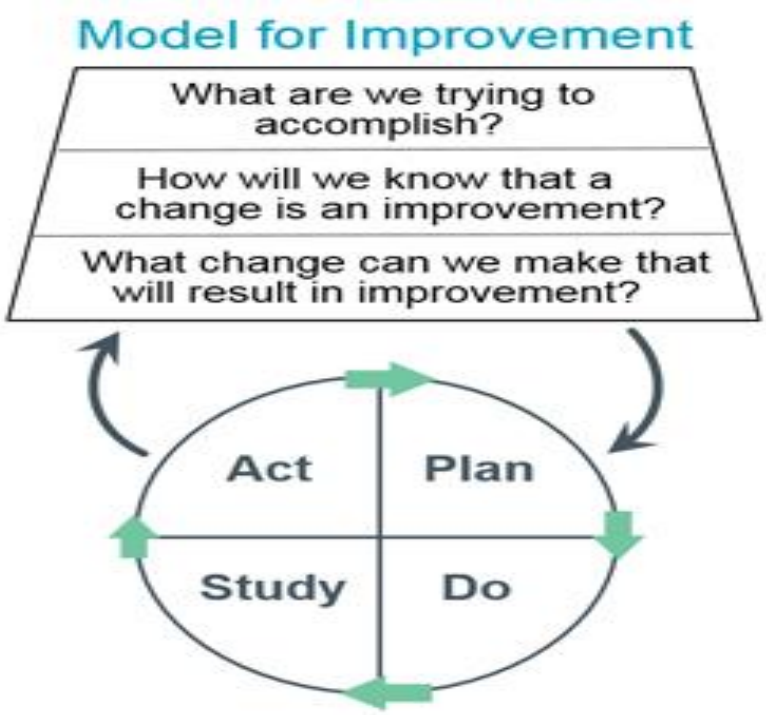


These defined levels of change will enable staff delivering care at the frontline to make a real difference while allowing leaders to assess the improvement or change based on an assessment of the risk, cost and complexity of that work.

Model for improvement

The model for improvement adopted by the Trust and in accordance with national guidance is the *Plan-Do-Study-Act* (PDSA) cycle. The PDSA cycle is part of the Institute for Healthcare Improvement Model for Improvement (Figure 2), and is a simple yet powerful tool for accelerating quality improvement. Once a team has set an aim, established its membership, and developed measures to determine whether a change leads to an improvement, the next step is to test a change in the real work setting. The PDSA cycle is shorthand for testing a change—by planning it, trying it, observing the results, and acting on what is learned (Figure 2). To support quality improvement, a number of work streams have already been established (Appendix 11.2).

Figure 2 PDSA model for improvement



Source: Langley, et al. (2009). The Improvement Guide: A practical approach to enhancing organizational Performance (2nd Edition). San Francisco, USA. Jossey-Bass Publishers.

Quality Improvement Group

The Trust's Quality Improvement Group (QIG) was developed in 2015 to assure safe, effective, caring, responsive, innovative and well-led practice in accordance with the Trust's Quality Improvement strategy.

The QIG has a large membership from across the Trust encompassing quality academy representatives, operational managers and management and leadership trios.

The QIG achieves its aims through

- Horizon scanning; interpretation and reporting of relevant national/local quality and safety directives
- Critical consideration of organisational quality and safety improvements
- Information sharing
- Risk scanning; ensuring proactive and systematic assessment and management of risks
- Sharing good practice between BDUs and Directorates
- Discussion, debate and forward planning between

The integrated change framework will be essential for the delivery of this strategy and to this end we will ensure that the framework will be incorporated into the business of our Quality Improvement Group the QIG. This will enable an improvement network where the different levels of change and quality improvement initiatives are closely aligned. The improvement network will be a regular feature of the QIG agenda and will support quality improvement across the trust.

Development of new Quality Scheme

The new Quality Scheme is designed to work alongside the existing Quality Monitoring Visit programme. It is an accreditation tool that is intended to help all teams to recognise their strengths and any areas where improvement is needed.

The aims of the Quality Scheme are:

- To improve the standards of quality care and safety within teams and services.
- To develop and embed our organisational culture of quality improvement.
- To provide a framework so that teams can focus on quality standards, self-assess and monitor their own standards and be used as part of their governance processes.
- To enable teams to reflect on their effectiveness and to be aware of areas where improvement is needed.
- To recognise and reward those teams that are providing consistently high standards of care and are sustained.

The introduction of the Quality Scheme in April 2018 is intended to have the following benefits:

- It will enable teams to be able to more closely monitor their performance.
- It will make their quality assurance systems more robust and will help them to identify their strengths and areas for quality improvement.
- It will empower teams to have ownership of their daily working practices and control over how they can impact and influence these.
- It will be a driver for developing teams and services to be outstanding.

3. Quality strategy objectives

3.1. Safety

We will ensure people are protected from avoidable harm and abuse

Where are we now?	What do we need to do?	What does success look like?
We're making good progress in achieving the desired outcomes set out in our patient safety strategy. This includes sign up to safety and suicide prevention initiatives. We're leading the West Yorkshire and Harrogate STP suicide prevention work stream, and launched a regional strategy in November 2017. We remain focused on quality improvement to drive safety, including the implementation of safety huddles, safety conversations, and an understanding of human factors. Duty of candour arrangements have been implemented	As part of our patient safety strategy, we will: • Implement human factors training for patient safety team and clinical representatives from each BDU • Further share learning and enhance the measuring and monitoring of safety framework. • Further develop safety huddles over the next 12 months - currently working on sustainability model and use of coaches. • Embed learning from healthcare deaths and bringing together information to explore areas for change.	Success will be demonstrated by: • Having systems in place to continuously improve the safety culture throughout the organisation • A reduction in the frequency and severity of harm resulting from patient safety incidents, including achievement of sign up to safety targets • Enhanced safety, effectiveness and positive experience of the services we provide • Reduced costs, both personal and financial associated with patient safety incidents • Reduction in suicides across the population serviced by

successfully. With our effort to improve patient safety data, we have seen improvements in our reporting and learning from incidents. This can be evidenced by commissioners encouraging other organisations to learn from our approach. Our continued focus on safer staffing is demonstrating benefits. We have centralised staff bank and recruitment, appointed a new master vendor for agency staff, implemented a peripatetic workforce and over-recruited onto wards. Our average staffing fill rates continue to exceed 100%. Our quarterly safeguarding data for 2016/17 demonstrates a strong commitment to ensuring a well-trained and well-informed workforce. We continue to report safeguarding data in a timely fashion, including NHS Prevent and FGM data.	As part of our safer staffing initiative, we will: • Extend and maximise functionality within our current e-rostering system. • Contribute to the development of a National Safer Staffing tool for inpatient mental health areas. • Increase capacity on our peripatetic workforce as identified in establishment and workforce reviews. • Review safer staffing in the community with a view to developing a community safer staffing tool. • Align safer staffing initiatives with the new Trust workforce strategy. • Develop a medical staff bank. • Review ward establishments after the NHS Improvement CHPPD analysis of staffing figures. • Implement our international nurse recruitment plan As part of our safeguarding annual plan, we will: • Further embed the human trafficking agenda and principles of 'Making Safeguarding Personal' • Achieve 85% in relation to Health WRAP 3 Prevent training by March 2018. • Enhancing clinical records with additional safeguarding information at the point of receipt within the duty system. • Further strengthen and improve our partnership relationships, in respect of the Children and Social Work Act 2017 and its change in emphasis. • Host an external facing safeguarding conference • Adopt the 'Are you afraid to go home tonight?' initiative,	WYPT and in targeted areas using a zero suicide philosophy • Safety huddles in all services, targeting key risks • Staffing establishments across inpatient and community settings reviewed and improved • Medical staff bank established

	which will provide a method of alerting staff to a person in potential danger.	

3.2. Effectiveness

We will achieve good outcomes with people based on best available evidence

Where are we now?	What do we need to do?	What does success look like?
We've seen an overall improvement in performance around the effective domain. Our increased focus on Mental Health Act and Mental Capacity Act training has shown significant results. This has improved understanding and application of both Acts. We have exceeded our internal target and reviewed our policy. At the same time, we have maintained our performance for other mandatory and statutory training, and have achieved our internal staff appraisal target of 95%. Our clinical supervision policy has been embedded within routine practice and a central reporting system has been established to good effect. Our focus on reporting will continue into next financial year. We have significantly strengthened our approach to mortality reviews, both in terms of policy and practice. Our collaborative approach with regional partners and Mazars has resulted in a high quality, outcomes-focused approach. This was recently highlighted by our NHS Improvement regional manager as good practice. We have significantly developed our volunteering service and are one of only eight NHS organisations to have *Investing*	We will: • Fully embed our central recording system for clinical supervision • Bring forward appraisal timescale to expedite strategic objectives being cascaded throughout the organisation • Increase volunteering opportunities within the Trust as part of NHS70 celebrations during 2018 • Update the learning from deaths policy in light of experience and revised guidance. • Review and enhance learning opportunities from the mortality review process. • Combining Immediate Life Support (ILS) with Management of Aggression and Violence training. • Implementation of new mental health clinical record system by 2019, building greater effectiveness into standard templates co-designed with clinicians. • Delivery of out of area bed project, following internal summit held in August 2017. We're also working with partners to reduce the need for patients to travel beyond West Yorkshire.	Success will be demonstrated by: • Clinical record system established that reduces unnecessary clinical variation in practice • New models of care that are co -produced and delivered with people who have used services • Introduction of outcomes tools to measure clinical effectiveness and improved patient experience • High quality, personalised and recovery-orientated care planning • Volunteers established in the workforce across the Trust • Out of area placements reduced significantly • Clinical supervision policy implemented across all our services

in Volunteers accreditation. Our commitment to volunteers can be seen in the newly refurbished volunteer lounge.		

3.3. Caring
We will involve and treat people with compassion, dignity and respect

Where are we now?	What do we need to do?	What does success look like?
As a values-based organisation, we pride ourselves in putting the person first and in the centre, and we recognise that families and carers matter. With this in mind, we were pleased to win 'best organisation' in the Kate Granger Compassionate Care Awards 2017. We continually strive to improve our patient experience feedback and act on what people tell us. This can be seen for example in our use of volunteers to help further embed patient feedback in our culture. Volunteers, particularly those with lived experience, are well placed in supporting people to give open and honest feedback. Our complaints process has been reviewed and we are implementing a revised approach that will see increased clinical ownership as close to the patient as possible. Feedback is important across all areas of the Trust, including our Board, where meetings now begin with a patient story. This helps to make sure that all board discussions are grounded in real life experiences of people who make use of our services.	We will • Re-launch of our patient experience focus and commitment across the organisation including branding and core principles • Continue to enhance our patient experience reporting, ensuring that data is triangulated at all levels in the organisation • Embed the use of patient stories at Trust Board so that discussions are grounded in real life experiences • Develop a 'learning from feedback' framework, strengthening our existing processes including complaints, serious incidents, patient experience and audit information. • Scale up our patient experience volunteer programme • Complete the nursing strategy (2015-18) action plan and redevelop the strategy in line national initiatives and priorities • Launch the next phase of embedding our values, focusing on translating values into behaviours • Extend capacity and capability of nursing associates in workforce planning • Introduce the HEE/NIHR	Success will be demonstrated by: • Improved patient experience • Reduced frequency of complaints by service users and improved response times • Reduction in the use of physical restraints • Centrally monitored clinical supervision with key performance achievements across all clinical staff • New action-orientated nursing strategy in place to maintain and improve compassionate care • Nursing Associates established within the clinical workforce • Patient's stories are standing item on Trust Board agenda • All complaints will receive a quality and timely response showing how we have learnt from the feedback

We put significant effort into caring for our workforce, so that they can in turn provide outstanding care. This can be seen in our commitment to staff wellbeing and the recent launch of a new staff wellbeing campaign. We set up system to support newly qualified registered staff and offered senior management mentorship as part of preceptorship plus. We have been working with HEIs to develop nurse training and we have introduced trainee nursing associates as part of national pilot.	Integrated Clinical Academic Internship scheme for nursing staff • Implement our revised approach to complaints	

3.4. Responsive
We will respond to peoples' needs in a timely way

Where are we now?	What do we need to do?	What does success look like?
Since our last CQC inspection, we have a defined priority programme focusing on operational excellence. The benefits of this have resulted in greater focus and action around out of area placements, patient flow, bed management and waiting times. Efforts to improve the responsiveness of our CAMHS and autism services have shown results, with a reduction in waiting times seen across several areas. We have launched a new perinatal mental health service following a successful NHS England new model of care bid. The service started taking referrals from 1 September and is helping to meet a previously	We will: • Recruit to CAMHS vacancies so that the revised pathways we have implemented work optimally, ensuring we can sustainably meet demand. • Implement an all-age liaison service to further improve responsiveness out of hours • Secure commitment from commissioners to fully meet demand for adult autism services • Utilise funding secured to reduce psychological therapy service waits in Calderdale • Strengthen the physical healthcare response for people with mental health problems & learning disability through the roll out of RAMPPs, consolidation of	Success will be demonstrated by: • Reduced waiting times against key performance targets, annually for all services • Access times improved for patients with first episode psychosis • Zero approach to out of area bed placements • Improved care hours per patient day in line with NHSi benchmarking • Parity between physical and mental health for all our service users • Access to local tier 4 CAMHS beds • Transitions between CAMHS and adult services are seamless, safe and effective for all

unmet need.
 	
As part of our estates strategy, we are building a new £17m mental health inpatient unit on the Fieldhead site, named the Unity Centre. The first phase has been complete, with two wards moving into new purpose-built facility this autumn, with flexible, gender specific accommodation. The second phase of the build will continue into 2018.
 	
Intermediate care wards at Mount Vernon Hospital in Barnsley moved safely to Barnsley Hospital in August, as part of a move to a new model for intermediate care. The inpatient element of the service transitioned to Barnsley Hospital NHS Foundation Trust on 1 December.
 	
Our Trust Board approved a new equality strategy (2017-2020), focusing on treating everyone with fairness and reducing inequalities within services.
 	
As mentioned in the 'Caring' section, we're implementing a revised approach to complaints. We have improved the quality of our complaints responses, and are now focusing on timeliness.
	the cardio metabolic assessment tool and audit of implementation of national early warning signs
	• Further develop and embed creative responses to care, through Creative Minds and Recovery approaches, ensuring these are sustainable
	• Work with partners on West Yorkshire and Harrogate STP-wide programmes, including focusing on:
	  ○ Shared acute bed base approach
	  ○ Work with partners to implement new models of care for adult eating disorders and CAMHS
	  ○ New CAMHS inpatient unit to be built in Leeds following the Chancellor's budget
	  ○ Adult autism and ADHD (SWYPFT lead)
	  ○ Suicide prevention (SWYPFT lead)
	• Complete Unity Centre development and move remaining ward in 2018.
	• Continue implementing equality strategy action plan.
	• Focus on reducing complaints handling time.	

3.5. Well led
We will work in partnership and learn from our mistakes

Where are we now?	What do we need to do?	What does success look like?
Our Members' Council are a fundamental part of our governance, and we were pleased to appoint a new lead governor. Our governors have	We will: • Disseminate our refreshed strategy • Launch our quality strategy and plan for next 12 months,	Success will be demonstrated by: • More service users, carers, volunteers and members involved in improvement

also overseen new NED and Chair appointments, as well as provided links in with local communities. Changes to the Board and Executive Team portfolios have strengthened clarity around roles and responsibilities, and placed us in a good position to respond to the changing environment. This has provided the leadership required to revise and focus on our strategic objectives, priority programmes and strategy refresh. We have also developed strategies on digital and workforce, with the latter including a new framework for leadership and management. This focuses on staff leading from every seat in the organisation. We have made further improvements to our governance arrangements and have received 'significant assurance' following completion of an internal audit of our risk management approach. Risks are now aligned to our strategic objectives and priority programmes, with oversight at designated Trust Board sub-committees. We remain in category 2 of NHS Improvement's single oversight framework. We have continued to undertake significant work around internal communications and engagement, including regarding our vision and values, priority programmes, performance, wellbeing, and internal and external pressures. This has improved ward to board communication and vice versa, which may help to account for our low level of whistleblowing concerns moving to formal stage.	including the introduction of an internal quality accreditation scheme • Continue to focus on strong financial management in a challenging climate, ensuring that messages are consistent and complement our quality and safety messages. • Implement our digital strategy • Implement our workforce strategy, including new leadership and management framework, helping to improve retention and succession planning • Continue to mature our freedom to speak up guardian arrangements • Develop further staff networks to ensure we have representative staffing, starting with disability network • Continue to pilot innovative approaches, for example the use of the ORCHA platform within CAMHS to support young people in making use of apps within their care pathway • Further establish our Trust charity to ensure the sustainability of our innovative and preventative offer e.g. Creative Minds. • Ensure our governance develops alongside accountable care systems and accountable care organisations in South Yorkshire and Bassetlaw, and in West Yorkshire and Harrogate, with capacity also aligned • Ensure portfolios for directors continue to remain appropriate and focused on external and internal changes • Refresh our business plan to reflect changes to the	work, and change programmes (including representative numbers for those that are defined as having protected characteristics) • Increased number of 'Do and Share' improvements annually • Increased the number of 'Local change improvements' at BDU level annually • Change and innovation approaches, increase annually through the Integrated Change Network and our leadership programmes • Financial sustainability with greater involvement of stakeholders • New quality measures developed through the Integrated change and improvement network and Quality Improvement Group

Our recent staff Excellence awards highlighted outstanding practice within the organisation. In addition, external accolades have validated our achievements. We remain committed to providing innovative and recovery-focused services, including our recovery colleges, Creative Minds, Mental Health Museum and Altogether Better. This is underpinned by a new focus on improvement, with digital infrastructure through our i-hub platform and practical support through our new change framework.	commissioning environment and budgets	

Delivery and outcome measures

To clearly define our success in delivering this strategy we need to develop baselines and systems for capturing measurement. We will then be able to measure success via improvements against a range of indicators. These will be developed and presented to Trust Board for approval. Agreed indicators will be added to the Integrated Performance Report for monitoring.

Each year a selection of the measures will be monitored via the quality account process. The selection will be made via service user and staff consultation, with final agreement being approved by Trust Board.

4. Risks

Key risks identified in the delivery of this strategy include:

- Reduced income for the Trust, which could impact on quality initiatives
- Transformation of services resulting in short-term disruption
- Partnership working and aligning our intentions with those of our commissioners and partners
- A lack of collective commitment and buy-in
- Resistance to new ways of working and new technologies
- Inability to meet expectations of service users and staff
- Inability to effectively communicate, engage and involve people
- Insufficient resources in terms of capacity within both BDUs and support services
- Financial pressures and challenging cost savings required in future years
- Capacity for change
- Regulatory intervention leading to a focus on quality assurance and not quality improvement

Key risks will be mitigated in line with our risk management strategy and risk appetite. This will be done through detailed action planning to underpin implementation.

Risk	Mitigation
Maintaining quality in times of austerity	Financial planning strategies Efficiency & effectiveness programmes of work Quality Impact assessment process
Maintaining quality whilst we are transforming our services	Deputy Director, Assistant Directors of Nursing are part of transformation work as are the Practice Governance Coaches in operational leadership teams Engagement with staff, service users, and other key partners Quality Improvement Group & change network focus on horizon scanning. Oversight by Clinical Governance Group Transformation Board oversight of new services
Developing partnerships to work together to deliver services without leaving gaps that compromise safety	Engagement in STP work streams Partnerships with wide range of local partners including Clinical Commissioning Groups, Local Authorities and NHS England Clarity of roles and responsibilities within partnerships – to avoid 'gaps' Clear mapping of stakeholder relationships and identification of priority partnerships to develop in order to develop extended care pathways
Recruitment of clinical staff	Established values-based assessment and recruitment centres. Established marketing approach to target graduates and experienced clinicians. Preceptorship plus offer to newly qualified staff nurses. Induction package for staff joining the organisation.

5. Resourcing, staffing and technology

The Quality Improvement and Assurance Team (QIAT) will lead implementation, monitoring and review of the strategy in partnership with Integrated Change Team and BDUs.

The QIAT will collaborate with services through the monthly Clinical Governance Group.

BDU Directors will need to ensure quality leads and Trios are equipped to deliver the strategy at local and Trust level, with support from corporate services.

In addition to the IPR quarterly reviews will be conducted by the Quality Improvement Group and reports provided to EMT and the Clinical Governance and Clinical Safety Committee. Additional resources may be required as the strategy begins to make an impact and business cases for staff, resources and technology will be developed as required. A detailed proposal will be included as a part of the implementation plan.

6. Member involvement – staff and public

We are committed to ensuring our members play a full part in owning and governing our Foundation Trust. Our long-established Members Council Quality Group will help to make sure that this is the case in all of our quality improvement activity, so that the views of stakeholders are heard and actioned. The strategy has been shared with staff, service users and carers, via our partnership team and members council.

7. Stakeholder considerations

It will be essential to work in partnership with others when implementing this strategy. We will need to stay closely linked to regional and national developments and work collaboratively with the quality leads of both the West Yorkshire and South Yorkshire Sustainability and Transformation Partnerships.

Our stakeholders will also be kept informed of our quality improvement developments on a regular and routine basis through our regular, routine reporting structures and promotion of our #allofusimprove campaign.

8. Next steps and governance arrangements

- This strategy will be delivered in partnership between the Business Delivery Units (BDUs) and support services.
- Establish strong clinical, operational and governance leadership.
- A quality strategy implementation plan will be developed by the Quality Improvement and Assurance Team in collaboration with the Quality Improvement Group.
- Each BDU will develop a local action plan for the local change level, as well as supporting the Do and Share level improvements within their teams and services using the I-Hub virtual change platform.
- Progress will be reported at least bi-annually into Clinical Governance and Clinical Safety Committee and monitored locally via the BDU governance groups for the local change level.
- Quality improvements will be discussed, debated and planned at the Quality Improvement Group, which gives critical consideration of organisation quality and safety improvements.
- Information will be shared and ideas generated on how to progress improvement activity.
- Monthly updates will be provided via internal comms.
- Staff will be encouraged to Do and Share improvements in line with our integrated change framework.
- Opportunities for generating knowledge and sharing ideas will be encouraged through the use of the I-Hub Knowledge cafes, randomised coffee groups, communities of practice and the integrated change network.
- Large and significant changes will be reported through the Trust Integrated Performance Report and quality account.

9. Evaluation and review

Progress in implementing the strategy will be monitored monthly by the QIAT in collaboration with the Clinical Governance Group.

EMT and the CGCS Committee will receive a progress report quarterly

The Quality Improvement Group (QIG) will review progress and refresh action plan annually for the three-year duration of the strategy

A three-year review will be conducted by the QIAT and QIG once the strategy implementation is completed in 2021

10. Quality and equality impact assessments

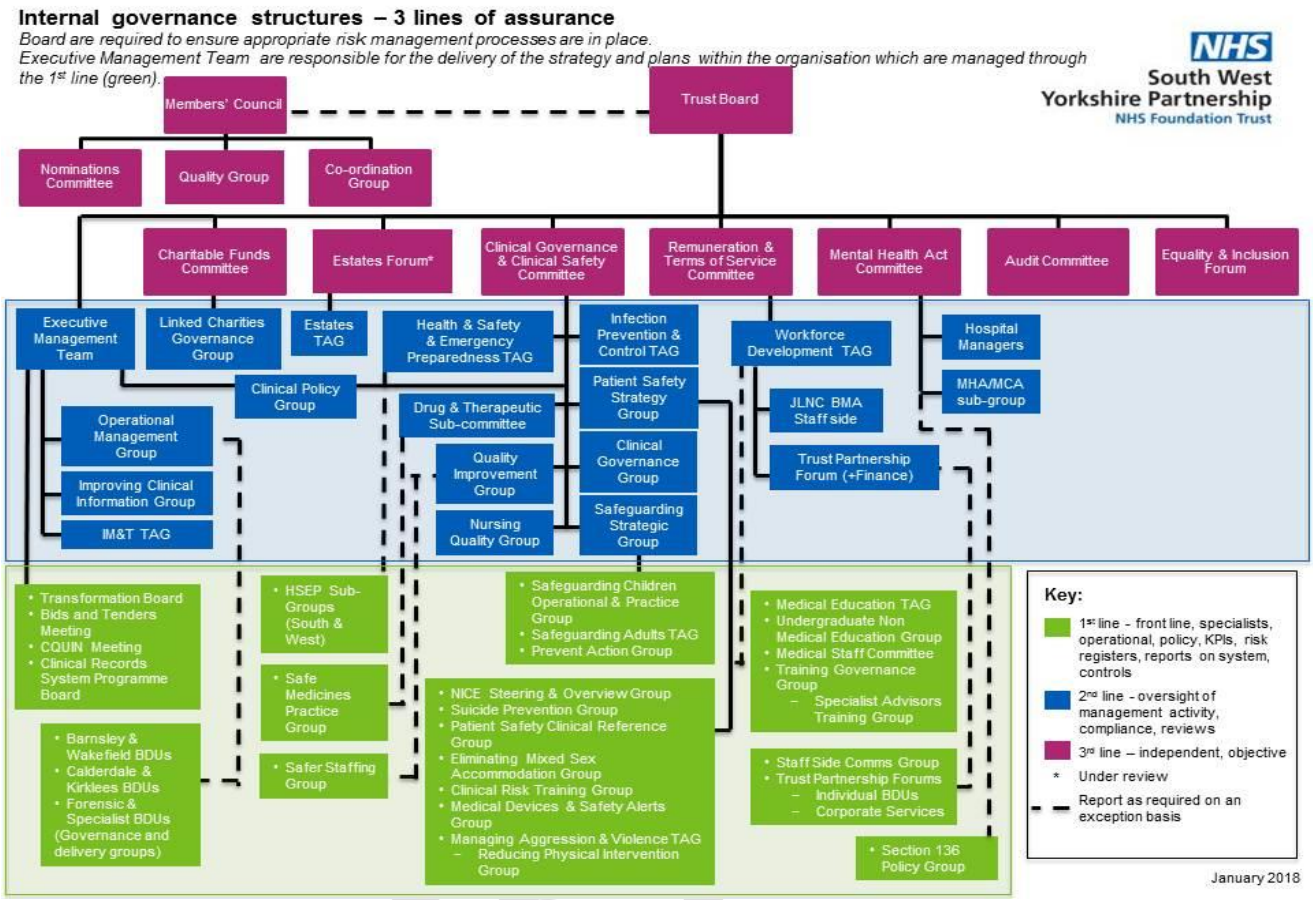
From a quality perspective, in approving this strategy our executive management team and Trust Board confirms that it:

- Will help improve service user experience
- Will help reduce harm
- Will help us to be more effective
- Is aligned to our mission and values
- Is aligned to our system intentions
- Is as ambitious as it can be in the current climate.

An equality impact assessment has been undertaken, and can be found in Appendix 11.3

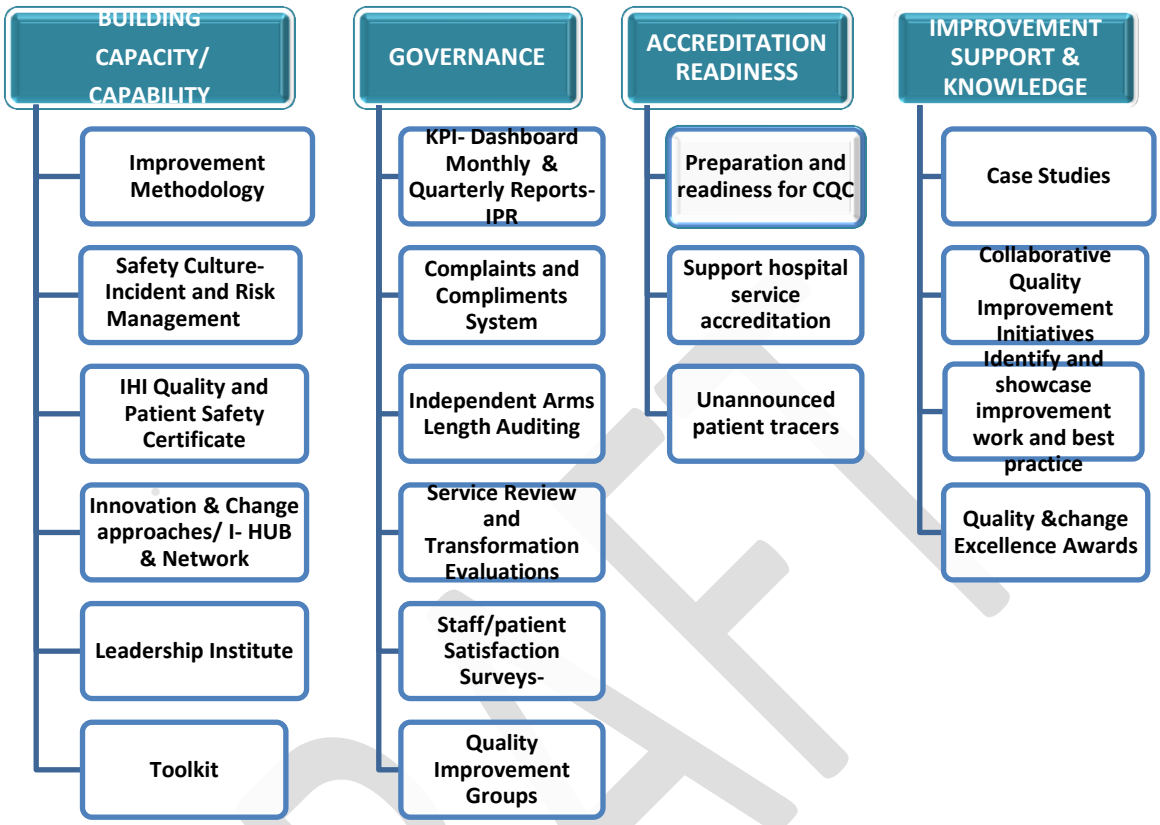
11. Appendices

Appendix 11.1 Quality Governance Framework



Appendix 11.2

Integrated change work streams



Appendix 11.3 – Equality impact assessment

Date of assessment: 29th December 2017

	Equality Impact Assessment Questions:	Evidence based answers & actions:
1	**Name of the document that you are Equality Impact Assessing**	Quality Strategy
2	**Describe the overall aim of your document and context?** **Who will benefit from this policy/procedure/strategy?**	This quality strategy sets out our commitment to providing high quality care for all stakeholders, while achieving our organisational mission to help people to reach their potential and live well in their communities It sets out what we mean by quality and provides a framework for how we assure and improve quality across the organisation. It also describes our Integrated Change Framework that supports innovation and improvement at all levels.
3	**Who is the overall lead for this assessment?**	• Director of Nursing and Quality
4	**Who else was involved in conducting this assessment?**	• Director of marketing, communication and engagement • Deputy Director of Nursing and Quality • Assistant Director of Nursing and Quality
5	**Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy?** **What did you find out and how have you used this information?**	• Staff - involved through clinical governance group and quality improvement group • Service user / carer / member / staff views - gathered during the development of the quality account and quality priorities Stakeholders will be involved through an externally commissioned survey, to be conducted annually for duration of the strategy. The results of which will feed into action planning. The feedback will be used to inform the strategy – promote 2-way dialogue, improve connection to the organisation and enable participation in decision making, service planning and delivery.
6	**What equality data have you used to inform this equality impact assessment?**	Population statistics for our localities in respect of race equality, disability, gender, age and sexual orientation, religion and belief, marriage and civil partnership from census data. We also have access to JSNAs and public health profiles for our localities. The makeup of our Trust membership and

			volunteers through individual self-declaration.
7	**What does this data say?**		Our local communities are diverse in many ways. This strategy and the quality improvements identified have equal applicability to all stakeholders with specific measures developed that are sensitive to diverse needs. We are committed to ensuring we understand our stakeholders and tailor our quality initiatives appropriately.
8	**Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavourably:**	**No**	**Evidence based answers & actions. Where negative impact has been identified please explain what action you will take to remove or mitigate this impact.** The purpose of the strategy is to improve the quality of our services for all stakeholders regardless of race, disability, gender, age, sexual orientation, religion, caring responsibilities, health or employment status. Targeted action planning will address the needs of specific audiences and we will work with communities, including people with protected characteristics, to share information and work in ways that meet their needs and preferences. Accessible, understandable and easy to read information will be provided including strategy on a page and frequently asked questions.
8.1	**Race**	**No**	Rationale as set out above
8.2	**Disability**	**No**	Rationale as set out above
8.3	**Gender**	**No**	Rationale as set out above
8.4	**Age**	**No**	Rationale as set out above
8.5	**Sexual orientation**	**No**	Rationale as set out above
8.6	**Religion or belief**	**No**	Rationale as set out above
8.7	**Transgender**	**No**	Rationale as set out above
8.8	**Maternity & Pregnancy**	**No**	Rationale as set out above
8.9	**Marriage & civil partnerships**	**No**	Rationale as set out above

8.10	**Carers (Our Trust requirement)**	**No**	Rationale as set out above
9	**What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-**		Current governance processes include monitoring of complaint themes, quality visits, quality indicators, IPR, PLACE reviews including service users, clinical audit and practice evaluations. Overview of performance through Equality and Inclusion Forum.
9a	**Promotes equality of opportunity for people who share the above protected characteristics;**		Action planning will be undertaken to monitor impact and effectiveness
9b	**Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;**		Staff wellbeing survey, WRES monitoring information, review of complaint themes, and BAME staff equality network.
9c	**Promotes good relations between different equality groups;**		WRES monitoring information.
9d	**Public Sector Equality Duty – "Due Regard"**		EDS2 workshop involving service users and staff
10	**Have you developed an Action Plan arising from this assessment?**		This strategy will be monitored through the delivery of an action plan, tailored to the needs of identified audiences
11	**Assessment/Action Plan approved by (Director Lead)**		**Sign: T Breedon** **Date: 29th December 2017** **Title: Director of Nursing & Quality**
12	***Once approved, you must forward a copy of this Assessment/Action Plan to the partnerships team:*** **partnerships@swyt.nhs.uk** **Please note that the EIA is a public document and will be published on the web.** **Failing to complete an EIA could expose the Trust to future legal challenge.**		

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 March 2018
Agenda item 9.2

Title:	**Update to the Trust Board declaration and register of fit and proper persons, interests and independence policy**
Paper prepared by:	Director of Finance Company Secretary
Purpose:	NHS England issued new guidance for the NHS organisations on managing staff conflicts of interests (https://www.england.nhs.uk/ourwork/coi/). This policy is an update to the Trust's policy to align with the guidance and Standards of Business Conduct policy (conflict of interest policy) for staff.
Mission/values:	The NHS as a whole spends a large amount of public money and therefore it is vital that this is done in the best interest of the population served. The Trust Board declaration and register of fit and proper persons, interests and independence policy, which is supported by NHS England's guidance, is designed to ensure that Directors and Non-Executive Directors are clear about the importance that decisions are seen to be arrived at without undue influence. This policy supports all the Trust's values but in particular the commitment to be honest, open and transparent.
Any background papers/ previously considered by:	Update to the previous *Policy for Trust Board declaration and register of fit and proper persons, independence, interests, gifts and hospitality* approved by Trust Board in March 2015. The update has been reviewed by the Executive Management Team on 8 March 2018 who support its approval.
Executive summary:	The Trust has held a policy in relation to Directors' declarations of interest since inception in April 2002. The current *Policy for Trust Board declaration and register of fit and proper persons, independence, interests, gifts and hospitality* was approved by Trust Board in March 2015 and is due for review. The Policy addresses the requirements of the following: ➢ Constitution of the Trust ➢ National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) ➢ Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ➢ Bribery Act 2010 It also takes into account the Codes of Conduct and Accountability issued by the Department of Health and UK Corporate Governance Code produced by the Financial Reporting Council. **Review** In October 2017, Trust Board approved the *Standards of Conduct in Public Service Policy* (conflicts of interest policy). This policy replaced the previous Standards of Business Conduct which forms part of all staff contracts of employment and was updated to further align with new NHS England guidance and model policy for NHS organisations on managing staff conflicts of interests. Within the policy it notes that some staff are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role referred to as 'decision making staff' which includes

	Trust Directors and Trust Board members. Following further clarification received from NHS England, it is recommended that Trust Board follow the same requirements within the *Standards of Conduct in Public Service Policy* for declaring interests which includes: gifts, hospitality, outside employment, shareholdings and other ownership issues, patents, loyalty interest, donations, sponsored events, sponsored research, sponsored posts, and clinical private practice. The Trust Board Policy and declaration form has been updated to reference the *Standards of Conduct in Public Service Policy*. However, it is recommended that the 'Declaration of interest duties of Directors' within the Trust Board Policy also remains, noting that, in the spirit of openness and transparency, Directors are also encouraged to declare all relevant and material interests. Further amendments to the Trust Board Policy include the update of Trust branding and terminology within the policy and declaration forms. Note, there are separate conflict of interest policy for the Members' Council (*Members' Council declaration and register of interests, gifts and hospitality*) which support the specific requirements 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. This policy will be reviewed and approved at the next Members' Council meeting. **Risk appetite** The Trust Board declaration and register of fit and proper persons, interests and independence policy remains compliant with the requirements under Constitution of the Trust, National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Bribery Act 2010. It has been reviewed to align it to the Standards of Conduct in Public Service Policy (conflicts of interest policy) which is compliant with the NHS England guidance. Therefore there is no change to any identified risks and it remains consistent with the agreed risk tolerance.
Recommendation:	**Trust Board is asked to APPROVE the updated policy which is aligned with the guidance issued by NHS England on managing conflicts of interest.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board declaration and register of fit and proper persons, interests and independence policy

Approved by Trust Board 27 March 2018

1. Introduction and background

In accordance with the Constitution of the Trust, the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and Monitor's Code of Governance for Foundation Trusts, and in recognition of the Codes of Conduct and Accountability issued by the Department of Health and the UK Corporate Governance Code produced by the Financial Reporting Council, the Trust is required to maintain a Register of Interests of Directors. The Trust is also required, under the new fundamental standard regulations set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to ensure its Directors meet fit and proper person requirements, which came into force on 1 October 2014.

2. Policy development

The Trust has had a policy in place in relation to Directors' declarations of interests since its inception in April 2002. This Policy was replaced in May 2009 when the Trust was authorised as a Foundation Trust.

In September 2011, the Policy was subsequently revised to incorporate the Bribery Act 2010, which came into force on 1 July 2011 and created criminal offences of being bribed, bribing another and failing to prevent bribery for all organisations, including the NHS. Under the Act, bribery is defined as an inducement or reward offered, promised or provided to gain personal, commercial, regulatory or contractual advantage. If a Director is offered, or any attempt is made to offer, any type of possible inducement or reward covered by the Bribery Act, details should be immediately reported to the Trust's Local Counter Fraud Specialist.

In December 2013, a further revision was made to reflect the changes to the Trust's Constitution as a result of the provisions in the Health and Social Care Act 2012 relating to Directors' interests.

In March 2015, a further revision was made to incorporate the fit and proper person requirement for directors set out in the new fundamental standard regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which came into force on 1 April 2015. Within the new regulations, the duty of candour and the fit and proper person requirements for Directors came into force earlier for NHS bodies on 1 October 2014.

In March 2018, a further revision was made to align the Policy with the Trust's Standards of Conduct in Public Service Policy (conflicts of interest policy) which addresses the requirements of the NHS England guidance and model policy for the NHS organisations on managing staff conflicts of interests.

This Policy applies to all directors and 'equivalents', which, for this Trust, includes both Non-Executive and Executive Directors of the Trust, and other Directors forming the Executive Management Team.

3. Fit and proper person requirement for directors

The fit and proper person requirement for directors states that individuals who have authority in organisations that deliver care are responsible for the overall quality and safety of that care and, as such, can be held accountable if standards of care do not meet legal requirements. It applies to all directors and 'equivalents', which, for this Trust, includes both Non-Executive and Executive Directors of the Trust, and other Directors forming the Executive Management Team. It is the responsibility of the Chair to ensure that all Directors meet the fitness test and do not meet any of the 'unfit' criteria.

In addition to the usual requirements of good character, health, qualifications, skills and experience, the regulation bars individuals who are prevented from holding the office (for example, under a director's disqualification order) and excludes from office people who:

"have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider."

The Care Quality Commission (CQC) is the body that will decide whether a person is not fit to be a director on the basis of any previous misconduct or incompetence in a previous role for a service provider. This would be the case even if the individual was working in a more junior capacity at that time, or working outside England.

The regulation requires the Chair to:

- confirm to the CQC that the fitness of all new directors has been assessed in line with the regulations; and
- declare to the CQC in writing that they are satisfied that they are fit and proper individuals for that role.

A notification is required following a new director-level appointment. The CQC will cross-check notifications about new directors against other information they hold or have access to, to decide whether it wants to look further into the individual's fitness. The CQC will also have regard to any other information they hold or obtain about directors in line with current legislation on when convictions, bankruptcies or similar matters are to be considered 'spent'.

Where a director is associated with serious misconduct or responsibility for failure in a previous role, the CQC will have regard to the seriousness of the failure, how it was managed, and the individual's role within that. There is no time limit for considering such misconduct or responsibility. Where any concerns about an existing director come to the attention of the CQC, it may also ask the Trust to provide the same assurances.

Should the CQC use its enforcement powers to ensure all directors are fit and proper for their role, it will do so by imposing conditions on the provider's registration to ensure the provider takes appropriate action to remove the director.

4. Fit and proper person requirement – Trust duties

To meet the requirements of the fit and proper person test, the Trust must carry out all necessary checks to confirm that persons who are appointed to the role of director in the Trust are:

- of good character (Schedule 4, Part 2 of the regulations);

- have the appropriate qualifications, are competent and skilled (including that they show a caring and compassionate nature and appropriate aptitude);
- have the relevant experience and ability (including an appropriate level of physical and mental health, taking account of any reasonable adjustments); and
- exhibit appropriate personal behaviour and business practices.

In addition, persons appointed to these roles must not have been responsible for, or known, contributed to or facilitated any serious misconduct or mismanagement in carrying on a regulated activity.

The Trust will ensure it has procedures in place to assess an individual against the fit and person requirements for new Director appointments prior to that appointment. The Company Secretary is responsible for ensuring procedures are in place and implemented for Non-Executive Director appointments and the Director of Human Resources for Executive and 'other' Director appointments.

The CQC does recognise that the Trust may not have access to all relevant information about a person, or that false or misleading information may be supplied to it; however, the CQC does expect the Trust to demonstrate due diligence in carrying out checks and that it has made every reasonable effort to assure itself about an individual by all means available to it.

If the Trust decides to appoint a director, or continues to employ or appoint a Director, who does not meet the 'fit and proper person' test, it will need a strong rationale for doing so, which is defendable by the Chair both to the CQC and to Monitor. Currently, the only outcome if the CQC decides an individual is not a 'fit and proper person' is removal.

5. Fit and proper person requirement – individual responsibilities

Although the obligation is on the Trust to ensure it meets the regulation particularly in relation to new appointments, Trust Board agreed in September 2014 that Directors have a responsibility to continue to make a declaration that they meet the fit and proper person requirement as part of the annual declaration of interests process and should their circumstances change.

The criteria for a 'fit and proper person' are as follows.

- The individual is of good character.
- The individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed or appointed.
- The individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed.
- The individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.
- None of the grounds for unfitness specified in Part 1 of Schedule 4 apply to the individual (see below):

  Schedule 4 criteria
  Fit and proper
  1. The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.

2. The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.
3. The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.
4. The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.
5. The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.
6. The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

And for good character

7. Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence.
8. Whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.

6. Conflicts of interest – duties of Directors

Meeting the fit and proper person requirement as set out above does not remove the responsibility of Directors of the Trust to adhere to the duties of a Director of the Trust, as set out in the Trust's Constitution, which include the following.

1. A duty to avoid any situation where a Director has (or could have) a direct or indirect interest that conflicts (or may possibly conflict) with the interests of the Trust. This duty is not infringed if the situation cannot reasonably be regarded as likely to give rise to a conflict of interest or the matter has been authorised in accordance with the Constitution.

2. A duty not to accept a benefit from a third party because they are a Director or doing (or not doing) anything in this capacity. This duty is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest. (A "third party" means a person other than the Trust or a person acting on its behalf.)

The Trust's *Standards of Conduct in Public Service Policy* (conflicts of interest policy), which addresses the requirements of the NHS England guidance and model policy for the NHS organisations on managing staff conflicts of interests, applies to Directors of the Trust as 'decision making staff'. The policy describes the requirements for declaring interests including gifts, hospitality, outside employment, shareholdings and other ownership issues, patents, loyalty interest, donations, sponsored events, sponsored research, sponsored posts, and clinical private practice. Further to this, Directors are expected to:

a) refuse gifts, benefits, hospitality or sponsorship of any kind that might reasonably be seen to compromise their personal judgement or integrity and/or exert influence to obtain preferential consideration. All such gifts should be returned and hospitality refused other than isolated gifts of a trivial nature, such as, calendars, or conventional hospitality, such as working lunches.
b) declare and register gifts, benefits and sponsorship of any kind within two weeks of it being offered, whether refused or accepted. If an individual is unsure whether the offer constitutes hospitality, gifts or rewards as defined by the Trust's policy, then they should declare.

This applies to both implicit and explicit offers and whether or not linked to the awarding of contracts or a change in working practices.

If a Director of the Trust has a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to Trust Board. If a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. Any declaration must be made before the Trust enters into the transaction or arrangement.

If the Director is not aware of an interest, or where the Director is not aware of the transaction or arrangement in question, no declaration is required.

A Director need not declare an interest:

a) if it cannot reasonably be regarded as likely to give rise to a conflict of interest;
b) if, or to the extent that, the Directors are already aware of it;
c) if, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered either by a meeting of the Board of Directors or by a committee of the Directors appointed for the purpose under the Constitution.

All declarations will be entered into the Trust's Register of Interests maintained by the Company Secretary.

7. Declaration of interest – duties of Directors

In a spirit of openness and transparency, Directors are also encouraged to declare all relevant and material interests. These apply to the Director as well as the husband/wife, partner, parent, child or sibling of the Director and can be defined as follows.

a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);
b) Ownership, part-ownership or directorship of private companies, business or consultancies likely or possibly seeking to do business with the NHS or which may conflict with the interests of the Trust;
c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS or which may conflict with the interests of the Trust;
d) A position of authority in a charity or voluntary organisation in the field of health and social care;
e) Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services; and
f) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS Foundation Trust, including but not limited to, lenders or banks.

If Directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair.

Details of any such interests will be recorded in the register of interests of the Directors as outlined below.

8. Declaration of interest – conduct at meetings

Any Director who fails to disclose any interest required to be disclosed under the Constitution and as set out in this Policy may be removed from office in accordance with the process for removing a Director as set out in the Trust's Constitution.

Any Director who has an interest in a matter to be considered by Trust Board that needs to be declared should declare such interest to Trust Board and:

1. withdraw from the meeting and play no part in the relevant discussion or decision; and
2. not vote on the issue (and, if by inadvertence, they do remain and vote, their vote shall not be counted).

At the time an interest is declared, it should be recorded in Trust Board meeting minutes. Any changes in interests should be officially declared at the next Trust Board meeting following the change occurring. The Trust should be informed in writing within four weeks of becoming aware of the existence of, or a change to, an interest. The Register of Interests will be amended on receipt within seven working days and the interest notified to the next relevant meeting.

During the course of a Trust Board meeting, if a conflict of interest is established, the Director(s) concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, a majority will resolve the issue with the Chair having the casting vote.

9. Register of interests

Details of any interests declared by Directors will be recorded in the Register of Interests of the Directors.

The details of Directors' interests recorded in the Register will be kept up-to-date by means of a monthly review of the Register by the Company Secretary during which any changes of interests declared during the preceding month will be incorporated.

An annual review process will be undertaken by the Company Secretary and the Register of Interests presented to Trust Board on an annual basis (usually in March each year). As part of this process, Trust Board will assess any apparent conflicts and/or any risks an interest might present to the Trust. This annual review is over and above the requirement for Directors to declare interests during the year and is a standing item on each public Trust Board meeting agenda.

Subject to contrary regulations being passed, the Register will be available for inspection by the public free of charge and will be available on the Trust's website. The Company Secretary will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it. Copies or extracts of the Register must be provided to members of the Trust free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-members for copies or extracts of the Register, informed by guidance from the Information Commissioner.

10. Determination of independence

Monitor's Code of Governance also requires the Board to identify in the Trust's annual report those Non-Executive Directors it considers to be independent in character and judgement and whether there are any relationships or circumstances likely to affect, or could appear to affect, the Director's judgement. In addition to the above fit and proper person requirements and declaration of interests, Non-Executive Directors are also asked to declare whether he/she:

a) has been an employee of the Trust within the last five years;

b) has, or has had within the last three years, a material business relationship with the Trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the Trust;
c) has received or receives additional remuneration from the Trust apart from the Non-Executive Directors' fee, participates in the Trust's performance related pay scheme, or is a member of the Trust's pension scheme;
d) has close family ties with any of the Trust's advisers, Directors or senior employees;
e) holds cross-directorships or has significant links with other Directors through involvement in other companies or bodies;
f) has served on the Trust Board for more than nine years from the date of their first appointment.

Non-Executive Directors have a responsibility to continue to make a declaration of independence as part of the annual declaration of interests process and should their circumstances change.

11. Appendices

- Fit and proper person declaration by the Chair and Directors of the Trust form
- Declaration of interests by the Chair and Directors of the Trust form
- Declaration of independence by the Chair and Non-Executive Directors of the Trust form

Approved by Trust Board 27 March 2018
Next review by Trust Board March 2021

South West Yorkshire Partnership NHS Foundation Trust

FIT AND PROPER PERSON DECLARATION BY THE CHAIR AND DIRECTORS OF THE TRUST

The Trust is required, under the Fundamental standard regulations set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to ensure its Directors meet fit and proper person requirements, which came into force on 1 October 2014. Trust Board agreed in September 2014 that it would undertake a retrospective declaration for all Directors as part of the annual declaration exercise in 2015. A declaration against the fit and proper person requirement will then become part of the annual declaration for existing Directors and part of the appointment process for new Directors.

In addition to the usual requirements of good character, health, qualifications, skills and experience, the fit and proper person regulation bars individuals who are prevented from holding the office (for example, under a director's disqualification order) and excludes from office people who:

> *"have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider."*

To meet the requirements of the fit and proper person test, the Trust will carry out all necessary checks to confirm that individuals who are appointed to the role of director in the Trust:

- are of good character (see below under Schedule 4 criteria);
- have the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed or appointed;
- able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed;
- have not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity;
- if none of the grounds for unfitness specified in Part 1 of Schedule 4 apply to the individual (see below):

<u>Schedule 4 criteria</u>
Fit and proper

1. The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.
2. The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.
3. The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.
4. The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.
5. The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.

6. The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

And for good character

7. Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence.
8. Whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.

You are asked to make the following Declaration:

I confirm that I do not fit within the definition of an "unfit person" as set out above and that there are no other grounds under which I would be ineligible to be appointed to or to continue in post. I undertake to notify the Trust immediately if I no longer satisfy the criteria to be a "fit and proper person" or other grounds under which I would be ineligible to continue in post come to my attention.

Name: _____ **Signed:**_____

Position: _____ **Date:** _____

NOTES REGARDING THE USE OF THIS INFORMATION

- Directors should note that, if they are not able to make a declaration against the fit and proper requirements, this could effectively prevent them from appointment to a Director post or continuing in such a post.
- If Directors have any doubt about making this declaration, it should be discussed with the Chair as a matter of urgency.
- The information provided on this form will be recorded in the minutes of Trust Board. These minutes will be drawn to the attention of the Trust's internal and external auditors.
- Any Declaration will also be included in a Register of Interests, which will be available to the public on request, available on the Trust's website and reported in the Trust's annual report.
- Any changes to the information provided should be declared to the Chair immediately. Such a change will be recorded in the relevant minutes and in the Register of Interests.

This form should be returned to:

Company Secretary
Block 7
Fieldhead
Ouchthorpe Lane
Wakefield
WF1 3SP

South West Yorkshire Partnership NHS Foundation Trust

DECLARATION OF INTERESTS
BY THE CHAIR AND DIRECTORS OF THE TRUST

In accordance with the Constitution of the Trust, the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and Monitor's Code of Governance for Foundation Trusts, and in recognition of the Codes of Conduct and Accountability issued by the Department of Health and the UK Corporate Governance Code produced by the Financial Reporting Council, the Trust is required to maintain a Register of Interests of Directors.

As set out in the Trust's Constitution, the duties of a Director of the Trust, whether Non-Executive or Executive, include the following.

1. A duty to avoid any situation where a Director has (or could have) a direct or indirect interest that conflicts (or may possibly conflict) with the interests of the Trust. This duty is not infringed if the situation cannot reasonably be regarded as likely to give rise to a conflict of interest or the matter has been authorised in accordance with the Constitution.

2. A duty not to accept a benefit from a third party because they are a Director or doing (or not doing) anything in this capacity. This duty is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest. (A "third party" means a person other than the Trust or a person acting on its behalf.)

If a Director of the Trust has a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to Trust Board.

In a spirit of openness and transparency, Directors are also encouraged to declare all relevant and material interests. These apply to the Director as well as the husband/wife, partner, parent, child or sibling of the Director.

Please complete the Declaration below.

1. Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).

2. Ownership, part-ownership or directorship of private companies, business or consultancies likely or possibly seeking to do business with the NHS or which may conflict with the interests of the Trust.

3. Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS or which may conflict with the interests of the Trust.

4. A position of authority in a charity or voluntary organisation in the field of health and social care.

5. Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services.

6. Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS Foundation Trust, including but not limited to, lenders or banks.

NOTES REGARDING THE USE OF THIS INFORMATION

- If Directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair.
- The information provided on this form will be recorded in the minutes of Trust Board. These minutes will be drawn to the attention of the Trust's internal and external auditors.
- Any Declaration will also be included in a Register of Interests, which will be available to the public on request, available on the Trust's website and reported in the Trust's annual report.
- Any changes to the information provided should be declared within four weeks of the change occurring. Such a change will be recorded in the relevant minutes and in the Register of Interests.
- If a conflict of interest is established during the course of a Trust Board meeting, the Director concerned is required to withdraw from the meeting and to play no part in the relevant discussion or decision.

Name: _____ Signed: _____

Position: _____ Date: _____

This form should be returned to:

Company Secretary
Block 7
Fieldhead
Ouchthorpe Lane
Wakefield, WF1 3SP

South West Yorkshire Partnership NHS Foundation Trust

DECLARATION OF INDEPENDENCE BY THE CHAIR AND NON-EXECUTIVE DIRECTORS OF THE TRUST

Monitor's Code of Governance requires the Board to identify in the Trust's annual report which Non-Executive Directors it considers to be independent in character and judgement and whether there are any relationships or circumstances which are likely to affect, or could appear to affect, the Director's judgement.

In addition to the declaration against the fit and proper person requirements and declaration of interests, Non-Executive Directors are also asked to declare whether he/she:

1. has been an employee of the Trust within the last five years;

2. has, or has had within the last three years, a material business relationship with the Trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the Trust;

3. has received or receives additional remuneration from the Trust apart from the Non-Executive Directors' fee, participates in the Trust's performance related pay scheme, or is a member of the Trust's pension scheme;

4. has close family ties with any of the Trust's advisers, Directors or senior employees;

5. holds cross-directorships or has significant links with other Directors through involvement in other companies or bodies;

6. has served on the Trust Board for more than nine years from the date of their first appointment.

NOTE REGARDING THE USE OF THIS INFORMATION

The information you have provided on this form will be recorded in the minutes of Trust Board in relation to the independence of Non-Executive Directors. These minutes will be drawn to the attention of the Trust's internal and external auditors. The Declaration will also be included in a Register of Interests, which will be available to the public on request, available on the Trust's website and reported in the Trust's annual report.

Any changes to the information you have provided should be declared within four weeks of the change occurring. Such a change will be recorded in the relevant minutes and in the Register of Interests.

If an issue regarding independence is established during the course of a Trust Board meeting, the Director concerned is required to withdraw from the meeting and to play no part in the relevant discussion or decision.

Name: _____ Signed: _____

Position: _____ Date: _____

This form should be returned to:

Company Secretary
Block 7
Fieldhead
Ouchthorpe Lane
Wakefield, WF1 3SP

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 March 2018
Agenda item 10.1

Title:	Appointment of Responsible Officer for Medical Staff Revalidation.
Paper prepared by:	Director of Human Resources, Organisational Development and Estates.
Purpose:	This paper provides the Trust Board with an update and confirmation of the arrangements for the Responsible Officer for Medical Revalidation following Dr Berry's retirement on the 11th April 2018.
Mission/values:	The appointments of the Medical Director and Responsible Officer for medical staff revalidation are key to the delivery of the Trust's Mission, Vision and Values.
Any background papers/ previously considered by:	The Remuneration and Terms of Service Committee (RTSC) agreed the process for the appointment of the Medical Director. This included the redesign of the Medical Director post and the agreement for Dr Berry to retire and return to the role of Responsible Officer for medical staff revalidation.
Executive summary:	The decision of Dr Berry to retire from the post of Medical Director on the 11th April 2018 gave the opportunity to re-look at the role. The RTSC considered the key priorities of the Medical Director role for the next two years and the importance of attracting high calibre candidates. It was agreed to redesign the role to allow the new Medical Director to maintain a clinical case load in the first instance. In order to do this it was also agreed to separate the Medical Director role and the Responsible Officer for Medical Revalidation role which a growing number of Trusts are now doing. It was felt that removing the Responsible Officer for Medical Staff Revalidation from the Medical Director role would enable the successful to initially maintain a clinical caseload. In order to facilitate this redesign the RTSC agreed to the retire and return of Dr Berry to continue with his current role as Responsible Officer for medical staff revalidation. Dr Berry is required to have a break in service and will leave on 11th April 2018 and be re-employed on the 1st May 2018. This would mean a potential gap in the Trust having a Responsible Officer for Medical Revalidation. Dr Thiyagesh has been appointed as Medical Director and will take up the role on the 12th April 2018 following Dr Berry's retirement. Dr Thiyagesh has attended the training for a Responsible Officer and the proposal is that she acts as Responsible Officer from the 12th April 2018 to 30th April 2018. This appointment and the robust selection process are consistent with the Trust's Risk Appetite.
Recommendation:	**The Trust Board is ASKED to confirm the appointment of Dr S Thiyagesh as Responsible Officer for Medical Revalidation from the 12th April 2018 to 30th April 2018. In addition to confirm Dr Berry as Responsible Officer for medical staff revalidation with effect from 1st May 2018.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 March 2018
Agenda item 10.2

Title:	**Eliminating mixed sex accommodation (EMSA) declaration of compliance**
Paper prepared by:	Director of Nursing and Quality
Purpose:	To appraise the Board of the Trust position in relation to eliminating mixes sex accommodation (EMSA) and to approve the annual declaration.
Mission/values:	We must support people to fulfil their potential and live well in their community. This includes safeguarding the privacy and dignity of service users when they are often at their most vulnerable. All values are relevant – person first and in the centre, respect and our aim to be outstanding are particularly prevalent.
Any background papers/ previously considered by:	Trust Board reviews the compliance statement on an annual basis. Any exception reports regarding EMSA are reported to the Clinical Governance and Clinical Safety Committee by the Director of Nursing. There have been no exception reports in 2017.
Executive summary:	**Background** This paper is intended to assure Trust Board of the organisation's level of compliance with the national standard in respect of eliminating mixed sex accommodation. The declaration of compliance, which will appear on the Trust's website, is shown below. The Trust is expected to make a declaration to commissioners by 31 March 2018 to confirm the Trust's position regarding compliance with the EMSA standard. The statement of compliance is then required to be posted on the Trust website. The guidance in relation to EMSA expects Trusts to provide the following accommodation. Single Sex accommodation can be provided in: ➢ single sex wards (the whole ward is occupied by men or women but not both); ➢ single rooms with adjacent single sex toilet and washing facilities; ➢ single sex accommodation within mixed wards (bays or rooms that accommodate either men or women, not both) with designated single sex toilet and washing facilities preferably within or adjacent to the bay or room. In addition, service users should not need to pass through accommodation or toilet/washing facilities used by the opposite sex to gain access to their own. The 2017 audit was conducted only on mixed sex areas or any area where any regulator made any comments or raised any issues in the past year. The main conclusions are:

	➢ There were no recorded breaches of EMSA policy in 2017. ➢ As the Trust continues to increase its single sex accommodation, the number of EMSA related incidents decreases. ➢ The number of EMSA incidents recorded on Datix fell from 23 in 2016 to 11 in 2017. Preventative measure put in place to safeguard safety and dignity and no harm occurred; therefore no breaches ➢ In 2017 EMSA incidents were only recorded in one ward, which is an improvement from 2016 where incidents were spread across 6 wards. ➢ Staff gender mix on wards can effect ability to provide same sex key worker, this is due mainly to the shortage of male staff. ➢ CQC focussed inspection of Ward 18 in December 2017 found that: *"All patients were protected from potential harm and abuse. Patients' individual needs were met through timely risk assessments that were reviewed and updated regularly. The service had enough staff with the right training and support to deliver safe care and treatment. Regular assessment of environmental risk ensured facilities and equipment were safe for patients and staff."* Recommendations ➢ To continue to explore opportunities through the transformation agenda for wards to be designated single sex and to continue to improve the availability of en-suite accommodation in all units. ➢ To continue considering ways to avoid allocating bedrooms in areas designated for the opposite sex *All incidents related to service users requiring urgent admission to maintain safety and being placed in a single room in an opposite sex area where no bed in appropriate sex area was available. All were managed via policy and increased levels of observations* **Current Trust position** During 2017 there have been no reported EMSA breaches. The Trust is, therefore, in a position to declare EMSA compliance as follows. *"Every service user has the right to receive high quality care that is safe, effective and respects their privacy and dignity. The South West Yorkshire Partnership NHS Foundation Trust is committed to providing every service user with same sex accommodation, because it helps to safeguard their privacy and dignity when they are often at their most vulnerable.* *"We confirm that mixed sex accommodation has been eliminated in our organisation. Service Users that are admitted to any of our hospitals will only share the room where they sleep with members of the same sex, and same sex toilets and bathrooms will be close to their bed. Sharing of sleeping accommodation with the opposite sex will never occur. Occupancy by a service user within a single bedroom that is adjacent or near to bedrooms occupied by members of the opposite sex will only occur based on clinical need. If this occurs the service user will be moved to a bedroom block occupied by members of the same sex as soon as possible. On all mixed gender wards there are women only lounges or rooms which can be designated as such."*

	Compliance monitoring The Clinical Governance and Clinical Safety Committee receive assurance through the Director of Nursing about the Trust's compliance with eliminating mixed sex accommodation. Any potential areas of risk are considered at quarterly EMSA review group meetings. During 2017, the EMSA review group has monitored all reported instances where service users have had to sleep in a single room on a corridor or pod designated for the opposite sex. From January to December 2017, there were 11 such instances reported on Datix compared with 23 for the same time period in 2016. The 2017 EMSA Best Practice Guidance Audit Report indicates that the Trust continues to perform well against best practice standards. The EMSA review group will implement action against any areas where improvements can be made. The Trust also has an action plan for continued monitoring and improvement, which is linked to the Patient-led Assessment of the Care Environment (PLACE). Provision of high quality facilities that meet the privacy and dignity of service users is a prime consideration when any changes to the Trust estate are made. The trust increased the numbers of single sex wards in 2017. Going forward, transformation projects will work with commissioners to look for opportunities to create new, and improve current single sex environments. **Financial implications** Non-compliance against the eliminating mixed sex accommodation standard is a 'nationally specified event'. An EMSA breach will continue to carry financial penalties. **Legal implications** The Trust will need to ensure that it is compliant with safeguarding issues related to the provision of services through safe delivery of the Department of Health guidance on eliminating mixed sex accommodation. **Equality and diversity** The Trust's statutory duties relating to equality and diversity have been met. The Trust has considered equality and diversity when developing its estate to meet the privacy and dignity needs of service users. **Risk Appetite** An EMSA breach could potentially be a clinical risk as well as a compliance risk. Through the flexibility within the Trust's accommodation the risk is mitigated in line with the Trust's risk appetite. However, it may be deemed safer to breach EMSA on an individual basis than not to admit in a clinical emergency and actions would be put in place to manage the individual risk.
Recommendation:	**Trust Board is asked to APPROVE the compliance declaration.**
Private session:	Not applicable

South West Yorkshire Partnership NHS Foundation Trust

Eliminating Mixed Sex Accommodation Trust Audit 2017

Summary report

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

Report produced by:
Victoria Hitchman
Quality Improvement & Assurance Team

Project reference 17/18AA02

March 2018

With **all of us** in mind.

EXECUTIVE SUMMARY

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

Our mission

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

Our values

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

Trust inpatient services are provided in Calderdale, Kirklees, Wakefield and Barnsley. As part of the annual audit programme and identified as a priority area for the Eliminating Mixed Sex Accommodation (EMSA) Quarterly Review Group is an audit of the inpatient accommodation.

The current report details the findings from the 2017 audit against best practice standards. The 2017 audit only included mixed sex ward areas, or any areas identified as having any EMSA issues following the 2016 CQC Inspection.

16 inpatient units/wards across the Trust undertook the self-assessment.

The main conclusions are:

- There were no recorded breaches of EMSA policy in 2017.
- As the Trust continues to increase its single sex accommodation, the number of EMSA related incidents decreases.
- The number of EMSA incidents recorded on Datix fell from 23 in 2016 to 11 in 2017. Preventative measure put in place to safeguard safety and dignity and no harm occurred; therefore no breaches
- In 2017 EMSA incidents were only recorded in one ward, which is an improvement from 2016 where incidents were spread across 6 wards.
- Staff gender mix on wards can effect ability to provide same sex key worker, this is due mainly to the shortage of male staff.
- In addition, the CQC focussed inspection of Ward 18 in December 2017 found that:

"All patients were protected from potential harm and abuse. Patients' individual needs were met through timely risk assessments that were reviewed and updated regularly. The service had enough staff with the right training and support to deliver safe care and treatment. Regular assessment of environmental risk ensured facilities and equipment were safe for patients and staff."

Recommendations

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

- To continue considering ways to avoid allocating bedrooms in areas designated for the opposite sex

INCIDENT REPORTING

There were no breaches of EMSA policy in 2017.

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

Where such an incident occurs mitigating action includes:

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

The following table details the number of incidents recorded on Datix by BDU and ward during 2017.

Table 1: Summary of reported EMSA incidents

Ward and BDU	Number of Incidents	Risk Category GREEN – no harm or injury/minor injury, impact, intervention YELLOW – moderate injury, impact or intervention AMBER – major injury, impact or intervention
Kirklees/Calderdale	***11***	
Ward 18	11	10 green / 1 yellow
Total	**11**	

This is a reduction from 23 EMSA incidents last year. In 2017 EMSA incidents were only recorded in one ward, which is an improvement from 2016 where incidents were spread across 6 wards.

This suggests that as the Trust continues to increase its single sex accommodation, the number of EMSA related incidents decreases.

Table 2: Summary of results - Trust Board

Trust Board Self-Assessment

The Trust does not have any mixed sex sleeping accommodation so the standards are judged to be met as determined in previous audits.

Commentary given is related to maintaining good practice in regard to Trust Board information

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

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 March 2018
Agenda item 10.3

Title:	**Information Governance Toolkit**
Paper prepared by:	Information Governance Manager
Purpose:	Advise the Trust Board on the Trust's position in relation to Information Governance as at March 2018.
Mission/values:	Information Governance (IG) is a key issue to support patient safety. Information Governance Toolkit compliance at level 2 across all 45 requirements is currently needed to remain IG Statement of Compliance (IGSoC) compliant.
Any background papers/ previously considered by:	Monthly IG updates are provided to the Executive Management Team (EMT) and headline information is communicated to Trust Board through the Integrated Performance Report. Continuous updates on delivery of key IG audit action plans and awareness raising of risks/issues are provided to the Audit Committee
Executive summary:	➢ Attached is the annual position statement. ➢ The information Governance Toolkit assessment has come out at level 2 (satisfactory). ➢ The internal audit has come out at "significant assurance". ➢ Improvements will continue to be made on IG in line with the audit and the risk appetite. **Risk appetite** The Trust risk appetite for IG remains as low with a target score of 1-3. Current risk given the impact is higher than this (4-6). Actions continue as identified above to reduce the likelihood of the risk occurring.
Recommendation:	**Trust Board is asked to NOTE the current position regarding the points noted and APPROVE the submission of the IGTK for 2017/18.**
Private session:	Not applicable

South West Yorkshire Partnership NHS Foundation Trust

Information Governance Toolkit

Outcome of IG toolkit and Internal Audit Review

The Information Governance Toolkit (IGTK) is a Department of Health (DH) policy delivery vehicle that NHS Digital is commissioned to maintain. It draws together the legal rules and central guidance set out by DH policy and presents them in a single standard as a set of Information Governance requirements. Organisations in scope are required to carry out annual, self-assessments of their compliance against 45 IG requirements. In order to be compliant organisations must achieve at least level 2 on each.

For mandatory IG training the target is for 95% of current employees, excluding those on long term sick or maternity leave, external secondments, etc. to be compliant. The Trust's position at 13/03/2017 was 96%. 208 employees were excluded from this statistic given this criteria, 204 (4%) members of staff were non-compliant at the above date.
The Trust has received a significant assurance opinion from 360 Assurance, for the IGTK for 201/17 which will now be submitted as follows:

Assessment	Level 0	Level 1	Level 2	Level 3	Not Relevant	Total Req'ts	Overall Score	Initial Grade	Current Grade
Version 14.1 (2017-2018)	0	0	44	0	1	45	66% Level 2	Satisfactory	Satisfactory

Director leads

The Director of Finance is the Trust's Senior Information Risk Owner (SIRO) and IG director lead. The Director of Nursing & Quality is the Trust's Caldicott Guardian and the lead director of clinical records. The Director of Finance (SIRO) is also the lead director for non-clinical records.

Incidents

Guidance is issued annually by NHS Digital requiring trusts to report any incidents scored level 2 or above to the Information Commissioners Office (ICO). The scoring criteria takes into account the number of individuals affected, the type of incident and the sensitivity of the information. As such, one letter with sensitive information wrongly addressed may score a level 2, as is the case with some of the incidents detailed below.

4 serious incidents were reported in year, of which one was later withdrawn. Currently one incident is being investigated, which involved sensitive information regarding two Forensic CAMHs service users being disclosed in error to each other's intended recipient.
Of the other two incidents, one involved a letter containing sensitive mental and physical health information being sent to a service user's home address. The service user had requested no correspondence as he suspected his family read his mail and they were unaware of his health concerns. The family did read the letter and significant distress was caused to the family and a complaint was made to the Trust.

The other incident involved a letter about a service user being found in a leaflet that was left with another service user following a visit from a community health professional. The health professional had printed the leaflet using on Trust equipment but the letter had been printed at the same time, by another user, and was accidentally stapled into the leaflet.

Further training has been undertaken with staff groups affected and the learning has been incorporated into the IG Training for 2018/19.

Data protection audit

Following the undertaking that was signed by the Trust in June 2015, the ICO conducted a consensual audit during w/c 28/11/2016. The overall conclusion was that there is a reasonable level of assurance, that processes and procedures are in place and delivering data protection compliance. Some scope for improvement in existing arrangements was identified that will reduce the risk of non-compliance with data protection legislation. We have been implementing all the recommendations that were made and will continue with our efforts to ensure confidential information remains that way. As at 13th March 2018 excellent progress has been made in training and awareness and all recommended actions for these scope areas are implemented.

Good progress has been made in subject access requests and all but one of the recommendations is now complete, this section will be fully complete by 30th April 2018.

Further focus will be applied to the data sharing actions that involve training other staff on the standards for data sharing and assessing privacy impact. Both will become mandatory requirements under the GDPR so it essential the learning is implemented before enforcement in May 2018.

The deadlines for Assessing Legality, Risks and Benefits and for Information Sharing and Logs actions will be completed by 30th April 2018 and will form part of the GDPR Plan, which will provide timely delivery of the training prior to the GDPR implementation.

Future plans

The EU General Data Protection Regulation (GDPR) will apply in the UK from 25/05/2018. The ICO has already published general guidance around data portability and the role of the Data Protection Officer. Draft guidance on consent has been published for consultation. Sector specific guidance is expected later in 2017. Indications are that the areas of most significance for health will be changes to the conditions for processing personal data and a new requirement to verify consent and enhanced protection for children's data.
As part of the Trust's audit plan, a review of progress toward implementing the GDPR was undertaken in August 2017. The review was based on the Information Commissioner's Office's 12 steps to take now, which are listed below:

1. Awareness
2. Information you hold
3. Communicating privacy information
4. Individuals' rights
5. Subject access requests (SARs)
6. Lawful basis for processing personal data
7. Consent
8. Children
9. Data breaches
10. Data protection by design/data protection impact assessments
11. Data protection officers
12. International

The actions identified as part of this audit have been factored into the Trust's action plan for GDPR. Regular updates on progress are provided to the Executive Management Team (EMT)

and Audit Committee. At this point in time all required actions against the action plan have been delivered, although resource remains a concern.

It should be noted that the UK derogations have not yet been agreed and guidance for health and social care organisations is still emerging and will continue to be issued both before and after the regulation is enforced.

Actions to be taken during quarter one 2018/19

The Trust will continue to review all relevant policies, procedures, guidance and protocols to ensure that there is a robust plan in place to be fully compliant (as per the legal requirement) by 31st October 2018. The plan will be supported by a detailed Training Needs Analysis and delivery plan by 30th April 2018. This plan will continue be submitted to Audit Committee during this period.

In light of the above changes a revised IGTK is expected for 2018/19. A review and consultation were undertaken that determined the IGTK is fit for purpose, but changes are required to the support provided during the assessment process and to the requirements to ensure they provide a robust assessment of performance.

Key areas of focus remain and there is more work to be done around the number of incidents being recorded by staff. The table below summarises IG incidents logged by BDU/Corporate Service over the past 12 months. The IG team has taken a number of steps to improve compliance with the data protection and confidentiality principles including targeted training (both mandatory IG training and ad-hoc awareness sessions), performing consensual and unannounced spot checks and providing guidance through the Trust's communication channels.

BDU	*Q4 15/16*	*Q1 16/17*	*Q2 16/17*	*Q3 16/17*
Barnsley	***26***	***41***	***36***	***19***
Wakefield	***6***	***10***	***17***	***6***
Calderdale	***7***	***6***	***6***	***2***
Forensic	***4***	***3***	***5***	***6***
Kirklees	***11***	***12***	***10***	***8***
Specialist services	***25***	***26***	***22***	***19***
Corporate	***3***	***7***	***6***	***11***
Total	***82***	***105***	***102***	***71***

BDU	*Q4 16/17*	*Q1 17/18*	*Q2 17/18*	*Q3 17/8*
Barnsley	***36***	***18***	***19***	***23***
Wakefield	***11***	***3***	***11***	***5***
Calderdale	***4***	***7***	***5***	***8***
Forensic	***2***	***2***	***1***	***5***
Kirklees	***10***	***9***	***6***	***9***
Specialist services	***13***	***17***	***13***	***11***
Corporate	***15***	***12***	***8***	***7***

Total	***91***	***68***	***63***	***68***

At the time of writing this report 57 incidents have been reported in Q4 2017/18.

The reporting outlined above is indicative of a “positive” culture and high levels of awareness of IG requirements.

The IG team will continue to raise awareness and provide training, advice and support across the organisation.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 March 2018
Agenda item 10.4

Title:	**Review of the Risk Appetite Statement**
Paper prepared by:	Director of Finance Company Secretary
Purpose:	To set out the process of review of the Trust's Risk Appetite Statement.
Mission/values:	Supports the Trust in delivering safe, effective and efficient services which underpins the Trust's mission of helping people reach their potential and live well in their community. Supporting delivery of a key value around improvement and the aim to be outstanding as a Trust.
Any background papers/ previously considered by:	Risk Management Strategy (including Risk Appetite Statement) approved by Trust Board. Corporate/Organisational Risk Register received quarterly by Trust Board. Risk Appetite discussion at Trust Board strategic in February 2018.
Executive summary:	**Background** The Trust aims to provide high quality, safe services which help people reach their potential and live well in their community. Trust Board acknowledges that the services provided by the Trust cannot be without risk and it ensures that, as far as is possible, this risk is minimised. The Trust does not seek to take unnecessary risks and determines its approach and its appetite for risk to suit the circumstances at the time. Risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to accept in the pursuit of its strategic objectives. The Risk Appetite Statement sets out Trust Board's strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds and supports delivery of the Trust's Risk Management Strategy. The statement of risk appetite is by its nature dynamic and its drafting will be an iterative process that reflects the challenging environment facing the Trust and the wider NHS. Under the Risk Management Strategy, the Trust should review its risk appetite at least annually. **Review approach** At the strategic session of Trust Board in February 2018, the Board discussed possible options for changes to the Risk Appetite Statement and supported that the levels should be reviewed. It was noted that there was a flaw in the methodology. In relation to the risk appetite 1-3 (Minimal / Low), that if the consequence score of a risk was 4 (Major) or 5 (Catastrophic) with a likelihood of 1 (Rare – This will probably never happen / reoccur) then it could never be within the current risk appetite

	level. The Executive Management Team (EMT) will discuss this further and make a recommendation on what the revised risk appetite by category should be with any proposed changes be reviewed by the Audit Committee prior to approval by the Trust Board in April 2018. **Risk appetite** The Risk Appetite Statement sets out Trust Board's strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds and supports delivery of the Trust's Risk Management Strategy. Where risks cannot be managed within the risk appetite of the Trust, they are subject to scrutiny by the relevant sub-committee as identified within the committee Terms of Reference.
Recommendation:	**Trust Board is asked to SUPPORT the approach to review the Risk Appetite Statement.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 March 2018

Agenda item 11 – Receipt of public minutes of partnership boards

Kirklees Health and Wellbeing Board

Date	22 March 2018
Invited Observer	Chief Executive / District Director – Forensic, Specialist, Calderdale and Kirklees
Items discussed	➢ To be confirmed.
Minutes	Papers and draft minutes (when available): https://democracy.kirklees.gov.uk/mgCommitteeDetails.aspx?ID=159

Calderdale Health and Wellbeing Board

Date	16 March 2018
Non-Voting Member	Medical Director / District Director – Forensic, Specialist, Calderdale and Kirklees
Items discussed	➢ Policing Issues on the Health and Wellbeing Board ➢ Public Health's Annual Report 2016 ➢ Single Plan for Calderdale ➢ Sustainability and Transformation Plan Update ➢ Delayed Transfers of Care Update
Minutes	Papers and draft minutes (when available): https://www.calderdale.gov.uk/council/councillors/councilmeetings/agendas-detail.jsp?meeting=23343

Barnsley Health and Wellbeing Board

Date	30 January 2018
Member	Chief Executive / District Director - Barnsley & Wakefield
Items discussed	➢ Barnsley Health and Care Together ➢ Integrated Carers Service ➢ Falls Prevention, Early Help and Frailty ➢ Pharmaceutical Needs Assessment
Minutes	Papers and draft minutes (when available): http://barnsleymbc.moderngov.co.uk/mgCommitteeDetails.aspx?ID=143

Wakefield Health and Wellbeing Board

Date	To be confirmed (last update from meeting 25 January 2018)
Member	Chief Executive / District Director - Barnsley & Wakefield
Items discussed	➢ To be confirmed.
Minutes	Papers and draft minutes are available at: http://www.wakefield.gov.uk/health-care-and-advice/public-health/what-is-public-health/health-wellbeing-board

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 March 2018

Agenda item 12 – Assurance from Trust Board Committees

Clinical Governance and Clinical Safety Committee

Date	6 February 2018
Presented by	Charlotte Dyson, Deputy Chair (Chair of the Committee)
Key items to raise at Trust Board	➢ Draft Quality Strategy. ➢ Apparent suicide report. ➢ Waiting list improvement plans. ➢ Quality Impact Assessment (QIA) CIP position. ➢ Audit Committee review of cross committee synergies.
Approved Minutes of previous meeting/s for information	➢ Approved Minutes of the Committee meeting held on 14 November 2017 (attached)

Nominations Committee

Date	22 February 2018
Presented by	Angela Monaghan, Chair (Chair of the Committee)
Key items to raise at Trust Board	➢ Non-Executive Director re-appointment recommendation to Members' Council. ➢ Future Non-Executive Director recruitment.
Approved Minutes of previous meeting/s for information	➢ Approved Minutes of the Committee meeting held on 24 October 2017 (attached)

Mental Health Act Committee

Date	6 March 2018
Presented by	Chris Jones, Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	➢ Section 136 changes. ➢ Recording of ethnicity. ➢ Review of internal audits – what audits come to Committee and ensure correct coverage. ➢ Operational Management Group (OMG) – strengthening work of the Committee in the Trust. ➢ Young people in 136 suites in the last Quarter.
Approved Minutes of previous meeting/s for information	➢ Approved Minutes of the Committee meeting held on 21 November 2017 and 19 December 2017 (attached)

Equality and Inclusion Forum

Date	6 March 2018
Presented by	Angela Monahan, Chair (Chair of the Forum)
Key items to raise at Trust Board	➢ Forum Annual Report 2017/18, including Terms of Reference and Work Programme 2018/19.
Approved Minutes of previous meeting/s for information	➢ Approved Minutes of the Forum meeting held on 2 October 2017 (attached)

Remuneration and Terms of Service Committee

Date	26 March 2018
Presented by	Rachel Court, Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	➢ Verbal update to be provided at the Trust Board meeting on 27 March 2018.

Minutes of Clinical Governance and Clinical Safety Committee held on 14 November 2017

Present:	Ian Black	Chair of the Trust
	Charlotte Dyson	Non-Executive Director (Chair)
	Dr Adrian Berry	Medical Director
	Tim Breedon	Director of Nursing and Quality
	Alan Davis	Director of Human Resources, Organisational Development and Estates
Apologies:	Committee	
	Rachel Court	Non-Executive Director
	Others	
	Carol Harris	District Director – Forensic and Specialist Services, Calderdale and Kirklees
	Karen Taylor	Director of Delivery
In attendance:	Mike Doyle	Deputy Director of Nursing
	Sarah Harrison	PA to Director of Nursing and Quality (author)
	Angela Monaghan	Non-Executive Director
	Richard Norman	Project Management Office Manager
	Kate Quail	Non- Executive Director Deputy Director of Operations
	Dave Ramsay	District Director – Barnsley and Wakefield
	Sean Rayner	Director of Strategy
	Salma Yasmeen	

CG/17/85 Welcome, introductions and apologies (agenda item 1)

The Chair Charlotte Dyson (CD) welcomed everyone to the meeting. The apologies, as above, were noted.

CG/17/86 Declaration of interest (agenda item 2)

The Committee noted that there were no declarations over and above those made in the annual return to Trust Board in March 2017 or subsequently.

CG/17/87 Minutes of previous meeting held on 19 September 2017 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the meeting held on 19 September 2017.

CG/17/88 Matters Arising (agenda item 4)

The action log from the meeting held on 19 September 2017 was noted and the following matters discussed:

CG/17/57 Whistleblowing and Freedom to Speak up Guardians
The Committee noted that the above is due back to the Committee in February for a six monthly review.

CG/17/27b Planned unannounced visit annual report
The new timetable for the planned visits starts in February 2018

CG/17/48 Quality Impact Assessment of cost improvement programme – SOP
Mike Doyle (MD) confirmed to the Committee that the Standard Operating Procedure (SOP) is now complete.

CG/17/51 Mandatory training annual report
The Committee asked for the training for Trust Board to be undertaken as soon as possible. Alan Davis (AGD) to speak to Nick Phillips.

Action : Alan Davis

CG/17/89 Considerations of items from the organisational risk register relevant to the remit of the Clinical Governance & Clinical Safety Committee (agenda item 5)

The paper included the details of the risks from the Organisational Risk Register (ORR) that are relevant to the Committee. A process was in place for a monthly review of the ORR to allow for the Executive Management Team (EMT)to provide assurance to the risk committees and Trust Board that risk action plans are being reviewed and actions taking place.

The Committee discussed the following risks:

- Risk ID 1078 - Risk that the long waiting lists to access CAMHS and ASD services lead to delay in young people starting treatment.
- Risk ID 1119 - Forensic BDU locks are now out of patent.
- Risk ID 1132 - Risks to the Trust's reputation caused by long waiting lists delaying treatment and recovery.
- Risk ID 1151 - Unable to recruit qualified clinical staff due to national shortages which could impact on the safety and quality of current services and future development.

The Committee noted that EMT had made some changes to the risk ratings which was reflected in the agenda and the Committee was asked to comment on three items:

- ORR is now in the new format and CD asked the Committee to comment on the new format. The Committee was happy to support the new format.
- Risk ID 275 = Local Authority Funding. Risk of impact on the demand for services as a result of continued reduction in Local Authority funding (LA as a provider) EMT had had a discussion on this which will be raised at Trust Board.
- Risks that exceeded the risk appetite – Child and Adolescent Mental Health Services (CAMHS), waiting lists these will be covered in the agenda today.

Ian Black (IB) commented on the risk ID 744. IB suggested that this is an equipment issue. Dr Adrian Berry (ABe) suggested that this is a clinical risk and the risk appetite should therefore be green. Ris ID 744 and 1079 need to be looked at as ABe didn't think that they should still be included.

Action: Dr Adrian Berry

It was RESOLVED to NOTE the current Trust-wide Corporate/organisation level risks, relevant to this Committee and be ASSURED that the current risk level, although above the Trust risk appetite, given the current environment is appropriate.

CG/17/90 Quality Account update (agenda item 6)

Tim Breedon (TB) reported that the quality account was an annual report that focuses on how the Trust performs against a set of quality priorities that we set for ourselves and a range of mandated items as identified by NHS Improvement. The aim is to identify how we provide safe and effective services, reflect areas that we need to improve upon and celebrate our successes. All our quality priorities are set out in the Integrated Performance Report (IPR) and quality priorities have been developed for action in 2017-18. The Trust continues to have a good governance system for monitoring and reporting against the actions that are required to support the quality account process. In past years quality account feedback from Deloitte has recommended that we start writing part 3 (progress against quality priorities) of the quality account report in Quarter 3 of the given year. To test out this recommendation, we have provided half of the interim reports that detail the progress of the improvement to date, with a full update being provided in March 2018 in the final quality account report. The remainder of the interim reports will be provided to the Committee at its February 2018 meeting, allowing the opportunity for the Committee to see a full draft content of an 'interim quality account report' prior to the full draft report provided for sign off in May 2018. The aim of this development in reporting is that over the year the quality account report will grow incrementally and amendments can be made along the way. The format of the interim reports is not uniform at this stage in the process; however they will have a consistent format in the final report. This element of reporting against the quality account process is developmental and will evolve over time.

- A timetable of activity has been planned for the production and authorisation of the quality account – this will be shared with key stakeholders
- Members' Council Quality Group has proposed a local indicator – waiting times in CAMHS
- Data testing of local and mandated items has been arranged for March and April 2017.

In Quarter 3 the Committee will receive an interim report on the reminder of quality projects. The Trust awaits the national guidelines for the production of the quality account 2017/18.

The Committee discussed the Quality Scheme. The Quality Scheme is designed to work alongside the existing Quality Monitoring Visit programme. It is an accreditation tool that is intended to help teams to recognise their strengths and any areas where improvement is needed. This will then be feed back into the Committee.

It was RESOLVED to RECEIVE the quality account progress report and NOTE the progress.

CG/17/90a Members Council Update (agenda item 6.1)

TB updated the Committee on the Members' Council Quality Group meeting. Deloittes attended to assist with choosing local indicators which was received extremely well. Items covered in the meeting include Quality Accounts, IPR and Customer Services report. It was a very useful meeting with good attendance.

CG/17/90b Transition Protocol (agenda item 6.2)

Recent U K Government policies have emphasised the significance of transition between Child and Adult Health Services for the individual and identify tools for facilitating such transition in practice.

Within the Trust it is essential that transition from Children's to Adult Health Services occurs in a timely and safe manner. A clear process of transition from Children's to Adult Health Services recognises the changing needs of individuals and the influences of age related changes including health, access to further education and employment, social care and benefit systems. Such a transfer of care requires specialist skills and expertise and for clinicians to be trained specifically in the assessment and implementation of ongoing care and support for young people with ongoing health needs.

Interfaces between different services and organisations are a potential source of clinical risk and unmet need; therefore transitional pathways can be an effective tool to ensure safe, seamless and timely transfer of care that reflects high standards of governance between different organisations and within service provisions of the same organisation. Service Manager's and General Manager's should work together in an integrated way to ensure seamless service provision to transition. The development of interagency protocols and pathways which adopt guiding set of principles will provide a vehicle to ensure that any potential barriers are overcome.

Our work on improving the transitions between children's and adult services started approximately 18 months ago and more recently we have brought our developments in line with the national CQUIN which focuses on this area.

The Trust is making progress with this improvement in clinical practice to ensure our service users receive care and treatment in the right place, at the right time by the right person.

Angela Monaghan (AM) queried the NICE Guidance on age and if we are starting the processes early enough. AM would like us to check our protocol to make sure this is included and we are compliant.

Action: Mike Doyle

CD questioned the delivery of the protocol as there was a lot of uncertainty amongst staff around the application when out on visits. MD assured the Committee that this was being addressed to ensure continuity.

CD asked if we follow up service users for feedback after they had left the service. TB said that this is covered in their care plans.

It was RESOLVED to RECEIVE the Transition Protocol Update report and NOTE the progress.

CG/17/91 Transformation programme quality impact update (agenda item 7)

Salma Yasmeen (SY) updated the Committee on the revised process of the reporting of quality impact for projects within the transformation programme and also for Trust priority programmes for 2017/2018.

SY outlined the status of quality impact assessments at each integrated change gateway for each programme with supportive narrative and timelines.

This included:

- Projects from the transformation programme, that were not subsumed into Trust priorities for 2017/2018, but still require assurance on quality impact by the committee
- The strategic priority programmes that are identified as 'major change'
- The strategic priority programmes that are identified as 'significant change'

No specific risks were identified, as risks for each programme are identified and managed through the agreed governance route. Updates would continue to be reported into the Committee.

It was RESOLVED to RECEIVE the report and NOTE progress.

CG/17/92 Waiting lists improvement plan (agenda item 8)

Calderdale & Kirklees Psychological Therapy (agenda item 8.1)

Sean Rayner (SR) provided an update on the work in Calderdale regarding the secondary care psychological therapy provision given the issues raised over a number of years with extended waiting times. The Trust has raised concerns with Calderdale Clinical Commissioning Group (CCG) regarding the under funding of secondary care Psychological therapies.

- The CCG have agreed that the service is insufficiently resourced but is unable to increase this funding to enable it to deliver against the 18 week referral to treatment pathway
- The numbers of people referred has significantly increased and waiting times to access secondary care psychology treatment has grown as a consequence.
- The CCG to lead on a whole system review of the Psychological Therapy Pathway in Calderdale to include Primary, secondary and third sector provision.
- To meet with the CCG and agree actions to manage demand and mitigate risk linked to extended waiting times for Therapy
- To work with the CCG to look at referral Pathways in to the services and identify possible alternatives within the Calderdale Locality
- To agree on the capacity of the service currently to begin focused work on managing referrals
- To review the profile of referrals in to service and agree on those more appropriate to enter secondary care services
- Agree on a Communication plan with all stakeholders

Conversations with CCG should now help rather than hinder and we need to now keep on top of this.

AM requested clarification on item 3 of the paper:

- Review the profile of service users taken into secondary care services and prioritise on that basis. This would help to achieve a longer term sustainable situation. This would

require reviewing the interface with Improving Access to Psychological Therapies (IAPT) as the main external referrer and them considering shorter pieces of work carried out in within the IAPT services. 40% referrals currently could be considered for this. This would require IAPT and APTS services to agree and develop a profile of service users whose needs could be addressed in this way and also a profile of service users who APTS staff would focus on.

The CCG expressed preference for option 3 and an agreement was reached that action planning against this option would commence. This would cover the following actions-

- A meeting arranged between Christine Marklow (APTS lead) and Caroline Taylor (CCG MH clinical Lead) to discuss how the referral cap will operate
- CCG to arrange a meeting between SWYPFT, CCG and Insight about IAPT referral thresholds.
- CCG to arrange fortnightly follow up calls to monitor progress.

AM requested clarification on:

- Risk associated with option 3
- Correct mitigating actions on the risk reg (action)
- Update to come back to next Committee (action)

Action: Sean Rayner

Specialist Services ADHD /Autism (agenda item 8.2)
The Committee agreed not to discuss this item as the right people were not in attendance.

Wakefield and Barnsley Psychological Therapy (agenda item 8.3)
Barnsley:

- Psychology waiting times in the Barnsley Enhanced teams have been successfully eliminated.
- A new psychology pathway has been introduced into the Barnsley Core Mental Health Service.
- Referral rates to Core Psychology have been 66% higher than were expected pre-transformation.
- The wait for a first assessment appointment within the Core Psychology service has remained relatively consistent over the last 6 months at an average of 17 weeks.
- The number of people waiting for psychological therapy within the Core Psychology service has dropped from 501 in April 2017 to 334 now. Some of this drop is likely to be to do with the different service offer for newly referred clients.
- The average wait for intensive intervention for those clients picked up over the last three months was 45 weeks, with the longest wait having been 129 weeks.
- The report highlights that this length of wait is unacceptable and that the overall trend is for these to continue to get worse before they improve.
- The report highlights that this worsening in waiting time for intensive intervention is partly due to the new pathway which means more appointments are offered to new referrals in order to deliver the stabilisation work, meaning fewer appointments are available for intensive intervention. Hence whilst this has been successful in

significantly reducing the flow of people onto the waiting list for intensive interventions, and so achieving its aim of bringing our service more into capacity, it has had a negative short-term impact of increasing the amount of time those currently waiting would have had to wait under the old pathway.

- Despite improvements in the overall numbers, it is unlikely that waits will be significantly reduced without additional capacity to address the backlog. Further discussions with the CCG are planned to discuss this.

Wakefield

- Measures implemented in Wakefield are resulting in significant improvements
- Use of 'champions' to own the issue locally have been particularly successful
- Further improvements are expected within existing resources

One of the main concerns for Barnsley is the back log and Sean Rayner (SR) would like the Committee to help with this AM asked why this was higher than predicted and SR suggested that focused evaluation work would be needed to be done to see why this is the case. Discussions with the CCG are in hand to see how we can deal with this going forward.

Action: Sean Rayner

It was RESOLVED to NOTE the programme on waiting lists and NOTE the outcome of risk.

CG/17/93 Care Quality Commission (agenda item 9)

Outcome of Care Quality Commission Inspection

The Trust was re-inspected by the Care Quality Commission (CQC) between November 2016 and January 2017. As with the previous inspection, we are required to complete an action plan and provide the CQC with regularly updates on our progress.

Currently in SWYPFT we have a number of mechanisms in place to assure the quality of our care. These include high level strategies, (with implementation plans), systems and processes to monitor quality improvement and assurance and structures that facilitate ward to board connectivity and meaningful activity to improve the safety, effectiveness and experience of care.

The focus of our action plan is to ensure the application of these mechanisms is consistent and effective across the Trust and to provide support where needed. This approach will require a whole systems approach from all staff and departments (Board to front line staff) and will be an invaluable opportunity to drive out any (unwarranted) variations in clinical practice and service standards.

- Initial inspection CQC action plan was submitted to CQC in May 2016.
- Re-inspection plan was submitted to CQC in April 2017.
- Governance arrangements have been implemented to monitor the implementation and effectiveness of the action plan.
- The CQC will monitor this plan through the newly established engagement meetings.
- The action plan is a live document that will be constantly updated to reflect the action undertaken and the further action to be carried out prior to the inspection.

October update on CQC action plan

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.

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 relates 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 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.

The Trust continues to have a good governance system of monitoring and reporting against the actions that are required following the re-inspection of services.

It was RESOLVED to RECEIVE the CQC action plan.

CG/17/94 Trust achievements (agenda item 10)

The Committee discussed the recent achievements of the Trust which included the:

- Excellence awards
- Nursing Times award for the CAMHS Team
- i-hub.

The Committee wanted to acknowledge the CAMHS Team for doing so well in pressing times.

CG/17/95 Child and adolescent mental health services - update (agenda item 11)

Dave Ramsay (DR) again acknowledged that the CAMHS Team was doing very well in pressing times and this was recognised in the awards for which they had been nominated.

DR provided a further update regarding clinical governance/risk issues and service development plans in Calderdale/Kirklees, Wakefield and Barnsley CAMHS.

- Tier 4 West Yorkshire New Care Model application
- Out of hours on call arrangements
- Serious Incident
- Waiting list initiative
- Wakefield

Tier 4 West Yorkshire New Care Model application

The New Model of Care business case has been submitted to NHS England (NHSE). Developed as part of the West Yorkshire and Harrogate Sustainability and Transformation Plans (STP) the proposal focuses on developing more robust and consistent approaches to reducing the need for inpatient stays through for example, strengthening the capacity of crisis and intensive home based treatment teams. The proposal assumes a transfer of the NHSE budget for Tier 4 admissions (estimate £9.5m) to a provider-based partnership led by Leeds Community Healthcare Trust and the outstanding issue regarding agreement of the business case is confirmation of the governance (including risk share) arrangements. Pump priming funding has been made available through NHSE in 2017/18 to facilitate the early recruitment of care navigation and project support roles and enable backfill for local clinical engagement/leadership.

Out of hours on-call arrangements

A formal grievance process regarding the on-call proposal has been concluded. The collective grievance was submitted by team members from the Barnsley CAMHS team in relation to the potential impact of on-call on personal health and wellbeing and on next 'next day' clinical responsibilities. It was not upheld. As such all relevant staff are expected to be on the on-call rota from 1 December 2017 with the necessary training etc. put in place to support this. However, until this point it is inevitable that the Barnsley rota will be incomplete. These gaps in the rota are a significant concern and form part of the CAMHS risk register.

A proposal has been drafted to establish an all-age psychiatric liaison function across the SWYPFT footprint. This is now subject to more detailed consideration within CAMHS and adult mental health services and it is anticipated that a final proposal be developed by end December 2017 for implementation from 1 April 2018. The approach recognises the Five Year Forward View for Mental Health requirement that; '*By 2020/21 no acute hospital should be without all-age mental health liaison services in emergency departments and inpatient wards'*. Early discussions have identified the importance of CAMHS being able to extend intensive home based treatment across weekend/bank holiday periods (currently a Monday-Friday provision).

This would offer an additional layer of safety when considering discharge from acute settings

Serious incident
Wakefield CAMHS were informed of the suicide of a 16 year old female patient on 12 October 2017. The patient had been assessed by CAMHS in A&E on 11 October 2017 and discharged with a safety plan. Due process has been followed with regard to Duty of Candor and a meeting with the family is being arranged. A Serious Incident investigation is being undertaken.

The Committee discussed the issue on timing for further learning coming into the system. KQ suggested that some learning can be instant and queried what is being done to apply this. MD informed the Committee that Julie Warren-Sykes has developed a checklist to work with agencies on this to avoid copy cats etc and that record keeping reminders to staff to keep details up to date. Safeguarding is also a key piece of learning.

MD informed the Committee that we are still waiting for the safeguarding board to decide if a SI review is needed in this matter.

Waiting list initiative

As previously reported £320k of the projected CAMHS underspend on staffing has been committed to securing additional bank/agency capacity for a 6 month period (September 17 to March 18). The intention was to use this capacity for a targeted waiting list initiative and enable 400 children/young people to receive more timely support and be removed from the waiting list. The current position (end October 2017) is detailed below. Team-based trajectories are currently being established.

Service	**Cases allocated from waiting list**	**Target**
Barnsley	103	
Calderdale	0	
Kirklees	39	
Wakefield	50	
Total	**192**	**400**

Wakefield
Work has been undertaken as part of the ASD Recovery Plan Summit process to respond to the SEND Ofsted/CQC Local Area Inspection and the requirement for a statement of action setting out plans to address current diagnostic assessment waits. As part of this plan Wakefield CAMHS is committed to undertake 18 psychology assessments per month in contributing to the under 14's pathway (led by Mid-Yorkshire Hospitals Trust) with the intention of reducing waiting times to 3 months by August 2018. The same trajectory has also been agreed for the over 14's pathway as delivered by CAMHS. Meeting this requirement will involve improved joint working with Mid-Yorkshire Hospitals Trust, educational psychology and the adult ASD service.

A series of meetings between Wakefield Social Services, CCG and SWYPFT management teams have been held to improve joint working and identify/address potential gaps in service delivery. Notable improvements made to date include a strengthened CAMHS and forensic CAMHS input to complex care panel processes. It has been recognised that key gaps in the local system included support for children presenting with extreme behavioural problems and/or self-harming with emerging personality disorders, ASD or ADHD. In developing a response it has been agreed to hold a meeting of lead professionals to consider a small number of existing complex cases. The intention is to identify key themes, areas of good practice etc. to inform

more detailed planning - specifically with regard to the potential for redesign of the current Forensic CAMHS offer. It has been noted that the national commissioning arrangements for forensic CAMHS has created an opportunity to reconsider local commissioning intent.

It was RESOLVED to NOTE the paper.

CG/17/96 Update on topical, legal and regulatory risks (agenda item 12)

Locala update (agenda item 12.1)

TB updated the Committee, there is no change from report given at Trust Board. The two CEOs from SWYPFT and Locala met in early July. They discussed approaches to strengthen the partnership and maximise opportunities to work together, to address the current issues as well as develop sustainable partnerships for the future. They agreed a number of actions that were progressed by the Trust with little progress, due to a number of on-going challenges with Locala.

Progress- Update

Since the last update to Trust Board there has been a number of leadership changes at Locala, including the CEO departing from the organisation. An interim CEO has been appointed Natalie McMillan. This appointment coincides with a new Chair taking up their role in the organisation. The CE of SWYPFT and the interim CEO of Locala have met to re-establish and clarify the agreements that were made with the previous CEO. Both agreed the following key actions that are being progressed;

- Hold a Board to Board meeting at the end of November
- Set up a four way meeting with the two CEOS and the two Chairs
- Care Closer to Home and 0-19 (Thrive)
- Locala CQC Improvement plan
- Princess Royal redevelopment
- Memorandum of Understanding

The Trust is attending a governance meeting tomorrow. The first offer still stands the other two to be reviewed after tomorrow's meeting.

CEO hospitals Inspector Report (agenda item 12.2)

- State of Care is the CQC's annual assessment of health and social care in England. The report looks at the trends, highlights examples of good and outstanding care, and identifies factors that maintain high quality care.
- This year's report shows that the quality of care has been maintained despite some very real challenges. Most people are receiving good safe care and many services that were previously rated inadequate have recognised the CQC's inspection findings, made the necessary changes, and improved.
- The fact that quality has been maintained in the toughest climate most can remember is testament to the hard work and dedication of staff and leaders. However, as the system continues to struggle with increasingly complex demand, access and cost, future quality is precarious.

AM reported that at a recent meeting of the Yorkshire Chairs the future focus on well led / resource utilisations remains prominent but lacks the resource to deliver.

Joint NHS Improvement / CQC (agenda item 12.3)

TB informed the Committee that the Trust is well sighted on this and he is now a peer reviewer with the NHS Improvement (NHSI).

TB briefed the Committee on the following:

- CQC have introduced a new assessment framework.
- There will be a more targeted approach to inspection with less comprehensive inspections so inspection teams will be smaller.
- An announced well-led review will be undertaken annually. This will involve CQC speaking with senior members of our organisation.
- At least one of our core services will also be inspected each year (CQC likely to target those services that previously received a 'requires improvement' rating and these visits will be unannounced.
- We will be asked to provide information about our organisation (PIR-Provider Information Request) 20-24 weeks prior to us having our well-led review. We will have three weeks to return this information. CQC will then hold their own provider meeting and decide which of our services they will visit.
- During the 12-24 week period prior to our well-led review we can expect CQC to carry out unannounced visits to our core services.
- CQC will place more emphasis on ongoing monitoring and relationship with their providers. For example, they hold engagement meetings with us, attend board meetings and other key groups; and have arranged and taken part in listening events with staff from various teams across the Trust.
- CQC and NHS Improvement (formerly Monitor) now have a 'single shared view of quality.' This will include NHSI carrying out an assessment of how we use our resources to provide and sustain high quality standards of care and safety. They will provide a rating about this, although it is not yet fully clear how this will link into our well-led rating.
- There are changes to the wording and numbers of key lines of enquiry (KLOE's). In total there are 58 new prompts and 68 changes to the wording of the five KLOE's.
- The present ratings system will continue.
- Reports following visits will be much shorter.

The Trust continues to have a good system in place to monitor, assess the impact and respond to the CQC's new model of inspection

CG/17/97 Issues arising from Performance Report (agenda item 13)

There were no issues to discuss regarding the IPR as already discussed at Trust Board.

CG/17/98 Quality Impact Assessment of cost improvement programme (agenda item 14)

MD informed the Committee that there was no update since the last meeting, challenge panels are happening at present and MD will bring an update to the next meeting.

Action: Mike Doyle

It was RESOLVED to NOTE the update.

CG/17/99 Safer Staffing (agenda item 15)

MD updated the Committee on Safer Staffing. There have been previous six-monthly papers submitted since July 2014 that outlined the work being done to ensure ward areas provide staffing levels that are safe and effective.

The national commitment to safer staffing is ongoing and the Trust needs to maintain the progress already made in delivering safer staffing. At a national level, there continues to be key changes around the delivery of this agenda and despite the lead on Safer Staffing having changed to NHS Improvement there has been no definitive publication of Safer Staffing guidance for inpatient Mental Health/LD wards.

CD asked MD about agency staff having access to the RiO system and what was the position on this. MD explained that they do have access however they do not have cards. There is a training day for regular agency staff set up for later this month and supervised access for other agency staff.

AM asked MD to check the NHSI guidance for safer staffing

Action: Mike Doyle

It was RESOLVED to NOTE the update.

CG/17/100 Internal audit reports (agenda item 16)

MD provided a summary of internal audits and national audits for 2017/2018 that are currently on going in the Trust

The Committee discussed which they want to see reported into the Committee:

- Internal audit
  - 2, Delivering Service Change
  - 3, Significant and Serious Untoward Incidents
  - 7, Clinical Record Keeping

- National audit
  - 3, Sentinel Stroke National Audit Programme (SSNAP) - clinical audit (carried forward from 16/17 plan)
  - 8, National audit of intermediate care
  - 16,Early intervention in psychosis audit (EIP)

Action: Mike Doyle

CG/17/101 Care Quality Commission Mental Health Act visits (agenda item 17)

Process is agreed to report by exception. There were no items to report.

CG/17/102 Serious Incidents Q2 Report (agenda item 18)

MD updated the Committee in relation to incidents in Quarter 2 and more detailed information in relation to serious incidents.

- Detailed Quarterly reports have been produced and shared with each BDU; this is available at service line level.
- The actions from incidents are managed at BDU level. Patient safety support team produces information on completion of action plans from serious incidents and these are monitored through the operational managers group.
- This report has overall figures for incident reporting – Trust reporting is up following a slight downwards trend in the previous two quarters. Q2 had 3,048 incidents which is higher than the previous two quarters.
- The annual reports show an overall trend in incident reporting is upwards in line with a good reporting culture.

All immediate actions have been taken and any future action plan achievement is monitored through BDU governance groups and assurance from the recent internal audit report on our SI process which showed significant assurance with minor improvements and mirrors the positive CQC reports.

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

CG/17/103 Annual report (agenda item 19)

MD informed the Committee that as of next year these updates will be merged to one document.

Safeguarding Adults and Children (agenda items 19.1 & 19.2)

The Trust has a legal, professional, contractual and ethical responsibility to ensure that the safeguarding of children and adults is fully embedded within and across our services. The purposes of these reports are to assure the Committee that the work undertaken by the Team supports the Safeguarding agenda to remain one of the highest priorities within the organisation. Effective leadership ensures that we continue to be focussed on key national priorities and the political direction of travel.

The CQC inspection earlier this year identified that Safeguarding remained one of the Trust's highest priorities and that comprehensive governance systems remained in place.

Increased visibility of the Safeguarding Team has come as a direct result of the amalgamation of both children and adults and greater support to the BDU's. This has also strengthened the 'Think Family' agenda.

The Team continue to develop strong partnership working across Local Authority Safeguarding Boards, Local Authorities, CCG's and NHS England. CSE and the Prevent agenda remain high priorities, with the increase in compliance rate for Prevent (Wrap 3) training being increased to 85% by March 2018.

The Trust have successfully implemented the FGM Strategy and complied with the requirement to report FGM cases to the National CAP platform, there have been two cases reported in 2016/17.

The establishment of the Safeguarding Co-ordinator and Multi-agency Risk Assessment Conference (MARAC) Forum has provided additional support to staff in discharging their duty to safeguard vulnerable adults. Training, supervision and the provision of guidance and advice remain a key function of the team to ensure that our service users and carers remain central to our thinking and that staff receive the appropriate level of guidance and support.

Strategic plans for 2017/18 include hosting a Safeguarding Conference, raising the profile of service users who may have additional vulnerabilities which may make them more vulnerable to abuse and exploitation, to further imbed the principle around 'Making Safeguarding personal', additional focus on the Human Trafficking agenda and continued promotion of the Prevent agenda.

It was noted by the Committee that we have 100% attendance across all the 8 safeguarding boards for both adults and children.

CD queried how the Trust keeps up with training levels and AM asked regarding a risk based approach to training.

AM raised a query around the Children FGM strategy. As this is new, were the two reported cases high? Is there national benchmarking on this.

Action: Mike Doyle

It was RESOLVED to NOTE the report.

Ligature (agenda item 19.3)
MD apologised for the late submission of the report and provided a summary of the ligature assessment process.

The annual Ligature and suicide risk assessment and management process is a fundamental element of safety operating in the centre of all good health care. A systematic approach to risk assessment and risk management is followed. During the 2016 round of audits, 35 ligature assessments were undertaken. In mental health this is particularly challenging due to the nature of some of the risks presented by service users, including the risk of suicide and self-harm.

The environmental risk assessment for suicide and self-harm is a component part of comprehensive clinical risk assessment which includes service user risk assessment, formulation and care planning. The appropriate use of observation and engagement, including positive risk-taking and environmental risk assessment, support the management of identified risks.

The Trust approach is to undertake inpatient environment risk assessments with a clinical lead, Health & Safety representative and third party clinician from another area to act as an objective and 'fresh' pair of eyes. Assessments include the buildings and fittings, the items the person has access to and other people.

The ligature audit has been reviewed by BDUs and the Quality Academy. Estates TAG have received the prioritised risk assessments from the BDU's and these have been incorporated into schemes or have been received as job requests on the Estates repairs and maintenance system.

Due to human ingenuity, limitations of technical solutions and need for comfort and dignity, it is not always possible to completely eliminate ligature points in ward areas. A lot of good work has been done and is ongoing to minimise the risk from ligature points in ward areas and action plans are progressing well.

It was noted that remedial work can take time and that mitigating action needs to be taken by ward teams in the interim. Concerns remain about securing capital funding in a timely way for major remedial work identified during environmental and ligature risk assessments.

The new build spec is now the benchmark for all other acute mental health and LD wards and this will inevitably result in additional pressures on the capital budget.

Trustwide areas of concern include movable beds, door handles, en-suite doors and non-anti ligature screws, hinges, wiring and pipework used in clinical areas.

Next steps:

- BDU's to ensure their managers are monitoring 2016-17 action plans and outstanding work throughout the year and escalate as required.
- Ligature risk assessments for 2017 commenced in September 2017. Due for completion end of November 2017.
- Estates staff to join assessment teams where required.
- The Manchester scale is being trialed as a means to prioritise remedial work and will be reviewed in January 2018.
- The ligature audit group to meet quarterly to review progress of ligature assessments and remedial work. Terms of reference and ligature policy will need to be reviewed.
- Estates TAG to continue managing capital expenditure and receive reports from ligature risk assessment group.

MD updated the Committee on the new building pros and cons i.e. beds moveable and non moveable and the need for capitol monies for larger projects and asked the Committee to consider this. MD to ask EMT to discuss the issues.

Action: Mike Doyle

MD informed the Committee that the actions plans will change daily and that the Ligature Audit Committee will now meet quarterly

AM asked regarding the training to undertake a ligature audit and who does them.
MD informed the Committee that a Ward representative, Health &Safety representative and Estates undertake them (clinically led).

Patient Safety (agenda item 19.4)
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.

Safety Huddles have been established and the Committee requested for these to be scaled up.

Action: Mike Doyle

CG/17/104 Sub-groups – exception reporting (agenda item 20)

Medicines management (agenda item 20.1)
No update.

Health and Safety and Emergency Planning Including PLACE (agenda item 20.2a & 20.2b)

The PLACE report is very favourable with the Trust mainly scoring better than last year and very favourably against national benchmarks. We do still score low on areas that are based on acute care environments as this is an exercise which does not discern between the difference between ourselves and the acute environment and the exercise is biased towards the acute hospitals. An area where this affects us is:

- Provision of individual TV's for service users, we cannot do this for safety reasons but are penalised because we don't as it is not discretionary in the assessment.

In addition it should be noted that Enfield Down has scored the lowest in many areas, whilst the service based here is subject to a wider review the Trust still needs to consider if any improvements can reasonably be made either through direct funding or by the Landlord.

The two areas that have reduced scores for privacy and dignity will be assessed to see what items other than the TV's have affected this score and suitable action taken, it should be noted that the scores achieved are far in excess of the national average,

Next Steps

- Estates Department will Survey Enfield Down and consult with the service on what improvements can be made based on future plans for the service. Following this the Landlord will be requested to make any improvements.

This is a good result overall good effort from everyone

It was RESOLVED to NOTE the report.

Health and Safety (agenda item 20.2c)
It was RESOLVED to NOTE the report.

Infection Prevention and Control (agenda item 20.3)
TB informed the Committee of the difficulty in keeping people engaged in the tag and we are looking at how we can improved that.

Action: Tim Breedon

It was RESOLVED to NOTE the report.

Safeguarding adults (agenda item 20.4)
It was RESOLVED to NOTE the report.

Safeguarding children (agenda item 20.5)
It was RESOLVED to NOTE the report.

Managing Aggression and Violence (agenda item 20.6)
The Committee asked for the correct proforma to be used for this item.

Action: Sarah Harrison / Mike Doyle

It was RESOLVED to NOTE the report.

Any feedback from other TAGs/groups (agenda item 20.7)
No further feedback was provided.

CG/17/105 Issues and items to bring to the attention of Trust Board (agenda item 21)

Issues were identified as:

- Strategic Risk
- Demand for resource
- Waiting lists
- Improvement plan
- CAMHS
- Annual reports received
- Positive outcome of PLACE

SI front sheet to be updated to send to Board

Action: Mike Doyle

CG/17/106 Consideration of any changes from the organisational risk register relevant to the remit of the Clinical Governance & Clinical Safety Committee (agenda item 22)

CD asked Committee if they are happy with mitigating actions that we have on waiting lists

Risk ID 1132 – option 3 – we need to understand this risk before returning to it.

CG/17/107 Horizon Scanning (agenda item 23)

There is a meeting organised for the 11th December with the Police and Crime Commissioner regarding Section 136 to discussed readiness

NHSI changes to out of area beds, the Committee asked for more information on this.

Action: TBC

CG/17/108 Committee work programme 2017-18 (agenda item 24)

As discussed previously, the following amendments would be made to the Committee work programme:

- Undetermined death report to now be apparent suicides report

Action: Sarah Harrison

It was RESOLVED to NOTE the work programme.

CG/17/109 Any other business (agenda item 25)

No further items were discussed.

CG/17/110 Date of next meeting (agenda item 26)

The next meeting will be held at 14:00 on Tuesday 6 February 2018 in Meeting room 1, Fieldhead Hospital, Ouchthorpe Lane, Wakefield WF1 3SP.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of the Nominations Committee held on 24 October 2017

Present:	Charlotte Dyson	Deputy Chair of the Trust (Chair of the meeting)
	Marios Adamou	Staff elected governor, medicine and pharmacy
	Jackie Craven	Lead Governor (Publicly elected governor, Wakefield)
	Nasim Hasnie	Publicly elected governor, Kirklees
	Rob Webster	Chief Executive
Apologies:	Members	
	Ian Black	Chair of the Trust (Chair of the Committee)
	Ruth Mason	Appointed governor, Calderdale and Huddersfield NHS Foundation Trust
In attendance:	Alan Davis	Director of Human Resources, OD and Estates
	Emma Jones	Company Secretary (author)

NC/17/33 Welcome, introduction and apologies (agenda item 1)

The Deputy Chair, Charlotte Dyson (CD) welcomed everyone to the meeting. The apologies above were noted.

NC/17/34 Declarations of interest (agenda item 2)

IB had previously declared a potential conflict of interest as current Chair of the Trust in relation to the Chair recruitment update. It was agreed that CD would Chair the meeting in his absence.

NC/17/35 Minutes of and matters arising from previous meeting held on 9 October 2017 (agenda item 3)

It was RESOLVED to APPROVE the minutes from the meeting on 9 October 2017. No matters arising were discussed:

NC/17/36 Chair recruitment - recommendation for appointment (agenda item 4)

Emma Jones (EJ) tabled a paper that detailed the process that has taken place as previously discussed at the Committee.

CD provided an updated on behalf of the final interview panel. She advised that good feedback had been provided from the three focus groups and that the recommended candidate by the panel was also the preferred candidate of those groups. At the end of the process the final interview panel had a lot of discussion regarding the two candidates who performed the strongest. The final recommendation was unanimous from the panel that Angela Monaghan be recommended for appointment as she had more experience as both a Chair and a Chief Executive within the NHS. Jackie Craven (JC) supported this as the chair of the final interview panel and Marios Adamou (MA) as a member of the final interview panel. The Committee supported this recommendation and that, should the recommended candidate not be accepted by the Members' Council, that the second candidate [redacted] be offered the role.

Alan Davis (AGD) commented that he felt the recruitment process had been very thorough and robust.

The Committee discussed the term of office and supported an initial three year term in accordance with the Constitution. A post induction review would take place at 4-6 months and an annual appraisal by the Members' Council facilitated by the Deputy Chair.

The Committee discussed current remuneration scale which was based on an independent review conducted by CAPITA. A table top review had been discussed by the Committee on 11 April 2017 and as it remained consisted with national and regional pay ranges no changes were suggested at that time other than a uplift of 1% in line with the national pay award for staff. This was agreed by the Members' Council on 28 April 2017. It was noted that the vacancy had been advertised at the bottom of this scale. Progression up the incremental scale was dependent on performance and would be considered annually based on the Chair's appraisal completed by Members' Council. The Committee discussed that since this scale was set the Trusts income had reduced and Directors portfolios and pay arrangements had been discussed. The Committee requested a further review of the scale using NHS Provider benchmarking prior to the annual appraisal of the Chair.

Action: Alan Davis / Emma Jones

The Committee discussed that JC as chair of the final interview panel would contact all candidates after the Committee meeting supported by CD and provided them with feedback. Penna to provide more detailed feedback to candidate if required.

Action: Jackie Craven / Charlotte Dyson

The Committee discussed possible options for a Non-Executive Director (NED) appointment. At the time of the last NED recruitment a third candidate was identified and supported by the Nominations Committee on 11 July 2017 for appointment if one of the two recommended candidates did not accept the offer. The Committee supported contacting this candidate, subject to discussion and agreement by the incoming Chair, to see if they would still be interested in the role. It was noted that any appointment would require the approval of the Members' Council.

Action: Emma Jones

It was RESOLVED to NOTE the update provided on the recruitment process and UNANIMOUSLY SUPPORT the recommendation of the final interview panel to appoint Angela Monaghan as the Chair from 1 December 2017 to the Members' Council at its meeting on 3 November 2017.

NC/17/37 Any other business (agenda item 5)

No further items were discussed.

NC/17/38 Issues and items to bring to the attention of Trust Board / Members' Council (agenda item 6)

Issues were identified as:

- Chair appointment recommendation to Members' Council.

NC/17/39 Date of next meeting (agenda item 7)

The date of the next meeting is to be confirmed.

Action: Ian Black / Emma Jones

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Minutes of the Mental Health Act Committee Meeting held on 21 November 2017

Present:	Dr Adrian Berry	Medical Director (lead Director)
	Tim Breedon	Director of Nursing and Quality
	Chris Jones	Non-Executive Director (Chair)
	Salma Yasmeen	Director of Strategy
Apologies:	Members	
	Ian Black	Chair of the Trust
	Laurence Campbell	Non-Executive Director
	Attendees	
	Shirley Atkinson	Professional Development Support Manager (Barnsley) – local authority representative
	Terry Hevicon-Nixon	Operations Manager - Working Age Mental Health (Calderdale) – local authority representative
	Anne Howgate	AMHP Team Leader (Kirklees) – local authority representative
	Victoria Thersby	Head of Safeguarding (Calderdale and Kirklees) – acute trust representative
	Carly Thimm	Mental Health Act/Mental Capacity Act Manager
In attendance:	Andy Brammer	Mental Health Act Professional Lead (Wakefield) – local authority representative
	Julie Carr	Clinical Legislation Manager
	Rui Collins	Insight Team
	Elaine Dower	Assistant Director, 360 Assurance – internal audit
	Claire Edgar	Head of Service, Mental Health, Disabilities & Professional Support (Barnsley) – local authority representative
	Yvonne French	Assistant Director, Legal Services
	David Longstaff	Independent Associate Hospital Manager
	Sarah Millar	PA to Medical Director (author)
	Angela Monaghan	Non-Executive Director
	Dr Swarupa Shinde	Consultant Psychiatrist in Older People's Services
	Stephen Thomas	MCA/MHA Team Manager (Wakefield) – local authority representative

MHAC/17/42 Welcome, Introductions and Apologies (agenda item 1)

The Chair, Chris Jones (CJ) welcomed everyone to the meeting. The apologies, as above, were noted.

It was noted that the meeting was not quorate and any necessary decisions would be taken by the members outside of the meeting.

There were no declarations of interest to record.

MHAC/17/43 The Act in Practice (agenda item 2)

MHAC/17/43a Old Age Psychiatry (agenda item 2.1)

Presentation from Dr Swarupa Shinde (SS) on Older People's Services

The Committee thanked SS for her presentation and CJ invited questions.

Tim Breedon (TB) queried, in relation to the third scenario where the 86 year old lady with dementia became distressed when in a different environment, what interactions had taken place with her family. SS advised that the patient's daughter had been involved in a best interest meeting and her views were taken into account. Despite some reservations to begin with, her daughter agreed to emergency respite and then a move to a permanent care home.

Adrian Berry (AB) added that the presentation gave a good example of the breadth of scenarios that older people's services deal with and interesting to hear about the use of DoLs, MCA and MHA in the context of older people's care.

The Committee discussed the use of CTO and DoLs, particularly in light of the changes to the DoLs legislation. Julie Carr (JC) confirmed that the Committee had been briefed on the changes earlier in the year.

CJ concluded that SS had presented on the cases clearly and indicated incorporation of the Trust's values in the scenarios.

MHAC/17/44 Legal update/horizon scanning (agenda item 3)

MHAC/17/44a Tribunal and Court services enforcement procedure (agenda item 3.1)

Julie Carr (JC) reported that in August the First Tier Tribunal Service released new guidance on their enforcement procedure incorporating directions and summons. It was noted that any changes to the attendees of the hearing must be sent to the Tribunal Service prior to any hearing taking place for a decision to be made on the appropriateness of the changes and that this must be managed through the MHA Administrator. JC confirmed that systems are already in place to manage this. JC advised that professional staff have been made aware of the changes to the Tribunal requirements through the Mental Health Act office and BDU trios. AB added that he is confident that processes are in place to deliver the service as best we can.

It was RESOLVED to NOTE the briefing.

MHAC/17/44b DH – Independent Review of the Mental Health Act 1983 (agenda item 3.2)

JC reported that on 4 October the details for the independent review of the MHA 1983 as indicated in the Queen's Speech were released by the Department of Health. The independent review will look specifically at how the legislation is currently used, its impact on service users, families and staff and to make recommendations for improving the legislation and related practices. The review will be chaired by Professor Sir Simon Wessely and an interim report will be produced in early 2018 with a final report containing detailed recommendations by autumn 2018. TB queried the opportunity for engagement in the review and JC advised that this was being monitored by the regional MH Act Group.

It was RESOLVED to NOTE the briefing.

MHAC/17/44c CQC – The State of Care in Mental Health Services (agenda item 3.3)

JC reported that at 31 May 2017, CQC inspectors rated 68% of core services provided by NHS trusts and 72% of independent mental health locations as good. SWYPFT was included in the 68%. The report describes how CQC inspectors found that the clear majority of services are caring and compassionate towards their patients, however there were also several areas of concern identified and TB commented in relation to SWYPFT:

- Difficulties around accessing services – some issues but no more than other trusts.
- Physical environments not designed to keep people safe – lots of good work is going on to address this.
- Care that is over-restrictive and institutional in nature – refers to blanket restrictions and there have been many improvements in the past 18 months.
- Poor recording and sharing of information that undermines the efforts of staff to work together to make sure that people get the right care at the right time – this is being addressed with a new system and the position is greatly improved.
- Concerns about 'locked rehabilitation wards' – SWYPFT do not provide any.
- Great variation between wards in how frequently staff use restrictive practices and physical restraint to deescalate challenging behaviour.
- The impact of staffing shortages – this is being dealt with through Safer Staffing.
- Poor quality clinical information systems.
- Commissioning of crisis care services.

TB advised that there is a particular focus on improving access and recording of information and that all areas of concern would be picked up as part of the unannounced visits.

It was RESOLVED to NOTE the briefing.

MHAC/17/44d CH v A Metropolitan Council (agenda item 3.4)

JC reported that on 28 July 2017 the Court of Protection approved a £10,000 damages settlement plus costs to a man (CH) with Down's Syndrome over delays in the provision of sex education. CH was married and enjoyed normal conjugal relations for around 5 years until a consultant psychologist concluded that CH lacked capacity to consent to sexual relations. The psychologist recommended that CH needed a course of sex education to achieve the necessary capacity but "for reasons that have never been satisfactorily explained, the local authority failed to implement the advice despite requests and protracted correspondence". A Court of Protection order was eventually issued and the course began. The case raised questions regarding capacity to consent to sexual relations and was referred to a higher court with an independent expert opinion. SWYPFT sought legal advice and the gravamen of the claim was the delay in implementing the advised programme of education.

It was RESOLVED to NOTE the briefing.

MHAC/17/44e Child X and Tier 4 CAMHS placement (agenda item 3.5)

JC reported that the President of the Family Division had recently handed down a series of judgements in the case of X in relation to national issues of access to Tier 4 CAMHS beds. The case highlighted that there was no suitable placement available anywhere in the country for X. JC advised that SWYPFT had a case of a very complex individual where no bed could be found and NHS England were unhelpful. Stephen Thomas (ST) also gave examples of similar experiences. CJ queried who had responsibility for finding beds and it was noted that we undertake to find a bed on behalf of the CCG but NHS England have ultimate responsibility for finding Tier 4 beds.

It was RESOLVED to NOTE the briefing.

MHAC/17/44f Government Interim response to the Law Commission report on Mental Capacity and Deprivation of Liberty (agenda item 3.6)
JC reported that on 30 October the government published their interim response to the Law Commission's proposals for the reform of the MCA and DoLs provisions. The Liberty Protection Safeguards are welcomed and an engagement process with stakeholders will commence to inform the final response which is due to be published in spring 2018, around the time that we expect to receive the interim report on the MHA.

It was RESOLVED to NOTE the briefing.

MHAC/17/44g Implementation of 135 & 136 Mental Health Act 1983 (agenda item 3.7)
Yvonne French (YF) reported that on 24 October 2017 a copy of the revised regulations relating to Sections 135 and 136 MHA 1983 together with Department of Health guidance was made available. The implementation date has been set for 11 December 2017 and a meeting has taken place between those responsible for the Trust Place of Safety suites. A further meeting was planned to consider the finer detail. The Standard Operating Procedure for the suites are being reviewed in line with the new regulations and we will be fully compliant by 11 December. Local 135 and 136 policies will also be reviewed.

The Committee discussed SWYPFT's preparedness for a move to the new regulations and how more work would be needed to achieve an effective whole system approach. It was noted that there are some unintended consequences of the revised regulations and discussions would take place between SWYPFT, local authorities and the police to ensure everyone is clear on their own role.

Angela Monaghan (AM) queried if there were any new risks in relation to the changes and AB will consider this.

Action: Adrian Berry

It was RESOLVED to NOTE the changes to the Mental Health Act.

MHAC/17/45 Minutes of previous meeting held on the 1 August 2017 (agenda item 4)

It was RESOLVED to APPROVE the notes of the meeting held on 1 August 2017 as a true and accurate record of the meeting.

MHAC/17/46 Matters arising (agenda item 5)

MHAC/17/46a Action points (agenda item 5.1)
The action points were noted and two items raised:

- MHAC/17/34c – JC advised that the CQC MCA training has been scheduled into the quality monitoring visit programme and an update will be brought back to the Committee in March. It was noted that the first visits would take place in January. CJ advised that he had asked Remuneration and Terms of Service Committee to consider the impact in relation to training.
- MHAC/17/36c – JC confirmed no IG breach had occurred.
- MHAC/17/21b – YF advised that monitoring of cancelled leave takes place across the Trust and feeds into Clinical Governance and Clinical Safety Committee. TB added that this links to the Safer Staffing work. YF indicated that future audits would be done over an extended period of time rather than in a single day.

MHAC/17/46b Consideration of items from the organisational risk register relevant to MHA Committee (agenda item 5.2)
There were no items to consider.

MHAC/17/47 Statistical information use of the Mental Health Act (MHA) 1983 and Mental Capacity Act (MCA) 2005 (agenda item 6)

MHAC/17/47a Monitoring information Trust Wide July-September 2017 (agenda item 6.1)
JC reported the following:

- 15% of people who are currently accessing the Trust's mental health services do not have ethnicity recorded.
- 10% of new admissions and 9% of new detentions do not have ethnicity recorded. There appear to be ongoing recording issues.
- Length of wait for a SOAD to provide the certificate of authorisation for treatment remains within the time frame agreed by the Trust with the CQC of 4 weeks from request to ensure compliance with the requirements of s.58 and s.58A. YF clarified that it would not usually take 4 weeks for a SOAD, rather that was the timeframe agreed with the CQC for escalation.
- High use of Internal Transfers, particularly from Priestley Unit and The Dales
- SWYPFT is required to return annual statutory figures for use of Mental Health Act. The following highlights issues for the attention of the MHA Committee:
  - The use of civil sections across the Trust has remained relatively stable when compared to the previous quarter. There were 224 uses of s.2 and 125 uses of s.3 over Quarter 2. This represents a combined increase of 37 from Q4, and an increase of 42 uses of the Act over the same period in the previous year's reporting.
  - The Forensic activity has increased over the past quarter with 11 uses of Part 3 with transfer activity being predominantly from Newton Lodge to low secure facilities outside the Trust.
  - There continues a decreasing trend for appeals to Hospital Managers with a corresponding increase in applications for Tribunals, with approximately 1/3 of appeals to the Hospital Managers resulting in a hearing and 1/2 of appeals to the Tribunal service resulting in a hearing.
- Use of Part 2 and 3 of the MHA. The use of Part 2 has remained stable on the previous quarter with a disproportionate use of s.2 and s.3 in the Priestley Unit when compared to the other inpatient services. The use of holding powers in the Dales Unit remains high relative to the other localities. There are four exception reports for s.5(2) that should be noted for Q2;
  - Patient 1 where the RC did not attend to review the s.5(2) prior to the expiry of the section.
  - Patient 2 where the patient was transferred to PGH prior to review by the RC.
  - Patient 3 where the AMHP was unable to contact the N/R and this delayed the Section 3 application, the 5(2) lapsed at 11.44 and the Patient was accepted under Section 3 at 14.00 the same day.
  - Patient 4 where a doctor completed part 1 of the H1 but the nurse did not complete part 2 however informed the patient that she was subject to s.5(2). Within an hour the patient absconded and was returned by the police 5 hours later. Part 2 of the H1 was completed 2 days later. MHA Assessment took place that same day, the 5(2) was discharged with the patient to remain on the ward on a voluntary basis.

- There was 1 use of s.4 over Q2 which related to the following case;
  - The first medical recommendation had been completed, the AMHP had contacted a further 20 doctors but it was anticipated that there would be a delay of 8-12 hours before there was a doctor available to attend. Due to the risk of absconding and the risks to the patient's personal health and safety, compulsory detention was necessary.
- High use of internal transfers remains a significant issue and continues to raise concern with the predominant reason for transfer being the return to home area. 39 of the 60 transfers came from the Priestley Unit (25) and the Dales (14). The Committee discussed how these figures could reflect an effective reduction in out of area placements, utilisation of whole bed base and returning patients to their home areas at the earliest opportunity. CJ requested clarification of this and AB will liaise with the trios for Calderdale and Kirklees and provide an update at the next meeting.

Action: Adrian Berry

AM queried if we routinely ask patients about their experience in relation to transfers and TB advised that the patient experience is checked at various points in the pathway, not just in relation to transfer.

- CTO activity continues to decline with a current Trustwide use at 71. The majority of CTO activity remains sited in the Halifax area. It is not clear if there are any factors in place to influence this higher level of activity in comparison to the rest of the Trust.
- Hospital Manager Activity:
  - Hospital Managers Appeals activity continues to show a significantly lower frequency in respect of appeals with a little under two thirds of all applications being cancelled prior to the hearing occurring.
  - The majority of Hospital Managers activity is found with reviews of detention accompanying renewal of a section (23) or extension of a CTO (15) rather than of appeal hearings (12).
  - The number of reviews held following the extension of a CTO (s.20A) replicates the pattern of the previous year but consistently at a lower rate of activity. This indicates a stable but lower number of uses of CTOs.
  - There was 1 hearing following the barring of a nearest relative discharge. This would indicate that nearest relatives are receiving and exercising their rights.
  - No discharges by the Hospital Managers occurred over Quarter 2.
- Across the Trust over Quarter 1 there were 111 certificates of authorisation for urgent treatment (medication) and 8 certificates of authorisation for urgent treatment (ECT which related to 5 patients) utilised and 4 certificates to authorise treatment under a CTO (medication). All SOAD requests are up to date with the 1 month standard agreed with CQC being met.
- Deprivation of Liberty:
  - The physical health wards at Mount Vernon continue to be the source of most applications.
  - Over Quarter 2 all of the applications made were requests for standard authorisations only. Of these applications, 6 were discharged prior to the DoLS assessments being completed and 3 were transferred to BDG before the assessment was concluded. No application resulted in an authorisation being received during the reporting quarter.
  - There were no records of any being rejected. Awaiting outcome of government's response to the Law Commissioner's request.
- There has been an increase in Section 49 requests.
- There was 1 death of a detained patient in 2017/18 Quarter 2.

JC summarised that:

- The Committee should continue to request feedback from the BDUs on clinical reasons which may impact on MHA and DoLS activity.
- The revised process agreed with the CQC for review of SOAD requests continues to be effective.
- Applications for Hospital Managers hearings continues to decrease and reasons for this are being considered.
- Section 49 activity is increasing.
- That the transfer activity relating to the Calderdale and Kirklees BDU remains at disproportionately high levels when compared with the other BDUs.

The Committee discussed the impact to the organisation of Section 49. It was noted that there had been 28 requests in total last year and 21 in the first half of this year and the amount of resource needed was significant. CJ queried if the Committee could assure Trust Board that SWYPFT was compliant with the requirements and AB confirmed the position but advised that the situation will be monitored and consideration given to adding to the Risk Register if significant resource implications were ongoing.

Action: Adrian Berry

CJ queried what was being done to improving ethnicity recording and TB advised that data goes to OMG and the position is monitored against a trajectory although it was noted that there had not been as much improvement as expected. CJ queried how we can ensure that certain ethnic groups are not being disadvantaged and TB advised this is monitored through the Equality and Inclusion Forum. TB will bring an update to the next meeting.

Action: Tim Breedon

It was RESOLVED to note the findings of the monitoring report and APPROVE the recommendations within the paper:

- **Ensure the BDU's review the ethnicity reporting and recording processes**
- **Approve a review of the use of Part 2 MHA 1983 in the Priestley unit**
- **Approve a review by the BDU's of transfer activity to and from the Priestley unit**

MHAC/17/47b Local Authority Information (agenda item 6.2)
The following updates were provided:

Barnsley – Claire Edgar (CE) reported some difficulties with people from outside of the Barnsley area using the 136 suite. This is leading to pressures in the system and issues with South Yorkshire Police who want the suite to be used only for South Yorkshire. CE further advised of difficulties with recruiting permanent AMHPs and the need for further appropriate training as Barnsley AMHPS are not always mental health specific. ST advised of a historic tripartite arrangement between Wakefield, Kirklees and Calderdale to share 136 suites as Kirklees do not have one. This arrangement pre-dated Barnsley joining SWYPFT and it was suggested that Barnsley and Wakefield local authorities meet to understand whether Barnsley should be included in the arrangement given the different police forces involved. The Committee look forward to hearing the outcome of the discussions.
Wakefield – ST advised that there continue to be around 6 requests per week for 136 use with the number translating into detention being quite low. Work is ongoing with the police to put plans in place for individuals who are repeatedly received into the suites.

Figures from Kirklees were noted and there was no update from Calderdale. TB suggested working with local authorities through OMG and the deputy district directors to reiterate that the Trust and Committee appreciate the attendance of local authority colleagues at the meeting and find the figures useful.

Action: Tim Breedon

MHAC/17/48 CQC compliance actions (agenda item 7)

MHAC/17/48a MHA Code of Practice action plan (agenda item 7.1)

YF reported that outstanding policies relate to multi-agency:

- Transporting patients under the Act – draft – awaiting sign off by all agencies.
- 136 policy – further draft dated July 2017 awaiting approval.
- Police assistance for people undertaking MHA assessments – transporting patients policy. Draft awaiting sign off by all agencies.
- Joint local policies for admission to hospital.
- Local Partnership arrangements to deal with people experiencing mental health crisis. 136 policy draft and Standard Operating Procedure for place of safety. YF is meeting with Anne Howgate to progress development of the SOP.

It was RESOLVED to NOTE the update.

MHAC/17/48b MHA/MCA/DoLS mandatory training update (agenda item 7.2)

YF reported the current position as:

- Mental Capacity Act/DoLS training – 88.95%
- Mental Health Act training – 83.37%

against an 80% target (to take into account sickness and maternity leave, etc).

YF advised that good progress is being made in the development of an e-learning course for Mental Health Act refresher training and changes to the Mental Health Act are being considered following the Queen's speech for potential impact on the new training programme. AM queried if there were any areas of concern and YF advised that there was some pressure in Barnsley as DoLS training had previously been commissioned from the local authority, however funding had been withdrawn so there were around 300 more people requiring training and extra sessions were being facilitated.

It was RESOLVED to NOTE the update.

MHAC/17/49 Audit and Compliance Reports (agenda item 8)

MHAC/17/49a Community Treatment order (agenda item 8.1)

JC reported that the CQC visits continue to routinely identify issues with the referral and access to Advocacy services in compliance with s.130A-D and s.132 MHA 1983 and s.36-s.38 MCA 2005. As a consequence the Committee has determined that assurance be sought through annual audit of compliance with the Trust legal requirements in respect of statutory independent advocacy.

The 2017/18 annual audit found that compliance with s.132A appears to have improved over the previous audit cycle and all respondents reported that their patients had been given their rights on re-grading from a s.3 to a CTO. A minority of responses were identified as falling short of the minimum requirements for compliance with the Code of Practice and these included:

- Reiteration of rights not being supported by a care plan. It was noted that patients were being given their rights on admission, the issue was in relation to reiteration and referral to the IMHA service if they do not understand.
- Patient not having rights reiterated over a 12 month period.
- Incorrect recording of the reiteration of patients' rights.

There was concern expressed over the very disappointing response rate and resultant suggested amber risk rating. CJ added that he did not feel the Committee could provide assurance based on the current evidence and was uncomfortable with waiting another year to re-audit. AB suggested finding an alternative way of getting assurance from the people who had not responded and it was agreed to defer RAG rating until sufficient evidence that we are compliant could be gathered from the BDUs.

Action: Adrian Berry

It was RESOLVED to note the audit findings and APPROVE the following recommendations:

- **For the BDUs to review compliance with the Trust policy for patients' rights and to provide the MHA Committee with an action plan to address identified issues or maintain standards of practice.**
- **For CTO patients' rights to remain on the MHA Committee annual work plan for next 12 months.**

MHAC/17/50 Care Quality Commission visits (agenda item 9)

MHAC/17/50a Recent visits summary report (agenda item 9.1)

JC reported that there were 5 CQC Mental Health Act visits in Quarter 2 to; Horizon Centre, Chippendale Ward (Newton Lodge), Melton Suite, Enfield Down and Appleton Ward (Newton Lodge).

Within the quarter, 4 MHA monitoring summary reports were received relating to visits made to; Horizon Centre, Chippendale Ward, Melton Suite and Enfield Down.

3 responses; Horizon Centre, Chippendale Ward and Melton Suite were required within the quarter and all were submitted in accordance with the timeframes set by the CQC.

Issues that remained outstanding from the previous CQC ward visit include;

- Care plans were lacking in meaningful patient involvement and did not include clear discharge plans. **(B)**
- Patients' consent and capacity to consent were not routinely assessed and recorded at the start of their treatment following admission. **(B)**
- The observation panels on the doors of patients' rooms do not afford privacy to patients in the rooms. **(B)**
- The garden in front of the seclusion room and outside patients' bedrooms was not very well maintained. The courtyard was bare and uninviting with only a bare wooden fence. **(C)**
- Patients were dissatisfied with the quality of the food. **(C)**

Reoccurring themes requiring action by the Trust arising from the visits were;

- A lack of recording of capacity assessments x2 **(A)**
- Issues with the giving and reiteration of patients' rights x2 **(A)**
- Blanket restrictions in place x3 **(B)**
- Issues identified with s.17 leave forms x2 **(B)**

- Lack of information for contacting the CQC on display x2 **(B)**
- Ward lacked appropriate gender separation x2 **(B)**
- Ensuring patients are provided with information when in high intensity support areas x1 **(B)**
- Lack of activities x1 **(B)**
- Issues with compliance with seclusion policy x1 **(B)**
- A lack of evidence of patient involvement in care planning x1 **(B)**
- A lack of internet access x1 **(B)**
- Safe levels of staffing x1 **(B)**

Reoccurring themes of positive practice identified included;

- Complete MHA documentation available x3
- Evidence of Tribunals and Hospital Managers hearings occurring x3
- Timely access to IMHA services x3
- MHA training available and being attended x2
- Positive comments and feedback regarding staff x2
- Assessments of capacity recorded x2
- Evidence of care plans and risk assessments x2
- Positive staff/patient interactions x1
- Evidence of regular physical health checks x1
- A range of appropriate activities available x1
- Ward based meetings for all to attend x1

YF advised that the reoccurring themes that require action or where issues were outstanding were graded A, B or C as follows:

- A – priority, legal requirement
- B – should do, requirement of the Code of Practice
- C – matter of good practice

The Committee discussed recurrent themes and how these are being addressed. It was noted that action plans are monitored in local BDU governance groups. AB added that in relation to food quality, PLACE audits had made significant improvements.

It was suggested that some recurring themes may relate to different areas and there was discussion on information sharing across BDUs. CJ indicated that the Committee could not be assured by the report in its current form. TB advised that themes and actions were also reported to Clinical Governance and Clinical Safety Committee where they are picked up in more detail. The report to this Committee related to the Acts in particular. TB will bring an update on actions to the next meeting.

Action: Tim Breedon

It was RESOLVED to NOTE the update.

MHAC/17/50b Outstanding Actions/Progress Report (agenda item 9.2)
YF reported that the following 4 actions have been outstanding for above 12 months:

- WIFI access – 8 separate actions relating to WIFI access for service users across the Trust Estates. Currently being trialled within Newton Lodge with the outcome of the trial to be brought to MHA committee. 2 removed following implementation in Forensic services.
- Poplars – refurbishment of garden area at Poplars – costings now received – for completion 2018.
- Newton Lodge – observation panels (bedrooms) have now been chosen. Funding agreed by EMT and schedule of work in place. Expected time of completion 2019.

- Poplars Environmental review – this is part of the transformation work for Older People's service.

YF reported that there are no red actions in Barnsley and Wakefield BDUs but 10 ambers including:

- Internet access – being picked up in a separate paper.
- Section 17 leave – not compliant re informing family of granted leave. There is now a form on RiO to address this.
- Environment – garden, etc – work in progress.
- Care planning – blanket restrictions.

There were also 3 green which have all been completed.

In Calderdale and Kirklees, there are no red actions but 6 amber including:

- Patient rights – reiteration and recording.
- Lockable storage – appropriate solutions are being considered.

And 6 green referring to:

- IMHA referral – being audited by Practice Governance Coaches.
- Signage for exit (locked doors policy) – there was a sign but the CQC said it was not big enough and this has been rectified.
- IMCA referral – capacity in relation to financial affairs and physical problems.

There are no red actions in Forensics and Specialist Services but 6 amber including:

- Internet – is currently being deployed.
- Community meetings – inconsistent across the Forensic service.
- Keys to bedrooms and buttery – relates to Horizon observation panel, community.

And 13 green actions.

The Committee discussed how some actions relating to the same issues are green in some BDUs and not others. It was noted that progress is on an individual ward basis and Practice Governance Coaches are sharing recommendations and learning to ensure all areas of the Trust are covered. It was agreed that there was clear evidence that issues are being taken seriously with a clear process for reporting and monitoring.

It was RESOLVED to NOTE progress and allow EMT to continue to receive updates.

<u>MHAC/17/50c IT paper – internet access (agenda item 9.2.2)</u>
YF reported that in May 2017 the Committee were advised that the Trust were trialling patient Wi-Fi in Forensic Services. It was agreed that a paper would be provided to the Committee advising how the trial had progressed and summarising the plans for any further rollout to all areas providing inpatient Mental Health Services across the Trust. Feedback to date has been particularly positive and has made a real difference to the lives of services users. Working alongside Daisy, the IM&T department have developed two provisionally costed options for EMT consideration and decision.

It was RESOLVED to NOTE the update.

MHAC/17/50d Oversight and escalation process (agenda item 9.2.3)
YF reported that the MHA Committee receives quarterly update reports on the progress of actions from routine Mental Health Act CQC visits to inpatient wards. This process was due for review after the initial 12 months of implementation and has been reviewed by the BDU directors.

It was RESOLVED to NOTE the updated paper and specifically the following additions:

- **Two weeks before submission to the MHA Committee, the MHA BDU action plans will be reviewed by the BDU Deputy Director for approval.**
- **A copy of the completed CQC (MHA) action plan will be discussed at the next available organisational management group.**

MHAC/17/51 Partner agency update (agenda item 10)

MHAC/17/51a Hospital Managers' Forum Notes 11 September 2017 (agenda item 10.1)
David Longstaff (DL) advised that he has now taken over as Chair of the forum with Gary Haigh as Deputy Chair. DL highlighted a drop in appeals which was concerning as Hospital Managers are supposed to undertake a minimum of 10 per year in order to maintain their skills.

It was RESOLVED to NOTE the update.

MHAC/17/51b Hospital Managers' annual review (agenda item 10.2)
DL reported that 28 Hospital Managers have been re-appointed for a further year. Two people stood down from the role over the year, one person has asked for a 6 month sabbatical and two people have indicated their intention to step down from the role over the coming year. It was noted that changes to tax legislation under IR35 have been a source of concern in respect of the independent status of the Hospital Managers.

CJ queried the effectiveness of the "You said, we did" reviews and DL confirmed that it had been positive and would inform the training programme for 2018.

It was RESOLVED to ACCEPT the annual report.

MHAC/17/51c Hospital Managers' Concerns – July-September 2017 (agenda item 10.3)
JC reported that there had been four compliments in the last quarter and three concerns. One concern related to a service user who had not been through their reports with a member of staff despite the reports being made available on the day of the hearing. It was noted that in cases where a regular member of staff is unavailable to provide a report, the patient should have a view on whether to postpone or have someone else complete the report. The patient should then confirm that they are happy with the quality of the report. TB will feed back through the OMG report that wards need to be reminded to share reports, although it was acknowledged that there may be a clinical risk management element in relation to how far in advance of the hearing it should be shared.

Action: Tim Breedon

It was RESOLVED to NOTE the update.

MHAC/17/51d Compliments/Complaints/Concerns in relation to the MHA, July-September 2017 (agenda item 10.4)
There was a nil return for this item.

MHAC/17/52 Partner agency update (agenda item 11)

There was no update for this item.

MHAC/17/53 Key Messages to Trust Board (agenda item 12)

The key issues to report to Trust Board were agreed as:

- New requirements for s.135/s.136 capacity/demand (MHAC/17/44g)
- Section 49 workforce capacity (MHAC/17/47a)
- Outliers in relation to patient transfers, particularly in Dewsbury (MHAC/17/47a)
- Poor response rate to the CTO audit (MHAC/17/49a)
- How manage response in relation to recurrent themes from the CQC visits and the BDU response to action plans (MHAC/17/50a)

MHAC/17/54 Date of next meeting (agenda item 13)

The next Committee is scheduled to be held in March and a date will be confirmed at the earliest opportunity.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Minutes of the Mental Health Act Committee Meeting held on 19 December 2017

Present:	Dr Adrian Berry	Medical Director (lead Director)
	Tim Breedon	Director of Nursing and Quality
	Chris Jones	Non-Executive Director (Chair)
	Kate Quail	Non-Executive Director
Apologies:	Nil	
In attendance:	Sarah Millar	PA to Medical Director (author)

MHAC/17/55 Welcome, Introductions and Apologies (agenda item 1)

The Chair, Chris Jones (CJ) welcomed everyone to the meeting to ratify the decisions made at the meeting held on 21 November 2017 when the Committee was not quorate.

MHAC/17/56 Minutes of previous meeting held on 1 August 2017 (agenda item 2)

It was RESOLVED to APPROVE the minutes from the meeting held on 1 August 2017.

MHAC/17/57 Statistical information use of the MHA 1983 and MCA 2005 (agenda item 3)

MHAC/17/57a Monitoring information Trust Wide July – September 2017 (agenda item 3.1)

It was RESOLVED to APPROVE the following recommendations:

- **Ensure BDUs review the ethnicity reporting and recording processes**
- **A review of the use of Part 2 MHA 1983 in the Priestley Unit**
- **A review by the BDUs of transfer activity to and from the Priestley Unit**

Adrian Berry (AB) will liaise with the BDUs.

Action: Adrian Berry

MHAC/17/58 Audit and Compliance Reports (agenda item 4)

MHAC/17/58a Community Treatment Order (agenda item 4.1)

It was RESOLVED to NOTE the audit findings and APPROVE the following recommendations:

- **For the BDUs to review compliance with the Trust policy for patient's rights and to provide the MHA Committee with an action plan to address identified issues or maintain standards of practice** – AB advised that this has already been done
- **For CTO patient's rights to remain on the MHA Committee annual work plan for 2018**

It was RESOLVED to NOT APPROVE the following recommendations:

- **That a questionnaire be developed seeking the views of consultant psychiatrists as to the effectiveness of CTOs 10 years on** – given the very poor response rate, it was decided not to repeat a questionnaire
- **Based on the poor response rate the MHA Committee are asked to support an Amber risk rating for this audit** – it was agreed that the Committee could take no assurance because of the poor response rate and no risk rating was supported.

MHAC/17/59 Date of next meeting (agenda item 5)

It was agreed that the next Committee meeting will be held on 6 March 2018, 10.30am-1.00pm, Meeting Room 1, Block 7, Fieldhead

South West Yorkshire Partnership NHS Foundation Trust

Equality and Inclusion Forum held on 2 October 2017

Present:	Ian Black	Chair of the Trust (Chair)
	Tim Breedon	Director of Nursing and Quality
	Alan Davis	Director of Human Resources, OD and Estates
	Charlotte Dyson	Deputy Chair of the Trust
	Rob Webster	Chief Executive
Apologies:	Members	
	Sean Rayner	District Director, Barnsley and Wakefield
	Karen Taylor	Director of Delivery
	Attendees	
	Dr Adrian Berry	Medical Director / Deputy Chief Executive
	Ashley Hambling	Human Resources Business Manager
In attendance:	Aboo Bhana	Equality and Engagement Development Manager, Partnerships Team
	Paul Brown	Human Resources Business Partner
	Bronwyn Gill	Deputy Director, Corporate Development
	Claire Hartland	Human Resources Business Manager
	Nasim Hasnie	Governor, Members' Council
	Emma Jones	Company Secretary (author)
	Zahida Mallard	Equality and Engagement Development Manager, Partnerships Team
	Juanita Gray	Pastoral care coordinator
	Angela Monaghan	Non Executive Director

EIF/17/27 Welcome, introduction and apologies (agenda item 1)

The Chair (IB) welcomed everyone to the meeting. The apologies, as above, were noted.

EIF/17/28 Minutes from the meeting held on 16 May 2017 (agenda item 2)

The minutes of the previous meeting held on 16 May 2017 were approved.

EIF/17/29 Matters arising from the meeting held on 16 May 2017 not taken elsewhere on the agenda (agenda item 3)

There were no matters arising discussed.

EIF/17/30 Feedback from BAME staff network (agenda item 4)

Draft Minutes from network meeting 31 August 2017

Aboo Bhana (ABh) highlighted the following items that were discussed by the BAME staff network:

- Reporting and recording of racially motivated incidents. Alan Davis (AGD) commented, in relation to the reporting of incidents, that questions could be built into the Robertson Cooper survey to further understand this area.

- Sub group formed around clinical governance to look at gaps and actions which will report into the clinical governance support team and the Executive Management Team (EMT).
- How the talent of BAME staff is recognised and the organisation's perspective on leadership development for BAME staff. Dr Subha Thiyagesh attended and shared her personal/career journey. Charlotte Dyson (CD) suggested that the text captured from this in the minutes of the BAME staff network meeting be circulated as it was inspirational.

Action: Aboo Bhana

- Planning and promotion of annual event.
- Support for staff to attend the BAME staff network. AGD commented that the network was seen as a priority area for the Trust and supports staff being released to attend. The Forum supported this. ABh commented that another factor was that meetings were currently all being held at Fieldhead, which could be affecting attendance, and the network would look at this.

Chair recruitment – BAME network input

IB advised that staff from the BAME staff network made up a discussion panel as part of the recent Non-Executive Director recruitment and he was aware that they would also be a part of a staff discussion panel which forms part of the current Chair recruitment process.

Feedback from 1st anniversary celebration event - 28 September 2017

Zahida Mallard (ZM) advised that the 1st anniversary celebration event was held on 28 September 2017 and she felt it was a good showcasing event and a reminder that the BAME staff network has progressed. She thanked RW for assisting in asking Dr Naqvi, Deputy Workforce Race Equality Lead, NHS England to present. The slides would be circulated to Forum members, which show areas of achievement as well as where we need to continue to improve.

Action: Zahida Mallard

Forum attendees talked about how the event was well attended and inspirational for staff.

EIF/17/31 Update on progress to establish a disability staff network (agenda item 5)

AGD advised that, given the success of the BAME staff network, discussion has been taking place on how to continue to move forward in terms of the broader equality agenda. Using the results from the Robertson Cooper and NHS surveys, it identified staff with a disability who feel excluded from a number of areas. Staff networks are established as self-managed leadership groups and staff who had identified themselves as having a disability were written to with 46 responses received. An initial meeting has been scheduled to discuss establishing a steering group and network and the initial priorities. ABh will attend to share the learnings from the BAME staff network.

Angela Monaghan (AM) asked if support could be shared across the networks. AGD commented that when looking at the best way to support the staff networks it was felt it should be managed within the individual network to aid confidential discussions. ABh commented that the Equality and Engagement Development Managers support all staff networks.

RW commented that he felt the establishment of the staff networks was being done at the right pace to engage staff. The BAME staff network had been invited to identify someone as a Freedom to Speak Up Guardian along with our staff governors, linking into membership, and it was also important to link it into the update of the Trust's Quality Improvement Strategy.

IB asked whether the Trust's volunteers should be represented on the staff networks. ZM commented that initially it would continue with staff as they felt it was a safe space to come to and connect with people. The staff network would potentially look for champions at each locality, which could include volunteers in some aspects.

IB asked, in relation to benchmarking, whether other Trusts had disability staff networks that we could learn from. AGD commented that when the BAME staff network was set up they looked at others with staff networks established for lessons learned. Dr Naqvi also advised that there was some good practice guidance that has been released which could be used as a reference.

EIF/17/32 Workforce Race Equality Standard (agenda item 6)

Summary report 2017

AGD reported that the presentation from the annual BAME staff network celebration was helpful in highlighting the national issue within the NHS. A central agenda has been created to focus on the key issues. He cautioned that the data was currently based on a small sample, however this year the NHS staff survey was open to all staff which would provide more detailed results. In this year's data it showed some good trends however it was important to keep areas in focus and continue to improve.

ZM highlighted that one of the areas that had been raised by the BAME staff network was around informal recruitment processes and the recording of information. AGD commented that for formal processes, information was recorded in recruitment data, however for internal restructure and acting up or secondments it is not always possible to capture it. AGD suggested that the secondment guidance be reviewed by the Executive Management Team (EMT) to ensure they are advertised correctly. All opportunities should be fair and open to anyone, however there may be operational areas where it would be more appropriate to have specific processes. ABh commented that some staff felt they do not receive the information to have an opportunity and when raised it was not handled positively. It was important to focus on how we nurture, encourage and support staff. RW requested a review of what acting up positions were currently in place and the processes undertaken. The Forum requested that the action plan be updated to include it.

Action: Alan Davis

ABh commented that BAME staff network members are keen to have recruitment training so that they can sit on interview panels. ZM commented that it was also important to have gender equality on interview panels.

EDS2 & WRES Action Plan 2017

AGD highlighted that work was taking place around the integration of EDS2 and WRES and that there were areas where we can make a difference and areas we need to do further work on, so we can make sure we make a difference.

EIF/17/33 Equality Delivery System (EDS2) (agenda item 7)

Tim Breedon (TB) highlighted that a plan is being developed at a local level and further work would take place to understand how this linked back to the place based plans. Local action groups would need to be established with clear measures in place and more formalised reporting of those through to the Operational Management Group (OMG).

The Forum noted the update and requested further information on how achievement of the requirements under EDS2 could be tracked.

Action: Tim Breedon

ZM raised a concern that she was not sure that Equality Impact Assessments (EIA) were taking placed when revised Quality Impact Assessments (QIA) took place. TB requested the details for follow up.

Action: Zahida Mallard / Tim Breedon

EIF/17/34 Equality Impact Assessments update (agenda item 8)

Juanita Gray (JG) from Pastoral Care attended the Forum to provide her feedback on completing an Equality Impact Assessment (EIA). She commented that there was a lot of helpful information in the intranet as well as the support provided by ABh. She highlighted that a positive part of completing the EIA was it highlighted gaps for improvement around producing key leaflets in other languages and also the accessibility of service users to female chaplains. Plans were in place to address these.

ZM commented that feedback had been received from practice governance coaches that could be circulated to the Forum.

Action: Zahida Mallard

EIF/17/35 Accessible information Standard (AIS) – final report on project phase (agenda item 9)

BG highlighted that an audit would take place in October 2017 and an update provided at the next Forum meeting.

Action: Bronwyn Gill

EIF/17/36 Equality Strategy action plans (agenda item 10)

TB highlighted that further details on the Key Performance Indicators was needed and clarity around the reporting arrangements to the Executive Management Team and Equality and Inclusion Forum.

EIF/17/37 The Insight Programme / Non-Executive Director recruitment (agenda item 11)

Update provided as part of feedback from BAME staff network discussion.

EIF/17/38 Forum Chair and membership (agenda item 12)

Review (in light of revised director portfolios, Non-Executive Director changes, revised management arrangements for Equality and Engagement)

Forum members discussed and supported the continuation of the Forum. IB commented that the Non-Executive Director membership on all committees and forums of the Trust Board would be reviewed prior to the end of November 2017 and any changes would be ratified by Trust Board.

Barnsley and Wakefield Local Action Group – Terms of Reference

RW requested that the governance of the group and flow of information be explored to determine if it was a BDU delivery group.

Action: Tim Breedon

EIF/17/39 Any other business (agenda item 13)

No further items were discussed.

EIF/17/40 Items to bring to the attention of Trust Board (agenda item 14)

These were agreed as:

- Robertson Cooper and staff feedback and how it has informed WRES action plan
- Equality Strategy action plan
- BAME staff network 1st anniversary
- Disability staff network

EIF/17/41 Date of next meeting (agenda item 15)

The date of the next meeting will be confirmed by the Chair and Lead Director.

Action: Ian Black / Tim Breedon

The Forum requested that an annual work programme be drafted linked to the WRES action plan.

Action: Ian Black / Tim Breedon

The Forum thanked IB for the work he has done as Chair to support the Forum.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board 27 March 2018
Agenda item 13

Title:	**Use of Trust seal**
Paper prepared by:	Company Secretary
Purpose:	The Trust's Standing Orders, which are part of the Trust's Constitution, require a report to be made to Trust Board on the use of the Trust's seal every quarter. The Trust's Constitution and its Standing Orders are pivotal for the governance of the Trust, providing the framework within which the Trust and its officers conduct its business. Effective and relevant Standing Orders provide a framework that assists the identification and management of risk. This report also enables the Trust to comply with its own Standing Orders.
Mission/values:	The paper ensures that the Trust meets its governance and regulatory requirements.
Any background papers/ previously considered by:	Quarterly reports to Trust Board.
Executive summary:	The Trust's Standing Orders require that the Seal of the Trust is not fixed to any documents unless the sealing has been authorised by a resolution of Trust Board, or a committee thereof, or where Trust Board had delegated its powers. The Trust's Scheme of Delegation implied by Standing Orders delegates such powers to the Chair, Chief Executive and Director of Finance of the Trust. The Chief Executive is required to report all sealing to Trust Board, taken from the Register of Sealing maintained by the Chief Executive. The seal has been used three (3) times since the report to Trust Board in December 2017 in respect of the following: ➢ Contract for sale and transfer of deed for Birdwell Clinic, Sheffield Road, Birdwell, Barnsley between the Trust and George Sharmon and Son. ➢ Overage agreement and transfer of land at Castleford, Normanton and District Hospital between the Trust and Persimmon Homes Limited. ➢ Contract for the Non-Secure Scheme on site at Fieldhead between the Trust and Interserve.
Recommendation:	**Trust Board is asked to NOTE use of the Trust's seal since the last report in December 2017.**
Private session:	Not applicable.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board annual work programme 2018-19

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	✘	✘	✘	✘	✘	✘	✘	✘
Business developments	✘	✘	✘	✘	✘	✘	✘	✘
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	✘		✘		✘		✘	
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	✘				✘			
Information Management and Technology update	✘				✘			
Safer staffing report		✘				✘		
Estates strategy update			✘				✘	
Annual items								
Draft Annual Governance Statement	✘							
Audit Committee annual report	✘							
Compliance with NHS provider licence conditions and code of governance - self-certifications *(date to be confirmed by NHS Improvement)*	✘							

Agenda item/issue	Apr	June	July	Sept	Oct	Dec	Jan	Mar
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		✘						
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				✘				
Workforce Race Equality Standard (WRES)					✘			
Assessment against NHS Constitution						✘		
Trust Board annual work programme								✘
Eliminating mixed sex accommodation (EMSA) declaration								✘
Information Governance toolkit								✘
Strategic objectives								✘
Operational plan (two year) *(next due in December 2019 - date to be confirmed by NHS Improvement)*								
Policies and strategies								
Membership Strategy *(next due for review in April 2019)*	✘							
Quality Improvement Strategy *(was 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)							✘	
Risk Management Strategy							✘	
Communication, Engagement and Involvement strategy *(next due for review in December 2019)*								
Organisational Development Strategy *(next due for review in December 2019)*								
Treasury Management Policy *(next due for review in January 2020)*								
Workforce Strategy *(next due for review in March 2020)*								
Digital Strategy *(next due for review in January 2021)*								

	Business and Risk (includes quarterly performance reports and quarterly reports to Monitor/NHS Improvement)
	Performance and monitoring
Strategic sessions are held in February, May, September and November which are not meetings held in public.	
There is no meeting scheduled in August.	
# Corporate Trustee for the Charitable Funds which are not meetings held in public.	