South West Yorkshire Partnership NHS Foundation Trust

Trust Board (performance and monitoring)
Tuesday 26 June 2018 at 9.30am
Room 49, Folly Hall, St Thomas Road, Huddersfield, HD1 3LT

AGENDA

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
1.	9.30	**Welcome, introductions and apologies**	Chair	**Verbal item**	5	To receive
2.	-	**Declarations of interest**	Chair	**Verbal item**	-	To receive
3.	9.35	**Minutes and matters arising from previous Trust Board meeting held 24 April 2018**	Chair	**Paper**	5	To approve
4.	9.40	**Service User Story**	District Director Forensic and Specialist Services, Calderdale and Kirklees	**Verbal item**	10	To receive
5.	9.50	**Chair and Chief Executive's remarks**	Chair Chief Executive	**Verbal item** **Paper**	15	To receive
6.	10.05	**Performance reports**				
	10.05	6.1 Integrated performance report month 3 2018/19	Director of Finance & Resource and Director of Nursing & Quality	**Paper**	55	To receive
	11.00	*Break*			15	

With **all of us** in mind.

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	11.15	6.2 Learning Disabilities Mortality Review (LeDeR) report	Director of Nursing & Quality	**Paper**	10	To receive
	11.25	6.3 Incident management annual report 2017/18	Director of Nursing & Quality	**Paper**	10	To receive
	11.35	6.4 Healthy Eating CQUIN	Director of Human Resources, Organisational Development & Estates	**Paper**	5	To receive
7.	11.40	**Business developments**				
	11.40	7.1 South Yorkshire and Bassetlaw Shadow Integrated Care System (SYBsICS) update	Director of Strategy and Director of Human Resources, Organisational Development & Estates	**Paper**	10	To receive
	11.50	7.2 West Yorkshire and Harrogate Health and Care Partnership (WYHHCP) update	Director of Strategy and Chief Executive	**Paper**	10	To receive
	12.00	7.3 West Yorkshire Mental Health Services Collaborative (WYMHSC) Memorandum of Understanding	Chair	**Paper**	5	To receive
8.	12.05	**Governance items**				
	12.05	8.1 Operational Plan 2018/19	Director of Finance and Resources	**Paper**	5	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	12.10	8.2 Update on Annual Report and accounts including Quality Account 2017/18	Director of Finance and Resources and Director of Nursing & Quality	**Paper**	5	To receive
	12.15	8.3 Trust Board self-certification (FT4) - corporate governance statement 2017/18	Director of Finance & Resource	**Paper**	5	To approve
	12.20	8.4 General Data Protection Regulations (GDPR) update	Director of Finance & Resource	**Paper**	5	To receive
9.	12.25	**Receipt of public minutes of partnership boards**	Chair	**Paper**	5	To receive
10.	12.30	**Assurance and receipt of minutes from Trust Board Committees** - Audit Committee 22 May 2018 - Clinical Governance & Clinical Safety Committee 15 May 2018 and 19 June 2018 - Equality & Inclusion Forum 12 June 2018 - Mental Health Act Committee 15 May 2018 - Nominations Committee 20 June 2018 - Workforce and Remuneration Committee 8 May 2018 - West Yorkshire Mental Health Services Collaborative Committees in Common 30 April 2018	Chair of committees	**Paper**	10	To receive
11.	12.40	**Use of Trust Seal**	Company Secretary	**Paper**	5	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
12.	12.45	**Trust Board work programme**	Chair	**Paper**	5	To receive
13.	12.50	**Date of next meeting** The next Trust Board meeting held in public will be held on Tuesday 31 July 2018 in the small conference room, Wellbeing and learning centre, Fieldhead, Ouchthorpe Lane, Wakefield.			-	
14.	12.50	**Questions from the public**	Chair	**Verbal item**	10	To receive
	13.00	*Close*				

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Trust Board meeting held on 24 April 2018
Conference centre Boardroom, Kendray, Barnsley

Present:	Angela Monaghan	Chair
	Charlotte Dyson	Deputy Chair
	Laurence Campbell	Non-Executive Director
	Kate Quail	Non-Executive Director
	Rob Webster	Chief Executive
	Mark Brooks	Director of Finance and Resources
	Dr Subha Thiyagesh	Medical Director
	Tim Breedon	Director of Nursing and Quality
	Alan Davis	Director of Human Resources, Organisational Development and Estates
Apologies:	Members	
	Rachel Court	Non-Executive Director
	Chris Jones	Non-Executive Director
	Other	
	Nil	
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
	Karen Taylor	Director of Delivery
	Salma Yasmeen	Director of Strategy
	Emma Jones	Company Secretary (author)
	Dr Richard Marriott	Consultant Psychiatrist, Guardian for Safe Working (for agenda item 10.1)

TB/18/30 Welcome, introductions and apologies (agenda item 1)

The Chair, Angela Monaghan (AM) welcomed everyone to the meeting. The apologies above were noted. AM welcomed to Dr Subha Thiyagesh to her first meeting as Medical Director. Dr Adrian Berry had now retired as Medical Director and the Board noted his long and distinguished service to the Board and Trust, originally joining as a Forensic Psychiatrist. Dr Berry would be returning to the Trust as Responsible Officer for medical staff revalidation. The Board expressed their appreciation and thanks to Dr Berry for his service, wished him well in his semi-retirement, and looked forward to his return as Responsible Officer.

TB/18/31 Declarations of interest (agenda item 2)

There were no further declarations over and above those made in the annual return in March 2018 or subsequently.

TB/18/32 Minutes and matters arising from previous Trust Board meeting held 27 March 2018 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 27 March 2018 as a true and accurate record. The following matters arising were discussed:

- TB/18/20a Integrated Performance Report (regarding complaints) - TB advised that it has been discussed by the Clinical Governance and Clinical Safety Committee and work is taking place on a performance plan. The trajectory will be circulated to the Board.
- TB/18/20a Integrated Performance Report (regarding the analysis of outcomes by ethnicity) - TB advised this would be discussed by the Equality and Inclusion Forum.
- TB/18/20b Serious incident report quarter 3 2017/18 - TB advised that Non-Executive Director involvement in the incident process was being considered as well as possible attendance at panel and post investigation meetings.

TB/18/33 Service User Story (agenda item 4)

The Trust Board heard a service user story. Sean Rayner (SR) advised that the Intermediate Care service was designed to optimise recovery and enable service users to take control of their lives and maintain independence. Intermediate Care was subject to major system change in Barnsley. Specifically the Trust supports the crisis response pathway and in addition to this there are independent service beds in Barnsley Hospital. The following stories illustrate the patient pathway as it is now and system we have tried to create to meet our mission.

> "Jane" was admitted to Accident and Emergency department following a fall while shopping. She was found to have a fracture to her femur resulting in an arthroplasty. Jane lived in a 2 bedroom terrace house alone and was independent and enjoyed going into town shopping and doing her own cleaning etc. Following her operation Jane struggled to get in and out of bed independently in hospital. She would be unable to navigate stairs safely in her home setting and there was no room in her home to have a bed downstairs. Jane agreed to a period of rehabilitation in an independent sector care home where she could continue to practice bed transfers and stair practice in a safe environment.
>
> Jane was transferred to Buckingham Care home Penistone where she spent 9 days regaining her confidence and practiced her transfer in and out of bed and stair practice. Jane was anxious about returning home. A care plan was put in place for the Neighbourhood Rehabilitation and Crisis Response Service (NRS) team to continue to support her in her own home and return to her activities of daily living.
>
> The NRS team (MDT of nursing and physiotherapists) assessed Jane's home on her discharge from Buckingham. A plan of visits was discussed and joint goals were agreed with Jane about what she wanted to achieve. Jane had morning and evening visits from our NRS Support Workers to support her on the stairs and a mid-morning visit to practice shopping and outdoor mobility. Jane regained full independence and the confidence to go back to shopping after 3 weeks on the pathway.
>
> "Anne" was referred to Crisis Response service after recently being discharged from hospital. She has a 5 week history of loose stools with diagnosed C-diff which is being treated with antibiotic. Anne fell overnight and now has reduced mobility and has become doubly incontinent. Anne has a known dementia diagnosis. She lives with husband and has 4 visits per day care package.

A full MDT assessment commenced. Initially placement within a care home (place of safety) was refused by Anne/her family. Extra support was arranged by the Crisis Response Nurse with appropriate equipment supplied. Care plans were agreed and in place. Placement in Independent Sector care home bed agreed and arranged due to Anne's husband's admission to hospital. Anne was unsafe to stay at home without 24-hour supervision. MDT support ongoing in the care home.

MDT meeting with Anne and family. Anne had returned to her previous ability and a discharge home with care package and initial support by Crisis Response team was discussed. After consideration the family agreed that a week of respite care, to allow her husband to recover from his admission, was required. A care package was arranged to commence after this with respite built in for when Anne's husband felt this was required. Anne discharged to respite care.

The Board asked to pass on their thanks to service users and carers for sharing their stories which demonstrated the person focus and support for carers through multi-disciplinary teams and the importance of communication and options available.

It was RESOLVED to NOTE the Service User Stories.

TB/18/34 Chair's and Chief Executive's remarks (agenda item 5)

Chair's remarks

AM highlighted the following:

- Members' Council elections - voting closed on 20 April 2018. The results are available on the Trust's website and will be formally reported to the Members' Council on 27 April 2018. The newly elected governors have been invited to attend the meeting and will commence a three year term from 1 May 2018.
- Non-Executive Director recruitment - a fourth and final information session will be held this evening for potential candidates. Information is available on the Trust's website and applications close on 7 May 2018.

Chief Executive's report

RW commented that The Brief communication to staff, that was included in the paper, provided an update on the local and national context as well as what was happening across the organisation. RW highlighted the following in addition to the report included in the papers:

- Currently within the pre-election period for Local Government which curtails some activity and decisions.
- The Prime Minister has committed to finding a long-term funding solution for the NHS and Jeremy Hunt MP has written to all conservative MPs to ask for their views.
- Welcome nominations for the NHS70 Windrush Awards which recognise the contribution of diverse communities to the NHS.

TB/18/35 Governance items (agenda item 10)

TB/18/35a Safe Working Hours Doctors in Training annual report (agenda item 10.1)

AM welcomed Dr Richard Marriott (RM) who is the Guardian of Safe Working.

RM reported that the requirement was put into place to ensure that trainees were not forced to work excessive hours, ensure the day job was not getting in the way of their training, and provides trainees with the opportunity to raise concerns. RM highlighted the following:

- Changes to the services to support trainees.
- Changes to the rota and the ability to staff the rota in Calderdale which has been the cause of concerns raised.
- Low number of exception reports which provides assurance.
- Survey of all trainees to ensure concerns were being raised, with some areas highlighted relating to the process, what would constitute an exception, and reporting culture.

LC asked if trainees were using incident reporting on Datix as an alternative. RM advised that sometimes exception reports would also require a Datix report if appropriate, dependent on the issue raised. RW asked if a triangulation of incident reports in relation to staff had been done. TB advised that it had not been done specifically in relation to Calderdale and the trainees. Any incidents raised in Datix are looked at by the Risk Panel. CD asked if it was possible to determine how many had been raised by trainees. SThi commented that trainees would be less likely to be doing independent practice so Datix reports may be input by others.

Action: Tim Breedon

LC asked what was in place to assist with the recruitment of trainees in Calderdale. RM advised that the Trust would like to offer places through the Royal College Medical Training Initiative to enable internationally qualified people to come for a two-year placement.

AM commented that it was important to have the right reporting culture in place to ensure they feel able to raise any concerns and a supportive environment to enable access to training. RM commented that part of the induction was to encourage reporting. RW commented that it was important that it was reinforced through consultants and medical management so that trainees understand the importance of raising concerns. SThi advised that it has been reinforcing with staff that the Medical Staff Committee is a forum for trainees to come and enable them to raise concerns, as well as the Junior Doctors' Forum.

AM noted that that quarterly reports in future would be received through the Integrated Performance Report (IPR).

It was RESOLVED to RECEIVE, REVIEW and CONFIRM their assurance that the Trust has met its statutory duties.

TB/18/36 Risk and assurance (agenda item 6)

TB/18/36a Strategic overview of business and associated risks (agenda item 6.1)

SY reported that the paper provides an update since October 2017, reflected through the PESTLE (Political, Economic, Social, Technological, Legal/Regulatory and Environmental) and SWOT (Strengths, Weaknesses, Opportunities and Threats) analyses aligned with the Trust risk register and priority programmes. Key updates are highlighted on the front cover of the paper.

LC asked if the information in the report was utilised and triangulated with the risk register. EJ commented that the quarterly report to Audit Committee on the triangulation of risk, performance and governance brings together information from this report, the Integrated Performance Report (IPR), Board Assurance Framework (BAF), and Corporate Organisational Risk Register (ORR) to highlight if there are any gaps in risks and assurance.

CD asked how it was utilised in informing the Trust's overall strategy. RW commented that from reviewing this information it was important for the Board to consider if the Trust's current strategy was still relevant in our context given the increase in issues such as co-production, social prescribing, working more closely with services for joined up care, changes to the Mental Health Act, and General Data Protection Regulations (GDPR).

CD asked if partners were clear about what the Trust's strategy was and our role. RW commented that there was a large number of external meetings that the Trust was involved and engaged in, including Health and Wellbeing Boards and through the Sustainability and Transformation Partnerships (STPs). Kate Henry (KH) commented that our external marketing needed more focus and work was currently taking place around our Commercial Strategy, which would come back to Trust Board. It was an area that was planned for focus in the last financial year, however there had been more of a focus on internal communications.

LC commented that it was important to focus on external communications as some of the biggest risks on the risk register related to loss of business. MB commented that it was important that anything included in potential marketing does not result in demand exceeding capacity. RW commented that part of the external communications was for all Board members to be able to describe our strategy, the priorities and provide examples of what makes us unique. In the recent CQC inspection they noted our clear strategy. The "Our Year" booklet demonstrates some of the great work the Trust has done. Some external stakeholder management information would be helpful. AM commented that being able to reflect performance against the Communications, Engagement and Involvement Strategy in the Integrated Performance Report may also assist.

Action: Salma Yasmeen / Kate Henry

It was RESOLVED to NOTE the content of the report.

TB/18/36b Assurance framework (agenda item 6.2)

MB highlighted the change in RAG rating for the use of resources strategic objective. EMT had discussed it in detail and felt that due to setting a financial deficit target for next year and risk identified in terms of gaining commissioner buy-in for income and growth, the overall RAG rating should be amber.

RW commented that strategic risks would not change a lot over time and that cost improvement and finances were the key areas of concern. An area that could be reflected more clearly is the environment the Trust operates in and how that drives additional demand in the system.

MB advised that during the recent Care Quality Commission (CQC) inspection they had advised that they found the Board Assurance Framework (BAF) difficult to follow in places, therefore the format of the report may be updated for 2018/19. TB commented that in discussion with the CQC it was clear that the BAF is fit for purpose, however may be difficult to understand. He has asked the CQC for any examples of best practice. MB asked Board members if they had seen good examples of a BAF used by other organisations to provide them. AM commented that the internal audit on current risk management processes and BAF had received significant assurance.

It was RESOLVED to NOTE the controls and assurances against the Trust's strategic objectives for Quarter 4 2017/18.

TB/18/36c Corporate / organisational risk register (agenda item 6.3)
MB highlighted the following:

- Each risk was aligned to a sub-committee of the Board for additional oversight and assurance around actions.
- Cyclical approach to reviewing risks by the Executive Management Team (EMT) each quarter.
- Over the last quarter, EMT challenged themselves quite hard around the consequence scores of risks and whether they are really "major" and "catastrophic" in light of the mitigations in place. For example, the risk in relation to organisational sustainability around workforce was reduced to "moderate" as there are a lot of mitigations in place and reflecting that if the worst case was to happen we would work with regulators to ensure the right actions were in place.
- The highest scoring risks were not necessarily the ones that we worry about the most e.g. out of area beds is a risk of significant focus

LC commented that the Audit Committee had questioned the lowering of the risk score in relation to tendering and sustainability issues. RW commented that it was important that there was a clear description of what the risks are. If we the Trust no longer existed, the regulators would come in to ensure there were services, which supported the reducing of the impact from "catastrophic".

KQ asked for further detail in relation to the out of area bed risk. MB commented that as part of the quarterly report to Audit Committee on the triangulation of risk, performance and governance, it was identified as an area from the Integrated Performance Report that was not currently a risk on the corporate/organisational (Trust Board) level risk register (ORR). As part of the recent Care Quality Commission (CQC) inspection, it was also identified and we outlined our processes around the management and control of out of area beds, including weekly reporting through the Operational Management Group (OMG) and EMT. CH commented that the risk is on the BDU level risk register and would have been escalated through the normal processes if the increased level continued. MB commented that in 2017 OMG and EMT had been fairly confident that when the Unity ward came into use it would reduce out of area bed use however there had been an un-forecasted increase in demand. The question is more whether the current processes are quick enough to identify a risk for escalation to the ORR. EJ commented that while the current processes were subject to an internal audit which received significant assurance, they had improved over the last year supported by the review and oversight of risks by committees. Improvements would continue to take place over the next year to incorporate changes to the risk appetite under agenda item 6.4 and feedback from the CQC.

CD asked if the detailed report received by the Clinical Governance and Clinical Safety Committee and priority programme would change the scoring of the risk in relation to waiting lists. CH commented that the scoring had been changed to "possible" rather than "likely" due to the number of mitigations in place, however the impact remains the same and it remains a concern. The priority programme reflects the collaborative and partnership working taking place across the patch.

AM commented that the dates of completion for actions was sometimes vague and requested if individual dates for actions could be added to assist the Board in tracking progress.

Action: Mark Brooks

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/18/36d Review of Risk Appetite Statement (agenda item 6.4)
MB reported that the Trust Board first introduced risk appetite in late 2016. A review had taken place, particularly in relation to the use of risk appetite 1-3. The update had been discussed at the last strategic meeting of Trust Board, briefly at last public meeting of Trust Board, and by the Executive Management Team (EMT) and Audit Committee. Changes to the risk appetite statement would impact the current risk management procedures with further development to take place over the next twelve months.

LC, as Audit Committee Chair, confirmed that the update had been discussed by the Committee. He felt the risk appetite score of 1-6 for financial risks was quite cautious and that the Audit Committee had requested that commercial risks be separated with a risk appetite score of 8-12.

AM commented that within the statement it referred to an annual review. Work programme to be updated.

Action: Emma Jones

It was RESOLVED to APPROVE the update to the Trust's Risk Appetite Statement.

TB/18/37 Business developments (agenda item 7)

TB/18/37a South Yorkshire and Bassetlaw Shadow Integrated Care System update (agenda item 7.1)
Alan Davis (AGD) highlighted the following from the South Yorkshire and Bassetlaw Shadow Integrated Care System (SYBsICS):

- System is in transition, reviewing governance arrangements and focusing on key priorities.
- Review of planning guidance arrangements.
- Hospital services review report delayed due to the local government election period.
- Refinement of draft capital bids which is currently £1b against a national allocation of £1.6b.

SY added that the stroke review would be taking place in Barnsley and the Trust would be a partner to those discussions.

RW commented, in relation to control total arrangements as part of an Integrated Care System (ICS), that the Trust's control total was not included under South Yorkshire and Bassetlaw. It would be included as part of West Yorkshire and Harrogate in the future should it become an ICS. The conversation regarding the Trust's current status as "partner to" the SYBsICS was going to be reviewed as part of the review of governance processes.

KH asked if Sustainability and Transformation Partnerships (STPs) had an impact on multiagency workforce planning. AGD commented that workforce planning was being discussed by both the SYBsICS and West Yorkshire and Harrogate Health and Care Partnership (WYHHCP).

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

TB/18/37b West Yorkshire and Harrogate Health and Care Partnership update (agenda item 7.2)
SY highlighted the following in relation to the WYHHCP:

- Some capital bids were successful particularly around digital health, technology, tele-health, and scans. While none of the bids were specific to mental health it was a good outcome for the system.
- The partnership has been invited to be part of the second wave of STPs to become formal ICSs.
- Work commencing around establishing a citizen panel.

RW added that there was a partnership leadership day next week. The agenda includes reviewing the process for the approval of the final Memorandum of Understanding (MoU), which had been to all boards for comment, discussion around a Workforce Advisory Board and reporting, and capital prioritisation.

It was RESOLVED to NOTE the update.

TB/18/38 Performance reports (agenda item 8)

TB/18/38a Integrated performance report month 12 2017/18 (agenda item 8.1)
TB highlighted the following in relation to the summary dashboard:

- Under 18 admissions - three people for a total of 30 days and is an important area to continue to keep in focus.
- Out of area beds - our Trust is in a similar position to others in terms of acuity and demand. KT commented that there was a significant spike at the end of the financial year with the biggest in relation to acute admissions, which has now reduced. PICU remains a challenge. RW commented that it was important to have a conversation with commissioners that, if the demand remains consistent, to ensure their commissioning reflects that. MB commented that historically the Trust has held much of the budget for out of area beds and there were ongoing conversations around working collaboratively with commissioners to ensure we understand the root courses and consistency of approach.
- Internal audit of our mortality review process received significant assurance.
- Overall quality performance has held up during period of significant acuity and financial pressures due to the hard work of staff. Challenges will remain in 2018/19.

Typographical errors were noted within the report in relation to staffing in Wakefield BDU, which should read 138% relating to intensive support for an individual, and prone restraint year end should be RAG rated as red.

AM commented that delayed transfers of care (DTOC), whilst RAG rated green, appeared to be worsening. TB advised that performance was still within the threshold, however it would be closely monitored. CH advised that a spike in Calderdale and Kirklees had been noted and operational teams had a focus on DTOC. SR advised that the spike in Barnsley had been reduced. KT added that there had been some challenges around reductions in social care systems.

CD asked when the performance targets would be reviewed for 2018/19. TB advised that this was taking places and any recommended changes would come back to Trust Board.

CH highlighted, in relation to Locality Calderdale and Kirklees, that Adult Acute activity on Ward 18 had seen increased acuity, which led to an increase in bank and agency expenditure in order to keep wards safely staffed.

SY highlighted the following in relation to Priority Programmes:

- Out of Area Beds (OOAB) - has remained at the top level and learning received through a Calderdale system flow event.
- Clinical Records System (CRS) - co-design is in progress.

CD commented that the Clinical Governance and Clinical Safety Committee has asked for greater assurance around clinical processes in relation to the CRS. LC commented that Audit Committee received a risk profile and have requested assurance around key milestones, particularly in relation to the implementation and cross over time between the old and new systems. SY advised that the process of data migration was detailed and would include three periods of testing. There are three gateways which would require formal signoff before moving to the next stage. RW asked for assurance from the Audit Committee after their next meeting in relation to the milestone plans, mitigation of risk around data migration, and overview of gateway signoff including Non-Executive Director oversight.

Action: Salma Yasmeen / Tim Breedon

MB highlighted the following in relation to Finance:

- Achieved year-end control total, which would not have happened without a number of one-off control measures.
- True run rate for March 2018 was a deficit of several hundred thousand pounds.
- This achievement guaranteed additional STF of £100k. The indicative STF "bonus" that we will receive is just short of £1.5m.
- Agency was £4m better than last year, however last two months were above the cap.
- Known increase in non-pay in relation to community equipment, laptops, training costs, estates.
- Cash has increased, which is not a true reflection of our underlying cash position.

The Board recognised the year end position and the huge effort of staff also noting the underlying position and run rate to start 2018/19.

AGD highlighted the following in relation to Workforce:

- Sickness absence is slightly higher than last year, with major initiatives taking place around health and wellbeing agenda in 2018/19.
- Middleground programme will focus on healthy teams.
- New appraisal system has a strong focus on health and wellbeing.
- Local wellbeing group piloted and will be rolled out across the BDUs.
- Recruitment and retention plan signed off by the Remuneration and Terms of Service Committee.
- Fire mandatory training levels will monitored in inpatient areas at a 95% target in 2018/19, although the attendance rate target for the organisation as a whole is 80%.

CD commented that, in relation to sickness absence, it was discussed at the Remuneration and Terms of Service Committee that, although there were a lot of actions in place, these were not always showing an impact. AGD commented that the target was a self-set stretch target and a number of factors could impact performance, such as good management and early referrals, and some are due to service issues, which can cause pressure on individuals. It was important to understand areas of hot spot for focus and a tailored approach.

KT commented that a lot of focus and effort had been placed on managing sickness absence, and, while higher than expected, without that work it could have been even higher. Deep dives are taking place in relation to the management of sickness absence which was a high priority for focus. RW commented that all but one BDU had reduced sickness absence in the last month. Two thirds of sickness absence was long term and if trends were identified it may have greater impact.

MB commented that it was important to recognise the tremendous amount of work of staff had done to provide the IPR to the Board early this month as last year the data was not available at this point in time.

It was RESOLVED to NOTE the Integrated Performance Report

TB/18/38b Customer services report Quarter 4 2017/18 (agenda item 8.2)
TB reported that a review of customer services processes was taking place. The Quality Improvement and Assurance team were conducting roadshows across the Trust's services to talk to people about their experience of using Customer Services, which will be used as part of the revision of our approach. From quarter 1 2018/19, the report to Trust Board would move towards a patient experience report.

CD commented that equality data slide indicated that more white British people raised complaints at 69% and asked if the processes supported people from other backgrounds to raise concerns. TB commented that this could be an area reviewed further by the Equality and Inclusion Forum.

Action: Tim Breedon

It was RESOLVED to NOTE the feedback received through Customer Services in Quarter 4 of financial year 2017/18.

TB/18/38c Safer staffing report (agenda item 8.3)
TB reported that the paper had been scrutinised by Clinical Governance and Clinical Safety Committee with areas discussed highlighted on the front sheet. A significant review was taking place in relation to the routine safer staffing approach which ties into acuity and demand and workforce plans.

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

TB/18/39 Strategies (agenda item 9)

TB/18/39a Digital Strategy - progress update (agenda item 9.1)
MB reported that, following the disbanding of the previous Information Management and Technology (IM&T) Forum, progress against the strategy was now reported twice yearly. The paper provided an update on key achievements which included:

- Commencement of the clinical records system implementation.
- Agreeing the updated Digital Strategy to incorporate the previous IM&T Strategy.
- IT infrastructure modernisation.
- Implementation of wifi programme.
- Delivery of the capital programme.
- Introduction of a clinical portal.
- Clinical records scanning.
- Achievement of the Information Governance (IG) toolkit.

KH commented that the implementation of wifi was a key example of digital inclusion within the Strategy, which had been piloted in Forensic services. This programme has put the Trust in a good position in relation to future national digital programmes with strong relationships with NHS Digital.

It was RESOLVED to NOTE the update of progress made against the Digital Strategy.

TB/18/40 Governance items (agenda item 10 continued)

TB/18/40a Equality and Inclusion Forum annual report (agenda item 10.2)

TB reported as lead Director for the Forum, that the annual report provides assurance that the Forum was meeting its Terms of Reference. The Terms of Reference had been updated to recommend that it now becomes a standing Forum of the Trust Board rather than time limited and that the governor in attendance now becomes a formal member. AM recommended that as a standing Forum the annual report should go to the Audit Committee in future prior to Trust Board as part of the committee annual report process.

Action: Tim Breedon / Mark Brooks

RW requested that Workforce Race Equality Standard indicators be included as part of the Integrated Performance Report.

Action: Tim Breedon

It was RESOLVED to:

- **RECEIVE the annual report from the Equality and Inclusion Forum as assurance that it is meeting the requirements of their Terms of Reference;**
- **APPROVE the update to the Equality and Inclusion Forum Terms of Reference, including that the Forum now be standing Forum of the Trust Board; and**
- **REQUEST future annual reports be received by the Audit Committee prior to Trust Board as part of the annual reporting process.**

TB/18/40b Audit Committee annual report including updated Terms of Reference for committees (agenda item 10.3)

LA reported as Audit Committee Chair that each committee chair and lead director was invited to the Audit Committee meeting on 10 April 2018 to present their annual reports, which provided assurance that they had met the requirements of their Terms of Reference. LA confirmed that the Audit Committee were assured from these reports that they were meeting their requirements, that the work programmes were aligned to the risks and objectives of the organisation, and that they demonstrated added value to the organisation.

The Board noted the renaming of the Remuneration and Terms of Service Committee to be the Workforce and Remuneration Committee to reflect the remit of their work in relation to workforce performance matters.

It was RESOLVED to:

- **RECEIVE the annual report from the Audit Committee as assurance of the effectiveness and integration of risk committees, and that risk is effectively managed and mitigated through:**
  - **committees meeting the requirements of their Terms of Reference;**
  - **committee work programmes are aligned to the risks and objectives of the organisation within the scope of their remit; and**
  - **committees can demonstrate added value to the organisation; and**

- **APPROVE the update to the:**
  - **Audit Committee Terms of Reference;**
  - **Mental Health Act Committee Terms of Reference;**
  - **Workforce and Remuneration Committee (previously Remuneration and Terms of Service Committee) Terms of Reference; and**
  - **Clinical Governance and Clinical Safety Committee Terms of Reference.**

TB/18/40c Draft Annual Governance Statement (agenda item 10.4)
RW commented that a large amount of work took place last year to ensure the Annual Governance Statement reflected changes within the organisation. Areas highlighted in grey within the statement were mandatory and there were still some areas which were subject to external audit. The final version would be approved by the Trust Board in private session in May 2018 as part of the approval of the Annual Report and accounts 2017/18.

It was RESOLVED to APPROVE the first draft of the Annual Governance Statement for 2017/18.

TB/18/40d Trust Board self-certification (G6CoS7) compliance with NHS provider licence (agenda item 10.5)
EJ reported that as part of the annual planning arrangements, NHS Improvement requires foundation trusts to make a number of governance declarations. The Board was required to make the following self-certifications by 31 May 2018:

- That the Trust provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (as required by condition G6(3) of the NHS Provider Licence); and
- If providing commissioner requested services (CRS), the Trust has a reasonable expectation that required resources will be available to deliver the designated service (as required by condition CoS7(3) of the NHS Provider Licence).

The paper provided assurance to Board that the Trust meets the conditions of its licence and identifies potential areas of risk as well as sets out the way the Trust complies with the continuity of services conditions in the NHS provider licence.

It was RESOLVED to:

- **NOTE the outcome of the self-assessments against the Trust's compliance with the terms of its Licence and with Monitor's Code of Governance; and**
- **CONFIRM that it is able to make the required self-certifications in relation to compliance with the conditions of its Licence.**

TB/18/41 Receipt of public minutes of partnership boards (agenda item 11)

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

- Calderdale Health and Wellbeing Board 12 April 2018
- Barnsley Health and Wellbeing Board 3 April 2018 - SR commented that winter deaths was significant compared to other districts.
- Wakefield Health and Wellbeing Board 29 March 2018 - RW commented that the pharmaceutical needs assessment did not include assessment of needs of people with mental health conditions.

- Kirklees Health and Wellbeing Board - CH commented that the meeting reviewed the winter plan and supported integrated ways of working.

It was RESOLVED to RECEIVE the updates provided.

TB/18/42 Assurance and receipt of minutes from Trust Board Committees (agenda item 12)

Clinical Governance and Clinical Safety Committee 17 April 2018

- Risks, as discussed under agenda item 6.3
- Quality Strategy.
- Freedom to Speak up Guardian role.
- Internal audit on learning from deaths received significant assurance.
- Post evaluation Specialist Adult Learning Disabilities report which included a number of performance indicators and a further review will take place in six months.
- Approved Minutes of the Committee meeting held on 6 February 2018 (to be provided with the next Trust Board papers).

Action: Tim Breedon

Audit Committee 10 April 2018

- Delivering Service Change - Need to review some projects at points before business as usual (BAU).
- SystmOne implementation - Committee currently not assured: risk levels, clarification of milestones and assurance at each point, design, conversion and full load risks.
- Risk Register - Growing/emergent risks as discussed previously.
- Agency internal audit - Limited assurance. We have more opportunity to tighten the process up.
- Out of area bed risk as discussed today.
- Risk appetite as discussed today.
- General Data Protection Regulations (GDPR) progress.
- Internal Audit plan 2018/19. To be circulated to the Trust Board for information.

Action: Mark Brooks

- Draft Head of Internal Audit Opinion 2017/18 'significant assurance'.
- Approved Minutes of the Committee meeting held on 9 January 2018 (attached with the papers).

Nominations Committee 10 April 2018

- Non-Executive Director recruitment update
- Deputy Chair / Senior Independent Director re-appointment recommendation to Members' Council.
- Approved Minutes of the Committee meeting held on 22 February 2018 (attached with the papers).

It was RESOLVED to RECEIVE the updates provided.

TB/18/43 Trust Board work programme (agenda item 13)

It was RESOLVED to NOTE the Work Programme.

TB/18/44 Date of next meeting (agenda item 14)

The next Trust Board meeting held in public will be held on Tuesday 26 June 2018 in room 49 / 50, Folly Hall, Huddersfield.

Signed: **Date:**

South West Yorkshire Partnership NHS Foundation Trust

TRUST BOARD 24 APRIL 2018 – ACTION POINTS ARISING FROM THE MEETING

Actions from 24 April 2018

Min reference	Action	Lead	Timescale	Progress
TB/18/35a Safe Working Hours Doctors in Training annual report	RW asked if a triangulation of incident reports in relation to staff had been done. TB advised that it had not been done specifically in relation to Calderdale and the trainees. Any incidents raised in Datix are looked at by the Risk Panel. CD asked if it was possible to determine how many had been raised by trainees. SThi commented that trainees would be less likely to be doing independent practice so Datix reports may be input by others.	TB		
TB/18/36a Strategic overview of business and associated risks	Some external stakeholder management information would be helpful. AM commented that being able to reflect performance against the Communications, Engagement and Involvement Strategy in the Integrated Performance Report may also assist.	SY / KH		
TB/18/36c Corporate / organisational risk register	AM commented that the dates of completion for actions was sometimes vague and requested if individual dates for actions could be added to assist the Board in tracking progress.	MB	July 2018	Update in progress for the next report to Trust Board in July 2018.
TB/18/36d Review of Risk Appetite Statement	AM commented that within the statement it referred to an annual review. Work programme to be updated.	EJ		Complete. Work programme updated.
TB/18/38a Integrated performance report month 12 2017/18	RW asked for assurance from the Audit Committee after their next meeting in relation to the milestone plans, mitigation of risk around data migration, and overview of gateway signoff including Non-Executive Director oversight.	SY / TB	July 2018	

Min reference	Action	Lead	Timescale	Progress
TB/18/38b Customer services report Quarter 4 2017/18	CD commented that equality data slide indicated that more white British people raised complaints at 69% and asked if the processes supported people from other backgrounds to raise concerns. TB commented that this could be an area reviewed further by the Equality and Inclusion Forum.	TB	October 2018	To be discussed at the Equality and Inclusion Forum meeting in October 2018.
TB/18/40a Equality and Inclusion Forum annual report	AM recommended that as a standing Forum the annual report should go to the Audit Committee in future prior to Trust Board as part of the committee annual report process.	TB / MB		
	RW requested that Workforce Race Equality Standard indicators be included as part of the Integrated Performance Report.	TB		
TB/18/42 Assurance and receipt of minutes from Trust Board Committees - Clinical Governance and Clinical Safety Committee 17 April 2018	Approved Minutes of the Committee meeting held on 6 February 2018 (to be provided with the next Trust Board papers).	TB	June 2018	Completed. Included in papers.
TB/18/42 Assurance and receipt of minutes from Trust Board Committees - Audit Committee 10 April 2018	Internal Audit plan 2018/19. To be circulated to the Trust Board for information.	MB		Complete. Circulated to Trust Board.

Outstanding actions from 27 March 2018

Min reference	Action	Lead	Timescale	Progress
TB/18/20a Integrated performance report month 11 2017/18	CJ asked in relation to complaints, improvements were not yet shown in the performance reporting and asked when it was expected. TB advised that there is a trajectory for improvement, which would be circulated to the Board. Update 24 April 2018: TB advised that it has been discussed by the Clinical Governance and Clinical Safety Committee and work is taking place on a performance plan. The trajectory will be circulated to the Board.	TB		
TB/18/20a Integrated performance report month 11 2017/18	CD commented that in relation to Improving Access to Psychological Therapies (IAPT) the Trust had worked hard to meet the target on outcomes. CD asked if information was collected in relation to ethnicity and if there were good outcomes for BAME service users. MB commented that the ethnicity of service users is collected however not specifically correlated to the outcomes. AM suggested that it could be discussed by the Equality and Inclusion Forum when they receive updates on EDS2.	AM / TB	October 2018	To be discussed at the Equality and Inclusion Forum meeting in October 2018.
TB/18/28Trust Board Work Programme 2018/19	TB commented that it was important to ensure that, once the work programmes for the committees of the Board were approved, that the sequencing of reports from committees into Board is aligned.	AM	May 2018	

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Trust Board 26 June 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 defines a context that will require us to focus on our mission and lead with due regard to our values.
Any background papers/ previously considered by:	This cover paper references several of the papers in the public and private parts of the meeting and also external papers and links. It will be supplemented by a verbal update.
Executive summary:	The May edition of *The Brief* is attached at Annex 1. This provides details of the national and local strategic context, performance, staffing and other issues. Board members should note the substantial amount of external issues covered in *The Brief,* which demonstrates the changing context within which we operate. Since publication of the Brief, there are areas to update and of emphasis to draw to the attention of the Board: 1. **Failings at Gosport Hospital in the 1980s and 1990s have dominated the headlines this week.** Inappropriate prescribing regimes have led to the early deaths of hundreds of people. Alongside the detail, the critical messages for us are around culture and clinical safety. The Secretary of State has spoken in Parliament about creating a safer culture where whistleblowers are protected from harm and where a learning culture predominates. The Board sets the tone in our organisation and will need to keep promoting this culture every day. 2. **The national health agenda has been dominated by the Prime Minister's announcement that there will be a 5 year funding settlement for the NHS equivalent to 3.4% growth per year in real terms.** This is a very welcome development. Board members should note that these funds exclude departmental and Arm's Length Body budgets – some of which are critical to the NHS. They also exclude local government spend on NHS services such as public health and prevention. And critically, they exclude a settlement on social care. These will all have to wait for the Autumn budget and without them, there will be a sub optimal settlement. I wrote about the consequences of this in the Health Service Journal. A copy of the article is attached at Annex 2. A helpful on the day briefing from NHS Providers is at Annex 3. 3. **The settlement sets in train a process of defining and**

With **all of us** in mind.

	developing a plan for the NHS. This will require cross party support if there are any legislative changes, which have now become a possibility. I spoke at the launch of the Health Select Committee report into integrated care in June. This excellent report set out the requirement for a long term spending and a long term workforce plan. It also, helpfully, set out the offer of Select Committee scrutiny of legislative changes before they go to Parliament. This would potentially allow for changes to happen more smoothly in a period of minority government and Brexit. 4. **The NHS Confederation Conference took place, bringing together the largest gathering of health leaders to debate the future of the NHS.** The Chair and I attended, and work from the local integrated care systems and the Trust was showcased. National political leaders and chief executives set out the agenda for the next year. There were explanations of changes to NHS Improvement and NHS England structures, welcome messages of support for integrated care systems and a shift towards support for senior leaders, moving away from a blame culture. In addition the Conference had a significant focus on equality and diversity. Notably Evelyn Beckley, Patient Affairs Officer/Admin Supervisor won the Operational Service Excellence Award at the NHS70 Windrush Awards and Debs Taylor, Creative Minds Peer Project Development Worker was number 5 in the NHS 70 standout stars. Well done to both, they demonstrate that leadership can come from every seat in the organisation. 5. **Integrated Care Systems (ICS) in West Yorkshire & Harrogate and South Yorkshire & Bassetlaw continue to develop.** The negotiations between the two ICS and the government continue. This includes the level of resources and authority that will be ceded to the ICS and the level of performance expected in return. Being involved in both ICS will allow us to have faster progress and an infrastructure when the changes and funding are announced around the next NHS plan. 6. **In this context an unwavering focus on safe services within the resources available continues.** NHS Improvement have been engaged with our managerial and our governance structures as part of our financial plan. The Care Quality Commission (CQC) are working with us as we finalise our inspection reports. And the integrated performance report shows the positive delivery and the stresses in our teams. 7. Crucially, the **Learning from Death Report for people with learning disabilities** is getting a full and frank discussion at this Board meeting. We believe we have good processes in place, something reflected in CQC feedback and must always assure ourselves that this is true. During Learning Disability Awareness Week, a welcome focus on people with some of the poorest health outcomes showed what is possible when we choose to tailor

	services that meet people's needs. Thanks to everyone who showcased good work in this area. The Board will also note that we are discussing taking a lead role in developing services in the region 8. **The European Association of Sport for Inclusion (EASI) Cup took place in Barnsley in June.** It was a brilliant event that saw 500 people from teams across Europe come together to play football. The teams had all been affected by mental health issues. Over 3 days, our staff from the trust, volunteers from the Exchange and Creative Minds demonstrated all that is good about what we do. We brought together people through sport. The Guardian covered the even as did the BBC. Service users described the impact on them – saving their lives and keeping them out of "the gutter". The winning team from Barnsley, the Afro Boys, were refugees from Eritrea and Somalia who spoke of "football having no language barrier" Well done particularly to Hannah Burton for being the power behind the scenes and to every volunteer and staff member involved. These are important times for the NHS. As we approach the 70th birthday of the service, we will celebrate its past and its durability. In doing so, we should remember that our system of social care is 70 years old too. And just as our birth came at the same time, our futures are entwined.
Recommendation:	**The Trust Board is asked to NOTE the Chief Executive's report.**
Private session:	Not Applicable.

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The Brief

31 May 2018

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

With **all of us** in mind.

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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

70 YEARS OF THE NHS 1948 - 2018

Staff shortlisted for NHS70 Windrush awards

With **all of us** in mind.

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Our priorities for 2018/19

	Improving health	Improving care	Improving resources
Strategic priorities	**Joined-up care** 1. Integrated Care Partnerships in our local areas: • Barnsley • Calderdale • Kirklees • Wakefield	**Safety first, quality counts** 2. Patient safety 3. Quality improvement 4. South Yorkshire projects 5. West Yorkshire projects, including leading on: • Forensic mental health • Suicide prevention • Autism and ADHD • Learning disabilities	**Operational excellence** 6. Flow and out of area beds 7. Workforce productivity 8. Financial sustainability: • Cost improvement programmes • New business
	People at the centre 9. Co-production, experience and involvement		
	Compassionate leadership 10. Leadership and management development		
	Digitally enabled 11. Digital infrastructure 12. Clinical record system		

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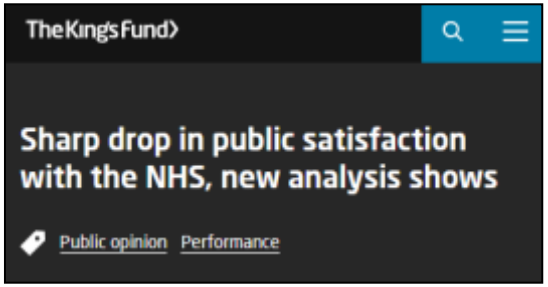
What's happening externally

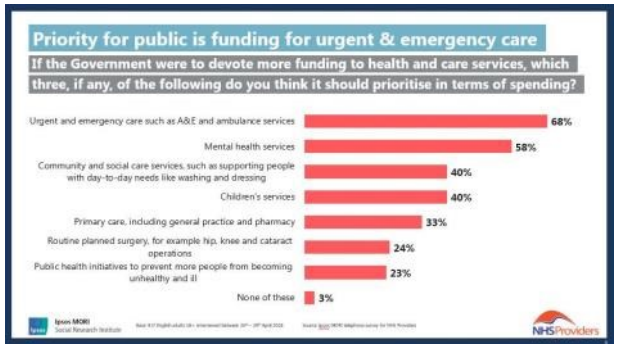
National and local news



British Social Attitudes survey finds 6% satisfaction drop – now at lowest levels since 2011

CQC braced for deteriorating care standards

Institute for Fiscal Studies: NHS needs an extra 4% a year for 15yrs



Mental health and community services jump in public priorities for funding poll

NHS Improvement publish 2017/18 provider sector performance:

Increase in demand

£960m total deficit

92,700 staff vacancies (8%)

With **all of us** in mind.

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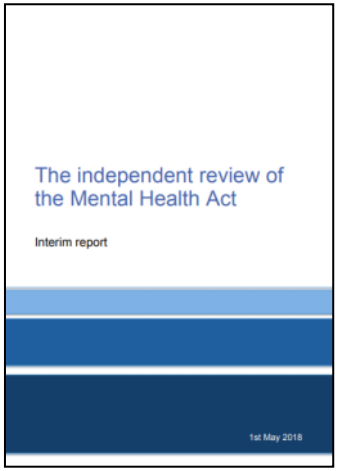
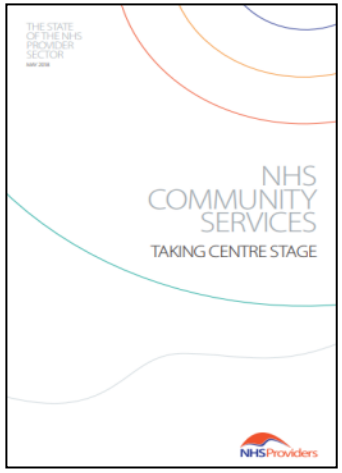
What's happening externally

National and local news



Mental Health Act review: Interim report published



NHS Providers: "Time to end neglect of NHS community services"

NHS England and NHS Improvement's new joint working plans

Education and Health and Social Care Committees release joint report critical of Govt. Green Paper

Learning Disabilities Mortality Review annual report published

West Yorkshire and Harrogate shadow integrated care system

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What's happening internally

Safety and quality

- We put safety first, always
- Reporting of incidents remains within expected range – please keep reporting via Datix
- 1,063 incidents reported in Apr:
  - 952 were rated green (no/low harm)
  - 103 were rated yellow or amber
  - 8 were rated as red
- 2 Serious Incidents reported in Apr – 1 apparent suicide and 1 concern of physical abuse / violence to a child
- Our risk panel meets each week to review serious incidents and scan for themes
- We're continuing to review our complaints process to make sure we listen and learn

Care Quality Commission

- Draft report received for factual accuracy check
- Expected to be published end June / early July
- We'll keep you updated

With **all of us** in mind.

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What's happening internally

Performance (Apr)

- **118%** overall safer staffing fill rate helped manage increased acuity – challenge remains
- **97%** of people recommend our community services, **86%** our mental health services
- **80%** of prone restraint lasted ≤3mins
- **8** confidentiality breaches
- **583** out of area bed days
- **1** young person admitted to an adult ward
- **94%** follow ups within 7 days of discharge
- **2/10** complaints closed within 40 days, although numbers of complaints are reducing

2018/19 measures

- Each year we review our performance reporting to make sure we're monitoring what matters
- Our Board agreed revised measures on 24 May
- We'll start using the revised measures from next month

With **all of us** in mind.

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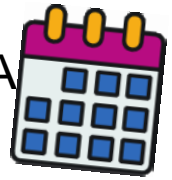
NHS Foundation Trust

What's happening internally

Staffing

- There's still chance for staff to attend a staff listening event and share your views. Details are on the intranet.
- Your feedback is important – our next wellbeing survey will be sent out from 3 July
- If you're not up to date with your mandatory training, book a session or complete your e-learning now
- Have you had your appraisal yet?
  - Bands 6 and above by end June
  - Bands 5 and below by end Sept
- Staff sickness absence was 4.6% in A just above our 4.5% target



Are you a manager and keen to develop?

What? Middle Ground 5

When? Various dates throughout the year

Why? Work with your peers to build healthy, resilient and high performing teams

How? Speak to your manager and visit the leadership and management intranet pages

With **all of us** in mind.

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What's happening internally

Month 1 finances (Apr)

We had a £0.3m deficit in Apr, which is slightly better than we had planned - we're planning for a £2.6m deficit in total for 2018/19

We spent £0.4m on agency - we're currently forecasting to spend more than our £5.2m cap for the year set by NHS Improvement

We saved £0.6m in cost improvement initiatives, £0.1m less than planned - we need to save £9.7m this year, with £1.8m still to be identified

Our planned deficit this year means our NHS Improvement financial risk rating has dropped to 3, with 1 being the highest and 4 the lowest

Our planned deficit this year is largely due to reduced income and cost pressures. It will be challenging to achieve and we must identify additional savings.

With **all of us** in mind.

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What's happening internally

Infrastructure

SystmOne for mental health is coming in Jan 2019

- Our co-design workshops are complete. Over 300 staff across all mental health services have been involved in co-designing a system that suits our needs.
- SystmOne needs you! Volunteer to become a super user - speak to your manager or email the crsprogramme.

- Coming soon… You'll soon be able to sign up to SystmOne training. Keep an eye out – details will be published soon.

Most of our sites now have public WiFi

Service users now have access to free internet in places such as reception areas, waiting rooms and inpatient wards.

A user guide is available on the intranet and posters are being sent out to display.

With **all of us** in mind.

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What's happening internally

Service change

Older people's mental health services
Proposed models for our older people's services have been reviewed by our Exec Management Team. We're now working with commissioners to further develop the case for change.

Neurological rehabilitation unit (NRU) beds
From 1 Oct Barnsley CCG are reducing the number of NRU beds it commissions (from 12 to eight). We currently have income from other commissioners for NRU beds so we're planning to retain existing bed capacity and staffing levels.

Barnsley Health and Care Together

We're working with partners to support more joined-up care in Barnsley. This includes the CCG on future integration plans and Barnsley Hospital as a Provider Alliance partner.

Attend the Barnsley staff listening event on 8 June to hear more.

With **all of us** in mind.

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What's happening internally

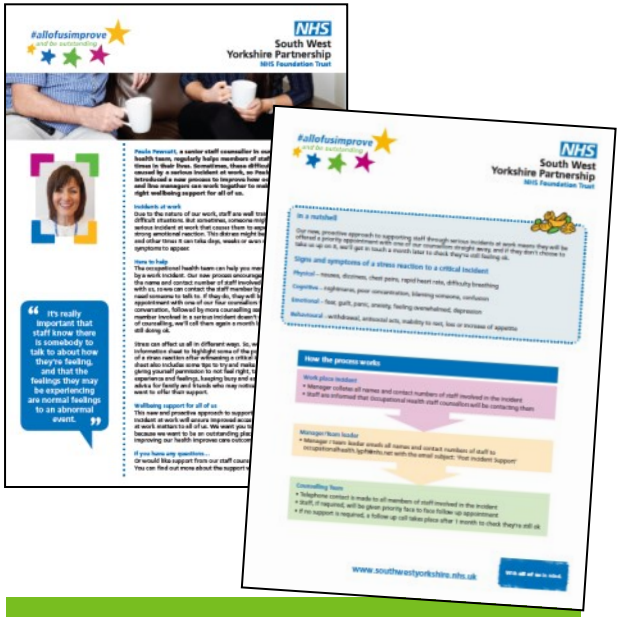
Quality improvement and innovation

Together, all of us can improve. We must get from where we are to where we want to be. You can do something to make a difference.

We're focusing on improving patient safety, operational excellence and experience of care.

A great example is our new support offer for staff involved in a serious incident at work:

- Managers / team leaders share names of staff involved with Occupational Health (OH)
- Staff are offered a priority appointment with a counsellor straight away
- If staff don't take up the offer, OH will follow up a month later to check they're still feeling ok



Find our more and read other case studies online

#allofusimprove
and be outstanding

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Take home messages

It's a challenging environment – we have a clear set of priorities upon which to focus

In tough times, we must put safety first, always, and live our values

At the same time, we must manage every pound we spend wisely

Delivering value through improving quality & finance is everyone's job - #allofusimprove

We're supporting leaders and managers in the Trust to be resilient – get involved

Your appraisal is the opportunity to focus on your needs as a person and in your role

Your wellbeing is important to #allofus – look out for the wellbeing survey

With **all of us** in mind.

31 May 2018

NHS
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NHS Foundation Trust

The Brief

Our mission and values

We exist to help people reach their potential and live well in their community. To do this we have a strong set of values that mean:

- We put people first and in the centre and recognise that families and carers matter
- We will be respectful and honest, open and transparent, to build trust and act with integrity
- We will constantly improve and aim to be outstanding so we can be relevant today, and ready for tomorrow.

Focus on:

Our priorities for 2018/19

Strategic priorities	Improving health	Improving care	Improving resources
	Joined-up care 1. Integrated Care Partnerships in our local areas: • Barnsley • Calderdale • Kirklees • Wakefield	**Safety first, quality counts** 2. Patient safety 3. Quality improvement 4. South Yorkshire projects 5. West Yorkshire projects, including leading on: • Forensic mental health • Suicide prevention • Autism and ADHD • Learning disabilities	**Operational excellence** 6. Flow and out of area beds 7. Workforce productivity 8. Financial sustainability: • Cost improvement programmes • New business
	People at the centre 9. Co-production, experience and involvement		
	Compassionate leadership 10. Leadership and management development		
	Digitally enabled 11. Digital infrastructure 12. Clinical record system		

What's happening externally?

National and local news

- Public satisfaction with the NHS has dropped 6 percentage points in a year, taking it to 57 per cent - its lowest level since 2011 – according to analysis of the National Centre for Social Research's (NatCen) British Social Attitudes survey, a gold standard measure of public views on the NHS.
- The Care Quality Commission has warned that standards could deteriorate in the health and social care sectors in 2018/19.
- The Institute for Fiscal Studies and Health Foundation have reported that the NHS needs an extra 4% funding a year - or £2,000 per UK household - for the next 15 years. It said the only realistic way this could be paid for was by tax rises.
- New Ipsos MORI polling shows that mental health and community services have

jumped up the public's priority list for any extra funding for health and care to second and third place.

- NHS Improvement published its quarterly performance report on the NHS provider sector, highlighting overall 2017/18 performance. The report showed a total provider sector deficit of £960m, with a significant increase in activity and 92,700 vacancies.
- An interim report into the Independent Review of the Mental Health Act was published, giving an update on the review's findings and the areas it will look at next.
- A report by NHS Providers calls for greater investment in community services to bring care closer to home.
- Education and Health and Social Care Committees have released a joint report critical of The Government's proposed Green Paper on Transforming Children and Young People's Mental Health. They say it lacks ambition and will provide little help to the majority of those children who desperately need it.
- The Learning Disabilities Mortality Review annual report was published. The programme was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives.
- NHS England and NHS Improvement announced plans to work more closely together, transforming the way they work to provide more joined-up, effective and comprehensive system leadership to the NHS.
- The West Yorkshire and Harrogate Health and Care Partnership has been named as a shadow integrated care system, one of four new areas in England that will be given additional freedom and flexibility to manage the delivery of local services.

What's happening internally?

Safety and quality

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- Our risk panel meets each week to review serious incidents and scan for themes
- We're continuing to review our complaints process to make sure we listen and learn

Following the CQC's well-led inspection in April, we've received our draft report which we're going to check for factual accuracies. The report is due to be published at the end of June/early July. We'll keep you updated

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Staffing

- There's still chance for staff to attend a staff listening event and share your views with chief executive Rob Webster and other directors. Details are on the intranet.
- Your feedback is important – our next wellbeing survey will be sent out from 3 July. Keep an eye out for this in your emails – you'll be sent a link to complete the survey.
- If you're not up to date with your mandatory training, book a session or complete your e-learning now.
- Have you had your appraisal yet?
    - Bands 6 and above need to have theirs by the end of June
    - Bands 5 and below need to have theirs by the end of September
- Staff sickness absence was 4.6% in Apr, just above our 4.5% target.

Are you a senior manager and keen to develop yourself and your team? Speak to your manager about attending Middle Ground 5. You'll work with your peers and learn the skills needed to build healthy, resilient and high performing teams.

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We saved £0.6m in cost improvement initiatives, £0.1m less than planned - we need to save £9.7m this year, with £1.8m still to be identified

Our planned deficit this year means our NHS Improvement financial risk rating has dropped to 3, with 1 being the highest and 4 the lowest.

The deficit this year is largely due to reduced income and cost pressures. It will be challenging to achieve and we must identify additional savings.

Infrastructure

SystmOne for mental health is coming in January 2019:

- Our co-design workshops are complete. Over 300 staff across all mental health services have been involved in co-designing a system that suits our needs. Thanks to all involved.
- SystmOne needs you! Volunteer to become a super user - speak to your manager or email the crsprogramme.
- You'll soon be able to sign up to SystmOne training. Keep an eye out – details will be published soon.

Most of our sites now have public WiFi so that service users now have access to free internet in places such as reception areas, waiting rooms and inpatient wards. A user guide is available on the intranet and posters are being sent out to display.

Service change

Older people's mental health services - Proposed models for our older people's services have been reviewed by our Executive Management Team. We're now working with commissioners to further develop the case for change.

Neurological rehabilitation unit (NRU) beds - From 1 October, Barnsley CCG are reducing the number of NRU beds it commissions (from 12 to eight). We currently have income from other commissioners for NRU beds so we're planning to retain existing bed capacity and staffing levels.

Barnsley Health and Care Together - We're working with partners to support more joined-up care in Barnsley. This includes the CCG on future integration plans and Barnsley Hospital as a Provider Alliance partner. Attend the Barnsley staff listening event on 8 June to hear more.

Quality improvement and innovation

Together, all of us can improve. We must get from where we are to where we want to be. You can do something to make a difference.

We're focusing on improving patient safety, operational excellence and experience of care.

A great example is our new support offer for staff involved in a serious incident at work:

- Managers / team leaders share the names of staff involved with Occupational Health
- Staff are offered a priority appointment with a counsellor straight away
- If staff don't take up the offer, Occupational Health will follow up a month later to check they're still feeling ok.

Find out more and read our case studies online.

Take home messages

1. It's a challenging environment – we have a clear set of priorities upon which to focus
2. In tough times, we must put safety first, always, and live our values
3. At the same time, we must manage every pound we spend wisely
4. Delivering value through improving quality and finance is everyone's job - #allofusimprove
5. We're supporting leaders and managers in the Trust to be resilient – get involved
6. Your appraisal is the opportunity to focus on your needs as a person and in your role
7. Your wellbeing is important to #allofus – look out for the wellbeing survey

Share your views about The Brief - comms@swyt.nhs.uk

The next issue will start on 28 June.

The PM has shown faith - we now need bold policies for change

Extra funding for the NHS has been secured despite Treasury scepticism that the health service can change. If there's a deal for social care and local government, backed by a more coherent policy landscape, we can prove them wrong, says Rob Webster

The prime minister's commitment to NHS funding over the next five years is a positive political gesture of faith in the NHS. As we saw in the NHS Plan in 2000, a combination of political leadership, policy coherence and long term financial investment can genuinely transform care.

At that time, long waiting times for treatment were the biggest problem faced by the NHS, closely followed by a workforce crisis and a crumbling estate. Two of those things feel very familiar to us today, with the availability of our workforce being our biggest rate limiting factor and backlog maintenance of £5.5bn.

Tackling multiple morbidity

Yet, the biggest issue patients and citizens face today is not waiting but getting support with multiple long term conditions. This multiple morbidity places unprecedented demand on services and must be addressed.

The excellent recent report from the Institute for Fiscal Studies and the Health Foundation showed the consequences of failing to do so. They concluded that spend on people with chronic diseases in hospitals will double over the next 15 years if things don't change. Crucially, they concluded that investment must go into the NHS and a similar level of growth into social care if we are to have a sustainable NHS at all.

Beyond the public narrative of "the National Health Service" which suggests a single structure that operates as a single organisation lies the reality. The NHS is a system not an organisation and it sits within a health and care system that itself reaches deep into every community.

Local government has as big a role to play as any NHS trust, clinical commissioning group or national leader in a successful future

Making sense of the system is a challenge faced by carers and patients every day. The complexity is staggering and leads to a "burden of treatment" alongside a "burden of disease". It's time to invert

our thinking and forget about people being a guest in our organisation and start thinking that we are a guest in people's lives.

These are lives blighted by chronic diseases that are prevalent in specific communities. They can be improved and we can organise better, simpler and more cost effective care together. This starts in communities, built from partnerships between local people, politicians and good primary care.

We should be ambitious here too. Modern health and care systems meet the physical, mental and social needs of people. The NHS and care system is no different and the prime minister's announcement is a start in giving us the tools to do the job.

Her welcome focus, for example, on mental health might mean I no longer have 16 year old children on adult units and that suicides are no longer the biggest killer of young men. It is a necessary step, a huge step, in the right direction but it is not yet sufficient to meet the needs of the people in the communities we serve.

That will require real and sustained financial support for social care. It will require a revolution in how we fund and think about prevention. And it will require genuine recognition that housing, education, employment, lifestyle and the environment are the biggest factors in your health and the biggest drivers of demand. Local government has as big a role to play as any NHS trust, clinical commissioning group or national leader in a successful future.

Additional resources

Over the coming weeks and months things should become clearer. We can then place additional resources alongside a new and more coherent policy framework for the health and care system.

Collaboration is critical to success, but collaboration is a noun, not a policy. The 2000s were defined by bold, often contentious, policies that made change happen. We need to see the development of better policies designed for the issues that face us today.

We need a long term workforce strategy that invests in our people today and secures a pipeline for the future

We are already seeing this emerge from the bottom up. Four of the six acute trusts in my Integrated Care System Partnership are on aligned incentive contracts that share risk in the system, for

example. Housing and health are a priority for West Yorkshire and Harrogate building on the wonderful work in Wakefield that is transforming help for vulnerable people.

General practices are being transformed with learning from vanguards and integration pioneers. This is being led by a network of local leaders bound by shared commitment in the face of conflicting policy and financial landscapes. Imagine what we could do if incentives, regulation and policies were aligned to support us.

Ultimately, delivery will require the commitment, effort and energy of our biggest cost and our biggest asset – our staff. We need a long term workforce strategy that invests in our people today and secures a pipeline for the future.

This starts with truly valuing staff who work in health and care right now and improving their working lives. It extends beyond them to every carer and every volunteer. Their efforts are what makes the health and care system work, because beyond the policies and the politics, this is all about people.

The next few months in the run up to the 2018 Budget will be critical. A “something for something” deal is being made between the NHS and the government. We all have a role to play in ensuring our partners in local government and social care are included.

Extra funding for the NHS has been secured at a time of often reported Treasury scepticism, who doubt that investment in the NHS will secure transformation. With a deal for social care and local government, backed by a more coherent policy landscape, we may finally have the tools to prove them wrong.

on the day BRIEFING

NHS Providers

Prime Minister's speech on NHS funding commitment: 18 June 2018

Today the Prime Minister Theresa May has announced a new five year funding settlement for the NHS, giving the service real terms growth of more than 3 per cent for the next five years. In a major speech today at the Royal Free London NHS Foundation Trust and two interviews over the weekend she has also tasked the NHS with producing a 10-year plan to improve performance, specifically on cancer and mental health care, and unpick barriers to progress.

This briefing summarises the announcements and includes our view on the announcements. Our press statement is also copied at the end of this document.

Key announcements

Government reveals more money for the NHS

- The government has announced a major new package of funding for the NHS covering the five financial years from 2019-20.
- The average annual uplift is 3.4 per cent per year above inflation – based on Office for Budget Responsibility projections.
- The funding is frontloaded, meaning the annual rates of growth are: 3.6%; 3.6%; 3.1%; 3.1%; 3.4%.
- This will equate to £20.5bn more revenue in real terms compared with 2018-19.
- A further £1.25bn has been found to deal with an increase in pensions costs associated with the new Agenda for Change pay deal.
- The funding is for the NHS England commissioning budget only. This means it does not include capital funding, public health, health education, or social care.
- In an appearance in front of the Public Accounts Committee this afternoon, Simon Stevens said there was an explicit commitment from the government that the adult social care budget would be set to not put further pressure on the NHS.
- Although there have been assurances that these will be protected, there is no hard data on these areas and it is not clear whether these budgets, which have been cut in the past, will be restored to or simply ring-fenced at their current levels.
- This afternoon, Simon Stevens told MPs the extra money does include funding for an increase in Agenda for Change salaries from next year.
- How the increase will be funded is unclear. While the prime minister has emphasised that some of it will come from monies no longer being paid to the European Union, along with tax and borrowing rises, the "Brexit" element has been disputed by economists.

A 10 year plan

- In return for the increase in funding, the NHS has been tasked to develop a 10-year plan, via an "assembly" convened by national leaders. The prime minister has emphasised that this should have strong clinical input.
- The 10-year plan, which will likely be delivered by the autumn budget, should set out how the service intends to deliver major improvements in mental health and cancer care.
- Ministers may be considering legislative reform: the prime minister described the number of contracts held between NHS organisations as a "problem", and said she wanted the service to suggest ways of breaking down any barriers that might hold up progress, including in the regulatory framework.
- The prime minister set out five priorities for the NHS: Putting the patient at the heart of how care is organised; a workforce empowered to deliver the NHS of the future; harnessing the power of innovation; a focus on prevention; and "true parity of care" between mental and physical health.
- The prime minister said she would like to see the 10-year plan set out ambitious "clinically defined access standards" for mental health.
- And, she said clinicians should confirm the NHS is focused on the right performance targets for both physical and mental health – indicating that ministers may be willing to reconsider key performance standards.

NHS Providers View

The government's recognition that the NHS needs significantly more money, urgently, and a credible long-term plan for improving care, is welcome.

The 3.4 per cent average annual real terms uplift is at the upper range of what the service could realistically expect given the pressures on the public finances – but is at the lower end of what the NHS needs to remain viable. It is significantly better than the NHS has received in recent years, and is of another order to what other public services have had since 2010. However it is still below the 3.7% average real terms growth the NHS has seen during its history.

It is also for the best that the funding is frontloaded as the provider sector needs cash upfront as soon as possible to return to balance. The confirmation that it will not include a further £1.25bn to cover a specific pensions cost is an encouraging sign that the government is serious that this new funding is spent on improving care.

However we should be under no illusion that this money will fix every problem the NHS has straight away. Workforce numbers to support improved capacity will not be able to rise overnight, and better service models take time to develop, test and implement. Most importantly, even if the £4bn underlying deficit stops growing, it means that much of this new money is effectively already being spent on services as they currently are. This must be borne in mind when it is decided what more should be asked of the service in return for the new money.

While provider trusts will agree with the prime minister that the 10 year plan should include a route out of deficit for every organisation, the government must know that this will be a tall order as long as extra funding only just keeps up with demand and cost growth. It will be impossible unless well-led trusts are offered the chance to reset their finances – for example ending the high-interest loans regime currently affecting some of the trusts most in need of assistance.

The new funding settlement only covers the core NHS England commissioning budget. There have been broad commitments to protect public health funding, health education, social care and capital – however we would like to be assured that these essential budgets, which have been cut in recent years to the detriment of the service, will be restored. We are particularly disappointed that there is no clear link between this announcement and the future of social care, as a long-term plan for one cannot be made without clarity and security for the other. Likewise the prime minister was right to identify prevention as a priority – the government must now back this up with serious investment.

Making mental health services a central theme in the Prime Minister's speech was appropriate and timely. These vital, life-saving services deserve national focus and we look forward to working with the government and arm's length bodies to work out how they can be expanded and patient experience improved.

The decision to ask the service itself to draw up the ten-year plan, with an emphasis on clinical input, is preferable to a set of requirements being handed down from Whitehall. It suggests that the government understands that any plan has a better chance of succeeding if it has buy-in from the frontline from the beginning. We will work with national leaders to ensure this is a meaningful process of engagement.

We will watch with interest how proposals to cut bureaucracy develop. The prime minister's speech today emphasised the difficulties caused by legislation and contractual barriers, and we would like to see these unpicked, although would caution against a large-scale reorganisation as these tend to be disruptive and take focus away from delivery. However in the past "cutting bureaucracy" has been used as a pretext for reducing spend on management, which in recent years has gone so far that is now impacting on the service's ability to operate effectively.

The prime minister has invited "the health and care community", as part of the 10-year planning process, to make proposals on where existing legislation and regulation create barriers to better care. This is the right approach, as the current framework is not fit for purpose. We look forward to helping inform this work, in the understanding that a service as large and as vital as the NHS will always need regulation, but this should be streamlined and not duplicative. We would like to see organisational obstacles to better care unpicked, although would caution against a large-scale reorganisation as these tend to be disruptive and take focus away from delivery.

We note the prime minister's comments that the 10 year plan should improve efficiency. We agree that every penny of taxpayers' money should be spent as wisely and effectively as possible, but would caution that the current rate of savings cannot be safely sustained: since 2010 much of the total saved has been

through holding down pay, and last year nearly £900m of provider-side efficiencies came non-recurrently. Generating more savings will have to come from large-scale service transformation which will require upfront investment.

While we share ministers' enthusiasm for technology as a key enabler of the best quality healthcare, we must not mistake it for an alternative to investing in skills or capacity.

NHS Providers press statement

Responding to the Prime Minister's speech on a long-term plan for the NHS, the chief executive of NHS Providers, Chris Hopson, said:

"We welcome the extra funding and ambitions for a long term plan to improve the quality of care the NHS is able to provide to the public. The NHS has faced a decade of austerity but we now have an opportunity to invest in our staff, buildings and services to meet the expectations the public rightly has.
"The proposed annual increases are in line with the level needed to maintain current services against rapidly rising demand. We know that to deliver improvements beyond this we will need to do more to make the NHS as efficient as possible. But we must be realistic about what more can be achieved given the NHS is already outperforming the wider economy on productivity. NHS trusts delivered efficiency savings last year of £3.2bn – this firmly places the NHS as one of the most efficient health care systems in the world.
"This welcome funding settlement will also still mean we face difficult choices on what our priorities should be. It is vital that NHS trusts have a strong role in shaping and agreeing the delivery plan so that the NHS frontline has a set of financial and performance goals that are realistic and can actually be delivered.

"A key part of this will be the delivery of a comprehensive plan to ensure we have the right staff and skill mix in place to deliver high quality services. It will also mean ensuring we are able to join-up and integrate services for the public much more effectively than we are now able to. The existing legislation continues to be a barrier to more integrated care and causes unnecessary bureaucracy, so we welcome the Prime Minister's offer for NHS leaders to develop proposals for how the legislation may be simplified.

"Finally, we welcome the Government's commitment to addressing social care as well as other critical areas of health expenditure, such as public health and prevention, that are not covered in this announcement. We are clear that fixing NHS funding without doing the same for these other vital areas will simply store up problems for front-line health services, as well as falling short of the care and support the public needs."

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 June 2018
Agenda item 6.1

Title:	**Integrated Performance Report**
Paper prepared by:	Director of Finance Director of Nursing and Quality
Purpose:	To provide the Board with the Integrated Performance Report (IPR) for May 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** ➢ Safer staffing fill rates continue to be maintained overall, pressures remain in terms of recruitment and patient acuity. ➢ Number of restraints have increased and is subject to in depth review. ➢ No admissions of under 18 to acute MH wards. ➢ Physical health monitoring metric position is positive. ➢ Friends and Family Test (FFT) for mental health shows the pressure in CAMHS. **NHSI Indicators** ➢ The Trust met the 7 day follow up target in May following a slight dip in performance in April. ➢ Proportion of people completing treatment and moving to recovery within Improving Access to Psychological Therapies (IAPT) remains above target. ➢ No children or younger people placed in adult inpatient wards in May. ➢ The Trust continues to achieve the vast majority of national metrics. **Locality** ➢ Pressure on adult acute wards remains high across West Yorkshire. ➢ Discussions continue with the commissioner in Barnsley to identify how the waiting lists for psychology can best be addressed within financial resources available. ➢ Discussions taking place with the specialist commissioner to agree initial funding for the introduction of the learning disability forensics outreach service. ➢ Average length of stay for Wakefield acute services remains in excess of target and has been identified as part of the trust-wide programme of improvement in addressing demand and capacity.

	Priority Programmes ➢ SystmOne for mental health co-design workshops have been completed. ➢ Initial data migration testing to commence week commencing June 25th. ➢ Local change plans to reduce out of area bed usage have now been agreed. ➢ Older people's transformation proposals being discussed with commissioners. **Finance** ➢ Net deficit of £204k in month which was favourable to plan. ➢ Cumulative deficit is now £496k. The run rate is adverse to the full year plan. ➢ Agency costs of £538k in month were 8% above the cap and increased by close to £0.1m compared to April. ➢ Net pay savings of £0.3m year-to-date. ➢ Out of area bed expenditure amounted to £363k. Cumulatively expenditure is adverse to plan by £161k and is 58% higher than the corresponding period for 2017/18. ➢ Year-to-date CIP delivery of £1.3m is £0.1m lower than plan. ➢ Cash balance of £23.m is £0.6m lower than plan and as expected is circa £3m below the 2017/18 year-end position. ➢ Financial risk rating of 2 given the deficit position. **Workforce** ➢ Sickness absence improved to 4.5% in May, which is in line with the Trust's target. ➢ Staff turnover is currently reported at being 8.5% year-to-date. ➢ Following discussion at the recent board development session it is suggested the training metrics included in the summary dashboard for 2018/19 are for compliance with managing violence & aggression and moving & handling training.
Recommendation:	**Trust Board is asked to NOTE the Integrated Performance Report and COMMENT accordingly.**
Private session:	Not applicable.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report
Strategic Overview

May 2018

With **all of us** in mind.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

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Introduction

Please find the Trust's Integrated Performance Report (IPR) for May 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. During May 18, the Trust has undertaken work to review and refresh the summary dashboard for 2018/19 to ensure it is fit for purpose and aligns to the Trusts new objectives for the coming year. At the Board development session the inclusion of suitable training metrics in the summary dashboard were discussed. It is recommended that progress against managing violence and aggression training and also moving and handling training are the measures included for 2018/19. Subject to full Board agreement these will be used in the next report. This report includes matching each metric against the updated Trust objectives. 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 and have been reviewed and refreshed for 2018/19.

KPI	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Year End Forecast
Single Oversight Framework metric	2	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	Green
Improve people's health and reduce inequalities	**Target**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Year End Forecast**
Total number of children & young people in adult inpatient wards 5	0	1	2	3	2	3	1	2	2	1	3	1	0	1
% service users followed up within 7 days of discharge	95%	97.3%	93.3%	97.2%	96.1%	94.7%	98.2%	98.2%	97.2%	98.0%	95.8%	94.3%	99.2%	4
% clients in settled accommodation	*60%*	82.2%	81.8%	81.8%	80.8%	80.7%	80.4%	80.4%	80.1%	79.7%	79.1%	78.9%	*78.4%*	4
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks 1	95%	80.3%		87.5%			86.8%			87.8%		Due July 18		N/A
Out of area beds 2	Q1 940, Q2 846, Q3 752, Q4 658	242	341	362	424	467	412	407	268	613	730	555	310	1
Physical Health - Cardiometabolic Assessment (CMA) - Proportion of clients with a CMA Community	Inpatient 90% Community 75%												89.1%	4
Inpatient 9													79.8%	4
Smoking Cessation 8												KPI Under Development		
Improve the quality and experience of care	**Target**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Year End Forecast**
Friends and Family Test - Mental Health	85%	86%	89%	79%	85%	86%	86%	85%	85%	85%	87%	86%	75%	85%
Friends and Family Test - Community	98%	98%	95%	99%	99%	97%	98%	100%	97%	97%	99%	97%	100%	98%
Patient safety incidents involving moderate or severe harm or death (Degree of harm subject to change as more information becomes available) 4	trend monitor	32	29	28	25	28	34	26	33	37	20	29	27	N/A
Safer staff fill rates	90%	103%	112.6%	109%	111.8%	112.9%	115.7%	113.4%	117.1%	117.5%	115.7%	118%	120%	100%
IG confidentiality breaches	<=8 Green, 9 -10 Amber,	12	6	10	6	5	12	7	7	10	4	8	11	
% people dying in a place of their choosing	80%	Reporting established from Sept 17			83%	91%	89%	88%	94%	84%	87%	83%	89%	N/A
Proportion of people detained under the MHA who are Black, Asian & Minority Ethnic 7	TBC			13.6%			15.1%			9.0%		Due July 18		N/A
CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks 3		Reporting Established from April 2018										36.3%	37.1%	
Improve the use of resources	**Target**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Year End Forecast**
Projected CQUIN Shortfall	£4.2m	£842k	£369k	£856k	£856k	£856k	£856k	£136k	£136k	£136k	£203k	-	£160k	£160k
Surplus/(Deficit)	In line with Plan	£95k	£204k	£226k	£6k	£158k	£235k	£551k	£635k	£1186K	£1139K	(£292k)	(£204k)	(£2626k)
Agency spend	In line with Plan	£500k	£457k	£446k	£435k	£515k	£531k	£430k	£465k	£563K	£555K	£444k	£538k	£5.3m
CIP delivery	£1074k	£1643k	£2306k	£2950k	£3452k	£4117k	£4815k	£5442k	£6157k	£6816k	£7475k	£619k	£1308k	£9.7m
Sickness absence	4.5%	4.7%	4.8%	4.9%	4.9%	4.9%	5.0%	5.1%	5.2%	5.3%	5.3%	4.6%	4.5%	4.9%
Staff Turnover 6		10.3%	10.3%	10.7%	11.7%	11.4%	12.1%	12.3%	12.4%	12.5%	12.6%	9.7%	8.5%	

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 introduced during 17/18 and counts first contact with service post referral.
2 - Out of area beds - From April 18, in line with the national indicator this identifies the number of inappropriate 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 inappropriate admission to Adult Acute and PICU Mental Health Services only.
3 - CAMHS referral to treatment - the figure shown is the proportion of clients waiting for treatment as at the end of the reporting period who at that point had waited less than 18 weeks from their referral receipt date.
4 - 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..
5 - further detail regarding this indicator can be seen in the National Metrics section of this report.
6 - Introduced into the summary for reporting from 18/19.
7 - Introduced into the summary for reporting from 18/19. Black, Asian & Minority Ethnic (BAME) includes mixed, Asian/Asian British, black, black British, other
8 - Work taking place to identify a suitable metric across all Trust smoking cessation services. Further update to be provided in next month's report.
9 - The figure shown is the proportion of eligible clients with a cardiometabolic assessment. This may not necessarily align to the CQUIN which focuses on the quality of the assessment.

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 2017 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 relates to our 16/17 agency expenditure performance and our financial risk.

Areas to Note:
Quality
• Safer staffing fill rates continue to be maintained overall, pressures remain in terms of recruitment and acuity.
• Number of restraints have increased and is subject to in depth review.
• Physical health metric position is positive
• Friends and family test position for mental health shows pressure in child and adolescent services

NHSI Indicators
• The Trust met the 7 day follow up target in May following a slight dip in performance in April
• Proportion of people completing treatment and moving to recovery within Improving Access to Psychological Therapies (IAPT) remains above target
• No children or younger people placed in adult inpatient wards in May
• The Trust continues to achieve the vast majority of national metrics

Locality
• Pressure on adult acute wards remains high across West Yorkshire
• Discussions continue with the commissioner in Barnsley to identify how the waiting lists for psychology can best be addressed within financial resources available
• Discussions taking place with the specialist commissioner to agree initial funding for the introduction of the learning disability forensics outreach service
• Average length of stay for Wakefield acute services remains in excess of target and has been identified as part of the trust-wide programme of improvement in addressing demand and capacity.

Priority Programmes
• SystmOne for mental health co-design workshops have been completed
• Initial data migration testing to commence week commencing June 25th
• Local change plans to reduce out of area bed usage have now been agreed
• Older people's transformation proposals being discussed with commissioners

Finance
• Net deficit of £204k in month which was favourable to plan
• Cumulative deficit is now £496k. The run rate is adverse to the full year plan
• Agency costs of £538k in month were 8% above the cap and increased by close to £0.1m compared to April
• Net pay savings of £0.3m year-to-date
• Out of area bed expenditure amounted to £363k. Cumulatively expenditure is adverse to plan by £161k and is 58% higher than the corresponding period for 2017/18.
• Year-to-date CIP delivery of £1.3m is £0.1m lower than plan
• Cash balance of £23.m is £0.6m lower than plan and as expected is circa £3m below the 2017/18 year-end position
• Financial risk rating of 2 given the deficit position

Workforce
• Sickness absence improved to 4.5% in May, which is in line with the Trust's target
• Staff turnover is currently reported at being 8.5% year-to-date

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	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Apr-18	May-18	Year End Forecast Position *
Quality	Referral to treatment times	Improving Health	Responsive	KT/SR/CH	TBC	KPI under development										N/A
Complaints	Complaints closed within 40 days	Improving Health	Responsive	TB	80%				28% 11/39	12.7% 8/63	12% 6/50	9.3% 4/43	29% 2/7	20% 2/10	21% 6/28	1
	% 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	19.8% 43/217	18.2% 38/208	7.7% 13/168	16% 10/64	5% 3/57	10% 5/50	4
Service User Experience	Friends and Family Test - Mental Health	Improving Health	Caring	TB	85%	72%	71%	71%		84%	84%	86%	86%	86%	75%	4
	Friends and Family Test - Community	Improving Health	Caring	TB	98%	98%	98%	98%	99%	98%	98%	98%	98%	97%	100%	4
Quality	Staff FFT survey - % staff recommending the Trust as a place to receive care and treatment	Improving Health	Caring	AD	80%	N/A	79.26%	N/A	80%	74%	75%	N/A	76%	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%	60%	64%	N/A	67%	N/A		N/A
	Number of compliments received	Improving Health	Caring	TB	N/A	Data not avail until Oct 16.		141	81	81	113	148	64	26	109	N/A
	Number of Duty of Candour applicable incidents 4	Improving Health	Caring	TB	N/A	73	86	83	86	337				21	Data due July 18	N/A
	Duty of Candour - Number of Stage One exceptions 4	Improving Health	Caring	TB	N/A	Reporting established from Oct 16		0	2	26				0		N/A
	Duty of Candour - Number of Stage One breaches 4	Improving Health	Caring	TB	0	Reporting established from Oct 16		0	1	1		2	1	0		
	% 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%	85.6%	85.0%	84.9%	86.3%	85.8%	4
	Un-outcomed appointments 6	Improving Health	Effective	KT/SR/CH	TBC		2.2%	2.9%	2.6%	4.3%	3.3%	2.5%	2.5%	5.4%	4.3%	N/A
	Number of Information Governance breaches 3	Improving Health	Effective	MB	<=8	36	25	29	36	33	22	24	21	8	11	
	Delayed Transfers of Care 10	Improving Care	Effective	KT/SR/CH	7.5% 3.5% from Sept 17	2.2%	2.6%	3.1%	2.7%	1.6%	2.3%	2.7%	3.7%	2.7%	2.1%	4
	Number of records with up to date risk assessment	Improving Care	Effective	KT/SR/CH	TBC	KPI under development										N/A
	Total number of reported incidents	Improving Care	Safety Domain	TB	trend monitor	3509	3405	3293	2946	2849	3064	2961	3435	1072	1062	N/A
	Total number of patient safety incidents resulting in Moderate harm. (Degree of harm subject to change as more	Improving Care	Safety Domain	TB	trend monitor					57	58	56	72	24	16	N/A
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more	Improving Care	Safety Domain	TB	trend monitor	10	19	19	20	3	8	9	7	2	1	N/A
	Total number of patient safety incidents resulting in death harm. (Degree of harm subject to change as more information becomes available) 9	Improving Care	Safety Domain	TB	trend monitor	73	79	73	84	12	16	23	11	3	10	N/A
	MH Safety thermometer - Medicine Omissions	Improving Care	Safety Domain	TB	*17.7%*	16.8%	17.7%	Data not avail	18.70%	18.2%	24.3%	16.5%	20.5%	19.9%	20.6%	3
	Safer staff fill rates	Improving Care	Safety Domain	TB	90%					109%	111.1%	114%	116.8%	118%	120%	4
	Safer Staffing % Fill Rate Registered Nurses	Improving Care	Safety Domain	TB	80%					107%	94.1%	99%	98.4%	99.2%	100%	4
	Number of pressure ulcers (attributable) 1	Improving Care	Safety Domain	TB	N/A	98	95	78	86	82	92	71	98	30	29	N/A
	Number of pressure ulcers (avoidable) 2	Improving Care	Safety Domain	TB	0	1	4	3	2	2	1	2	2	0	0	3
	Eliminating Mixed Sex Accommodation Breaches	Improving Care	Safety Domain	TB	0	0	0	0	0	0	0	0	0	0	0	4
	% of prone restraint with duration of 3 minutes or less 8	Improving Care	Safety Domain	KT/SR/CH	80%	Reporting Established from July 16	79.7%	75.6%	66.3%	75%	80%	77%	76%	80%	61%	4
	Number of Falls (inpatients)	Improving Care	Safety Domain	TB	TBC	162	158	136	95	139	139	150	181	39	40	N/A
	Number of restraint incidents	Improving Care	Safety Domain	TB	N/A	Data not avail				345	424	442	589	173	211	N/A
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	Improving Care	Safety Domain	TB	6	0	0	1	2	1	0	0	0	0	0	4
	C Diff avoidable cases	Improving Care	Safety Domain	TB	0	0	0	0	0	0	0	0	0	0	0	4
Quality	No of staff receiving supervision within policy guidance 7	Improving Care	Well Led	KT/SR/CH	80%	39.5% (March 17)				59.3%	61.0%	64.7%	86.5%	Due July 18		4

** 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 - 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.
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%.

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.

Please see the points below for indicators that are performing outside expected levels or where additional supporting information is available.

• The total number of all restraints incidents reported has increased during the month and is above the mean number of restraints over the past 24 months which is 142.67. Further analysis of this data is being undertaken but it is anticipated this may be linked to the acuity. The incidents are spread across BDUs and a small number of individuals have multiple incidents reported.

• 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 inpatient 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 inpatient units is currently at 16%, SWYPFT has been around the 20% mark. Analysis of the data has been undertaken and it has been identified that the monthly figures presented on the national system are not always that month's data but can include the previous month's data if it has been input the following month. In order to assist with this the Trust will be tightening up the data entry process. Previous analysis of patient level data related to medicine omissions acuity levels on older people's wards and the response to winter pressures. The biggest reason for medicine omissions was refusal by the service user.

• Number of falls (inpatients) - February saw a spike in the number of reported falls and the detail around this was reported in last months report. March 18 has seen a decrease, however, the number of falls remains slightly over the monthly average with 61 falls being reported. The number of falls reported in April and May 18 has decreased further and is now below last years average with 40 falls being reported each month.

• 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.

Safety First

Summary of Incidents during 2017/18 and 2018/19

	Q1 18/19	Q2 17/18	Q3 17/18	Q4 17/18	Jun-17	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May-18	Total
Green no harm	1320	1894	1777	2010	603	662	669	563	608	587	582	663	649	698	689	631	**7604**
Green	576	856	826	1051	268	317	297	242	272	264	290	338	357	356	271	305	**3577**
Yellow	174	226	261	282	73	77	87	62	84	102	75	86	95	101	76	98	**1016**
Amber	43	59	63	68	26	18	25	16	21	28	14	23	30	15	27	16	**259**
Red (should not be compared with SIs)	21	29	34	24	8	9	6	14	11	12	11	8	7	9	9	12	**116**
Total	**2134**	**3064**	**2961**	**3435**	**978**	**1083**	**1084**	**897**	**996**	**993**	**972**	**1118**	**1138**	**1179**	**1072**	**1062**	**12572**

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

Summary of Serious Incidents (SI) by category 2017/18 and 2018/19

	Q1 18/19	Q2 17/18	Q3 17/18	Q4 17/18	June 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Total
Administration/supply of medication from a clinical area	0	1	1	0	0	1	0	0	0	1	0	0	0	0	0	0	2
Death - cause of death unknown/ unexplained/ awaiting confirmation	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Fire / Fire alarm related incidents	0	1	0	0	1	1	0	0	0	0	0	0	0	0	0	0	2
Formal patient absent without leave	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Information disclosed in error	0	1	2	0	0	0	0	1	0	2	0	0	0	0	0	0	3
Self harm (actual harm)	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Self harm (actual harm) with suicidal intent	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	1
Suicide (incl apparent) - community team care - current episode	4	10	14	6	2	5	2	3	4	5	5	2	3	1	1	3	36
Suicide (incl apparent) - community team care - discharged	0	2	2	0	0	1	0	1	1	0	1	0	0	0	0	0	4
Suicide (incl apparent) - inpatient care - current episode	0	0	2	2	0	0	0	0	0	1	1	1	0	1	0	0	4
Vehicle Incident	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Allegation of violence or aggression	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	1
Homicide by patient	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Physical violence (contact made) against other by patient	0	1	1	1	1	0	0	1	1	0	0	0	0	1	0	0	4
Pressure Ulcer - grade 3	0	1	3	1	1	1	0	0	1	1	1	1	0	0	0	0	6
Physical/sexual violence by other	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Total	4	18	26	12	9	9	2	7	7	11	8	4	4	4	1	3	69

• 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 has increased the number of red incidents. Deaths are re-graded upon receipt of cause of death/clarification of circumstances.
• 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 May 2018.

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

Mortality

Assurance: 360 Assurance Internal audit report on Learning from Healthcare Deaths has been received giving Significant Assurance. Mortality review group workshop is being held at the end of June to plan implementation of the audit findings.
Reporting: 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.
See http://www.southwestyorkshire.nhs.uk/about-us/performance/learning-from-deaths/
Learning: 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 - currently being finalised
-Structured Judgement Record Reviews – 11 cases have been completed for reviews from Q1 - Q3. Due to small numbers to date, it is difficult to identify any themes. 55% of cases the overall care was rated good or excellent [good (4) or excellent (2)]. 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.
Policy: A review of the Learning from Healthcare Deaths policy will take place to include feedback from the audit findings and learning from the first six months of policy implementation in consultation with Northern Alliance colleagues. A meeting of the Alliance was held in May.
Any comments on the policy are welcomed to feed into the review process via risk@swyt.nhs.uk

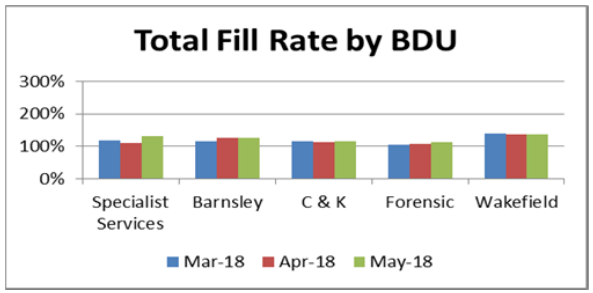
Safer Staffing

Overall Fill Rates: 120%
Registered fill rate: (day + night) 100%
Non Registered fill rate: (day + night) 138.3%

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

BDU Fill rates - Feb 18 - May 18

Overall Fill Rate	Month-Year		
Unit	Mar-18	Apr-18	May-18
Specialist Services	119%	111%	131%
Barnsley	116%	126%	127%
C & K	114%	112%	115%
Forensic	105%	108%	112%
Wakefield	138%	137%	136%
Overall	**116%**	**118%**	**120%**



Registered Staff:
Days - 93% (remained constant from April); Nights -107% (increase of 2% on April)
Registered average fill rate:
Days and nights - 100% (increase 0.8% on April)
Non Registered Staff:
Days -136.1% (increase of 3.8% on April); Nights 145.6% (increase of 5.4% on April)
Non Registered average fill rate:
Days and nights - 138.3% (increase of 2.0% on April)
Overall average fill rate all staff:
120% (increase of 2.0% on April)

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

Summary

For the ninth consecutive month, no ward fell below a 90% overall fill rate in May. Of the 31 inpatient areas listed 24 (707%) achieved greater than 100%. Indeed of these 24 areas, 13 achieved greater than 120%.
Registered On Days (Trust Total 93 %)
There has been a decrease in the number of wards that have failed to achieve 80%, two wards in all (6.4%) compared to 3 (9.6%) in April. Within the Forensic BDU Chippendale decreased by 1% to 68%, Appleton decreased by 9% to 71%.
Registered On Nights (Trust Total 107%)
No ward has fallen below the 80% threshold. The number of wards who are achieving 100% and above fill rate on nights increased to 74.2% (23 wards) for May.
Average Fill Rates for Barnsley BDU increased by 1% to 127%. Calderdale and Kirklees BDU increased by 3% to 115%. Forensic BDU were 112% an increase of 4%. Wakefield BDU were 136% with a decrease of 1%. Specialist services were 131% with an increase of 20%.
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 the Wakefield BDU, Ward 18, Appleton, Johnson, Neuro and stroke rehab 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 teams with bank, agency and off ward staff during this period.

Complaints closed within 40 days

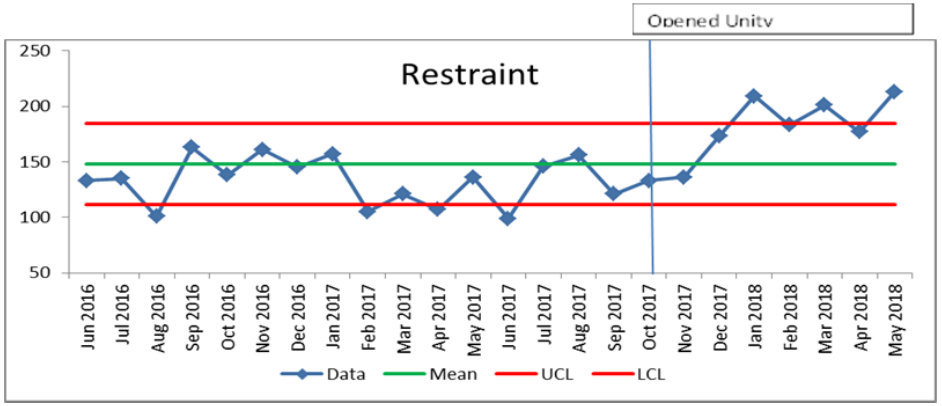
The Trust adopts an approach to complaints and feedback that promotes resolving issues at service line wherever and whenever this is possible.
The process to ensure robust investigation of issues and sign off of complaints is under review. The current process involves investigators, general managers, 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 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 services before they are returned to Customer Services. Draft responses will then be prepared in Customer Services. Draft responses will be reviewed by services 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 version shared with the Chief Executive for review and signature.
The initial aim of the process review is to ensure we respond to people's complaints within our internal target of 40 days, with a longer term view to be able to respond to complaints within 25 days by 2020.
We have set an internal trajectory to achieve the 40 day target by December 2018 and to achieve this there is significant work in progress, including:
• Mapping of existing customer services process, workloads and workforce skills
• Development of new pathways
• Partnership working with Business Delivery Units to ensure robust processes across the support and operational services
• Review of complaints investigation training (looking to combine with root cause analysis training)
Early findings indicate:
• As a result of the new approach to addressing concerns in a timely manner, the number of formal complaints are reducing
• We have overly bureaucratic processes
• There is considerable 'waste' in the customer service process which is causing delay in the process. We have plans to eliminate this.
• Significant paper processes are hindering timescales – early enquires indicate that the DATIX system will help reduce the workload
• Workforce skills require development
• Customer services' model (in addition to complaints process) requires review .

Restraint

IPR report for May 2018 identifies the raise in restraint figures in quarter 4 2018

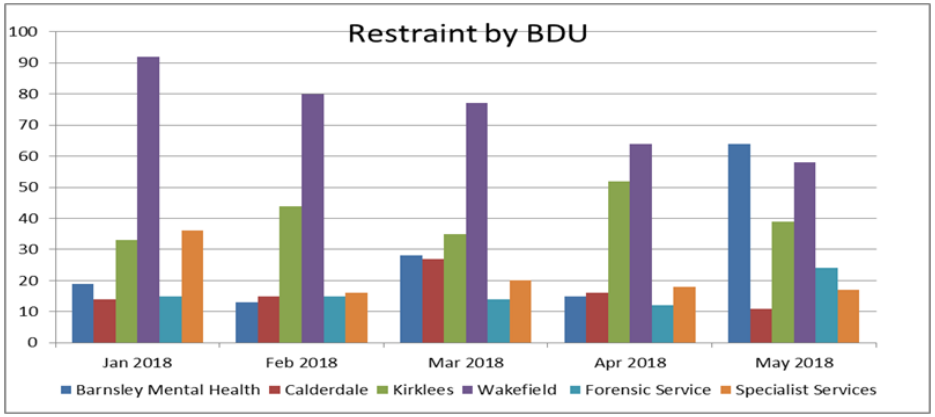
Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
345	424	442	589

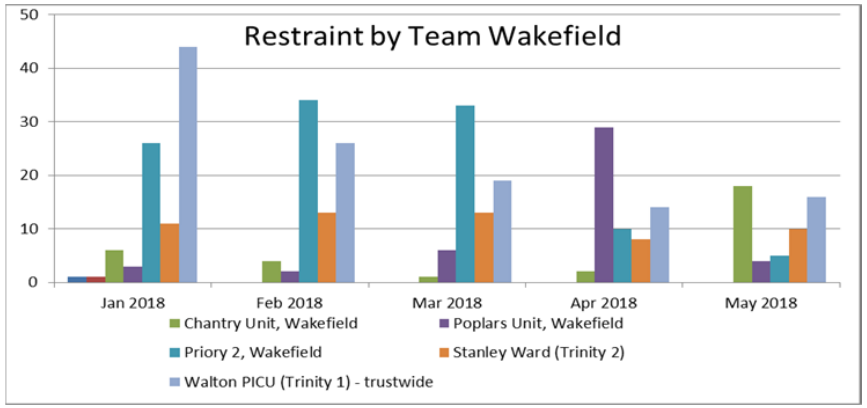
We can establish from the graph below that from the January 2018 restraint can clearly be seen to be high. Using simple statistical techniques we can define the limits of variation, an Upper Control Limit (UCL) and a Lower Control Limit (LCL). As the number of restraints is outside the Upper Control Limit we should locate the "special cause "for this.



Restraint cont…

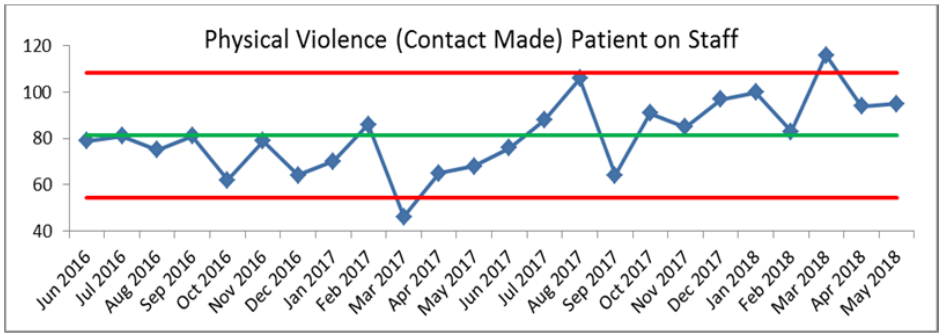
We must first locate where most restraint is being used since 1st January 2018

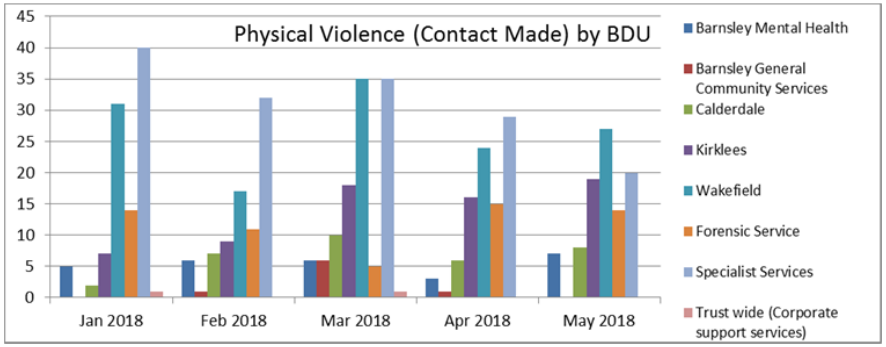




Stanley has remained constant throughout this time period. Each of the other wards has had a spike in the number of restraints most notably Priory 2 until March18. Poplars had a spike in April 18, and Chantry in May 18.
Priory 2 accounted for 108 (29%) restraints in this time period in Wakefield with 20 individuals restrained. 2 services user accounted for 57(53%) of the restraints on Priory 2.
There 44 restraints on Poplars 32 (66%) from 1 individual
In Barnsley in May18, 1 service user accounted for 52(81%) out 64 incidents

Small numbers of service users can make large differences to the number of restraints. Some have been recognised as having long term issues with challenging behaviours over a period of months, whilst others are short term acute crisis. Early recognition of these service users is important. Supporting staff, assisting with care planning, training and offering supervision to manage particular individuals has helped reduce the high levels of restraint in Wakefield in the above months.
It should also be noted that the beginning of the increases in restraint in Wakefield began in October 2017. This is also replicated in Physical Violence (Contact Made) Patient on Staff where the is a shift upwards (8 consecutive months all above the centreline from October 17 onwards)





Both Wakefield BDU and Specialist Services are notably high than other BDUs. There are a very small number of service users on Horizon who account for some of this.

The only “special cause” at that time in Wakefield was the opening of the Unity Centre. This involved changes in Bed numbers, transfers in patients and staff, unfamiliar environments, teething troubles, changes in working practices and the relative isolation of Priory 2. It may be that the opening and transfer of patients and staff to a new unit causes conditions where challenging behaviour can occur more frequently for a longer period than we might expect. We should review the evidence and plan accordingly.

Information Governance

There were 11 confidentiality breaches during May involving Information disclosed in error, patient healthcare record issues and data/information lost in transit. This is the highest number of incidents reported since November 2017.

No incidents were reported to the Information Commissioners Office (ICO).

Commissioning for Quality and Innovation (CQUIN)

CQUIN leads have been agreed for 2018/19. Services are now working towards the requirements for 18/19 and the first set of reports are due to be submitted at the end of quarter 1 (July 18).

A new set of indicators for the Barnsley alliance contract for 2018/19 have been negotiated and these include:
• NHS Staff Health and Wellbeing which aligns to the requirements across the other Trust contracts.
• Improving the assessment of wounds
• Personalised Care / support planning
The following indicators are applicable to the Intermediate Care pathway:
• Patient self-administering of medication
• Patients at risk of readmission
• #endpjparalysis
Work is taking place locally to review and create action plans relating to this new set of indicators.

All CQUINs for 2018/19 have a RAG rating of green with the exception of:
• NHS Staff Health and Wellbeing – risk in achievement linked to the improvement of staff health and wellbeing. To achieve would mean that the Trust would need to be in the top 6 of 200+ trusts nationally to achieve the required threshold.
• Cardio metabolic assessment and treatment for patients with psychoses - The early intervention in psychosis element of this indicator has been rated as amber until the results of the 17/18 have been finalised.
The total CQUIN value for 2018/19 is £4.4m. The Trust currently has a risk of £262k shortfall for 2018/19. CQUIN leads are working to mitigate this risk as far as possible.

Patient Experience

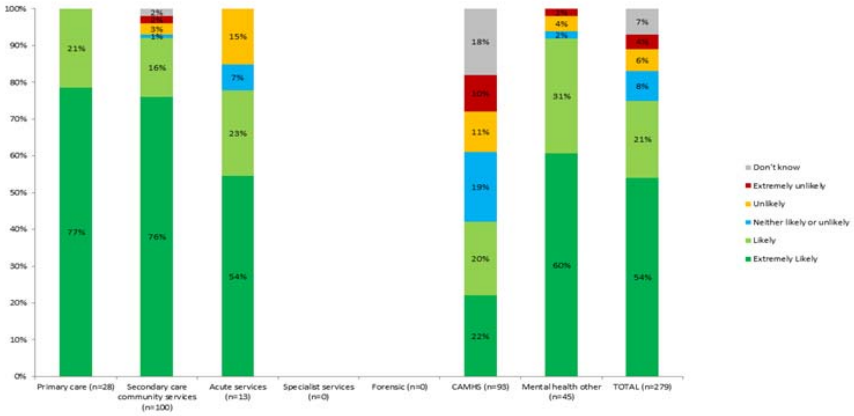
Friends and family test shows

- Community Services – 100% would recommend community services.
- Mental Health Services – 75% would recommend mental health services.
- Significant variance across the services in the numbers extremely likely to recommend the Trust – between 21% in Child and Adolescent Mental Health Services (CAMHS) and 77% in primary care mhh services

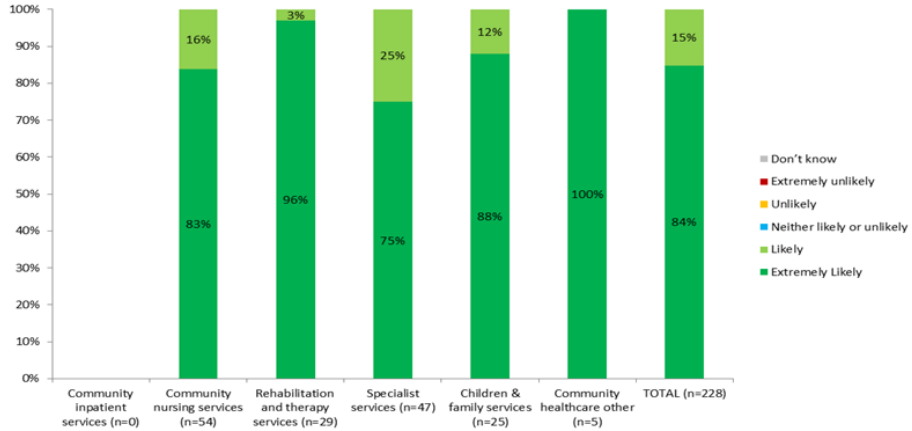
The % of people extremely likely/likely to recommend is low at 75% due to a high proportion of negative responses from CAMHS.
CAMHS contributed 93 responses in May from a Trust wide total (Mental Health) of 293. The CAMHS score breakdown:
• 41% extremely likely/likely to recommend
• 38% maybe/don't know
• 20% extremely unlikely/unlikely
The supplementary free text comments were negative and offered a number of suggestions. These have been sent to the service for action.
It is felt that the use of feedback kiosks in CAMHS waiting rooms is having a detrimental effect on the FFT % due to children using the machines unsupervised. Alternative methodologies are showing a more valid response. If CAMHS results were removed from the Trust mental health response, the percentage of respondents extremely likely/likely to recommend for May would be 92%.

- Small numbers stating they were extremely unlikely to recommend.

Mental Health Services



Community Services



Care Quality Commission (CQC)

Summary
The Trust was inspected by the Care Quality Commission (CQC) throughout March and April 2018. Six core services were inspected in March and a well led inspection was carried out between 9th – 11th April 2018. As a learning organisation, the Trust's values are at the heart of everything it does, and the CQC visit and its independent view of services was welcomed.

The Trust received its draft reports on 25th May 2018. There is a 10 day period for factual accuracy checking. We received an Evidence document (293 pages), which detailed the information the CQC has considered and the findings from the inspection, and a Quality Report which summarised the findings and ratings. The reports are in a different format from those received previously.

The draft reports were checked for factual accuracy by senior members of operational and corporate support services and any immediate remedial action required was taken. We focussed on the areas where we felt the CQC had not considered all the information we provided, had misinterpreted the data we submitted or misunderstood what had been told to them. We prioritised the SAFE domain for action, as we had strong evidence in a number of core services, that we were performing better in April 2018, than we were in Jan 2017 but this was not reflected in the report. We submitted a significant amount of evidence to challenge the mental health acute wards and PICU, CAMHS and community mental health teams inspection findings.

The factual accuracy reports were submitted within the required timeframe (11th June) and a scheduled engagement meeting was held with SWYPFT inspection manager, Joanne Walkinshaw, on 13th June, who confirmed that she will reconsider the evidence submitted. She also noted that there would need to be further Management Review Meetings for the three core services, noted above, to consider our evidence.

A letter detailing the areas the Trust wanted the CQC to consider was discussed with Joanne, by Director of Nursing, Tim Breedon

Timeline:
June 18th – 30th CQC to review the evidence submitted by SWYPFT
July 2018 – reports returned to trust for confirmation of ratings
July 2018 – reports published

There is no longer a requirement to have a quality summit.

Operational teams have started to take action against the findings of the report. A trust wide action plan is in development and will be monitored via the Clinical Governance Group and reported in the IPR and to the Clinical Governance & Clinical Safety Committee.

Safeguarding

Safeguarding Children
• Acting named nurse has delivered a training session "Parental mental health" this was part of the multi-agency programme through the local authority.
• Information for potential Serious Case Reviews (SCR's) and Learning Lessons Reviews (LLR's) has been provided to the Safeguarding Children Board's in a timely manner.
• Safeguarding children's nurse advisor is contributing to a SCR in Calderdale.
• Report from SWYPFT for SCR in Wakefield has been submitted and accepted with no extra information required.
• Staff have actively been accessing Safeguarding Children Supervision. Additional work has been completed to ensure equity across the Trust.
• The safeguarding children's team have accessed relevant training to maintain their Continued Professional Development and ensure that the workforce receives the most current up to date information, in particular Female Genital Mutilation, this will be added into safeguarding adults and children's training package.

Safeguarding Adults
• The Safeguarding Specialist Adviser has delivered 1:1 safeguarding supervision to practitioner in Forensic service, to practitioners with a complex case in the Learning Disability team following the LD Governance meeting and to the clinical team in Lyndhurst.
• The Safeguarding Specialist Adviser attended a ward round, following discussion with the Practice Governance Coach, to support practitioners with a service user from Chantry with complex physical and mental health needs who was being nursing in seclusion and discussion about future placement, care needs and risk management.
• The Safeguarding Specialist Adviser has been identified to undertake training for 'train the trainer' in Barnsley for new self-neglect and hoarding procedures.
• The Individual Management Review has been submitted following amendments to the Safeguarding Adults Review (SAR) panel.
• The Safeguarding team have provided information to inform Barnsley SAR panel of possible SAR's
• There is continued support to the Quality Intelligence Group (QIG) meeting in Wakefield and the Hoarding Panel in Kirklees.
• The Safeguarding Specialist Adviser attended the safeguarding practitioner's forum (Wakefield Safeguarding) to comment on the new safeguarding procedures and their implementation in Wakefield.

Adults and Children
• Week commencing 25th June 2018 is West Yorkshire Safeguarding Week; the safeguarding team are supporting this and delivering a presentation on "Perinatal mental health and Safeguarding".
• Trust wide training statistics are above the mandatory expected numbers.
• Section 11 audit completed for Calderdale for Safeguarding Adults and Children.

Infection Prevention Control (IPC)

- No infection prevention and control cases to report in May 18.
- Annual plan 2018-19 is progressing well.Q1 is all completed.
- Training levels for Trust being achieved- Hand Hygiene - 90.26%, Infection Prevention Control - 86.40%
- Policies and procedures are up to date.
- PLACE is taking place within the inpatient areas. Result for this will be released in August.
- There is still reduced capacity within the team, (there is 1 IPC nurse vacant), unfortunately the recruit expected for 30th April 2018 has given back word. The team have review current process and put contingency plans in place.

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	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Apr-18	May-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%	98.3%	96.8%	95.0%	97.4%	97.1%	97.3%	4	
Maximum 6-week wait for diagnostic procedures	Improving Care	Responsive	SR	99%	99.6%	100%	100%	100%	99.7%	100%	100%	100%	100%	100%	4	
% Admissions Gate kept by CRS Teams	Improving Care	Responsive	SR/CH	95%	96.9%	99.3%	99.2%		98.5%	96.6%	96.9%	99.6%	*95.5%*	98.3%	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%	97.6%	95.5%	96.9%	96.7%	94.3%	99.2%	4	
Data Quality Maturity Index 4	Improving Health	Responsive	SR/CH	95%	Reporting from Nov 17					98%	98.1%				4	
Out of area bed days 5					Reporting from April 17.				885	1127	1286	1608	555	310	1	
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%	50.1%	49.2%	53.8%	54.0%	52.9%	*55.6%*	3	
IAPT - Treatment within 6 Weeks of referral 1	Improving Health	Responsive	SR/CH	75%	76.1%	83.6%	88.9%	86.0%	81.9%	81.1%	89.8%	90.6%	91.6%	*87.7%*	4	
IAPT - Treatment within 18 weeks of referral 1	Improving Health	Responsive	SR/CH	95%	98.9%	99.3%	97.9%	99.9%	99.5%	99.4%	99.6%	100%	100%	*98.7%*	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%	89.2%	84.4%	89.5%	89.8%	93.5%	80.9%	4	
% clients in settled accommodation 1	Improving Health	Responsive	SR/CH	*60%*	Reporting developed from Sept 16		82.7%	82.9%	82.2%	80.8%	80.2%	79.1%	78.9%	*78.4%*	4	
% clients in employment 1	Improving Health	Responsive	SR/CH	*10%*	Reporting developed from Sept 16		8.3%	8.8%	9.0%	8.7%	8.6%	9.1%	9.0%	*8.7%*	1	
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) inpatient wards / b) early intervention in psychosis services / c) community mental health services (people on Care Programme Approach)	Improving Care	Responsive	SR/CH								Due June 18		Due June 19		2	

Mental Health Five Year Forward View	Objective	CQC Domain	Owner	Target	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Apr-18	May-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	4	108	62	96	2	0	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	2	4	5	4	1	0	N/A	
Number of detentions under the Mental Health Act	Improving Care	Safe	SR/CH	*TBC*	167	174	156	168	212	221	186	180	Due July 18		N/A	
Proportion of people detained under the MHA who are BAME 2	Improving Care	Safe	SR/CH	*TBC*	15.0%	10.3%	10.9%	19.6%	10.8%	13.6%	15.1%	9.0%			N/A	

NHS Standard Contract	Objective	CQC Domain	Owner	Target	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Apr-18	May-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%	98.7%	97.1%	98.4%	98.1%	97.4%	*98.6%*	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 1	Improving Health	Responsive	SR/CH	99%	99.5%	99.6%	99.7%	99.7%	99.7%	99.8%	99.8%	99.8%	99.8%	*99.8%*	4	
Completion of Mental Health Services Data Set ethnicity coding for all Service Users, as defined in Contract Technical Guidance 1	Improving Health	Responsive	SR/CH	90%	89.6%	91.1%	94.0%	90.2%	89.3%	90.3%	90.8%	90.6%	90.7%	*90.3%*	4	

** See key included in glossary.*
1 - In order to provide the board with timely data, data from the IAPT and mental health minimum datasets primary submissions are used to give an indication of performance and then refreshed the following month using the refreshed dataset's data.
2 - Black, Asian & Minority Ethnic (BAME) 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 - The figure for 17/18 reflected the total number of out of area bed days in the Trust, for 18/19 this has been aligned to the national indicator and therefore only shows the number of bed days for those clients whose out of area placement was inappropriate. Progress in line with agreed trajectory for elimination of inappropriate adult acute out of area placements no later than 2021. 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
- After a slight dip in performance against target in April, the percentage of service users followed up within 7 days of discharge reached 99.2% to be above target in May.
- Given the hard work and focus of our staff, we continue to meet the target for proportion of people complete ting treatment who move to recovery within Improving Access to Psychological Therapies (IAPT), although this continues to be a challenge.
- Out of area placements continues to be a significant pressure and currently the target for reduction in such usage is not being met
- May was the first time for some months that no children or younger people were placed in an adult inpatient ward. When this does occur the Trust has robust governance arrangements in place to safeguard young people; 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. The Trust has 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 Trust's 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.
- As identified above the Trust has submitted a reduction trajectory for the use of out of area bed placements. This trajectory has been agreed with commissioners and requires a 30% reduction in inappropriate admissions during the year. This target is currently not being met

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

• Improving Access to Psychological Therapies (IAPT) has sustained its improved performance against required key performance indicators.
• Acknowledged deficits in capacity in leadership in community services is impacting on data quality and in the ability to address areas of required service improvement. This is now being addressed through the implementation of an organisational change process.
• Performance around care programme approach (CPA) reviews remains below target for month end but is on track to improve by quarter end.
• Review of performance data is taking place between intensive home based treatment team (IHBT) and psychiatric liaison team (PLT) to consider performance and activity attribution.
• Food safety training figures in acute remain below required standards and are being addressed through skill-mixing on the wards and a review of staff training requirements.
• Average length of stay (ALOS) remains in excess of target and has been identified as part of the trustwide programme of improvement in addressing demand and capacity in acute services.
• Planning and implementation continues around the required changes to mental health community services required in the context of the agreed the dissolution of the S75 agreement between SWYFT and Barnsley metropolitan brought council August 2018. Human resources, finance, performance and caseload and clinical management issues are being addressed. Consultation with affected SWYFT staff has commenced regarding the consequent reduction of enhanced teams from three to two. Work is ongoing to understand the impact of the changes in terms of the standard operating procedures and coping with demand and capacity and ensuring operational effectiveness going forward.
• Negotiations continue with the clinical commissioning group (CCG) to address the waiting lists in psychology in the community service line. The CCG noted the improvements made 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 which has resulted in minimal waits for new referrals. A meeting with the CCG is planned for July 2018 to look at options to address within financial resources available.

General Community

• CQUIN – 3 new local CQUINS have been applied to Alliance Contract (pj paralysis; self-medication; re-admissions). These currently apply to Intermediate care pathway. Q1 will be has been met and project plans submitted.
• Stroke services – we are progressing on development of virtual partnership team to deliver joint clinics and working on a business case in development for early supported discharge in stroke following hospital services review and the local stroke workshop held in 15th May.
• Musculo-Skeletal – data quality issues being reviewed and addressed.
• Formal notification received from CCG re rapid access clinic review.

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).

Calderdale & Kirklees BDU:

Key Issues
• Delayed transfers of care improved better care fund (iBCF)- monthly figures continue to be scrutinised at Clinical Commissioning Group (CCG) level as a reduction target has been set against IBCF investment.
• Out of area (OOA) placements has increased for a period in May. This has been a fluctuating issue with no clear cause. Community and in-patient teams are working together to focus on admission prevention and flow. Our Calderdale Intensive home based treatment (IHBT) manager has been seconded into actively taking management of OOA discharge planning as from June.
• Adult acute ward pressures remained high on Ward 18 and in Ashdale due to a number of high risk male patients.
• 7 day follow ups in Kirklees and Calderdale achieved.

Strengths
• Strong performance on Mandatory training.
• Sickness levels below 3.5% in older adult service line.
• Supervision levels are green.
• Improvements in improving access to psychological therapies (IAPT) performance in spite of underfunded workforce.

Challenges
• Recruitment is underway in community consultant roles but gaps will remain for trainee posts until rotation in August. Alternative options such as Advanced Nurse Practitioners (ANP)/prescribers are being explored in the business delivery unit.
• Bed occupancy levels (high above 95%) and continue to be monitored closely.
• Sickness levels have improved but at 4.8% is an improvement on previous months.

Areas of Focus
• Admissions and discharge flow in acute adults
• Reduction of sickness in hotspots.
• Continue to improve performance in service area hotspots.
• Recruitment to posts in community especially Kirklees IAPT and early intervention in psychosis (EIP).

Forensic BDU:

Medium and Low Secure
• Low Secure – The external homicide review has commenced. Internal review and action plan have both been completed.
• Forensic outreach service learning disability – currently awaiting final confirmation of the pump priming figure. Leeds CCG will distribute the monies when agreed. Implementation plan being developed.
• National service review continues we have recently met with NHSE and discussed a way forward. It is likely we will explore the development of a male personality disorder service within the service.
• NHSE have signalled an intention to discuss under occupancy with us particularly in relation to learning disability wards in medium secure.
• Focus on reducing sickness continues.

Forensic Child and Adolescent Mental Health Services
• High number of vacancies leading to service pressures. Recruitment process in place.
• Sickness levels are reducing.
• Secure estate has seen an increase in admissions caused by rationalisation of the estate and an increase in violent crime. That has led to some pressure on the workload.
• Implementation of secure stairs (a more psychologically/multi disciplinary team way of working with young people in custody) has commenced in Adel Beck and Wetherby.

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).

Specialist BDU:

Child and Adolescent Mental Health Services (CAMHs)

•

Learning Disability

•

Wakefield BDU:

• The acute service line continues to experience high demand and staffing pressures. Use of out of area beds (OOA) acute and psychiatric intensive care (PICU) for Wakefield service users has continued to present a challenge although intensive work is ongoing to explore all possible alternatives at the point of admission, and to reduce OOA episode duration once commenced. This usage has however increased significantly for this month and is having an adverse impact financially and on the quality of service user and carer experience.
• Average length of stay remains in excess of target and has been identified as part of the trustwide programme of improvement in addressing demand and capacity in acute services.
• Work to develop and refocus the intensive home based treatment offer is ongoing and recruitment to additional posts now completed, informed and focussed by the action plan from the core fidelity audit undertaken across Wakefield and Barnsley.
• Care Programme Approach (CPA) reviews for month end are below target but forecast to be within range by quarter end. Issues have been identified with sequencing of reviews and data quality.

Communications, Engagement and Involvement

• Our Year: Summary of 2017/18 achievements produced and disseminated
• Staff listening events: First two events held, two further planned for June
• External award entries: Submitted for Windrush awards, NHS70 Top Star awards and HSJ awards
• MP engagement: Meetings and visits held with Barry Sheerman and Holly Lynch, and system leaders and MPs meeting attended in Wakefield
• Volunteering: Recruitment process refined and roles now available via NHS jobs
• EyUp! charity communications: EyUp! registered with NHS Charities Together and set to benefit from a celebrity endorsed song for NHS70. Filming took place with ITV Calendar.
• New Trust website: Development in final stages before launch, 4250+ items migrated
• #NHS70superstars: 1,400 nominations received

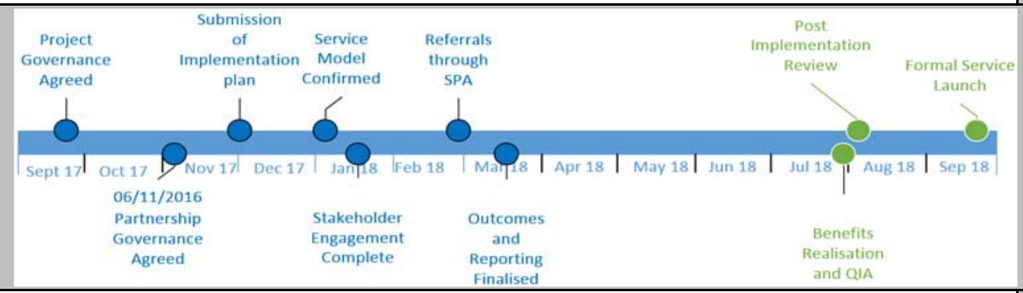
This is the latest update on the progress being made against the Trust priorities for 2018/2019.
To avoid duplication where the priority is already reported in other sections of the integrated performance report (IPR), for example patient safety, then updates will not be repeated in this priority page where they would normally be reported. Those that are reported on this priority page of the IPR are:
1. South Yorkshire Projects – for stroke services, neurological rehabilitation and autism and attention deficit and hypersensitivity disorder (ADHD)
2. West Yorkshire Projects – for forensics, community forensic child and adolescent mental health services (CAMHs), forensic Community learning disability (LD), autism and ADHD, learning disability, inpatient CAMHs and eating disorders.
3. Flow and out of area beds
4. Workforce productivity
5. Clinical Record System
Since the last update in May 2018 it has been agreed by the executive management team (EMT) that the older people's services transformation project is to be included as one of the priorities for 2018/19 and therefore this project is now included in the update.
Not all priorities are updated in the IPR monthly – some will be updated bi-monthly as determined by the inherent degree of cost, risk and complexity.
Given the majority of priorities are new for 2018/19 then scoping, establishment of governance and resources allocation is ongoing. However for those priorities that continue from 2017/18 there are the following updates:

Flow and out of area beds:
• Bed pressures remain in the system and the long term trend of high out of area OOA placements has continued through May.
• Local change plans have now been agreed. Key priority areas include reducing the number of admissions in Calderdale and Kirklees, reducing length of stay (LOS) elsewhere and a focus on higher longer term number of psychiatric intensive care unit (PICU) admissions from Wakefield.
• Learning visits with Bradford have been held and activity is now taking place to develop systems that focus on facilitating discharges as soon as it is clinically appropriate.
• Learning visit also held in Tyne, Esk and Weir Valley NHS Foundation Trust around their recent PICU changes.

Clinical Record System
• 100% of the co-design workshops have been completed, marking the end of the co-design phase.
• The initial data production has been completed successfully meaning that 300,000 patient records were successfully migrated from Rio and imported into SystmOne in readiness for initial testing.
• Testing of the migrated data by the Trust will commence w/c 25th June.
• The Training workstream have re-planned their approach to training to more closely align with Trust ways of working. They have co-produced a training proposal, including the schedule, as requested by the operational management group.

Older People's Services
Following an EMT decision on the proposed model for the older people's services transformation project permission has been granted to move into commissioner conversations.

Priority	Scope	Narrative Update	Area	RAG
IMPROVING CARE				
Safety First, Quality Counts				
South Yorkshire Projects: Stroke Service Review	Work with our South Yorkshire partners to deliver shared objectives as described in the Sustainability and Transformation plan. This includes work on: • Stroke service review	An initial meeting has been set up to drive forward the work necessary in agreeing and documenting the scope for this priority and determining the boundaries of the work involved, governance arrangements and resource implications.	Progress Against Plan	
		No known risks identified at this time.	Management of Risk	
		Implementation Plan is in development		
South Yorkshire Projects: Neurological rehabilitation	Work with our South Yorkshire partners to deliver shared objectives as described in the Sustainability and Transformation plan. This includes work on: • Neurological rehabilitation	• The governance route for this priority is via the Trusts operational management group (OMG) and is reported bi-monthly on the IPR. • Barnsley clinical commissioning group (CCG) has informed SWYPFT that from 1 October 2018 it will be reducing the number of neuro rehabilitation unit (NRU) beds it commissions from the current twelve to eight.	Progress Against Plan	
		No known risks identified at this time.	Management of Risk	
		Implementation Plan is in development		
South Yorkshire Projects: Autism and ADHD	Work with our South Yorkshire partners to deliver shared objectives as described in the Sustainability and Transformation plan. This includes work on: • Autism and ADHD	The governance route for this priority is via the transformation board and is reported bi-monthly on the IPR. There is no update this time but a report will be included in the July IPR.	Progress Against Plan	
		No known risks identified at this time.	Management of Risk	
		Implementation Plan is in development		
West Yorkshire Projects: Forensics	Work across the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) to deliver shared objectives with our partners in the area of: • Forensics: work with NHS and private sector partners in the region to develop and deliver a co-ordinated approach to forensic care.	This is a continuing priority from 2017/18 • Work had commenced with the Trust working with NHS and private sector partners in the region to develop and deliver a co-ordinated approach to forensic care however NHSE have formally paused this work whilst other changes take place and therefore this priority is currently paused.	Progress Against Plan	N/A
		None	Management of Risk	N/A
		Project Paused		
West Yorkshire Projects: Community Forensics CAMHS	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&H HCP) to deliver shared objectives with our partners in the area of: • Community Forensic CAMHS	This is a continuing priority from 2017/18 • A variation to the secure estate contract is in place and partner sub-contracts are awaiting further information prior to final sign off. • Due diligence is ongoing by SWYPFT for all partners. • Forensic CAMHs (FCAMHs) partnership board and FCAMHs operational meetings are established and ongoing. • Acceptance of referrals continues through the single point of access (SPA). • Communication and promotion of the service to agencies across the region continues. • Monthly key performance indicators (KPI) reporting has commenced.	Progress Against Plan	

West Yorkshire Projects: Community Forensics CAMHS		• There are currently no high level risks identified in this project. • Risk sharing agreements are being developed for the partnership	Management of Risk	
				
West Yorkshire Projects: Forensic Community Mental Health	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&H HCP) to deliver shared objectives with our partners in the area of: • Forensic community mental health	In February 2018, NHSE approached SWYPFT regarding an opportunity to be one of three wave 1 trial sites for a specialist community forensic team. A bid was duly prepared for this opportunity and submitted. We have been informed that our bid was not successful and that SWYPFT have not been chosen as one of the three specialist community forensic team wave 1 trial sites. Following initial verbal feedback on the bid our forensic services team have been invited to take part in a learning network with those from the successful wave 1 specialist community forensic team sites and further formal feedback on the bid has been requested. Wave 2 will be open for applications in September/October this year.	Progress Against Plan	N/A
		Not applicable	Management of Risk	N/A
		Not applicable		
West Yorkshire Projects: Forensic Community LD	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&H HCP) to deliver shared objectives with our partners in the area of: • Forensic community learning disability	• NHSE requested a proposal from SWYPFT for provision of a community forensic learning disability Service to support individuals with learning disability and autism who display offending behaviour more effectively within the community, safely managing risk and avoiding contact with the criminal justice system or admission to secure hospital where possible. • This request was within the context of the planned closure of some secure learning disability inpatient beds across the Yorkshire and Humber region which is thought will deliver savings of £6.4 million, of which approximately £4 million is planned to be invested across the three sustainability and transformation plans (STP) regions into community services to support the learning disability (LD) population. • SWYPFT were asked to provide a proposal for provision of a Community Forensic Learning Disability Service to the West Yorkshire STP, which was submitted to NHSE in September. • Following this submission NHSE have invited all Trusts who expressed an interest in this provision to work together to ensure consistency of new service model. SWYPFT was asked to develop a proposal for West Yorkshire, building on our original bid. • NHSE have invited bids for £50k initial implementation funding for this service, which SWYPFT have submitted in March 2018. • We are currently awaiting confirmation of funding.	Progress Against Plan	

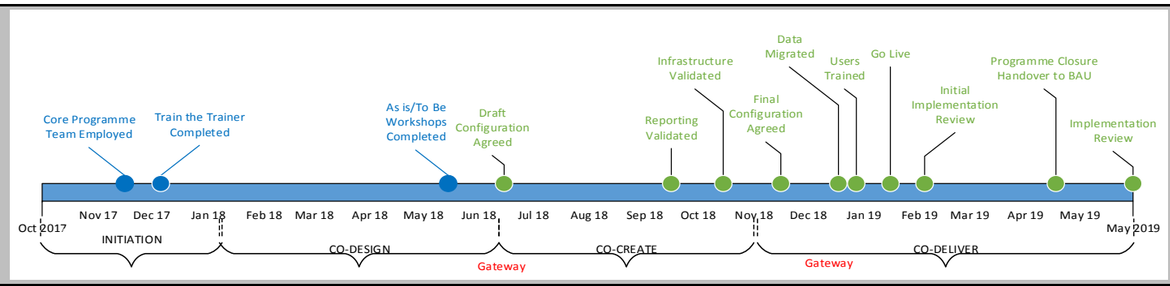
		No known risks identified at this time.	Management of Risk	
		An implementation plan will be developed once a successful bid is approved		
West Yorkshire Projects: Improving Autism and ADHD	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&H HCP) to deliver shared objectives with our partners in the areas of: • Improving autism and ADHD	The Trust is going to be lead provider for the adult pathways across the West Yorkshire Mental Health collaborative. Development of an implementation plan of key milestones are yet to be identified.	Progress Against Plan	
		No known risks identified at this time.	Management of Risk	
		Development of an implementation plan of key milestones is yet to be identified		
West Yorkshire Projects: Learning Disability ODN	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&H HCP) to deliver shared objectives with our partners in the area of: • Learning Disability ODN (Organisational Development Network)	The Trust was successful in being selected to host an Operational Delivery Network (ODN) for learning disabilities and autism in Yorkshire and Humberside from April 2018. Mobilisation of the ODN and initial scoping for the network and drafting of a plan for the network has commenced. • Work on agreeing and documenting the scope for this new priority and determining the boundaries of the work involved, governance arrangements and resource implications continues. • NHSE have asked that SWYPFT establishes an initial meeting with other ODN providers and focuses on how we will appoint clinical leadership for this priority • Priority is being supported by the integrated change team	Progress Against Plan	
		No known risks identified at this time.	Management of Risk	
		An implementation plan is in development.		
West Yorkshire Projects: Inpatient CAMHS	Work across the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) to deliver shared objectives with our partners contributing to the following areas of work across WY&H HCP: • Inpatient CAMHS	• Work in this project is focused on the delivery of 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. • The project is two-year pilot • SWYPFT contribution to the new care model 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 Projects: Eating Disorders	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&H HCP) to deliver shared objectives with our partners contributing to the following areas of work across WY&H HCP: • Eating Disorders	• 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 eating disorders West Yorkshire and Harrogate network includes SWYPFT as a partner. • Funding has been secured though STP new models of care (NMoC) work stream • SWYPFT are active on the new care models programme board and steering group	Progress Against Plan	
		Any implementation risks are with Leeds and do not transfer to SWYPFT	Management of Risk	
		Implementation plan in development		

IMPROVING RESOURCES

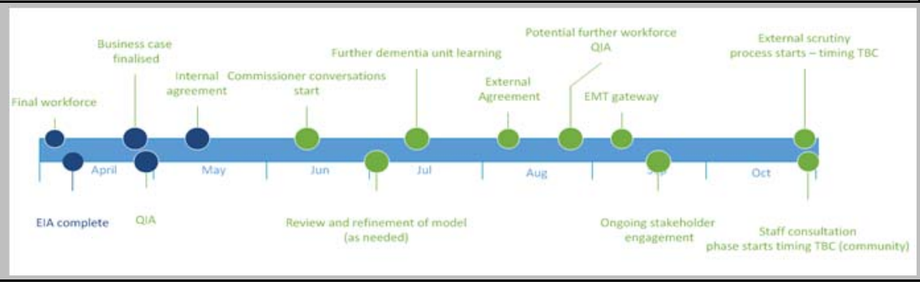
Operational Excellence

Flow and out of area beds	Stop people under the care of SWYPFT being placed out of area and ensure everyone is as near to their own home as possible. Work with others across West Yorkshire & Harrogate to help stop all of us placing people out of area. Implement Personality disorder pathway.	• Bed pressures remain in the system and the long term trend of high OOA placements has continued through May. • Local change plans have now been agreed. Key priority areas include reducing the number of admissions in Calderdale and Kirklees, reducing LOS elsewhere and a focus on higher longer term number of PICU admissions from Wakefield. • Learning visits with Bradford have been held and activity is now taking place to develop systems that focus on facilitating discharges as soon as it is clinically appropriate. • Learning visit also held in TEWV around their recent PICU changes. • The patient flow event in Calderdale, sponsored by the Academic Health Science Network, was held on 1 May 2018 with a range of stakeholders. It focussed on the issues that lead to hospital bed use in that locality. A write up has now been received and key issues themed so they can feed into local plans.	Progress Against Plan	
		Current risk is that we continue send people out of area, which has an adverse impact on their care. This risk remains off project trajectory with ongoing pressures across the system.	Management of Risk	
				
Workforce Productivity	Develop & deliver clinical support worker strategy. Develop new roles to improve rostering, reduce agency spend and enhance skill mix. Develop & deliver a retention strategy.	• Initial meeting held with Karen Taylor and Alan Davis to agree scope. • TAG group for workforce productivity to be set up. • The retention strategy for the Trust has been written and signed off at EMT, Board and with NHS Improvement as external support. • Lead identified for recruitment and retention strategy is workforce planning lead (Richard Butterfield) with support from integrated change team. • Initial scoping meeting conducted. • Further monthly steering group and task groups meetings being arranged. • Draft action plan is now in development for recruitment and retention strategy and a small project team in place. Activity is being led by workforce planning lead (Richard Butterfield) and the Integrated Change Team are supporting. Current focus is to ensure that activity required is well defined and that there are action owners in place for each strand of activity.	Progress Against Plan	

		A risk review will take place in June and initial risks will be identified on the next report.	Management of Risk	
		Implementation Plan is in development.		
People at the Centre				
Compassionate Leadership				
Digitally Enabled				
Clinical record system	Plan and deliver a new clinical record system which supports high quality care	• We've completed 100% of our co-design workshops which marks the end of our co-design phase. • The initial data production completed successfully meaning that ~300,000 patient records were successfully migrated from Rio and imported into SystmOne in readiness for initial testing by TPP. • The first phase of testing of the migrated data by the Trust has been postponed to w/c 25th June, making use of time from the planned contingency. This was due to problems TPP were experiencing in getting the data from the extract from RiO into SystmOne; these initial issues have been successfully resolved. The overall programme schedule remains on track. • The Training workstream have re-planned their approach to training to more closely align with Trust ways of working. They have co-produced a training proposal, including the schedule, as requested by the operational management group. This is due to go to OMG on the 6th June for approval. Work is now taking place with IM&T to standardise lesson plans and ensure these are fit for purpose and for transfer to BAU.	Progress Against Plan	
		Risks Identified: • Risk ID 1223: Change Management - In the event of staff not engaging there will be a risk of not capturing all processes/ways of working which will result in incorrect configuration of SystmOne for Mental Health • Risk ID 1224 Training - In the event of staff not being trained there will be a risk of staff unable to access the clinical records system which will result in lack of visibility of the shared record • Risk ID 1251 Cutover - during the transition (cut over) period before go live there is no clinical record system to use, there will be a risk of services have to revert to services business continuity plans and there will be no access to an electronic patient record which will result in delay and inconvenience to patients, services and staff followed up later by the need to re-enter data from paper and the inability to produce reports. • Risk ID 1261 Reporting server is not available in line with planned assumptions to commence report build. Linked to Infrastructure Risk ID 1293 • Risk ID 1281 Reporting - It is currently unclear whether data that will be migrated from RiO to SystmOne will be suitable for use for reporting. If not suitable, reporting will need to "stitch together" RiO and SystmOne data. • Risk ID 1285 Data Migration - Delays in organisational sign off of DM options appraisal - Timescale slippage; clinical staff feeling disengaged from the process - Data migration timetable is delayed causing risk to project timescale/go-live date • Risk ID 1293 Infrastructure – Following the assessment of the infrastructure to meet the suppliers warranted environment specification (WES), there may be insufficient funding available to comply • Risk ID 1305 Configuration - Insufficient time for system analysts to create required configuration from co-design workshop output • Risk ID 1316 Testing – It is not possible to replicate the live environment in full prior to system go-live, which might reveal poor technical performance, system user authentication issues, technical unit limits being exceeded, inadequate clinical data availability and reporting	Management of Risk	

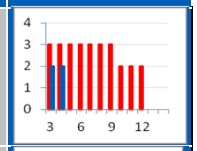
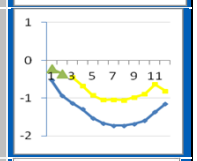
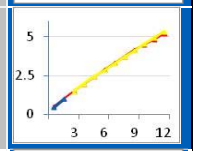
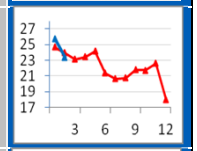
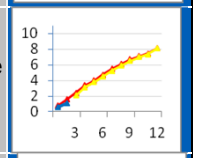
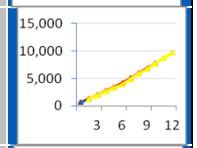
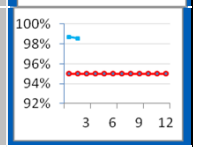


Older Peoples Services Transformation	Co-produce, develop and agree a new model of care for older people with mental health difficulties that improves outcomes, experience and efficiency. To effectively implement this model and demonstrate the impact.	Since the last update: • The project team are moving into the next phase of the project, following the EMT discussions on 3 May, where there was full support for the proposed model and permission to move into commissioner conversations. • A paper has been drafted to EMT to establish and confirm that the project is now / remains a Trust priority. Initial conversations have been held with commissioners, a summary slide pack shared and further conversations are planned for late June.	Progress Against Plan	
		• We will need to receive wide external support from partners to take the inpatient options being considered through an external consultation process. • The ongoing risk of slippage in the project timescale due to limited capacity across the project and across the business delivery units (BDU) remains, the project will need to ensure it is well resourced when moving on beyond commissioner conversations.	Management of Risk	



Overall Financial Performance 2017 / 2018

Executive Summary / Key Performance Indicators

	Performance Indicator	Year to date	Forecast	Narrative	Trend
1	NHS Improvement Finance Rating	2	2	The year to date deficit positon is currently favourable to plan and results in an I & E margin metric of 3. All other metrics were in line with plan or better. This is a deterioration from the rating of 1 achieved in 2017/18.	
2	Normalised Surplus (inc STF)	(£0.3m)	(£1.2m)	May 2018 finance performance excluding Provider Sustainability Fund (PSF) is ahead of plan at a deficit of £0.5m. Including PSF this is a deficit of £0.3m. The year end forecast is in line with plan with a deficit of £1.2m including PSF and £2.6m excluding PSF.	
3	Agency Cap	£1m	£5.3m	Agency expenditure in May 2018 is above the NHS Improvement cap at £0.5m. The year end forecast of £5.3m exceeds the NHSI Agency cap by £0.1m (2%).	
4	Cash	£23.4m	£18m	The Trust cash position is £0.6m below plan in May. Outstanding debts are being chased.	
5	Capital	£1.1m	£8.1m	Capital Expenditure is £0.5m lower than plan to date and is expected to be back in line with plan by the end of quarter 1.	
6	Delivery of CIP	£0.6m	£9.7m	Year to date CIP delivery is £0.1m behind plan (5%). At May 2018 the forecast position assumes delivery of the potential upside scenarios. There is currently £1.6m not confirmed.	
7	Better Payment	99%		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

Contracting - Trust Board

Contracting Issues - General

New contracts commenced from 1 April 2018 for the following services: Barnsley musculo skeletal (MSK), Doncaster smoke free, Wakefield tuberculosis (TB), regional community forensic child and adolescent mental health services (CAMHs) and secure stairs within the forensics secure estate. The contract variation with NHS England for forensic services remains to be agreed.

Commissioning for Quality and Innovation (CQUIN)

Q4 17/18 Forecast is £2,031k against a target of £2,067k, final position cannot be confirmed until end of June when national results of Centre for Quality Improvement (CCQI) audit for Early Intervention in Psychosis are published.
Q1 18/19 No delivery problems anticipated

Contracting Issues - Barnsley

Key strategic work areas in Barnsley continue across intermediate care, Respiratory, MSK and stroke services. The new MSK service was successfully mobilised and commenced 1 April 2018. Diabetes services transferred to BHNFT on 1 April 2018. Barnsley CCG has confirmed investment to increase capacity for police to access advice from mental health practitioners to inform section 136 admissions to meet requirements set out in the Police and Crime Act. Barnsley Clinical Commissioning Group has confirmed the intention for additional investment within adult attention deficit hyperactivity disorder (ADHD) / autism spectrum disorder (ASD) services.

Contracting Issues - Calderdale

An enhanced ASD service for adults commenced from 1 April 2018. Key ongoing work streams include the mobilisation and implementation of the expansion of IAPT services to long term conditions and continued 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. Ongoing in year priorities include early intervention in psychosis services, mental health liaison and 24/7 intensive home based treatment services.

Contracting Issues - Kirklees

The current priority areas of work related to Kirklees CCG's contracts include Improving Access to Psychological Therapies (IAPT) services and expansion to core IAPT services and long term conditions, expansion of early intervention In psychosis services and continued implementation of the perinatal service across Barnsley, Wakefield, Calderdale and Kirklees. An enhanced specialist ASD service for adults commenced on 1 April 2018.

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. The new TB service was successfully mobilised and commenced 1 April 2018.

Contracting Issues - Forensics

Following successful award of the lead provider role for the Yorkshire & Humber delivery of community forensic CAMHs work continues on implementation. Implementation of secure stairs within the forensics secure estate is ongoing.

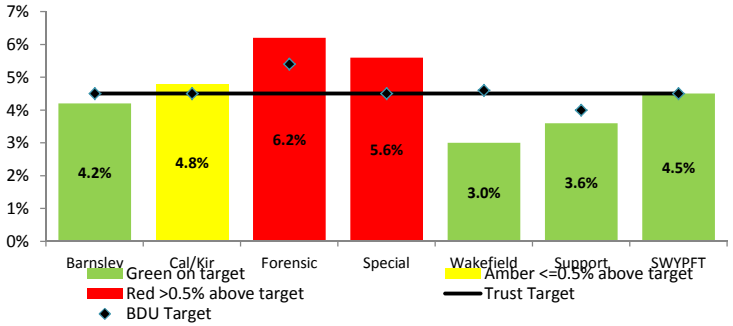
Contracting Issues - Other

The new smoke free services model for Doncaster commenced 1 April 2018.

Workforce

Human Resources Performance Dashboard - May 2018

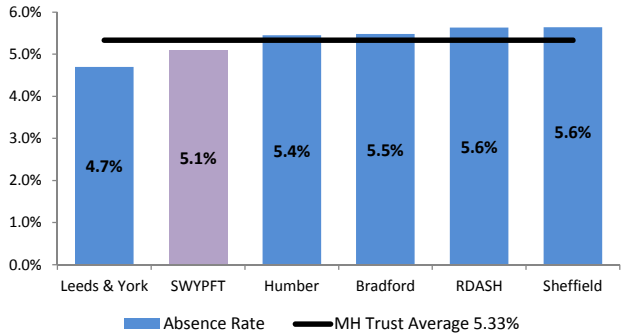
Sickness Absence



Current Absence Position and Change from Previous Month - May 2018

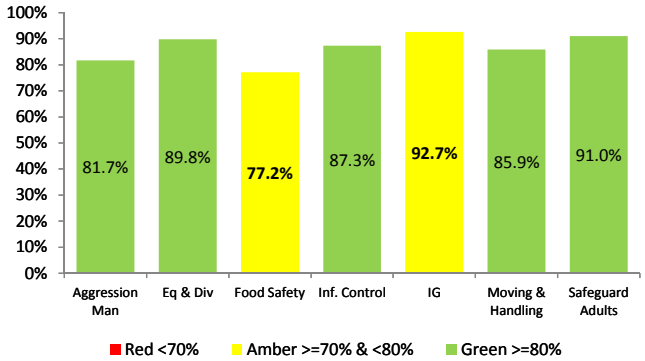
	Barn	Cal/Kir	Fore	Spec	Wake	Supp	SWYPFT
Rate	4.0%	4.8%	6.1%	5.8%	3.3%	3.7%	4.4%
Change	↓	↓	↓	↑	↑	↑	↓

The Trust YTD absence levels in May 2018 (chart above) were on target at 4.5%



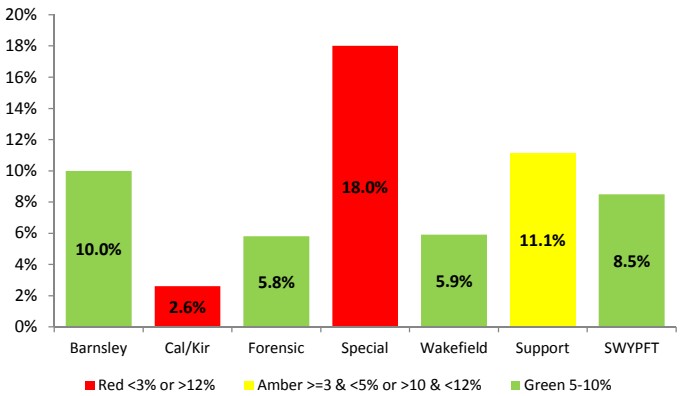
The above chart shows the YTD absence levels in MH/LD Trusts in our region for the period April 2017 to December 2017.
During this time the Trust's absence rate was 5.10% which is below the regional average of 5.33%.

Mandatory Training - All Staff

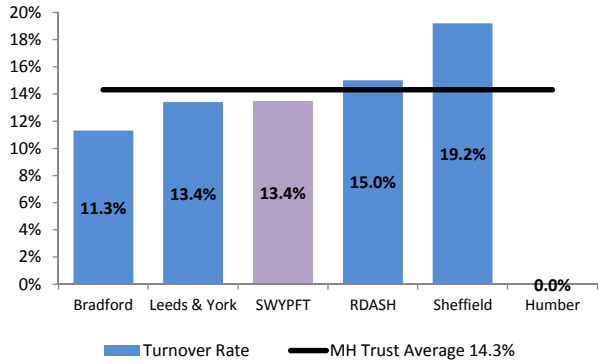


The above chart shows the mandatory training rates for the Trust to the end of May 2018.
The Trust target for all mandatory training is 80% apart from Information Governance (IG) which has a target of 95%. All are based on a rolling year.

Turnover and Stability Rate Benchmark

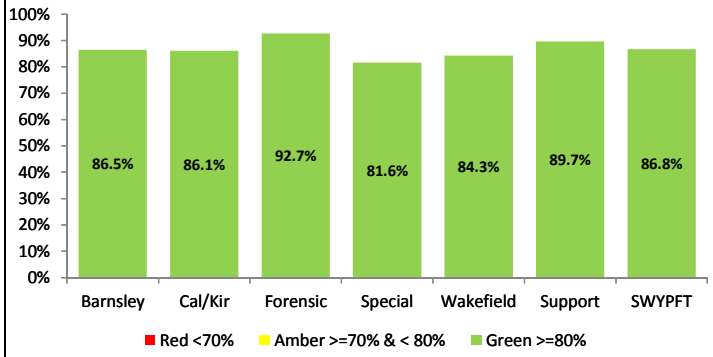


This chart shows the YTD turnover levels up to the end of May 2018.
Turnover figures may look out of line with the average across the Trust but this is because of the small amount of data; the figures will level out over the new reporting year.
*The turnover data excludes recently TUPE'd services



This chart shows turnover rates in MH Trusts in the region for the 12 months ending in February 2018. The turnover rate shows the percentage of staff leaving the organisation during the period.
This is calculated as: leavers/average headcount.
SWYPFT figures exclude decommissioned service changes.
Figures for Humber are not available.

Fire Training Attendance



The chart shows the 12 month rolling year figure for fire lectures to the end of May 2018. The Trust continues to achieve the 80% target across all BDUs.

Workforce - Performance Wall

Trust Performance Wall

Month	Objective	CQC Domain	Owner	Threshold	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Sickness (YTD)	Improving Resources	Well Led	AD	<=4.5%	4.7%	4.8%	4.9%	4.9%	5.0%	5.0%	5.1%	5.2%	5.3%	5.3%	4.5%	4.5%
Sickness (Monthly)	Improving Resources	Well Led	AD	<=4.4%	4.8%	5.0%	5.2%	5.0%	5.2%	5.6%	5.8%	6.2%	6.0%	4.9%	4.5%	4.4%
Appraisals (Band 6 and above) 1	Improving Resources	Well Led	AD	>=95%	61.3%	80.9%	89.0%	91.0%	92.7%	97.6%	98.1%	97.9%	97.8%	97.8%	7.3%	26.1%
Appraisals (Band 5 and below)	Improving Resources	Well Led	AD	>=95%	18.4%	31.1%	46.2%	75.8%	82.7%	95.5%	95.7%	95.9%	95.9%	96.0%	0.8%	2.8%
Aggression Management	Improving Care	Well Led	AD	>=80%	78.1%	76.6%	77.0%	77.6%	76.4%	79.0%	78.0%	77.9%	78.2%	79.3%	79.3%	81.7%
Cardiopulmonary Resuscitation	Improving Care	Well Led	AD	>=80% by 31/3/17	74.7%	73.1%	71.9%	73.4%	72.8%	75.4%	76.6%	77.0%	78.5%	81.4%	82.3%	84.0%
Clinical Risk	Improving Care	Well Led	AD	>=80% by 31/3/17	69.1%	74.6%	77.3%	79.2%	80.7%	82.3%	82.5%	83.8%	85.3%	85.1%	85.6%	85.5%
Equality and Diversity	Improving Health	Well Led	AD	>=80%	86.0%	86.6%	87.1%	85.7%	85.4%	87.0%	86.9%	88.3%	88.9%	88.5%	89.0%	89.8%
Fire Safety	Improving Care	Well Led	AD	>=80%	81.5%	81.8%	82.6%	82.8%	82.8%	83.3%	82.4%	83.8%	84.6%	85.4%	85.3%	86.8%
Food Safety	Improving Care	Well Led	AD	>=80%	80.3%	79.1%	79.2%	77.0%	76.2%	78.4%	78.6%	79.3%	77.8%	77.2%	76.2%	77.2%
Infection Control and Hand Hygiene	Improving Care	Well Led	AD	>=80%	84.0%	83.7%	83.6%	82.3%	81.8%	83.2%	83.2%	85.0%	86.5%	86.8%	87.0%	87.3%
Information Governance	Improving Care	Well Led	AD	>=95%	91.3%	90.4%	89.1%	88.3%	86.2%	85.9%	83.8%	89.2%	95.7%	96.5%	92.4%	92.7%
Moving and Handling	Improving Resources	Well Led	AD	>=80%	78.8%	79.3%	79.3%	79.3%	80.7%	81.6%	81.9%	84.1%	85.4%	85.5%	85.2%	85.9%
Mental Capacity Act/DOLS	Improving Care	Well Led	AD	>=80% by 31/3/17	78.0%	82.5%	86.1%	87.6%	88.9%	90.3%	91.1%	91.0%	91.1%	90.7%	91.1%	91.4%
Mental Health Act	Improving Care	Well Led	AD	>=80% by 31/3/17	70.5%	75.0%	80.3%	81.6%	83.4%	84.7%	86.6%	86.4%	86.0%	84.7%	85.7%	86.8%
No of staff receiving supervision within policy guidance	Quality & Experience	Well Led		>=80%		61.0%				64.7%			86.5%		Due end of Q1	
Safeguarding Adults	Improving Care	Well Led	AD	>=80%	86.7%	86.2%	86.0%	86.3%	86.3%	87.4%	87.8%	89.0%	89.8%	89.9%	90.0%	91.0%
Safeguarding Children	Improving Care	Well Led	AD	>=80%	83.6%	84.3%	84.7%	84.8%	84.1%	85.4%	85.1%	86.7%	87.5%	87.8%	88.4%	88.6%
Sainsbury's clinical risk assessment tool	Improving Care	Well Led	AD	>=80%	91.7%	93.2%	94.2%	94.2%	92.9%	93.4%	93.3%	93.8%	94.3%	93.4%	94.4%	95.1%
Bank Cost	Improving Resources	Well Led	AD	-	£579k	£576k	£518k	£614k	£545k	£534k	£534k	£604k	£655k	£907k	£557k	£603k
Agency Cost	Improving Resources	Effective	AD	-	£500k	£457k	£446k	£435k	£515k	£531k	£430k	£465k	£563k	£555k	£444k	£538k
Overtime Costs	Improving Resources	Effective	AD	-	£9k	£9k	£12k	£12k	£7k	£10k	£8k	£11k	£13k	£6k	£8k	£13k
Additional Hours Costs	Improving Resources	Effective	AD	-	£48k	£44k	£38k	£45k	£44k	£50k	£39k	£34k	£24k	£23k	£29k	£15k
Sickness Cost (Monthly)	Improving Resources	Effective	AD	-	£487k	£493k	£527k	£499k	£547k	£550k	£594k	£633k	£532k	£483k	£426k	£436k
Business Miles	Improving Resources	Effective	AD	-	285k	299k	267k	283k	291k	265k	305k	271k	275k	230k	274k	264k

1 - this does not include data for medical staffing.

Workforce - Performance Wall cont….

Notes:

Green Compliance Status:
• Aggression Management – 81.7% 2.4% increase on last month and the subject has moved from amber to green status.
The Aggression Management/Physical Interventions is at 89.4% compliance (Forensic services at 92.1%).
• Cardio Pulmonary Resuscitation – 84% 1.7% increase on last month. This is the 7th consecutive month that CPR compliance has increased.
• Clinical Risk – 85.5% no significant change on last month.
• Equality and Diversity – 88.8% no significant change on last month.
• Fire Safety – 86.8% 1.5% increase on last month. The 95% compliance requirement for ward based staff is monitored at service level and no particular 'hot spots' were highlighted this month.
• Infection Control and Hand Hygiene – 87.3% no significant change on last month.
• Mental Health Act – 86.9% 1.2% increase in compliance from last month.
• Mental Capacity Act – 91.4% no significant change in compliance from last month.
• Moving and Handling – 85.9% slight increase on last month. Training has resumed in the Barnsley BDU and is now based at Monk Bretton HC; dates remain as advertised in the training brochure.
• Safeguarding Adults – 91% 1% increase on last month
• Safeguarding Children – 88.6% no significant change in compliance from last month
• Sainsbury's Tool – 95% no significant change in compliance from last month

Amber Compliance Status:
• Data Security Awareness Level 1 (formally IG) – 92.7% no significant change on last month.
• Food Safety – 77.2% 1% increase on last month. The review of Food Safety training continues with regard to reviewing staff groups that require mandatory Food Safety training according to their role.

Red Compliance Status:
No mandatory training subjects were in red compliance for this period

Sickness
• The Trust sickness has shown a positive downward trend in both April and May and the year to date sickness rate is currently 4.5%. Whilst we would expect to see a lower sickness rate in April and May these are both lower than the figures for the same time last year.
• Wakefield BDU has shown a significant reduction in its sickness rate and at 3% is the lowest in the Trust. Barnsley BDU and Corporate Services are also below target levels with Calderdale and Kirklees BDU only slightly above. Specialist Services has seen a slight drop in sickness rate compared to the same period last year (Apr -May 17/18 5.8%, 18/19 5.6%) but is still above the target level. Forensic has the same sickness rate as at the same time last year and remains above target
• 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 E-Rostering has been developed for absence due to musculo-skeletal 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.
• 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 healthy teams.
• Staff counselling is now fully recruited to and waiting times have reduced significantly.
• New valued based appraisal has a stronger focus on health and wellbeing
• Wellbeing group established in forensic services and plan to roll these out across all BDUs

Publication Summary

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

Direct access audiology waiting times: March 2018

NHS sickness absence rates: January 2018

NHS workforce statistics: February 2018

Bed availability and occupancy: Q4 2017/18

NHS Improvement provider bulletin: 23 May 2018

Quarterly hospital activity data: Q4 2017

NHS Improvement provider bulletin: 30 May 2018
- consultancy spending approvals and requirements
- innovative approaches to retention
- effective workforce planning

NHS Improvement update: May 2018

NHS Improvement provider bulletin: 6 June 2018
- provider sector performance
- corporate services toolkit

Psychological therapies: reports on the use of IAPT services, England: March 2018 final, including reports on the IAPT pilots and Q4 2017-18 data

Provisional monthly Hospital Episode Statistics for admitted patient care, outpatient and accident and emergency data: April 2017-March 2018

Out-of-area placements in mental health services: March 2018

Mental health services monthly statistics, final: March 2018

Monthly hospital activity data: April 2018

Mixed-sex accommodation breaches: April 2018

Mental health early intervention in psychosis: April 2018

Delayed transfers of care: April 2018

NHS Improvement provider bulletin: 13 June 2018
- analytical services and information teams
- reducing reliance on medical agency staff
- NHS pay deal

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Finance Report

Month 2
(2018 / 19)

Appendix 1

With **all of us** in mind.

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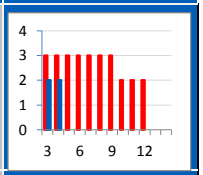
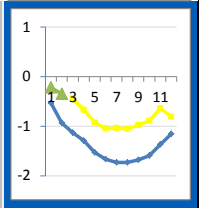
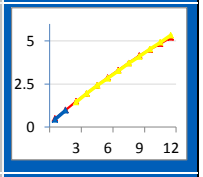
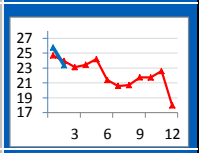
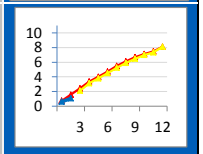
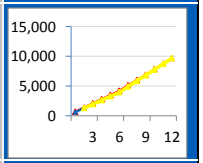
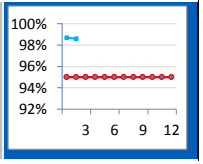
Contents

1.0 Executive Summary / Key Performance Indicators

Performance Indicator		Year To Date	Forecast	Narrative	Trend
1	NHS Improvement Finance Rating	2	2	The year to date deficit positon is currently favourable to plan and results in an I & E margin metric of 3. All other metrics were in line with plan or better. This is a deterioration from the rating of 1 achieved in 2017/18.	
2	Normalised Deficit (inc PSF)	(£0.3m)	(£1.2m)	May 2018 finance performance excluding Provider Sustainability Fund (PSF) is ahead of plan at a deficit of £0.5m. Including PSF this is a deficit of £0.3m. The year end forecast is in line with plan with a deficit of £1.2m including PSF and £2.6m excluding PSF.	
3	Agency Cap	£1m	£5.3m	Agency expenditure in May 2018 is above the NHS Improvement cap at £0.5m. The year end forecast of £5.3m exceeds the NHSI Agency cap by £0.1m (2%).	
4	Cash	£23.4m	£18m	The Trust cash position is £0.6m below plan in May. Outstanding debts are being chased.	
5	Capital	£1.1m	£8.1m	Capital Expenditure is £0.5m lower than plan to date and is expected to be back in line with plan by the end of quarter 1.	
6	Delivery of CIP	£0.6m	£9.7m	Year to date CIP delivery is £0.1m behind plan (5%). At May 2018 the forecast position assumes delivery of the potential upside scenarios. There is currently £1.6m not confirmed.	
7	Better Payment	99%		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.

			Actual Performance		Plan - Month 2	
Area	Weight	Metric	Score	Risk Rating	Score	Risk Rating
Financial Sustainability	20%	Capital Service Capacity	2.0	2	1.0	4
	20%	Liquidity (Days)	23.4	1	21.1	1
Financial Efficiency	20%	I & E Margin	-1.0%	3	-2.6%	4
Financial Controls	20%	Distance from Financial Plan	1.7%	1	0.0%	1
	20%	Agency Spend	-1.8%	1	0.0%	1
Weighted Average - Financial Sustainability Risk Rating				2		3

Impact

The current finance risk rating is 2. The Trust's I & E Margin is less than a deficit of 1% at month 2, achieving a risk rating of 3 (this is ahead of the planned position). As no individual metric is 4 this means that the maximum threshold of 3 is not applied this month.

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 £5.2m has been set for the Trust in 2018 / 2019. This metric compares performance against this cap.

1.2 NHS Financial Context

Provider Type	Plan £m	Forecast £m	Variance £m	Deficit Providers	Variance - Q3 £m	Movement £m
Acute	(1,068)	(1,717)	(649)	89	(1,922)	205
Ambulance	(4)	36	40	0	9	27
Community	28	50	22	3	24	26
Mental Health	125	297	172	6	103	194
Specialist	19	248	229	4	92	156
Total - Deficit	**(900)**	**(1,086)**	**(186)**	**102**	**(1,694)**	**608**
Adjustments	(30)	116	146		(15)	131
Uncommitted STF	434	10	(424)		778	(768)
Adjusted Deficit	**(496)**	**(960)**	**(464)**		**(931)**	**(29)**

NHS Improvement published Quarter 4 draft unaudited performance of the NHS Provider Sector 31st May 2018.

This summarises operational and financial performance for the period of April 2017 to March 2018.

Overall financial performance is a deficit nearly double that originally planned. The consequence of this in the national picture is still to be finalised.

Operationally frontline NHS staff and managers have continually risen to the challenges which they are facing and cared for more patients than ever before. However this surge in demand has affected key NHS performance areas such as waiting times and its reliance on temporary workers. This reliance was already in existence with 93,000 vacancies being noted nationally; an overall vacancy rate of 8%.

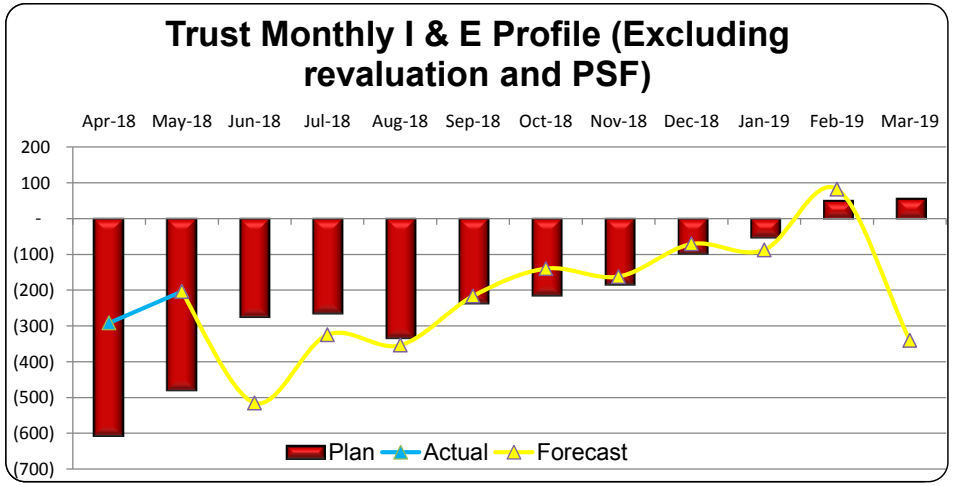
In financial terms the provider sector draft deficit of £960m is £464m higher than planned and a further £29m higher than anticipated in December 2017. However the NHS as a whole is broadly in balance with a draft underspend of £955m being reported by the healthcare commissioning sector. As in previous years a number of one off benefits and savings such as the sale of estate have helped to secure this position.

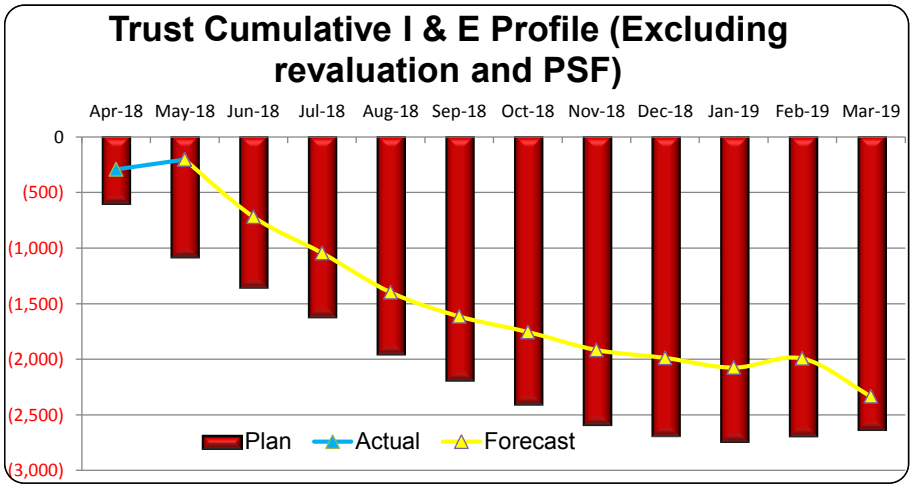
This provider position includes £1,793m of distributed Sustainability and Transformation Funding. (This implies that without this funding an underlying deficit of £2.8bn would have been recorded)

Whilst the majority of deficits are within acute providers (89 out of 136 - 65%) a total of 9 (out of 71 - 13%) Mental Health and Community providers also reported a deficit in 2017/18 although the sectors overall remain in surplus.

2.0 Income & Expenditure Position 2018 / 2019

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
				16,688	16,620	(68)	Clinical Revenue	33,340	33,316	(24)	199,811	199,589	(222)
				16,688	**16,620**	**(68)**	**Total Clinical Revenue**	**33,340**	**33,316**	**(24)**	**199,811**	**199,589**	**(222)**
				1,072	1,148	76	Other Operating Revenue	2,152	2,247	95	12,395	12,342	(54)
				17,760	**17,768**	**8**	**Total Revenue**	**35,492**	**35,563**	**71**	**212,206**	**211,930**	**(276)**
4,075	4,009	(66)	1.6%	(13,873)	(13,789)	84	Pay Costs	(27,713)	(27,399)	314	(165,680)	(164,319)	1,361
				(3,443)	(3,588)	(145)	Non Pay Costs	(6,973)	(7,024)	(51)	(40,214)	(42,575)	(2,361)
				(141)	179	320	Provisions	(326)	(81)	245	414	1,692	1,278
4,075	**4,009**	**(66)**	**1.6%**	**(17,457)**	**(17,197)**	**260**	**Total Operating Expenses**	**(35,012)**	**(34,505)**	**507**	**(205,480)**	**(205,202)**	**278**
4,075	**4,009**	**(66)**	**1.6%**	**303**	**571**	**267**	**EBITDA**	**480**	**1,059**	**579**	**6,726**	**6,728**	**2**
				(474)	(474)	(0)	Depreciation	(948)	(948)	(0)	(5,671)	(5,673)	(1)
				(310)	(310)	0	PDC Paid	(621)	(620)	1	(3,726)	(3,725)	1
				4	9	6	Interest Received	8	13	6	45	43	(2)
4,075	**4,009**	**(66)**	**1.6%**	**(477)**	**(204)**	**273**	**Normalised Surplus / (Deficit) Excl PSF**	**(1,081)**	**(496)**	**585**	**(2,626)**	**(2,626)**	**0**
				74	74	0	PSF (Provider Sustainability Fund)	148	148	0	1,470	1,470	0
4,075	**4,009**	**(66)**	**1.6%**	**(403)**	**(130)**	**273**	**Normalised Surplus / (Deficit) Incl PSF**	**(933)**	**(348)**	**585**	**(1,156)**	**(1,156)**	**0**
				0	0	0	Revaluation of Assets	0	0	0	0	0	0
4,075	**4,009**	**(66)**	**1.6%**	**(403)**	**(130)**	**273**	**Surplus / (Deficit)**	**(933)**	**(348)**	**585**	**(1,156)**	**(1,156)**	**0**





Income & Expenditure Position 2018 / 2019

Whilst financial performance for the first two months of the year has been positive (in that it is better than planned) the monthly run rate remains at a deficit.

Month 2

The May position is a pre PSF deficit of £204k and a post PSF deficit of £130k, this is £273k ahead of plan. The normalised year to date position is a pre PSF deficit of £496k and a post PSF deficit of £348k, this is £585k ahead of plan. The key headlines are below. Whilst better than plan the recording of a deficit is a concern and the run rate must improve in order to achieve the year-end plan.

In month 2, underspending is on pay and non clinical non pay areas, such as travel and office costs, offset by an overspend on out of area bed placements, drug expenditure and clinical supplies.

Income

At month 2 income is £8k ahead of plan, a full breakdown of Income is shown on page 8.

2018/19 CQUIN income totals £4.3m, a full review of requirements has been undertaken and identified a risk of £0.2m. Actions have been identified to try to reduce this risk.

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 increased in May to £538k, in line with forecast (8% above cap), year to date agency expenditure is 2% below cap.

Non Pay Expenditure

Non pay is overspending by £145k. May 2018 out of area bed placements expenditure has reduced from the extremely high level reported in March 2018 and totalled £363k (£128k overspend). Drugs expenditure remains a pressure, some savings have been identified and will be implemented across the year.

Forecast

Delivery of the financial plan and control total is very challenging and will only be achieved if actions are taken to reduce overspends, deliver existing CIP plans, identify new CIP plans and mitigate risks.

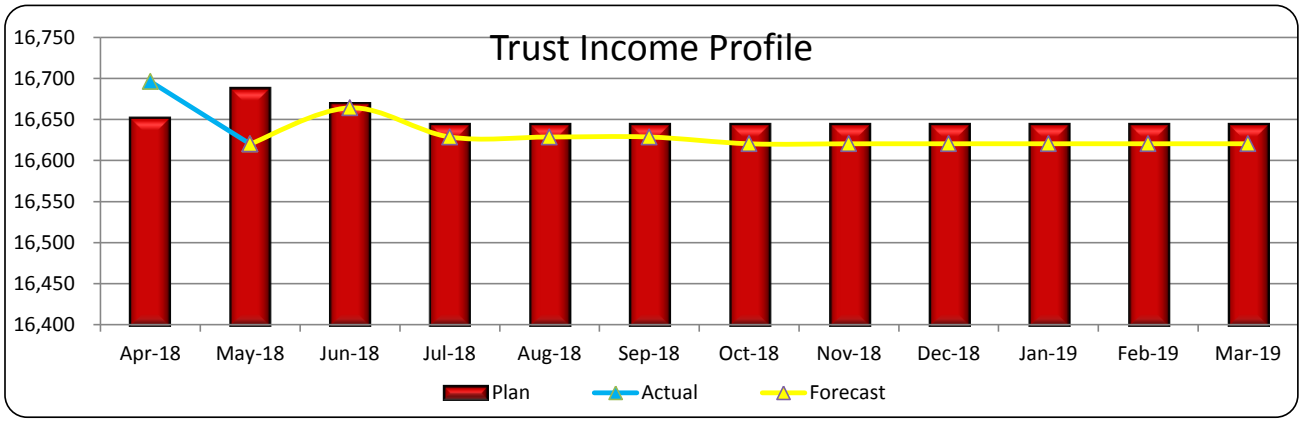
Income Information

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.

Income to date remains in line with agreed contracts and has been invoiced accordingly. A small number of commissioner contracts are unsigned, but are expected to be resolved during June 2018.

The May position includes the first assessment on CQUIN risk for 2018 / 2019 (information was not available for month 1). This has also been factored into the revised forecast position. As per guidance no risk for STP / ICS related CQUIN has been included in the position.

Commissioner	Year to Date			Variance Headlines			Forecast			Variance Headlines		
	Budget £k	Actual £k	Variance £k	CQUIN £k	Other £k	Total £k	Budget £k	Actual £k	Variance £k	CQUIN £k	Other £k	Total £k
CCG	24,265	24,144	(121)	(44)	(77)	(121)	145,147	144,885	(262)	(262)	0	(262)
Specialist Commissioner	3,893	3,893	0	0	0	0	23,356	23,356	0	0	0	0
Alliance	2,158	2,158	0	0	0	0	12,950	12,950	0	0	0	0
Local Authority	843	843	(0)		(0)	(0)	5,060	5,000	(60)		(60)	(60)
Partnerships	1,154	1,154	0	0	0	0	6,922	6,922	0	0	0	0
Other	1,028	1,124	97	0	97	97	6,377	6,477	100	0	100	100
Total	**33,340**	**33,316**	**(24)**	**0 (44)**	**19**	**(24)**	**199,811**	**199,589**	**(222)**	**(262)**	**40**	**(222)**



CQUIN Risk - Summary	YTD	Forecast
Wellbeing Improvement	27	161
Ill Health by Risky behaviour	17	101
Total	**44**	**262**

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 in excess of 75% of total Trust expenditure.

The Trust workforce strategy was approved by Trust board during 2017 / 2018 with the Strategic workforce plan approved in March 2018.

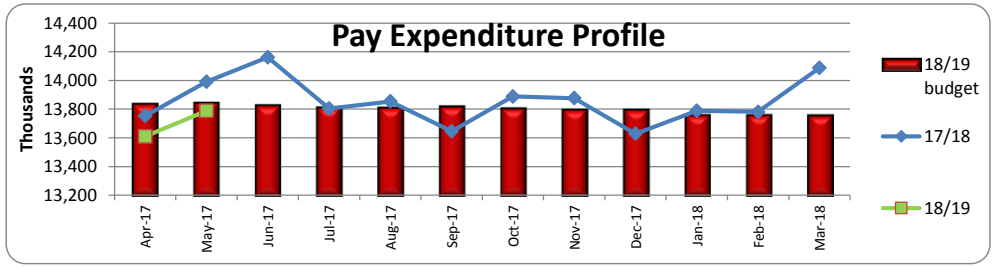
Current expenditure patterns highlight the usage of temporary staff (through either internal sources such as Trust bank or through external agencies). Actions are focussed on providing the most cost effective workforce solution to meet the service needs.

	Apr-18 £k	May-18 £k	Jun-18 £k	Jul-18 £k	Aug-18 £k	Sep-18 £k	Oct-18 £k	Nov-18 £k	Dec-18 £k	Jan-19 £k	Feb-19 £k	Mar-19 £k	Total £k
Substantive	12,595	12,598											**25,193**
Bank & Locum	571	652											**1,223**
Agency	444	538											**982**
Total	**13,610**	**13,789**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**27,399**
17/18	13,752	13,992	14,161	13,804	13,854	13,645	13,889	13,876	13,629	13,788	13,781	14,087	**166,257**

Bank as %	4.2%	4.7%											4.5%
Agency as %	3.3%	3.9%											3.6%

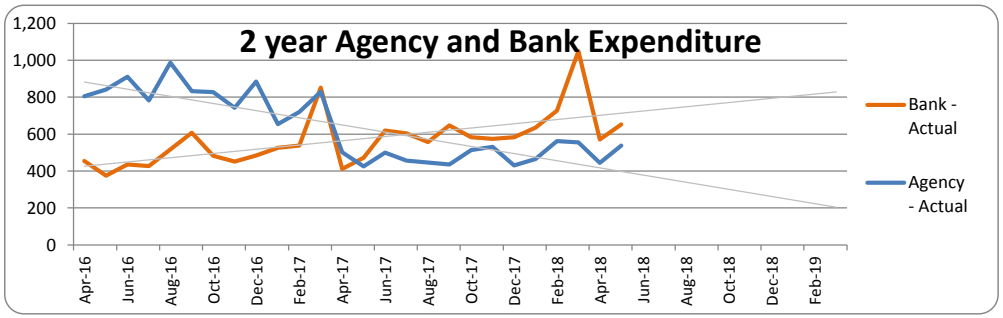
Year to Date expenditure - by staff group

	Substantive £k	Temp £k	Agency £k	Total £k
Medical	2,973	63	529	3,565
Nursing Registered	8,647	380	99	9,126
Nursing Unregistered	2,743	575	232	3,550
Other	6,717	102	123	6,942
Admin	4,113	102	0	4,216
Total	**25,193**	**1,223**	**982**	**27,399**



April WTE Analysis

	Budgeted	Contracted	Bank	Agency	Variance
Medical	211	164	3	18	(26)
Qualified Nursing	1,374	1,241	51	12	(71)
Unqualified Nursing	640	609	114	44	127
Other Clinical	852	766	8	9	(68)
A & C	802	731	24	0	(46)
Other	314	294	8	1	(11)
Staff Vacancy Factor	(118)	0	0	0	118
Total	**4,075**	**3,806**	**207**	**85**	**23**



Key Messages

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 different from plan with the use of temporary staff. The majority of temporary nursing spend is incurred on unregistered nursing on inpatient wards. Demand remains for registered staff but these have been difficult to fill and have on occasions, been filled by unregistered staff. Overall usage is above current substantive workforce establishments in order to meets the demands of the ward.

Substantive pay in May remained at the same level as April however temporary staffing increased by £175k. May 2018 has seen increased usage of bank shifts whilst the agency increase is due to increased acuity on wards and backdated medical agency expenditure.

2.1 Agency Expenditure Focus

The NHS Improvement agency cap for 2018/19 is £5.2m

In May the agency cap was breached by 8%

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 has experienced increased levels of agency spend rising from £3.6m in 2013 / 2014 to £9.8m in 2016 / 2017. A reduction in the number of agency staff used and a reduction in hourly rate paid (in particular qualified nursing staff who are now paid within the NHS Improvement capped rates) resulted in a significantly lower level of agency spend in 2017/18 of £5.8m.

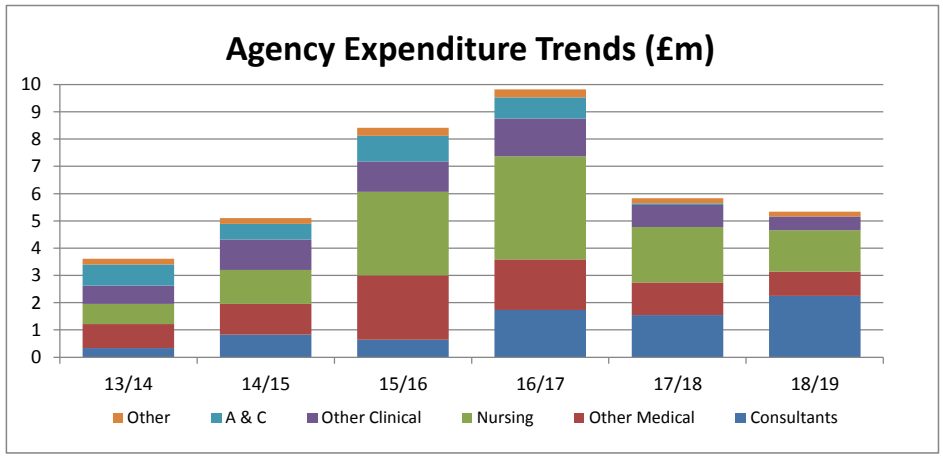
One of these measures was the introduced by NHSI is a maximum agency cap (as monitored within the Trusts risk rating). The Trust cap for 2018 / 2019 is £5.2m, £0.4m lower than the 2017/18 level of agency spend.

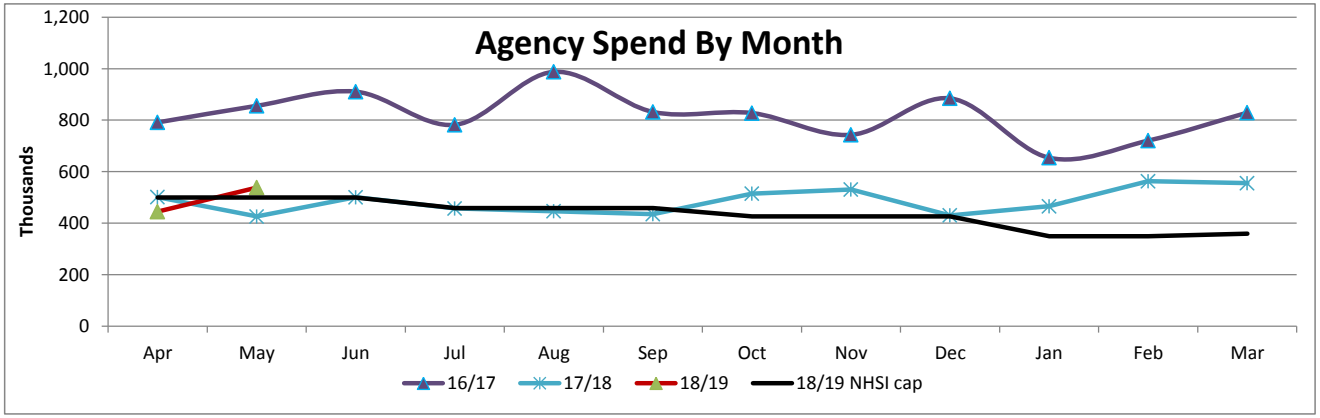
The NHS Improvement cap has been profiled to reduce spend across the year as actions have their desired impact. The cap profile reduces from 500k per month in April 2018 to £359k per month in March 2019. Actual expenditure needs to reduce to remain under this cap.

At month 2 agency spend is £538k, 8% above cap although year to date expenditure is 2% below cap.

This increase has been experienced with medical staff with gaps during April for turnover of staff (£43k) and increased nursing shift requirements to support the inpatient wards.

Agency expenditure is currently forecast at an average of £435k a month breaching the cap by 2%, an average monthly spend of £420k would result in expenditure within cap.



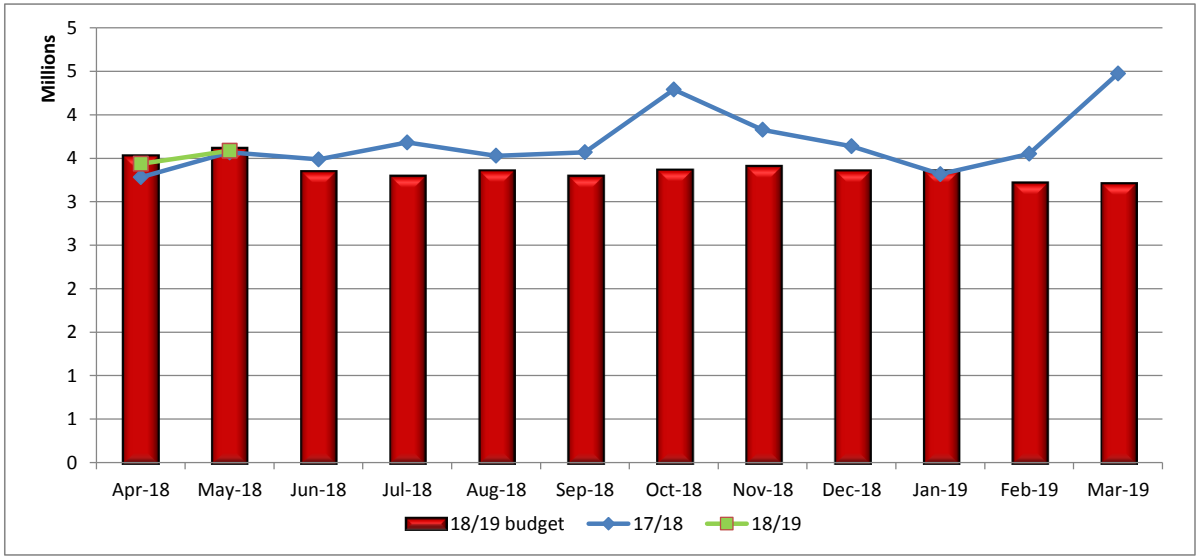


2.1 Non Pay Expenditure

Whilst pay expenditure represents approximately 75% of all Trust 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).

	Apr-18 £k	May-18 £k	Jun-18 £k	Jul-18 £k	Aug-18 £k	Sep-18 £k	Oct-18 £k	Nov-18 £k	Dec-18 £k	Jan-19 £k	Feb-19 £k	Mar-19 £k	Total £k
2018 / 2019	3,437	3,588											**7,024**
2017 / 2018	3,281	3,568	3,488	3,681	3,529	3,570	4,292	3,829	3,637	3,318	3,552	4,474	**44,219**

Non Pay Category	Budget YTD £k	Actual YTD £k	Variance £k
Clinical Supplies	459	498	(39)
Drugs	492	562	(70)
Healthcare subcontracting	998	1,126	(128)
Hotel Services	305	302	3
Office Supplies	871	813	58
Other Costs	724	683	41
Property Costs	946	989	(43)
Service Level Agreements	1,017	992	25
Training & Education	102	67	35
Travel & Subsistence	641	538	103
Utilities	201	223	(22)
Vehicle Costs	218	233	(15)
Total	**6,973**	**7,024**	**(51)**
Total Excl OOA and Drugs	**5,483**	**5,337**	**146**



Key Messages

Healthcare subcontracting relates to the purchase of all non-Trust bed capacity and is overspending by £128k. As a fluctuating pressure the Out of Area focus provides further details on this.

Drugs continue to present a significant financial pressure, savings are being identified using the new system implemented in 2017/18 and are being phased in across 2018/19. To date, savings have been identified with a recurrent full year effect of £263k. This includes the reviewing of prescribing practices, standardisation of drugs used and pricing changes. Drugs spend during 2017 / 2018 was £3.7m (£0.7m for April and May 2017) so the current projection is a reduction although it is important to remember that Trust service provision has also changed during this time.

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 excludes activity relating to locked rehab in Barnsley.

Out of Area Expenditure Trend (£)

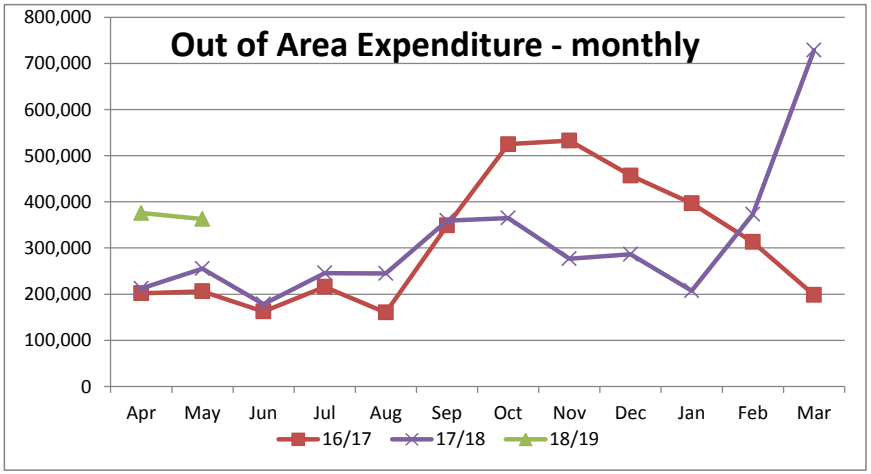
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
16/17	202	206	162	216	160	349	525	533	457	397	313	198	**3,718**
17/18	212	255	178	246	245	359	365	277	286	208	373	729	**3,733**
18/19	376	363	0	0	0	0	0	0	0	0	0	0	**739**

Bed Day Trend Information

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
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	626	762	**5,044**
18/19	607	440	0	0	0	0	0	0	0	0	0	0	**1,047**

Bed Day Information 2018 / 2019 (by category)

PICU	316	267	**583**
Acute	278	120	**398**
Gender	13	53	**66**



Due to the increasing levels of high demand from January to March 2018 the out of area budget has been weighted to account for higher spend at the start of the year reducing significantly across the year as actions from the project board are implemented.

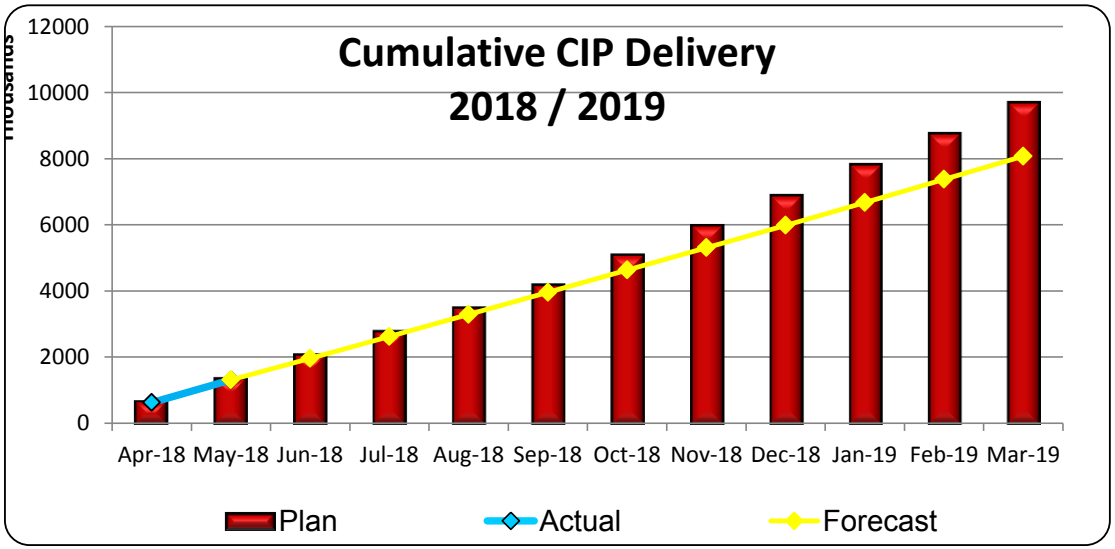
Even with this budget phasing, out of area has overspent by £161k year to date. Expenditure remains high despite a reduction in bed usage due to a higher ratio of PICU beds which are traditionally more expensive.

Both PICU and Acute demand are higher than commissioned levels. Work continues to focus on the reason for each admission and to take appropriate action to reduce. We are working collectively on an action plan to address with our commissioning colleagues.

These actions will include working closely with STP partners to gain an understanding of bed utilisation across the area.

2.1 Cost Improvement Programme 2018 / 2019

	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	691	1,382	2,091	2,798	3,501	4,203	5,100	5,997	6,894	7,823	8,762	9,701	691	9,701
Delivery as originally planned	582	1,188	1,780	2,381	2,989	3,597	4,205	4,816	5,426	6,059	6,701	7,343	582	7,343
Mitigations - Recurrent & Non-Recurrent	37	119	180	240	300	361	426	491	557	616	675	734	37	734
Mitigations - Upside schemes							271	542	813	1,084	1,355	1,624	0	1,624
Total Delivery	**619**	**1,308**	**1,960**	**2,622**	**3,289**	**3,957**	**4,902**	**5,849**	**6,796**	**7,759**	**8,731**	**9,701**	**619**	**9,701**
Variance	(72)	(74)	(132)	(177)	(211)	(246)	(198)	(148)	(99)	(64)	(31)	(0)	(72)	(0)



The Trust has CIP requirement for 2018 / 19 totalling £9.7m. This includes £1.6m of unidentified savings at the beginning of the year.

Identification of cost reduction opportunities remain challenging. A stock take of the Quality Impact Assessments (QIA) of these schemes has been undertaken with schemes actioned rated as green, amber or red.

To date the majority of schemes (94%) have delivered as planned. Additional saving opportunities are being assessed and delivery of these potential upsides is included within the forecast.

3.0 Balance Sheet 2018 / 2019

	2017 / 2018 £k	Plan (YTD) £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	123,810	124,153	123,924	1
Current Assets				
Inventories & Work in Progress	232	232	232	
NHS Trade Receivables (Debtors)	1,388	2,007	2,036	
Non NHS Trade Receivables (Debtors)	1,867	2,977	803	2
Other Receivables (Debtors)	1,219	1,000	1,840	3
Accrued Income	3,660	4,900	5,639	4
Cash and Cash Equivalents	26,559	23,952	23,382	5
Total Current Assets	**34,925**	**35,068**	**33,931**	
Current Liabilities				
Trade Payables (Creditors)	(9,958)	(4,860)	(8,616)	6
Capital Payables (Creditors)	(1,142)	(1,442)	(688)	6
Tax, NI, Pension Payables	(5,782)	(6,000)	(6,105)	
Accruals	0	(6,000)	(902)	7
Deferred Income	(670)	(670)	(718)	
Total Current Liabilities	**(17,552)**	**(18,972)**	**(17,029)**	
Net Current Assets/Liabilities	**17,373**	**16,096**	**16,903**	
Total Assets less Current Liabilities	**141,183**	**140,249**	**140,826**	
Provisions for Liabilities	(6,490)	(6,490)	(6,481)	
Total Net Assets/(Liabilities)	**134,693**	**133,759**	**134,345**	
Taxpayers' Equity				
Public Dividend Capital	44,015	44,015	44,015	
Revaluation Reserve	24,938	24,938	24,938	
Other Reserves	5,220	5,220	5,220	
Income & Expenditure Reserve	60,520	59,586	60,172	8
Total Taxpayers' Equity	**134,693**	**133,759**	**134,345**	

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.

Additional levels of detail have been included when compared to 2017 / 2018 to highlight accrued income and payables due to tax, NI and pension arrangements.

1. Capital expenditure is detailed on page 15. Overall spend is below plan meaning that the value of Trust assets is lower than plan.

2. As far as possible physical invoices have been raised with the majority paid supporting a lower than planned level of Non-NHS debts, unraised invoices are reflected in accrued income.

3. Other Receivables includes Prepayments, this is currently higher than plan, the majority of this relates to licences.

4. Accrued income is currently higher than plan, this is expected to reduce in June when the Q1 invoices are raised. Outstanding Purchase Orders with commissioners have been chased.

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

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

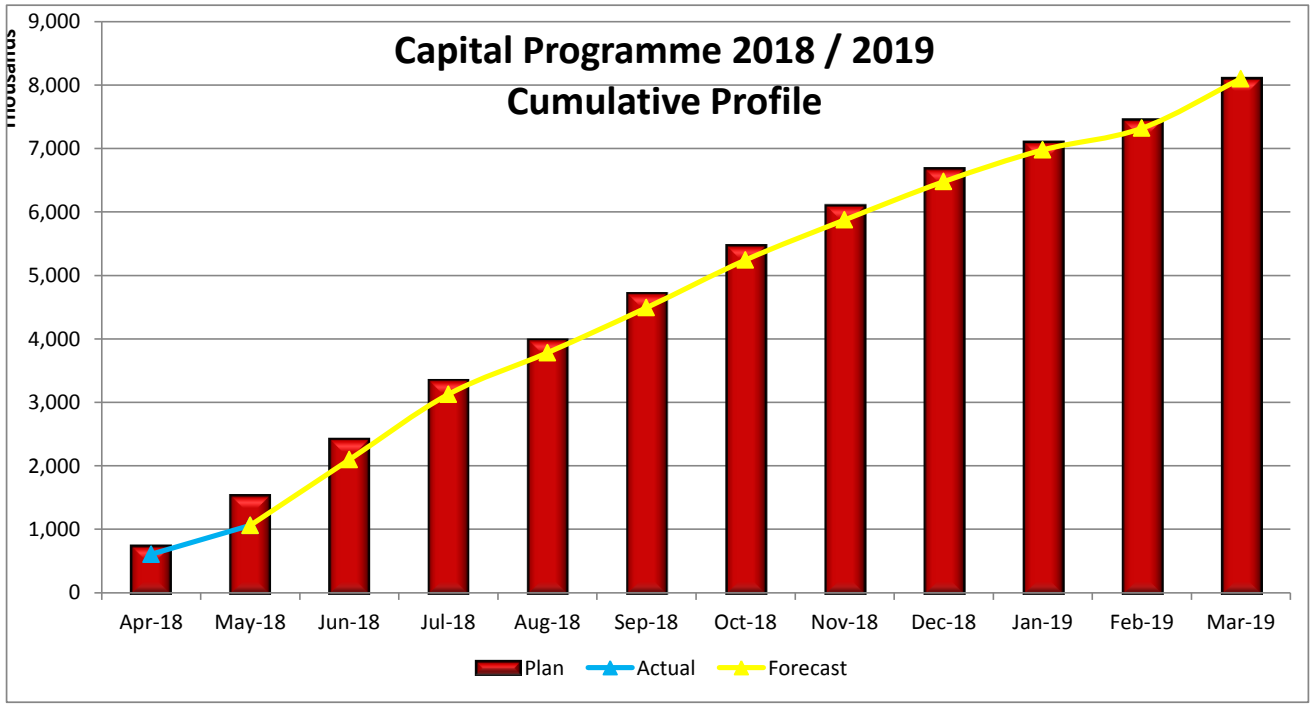
7. Accruals are higher than plan.

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

3.1 Capital Programme 2018 / 2019

	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	1,493	56	55	(1)	1,524	32	
Equipment Replacement	0	0	21	21	21	21	
IM&T	1,550	285	(16)	(301)	1,519	(31)	2
Major Capital Schemes							
Fieldhead Non Secure	4,229	1,051	926	(125)	4,229	(0)	
Clinical Record System	828	161	97	(64)	828	(0)	3
VAT Refunds	0	0	(22)	(22)	(22)	(22)	
TOTALS	**8,100**	**1,553**	**1,061**	**(492)**	**8,100**	**(0)**	1

Spend to date is being plan specifically within IM & T. Work schemes are being progressed to ensure value for money.



Capital Expenditure 2018 / 2019

1. The capital plan for 2018 / 2019 is £8.1m and schemes are guided by the current Estates Strategy.

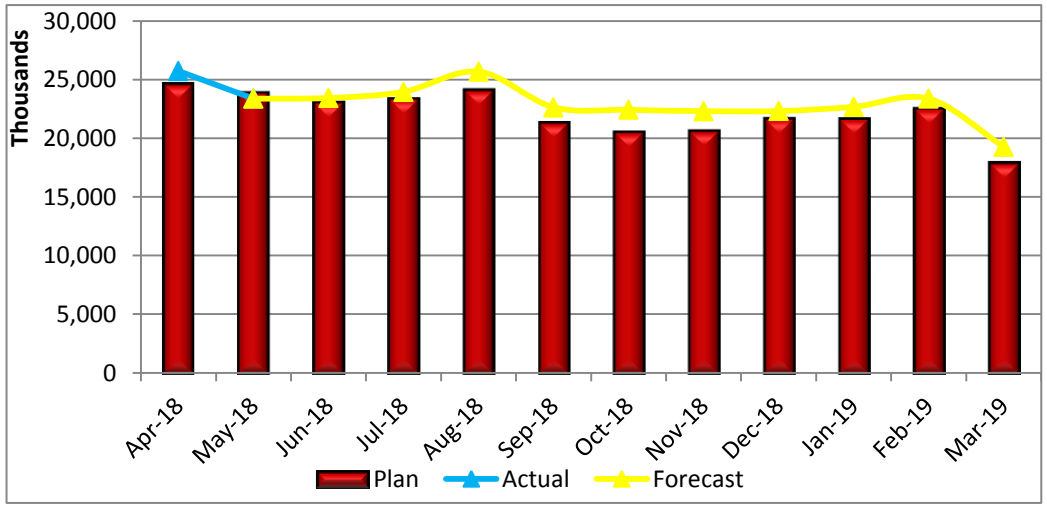
The year to date position is £470k (32%) lower than plan excluding VAT refunds.

2. There has been a timing delay in commencement of the IM & T schemes for 2018 / 2019. These are expected to be back in line with profile by the end of Quarter 1.

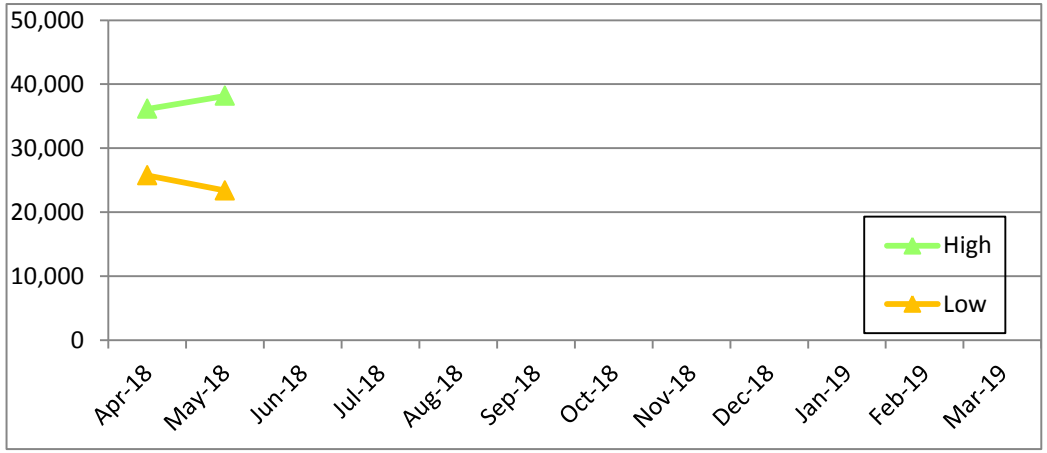
3. Additional cost pressures identified relating to the IM & T hardware requirements of the Clinical Record System are being validated and will be incorporated into the

4. An additional £0.5m capital expenditure is being considered for the demolition of vacant estate. This will consider both the health and safety aspects alongside ensuring best value for money and maximising potential sale proceeds.

3.2 Cash Flow & Cash Flow Forecast 2018 / 2019



	Plan £k	Actual £k	Variance £k
Opening Balance	26,559	26,559	
Closing Balance	23,952	23,382	(570)



Cash is £0.6m behind plan. Outstanding debts will be chased in month so cash returns to plan in Month 3.

Cash is below plan mainly due to higher accrued income. Cash continues to be closely monitored. A review of recent HFMA guidance on cash management best practice has been undertaken.

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

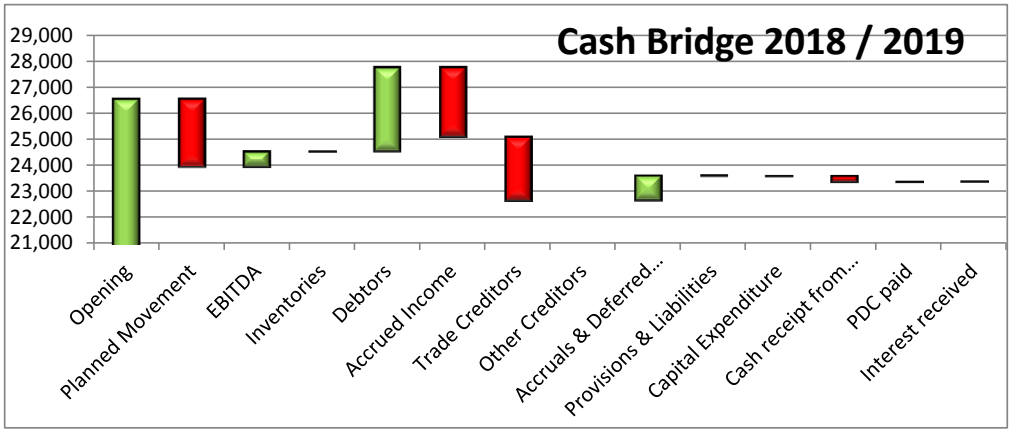
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £38.2m
The lowest balance is: £23.4m

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	**26,559**	**26,559**	0	
Surplus / Deficit (Exc. non-cash items & revaluation)	626	1,207	581	1
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	(2,750)	482	3,232	2
Accrued Income / Prepayments	0	(2,665)	(2,665)	4
Trade Payables (Creditors)	800	(1,640)	(2,440)	5
Other Payables (Creditors)	0	0	0	
Accruals & Deferred income	0	950	950	3
Provisions & Liabilities	0	(9)	(9)	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(1,291)	(1,515)	(224)	
Cash receipts from asset sales	0	0	0	
PDC Dividends paid	0	0	0	
PDC Dividends received			0	
Interest (paid)/ received	8	13	5	
Closing Balances	**23,952**	**23,381**	**(570)**	



The plan value reflects the April 2018 submission to NHS Improvement.

Factors which increase the cash positon against plan:

1. In year deficit is favourable to plan which has a positive impact on cash.
2. Debtors remain lower than plan, NHS debt remains lower than plan following the year-end agreement of balances exercise. This does not include 2017/18 STF income as this is received as a direct payment (no invoices are raised).

3. Accruals and Deferred income are higher than plan, this is expected to reduce in June 2018.

Factors which decrease the cash position against plan:

4. Accrued income is higher than plan, purchase order numbers are still outstanding for £1.5m. These are been chased to ensure that they are reduced in Month 3.

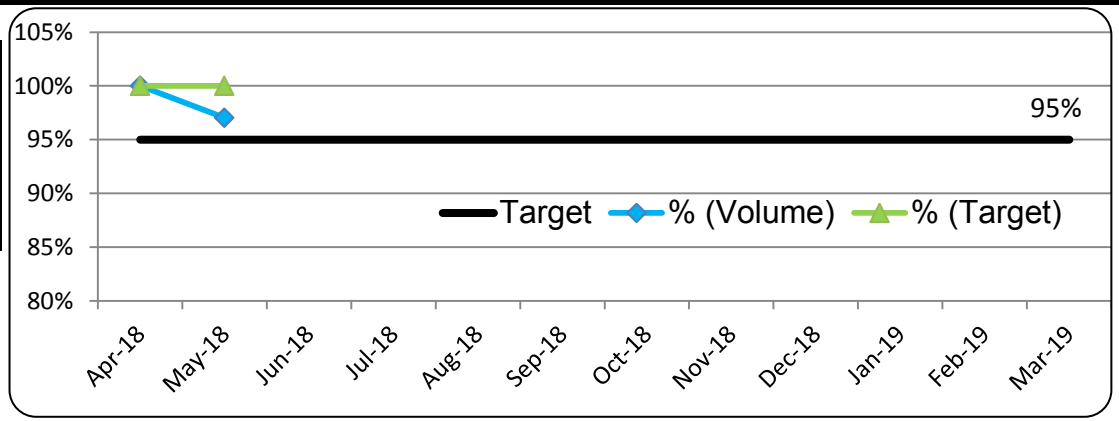
5. Creditors are lower than planned. Invoices are paid in line with the Trust Better Payment Practice Code.

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

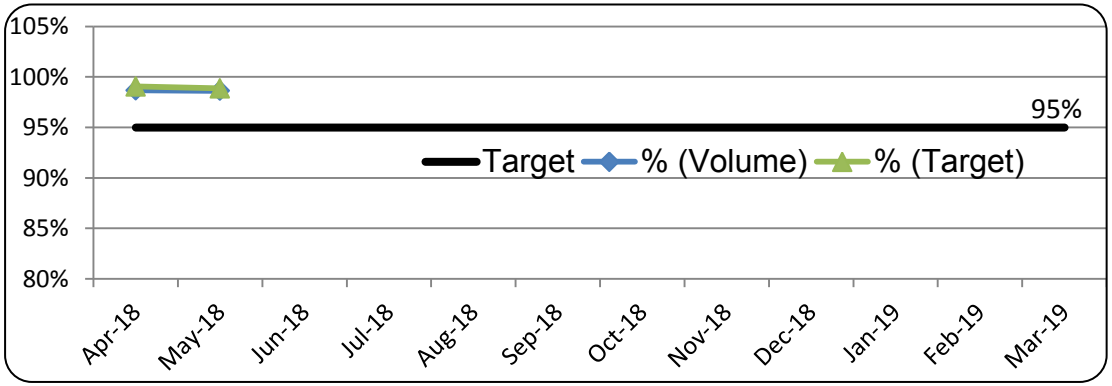
4.0 Better Payment Practice Code

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.
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 April 2018	100%	100%
Year to May 2018	97%	100%



Non NHS	Number %	Value %
Year to April 2018	99%	99%
Year to May 2018	99%	99%



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 (£)
11-May-18	Property Rental	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	3071613	219,053
11-May-18	Property Rental	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	3071614	219,053
15-May-18	Other Costs	Trustwide	Care Quality Commission	3071789	161,223
15-May-18	Legal/Prof fees	Trustwide	NHS Litigation Authority	3071796	61,855
08-May-18	Staff Recharge	Trustwide	Leeds and York Partnership NHS FT	3071071	46,610
23-Apr-18	Drugs FP10´s	Trustwide	NHSBSA Prescription Pricing Division	3069538	42,886
10-May-18	Property maintenance	Kirklees	Mid Yorkshire Hospitals NHS Trust	3071391	39,500
04-Apr-17	Staff Recharge	Trustwide	Leeds and York Partnership NHS FT	3031206	39,228

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

* Surplus - Trust income is greater than costs

* Deficit - Trust costs are greater than income

* 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 / Deficit - This is the surplus or deficit we expect to make for the financial year

* Target Surplus / Deficit - This is the surplus or deficit 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 2018 / 2019 the Trust were set a control total deficit.

* 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.

* Provider Sustainability Fund (PSF) - is an income stream distributed by NHS Improvement to all providers who meet certain criteria (this was formally called STF - Sustainability and Transformation Fund)

Appendix 2 - Workforce - Performance Wall

Barnsley District

Month	Objective	CQC Domain	Owner	Threshold	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	5.0%	5.1%	5.2%	5.1%	4.4%	4.2%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	5.9%	5.5%	5.9%	4.8%	4.5%	4.0%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	96.9%	96.6%	96.6%	96.7%	7.0%	25.4%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	94.5%	94.5%	94.3%	94.3%	1.0%	2.5%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	77.6%	77.4%	77.5%	77.9%	81.3%	81.9%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	78.8%	77.2%	78.7%	80.7%	80.2%	83.0%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	87.4%	87.4%	88.0%	88.9%	90.8%	90.4%
Equality and Diversity	Resources	Well Led	AD	>=80%	89.3%	91.0%	92.4%	91.4%	91.3%	92.1%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	77.4%	81.0%	82.0%	84.1%	84.2%	86.4%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	62.5%	66.4%	62.9%	63.3%	60.7%	63.2%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	81.7%	84.4%	85.2%	85.6%	85.8%	86.4%
Information Governance	Resources	Well Led	AD	>=95%	82.3%	88.4%	95.9%	96.8%	91.6%	91.9%
Moving and Handling	Resources	Well Led	AD	>=80%	81.8%	84.0%	84.7%	83.9%	82.1%	81.5%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	87.5%	88.0%	88.7%	89.2%	89.9%	90.9%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	84.5%	85.8%	86.7%	87.9%	88.2%	88.9%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	94.5%	94.0%	94.3%	93.2%	95.6%	96.3%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	84.4%	84.3%	84.2%	83.3%	84.3%	84.7%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	78.1%	78.6%	77.8%	76.3%	78.9%	81.4%
Agency Cost	Resources	Effective	AD		£68k	£105k	£104k	£87k	£78k	£79k
Overtime Costs	Resources	Effective	AD		£3k	£4k	£3k	£1k	£3k	£5k
Additional Hours Costs	Resources	Effective	AD		£19k	£17k	£11k	£13k	£14k	£8k
Sickness Cost (Monthly)	Resources	Effective	AD		£182k	£163k	£151k	£132k	£114k	£118k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		158.63	191.9	166.28	166.52	79.14	92.5
Business Miles	Resources	Effective	AD		107k	101k	90k	90k	96k	93k

Calderdale and Kirklees District

Month	Objective	CQC Domain	Owner	Threshold	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.9%	5.1%	5.3%	5.3%	4.9%	4.8%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	5.9%	6.9%	6.5%	5.2%	4.9%	4.8%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	97.9%	97.9%	97.9%	97.9%	6.1%	33.8%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	95.6%	95.8%	96.0%	95.9%	0.0%	1.5%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	76.8%	76.0%	77.6%	78.5%	78.4%	80.7%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	72.9%	73.1%	75.1%	78.7%	80.9%	84.3%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	82.4%	84.2%	87.5%	86.7%	86.9%	86.2%
Equality and Diversity	Resources	Well Led	AD	>=80%	83.9%	86.9%	86.8%	87.8%	88.1%	89.0%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	80.7%	83.4%	84.3%	85.4%	84.7%	86.1%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	82.4%	83.3%	80.3%	79.6%	76.5%	78.7%
Infection Control and Hand Hygiene	Quality & Experience	Well Led		>=80%	82.7%	85.2%	86.5%	87.2%	87.3%	86.7%
Information Governance	Resources	Well Led	AD	>=95%	84.9%	94.1%	98.5%	98.3%	93.6%	93.1%
Moving and Handling	Resources	Well Led	AD	>=80%	79.3%	83.0%	84.1%	84.3%	85.8%	86.2%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	85.5%	86.8%	89.8%	89.6%	89.8%	89.9%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	78.5%	82.4%	84.5%	85.1%	85.3%	84.5%
Sainsbury's clinical risk assessment	Quality & Experience	Well Led	AD	>=80%	94.0%	95.1%	95.6%	95.1%	95.4%	95.9%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	92.9%	92.7%	93.1%	92.9%	93.1%	93.9%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	90.4%	90.2%	90.5%	89.8%	91.4%	91.9%
Agency Cost	Resources	Effective	AD		£92k	£108k	£131k	£133k	£98k	£143k
Overtime Costs	Resources	Effective	AD		£5k	£2k	£8k	£4k	£3k	£8k
Additional Hours Costs	Resources	Effective	AD		£2k	£1k	£1k	£1k	£3k	£0k
Sickness Cost (Monthly)	Resources	Effective	AD		£138k	£167k	£139k	£118k	£109k	£108k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		62.96	62.78	67.83	62.79	58.91	62.81
Business Miles	Resources	Effective	AD		64k	65k	69k	53k	70k	53k

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

Forensic Services

Month	Objective	CQC Domain	Owner	Threshold	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Sickness (YTD)	Resources	Well Led	AD	<=5.4%	6.4%	6.6%	6.8%	6.8%	6.4%	6.2%
Sickness (Monthly)	Resources	Well Led	AD	<=5.4%	7.4%	8.4%	8.4%	7.1%	6.4%	6.1%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	98.7%	98.7%	98.7%	98.7%	14.1%	32.1%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	97.7%	97.7%	97.7%	98.0%	3.1%	8.1%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	85.7%	86.3%	84.9%	84.9%	85.1%	88.1%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	79.4%	80.4%	82.1%	86.6%	88.0%	87.3%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	82.9%	86.0%	86.9%	85.8%	86.3%	86.5%
Equality and Diversity	Resources	Well Led	AD	>=80%	87.1%	88.4%	88.8%	89.5%	90.2%	91.7%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	90.4%	91.8%	88.8%	90.7%	90.4%	92.7%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	86.0%	84.7%	87.3%	85.3%	85.4%	84.4%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	85.4%	86.5%	89.2%	91.4%	89.7%	90.5%
Information Governance	Resources	Well Led	AD	>=95%	87.2%	89.8%	95.6%	96.4%	91.9%	92.4%
Moving and Handling	Resources	Well Led	AD	>=80%	87.5%	88.9%	89.0%	90.9%	90.2%	91.2%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	89.0%	91.8%	89.7%	89.2%	89.0%	91.9%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	87.1%	87.4%	86.6%	86.3%	86.8%	87.5%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	77.8%	100.0%	94.7%	86.4%	87.5%	83.3%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	92.6%	92.0%	92.2%	91.9%	92.2%	92.9%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	86.5%	85.7%	85.5%	83.9%	83.4%	83.6%
Agency Cost	Resources	Effective	AD		£30k	£26k	£36k	£35k	£41k	£39k
Overtime Costs	Resources	Effective	AD		£0k	£0k	£0k	£0k	£1k	£0k
Additional Hours Costs	Resources	Effective	AD		£1k	£3k	£1k	£0k	£1k	£0k
Sickness Cost (Monthly)	Resources	Effective	AD		£72k	£82k	£72k	£65k	£58k	£55k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		36.55	42.11	45.72	45.42	52.45	49.26
Business Miles	Resources	Effective	AD		12k	8k	6k	4k	7k	9k

Specialist Services

Month	Objective	CQC Domain	Owner	Threshold	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	5.7%	5.7%	5.6%	5.6%	5.3%	5.6%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	5.9%	6.2%	4.7%	5.1%	5.3%	5.8%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	99.5%	99.4%	99.4%	99.4%	1.8%	14.7%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	100.0%	100.0%	100.0%	99.0%	0.0%	4.0%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	74.4%	71.9%	71.4%	75.9%	76.8%	80.9%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	76.1%	80.1%	83.8%	86.5%	87.9%	86.2%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	85.2%	85.6%	84.7%	86.0%	86.2%	90.2%
Equality and Diversity	Resources	Well Led	AD	>=80%	86.5%	84.4%	85.6%	84.9%	86.0%	87.0%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	80.4%	79.7%	84.0%	83.0%	81.8%	81.6%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	73.9%	75.0%	69.2%	69.2%	68.0%	68.0%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	82.3%	84.7%	87.7%	87.3%	87.4%	88.2%
Information Governance	Resources	Well Led	AD	>=95%	82.7%	85.7%	95.3%	95.3%	92.4%	93.6%
Moving and Handling	Resources	Well Led	AD	>=80%	79.9%	81.1%	84.7%	86.1%	86.0%	86.8%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	88.2%	87.0%	88.9%	89.0%	89.6%	89.7%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	86.5%	87.5%	87.3%	87.3%	89.3%	89.5%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	91.6%	91.0%	91.6%	91.0%	92.3%	95.0%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	93.6%	92.9%	92.0%	92.5%	92.6%	92.9%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	88.4%	87.1%	85.5%	84.1%	84.6%	87.1%
Agency Cost	Resources	Effective	AD		£148k	£153k	£174k	£182k	£144k	£183k
Overtime Costs	Resources	Effective	AD			£5k	£0k			
Additional Hours Costs	Resources	Effective	AD		£1k	£3k	£1k	£1k	£3k	£0k
Sickness Cost (Monthly)	Resources	Effective	AD		£66k	£67k	£42k	£64k	£63k	£62k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		52.42	54	50.8	53.28	43.32	41.54
Business Miles	Resources	Effective	AD		46k	37k	35k	35k	38k	39k

Appendix 2 - Workforce - Performance Wall cont….

Support Services

Month	Objective	CQC Domain	Owner	Threshold	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Sickness (YTD)	Resources	Well Led	AD	<=4.0%	4.4%	4.6%	4.6%	4.6%	3.5%	3.6%
Sickness (Monthly)	Resources	Well Led	AD	<=4.0%	5.0%	5.7%	5.4%	4.1%	3.5%	3.7%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	98.0%	98.0%	98.0%	98.0%	8.9%	17.7%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	95.8%	96.6%	96.6%	96.8%	0.2%	1.0%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	69.8%	72.6%	74.9%	77.2%	76.6%	79.5%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	82.1%	96.3%	96.3%	92.3%	92.3%	92.9%
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%	87.0%	87.5%	88.1%	87.4%	87.9%	89.0%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	86.6%	87.0%	88.0%	87.4%	88.5%	89.7%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	100.0%	100.0%	98.1%	98.2%	97.3%	97.3%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	85.4%	85.6%	87.0%	87.3%	87.7%	88.6%
Information Governance	Resources	Well Led	AD	>=95%	81.4%	88.2%	93.3%	95.7%	92.9%	93.7%
Moving and Handling	Resources	Well Led	AD	>=80%	89.0%	90.4%	90.9%	90.6%	90.1%	92.9%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	88.4%	91.1%	91.8%	91.9%	92.3%	94.0%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	95.0%	96.1%	95.9%	94.6%	94.8%	95.9%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	98.6%	98.8%	98.9%	98.9%	99.1%	98.9%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	86.2%	92.3%	88.9%	85.7%	84.6%	85.2%
Agency Cost	Resources	Effective	AD		£4k	£1k	£5k	£1k		
Overtime Costs	Resources	Effective	AD		£1k	£1k	£1k	£0k	£1k	£0k
Additional Hours Costs	Resources	Effective	AD		£13k	£8k	£9k	£6k	£8k	£5k
Sickness Cost (Monthly)	Resources	Effective	AD		£78k	£90k	£76k	£65k	£53k	£50k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		62.71	57.42	60.97	64.78	30.78	35.33
Business Miles	Resources	Effective	AD		38k	26k	36k	19k	32k	35k

Wakefield District

Month	Objective	CQC Domain	Owner	Threshold	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Sickness (YTD)	Resources	Well Led	AD	<=4.6%	5.0%	5.0%	5.0%	4.9%	2.7%	3.0%
Sickness (Monthly)	Resources	Well Led	AD	<=4.6%	4.9%	5.6%	4.8%	3.3%	2.7%	3.3%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	99.4%	98.9%	98.3%	97.8%	11.7%	33.2%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	94.4%	94.4%	95.4%	95.2%	0.4%	2.6%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	83.5%	83.9%	82.5%	82.1%	77.7%	80.2%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	75.7%	77.4%	75.4%	78.9%	80.0%	80.9%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	75.6%	76.3%	77.6%	76.7%	76.8%	74.6%
Equality and Diversity	Resources	Well Led	AD	>=80%	85.9%	88.0%	87.9%	86.6%	88.0%	87.4%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	87.6%	83.4%	84.3%	82.8%	82.9%	84.3%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	71.8%	70.9%	68.6%	67.4%	64.4%	64.9%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	83.4%	84.4%	85.3%	83.7%	85.7%	85.1%
Information Governance	Resources	Well Led	AD	>=95%	87.4%	86.7%	93.8%	94.5%	91.6%	91.4%
Moving and Handling	Resources	Well Led	AD	>=80%	73.1%	74.5%	78.1%	78.3%	79.1%	80.5%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	90.5%	91.8%	90.2%	90.4%	88.4%	88.9%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	80.6%	80.8%	83.2%	83.9%	85.9%	84.5%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	93.7%	92.9%	93.7%	92.9%	93.8%	93.4%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%	90.5%	90.3%	91.5%	90.7%	90.3%	90.2%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%	86.5%	86.5%	86.4%	84.5%	83.8%	85.1%
Agency Cost	Resources	Effective	AD		£90k	£73k	£114k	£116k	£83k	£95k
Overtime Costs	Resources	Effective	AD			£0k	£1k	£1k		£0k
Additional Hours Costs	Resources	Effective	AD		£3k	£4k	£1k	£1k	£1k	£1k
Sickness Cost (Monthly)	Resources	Effective	AD		£57k	£64k	£52k	£39k	£29k	£43k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		45	55.2	62.34	60.66	56.33	53.65
Business Miles	Resources	Effective	AD		37k	33k	38k	29k	31k	35k

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
IBCF	Improved Better Care Fund
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

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Trust Board 26 June 2018
Agenda item 6.2

Title	**The Learning Disabilities Mortality Review (LeDeR) Programme Annual report**
Paper prepared by	Director of Nursing and Quality
Purpose:	This report provides an overview of the LeDeR programme annual report, highlights the findings and recommendations and considers the implications for the Trust.
Mission/values	➢ Achieve the Trust's mission to help people reach their potential and live well in their communities ➢ Improve people's health and wellbeing, to improve the quality and experience of all that we do, and improve our use of resources. ➢ We put people first and in the centre & we recognise that families and carers matter
Background papers	➢ Previous report to CGCS committee outlining new LeDeR process 2016 ➢ The Learning Disabilities Mortality Review (LeDeR) Programme Annual report published 4 May 2018: http://www.bristol.ac.uk/university/media/press/2018/leder-annual-report-final.pdf
Executive summary	**Background** ➢ The Learning Disabilities Mortality Review (LeDeR) programme was established in 2016 to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives. ➢ All deaths will have an initial review – if further learning felt useful a multi-agency review will be conducted ➢ Certain groups (people aged from 18-24 years old or people from a black & ethnic minority groups) identified as priority and automatically have a multi-agency review ➢ The most significant challenge has been to provide timely reviews largely driven by four key factors: a) large numbers of deaths being notified before full capacity was in place locally to review them b) the low proportion of people trained in LeDeR methodology who have gone on to complete a mortality review c) trained reviewers having sufficient time away from their other duties to be able to complete a mortality review and d) the process not being formally mandated. **Findings** ➢ People with Learning Disabilities have poorer health than the general population resulting in earlier death (15-20 years earlier) ➢ From 1st July 2016 to 30th November 2017, 1,311 deaths were notified to

With all of us in mind.

	the LeDeR programme. The most frequent role of those notifying a death was Learning Disability Nurse (25%), most commonly working in a Community Learning Disabilities Team. ➢ Key information about the people with learning disabilities whose deaths were notified to the LeDeR programme includes: • Just over half (57%) of the deaths were of males • Most people (96%) were single • Most people (93%) were of White ethnic background • Just over a quarter (27%) had mild learning disabilities; 33% had moderate learning disabilities; 29% severe learning disabilities; and 11% profound or multiple learning disabilities. • Approximately one in ten (9%) usually lived alone • Approximately one in ten (9%) had been in an out-of-area placement. ➢ From the 103 completed LeDeR reviews, there were 189 learning points or recommendations identified. The most commonly reported recommendations were made in relation to the need for: a) Inter-agency collaboration and communication b) Awareness of the needs of people with learning disabilities c) The understanding and application of the Mental Capacity Act (MCA). **Recommendations** ➢ In the forthcoming year the LeDeR programme will focus on actions that are being taken locally and sharing examples of good practice to affect service improvement ➢ Health Action plans are formulated with people with learning disabilities where accessible format is required by learning disability service and these are shared accordingly ➢ Health & Social Care Records should be improved and easier to share ➢ Health Action Plans should be shared between services ➢ There should be a named person (Care Co-ordinator) to help professionals work together ➢ Reasonable adjustments should be recorded on individual records ➢ Learning Disability Awareness Training should be provided to all those who support people with learning disabilities ➢ People need to understand more about the problems with infections in people with learning disabilities (pneumonia & sepsis in particular and constipation) ➢ There should be much more of a focus on the use of the Mental Capacity Act ➢ A strategic approach is required to training reviewers **Implications** ➢ Since reporting notifications commenced on the 1st November 2016 SWYPFT have reported 57 Deaths of people with learning disabilities via Datix (up to 30th May 2018) ➢ In SWYPFT we currently have three trained reviewers and another person being trained in June 2018

	➢ SWYPFT need to continue to support the review process and more reviewers will be required ➢ SWYPFT will consider how reasonable adjustments are evidenced in records ➢ LD awareness training will be made available for all SWYPFT staff subject to resources being established ➢ The community learning disability team will continue to support the development of health action plans in an accessible format to support people with learning disabilities to maintain and improve their health through better understanding of conditions ➢ The Trust will develop a system for learning from reviews to enable service improvement to occur and a lead for the Trust should be considered ➢ The Trust need to consider Information Sharing agreements with Partners – Systmone will be helpful in terms of sharing information with GP's ➢ The Trust need to develop system for reasonable adjustments to be evidenced on SystmOne ➢ Action plan to be developed, monitored and delivered by Trust LeDeR Lead in response to recommendations Link to full report: http://www.bristol.ac.uk/university/media/press/2018/leder-annual-report-final.pdf
Recommendation:	**Trust Board is asked to RECEIVE the report and NOTE the implications and plans for SWYPFT.**
Private session:	Not applicable.

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Trust Board 26 June 2018
Agenda item 6.3

Title	**Incident Management Annual Report 2017-18**
Paper prepared by	Director of Nursing and Quality
Purpose:	This report provides an overview of all the incidents reported in the Trust during 2017/18. It also includes further analysis of Serious Incidents, and brief analysis of recommendations arising from completed Serious Incident investigations submitted to commissioners for the period of 1 April 2017 to 31 March 2018.
Mission/values	➢ Achieve the Trust's mission to help people reach their potential and live well in their communities ➢ Improve people's health and wellbeing, to improve the quality and experience of all that we do, and improve our use of resources. ➢ We put people first and in the centre & we recognise that families and carers matter
Background papers	Quarterly serious incident reports go to CGCS committee and the Trust Board
Executive summary	**Summary of incidents** ➢ 12303 incidents reported on DATIX (NB - high reporting rate with high proportion of no/low harm is indicative of a positive safety culture) ➢ 6.3% decrease in reporting since 2016/17 ➢ 89% of incidents resulted in no/low harm ➢ 71 Serious incidents reported ➢ 1 homicide ➢ No Never Events ➢ Serious Incidents account for 0.58% of all incidents reported ➢ Apparent suicides increased to 43 from 27 in 2016/17 **Outcomes** ➢ Improvement in some key findings from staff survey for incident reporting ➢ Internal audit result for serious incidents requiring investigation was significant assurance with minor improvement opportunities ➢ Internal audit result for learning from healthcare deaths was significant assurance ➢ Positive feedback from Care Quality Commission on our serious incident and mortality review process ➢ Positive outcomes from the patient safety strategy ➢ Achievement of Sign up to Safety targets ➢ Supported implementation of the Patient Safety Strategy, including the national Sign up to Safety initiative and monitoring the Suicide Prevention Strategy action plan. ➢ Development of our Learning from healthcare deaths – the right thing to do

With all of us in mind.

	Policy received significant assurance following internal audit. **Plans for 2018-19 include:** ➢ Patient Safety Strategy: continued implementation including:- o National *Sign up to Safety* initiative: Safety improvement plans have been updated for 2018 for the remaining area of harm reduction, which are led by specialist advisors. Work will continue to reduce avoidable harm. Data is monitored through Datix Dashboards and discussed in the Patient Safety Strategy Implementation group. o Continued support for Safety Huddles and adopt to prevent suicidal behaviour o Focus on safety conversations/kitchen table events o Using improvement methodologies to improve safety, e.g. human factors o Suicide prevention strategy: to support the suicide prevention lead with implementation and monitoring of the action plan. o Implementation of the Significant Event Analysis tool o Continue to developing ways of capturing and sharing lessons learned and evidence of positive change ➢ Continue to support West Yorkshire wide patient safety initiatives including learning from healthcare deaths collaboration and suicide prevention. ➢ Further development of the serious incident action themes to enable improved analysis. ➢ Continue to embed and improve upon the work to date on systems and processes for learning from healthcare deaths. Work closely with other Trusts in the northern Alliance to share experiences and learning to meet the national policy requirements. Ensure local policies are updated to include learning from deaths requirements. ➢ Continue to support research. ➢ Datix o Implement future Datix release upgrades and exploit the features available to support safety o To maintain the Datix dashboard configuration and monitor additional requests o Continue with Datix system audits to ensure IG requirements are met o Ensure Datix configuration reflects the current management structures o Working with business intelligence to triangulate data o Improving incident report content o To ensure the Datix system is reviewed and refined to meet user needs ➢ To continue networking with other Trusts across West Yorkshire **This report was scrutinised by the Clinical Governance and Clinical Safety Committee meeting held on the 19 June 2018.** The Committee reviewed the annual report alongside the 17/18 Apparent Suicides report which informed the discussion and scrutiny The Committee commented as follows:- ➢ The report is of high quality and well structured ➢ 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 Committee took assurance from the internal audit reports relating to

	serious incident reporting & learning from deaths, both of which have a significant assurance rating. ➢ Feedback from the CQC report on serious incidents and mortality reviews provides an additional external positive opinion. ➢ The Committee requested assurance that the Annual Incident report and Apparent Suicides report outcomes and actions are contained within the Patient Safety Strategy action plan, with particular reference to reduction in incident reporting ➢ The Committee noted that the deep dive report into the increase in Apparent Suicides in Kirklees will be considered at the next Committee meeting to complete the assurance that the appropriate actions are in place. The initial review does now show any immediate concern or trends. **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 provides assurance for compliance risk relating to health and safety legislation and compliance with CQC standards for incident reporting. This meets the risk appetite
Recommendation:	**Trust Board is asked to RECEIVE the report and NOTE plans for 2018/19.**
Private session:	Not applicable.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Incident Management Annual Report

April 2017 to March 2018

Patient Safety Support Team

1 June 2018

With **all of us** in mind.

Executive Summary

This report provides an overview of **all** the incidents reported in the Trust during 2017/18. It also includes further analysis of Serious Incidents, and brief analysis of recommendations arising from completed Serious Incident investigations submitted to commissioners for the period of 1 April 2017 to 31 March 2018. The report provides an overview of the national developments related to patient safety that have occurred throughout the year and summary of the work undertaken by the Patient Safety Support Team.

This report does not cover the work of the BDUs in terms of implementing the learning; a report on this will be available here separately.

- **12303** incidents reported
- **6.3%** decrease in reporting on 2016/17
- **89%** of incidents resulted in no/low harm
- **71** Serious incidents reported
- **1** homicide
- No Never Events
- Serious Incidents account for **0.58%** of all incidents reported
- High reporting rate with high proportion of no/low harm is indicative of a positive safety culture[1]

The Trust reported **12303** incidents during the year; a slight decrease on the previous year. A high level of incident reporting, particularly of less severe incidents is an indication of a strong safety culture (NPSA: Seven Steps to Patient Safety[1]). The distribution of these incidents is in line with an established reporting process showing a triangle with **89%** of incidents resulting in no/low harm.

There were **71** serious incidents reported during the year accounting for 0.58% of all incidents, a small increase in both number and percentage of all incidents reported than in 2016/17. The highest overall category of serious incident is apparent suicide (43); an increase on 2016/17 figure (27) but comparable with 2015/16 (41). Separate analysis of serious incidents is included in this report. Analysis of apparent suicides reported as serious incidents has been prepared separately, but included as Appendix A to this report.

No 'Never Event' incidents were reported by SWYPFT in 2017/18. The last Never Event reported by the Trust was in 2010/11. Never Events is a list (DOH) of serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

One homicide was reported by the Trust in 2017/18.

[1] NPSA. (2004). Seven Steps to Patient Safety

During 2017/18, many positive outcomes have been achieved in relation to patient safety.

- Improvement in some key findings from staff survey for incident reporting
- Internal audit result for serious incidents requiring investigation was significant assurance with minor improvement opportunities
- Internal audit result for learning from healthcare deaths was significant assurance
- Positive feedback from Care Quality Commission on our serious incident and mortality review process
- Positive outcomes from the patient safety strategy
- Achievement of Sign up to Safety targets

This has included supporting the implementation of the **Patient Safety Strategy,** including the national **Sign up to Safety** initiative and monitoring the **Suicide Prevention Strategy** action plan.

Mortality has featured heavily this year, with the development of our Learning from healthcare deaths – the right thing to do Policy and supporting processes, which received significant assurance following an internal audit.

The 2018/19 plan will continue to support implementation of patient safety strategy, suicide prevention strategy, mortality along with ensuring we continue to develop learning from incidents to reduce harm.

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Introduction

The purpose of this incident management annual report for 2017/18 is to present key headline data for incidents reported within the Trust on the incident management system (Datix). This includes brief analysis of all incidents and more detailed analysis of serious incidents. A summary of work undertaken during the year will be given and some of the key next steps planned for 2018/19.

The report does not cover incidents that are managed through other processes such as safeguarding (including Serious Case Reviews, Domestic Homicide Reviews) or whistleblowing (staff survey). Where incident reporting patterns are identified, further analysis can be provided by the responsible Trust group (e.g. Management of Violence and Aggression, Safer Staffing, Smoke Free) as required.

Further information can be provided on request. In addition to this report, Our learning journey report, presenting the work of the BDUs in terms of implementing learning and learning from serious incident investigations will be available separately.

The report is structured into the following sections:

Section 1 provides an overview of the current context around patient safety, including national developments, external scrutiny and a summary of the work of the Patient Safety Support Team in relation to incident management

Section 2 includes a summary of all reported incidents occurring from 1 April 2017 to 31 March 2018. It should be noted that this report provides only an overview; detailed reports are produced on a quarterly basis for Business Delivery Units and many specialist advisors run/analyse incident reports.

Section 3 focusses on reported deaths in line with the Learning from health care deaths policy. It includes figures on deaths that were reported as serious incidents.

Section 4 focusses on incidents reported as Serious Incidents during 2016/17. The first part looks at what these incidents were, and secondly provides more details on the different types of serious incidents that were reported. It includes detailed analysis of apparent suicides reported as serious incidents.

Section 5 sets out an analysis of the serious incident investigations that have been completed and sent to commissioners during 2017/18. It includes an analysis of the themes arising from serious incident recommendations.

Section 6 gives a summary of the development plans of the Patient Safety Support Team for 2017/18.

Section 1: Background and 2017/18 developments

This section of the report provides an overview of the Trust's governance arrangements around incidents and serious incidents; some of the national developments relating to mortality and our response and examples of external scrutiny relating to incident reporting and management. It concludes with a summary of the work of the Patient Safety Support Team in relation to incident management.

- Improvement in some key findings from staff survey for incident reporting
- Internal audit result for serious incidents requiring investigation was significant assurance with minor improvement opportunities
- Internal audit result for learning from healthcare deaths was significant assurance
- Positive feedback from Care Quality Commission on our serious incident and mortality review process
- Positive outcomes from the patient safety strategy
- Achievement of Sign up to Safety targets

Governance structure

Reporting, analysis and learning from incidents is managed through a clear governance structure. The Director of Nursing, Quality and Professions works closely with the Medical Director to ensure there are robust processes in place. This is supported by an Assistant Director for Patient Safety and an Associate Medical Director (AMD) for Patient Safety. The Patient Safety Support Team provides support to all Business Development Units (BDU's) and Quality Academy teams. Investigation of serious incidents is undertaken by full-time lead investigators, supported by dedicated sessions from medical investigators. A list of co-opted experts within the Trust has been developed from a variety of specialties and disciplines to provide specialist support to serious Incident investigators where necessary.

The Clinical Governance and Clinical Safety Committee ensure robust scrutiny on behalf of the Board. The Committee receives performance information including serious incident quarterly reports. The Committee also received the learning journey reports that capture the implementation and learning from incidents. This year the Committee has continued to receive papers in relation to national documents on learning from healthcare deaths.

The bi-monthly patient safety clinical reference group meetings, chaired by the AMD for patient safety, is a forum for collecting and disseminating ideas and information between a core group of individuals directly involved in developing, implementing and monitoring systems to improve patient safety.

The Clinical Risk Panel meets weekly to assess and make recommendations in response to clinical risks impacting on the Trust arising from actual and potential serious incidents, deaths, legal and safeguarding activity.

A monthly mortality review group meets to consider all in scope deaths, confirm the level of investigation and review outcomes. The group focusses on the process and technical development to support learning from healthcare deaths.

The Operational management group receives a monthly Clinical Risk report prepared by Patient Safety Support Team which includes activity on serious incidents, apparent suicides, duty of candour, learning points and performance of incident management.

Each BDU has developed and strengthened governance groups whose function includes examining trends and learning from incidents and ensuring action plans are delivered.

Each BDU has a linked Lead Serious Incident Investigator who is responsible for working with BDU's on learning from incidents, using Datix to assist with such learning. They also have a Practice Governance Coach (or personnel with a similar role) to assist in the dissemination of learning arising from incidents. They work closely together to enable learning closer to frontline staff and provide greater opportunities to capture the impact of learning. In addition, BDUs have held wider learning events for staff led by Practice Governance Coaches to highlight themes and trends from incidents (both serious and otherwise) along with lessons learned. Lead Investigators have supported these events and provided presentations.

Learning from Healthcare Deaths developments

Scrutiny of healthcare deaths has been high on the Government's agenda for some time. Reports such as the Francis report and Southern Healthcare has intensified this. During 2016/17, there were two major reports published: **Learning, Candour and Accountability**[2] report from the CQC (December 2016) and the **National guidance on learning from deaths**[3] from the National Quality Board (March 2017).

All 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 fully supports this approach and has developed the policy with other providers in the North of England as part of our collaborative approach to learning from deaths. Our Learning from healthcare deaths – the right thing to do policy came into effect from 1 October 2017. A review of the policy with our alliance colleagues is planned.

Trusts were also required to report and publish 2017/18 (from quarter 3 2017/18 onwards). This information is published on our website.

The Patient Safety Support Team has continued to provide substantial resources to support and develop the Trust's learning from healthcare deaths systems and processes. A business case is being developed to further this work (2018/2019 work plan).

A review of learning from healthcare deaths has been completed by internal audit providing significant assurance. The report stated "A significant amount of work has taken place at the Trust in developing, implementing and establishing arrangements for learning from deaths in compliance with the NQB requirements (issued in March 2017). Whilst there are still some requirements which need to be fulfilled, the Trust is acutely aware of these and work is continuing to achieve these." The Mortality review group will be holding a workshop to explore how best to implement the audit findings.

[2] Care Quality Commission. 2016. Learning, Candour and Accountability.
[3] National Quality Board. 2017. National guidance on learning from deaths.

External scrutiny and feedback

Care Quality Commission Inspection

In April 2018, the Care Quality Commission conducted their announced well-led review of our organisation over a three day period. This included interviews with key individuals, a number of focus groups and looking at information files of live cases in relation to such things as ongoing complaints and serious incidents. We did receive some verbal feedback at the end of the well-led review which provided positive feedback. In relation to patient safety they reported a number of very positive findings including really good serious incident and mortality review process.

National Staff Survey 2017

A number of questions are asked within the National Staff Survey 2017[4] which provides direct feedback on staff views with regards to the incident reporting system. The 2017 staff survey was published in 2018. For the full report, click here.

Positive findings are indicated in Figure 1 with a green arrow ↑ (e.g. where the Trust is better than average, or where the score has improved since 2016). Negative findings are highlighted with a red arrow ↓ (e.g. where the Trust's score is worse than average, or where the score is not as good as 2016). An equal sign indicates that there has been no change. Included is the 2015 to be able to see the three year trend.

Figure 1 Questions relating to Incident reporting systems from Staff Survey 2017

Key finding	Trust score 2016	Trust score 2017		National 2017 average for combined MH/LD and community Trusts	Best 2017 score for combined MH/LD and community Trusts	
28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month (Lower score is better)	27%	26%	=	23%	17%	↓
29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month (higher score is better)	96%	93%	=	92%	95%	=
30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents(0-5 scale)	3.75	3.72	=	3.76	3.92	=
31. Staff confidence and security in reporting unsafe clinical practice (0-5 scale) (higher score is better)	3.60	3.71	↑	3.72	3.90	=

Within the Trust compared to last year, three of the results are equal and one has improved. Compared to national figures three are average and one question, number 28, worse, than average.

There has been improvement as last year both question 28 & 31 were within the Trust bottom five ranking scores. This year question 28 remains within the Trust bottom five ranking scores.

Question 31 has moved from being in the within the Trust bottom five ranking scores to one of the highest within the Trust. Question 30 the Trust score has improved each of the last three years and moved from being one of the Trust bottom five ranked score three years ago.

[4] SWYPFT Staff Survey results 2017

From April 2016 staff have been able to request feedback from the incident when it has been reviewed by the manager, last year in this report we hoped this would this increase staff confidence that action is taken and that incidents are managed in a fair and effective manner. We also believed this would impact on staff confidence in one method of reporting unsafe practice. The results Question 30 & 31 indicate this is the case.

The area for further work is in relation to Question 28 - the percentage of staff witnessing errors, near misses and incidents in the last month was 27%, the national average is 23%. Forensic BDU has the highest percentage of staff reporting followed by Calderdale/Kirklees and Wakefield.

The Trust's Patient Safety Strategy 2015-2018 is supported by a detailed action plan and there is evidence of reduction in harm in the Sign up to Safety targets and wards that have adopted safety huddles.

Work has taken place to explore further introduction of safety huddles in a sustainable way. Information is available on the intranet.

The Patient Safety Support Team continues to support BDU's in enabling staff to report incidents. The team constantly review the support offered and respond to request from services including delivery of training and improved guidance.

Internal Audit

Serious Incidents

In April 2017 internal audit issued a report following reviewing the Trust's policies with regard to the management of serious incidents and assessed whether the policies were effective for staff to respond to a serious incident. They also selected a sample of closed serious incidents to assess compliance with Trust policy.

The report found significant assurance with minor improvement opportunities.

The report identified a number of good practices. An action plan was developed which has been completed.

Learning from Healthcare Deaths Review

As part of 2017/18 annual audit plan, South West Yorkshire Partnership NHS Foundation Trust (the Trust), requested a review of Mortality.

The objective of this review was to provide independent assurance over the robustness of the governance arrangements in place within the Trust to oversee mortality and the quality of mortality data being reported.

In order to meet this objective internal audit assessed the systems and processes in place to ensure the Trust was compliant with the requirements of the National Quality Board's (NQB) 'National Guidance on Learning from Deaths' framework for NHS Trusts and NHS Foundation Trusts (March 2017), focusing on:

- Identifying
- Reporting
- Investigating and
- Learning from deaths in care.

The report was issued on 2 April 2018. The audit opinion was significant assurance. The report noted:

"*A significant amount of work has taken place at the Trust in developing, implementing and establishing arrangements for learning from deaths in compliance with the NQB requirements (issued in March 2017). Whilst there are still some requirements which need to be fulfilled, the Trust is acutely aware of these and work is continuing to achieve these."*

An action plan has been developed and agreed with completion date of September 2018.

Homicide Independent Reviews

Under the Department of Health guidance HSG(94)27, an independent investigation must be undertaken when a homicide has been committed by a person in receipt of specialist mental health services under the Care Programme Approach in the six months prior to the event. Such investigations are to provide "an external verification and quality assurance review of the internal investigation with limited further investigation".

There were three homicide independent investigations that were concluded during 2015/16. These were historical cases from 2010/11. A themed analysis also took place, covering these three homicides and three previous homicides in 2007/8. The Trust is awaiting closure of two of the action plans by NHS England's Local Area Team.

The Trust has also been involved in an independent investigation that took place in a neighbouring locality. This incident took place in 2014 and the report has been published in May 2018.

The internal investigation into a homicide (2017/16452) that occurred in Quarter 1 2017/18 has been concluded. At the time of the incident, the patient was under the care of Forensic low secure community team. The Independent Inquiry process has started and is being led by Sancus Solutions.

Patient Safety Strategy developments

The patient safety support team has supported the development and coordination of the Patient Safety Strategy implementation plan. During 2017 and into 2018, the implementation plan focused on 10 overarching priority areas. These have included:

Measurement and Monitoring of Safety Framework
During the year, colleagues from the Patient Safety Support Team attended a course on implementing the Health Foundation's Measurement and Monitoring of Safety Framework (MMSF).

- The Framework supports patient safety by encouraging us to think about making sure we include all five domains of the framework in patient safety work
- We have changed our conversation to focus on 'how we keep safe today' rather than just focussing on harm
- We identified that we needed to build MMSF into existing work including that of the Patient Safety Strategy implementation plan
- The wider implementation of the framework has been included in the Trust's Integrated Change programme

Patient safety communication
The **#allofusimprove** has been launched with patient safety as one of its key areas. The first case study focused on safety huddles and our approach. A plan has been agreed with the patient safety strategy group for other patient safety work to be promoted using #allofusimprove.

Safety Huddles
Following a pilot with three wards in early 2017, interest has grown, with 13 wards now involved in or working towards holding their own huddles. The focus of huddles is broad, with some teams looking at reducing violence and aggression, falls, seclusion, promote safeguarding reporting. Significant achievements have been made in reducing harm:

- Chantry ward - silver certificate for reducing Violence & aggression – was 2 incidents/week*, best run 39 days
- Stroke Unit – gold certificate for reducing Falls - was 1 fall/6 days*, best run 45 days

- Work to scale up Safety huddles to meet future demand has taken place, and a toolkit has been developed to support teams.
- Our learning has been shared at Improvement Academy network meetings
- Safety huddles development was shortlisted in the Excellence awards for 'Improving Care'.

Human factors
We are continuing to explore the use of Human Factors methodology:

- Human Factors is included in the Integrated Change plan and a working group has been established to support developments; an intranet page has been developed.
- E-learning is now available to the Trust as Bronze on-line training through the Improvement Academy. All lead investigators have completed this training.
- Human Factors continue to be examined as part of investigations
- The Patient Safety Support Team have developed a Significant Event Analysis template as a tool that can be used to analyse an adverse event, which helps teams to focus on Human Factors

Significant event analysis (SEA)
Work has been done between patient safety support team, management of violence and aggression team and health and safety to develop and then pilot a significant event analysis tool. The tool helps teams to focus on human factors involved in an incident. The pilot has involved using the tool for any incident of violence and aggression that has resulted in a Riddor reportable incident. Fifteen reviews have now been conducted using the tool, and analysis is now underway to extract themes and learning. Feedback has been positive. The tool will be adapted following feedback.

Learning
Developments to strengthen methods of learning and sharing have continued:

- Bluelight alerts have been introduced to share urgent learning quickly across the Trust – using the SBAR framework (situation, background, assessment, recommendation). These are circulated to all staff by email. Previous alerts are available on the Bluelight intranet pages.
- Greenlight alerts have been introduced to share learning and information related to medication safety. Alerts sent are available on the Greenlight intranet page.
- Staff have been asked to suggest ideas for sharing learning through i-hub and intranet
- Intranet pages have been developed to draw together learning from various sources
- A working group established with a number of quality academy teams to develop a systematic approach to learning as part of the integrated change programme.
- Questions added to Datix to prompt managers to consider sharing learning from incidents with others

BDU patient safety priorities
In addition, each Business Delivery Unit identified their top 5 patient safety priorities to progress locally. These included:

- Safer staffing
- Harm reduction

- Learning from incidents to promote patient safety
- Clinical environment safety
- Medication safety
- Record keeping
- Safeguarding
- Staff recruitment and retention
- Patient safety supervision

Sign up to Safety and Suicide prevention work are also part of the Patient Safety Strategy and are updated below.

Sign up to Safety

Sign up to Safety data for 2017 showed some positive outcomes, with a number of our 3 year targets being achieved as shown in Figure 2. Work towards the remaining targets continues. Not all our targets had the same 3 year timeframe due to improvements in data collection.

Figure 2 Sign up to Safety measures at 31/12/2017

Area	Target	Baseline period	% reduction from baseline	End period
Falls	To reduce the frequency of falls by inpatients by 15% by 2018	2014	Achieved 36.4% reduction in 3 years	31/12/2017
Falls	To reduce the frequency of inpatient falls resulting in moderate/severe harm or death by 10% by 2018	2014	Small numbers involved, affecting percentages. Has seen reductions in 2 of 3 years. Overall the figure remained the same	31/12/2017
Restraint	To reduce moderate harm and above to patients in incidents that resulted in restraint **by 30% target by 31/12/2017**	2014	Achieved 71.4% reduction in 3 years	31/12/2017
Medicine omissions	To reduce unintended missed doses by 25% by 2018	2015	On track to meet target	31/12/2018
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 to meet target currently 69.5% reduction	31/12/2018
Prone Restraint	To reduce the frequency (use of) of prone restraint by 30% by 2018	2015	Currently 18.3% reduction*	31/12/2018
Prone duration	To have 90% of prone restraints with a duration of 3 minutes or less by **31/12/2019 (80% by end 2018)**	2016	Currently 75%*	31/12/2019

Further work on data for prone restraint and prone duration continues as small numbers affect reporting. Statistical Process Control charts are being developed to improve reporting. Care should be taken not to compare this data with performance information as criteria and date ranges are not the same.

Suicide Prevention Strategy

During 2017/18 work on the Trust's suicide prevention strategy has continued. We are implementing our Trust wide 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; Kirklees). In response to 2016/17 analysis of apparent suicides, several work streams are underway around the following themes:

- Analysis of younger adults dying by apparent suicide
- Dual Diagnosis
- IHBTT and recent discharge
- Self harm
- Discharged patients
- recognition and treatment of depression

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. The Trust's strategy is complimentary to this.

Learning from incidents

The Trust continues to explore other ways in which it can learn from incidents of all grades. We have a moral obligation to learn from incidents; some of the lessons come at a great cost including loss of life and significant harm.

Learning from incidents occurs at many different levels in the organisation, examples of these levels are available here.

Incident analysis

Incident management reports and data are prepared for a range of Trust meetings, groups and managers by the Patient Safety Support Team, Specialist Advisors or Operational Managers who have access to reported incidents and reporting functions on Datix. Aggregated incident reports including comparative data are provided to the Trust Board, Committees, the Executive Management Team, Operational Management Group, Trust Action Groups, Business Delivery Units and Sub-Groups, from which peaks and trends can be identified and explored. Examples of the key reports are available here.

The lead investigators continue to work closely with the practice governance coaches to produce reports on the learning from incidents in each BDU. The 'Our Learning Journey' report will be available separately.

Every Serious Incident investigation is followed by a learning event for the individual team or service involved, led by the lead investigator.

Incident data (including SIs) is often requested under the Freedom of Information Act (FOIA) 2000. During 2017/18, the number of requests has fallen, 14 requests were made and responded to by the patient safety support team. Many of these requests are complex in nature, and continue to include requests for information relating to deaths, AWOL, restraints, assaults, self-harm and numbers of SIs.

The Trust has continued to contribute to national learning via the National Reporting and Learning System[5] (NRLS - key functions moved to NHS Improvement in April 2016) by ensuring the Trust's patient safety incidents are regularly transferred to the national system (NRLS).

The Patient Safety Support Team continued to support and monitor the Serious Incident process, particularly through the provision of information to the Clinical Governance and Clinical Safety Committee.

This year, the team has continued the analysis of recommendations from serious incident investigation reports, by coding each recommendation. The analysis can be by category or within clinical settings e.g. all recommendations linked to an inpatient serious incident. The team leads reporting on this.

Datix developments

The Trust has continued to use and develop the Datix incident management database to record, analyse and aggregate incident information. Datix is a dynamic system and the team, in collaboration with services and specialist advisors, continue to examine ways to exploit the system. One area this year has been the development of questions specifically around learning around systems and process changes and how learning has been shared. The data collect on this commenced in April 2017. Unfortunately this did not result in the qualitative data expected. The patient safety support team will review how this can be improved.

Each year, as the footprint of the organisation changes with services and teams being created and changed, the Patient Safety Support Team maintain Datix to accurately reflect the current structures to enable Trust reporting and the functionality of Datix to support learning. During the year, this work has been recognised within the Trust. As a result, the team's structure framework is now saved on a shared network drive to enable other teams such as SystmOne, Performance and Information and Quality Improvement and Assurance Team to access directly and contribute information.

A new feature was implemented in April 2016 which enabled staff reporting incidents to request feedback on the outcome from the manager; supporting staff with closing the loop. This is optional and not possible to report on, but anecdotally staff report that the feedback from incidents is improved and results from staff survey support this. On a couple of occasions, staff have contacted the team because they had not received feedback. On further exploration, it was identified that this was because they had used personal email addresses rather than their work email address e.g. @swyt.nhs.uk, @nhs.net, @gov.uk. Datix is configured to only send emails to recognised addresses to protect sensitive data.

The Patient Safety Support Team constantly examines ways of effectively supporting the Trust to meet regulatory and best practice in terms of incident management. The culture within the team is to look for creative and innovative ways of delivering this work, focused on customer support to improve customer experience of using the Datix system and learning from incidents. The team use internal training to develop and share skills to ensure continuity of the service. Lean methodology is regularly used in the team to evaluate incident reporting and serious incident investigation processes, reducing duplication and increasing efficiencies which have resulted in additional services being supported.

The Patient Safety Support Team continues to provide Datix system administration support and technical expertise to a number of corporate customers who lead other modules (e.g. risk, customer services, legal services). Audits of the system to ensure good governance are undertaken regularly to comply with the IG toolkit.

[5] NHS Improvement. National Reporting and Learning System

An example of this has been how the Patient Safety Support team worked closely with the Trust's Legal services team to develop a web based legal module. This involved bring the existing claims and Inquests modules together and incorporating legal affairs data in one web based system. This has helped streamlined the way legal services record and manage data through Datix to record claims, inquests and other legal activity, which can now be linked to incidents and feedback.

Throughout the year, the recording of Duty of Candour information has been refined to ensure accurate information is available for analysis.

During the end of 2016/17 significant work took place to develop the Datix system to capture mortality information and redesigning sections to gather improved information in relation to serious incidents to aid decision making in the new Managers 48 hour review section (formerly known as 'serious incident additional information'). This has provided improved information for decision making. The data extracted from deaths reported on datix has been critical to the implementation of learning from healthcare deaths processes.

The Team works closely with specialist advisors to review and improve how incidents are coded to ensure consistency of reporting and to aid their data analysis.

The Datix system supports the collection of data that is used for many CQUIN targets, KPIs, contract information, quality accounts and benchmarking both local and national. The Patient Safety Support Team provides regular compliance information to support fulfillment of these requirements. This includes is providing incident data for a range of national benchmarking returns.

Policy Developments

During 2017/18 the Incident Reporting and Management Policy and the Investigation and analysis policy have been reviewed and a new policy on Learning from Healthcare Deaths developed and introduced in October 2017.

Training

Datix training has continued to be delivered during 2017/18 following the success of the bespoke face to face approach introduced in 2016/17. Staff can book a session with a member of the team who will tailor the content to individual or group needs. The team also offers a wide range a range of support materials on their intranet pages.

The team has continued to deliver Systems Analysis training in the Trust during the year. This training is aimed at managers who review and investigate amber incidents and who conduct service level investigations. The aim is provide a good understanding of the principles of Root Cause and Systems Analysis as well as a number of useful tools that can be utilised when completing this level of investigation.

Guidance on reporting incidents is available to all staff on the intranet in written and video format. This includes the principles behind incident reporting. In addition, the Datix incident reporting module has been configured to include multiple reminders and help text to support all staff with each stage of incident reporting and management.

The team continues to provide sessions at the Medical Trainee Inductions.

Audit and Service Evaluations

Following completion of work last year the apparent suicide audit is now incorporated into Datix, the Investigators complete the data while undertaking investigations. This now enables more scope for

analysis. This year the information has been included within this report rather than a separate report.

The Patient Safety Support Team support other audits and service evaluations throughout the year by providing more detailed analysis of incidents. The teams have provided a number of reports to support transformation work.

External partnerships

The Patient Safety Support Team works closely with a range of external agencies in relation to incidents. This includes the Care Quality Commission and Clinical Commissioning Groups (CCG) in terms of reporting and performance monitoring of serious incidents. The team has also been involved more in joint investigations with the acute Trusts. The team is a key partner in the Northern alliance, the suicide strategy federation of Trust's group. The team has partnered with the Yorkshire Improvement academy - assistant Director of patient safety has been involved group examining communication for carers and families group following bereavement which has been shortlisted for two national wards and the mortality review process which again has been nominated for national awards. The patient safety manager has worked with them re implementation of safety huddles again shortlisted for an award.

Team resources

Resources are always a challenge and the team looked for creative ways to cover this, enabling staff to gain new skills and experience. The team are supported to develop and encouraged to get involved in Trust initiatives/networks to widen their perspectives.

Section 2 - Incident Reporting Analysis

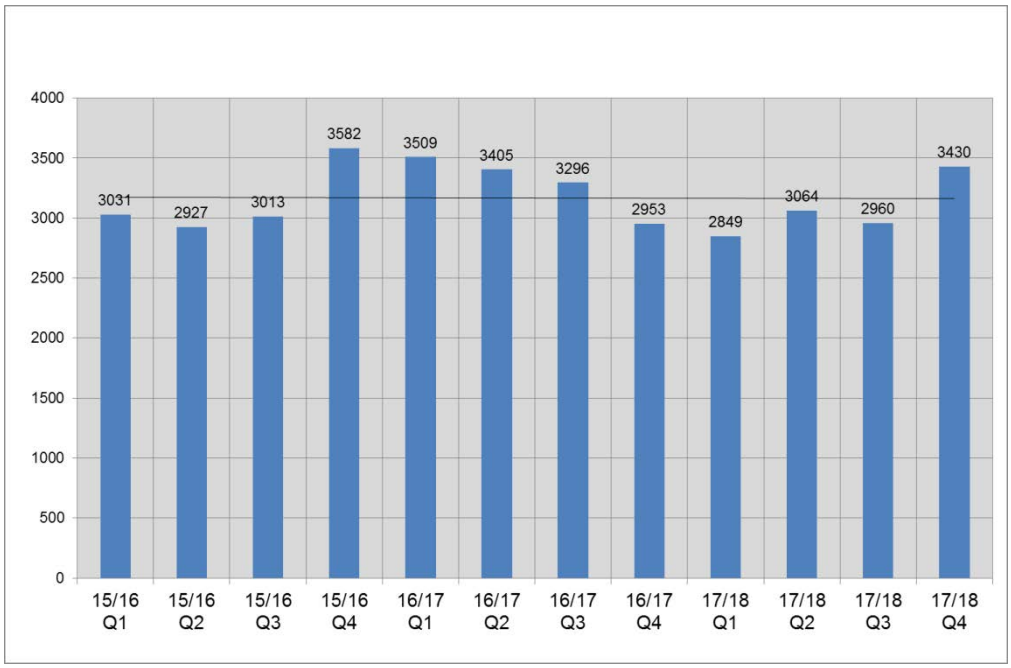
Headlines

The Trust reported **12303** incidents of all severity during the year, a 6.3% reduction on 2016/17 (13126). The average number of incidents reported per financial year over a 3 year period is 12673 incidents.

- **12303** incidents reported
- **6.3%** decrease in reported incidents on 2016/17
- **89%** of incidents resulted in **no/low harm**
- **71** Serious incidents reported (0.58% of all incidents)
- Increase in serious incidents than in 2016/17 (65)
- High reporting rate with high proportion of no/low harm is indicative of a positive safety culture

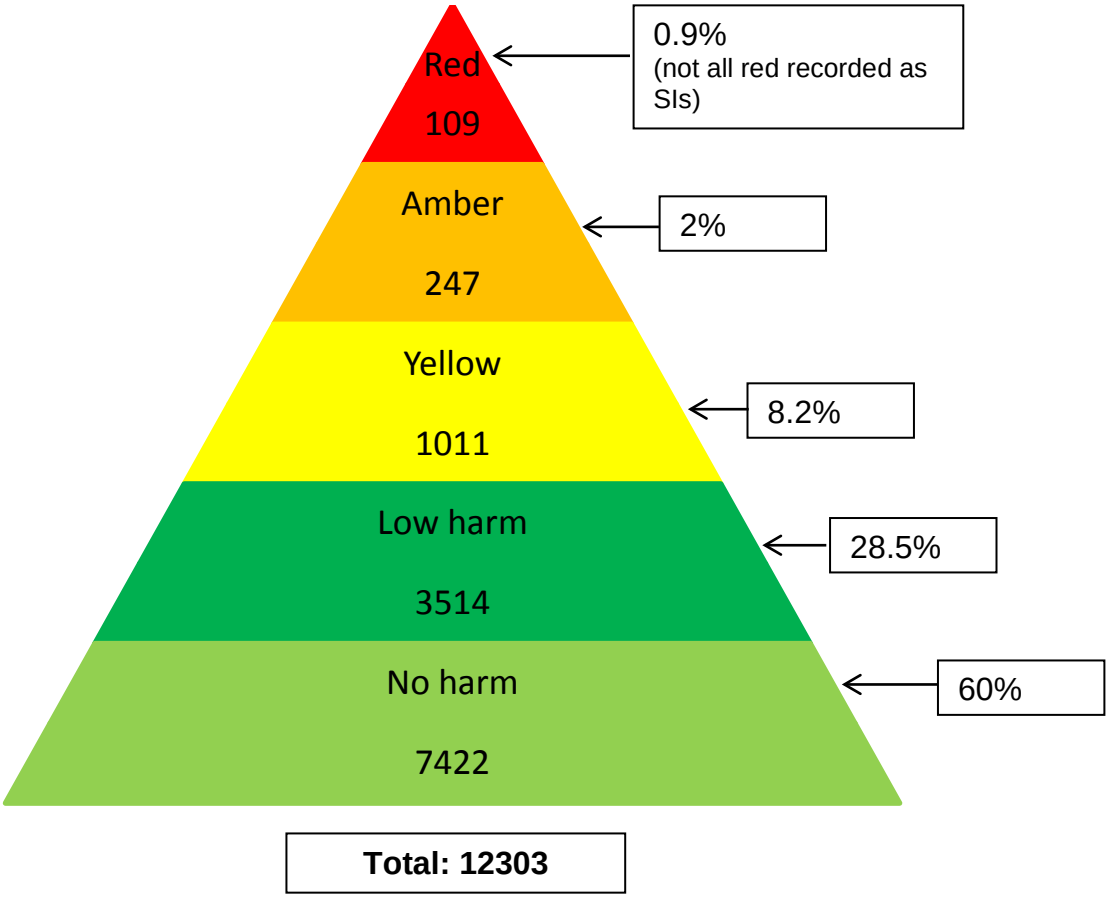
Figure 3 below shows the pattern and number of incidents reported by quarter in the Trust over the last 3 financial years, and indicates the average is stable, with natural fluctuations each quarter. It should be noted that direct comparisons should be viewed with caution due to the Trust changing profile of services.

Figure 3 Comparative number of incidents reported by financial quarter 2015/16 to 2017/18



The distribution of these incidents in terms of severity is pyramid-shaped, with serious incidents being fewest in number; and most incidents (89%) resulting in no/low harm, as illustrated in Figure 4. The proportion of no/low harm incidents has remained consistent with 2016/17. The number of serious incidents reported slightly increased during 2017/18, which will be reported on later in the report. An organisation with high reporting rate, particularly with a high proportion of no/low harm is indicative of a positive safety culture where staff are encouraged to report incidents and near misses.

Figure 4 Incidents reported by severity 2017/18



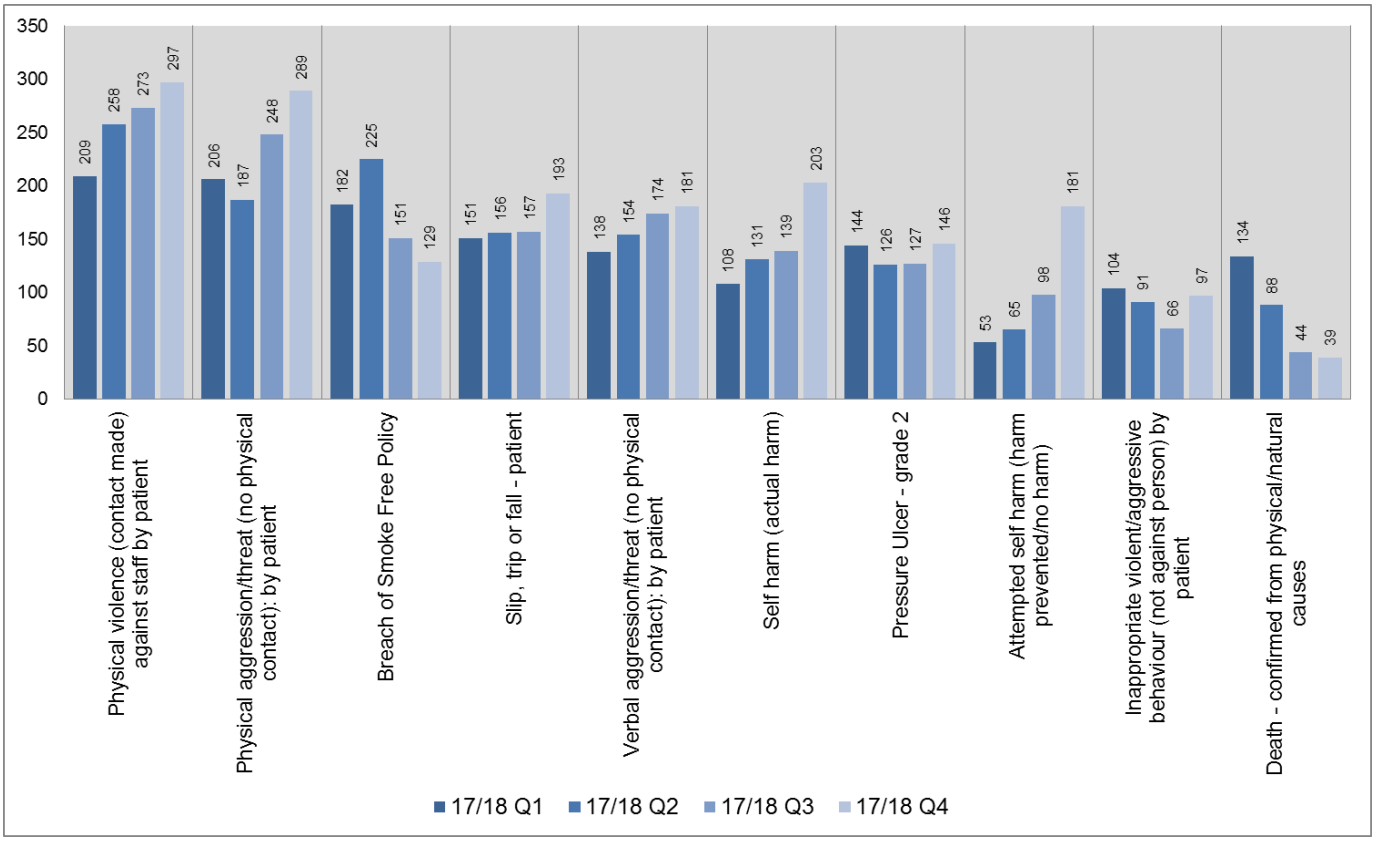
Note: The red incidents in this chart are based on the date when the incident occurred, which is often different to the date it was reported on the Strategic Executive Information System (StEIS) as a Serious Incident (SI) figures use the date reported on StEIS. Not all Red incidents are reported as SIs.

Type and Category of incidents

All incidents are coded using a three tier method to enable detailed analysis. Type is the broadest grouping, with Type breaking into categories, and then onwards into subcategories.

Figure 5 shows the top 10 highest reported categories of incidents across the Trust during 2017/18. During 2017/18 incidents were reported against 142 different categories of incident. The top 10 categories account for nearly 50% of all incidents reported.

Figure 5 Trust-wide Top 10 most frequently reported incident categories in year 2017/18



Physical violence against staff by patient (where contact was made) was the highest reported incident category with a total of 1037 incidents in the year accounting for 8.4% of all incidents reported. This has seen an increasing rate over the year.

There are three other categories of violence and aggression related incidents appearing in the top 10; 'Physical aggression/threat (no physical contact): by patient' has increased over the year; as has 'Verbal aggression/threat (no physical contact): by patient'. 'Inappropriate violent/aggressive behaviour (not against person) by patient' also continues to appear in the top 10.

In relation to incidents of Physical violence (contact made) and Physical aggression (No contact made) against staff by patient, the last 2 Quarters have seen an increase in acuity across certain areas. Some of these incidents also feed into the other sections of the report as contributing factors, e.g. Breach of smoke free policy and self-harm. This is due to a large increase in actual and attempted self-harm within areas and the need for staff's intervention. The Reducing Restrictive Intervention Team continued to push the need for consistent and precise reporting of all incident of both physical and verbal aggression. The consistently improving reporting of verbal aggression is to be commended as this can be used by staff to identify changes or increasing levels of aggression with service users presentation, and also show that there are many incidents (near misses) where

staff have been confronted by an angry aggressive individual and through the de-escalation skills employed, have limited the incident to verbal aggression.

In 2016/17 Breach of Smoke Free policy incidents have reduced during 2017/18 compared with 2016/17 when it was the highest reported incident.

Patient falls is the fourth highest category. This has remained at a similar level through the year, with an increase in quarter 4. Reporting rates are similar to the previous year.

Self harm incidents have risen; both actual harm and incidents where self harm was attempted and prevented through the year, with particular increases in quarter 4. Again this is indicative of staff reporting near misses or where patients have been prevented from self harming. Figures are affected by individual service user presentation.

'Grade 2 Pressure ulcer' category appears in the top 10 It should be noted that these are incidents that are generally identified by staff in the community and many are attributable to other agencies. The Datix system is used to capture the identification and actions taken by our staff.

During 2017/18 work has been done to improve the categorisation of reported deaths on Datix to support the Learning from Healthcare Deaths policy. In 2016/17, 'death –other cause' appeared in the top 10. Now, in 2017/18 the category 'Death - confirmed from physical/natural causes' appears in the top 10, showing improved recording. The reporting in the first half of the year was higher, which reporting any death was encouraged. The latter half of the year saw lower rates, coinciding with the introduction of the Learning from Healthcare Deaths policy on 1 October 2017. The policy introduced different reporting requirements (see Learning from health care deaths section). Further analysis on all deaths reported is provided in this report.

External comparison

During 2017/18, 5764 patient safety incidents have been uploaded to the National Reporting and Learning System (NRLS)[6] (by 17 April 2018). There are limited opportunities to compare the Trust data but where this is available it indicates the Trust has a strong safety culture. The NRLS Team produce six-monthly reports comparing Trust data, however, there are limitations, in that SWYPFT is compared with Trusts' providing only mental health services, whereas the Trust also provides community services and has a large forensic component. Subject to this caveat, the latest report for April–September 2016 shows the Trust remains in the centre of the middle 50% of reporters, with a reporting pattern for numbers of incidents in particular categories similar to other Trusts. However the Trust has reported more no harm incidents (77.9%) compared with the mental health cluster (64.8%). We are on a par with others on severe harm and death.

The Trust's data is available on NHS Improvement website[7] accessible here. Not all incidents are reportable to the national database, which has strict criteria, based on patients being directly affected by an incident; as such, violence against staff incidents are not shared with NRLS. Other external reporting processes are used for staff incidents.

[6] NHS Improvement. National Reporting and Learning System
[7] NHS Improvement. South West Yorkshire Partnership NHS Foundation Trust comparative data. March 2017

Duty of Candour

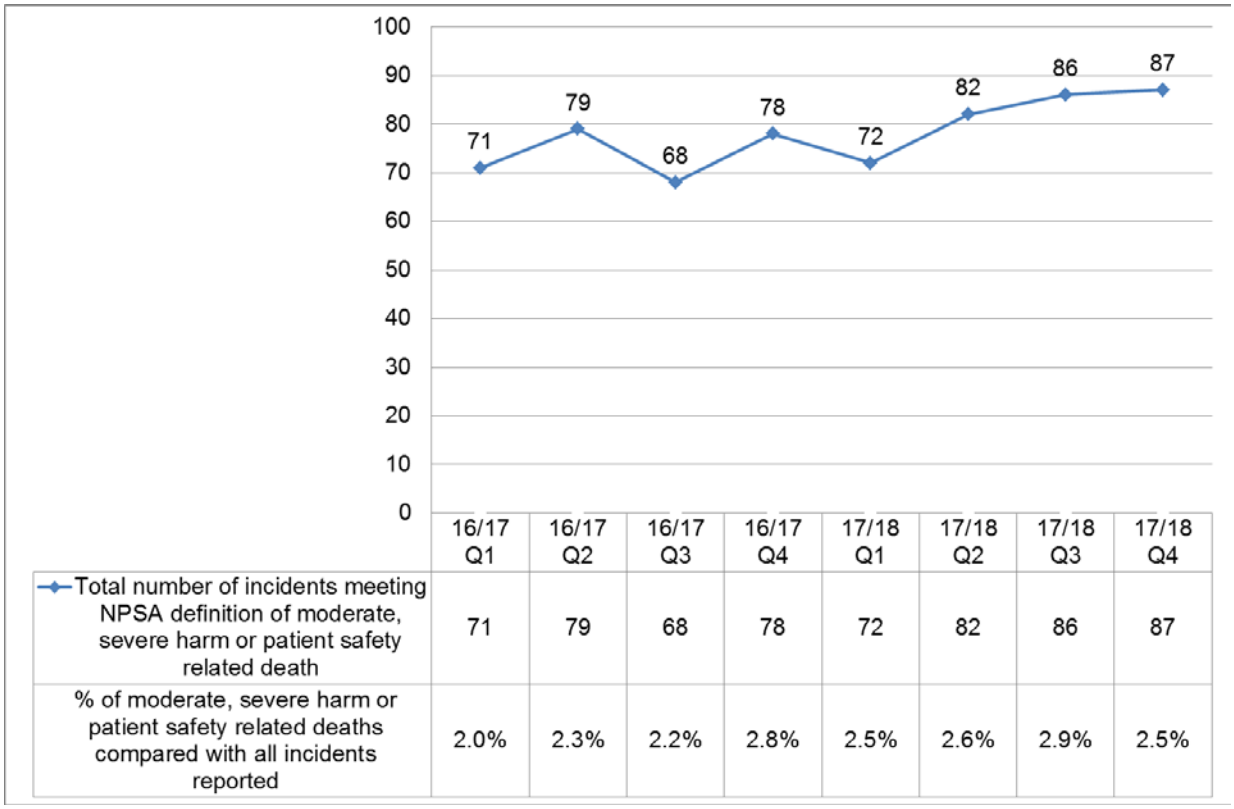
Duty of Candour applies to all patient safety incidents that result in moderate harm or above. The Trust has been following the principles of Being Open since 2008 and had a policy in place since that time. The NHS contract includes Duty of Candour for patient safety incidents with moderate harm and above and the Trust has been reporting on this since April 2014. In November 2014 this was strengthened when this became a statutory CQC regulation[8] to fulfil the Duty of Candour requirement.

Failure to comply with the contractual requirements could result in recovery of the cost of the episode of care or £10,000 if the cost of the episode of care is unknown (NHS Contract) and/or it is a criminal offence to fail to provide notification of a notifiable safety incident and/or to comply with the specific requirements of notification. On conviction a health service body would be liable to a potential fine of £2,500.

The data contained in this section of the report was correct at the time of reporting (2/5/18). The data is extracted from a live system, and is subject to change. The degree of harm (moderate, severe or death) is initially recorded by the Patient Safety Support Team based upon the potential harm, and is subject to change as further information becomes available e.g. when actual injuries or cause of death are confirmed.

During 2017/18, there were 327 potentially applicable patient safety incidents (2.6% of all incidents reported). The number of patient safety incidents meeting the NRLS definition of moderate or severe harm or death has steadily risen over the past two years, as shown in Figure 6. The percentage of Duty of Candour applicable incidents against the total number of incidents reported each quarter has remained fairly similar. Some data is still subject to change.

Figure 6 Total number of patient safety incidents with moderate or severe harm or death between 2016/17 and 2017/18



	16/17 Q1	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4
Total number of incidents meeting NPSA definition of moderate, severe harm or patient safety related death	71	79	68	78	72	82	86	87
% of moderate, severe harm or patient safety related deaths compared with all incidents reported	2.0%	2.3%	2.2%	2.8%	2.5%	2.6%	2.9%	2.5%

[8] Care Quality Commission. Duty of Candour guidance

Figure 7 shows the degree of harm (moderate, severe or death) from patient safety incidents over a two year period. The average for each degree of harm has been added.

Figure 7 Duty of Candour applicable incidents by degree of harm and month 1/4/2016 – 31/3/18

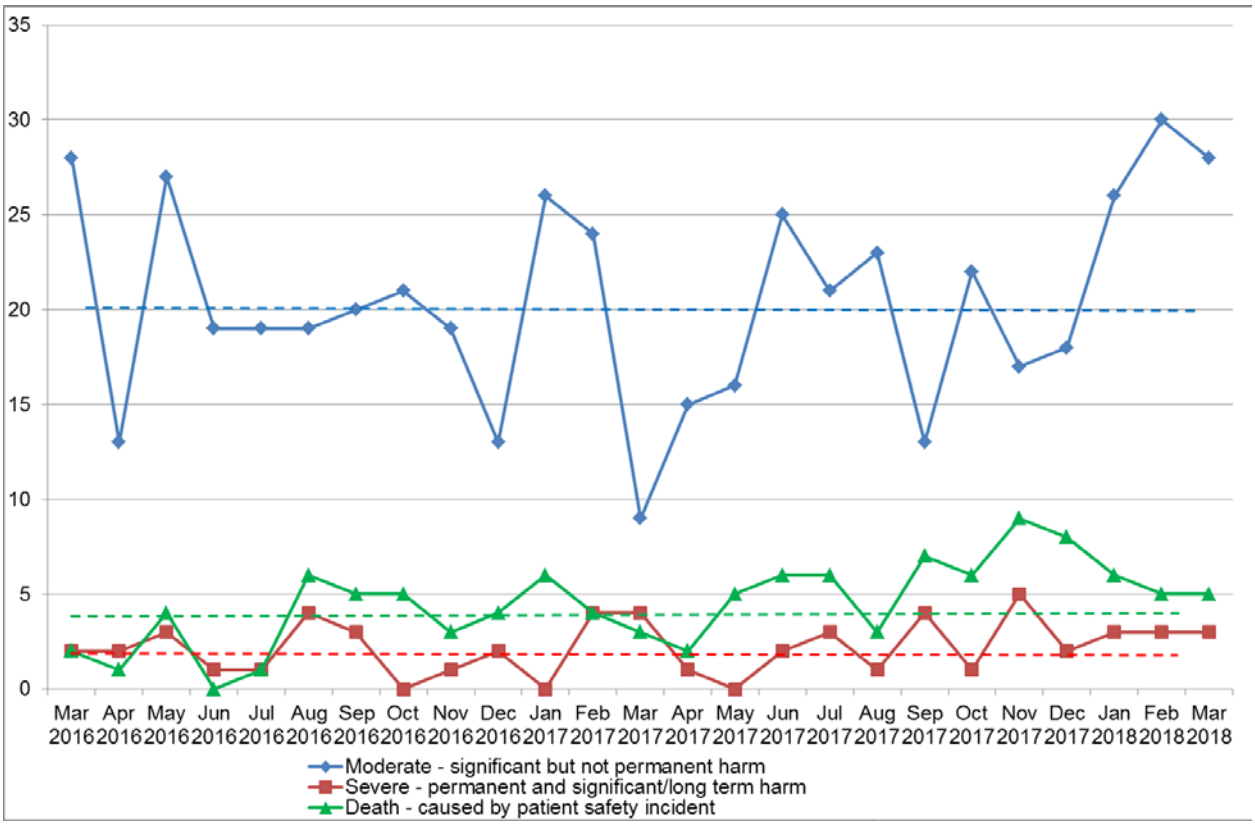


Figure 8 shows the highest number of applicable incidents is in Barnsley General Community Services with 138 incidents. This is a reduction on 171 in 2016/17. A high proportion of these were pressure ulcers, 117 grade 3 (moderate harm), and 13 grade 4 (severe harm).

Figure 8 Duty of Candour incidents in 2017/18 by BDU and financial quarter

	Barnsley Mental Health	Barnsley General Community Services	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	**Total**
17/18 Q1	8	34	8	13	7	2	0	**72**
17/18 Q2	10	37	17	11	6	1	0	**82**
17/18 Q3	11	27	7	25	10	4	2	**86**
17/18 Q4	7	40	14	13	8	2	3	**87**
Total	**36**	**138**	**46**	**62**	**31**	**9**	**5**	**327**

Compliance with Duty of Candour

Each BDU has identified a lead to review compliance with Duty of Candour. Figure 9 shows the monitoring position which breaks down as below:

- In 74% of cases (243), a verbal conversation has happened with the patient and/or family within 10 days of the incident occurring or being identified (as per the contract).
- There were 26 cases where Duty of Candour was not completed but exception reasons were given (8%). The number of exceptions has increased on 2016/17 (3.5%).
- There were 4 breaches of duty of candour recorded during 2017/18. In all cases, an apology was given, but after the 10 day timeframe.
- There were 3 cases where managers were asked to provide further clarification on the harm that occurred and if a verbal apology had taken place.
- There are a number (51) of incidents that remain under review by BDUs. These may be subject to change as further information becomes available e.g. when actual injuries or cause of death are confirmed. It should be noted that these may include breaches.

Figure 9 Duty of Candour compliance 2017/18

	Barnsley Mental Health	Barnsley General Community Services	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	**Total**
Stage 1 Duty of Candour - verbal apology completed within 10 days	29	98	33	47	25	8	3	**243**
Stage 1 Duty of Candour verbal apology not given following MDT decision (exception)	1	0	0	0	0	0	0	**1**
Stage 1 Duty of Candour - not completed (exception)	2	3	9	7	4	0	0	**25**
Stage 1 Duty of Candour - verbal apology completed after 10 days (breach)	0	0	0	2	2	0	0	**4**
Stage 1 Duty of Candour - awaiting further clarification from manager	1	1	1	0	0	0	0	**3**
Awaiting review by BDU	3	36	3	6	0	1	2	**51**
Total	**36**	**138**	**46**	**62**	**31**	**9**	**5**	**327**

Exception reasons include verbal apology not being given following MDT decision due to clinical presentation or being detrimental to patient's wellbeing. In other cases Duty of Candour was not possible with the patient as they were too unwell. In some cases, particular where patients had died, there were no family contact details known to enable us to make contact with family members.

Section 3 Learning from healthcare deaths

Introduction

Scrutiny of healthcare deaths has been high on the government's agenda for some time. Reports such as Francis report and Southern Healthcare report has intensified this.

All Healthcare providers were asked to develop a healthcare deaths Policy by 30 September 2017 that set out how we identify, report, review and learn following the death of a patient.

The Trust fully supports this approach and has developed the policy with other providers in the North of England as part of our collaborative approach to learning from deaths. Our Learning from healthcare deaths – the right thing to do policy came into effect from 1 October 2017. A review of the policy with our alliance colleagues is planned.

Trusts were also required to report and publish data for 2017/18 from quarter 3 2017/18 onwards, available on our website.

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 reviews deaths which have been agreed which are in scope through the policy. We aim to work with families/carers of patients who have died as they 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.

April 2017 – September 2017
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
From 1 October 2017, Trust staff have been reporting 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 reportable death has then been 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, including Structured Judgment Record Review (SJRR)
3. Investigation – including service level, serious incident 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 came into effect from 1 October 2017.

Following the publication of the Trust policy, it was expected that the total number of deaths not in scope would reduce. However, during this time, staff have still been gaining confidence so we have seen deaths that are not in scope being reported, which is due to clarity being sought following the death and staff not understanding what can be recorded on the clinical system and what needs reporting on Datix. The numbers of deaths in scope have risen as expected through the expansion of scope from 1 October 2017.

Learning from Healthcare Deaths reporting

During 2017/18, 2884 of South West Yorkshire Partnership NHS Foundation Trust patients died (see figure 10). This figure relates to deaths of people who had any form of contact with the Trust within 180 days (approx. 6 months) prior to death, identified from our clinical systems through Business Intelligence software. This includes services such as end of life, district nursing and care home liaison services. Of note is that for a large number, the Trust was not the main provider of care at the time of death.

Not all these deaths were reportable as incidents on Datix. The figures in Figure 10 illustrate the number deaths that were reported on Datix in each financial quarter. For the purpose of this section, the date of reporting on Datix is used rather than the date of death. This is to ensure all deaths are systematically reviewed. The figures may differ from other sections of the report.

Figure 10 Summary of 2017/18 Annual Death reporting by financial quarter to 31/3/2018

	Quarter 1 2017/18	Quarter 2 2017/18	Quarter 3 2017/18	Quarter 4 2017/18	2017/18 total
1) Total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of date of death	745	675	725	739	**2884**
2) Total number of deaths reported on Datix by staff (by reported date, not date of death)	162	178	146	97	**583**
3) Total number of deaths reviewed	162	178	146	97	**583**
4) Total number of deaths which were in scope	27	23	62	55	**167**
5) Total number of deaths reported on Datix that were not in the Trust's scope	131	145	22	15	**313**
6) Total number of reported deaths which were rejected following review, as not reportable or duplicated.	4	10	62	26	**102**

Of the 583 deaths that were reported, 480 were appropriately recorded on Datix (row 4 and 5 in figure 10). There were a further 102 deaths reported which, on review, did not meet the reporting requirements (as previously outlined).

Figure 11 Reported deaths by category and BDU reported during 2017/18

	Barnsley Mental Health	Barnsley General Community Services	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Total
Death - confirmed from physical/natural causes	107	12	45	65	83	0	20	332
Death - cause of death unknown/ unexplained/ awaiting confirmation	10	0	7	23	15	0	7	62
Suicide (incl apparent) - community team care - current episode	5	0	5	21	8	1	3	43
Death - confirmed from infection	0	0	4	3	3	0	3	13
Suicide (incl apparent) - community team care - discharged	0	0	4	3	5	0	0	12
Death - confirmed related to substance misuse (drug and/or alcohol)	2	0	2	2	1	0	0	7
Death - confirmed as accidental	0	0	0	0	2	0	1	3
Suicide (incl apparent) - inpatient care - current episode	0	0	1	2	0	0	0	3
Fire / Fire alarm related incidents	0	0	1*	0	0	0	0	1
Informal patient absent without leave (which resulted in death)	0	0	0	1*	0	0	0	1
Self harm (which resulted in death)	0	0	1*	0	0	0	0	1
Patient fall	0	0	0	1*	0	0	0	1
Unwell/Illness	0	1*	0	0	0	0	0	1
Total	124	13	70	121	117	1	34	480

Figure 11 shows the deaths reported by the category and BDU. There are five categories relating to five deaths marked with asterisks. These were all incidents which occurred which resulted in the service user's death, which are summarized in Figure 12.

Figure 12 Breakdown of deaths categorised as other incidents

Category	Incident summary	Review process
Unwell/illness	Patient collapsed at a general community inpatient ward, and later died in the acute trust from pulmonary embolism	Structure Judgment Record Review
Patient Fall	Patient fell in an inpatient unit, resulting in fractured neck of femur. Patient died approximately 4 weeks later.	Structure Judgment Record Review
Fire	Patient died in an accidental house fire	Service level investigation
Self harm	Patient was hit by a train resulting in significant injuries. This was an SI investigation at this point. The patient subsequently died from their injuries.	SI investigation
Informal patient died whilst absent from the ward	Patient was on planned home leave from an inpatient ward. Patient went missing from home and was later found deceased.	SI investigation

Of the 480 deaths, 167 met the Learning from Healthcare Deaths review criteria and were classed as being 'in scope' for mortality review processes. Figure 13 shows the review process and the financial quarter they were reported in. This shows the expected increase in deaths in scope in quarters 3 and 4 in line with the introduction of the new policy.

Figure 13 Learning from Healthcare Deaths during 2017/18 by financial quarter and mortality review process

Financial Quarter	Structure Judgement Record Review (SJRR)	Manager's 48 hour review (1st stage case note review)	Serious Incident Investigation	Service Level Investigation	Learning Disability Death process (LeDeR)	Other review process	Safeguard review	Certified	**Total**
Quarter 1	4	N/A	11	0	0	0	1	11	**31**
Quarter 2	6	N/A	12	2	1	0	1	1	**29**
Quarter 3	13	3	16	5	5	0	1	18	**77**
Quarter 4	9	19	7	2	9	1	1	8	**84**
total	**32**	**22**	**46**	**9**	**15**	**1**	**4**	**38**	**167**

Understanding the data around the deaths of our service users is a vital part of our commitment to learning from all deaths. Working with eight other mental health trusts in the North of England Alliance, we have developed a reporting dashboard that brings together important information that will help us to do that. We will continue to develop this over time, for example by looking into some areas in greater detail and by talking to families about what is important to them. We will also learn from developments nationally as these occur. The Northern Alliance are unable to report on what are described in general hospital services as "avoidable deaths" in inpatient services. This is because there is currently no research base on this for mental health services, no satisfactory definition of 'avoidable' and no consistent accepted basis for calculating this data. We also consider that an approach that is restricted to inpatient services would give a misleading picture of a service that is predominately community focused. We will continue to review this decision and will continue to support work to develop our data and general understanding of the issues.

Deaths reported as SIs

Of the 167 deaths reported on Datix between 1 April 2017 and 31 March 2018, 48 were reported as serious incidents, however 4 of these were later removed (delogged) as serious incidents. Three had had SI investigations completed, but no learning was identified; the other case moved into safeguarding review processes. These figures will not match those reported in the Serious Incident

section of this report due to the use of different dates for different processes (SI uses date reported on STEIS; mortality uses date reported on Datix).

Suicides not reported as SIs

Within the 167 deaths, there are 15 apparent suicides that were not reported (or are no longer classed) as serious incidents. Figure 14 shows this breakdown by method of apparent suicide and BDU.

Figure 14 Apparent Suicides not reported as Serious Incidents by method and BDU

	Calderdale	Forensic Service	Kirklees	Wakefield	Total
Suicide (incl apparent) - community team care - current episode					**8**
Hanging - self injury	0	1	1	2	4
Illicit drug - self poisoning	1	0	0	1	2
Jumping from height	0	0	1	0	1
Suffocation - self injury	0	0	1	0	1
Suicide (incl apparent) - community team care - discharged					**7**
Contact with moving vehicle (car, train) - self injury	1	0	0	0	1
Hanging - self injury	1	0	2	2	5
Jumping from height	1	0	0	0	1
Total	**4**	**1**	**5**	**5**	**15**

The Serious Incident Framework[9] defines that a serious incidents are;
"events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare."

All 15 deaths have been reviewed by managers and been discussed at the clinical risk panel and/or mortality review group and the cases did not or no longer met this criteria. All cases have been reviewed through other processes, as set out in figure 15. Some examples are given below:

- Three cases were originally reported as serious incidents, but on completion of the investigation the Clinical Commissioning Group proposed withdrawal as a serious incident, as there was no learning identified.
- Another case was formerly reported as an SI but due to the circumstances was transferred into Safeguarding processes, and was delogged from STEIS.
- Some cases were identified for review through a sample of cases identified through the wider Business intelligence dataset, resulting in Structured Judgement Record Review.
- Structured Judgement Record Reviews have been undertaken where there has been limited contact with services, for example:
    - Seen once by services and they requested no further follow up. They were discharged 2-3 months prior to their death.
    - Referred to the Trust, they were screened but not seen before their death. The response to the referral was as expected and reasonable.

[9] NHS England. Serious Incident Framework. March 2015

- Last contact with the service was three months prior to their death, and they were not on a caseload. They had previous contact with the Trust approximately 12 months prior to death.

Figure 15 Apparent suicides not reported as serious incidents by category and review process

	Safeguarding review	Serious Incident Investigation (now delogged)	Service Level Investigation	Structure Judgement Record Review (SJRR)	**Total**
Suicide (incl apparent) - community team care - current episode	1	3	2	2	**8**
Suicide (incl apparent) - community team care - discharged	0	0	1	6	**7**
Total	**1**	**3**	**3**	**8**	**15**

These cases have ***not*** been included in the apparent suicide report.

Next Steps

A review of learning from healthcare deaths has been completed by internal audit providing significant assurance. The report stated "A significant amount of work has taken place at the Trust in developing, implementing and establishing arrangements for learning from deaths in compliance with the NQB requirements (issued in March 2017). Whilst there are still some requirements which need to be fulfilled, the Trust is acutely aware of these and work is continuing to achieve these." The Mortality review group workshop has been arranged to explore how best to implement the audit findings. The report has identified 4 risks (1 medium and 3 low) and proposed/agreed 10 actions (6 medium and 4 low)

This will include:

- A review of the Learning from Healthcare Deaths policy will take place to include feedback from the audit findings and learning from the first six months of policy implementation in consultation with Northern Alliance colleagues.
- To agree the function, accountability and purpose of the mortality review group, including a review of mortality groups terms of reference
- Develop an annual work plan to support work stream priorities
- We will further develop processes and consistency in sharing learning
- Strengthen our approach to identification and recording of main providers other than SWYPFT and processes to support sharing of information is strengthened.
- We will continue to be on part of the group work with Improvement academy with service users and carers about communication and approach following mortality. This work is nearing completion and has been shortlisted for three awards:
  - HSJ Patient safety award for QI initiative of the year
  - BMJ patient safety award
  - RCP Excellence award for patient safety team
- The resource and capacity to undertake and develop this work is significant and a business case to support this will be submitted to enable this work to take place.
- The Trust is providing training to increase the number of Structured Judgment Record Reviewers.

Section 4 - Serious Incidents reported during 2017/18

Background context

Serious incidents are defined by NHS England as;

> "…events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare." [10]

There is no definitive list of events/incidents. However, there is a definition in the Serious Incident Framework which sets out the circumstances in which a serious incident must be declared:

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

- the unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- serious harm to one or more patients, staff, visitors or members of the public or where outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm (this includes incidents graded under the NPSA definition of severe harm)
- a scenario that prevents, or threatens to prevent, a provider organisation's ability to continue to deliver health care services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment. IT failure or incidents in population programmes like screening and immunisation where harm potentially may extend to a larger population
- allegations of abuse
- adverse media coverage or public concern for the organisation or the wider NHS one of the core set of *Never Events*[11].

Investigations

Investigations are initiated for all serious incidents in the Trust to identify any systems failure or other learning, using the principles of root cause and systems analysis. The Trust also undertakes a range of reviews to identify any themes or underlying reasons for any peaks. Most serious incidents are graded amber or red on the Trust's severity grading matrix, although not all amber/red incidents are classed as serious incidents and reported on the Strategic Executive Information System (StEIS). Some incidents are reported, investigated and later de-logged from StEIS following additional information. Conversely, some incidents are reported as Serious Incidents on StEIS after local investigation.

[10] NHS England. Serious Incident Framework. March 2015
[11] NHS Improvement. Never Event policy and framework 2018

Headlines

During 2017/18, 71 Serious Incidents were reported to the relevant Clinical Commissioning Group (CCG) via the NHS England Strategic Executive Information System (StEIS). This is a small increase overall on 2016/17 (65). During the year, the patient safety support team have been ensuring consistency of serious incident reporting, e.g. fire incidents in acute wards.

Never Events[12] are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There were **no 'never event'** incidents reported by SWYPFT in 2017/18. The last Never Event reported by the Trust was in 2010/11. A revised list of Never Events came into effect on 1 February 2018. This is available on the Trust intranet.

There was **one homicide** reported in 2017/18.

- 71 Serious incidents reported
- Serious incidents account for 0.58% of all incidents
- Increase on total on 2016/17 (65)
- One homicide reported
- No Never Events

[12] NHS Improvement. Never Event policy and framework 2018

Serious Incident Analysis

Figure 16 below shows all serious incidents reported on StEIS between 1 April 2013 and 31 March 2018. During this time, the definitions of serious incidents has changed, and also the reporting criteria for pressure ulcers has changed over time, a) with the introduction of recording as SIs from 2013/14 onwards, and in February 2015, to report only those that are avoidable.

Figure 16 Total number of Serious Incidents reported by financial year 2013/14 to 2017/18

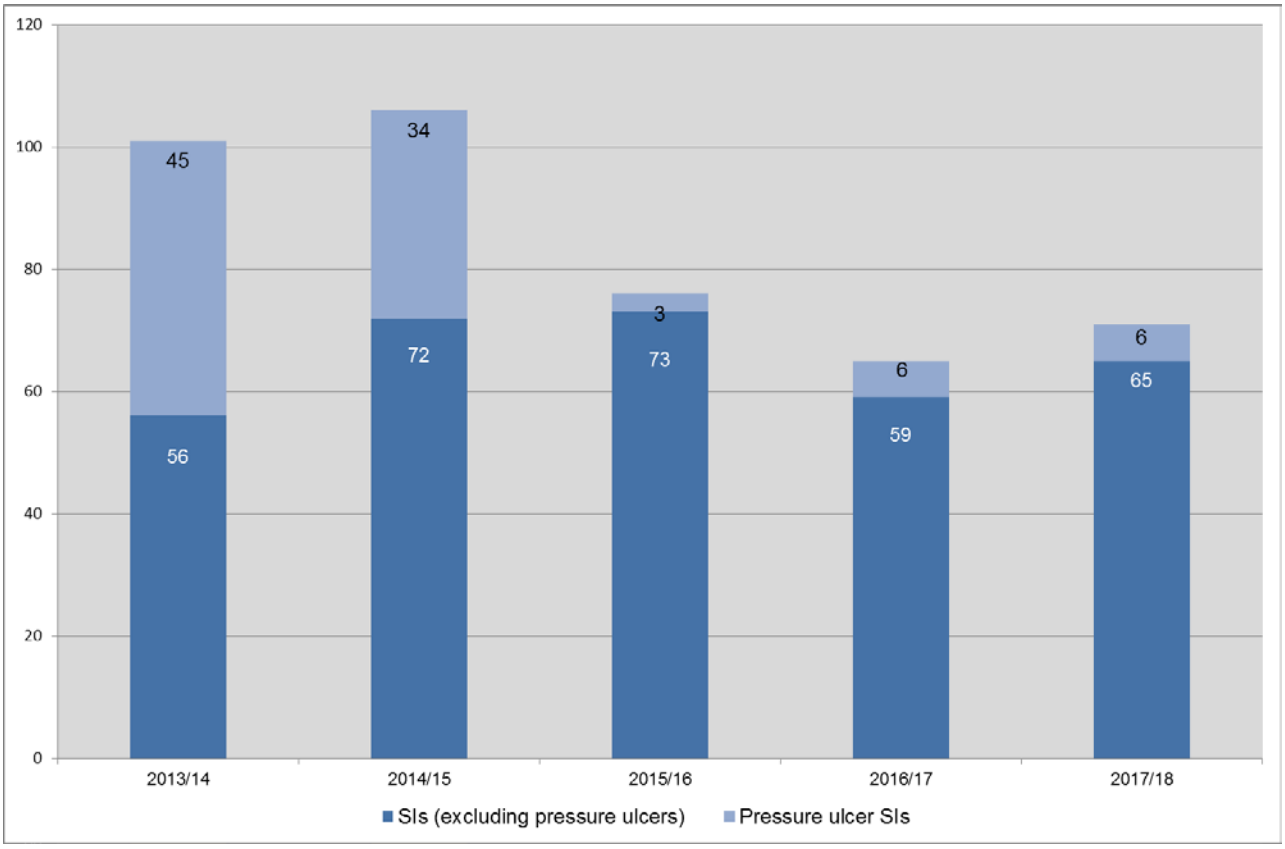
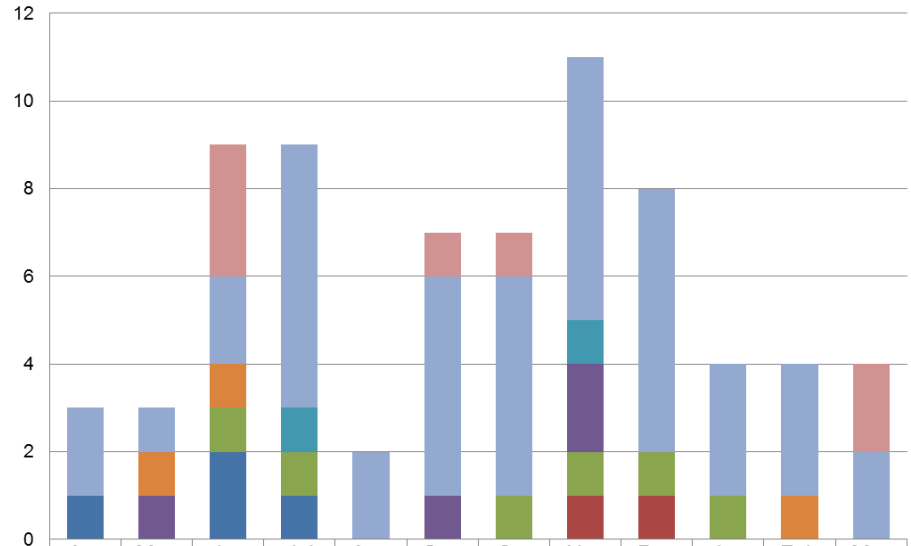


Figure 17 shows a breakdown of the 71 serious incidents by the type of incident by the month reported. The patient safety support team has undertaken analysis of all serious incidents that have been reported by category, team, month and year. The number of SIs reported in any given period of time can vary, and given the relatively small numbers involved and the wide definition of an SI, it can be difficult to identify and understand the reasons for this. However it is important that any underlying trends or concerns are identified through analysis. There are no obvious trends by teams or category from previous years.

Figure 17 Types of All Serious Incidents reported in 2017/18 by date reported on StEIS



	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018
Violence and Aggression	0	0	3	0	0	1	1	0	0	0	0	2
Death (including suspected suicide)	2	1	2	6	2	5	5	6	6	3	3	2
Self Harm	0	1	1	0	0	0	0	0	0	0	1	0
Medication	0	0	0	1	0	0	0	1	0	0	0	0
Information Governance Incidents	0	1	0	0	0	1	0	2	0	0	0	0
Care Pathway, Clinical and Pressure Ulcer Incidents	0	0	1	1	0	0	1	1	1	1	0	0
Missing/absent service users	0	0	0	0	0	0	0	1	1	0	0	0
Health and Safety (including fire)	1	0	2	1	0	0	0	0	0	0	0	0

As in previous years, the highest type of serious incident (as described in section 2) is death of a service user (Figure 17). Further analysis of deaths shows that the highest proportion of these being by apparent suicide (40) and a further 5 deaths which were unexpected (this includes 2 which remained recorded as the originating incident i.e. a self-harm incident where the patient died from their injuries, and a death of a patient after they were on leave from a ward). Further breakdown is available later in this section.

Figure 18 Serious Incidents reported during 2017/18 by reported category

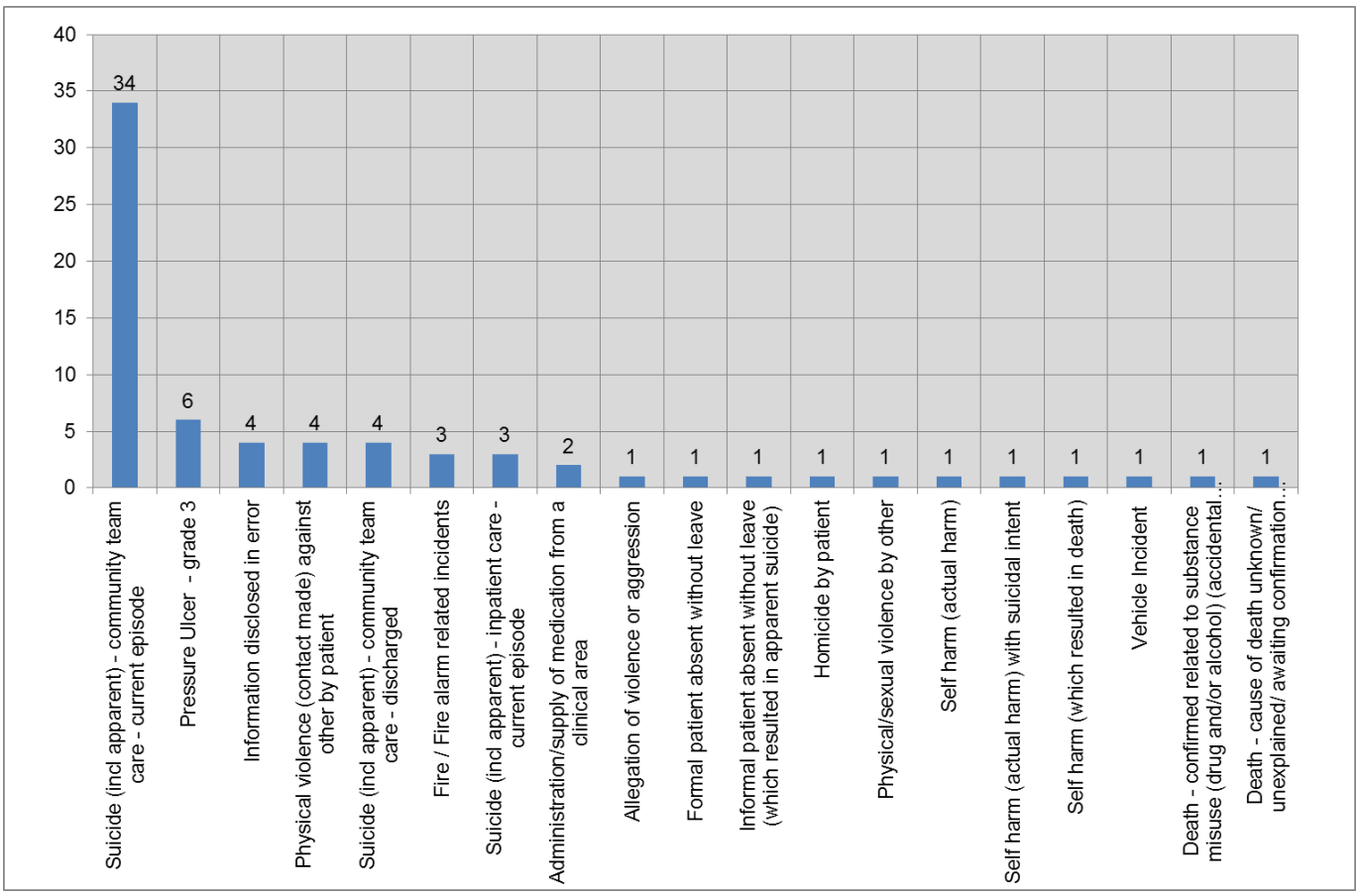


Figure 18 shows a breakdown of the reported serious incidents by category. The category of incident (a subset of 'type', as shown in Figure 17) provides more detail of what occurred. It shows that apparent suicide of service users in current contact with community teams is the highest reported category with 34 (2016/17 [17]; 2015/16 [29]). There are a further 9 incidents relating to apparent suicide. These include 3 deaths where the patient was under the care of inpatient services at the time of death; 4 deaths where the service user was discharged from mental health services at the time of their death; an informal patient who went absent without leave and took their own life and a self-harm incident which resulted in the death of the service user. The latter two are categorised as the originating incident with death being the result (Figure 18). The apparent suicide report provides further breakdown.

As Figure 19 shows, during 2017/18, the area with the highest number of SIs reported was Kirklees (30), an increase on 2016/17 (20). This is followed by Calderdale and Barnsley mental health services both with 10 SIs reported in 2017/18. In 2016/17 these two areas had 5 and 11 SIs respectively. Wakefield's figure has reduced from 11 (2016/17) to 8 (2017/18). Barnsley General Community has remained the same number; Forensic services have 2 SIs compared with 3 in 2016/17 and Specialist services have had a reduction to 3 SI's, compared with 6 in 2016/17.

Figure 19 2017/18 Reported Serious incidents by BDU and category

	Barnsley General Community Services	Barnsley Mental Health	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	**Total**
Suicide (incl apparent) - community team care - current episode	0	5	4	17	5	0	3	**34**
Pressure Ulcer - grade 3	6	0	0	0	0	0	0	**6**
Information disclosed in error	1	0	1	1	0	1	0	**4**
Physical violence (contact made) against other by patient	0	1	1	2	0	0	0	**4**
Suicide (incl apparent) - community team care - discharged	0	0	0	1	3	0	0	**4**
Suicide (incl apparent) - inpatient care - current episode	0	0	1	2	0	0	0	**3**
Fire / Fire alarm related incidents	0	0	1	2	0	0	0	**3**
Administration/supply of medication from a clinical area	1	1	0	0	0	0	0	**2**
Allegation of violence or aggression	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 (which resulted in apparent suicide)	0	0	0	1	0	0	0	**1**
Homicide by patient	0	0	0	0	0	1	0	**1**
Physical/sexual violence by other	0	1	0	0	0	0	0	**1**
Self harm (actual harm)	0	1	0	0	0	0	0	**1**
Self harm (actual harm) with suicidal intent	0	1	0	0	0	0	0	**1**
Self harm (which resulted in death)	0	0	1	0	0	0	0	**1**
Vehicle Incident	0	0	0	1	0	0	0	**1**
Death - confirmed related to substance misuse (drug and/or alcohol) (accidental overdose)	0	0	1	0	0	0	0	**1**
Death - cause of death unknown/ unexplained/ awaiting confirmation (house fire)	0	0	0	1	0	0	0	**1**
Grand Total	**8**	**10**	**10**	**30**	**8**	**2**	**3**	**71**

Demographic comparison of Serious Incidents reported

The numbers in Figure 19 must be considered by BDU population sizes and service configuration.

Population

When serious incidents are viewed against population size (Figure 20) it shows Barnsley and Kirklees were the areas that had more serious incidents per 100,000 population in 2017/18 as they

were in 2016/17. It must be noted that the numbers are small. Barnsley has seen a slight decrease on 16/17, Wakefield has remained the same, and both Calderdale and Kirklees have seen an increase in the number of Serious Incidents reported on STEIS per 100,000 population. The Trust total for SIs reported used in Figure 20 was 70 (excludes one Serious incident not geographic specific). Three Serious incidents in CAMHS services in Wakefield have been included under Wakefield, and the Kirklees figure includes a Forensic low secure community serious incident.

Figure 20 BDU population estimates and serious incident figures (STEIS reported) per 100,000 population and 10000 mental health contacts

Geographical district	Population ONS[13] – population estimates Mid 2016	Serious Incident figures per 100,000 population for 2016/17 (incl BGCS)	Mental health service users who have had one or more contacts 2016/17	Serious Incidents 2016/17 per 10,000 mental health contacts (only mental health SIs)	Serious Incident figures per 100,000 population for 2017/18*	mental health service users who have had one or more contacts 2017/18	Serious Incidents 2017/18 per 10,000 mental health contacts (only mental health SIs)**
Barnsley	241,218	7.9	13163	8.3	7.46	13544	7.38
Calderdale	209,770	2.1	5712	8.7	4.76	5561	17.98
Kirklees	437,047	4.6	15922	12.6	7.09	15884	18.88
Wakefield	336,834	3.3	9432	11.7	3.26	9273	8.62
Total	**1,224,869**	**4.5**	**44229**	**10.6**	**5.71**	**42641**	**13.6**

* 2017/18 Serious incident total includes Barnsley General Community Services SIs, Forensic low secure SI and CAMHS Wakefield SIs). One SI is excluded as it was not geographic specific (Forensic CAMHS)
** excludes 2017/18 Forensic services and CAMHS services SIs

Mental Health contacts

When comparing serious incident reported on STEIS against mental health service users who have had one or more contacts recorded per 10,000 contacts, the range is between 7.38 for Barnsley and 18.88 for Kirklees. For the purposes of this report, SIs reported by Barnsley General Community services, Forensic services and CAMHS services have been removed as these services are not included in the mental health contacts data.

The rate of serious incidents by mental health contacts shows a significant increase in both Calderdale and Kirklees. Barnsley has seen a slight reduction in rate, and Wakefield has also reduced.

[13] Office of National Statistics

Deaths reported as Serious Incidents (apparent suicides and unexpected deaths)

Of the 71 serious incidents reported, 45 related to the death of a service user as mentioned earlier. Of the 45 deaths, 34 patients were male (76%) and 11 female (24%) (figure 21).

Figure 21 Deaths reported as Serious Incidents 2017/18 by gender and age band

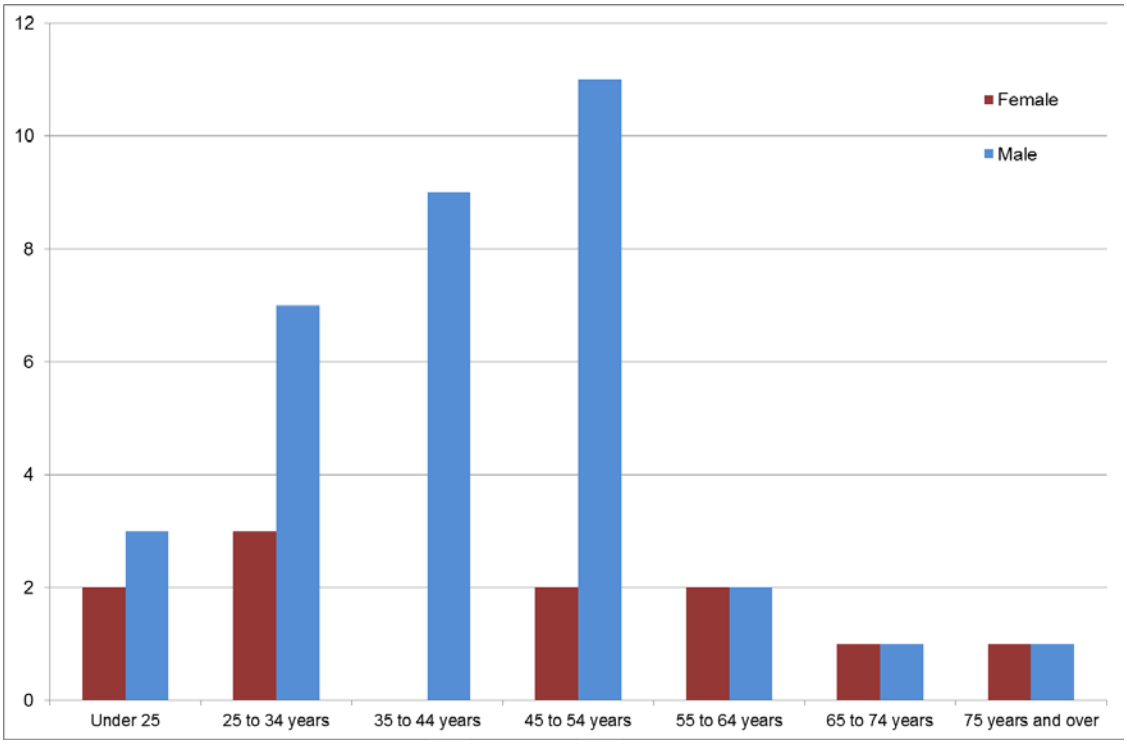


Figure 22 shows the apparent category of death at the time of writing.

Figure 22 Breakdown of all deaths reported as SIs 2017/18 by category of death and BDU

	Barnsley Mental Health	Calderdale	Kirklees	Specialist Services	Wakefield	**Total**
Suicide (incl apparent) - community team care - current episode	5	4	17	3	5	**34**
Suicide (incl apparent) - community team care - discharged	0	0	1	0	3	**4**
Suicide (incl apparent) - inpatient care - current episode	0	1	2	0	0	**3**
Informal patient absent without leave (which resulted in apparent suicide)	0	0	1	0	0	**1**
Self harm (which resulted in death)	0	1	0	0	0	**1**
Death - cause of death unknown/ unexplained/ awaiting confirmation (house fire)	0	0	1	0	0	**1**
Death - confirmed related to substance misuse (accidental overdose)	0	1	0	0	0	**1**
Grand Total	**5**	**7**	**22**	**3**	**8**	**45**

Deaths of service users where the cause of death appears to be natural or physical cause would not be reported as Serious Incidents.

Apparent and actual suicide

There were a total of 43 apparent suicides reported as serious incidents during 2017/18. As shown in figure 22, this includes a service user who was absent without leave who took their own life and a self-harm incident where the service user later died from their injuries).

Although this is a significant increase on 2016/17 [27], it is comparable with 2015/16 when there were 41 apparent suicides reported. Work has taken place during 2017/18 to strengthen links with HM Coroner (through Legal services) which has resulted in improved and timelier information about causes of death/inquest conclusions. This information has been updated on Datix which has resulted in more accurate information being collected. As a result, this year there are only 2 unexpected deaths; in previous years this was much higher.

Further detailed analysis of apparent suicides is available separately in the 2017/18 apparent suicide report; however a summary of the findings is included below.

Summary of findings from 2017/18 apparent suicide report

- 43 apparent suicide reported as serious incidents during 2017/18, compared with 2016/17 (27) and 2015/16 (41).
- Four year average rate of 38.75/year is higher than national figures would predict.
- During 2017/18 the demographics of the service users dying by suicide has changed. For age comparison:
    - The largest number of deaths in 2017/18 occurred within the 45-54 years age range with 12 deaths (28%), 10 of which were male. This is A significant increase on 2015/16 and 2016/17 where there were 6 each year.
    - There were 19 deaths (44%) recorded all together in the 25-34 and 35-44 age ranges (10 and 9 respectively). This compares with 6 and 5 respectively in 2016/17).
    - Deaths of those under 25 have reduced to 5 (11.6%) compared with 8 in 2016/17.
    - Compared with recent years, there have been more deaths of those over 55 in 2017/18 (7) compared with 2 in 2016/18.
    - 44% of apparent suicides occurred within males under 35 (19 deaths).
- 23% of deaths were by females (10), an increase on 2016/17 (2). There was no specific age group affected; deaths were across the age bands for those under 25 to 75 and over.
- 79% of deaths by suicide were from those in the white - British ethnic group, an increase on 70% in 2016/17.
- The number of service users recorded as unemployed remains high with 44% recorded as being unemployed, an increase on 2016/17 (37%).
- The number of service users recorded as living alone continues to be high. 39% of service users were recorded as living alone in 2017/18. In 2016/17 this was 27%.
- The most common method of suicide continues to be hanging with 51% of deaths recorded as hanging. This is higher than the national percentage and an increase on 2016/17 (48%).
- The most common location of apparent suicide is at the patient's own home with 51%.
- For those dying by suicide, the primary diagnosis is analysed. 37% of deaths had a primary diagnosis of depressive illness (16), this compares with 19% (5) in 2016/17. In the previous year, Schizophrenia and other delusional disorder was highest at 22%, which has reduced this year to 16% (7).
- Of the 43 cases, 42% of service users (18) had a history of alcohol misuse. 40% (17) had a history of drug misuse. 13 of these service users had a history of both alcohol and drug misuse (30%).
- During 2017/18 there were 4 deaths associated with inpatient care. All of these deaths occurred whilst the individual was on leave from the ward environment. 2 of the patients were detained under the Mental Health Act. No deaths occurred in an inpatient setting.

- Of the 43 deaths, 23% (10) were where the individuals' last contact was with Intensive Home Based Treatment Teams (IHBTT). This is followed by Core Pathway (9) and Enhanced Pathway (5).
- 49% (21) of all apparent suicides occurred in Kirklees BDU however, population sizes, service configuration and number of mental health contacts must be taken into consideration (see figures 1 and 2).
- Of the acute mental health and LD providers, Kirklees has the highest rate of suicide per 100,000 service users (132.2), substantially higher than next highest, Wakefield (57.96) followed by Barnsley (36.91).
- In 17 cases (40%) the incident investigators recorded that the patient was known to have experienced a significant life event however, the nature of this event was not recorded.
- Of the 43 people who died by suicide, 53% had a documented history of self harm.
- The last contact with services was routine or non-urgent in 60% of cases.

Death – other causes

There were 2 serious incidents reported relating to the unexpected death of service users which has decreased significantly over a number of years (8 in 2016/17; 14 in 2015/16), as noted above. The 2 unexpected deaths related to a service user who died in a house fire (awaiting inquest conclusion) and a service user who died at home where cause of death was unclear at the time. This was later reported to be from accidental overdose of prescribed medication. It can take a significant amount of time for the cause of death to be identified through the coroner's office. However, irrespective of the outcome, this does not prevent the investigation being completed.

During the 2017/18 we have introduced our Learning from Healthcare Deaths policy and procedures, which has also given the Trust other methods of reviewing deathse.g.eg Structured Judgment Record Review), which were not available to us previously.

Information Governance

During 2017/18 four Information Governance incidents were reported as Serious Incidents. This is a reduction on the 10 reported in 2016/17, returning reported incidents to that seen in 2015/16 [4].

All four incidents reported as serious incidents during 2017/18 involved information being disclosed in error as correspondence was sent to the wrong address or preferences were not followed; 4 patients were affected. We have not had any of the large scale incidents that occurred during 2016/17 and, whilst we have recently reported incidents involving misdirected correspondence, the awareness raising seems to be working and the number has reduced. The incidents were spread across four different teams in different BDUs.

Information Governance and IT incidents which have an IG score of 2 or above on the Department of Health (DOH) table[14] are managed as a Serious Incident (reported on StEIS) and also reported to the Information Commissioner as a Serious Incident Requiring Investigation (SIRI). For further information please contact the Information Governance Team.

Pressure ulcers

During 2017/18, a total of six grade 3 pressure ulcers were reported as Serious Incidents on StEIS. This figure is consistent with that reported in 2016/17. These were all reported by District Nursing/Neighbourhood teams in Barnsley General Community Services. These incidents are recorded with an amber severity on the Datix System. Four of the six pressure ulcers occurred in male patients.

[14] Further information on IG scores is available in the Trust's Incident Reporting and Management Policy

Violence and Aggression

During 2017/18 there were 6 violence and aggression incidents, consistent with 2016/17. In contrast to 2016/17, all six violence and aggression serious incidents in 2017/18 occurred in community settings (3 in 2016/17 were in inpatient settings).

Four incidents related to alleged assaults on third parties involving weapons. The other incidents involved a homicide of a relative by a patient in home; physical violence by member of the public against a member of staff (shot with pellet gun) and an alleged assault on a third party by a patient. All service users were under the care of community services at the time of the incidents.

Self-harm/attempted suicide

During 2017/18 there were 3 serious self-harm incidents, compared with 4 in 2016/17. The incidents included an incident of jumping from a roof (Core Team, Barnsley), a self-injury by cutting (SPA Team, Barnsley), and self-injury from being hit by a moving train which resulted in death (Intensive Home Based Treatment Team, Calderdale). The death is included in the deaths and apparent suicide sections.

Falls

No falls serious incidents during 2017/18.

Medication

During 2017/18 there were two serious incidents involving medication errors. The last medication incident of this severity was in 2008. The incidents included administration of a higher dose of medication than was prescribed (Clark ward, Barnsley mental health), and an incident of administering medication to the wrong patient (Neighbourhood Nursing Team, Barnsley general community services).

Absent without Leave

During 2017/18 there were two incidents of this type. The first related to a detained patient who absconded from staff whilst on planned leave from a ward (Ashdale ward, Kirklees). This patient subsequently sustained a fall resulting in serious injuries. The second incident involved an informal patient on home leave, who left home and was later found deceased (Ward 19, Kirklees). The death is included in the deaths and apparent suicide sections.

Fire

During 2017/18 there were three fire related serious incidents. Two were in inpatient settings. The first was where a patient set a fire in a bedroom causing substantial fire damage to the room itself. The patient was arrested by the Police following the Fire service investigation determining deliberate ignition. They were not charged by the Police due to lack of evidence. The room was out of action for a number of weeks but the ward resumed normal activity within 24 hours (Ashdale Ward, Kirklees). The second was at Ward 18, Kirklees where a patient set fire to the bed/bedding. The fire was extinguished by the patient on staff arrival. There was minimal damage to bedding only. This was reported to the Police but no further action was taken due mental illness of the patient. The patient was transferred to Psychiatric Intensive Care Unit. The third fire occurred in the community, where a patient admitted setting fire to a third party's house. They were arrested for arson and charged and remanded to custody.

Health and Safety

In other serious health and safety incidents in 2017/18, a community patient was hit by a bus. It is currently unclear if this was accidental or deliberate.

Section 5 - Findings from Serious Incident Investigations completed during 2017/18

This section of the report focusses on the **68** serious incident investigation reports were completed and submitted to the relevant commissioner during the period 1 April 2017 to 31 March 2018. Please note this is not the same data as those reported in this period (see Section 3) as investigations take a number of months to complete. The term 'completed' is used in this section to describe this.

- 68 serious incident investigations completed
- 251 recommendations made
- 260 associated actions
- 5 investigations had no recommendations
- Most investigations include a recommendation to share learning
- Top 3 action themes:
  1) Record keeping
  2) Staff education, training and supervision
  3) Team/service systems, roles and management

Performance

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

Serious Incident investigation progress is monitored through the weekly patient safety support team investigators meeting, and reported through the weekly clinical risk panel. There can be delays in completing investigations within the 60 working days. Reasons for delays varying, but generally relate to issues such as complexity, staff availability to conduct interviews and investigation allocation delays due to capacity. Some of the investigations in 2017/18 have involved a number of organisations and this increases complexity. Bank investigators and external investigators have been used to manage some of this pressure and during the year we have trialed a temporary Band 7 developmental post.

The Patient Safety Support Team occasionally experiences difficulties in allocating investigations due to fluctuations in reporting rates, which consequently impacts on the ability to complete within the timescales.

Headline data

Of the 68 serious incident investigation reports completed and submitted to the relevant commissioner between 1 April 2017 and 31 March 2018, 63 resulted in an action plan (Figure 23). A standard recommendation to share learning and the outcome of the investigation with staff involved and wider is now in place. This has increased the number of actions.

Figure 23 Breakdown of the number of Serious Incidents completed, compared with the number of recommendations and associated actions

2017/18	**SIs completed**	**Number of Recommendations**	**Number of Actions**
Barnsley General Community	10	40	43
Barnsley Mental Health	11	33	39
Calderdale	8	21	21
Kirklees	19	60	60
Forensic	4	32	32
Specialist Services	4	25	25
Wakefield	12	40	40
total	**68**	**251**	**260**

From the 68 serious incidents completed during 2017/18 there were 260 actions made (figure 23). Of those, 51 were related to sharing learning. It should be noted that one recommendation can result in a number of associated actions. For the purposes of analysis, actions are used in this report. In addition, one incident investigation can generate a high number of actions as shown in figure 25 when considered by service type across the Trust.

Figure 24 Top 3 service areas with highest number of actions with number of SIs

Service area – trust wide	**Number of actions**	**Number of SIs**
Crisis/IHBTT (Adult)	41	10
Acute Inpatients (Adult)	40	7
Community mental health teams (Adult)	37	10

Over the last 3 years the highest numbers of actions have arisen from apparent suicide incidents. This correlates with this being the largest type of Serious Incident reported.

It is important to understand that in undertaking an investigation of an incident, the Trust takes the view that all areas for learning or improvement should be identified and lead to a recommendation being made. These are often care delivery issues, and not considered to have been the direct root cause of the incident.

A majority of the recommendations from serious incident investigations apply directly to the team or BDU involved. Each BDU lead investigator works closely working with the practice governance coaches and BDUs to produce a report on learning from recommendations hyperlink where further information/breakdown about each BDU and the lessons learnt is presented. This is called 'Our learning journey from incidents'.

Categorisation of actions

In order to analyse actions, each action is given a theme to capture the issue/theme that best matches from a pre-designed list of approximately 20 themes. In an attempt to gain consistency, this is undertaken by the Lead Serious Incident Investigators. It isn't always straightforward to identify which theme an action should be given - some don't easily fit into any theme, and some could be included under more than one.

Figure 25 Ordinal list of action themes from 2017/18 compared with 2016/17

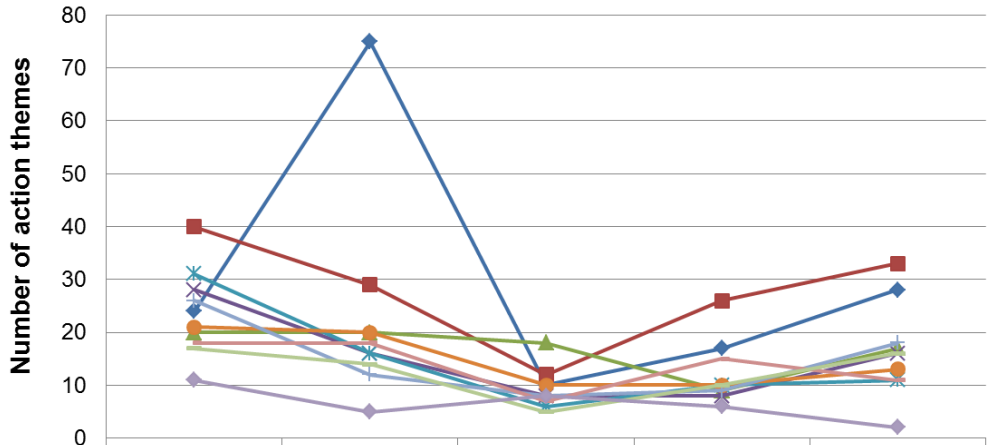
Top 6 action themes	2017/18	2016/17
A5* Record keeping	1	1
F1 Staff education, training and supervision	2	2
F4 Team service systems, roles and management	3	joint 6
G1 Organisational systems, management issues	4	joint 6
A4 Risk assessment	5	Not in top 6
F2.1 Policy and procedure - in place but not adhered to	5	Not in top 6
F2.2 Policy and procedures, not in place (new option)	5	N/A
A2 Care delivery	6	5

*the prefix is used to help order themes within Datix.

Figure 25 illustrates the ranking of the most common themes this year in comparison to last year. 'Record keeping' remains the highest, with 'staff education, training and supervision' remaining the second most common theme. 'Team/service systems, roles and management' has moved up from joint sixth to third place. 'Policy and procedures not in place' is a recent addition to the list. Communication issues and care pathway issues identified in 2016/17 are no longer in the top 6 list.

The top 10 action themes have also been reviewed over the last five financial years for comparison. As shown in Figure 26, there was a peak of staff education/training/supervision in 2014/15 which was related to a high volume of pressure ulcer SIs during that year. Many of the themes have reduced over time. Record keeping has remained one of the highest themes, along with staff education and training.

Figure 26 Top 10 action themes in the 5 years between 1/4/2013 and 31/3/18



	2013-14	2014-15	2015-16	2016-17	2017-18
F1 Staff education, training and supervision	24	75	10	17	28
A5 Record keeping	40	29	12	26	33
G1 Organisational systems, management issues	20	20	18	9	17
A4 Risk assessment	28	16	8	8	16
A1 Care pathway	31	16	6	10	11
A2 Care delivery	21	20	10	10	13
F4 Team service systems, roles and management	26	12	8	9	18
B1 Communication	18	18	7	15	11
F2.1 Policy and procedure - in place but not adhered to	17	14	5	10	16
B3 Carers/family	11	5	8	6	2

At a time of leadership and management change and transformation, it is important that all recommendations are actioned and shared across a wide range of services.

In 2017-18 the most frequent three action themes were record keeping, staff education, training and supervision, and Team service systems, roles and management issues. Below is a summary of some of the issues identified within these themes. As can be seen, there is some overlap between themes.

1) Record keeping:

Record keeping has remained within the top 3 action themes in the last six years. Some examples of areas for action are given below. Where possible these have been grouped by sub-theme:

Clinical record keeping

- All clinically relevant information should be recorded in the clinical notes
- All contacts with service users including text messages and phone calls should be recorded in records
- Handovers are accurately recorded
- Reminder of the 'Clinical Record Keeping: Guidance for clinical practice'
- Ensuring systems are in place to audit the quality of electronic record entries and documentation, including care plans and crisis and contingency plans and to ensure that the risk formulation has been documented in the summary and management plan section of the risk assessment.

Care planning

- Care plans should be kept up to date which is particularly important during transitions of care
- All medical care plans should be documented on RiO
  Care planning and Care Programme Approach reviews must be conducted and documented in line with Trust policy.
- Ensuring that care plans together with crisis and contingency plans are completed in line with Trust policy.
- Documentation and care planning should be in place to evidence what actions taken to address safeguarding issues raised by family members

Discharge

- Ensuring discharge is fully documented including letters sent to GPs and ensuring that information about the discharged individual is communicated with the receiving team
- When any service user is discharged from the service, to ensure the clinical rationale is recorded in the clinical record

Multi-Disciplinary Team meetings:

- Procedures for recording and validating multidisciplinary team notes should be reviewed to make them fit for purpose and consistent with Trust and professional record-keeping standards.
- There is also no evidence of any Multi-disciplinary team meetings taking place which may have enabled a management plan to be put into place including pre-emptive medications that may have been required, and the provision of a profiling bed and alternating mattress prior to discharge.
- The inpatient ward to ensure that the outcome of time out is documented in the progress notes and the ward should complete a full review of the multidisciplinary team ward review template. This should include the outcome of time out and risk formulation from the multidisciplinary ward team perspective in the development of a risk management plan.
- Multidisciplinary team and clinical discussions should be entered into the clinical record ASAP

Documents

- Review of the content of assessment reports that are sent to service users to minimise amount of sensitive information being posted.
- Incorporating report covering letters into the electronic record to use the service user contact details held in the clinical system to avoid error in typing details manually.
- Ensuring document naming conventions are agreed to assist when uploading documents onto a client record
- Improving the use of multiagency communication sheets
- The forms used to record observations should be reviewed to ensure the abbreviations used are consistent.
- All records received from external sources should be scanned onto the RiO electronic records system when they are received.

Service user information

- Ensuring vigilance when processing service user data and that breaching confidential information places service users at risk
- All service user contact details must be updated when the person is readmitted including when they have only recently been discharged from the ward
- All service users' names that may be confused with other people should be clearly marked
- When a service user is in an informal or formal caring role this should be fully explored and the outcome documented
- Confidentiality and information sharing should be discussed with service users on first contact and the outcome clearly documented in the patient record

Family and carers

- Ensuring there are systems in place to ask service users for next of kin details
- When service users will not provide next of kin details, this must be clearly documented

2) Staff education, training and supervision:

Staff education, training and supervision has remained within the top 3 action themes. Some examples of areas for action are given below. Where possible these have been grouped by sub-theme:

Training compliance

- Several incidents identified the need to ensure completion of mandatory training including clinical risk training, fire safety, information governance, CPR and safeguarding.

Clinical presentation

- Undertaking a peer review where mechanical restraints are used for clinical purposes.
- The importance of taking into account an individual's weight loss. Low weight/BMI impairs immune response and increases risk of infection and of impairs wound healing
- Where alcohol is a factor in a patient's presentation, a process should be identified to allow a more objective estimation of the level of alcohol use
- Ensuring that knowledge and skills relating to risk assessing and identification of a deteriorating patient and wound, including Waterlow scores
- The importance of ensuring the security of health records whilst transporting them to and from service users homes and/or professional meetings.

Information governance and record keeping

- All students as part of their introduction to their placement should be asked if they have undertaken IG training; ensuring they are aware of their responsibilities in terms of the security of health records and that they should not be taking service user documentation home.
- Developing and sharing a briefing paper on the principles and practice for correspondence

Clinical records

- Ensuring clinical team meetings are recorded and documented in the clinical record
- The importance of checking and understanding the process of recording correspondence addresses in RIO.
- The importance of the process of 'Syncing' records
- Development of training for clinical system sponsors including responsibilities as well as how to perform system functions.

Risk assessment

- Provide further training to staff members in Waterlow risk scoring to ensure that staff members have an understanding of how long term conditions can impact on Waterlow scores and decisions in the provision of pressure relieving equipment.

Safeguarding

- When there is disclosure of historical abuse, advice should be sought from Specialist Advisors and documented.
- Better understanding of reporting harm and safeguarding responsibilities

Clinical supervision

- Caseload management/supervision should be in place to ensure that care plans, crisis and contingency plans, risk assessments and any safeguarding and family concerns are being reviewed as part of the supervision process
- Determine the frequency of management supervision for clinicians working in the community team.

Other

- Raising awareness of substance misuse service provision
- Review carer competence
- Updating of Preceptorship policy

3) Team service systems, roles and management issues:

Team service systems, roles and management issues has risen into the top 3 action themes. Some examples of areas for action are given below. Where possible these have been grouped by sub-theme:

Clinical presentation

- When a service user displays offence paralleling behaviour as part of their presentation a forensic referral should be considered.
- When a service user displays a history of fire setting, the clinical team should consider seeking advice from the Fire Safety Advisor.
- When a service user discloses they have been the victim of a sexual assault, liaison with the safeguarding team should take place to ensure the appropriate referral can be made if required.
- When assessing an Early Intervention patient, a psychiatric assessment should be undertaken.

Communication

- Ensuring staff are aware of the management structure for escalation purposes when a manager is on leave
- Annual reviews of Business Continuity Plans should take place ensuring contact numbers are up to date, new staff are aware and outstanding actions have been completed. The plan should be split to include sufficient detail for separate services to respond to an emergency
- Review of multi-disciplinary team discussion process

Procedures

- Review of Trust wide Business Continuity Management Procedure.

Documents

- All outgoing clinical correspondence should be checked by a clinician before posting.
- The core team duty system should be formally documented so staff are clear on what was required of them.

Systems

- Ensuring systems are in place to check appropriate access to Trust clinical systems
- Where Access to Work recommendations are made and cannot be implemented the risk should be analysed and an alternative solution implemented.
- Ensuring post Serious Incident support is available for all staff

Information Management

- Establish systems to proof read correspondence, and facilitating the use of specialist software to support staff
- Developing systems to enable correspondence to be dictated
- Introducing the use of voice recognition software and ensuring there is a suitable environment to use this.

Staffing

- Development and implementation of a strategy to promote consistency of nursing staff (with the appropriate qualifications and expertise) on its wards, including guidance for the use of bank and agency staff.
- Capacity and demand of psychiatrist work load

Work to ensure monitoring and implementation of all Serious Incident action plans continues.

Implementation of recommendations and actions

The question everyone asks is whether the investigations and recommendations change practice.

It is very difficult to answer. Over the years we have been analysing the actions, we have seen a change in the ordinal list which could be an indication of learning. Anecdotally, we know the investigation process is valued by individuals and teams and we know the quality of reports is high from the Commissioners' reviews.

The BDUs ensure that recommendations and resulting actions are SMART and that evidence is collected against each action to demonstrate implementation. We know that the BDUs value their contribution to the action plan in ensuring the action will result in change.

The outcome of an incident does not reflect the care given. The number of reports with no recommendations will reduce over time as standard recommendations to share learning are embedded.

The Patient Safety Support Team share learning from incidents in monthly reports and have been include more examples of learning in reports.

Some Business Delivery Units hold regular learning lessons events that look at the themes of learning and have presentations on key topics. All BDUs are supported to hold these events and feedback from the events run have been very positive.

Section 6 - Key Actions and Areas for Development in 2018/19

Recent years have seen substantial developments in the serious incident framework, mortality processes, personnel and processes supporting the investigation, management and learning from incidents in the Trust. This provides a secure platform from which to develop further, particularly with an emphasis on learning.

Plans for 2018-19 include:

- Patient Safety Strategy: continued implementation including:-
  - National *Sign up to Safety* initiative: Safety improvement plans have been updated for 2018 for the remaining area of harm reduction, which are led by specialist advisors. Work will continue to reduce avoidable harm. Data is monitored through Datix Dashboards and discussed in the Patient Safety Strategy Implementation group.
  - Continued support for Safety Huddles and adopt improvement methodology to prevent suicidal behaviour
  - Focus on safety conversations/kitchen table events
  - Using improvement methodologies to improve safety, e.g. human factors
  - Suicide prevention strategy: to support the suicide prevention lead with implementation and monitoring of the action plan.
  - Implementation of the Significant Event Analysis tool
  - Continue to developing ways of capturing and sharing lessons learned and evidence of positive change

- Continue to support West Yorkshire wide patient safety initiatives including learning from healthcare deaths collaboration and suicide prevention.

- Further development of the serious incident action themes to enable improved analysis.

- Continue to embed and improve upon the work to date on systems and processes for learning from healthcare deaths. Work closely with other Trusts in the northern Alliance to share experiences and learning to meet the national policy requirements. Ensure local policies are updated to include learning from deaths requirements.

- Continue to support research.

- Datix
  - Implement future Datix release upgrades and exploit the features available to support safety
  - To maintain the Datix dashboard configuration and monitor additional requests
  - Continue with Datix system audits to ensure IG requirements are met
  - Ensure Datix configuration reflects the current management structures
  - Working with business intelligence to triangulate data
  - Improving incident report content
  - To ensure the Datix system is reviewed and refined to meet user needs

- To continue networking with other Trusts across West Yorkshire

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 June 2018
Agenda item 6.4

Title:	**Healthy Eating CQUIN**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates
Purpose:	This paper updates the Board on progress on the CQUIN and is used to evidence that Board are sighted on this issue which is a requirement for compliance.
Mission/values:	This CQUIN commenced in 2016/17 with a first phase of reducing consumption of high sugar drinks and limiting certain items on calorific value. 2017/18 provides for additional healthy eating targets and further reductions in key areas. This ties into the Trust Values of Transparency and putting the person first and in the centre.
Any background papers/ previously considered by:	The CQUIN is referenced in the overall CQUIN documentation supplied elsewhere. This paper is additional and is needed to ensure we fully comply with the CQUIN.
Executive summary:	The Trust has met the technical requirements for the 2017/18 CQUIN in full. Reports to Board and to the relevant Clinical Commissioning Group's (CCG's) will be an ongoing commitment to the organisation in order to achieve full compliance. The only wider impact of the CQUIN is financial as it is not anticipated that the reduction in sugary drinks will result in reduced sales as the low sugar options are the better sellers already as people take greater responsibility for their health.
Recommendation:	**Trust Board is asked to NOTE the content of the report and APPROVE the circulation of this report to the relevant Quality Boards.**
Private session:	Not applicable

South West Yorkshire Partnership
NHS Foundation Trust

Trust Board: 26 June 2018

Healthy Eating CQUIN 2016-19

1. INTRODUCTION

Within the CQUIN for 2016 to 2019 the Trust is subject to a national item for healthy eating which covers service users, visitors and staff. In 2016/17 the value of this to the Trust was £374,000 the reporting for which is all in Q4.

The Trust is compliant with the CQUIN and has to report in the following manner to prove technical compliance

- Uploading compliance information to UNIFY database
- Board report to Trust detailing compliance
- Reports to all CCG's concerned

The uploading of the information has been undertaken. This report is being presented to the Trust Board. The CCG's will be informed through the quality boards following Trust Board approval

2. REQUIREMENTS

The requirements to achieve the healthy eating CQUIN are aimed mainly at outsourced provision within the NHS and the prevention of price and product promotions, along with some changes to staff provision for access to healthy food and drinks 24 hours a day. As the Trust does not extensively outsource catering, compliance has been a relatively routine process as follows.

The Trust has been expected to build on the 2016 CQUIN:

By firstly maintaining the four changes that were required in the 2016/17 CQUIN on both 2017/18 and 2018/19.

<u>2016/17 CQUIN</u>

a) The banning of price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS).

b) The banning of advertisements on NHS premises of sugary drinks and foods high in fat, sugar or salt (HFSS);

c) The banning of sugary drinks and foods high in fat, sugar or salt (HFSS) from checkouts;

d) ***Ensuring that healthy options are available at any point including for those staff working night shifts.***

Secondly introducing three new changes to food and drink provision:

<u>In year one (2017/18)</u>

a) 70% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml). In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml).

No high energy drinks sold. Between 70 and 80% of vending and counter sales of drinks are sugar free with the intention to be 100% sugar free drinks available within the next 12 months for counter sales with vending contractors also working towards this.

b) 60% of confectionary and sweets do not exceed 250kcal

In both vending machines and counter sales, small(er) packets, bars of confectionery and sweets are offered and do not exceed 250 kcal

c) At least 60% of pre packed sandwiches and other savoury pre packed meals available contain 400kcal or less per serving and no not exceed 5g saturated fat per 100g (note pre-packed for this purpose means items made by others and brought to site already packaged)

All sandwiches and salads are made fresh on site so are not included within the above statement.

Detailed information on food and drinks is available if required

<u>In year two (2018/19)</u>

In the same three areas will be kept but a further shift in percentages will be required.

a) 80% of drink lines stocked must be sugar free.
The Trust currently stands at 77% of drinks being sold as zero sugar the target will be met by Q4 as the ordering of the one remaining sugar sweetened drink (Coca Cola) has been reduced from the first of April

b) 80% of confectionary and sweets do not exceed 250kcal
The Trust meets this standard in full.

c) At least 75% of pre packed sandwiches and other savoury pre packed meals available contain 400kcal or less per serving and no not exceed 5g saturated fat per 100g
All sandwiches and salads are made fresh on site so are not excluded from the data collection meaning the Trust is compliant with the CQUIN

3. SUMMARY

The Trust is positioned to fully comply with the CQUIN for 2016 through to 2019 but will have a requirement to continue to report to ensure total compliance.

- Reduction in percentage of sugar / salt products displayed
- Increase in healthier alternatives
- Avoidance of overt promotion

The Trust must evidence that they have maintained the changes in 2016/17 and introduced the 2017/18 changes by providing a signed document between the NHS Trust and any external food supplier committing to keep the changes

The Trust and vending suppliers have committed to the Sugar Sweetened Beverage Sales Reduction Commitment as proposed by NHS England. See Appendix A.

4. RECOMMENDATION

The Trust Board is recommended to:

- Note the contents of this report
- Approve its submission to the relevant Quality Boards

Alan Davis
Director of Human Resources, Organisational Development and Estates

SUGAR-SWEETENED BEVERAGE SALES REDUCTION SUPPLIER COMMITMENT

This document sets how PELICAN ROLLS (Supplier Name) will deliver a voluntary sales reduction scheme for sugar-sweetened beverages on NHS premises.
Please complete and return by 31 July 2017 to england.healthworkforce@nhs.net.

1. COMMITMENT

PELICAN ROLLS (Supplier Name) agrees to:

- Reduce the total volume of monthly sugar-sweetened beverage sales per NHS outlet, reaching a target of 10% or less of total volume of drinks sales for the whole month of March 2018 and continuing thereafter and in future contracts;
- Commit to the definition of sugar-sweetened beverages as set out in Annex B;
- Provide NHS England with quarterly self-reported data, comprising total monthly beverage sales by volume (litres), including the total number of sugar-sweetened beverage sales, on a site-by-site basis; and
- Submit the first data return, while will encompass data from Quarter 2, to NHS England by 31 October 2017 and submit data returns on a quarterly basis thereafter.

DECLARATION

Signed on behalf of 'Supplier X'	Signed on behalf of NHS England
Name: DANIEL ABRAHAMS	
Position: MANAGING DIRECTOR	
Signature:	
Date: 28/7/2017	

Health and high quality care for all, now and for future generations

OFFICIAL

SUGAR-SWEETENED BEVERAGE SALES REDUCTION SUPPLIER COMMITMENT

This document sets how SWYPFT (Supplier Name) will deliver a voluntary sales reduction scheme for sugar-sweetened beverages on NHS premises.
Please complete and return by 31 July 2017 to england.healthyweightforce@nhs.net

1. COMMITMENT

SWYPFT (Supplier Name) agrees to:

- Reduce the total volume of monthly sugar-sweetened beverage sales per NHS outlet, reaching a target of 10% or less of total volume of drinks sales for the whole month of March 2016 and continuing thereafter and in future contracts;
- Commit to the definition of sugar-sweetened beverages as set out in Annex B;
- Provide NHS England with quarterly self-reported data, comprising total monthly beverage sales by volume (litres), including the total number of sugar-sweetened beverage sales, on a site-by-site basis; and
- Submit the first data return, which will encompass data from Quarter 2, to NHS England by 31 October 2017 and submit data returns on a quarterly basis thereafter.

DECLARATION

Signed on behalf of 'Supplier X'	Signed on behalf of NHS England
SWYPFT	
Name: KAREN WHITTAM	
Position: HEAD OF FACILITIES	
Signature: K Whittam	
Date: 1-12-2017	

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NHS
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NHS Foundation Trust

Trust Board 26 June 2018
Agenda item 7.1

Title:	**South Yorkshire and Bassetlaw Shadow Integrated Care System (SYBsICS): Update on Engagement on the Hospital Services Review for South Yorkshire, Bassetlaw, North Derbyshire and Mid Yorkshire**
Paper prepared by:	Director of Strategy and Director of Human Resources, OD and Estates
Purpose:	The purpose of this paper is to update the Trust Board on the development of the South Yorkshire and Bassetlaw shadow Integrated Care System (sICS).
Mission/values:	The Trust's mission to **enable people to reach their potential and live well in their communities** will require strong partnership working across the different health economies. It is therefore important that the Trust plays an active role in the South Yorkshire and Bassetlaw sICS.
Any background papers/ previously considered by:	The Trust Board have received regular updates on the progress and developments in the SYB sICS (formerly Sustainability and Transformation Partnership).
Executive summary:	The South Yorkshire and Bassetlaw Collaborative Partnership Board met on the 8th June and the key issues discussed were: ➢ Discussions are progressing well regarding the next phase of the development of SYB Integrated Care System (ICS) and proposals are expected back to the Partnership Board in July. ➢ An agreed revised Memorandum of Understanding to support the next phase of the ICS development will also be discussed in July. ➢ A new operational model for the next phase of the ICS, including management and governance structures, is expected to be in place by September. ➢ The Hospital Services Review continues to progress and the next phase is due to be published in July. ➢ The Allied Health Professionals (AHP) Strategy was launched. The strategy includes the establishment of an AHP Council by September and having AHP representation at ICS level. ➢ Local ICS plans to be published in September. ➢ An update on the 15 ISC work streams was provided and the RAG (Red, Amber and Green) rating for each area is shown below: Cancer Alliance **Amber** Children's and Maternity **Amber** Corporate services **Green** Digital and IT **Green** Elective and Diagnostics **Green** Estates **Green** Medicines Optimisation **Green**

With **all of us** in mind.

	Mental Health and Learning Disabilities — **Green** Pathology — **Green** Prevention — **Amber** Primary Care — **Green** Research and innovation — **Green** Stroke — **Amber** Urgent and Emergency Care — **Amber** Workforce — **Green** **South Yorkshire Mental Health Trust Collaboration** The Trust continues to work well with other mental health trust providers in South Yorkshire (Rotherham, Doncaster and South Humber and Sheffield Care Trust on a number of key priorities as part of the ICS work stream. The key priority areas for 17/19 were: ➢ Perinatal mental health ➢ CAMHs Crisis Care ➢ Out of Area Placements ➢ ASD and ADHD ➢ Employment ➢ Suicide prevention Update on progress: ➢ Perinatal mental health implementation groups are being established to develop services in Doncaster, Rotherham and Sheffield with the aim of launching this in October 2018. Barnsley was part of the West Yorkshire Perinatal Mental Health bid which was achieved in first wave of funding. ➢ The revised multi-agency suicide and prevention steering group are meeting with the NHS England suicide prevention support team at the end of June. ➢ Joint Mental Health and Urgency and Emergency Care workshop was held on 30th May 2018 to look at how the needs of people attending urgency and emergency care services with mental health problems can be best met. **Risk Appetite** This update supports the risk appetite identified in the Trust's organisational risk register.
Recommendation:	**Trust Board is asked to NOTE the update from the SYB sICS Collaborative Partnership Board.**
Private session:	Not applicable.

NHS
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NHS Foundation Trust

Trust Board 26 June 2018
Agenda item 7.2

Title:	**West Yorkshire & Harrogate Health and Care Partnership (WYHHCP) update**
Paper prepared by:	Director of strategy Chief Executive
Purpose:	The purpose of this paper is to provide the Trust Board with an update on the development of the West Yorkshire and Harrogate Health and Care Partnership.
Mission/values:	The development of joined up care through place-based plans is central to the **Trust's emerging strategy**. As such it is supportive of our mission, particularly to **help people to live well in their communities.** **The way in which the Trust approaches strategy and strategic developments must be in accordance with our values**. The approach is in line with our values - being relevant today and ready for tomorrow. This report aims to assist the Trust Board in shaping and agreeing the strategic direction and support for collaborative developments that support the Trusts strategic ambitions.
Any background papers/ previously considered by:	Strategic discussions and updates on place based plans have taken place regularly at Trust Board including an update to April and May Trust Board.
Executive summary:	The Trust Strategy refresh outlines the importance of the Trust's role in each place it provides services, including the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP). Progress and key developments are summarised below: The West Yorkshire and Harrogate Health and Care Partnership continues to make significant progress through strengthened partnerships. **Integrated Care System -** West Yorkshire and Harrogate Health and Care Partnership has been named as one of four new areas in England that will be given additional freedom and flexibility to manage the delivery of local services. The Partnership will join the Integrated Care System programme, putting the area at the forefront of nationwide action to provide better co-ordinated and more joined up care for 2.6 million people. This national recognition for the Partnership is a positive step forward. It will bring control and influence over spending and transformation closer to local people and local places. SWYPFT is a partner and

With all of us in mind.

	leading on a number of programmes through the mental health collaborative. **Engagement -** A number of programmes to support engagement with communities are being taken forward. These include: • Co-production of a chair of public panel network with representation across the partnership • Mapping out the work of youth forums across our area • Stroke engagement work around developing the criteria for potential options • Carers event in September aimed at GPs and community health care professionals • Supporting the "More in Common" social movement • Application to Building Health Partnerships [VCS work] for elective care – this has been accepted onto the programme • Engagement and consultation mapping across the six local places **Workforce Plan** - WY&H HCP have published their workforce plan *'A healthy place to live, a great place to work'.* The publication describes how the health and social care workforce of over 100,000 in West Yorkshire and Harrogate is changing to meet the current and future needs of the 2.6 million people living across the area. Reshaping healthcare requires a reshaping of the health and care workforce. New teams are emerging with an increased role for non-medical staff to work alongside medical staff; non-registered staff to work alongside registered professionals and new roles alongside traditional ones. The plan also recognises the huge contribution community organisations and volunteers make; and the vital role of the 260,000 unpaid carers who care for family and friends day-in day-out and whose numbers are more than that of the paid workforce. Supporting working carers is also an important partnership priority. **Mental Health programme Update** Progress is being made against all programmes as reported through the Trust Integrated Performance Report. Chief executives of providers of mental health and learning disability services met this month at the mental health providers collaborative. SWYPFT are taking a lead role through the Operational Delivery Network and Transforming Care Partnership on improving services for people with a learning disability. **Risk Appetite** The development of key partnerships within each place-based plan is in line with the Trust's risk appetite supporting the development of strategic partnerships that enhance the Trusts sustainability. 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:** ➢ **RECEIVED the update; and** ➢ **DISCUSS and COMMENT on the development of the West Yorkshire and Harrogate Health and Care Partnership**
Private session:	Not applicable.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board 26 June 2018
Agenda item 7.3

Title:	**West Yorkshire Mental Health Services Collaborative draft Memorandum of Understanding**
Paper prepared by:	Company Secretary on behalf of the Chair
Purpose:	To receive the final version of the Memorandum of Understanding for the West Yorkshire Mental Health Services Collaborative.
Mission/values:	The development of place based partnership arrangements supports the Trust's mission of **enabling people to reach their potential and live well in their communities**. It places people and services ahead of organisational interests. The approach is in line with our values – specifically **being relevant today and ready for tomorrow.**
Any background papers / previously considered by:	Trust Board (private session) 3 October 2017 and 27 March 2018 (Draft Memorandum of Understanding Trust Board). Updates to Trust Board (public session) regarding the West Yorkshire & Harrogate Health and Care Partnership (previously Sustainability and Transformation Plan (STP)).
Executive summary:	**Background** The West Yorkshire Mental Health Services Collaborative (WYMHSC) is the coming together of the four mental health and community NHS trusts in West Yorkshire (Bradford District Care Foundation Trust, Leeds and York Partnership Foundation Trust, Leeds Community Healthcare NHS Trust, and South West Yorkshire Partnership Foundation Trust) to work collaboratively to ensure high quality, sustainable mental health services now and into the future. At its Trust Board meetings in March 2018 (private session), the Boards of the four organisations agreed the Memorandum of Understanding (MoU) subject to a number of points of clarification. These points were clarified with the members of the Committees in Common and at its meeting on 30 April 2018 the Chairs of the four organisations signed the MoU. The final version is attached for information. The Board is reminded that the MoU is not a legal contract, but is a formal agreement between all of the partners. It does not replace or override the legal and regulatory frameworks that apply to our statutory NHS organisations. Instead it sits alongside and complements these frameworks, creating the foundations for closer and more formal collaboration.
Recommendation:	**Trust Board is asked to RECEIVE the final version of the Memorandum of Understanding.**

With **all of us** in mind.

Private session:	Not applicable.

WEST YORKSHIRE MENTAL HEALTH SERVICES COLLABORATIVE

DATE

30 April 2018

1. **BRADFORD DISTRICT CARE NHS FOUNDATION TRUST**
2. **LEEDS & YORK PARTNERSHIP NHS FOUNDATION TRUST**
3. **LEEDS COMMUNITY HEALTHCARE NHS TRUST**
4. **SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST**

MEMORANDUM OF UNDERSTANDING
FOR WEST YORKSHIRE MENTAL HEALTH SERVICE COLLABORATIVE (WYMHSC)

No	Date	Version Number	Author
1	15/11/17	01 -	Trust Company Secretaries / Governance leads
2	29/11/17	0.2	Trust Company Secretaries / Governance leads
3	4/12/17	0.3	Trust Company Secretaries / Governance leads
4	15/01/18	0.4	Trust Company Secretaries / Governance leads
5	7/03/18	0.5	Trust Company Secretaries/Governance lead
6	15/03/18	0.6 Incorporating comments from audit committee chairs	Trust Company Secretaries/Governance lead
7	25/04/18	0.7 Incorporating comments from Boards	Trust Company Secretaries/Governance lead

CONTENTS

Date: TBC

This Memorandum of Understanding (**MoU**) is made between:

(1) **BRADFORD DISTRICT CARE NHS FOUNDATION TRUST** of New Mill, Victoria Road, Saltaire, Bradford, West Yorkshire, BD18 3LD;

(2) **LEEDS & YORK PARTNERSHIP NHS FOUNDATION TRUST** of 2150 Century Way, Thorpe Park, Leeds, West Yorkshire, LS15 8ZB

(3) **LEEDS COMMUNITY HEALTHCARE NHS TRUST** of First Floor, Stockdale House, Headingley Office Park, Victoria Road, Leeds, West Yorkshire, LS6 1PF

(4) **SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST** of Fieldhead, Ouchthorpe Lane, Wakefield, West Yorkshire, WF1 3SP

(each a "**Party**" and together the "**Parties**").

RECITALS

(A) In entering into and performing their obligations under this MoU, the parties are working towards a collaborative programme including ownership and commitment to collaboration as set out in the West Yorkshire and Harrogate Health and Care Partnership (STP) ("**WYHHCP**").

(B) The Parties together form the West Yorkshire Mental Health Services Collaborative ("**WYMHSC**") and have agreed to collaborate in delivering region-wide efficient and sustainable acute and specialist mental health services for patients. The Parties have formed Committees in Common ("**WYMHSC C-In-C**") which have the specific remit of overseeing a comprehensive system wide collaborative programme to deliver the objective of a more collaborative model of care for acute and specialist mental health services in West Yorkshire (WY). The intention being to deliver a system model, operating as a network, that is coherent, integrated, consistent (reducing unwanted variation) and focused on quality and value for the population and patients (the "**WYMHS Collaborative Programme**").

(C) This MoU is focused on the Parties' agreement to develop the detail in relation to the function and scope of the WYMHSC C-In-C; developing the principles that will underpin collaborative working and the timetable for implementation in order to tackle a number of significant operational, clinical and financial challenges for services in the WYMHSC service area.

(D) The Parties recognise the different levels of provision of acute and specialist mental health services in portfolios of services and this will be reflected in any agreements the collaborative makes and managed through the Gateway Decision Making Process.

OPERATIVE PROVISIONS

1. DEFINITIONS AND INTERPRETATION

1.1. In this MoU, capitalised words and expressions shall have the meanings given to them in this MoU.

1.2. In this MoU, unless the context requires otherwise, the following rules of construction shall apply.

1.3. a reference to a "**Party**" is a reference to the organisations party to this MoU and includes its personal representatives, successors or permitted assigns and a reference to "**Parties**" is a reference to all parties to this MoU;

2. PURPOSE AND EFFECT OF MOU

2.1. The Parties have agreed to work together on behalf of patients and the population to deliver the best possible care, experience and outcomes within the available resources for acute and specialist mental health services in WY. The aim is for the Parties to organise themselves around the needs of the population rather than planning at an individual organisational level so as to deliver more integrated, high quality cost effective care for patients as detailed in Schedule 1. The Parties wish to record the basis on which they will collaborate with each other through the WYMHSC in this MoU.

2.2. This MoU sets out:

2.2.1. the key objectives for the development of the WYMHSC;
2.2.2. the principles of collaboration;
2.2.3. the governance structures the Parties will put in place; and
2.2.4. the respective roles and responsibilities the Parties will have during the development and delivery of the collaboration model.

2.3. In addition to the MoU, the Parties will seek to agree additional documents to manage the relationships for confidentiality, conflicts of interest and sharing of information between themselves in more detail.

3. KEY PRINCIPLES

3.1. The Parties shall undertake the development and delivery of the WYMHS Collaborative Programme in line with the Key Principles as set out in Schedule 1 (the "**Key Principles**").

3.2. The Parties acknowledge the current position with regard to the WYMHSC and the contributions, financial and otherwise, already made by the Parties.

4. PRINCIPLES OF COLLABORATION

4.1. The Parties agree to adopt the following principles including shared values and behaviours when carrying out the development and delivery of the WYMHS Collaborative Programme (the "**Principles of Collaboration**"):

4.1.1. address the vision - in developing WYMHSC the Parties seek to establish a model of collaborative care, to provide high quality, sustainable acute and specialist mental health services for the population, enabled by integrated solutions and delivering best value for the taxpayer and operating a financially sustainable system;

4.1.2. collaborate and co-operate - establish and adhere to the governance structure set out in this MoU to ensure that activities are delivered and actions taken as required to deliver change collectively and in partnership with each other and the wider NHS;

4.1.3. hold each other mutually accountable for delivery and challenge constructively - take on, manage and account to each other, the wider WYHHCP and the WYMHSC service area population for performance of the respective roles and responsibilities set out in this MoU;

4.1.4. be open and transparent and act with honesty and integrity - communicate openly with each other about major concerns, issues or opportunities relating to WYMHSC and comply with the seven Principles of Public Life established by the Nolan Committee (the Nolan Principles) and where appropriate the NHS Foundation Trust Code of Governance (as issued by Monitor and updated in July 2014) including implementing a transparent and explicit approach to the declaration and handling of relevant and material conflicts of interests arising;

4.1.5. adhere to statutory requirements and best practice - comply with applicable laws and standards including procurement rules, competition law, data protection and freedom of information legislation;

4.1.6. act in a timely manner - recognise the time-critical nature of the WYMHS Collaborative Programme development and delivery and respond accordingly to requests for support;

4.1.7. manage stakeholders effectively - ensure communication and engagement both internally and externally is clear, coherent, consistent and credible and in line with the Parties' statutory duties, values and objectives.

4.1.8. deploy appropriate resources - ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in this MoU; and

4.1.9. act in good faith - to support achievement of the Key Principles and in compliance with these Principles of Collaboration.

5. GOVERNANCE

5.1. The governance structure (summarised below in Schedule 2) of this MoU provides a structure for the development and delivery of the WYMHS Collaborative Programme.

5.2. The governance arrangements will be:

5.2.1. based on the principle that decisions will be taken by the relevant organisations at the most appropriate level in accordance with each organisation's internal governance arrangements, particularly in respect of delegated authority;

5.2.2. shaped by the Parties in accordance with existing accountability arrangements, whilst recognising that different ways of working will be required to deliver the transformational ambitions of the WYMHS Collaborative Programme. The Parties intend that there should be as far as permissible a single governance structure to help oversee and deliver the WYMHS Collaborative Programme in accordance with the Key Principles; and

5.2.3. underpinned by the following principles:

(a) the Parties will remain subject to the NHS Constitution, their provider licence and their own constitutional documents and retain their statutory functions and their existing accountabilities for current services, resources and funding flows; and

(b) clear agreements will be in place between the providers to underpin the governance arrangements.

6. ACCOUNTABILITY AND REPORTING LINES

Accountability and reporting should be undertaken at the following levels within WYMHSC:

WYMHSC Committees in Common ("WYMHSC C-In-C")

6.1. The WYMHSC C-In-C will receive reports at each meeting from the Programme Executive highlighting but not limited to:

6.1.1. progress throughout the period;
6.1.2. decisions required by the WYMHSC C-In-C;
6.1.3. issues and risk being managed;
6.1.4. issues requiring escalation to the WYMHSC C-In-C; and
6.1.5. progress planned for the next period.

Under a standing agenda item, WYMHSC C-In-C will agree the key communications arising from its meetings that should be relayed to the Parties' respective organisations. The minutes, and a summary report from the Programme Director will be circulated promptly to all WYMHSC C-In-C Members as soon as reasonably practical for inclusion on the private agenda of each Parties' Board meeting. The Programme Director will provide a summary for sharing in the public domain.

WYMHSC Programme Executive

6.2. The WYMHSC C-In-C will hold each of the Parties' Chief Executives to account for the delivery of their sponsored workstreams within the WYMHS Collaborative Programme via the WYMHSC Programme Executive.

7. ROLES AND RESPONSIBILITIES

The Parties shall undertake the roles and responsibilities set out in this MoU to help develop the WYMHS Collaborative Programme in line with the Key Principles:

WYMHSC Committees in Common

7.1. The WYMHSC C-In-C comprises senior members of the Parties and provides overall strategic oversight and direction to the development of the WYMHS Collaborative Programme. It is chaired by existing Chairs of the Parties, on a rotational basis, as underpinned by principles of continuity and equity collectively agreed by members, for a minimum duration of 12 months.

7.2. The WYMHSC C-In-C shall be managed in accordance with the governance arrangements in section 5 and the Terms of Reference in Schedule 5.

WYMHSC Executive Group

7.3. The WYMHSC Executive Group will provide assurance to the WYMHSC C-In-C that the key deliverables are being met and that the development of the WYMHS Collaborative Programme is within the boundaries set by the WYMHSC C-In-C. It will provide management at programme and workstream level.

8. DECISION MAKING

8.1. The Parties intend that WYMHSC C-In-C individual Members will each operate under a model scheme of delegation whereby each WYMHSC C-In-C individual Members shall have delegated authority to make decisions on behalf of their organisation relating to:

- matters falling under the scope of the WYMHSC C-In-C and agreed collaborative programme underpinned by a 'case for change' set out in Schedule 2;
- the devolving of the Key Principles set out in Schedule 1; and,
- in accordance with the WYMHSC Gateway Decision Making Framework set out in Schedule 4 on behalf of their respective organisations.

Each party will reflect in its individual Scheme of Delegation the authority delegated to its representatives on the WYMHSC C-In-C.

8.2. The Parties intend that WYMHSC C-In-C Members shall report to and consult with their own respective organisations at Board level, providing governance assurance that is compliant with their regulatory and audit requirements, for organisational decisions relating to, and in support of the WYMHSC Key Principles and facilitating these functions in a timely manner.

9. ESCALATION

9.1. If any Party has any issues, concerns or complaints regarding the WYMHS Collaborative Programme, or any matter in this MoU, such Party shall notify the other Parties and the Parties acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

9.2. Subject as otherwise specifically provided for in this MoU, any dispute arising between the Parties out of or in connection with this MoU will be resolved in accordance with Schedule 3 (Dispute Resolution Procedure).

9.3. If any Party receives any formal or media enquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act 2000) in relation to the development of the WYMHSC, the matter shall be promptly referred to the WYMHSC Programme Director in the interests of consistency, however recognising the request remains the responsibility of the receiving organisation.

10. CONFLICTS OF INTEREST

10.1. The Parties agree that they will:

10.1.1. disclose to each other the full particulars of any relevant or material conflict of interest which arises or may arise in connection with this MoU, the development of the collaboration model or the performance of activities under the WYMHS Collaborative Programme, immediately upon becoming aware of the conflict of interest whether that conflict concerns the Parties or any person employed or retained by the Parties for or in connection with the development and delivery of the WYMHS Collaborative Programme; and

10.1.2. not allow themselves to be placed in a position of conflict of interest or duty in regard to any of their rights or obligations under this MoU (without the prior consent of the other Parties) before participating in any action in respect of that matter.

10.1.3. Comply with the terms of any agreed conflict of interest protocol as set out in paragraph 2.5 above.

11. FUTURE INVOLVEMENT AND ADDITION OF PARTIES

The Parties are the initial participating organisations in the development of the WYMHS Collaborative Programme but it is intended that other providers to the WYMHSC service area population may also come to be partners (including for example independent sector and third sector providers). Partner organisations may where appropriate be invited to meetings of the WYMHSC C-In-C as observers or through an additional stakeholders forum. If appropriate to achieve the key deliverables, the Parties may also agree to include additional party or parties to this MoU. If they agree on such a course the Parties will cooperate to enter into the necessary documentation.

12. COMPETITION AND PROCUREMENT COMPLIANCE

The Parties recognise that it is currently the duty of the commissioners, rather than the Parties as providers, to decide what services to procure and how best to secure them in the interests of patients. In addition, the Parties are aware of their competition compliance obligations, both under competition law and, in particular under the NHS Improvement/Monitor Provider Licence for providers, and shall take all necessary steps to ensure that they do not breach any of their current or future obligations in this regard. Further, the Parties understand that in certain circumstances collaboration or joint working could trigger the merger rules and as such be notifiable to the Competition and Markets Authority and NHS Improvement/Monitor and will keep this position under review accordingly.

The parties agree not to disclose or use any confidential information which is to be disclosed under the arrangements in a way which would constitute a breach of competition law.

13. REVIEW

13.1. A formal review meeting of the WYMHSC C-In-C shall take place 12 months after the date of implementation of this MoU (1st April 2018) or sooner if deemed as required by the Parties.

13.2. The WYMHSC C-In-C shall discuss and agree as a minimum:

13.2.1. the principles of collaboration;
13.2.2. the governance arrangements as set out in Section 5;
13.2.3. the scope of the WYMHS Collaborative Programme and individual workstreams;
13.2.4. the progress against the key deliverables; and
13.2.5. key decisions required in support of Schedule 4.

14. TERM AND TERMINATION

14.1. This MoU shall commence on 1st April 2018 (having been executed by all the Parties)

14.2. This MoU may be terminated in whole by:

14.2.1. mutual agreement in writing by all of the parties
14.2.2. in accordance with paragraph 15.2; or
14.2.3. in accordance with paragraph 1.5 of Schedule 3.

14.3. Any Party may withdraw from this MoU giving at least six calendar months' notice in writing to the other Parties, or the length of the remainder of any existing contract, whichever is longer. The MoU will remain in force between the remaining parties (unless otherwise agreed in writing between all the remaining parties) and the remaining Parties will agree such amendments required to the MoU in accordance with section 16.

14.4. In the event a Party is put into administration, special measures and/or is otherwise not able to perform its role under the WYMHS Collaborative Programme and this MoU, the remaining Parties shall be entitled to consider and enforce, on a case by case basis, a resolution of the WYMHSC C-In-C for the removal of the relevant Party from the MoU on a majority basis provided that:

14.4.1. reasonable notice shall have been given of the proposed resolution; and

14.4.2. the affected Party is first given the opportunity to address the WYMHSC C-In-C meeting at which the resolution is proposed if it wishes to do so.

14.5. This MoU shall be terminated in accordance with the provision at paragraph 14.2.

15. CHANGE OF LAW

15.1. The Parties shall take all steps necessary to ensure that their obligations under this MoU are delivered in accordance with applicable law. If, as a result of change in applicable law, the Parties are prevented from performing their obligations under this MoU but would be able to proceed if a variation were made to the MoU, then the Parties shall consider this in accordance with the variation provision at section 16.

15.2. In the event that that the Parties are prevented from performing their obligations under this MoU as a result of a change in applicable law and this cannot be remedied by a variation or a variation is not agreed by all Parties, then the Parties shall agree to terminate this MoU on immediate effect of the change in applicable law.

16. VARIATION

This MoU may only be varied by written agreement of the Parties signed by, or on behalf of, each of the Parties.

17. CHARGES AND LIABILITIES

17.1. Except as otherwise provided, the Parties shall each bear their own costs and expenses incurred in complying with their obligations under this MoU, including in respect of any losses or liabilities incurred due to their own or their employee's actions.

17.2. No Party intends that any other Party shall be liable for any loss it suffers as a result of this MoU.

18. NO PARTNERSHIP

Nothing in this MoU is intended to, or shall be deemed to, establish any formal or legal partnership or joint venture between the Parties, constitute any Party as the agent of another Party, nor authorise any of the Parties to make or enter into any commitments for or on behalf of the other Parties.

19. COUNTERPARTS

19.1. This MoU may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this MoU, but all the counterparts shall together constitute the same agreement.

19.2. The expression "**counterpart**" shall include any executed copy of this MoU transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e mail attachment.

19.3. No counterpart shall be effective until each Party has executed at least one counterpart.

We have signed this Memorandum of Understanding on the date written at the head of this memorandum.

SIGNED by	)	.....
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
BRADFORD DISTRICT CARE NHS FOUNDATION TRUST	)	DATE: 30 April 2018

SIGNED by	)	.....
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
LEEDS & YORK PARTNERSHIP NHS FOUNDATION TRUST	)	DATE: 30 April 2018

SIGNED by NEIL FRANKLIN	)	.....
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
LEEDS COMMUNITY HEALTHCARE NHS TRUST	)	DATE: 30 April 2018

SIGNED by	)	.....
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title: Chair
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	)	DATE: 30 April 2018

SCHEDULE 1

THE KEY PRINCIPLES

1. The continued challenge of ensuring the quality and financial sustainability of mental health services requires a more collaborative approach between providers ensuring that the best possible care can be delivered to people in WY making best use of the collective resources.

2. Through the WYMHS Collaborative Programme, the Parties Key Principles are to achieve sustainable, safe, high quality and cost effective acute and specialist mental health services across WY, based on clear integrated and standardised operating models, networks and alternative service delivery models where risk and benefits will be collectively managed. This will be achieved through addressing the following:

   2.1. Achieving the clinical and financial stability across the WYMHSC service areas.

   2.2. Enhancing partnership working through collaboration between providers, leading to interdependency, care delivered by stream or pathway rather than by individual organisations and by collective provider responsibility.

   2.3. The approach to collaboration:

   - The Parties will work on the greatest challenges together to ensure high quality, sustainable mental health services now and in the future.

   - Reduce variation in quality by building on best practice and developing standard operating procedures and pathways to achieve better outcomes for people in WY.

   - Take a collaborative approach to the delivery of acute/specialist mental health services via clinical pathways and networked services (rather than individual place/provider led developments).

   - Developing 'centres of excellence' for the more specialist mental health services e.g. forensic services, Child and Adolescent Mental Health Services (CAMHs) Tier 4, adult eating disorders,

   - Delivering economies of scale in mental health service support functions

   - Build constructive relationships with communities, groups, organisations and the third sector to ensure there are lines of communication and ways of engaging on issues which have an impact on people's health and wellbeing

   - Ensure there is appropriate public engagement on those matters which need to be communicated more widely.

SCHEDULE 2

WYMHS COLLABORATIVE PROGRAMME APPROACH AND KEY STAGES

1. Purpose of the Collaborative Programme

The purpose of the collaborative programme is to reduce variation and deliver sustainable acute and specialist mental health services to a standardised model which is efficient and of high quality. In developing this programme the Parties will be designing services over a wider NHS footprint (the WYMHSC service area), thinking of different models of care and making collective efficiencies where the potential exists.

2. The WYMHS Collaborative Programme Approach

The Key Principles and five key steps to developing the WYMHS Collaborative Programme approach are set out in Schedule 1.

3. WYMHS Collaborative Programme Priorities

The WYMHS Collaborative Programme priorities are expected to be generated as a result of the following internal and external drivers;

- WYMHS clinical and operational sustainability priorities.
- WYMHS analysis of variation.
- West Yorkshire & Harrogate Health and Care Partnership (formerly STP).
- Regulatory requirements.

The structure of the programme will reflect these priorities as shown in the workstreams below (as at 1st April 2018):

Urgent & Emergency Care and Liaison: • Mental health liaison • 24/7 crisis services	• 40% reduction in unnecessary A&E attendance • 50% reduction of Section 136 Place of Safety • 24/7 crisis services
Suicide Prevention	• A zero suicide approach to prevention (10% overall reduction in suicides by 2020/21 and 75% reduction in targeted services by 2022)
Care Closer to Home (Out of Area Placements): • Adult acute • Psychiatric Intensive Care Unit (PICU) • Locked rehab and learning disabilities	• Elimination of out of area placements for non specialist acute care within 12 months • Shared bed management function
Specialist Services: • Child and Adolescent Mental Health services (CAMHS) tier 4 • Low / medium secure forensic - Adult eating disorders	• Elimination of out of area placement for children and young people • Development of new care models
Autism Spectrum Disorder (ASD) / Attention Deficit Hyperactivity Disorder (ADHD)	• Reduction in waiting times for autism assessment

4. Key Workstream Stages

4.1 Workstream priorities will be developed in line with key stages based on a robust case for change (risk and benefit evaluation of workstream potential based on current service models) and best practice business case approaches for designing future operating models, developing and evaluating options.

4.2 The table below illustrates the sequence of stages of the workstream development process, this will be a scalable process and proportionate to the workstream:

Stage	Outputs	Key Requirements
1. Case for change (Proposal)	Detailed description of current services Gap/challenges relating to safety, resilience, quality, sustainability (Data analysis) Scope for improvement Evaluation framework Risk sharing approach	Clinical leadership and involvement External Experts and Clinical Senate involvement
2. Design the Future Operating Model	Standardise operating procedures Workforce models Capacity modelling Best Practice benchmarks for future performance Scale of improvement which can be achieved	
3. Develop Options	New Models of Care Organisational change Operational networks Alternative provider arrangements and service delivery models Commissioner requirements and consultation	
4. Evaluation & selection of the preferred option	Clinical (Quality) Financial/Legal/Regulatory Workforce Performance Quality impact assessments Equality impact assessments	
5. Implementation planning	Timescales Resources Evaluation and review delivery of benefits Management of risks and issues	

4.3 The WYMHSC Executive will be responsible for the execution and delivery of the programme governance and ensuring that a common approach is applied to all applicable workstreams (some workstreams may not require this approach) and that the workstream pipeline is managed within defined timescales.

4.4 Each workstream will have a WYMHSC Director (identified by the WYMHS Collaborative Executive) and Senior Lead Clinical sponsor. The inputs at each stage will include:

- Clear articulated case for change i.e. use of data, standards etc.
- Identification and use of organisational change/service improvement models
- Targeted clinical/staff engagement and empowerment in order to lead the design and change e.g. facilitated workshops
- Transparent options appraisal process
- Quality impact assessments
- Equality impact assessments
- Use of external scrutiny
- Appropriate commissioner engagement
- Appropriate public/patient engagement
- Governor engagement

4.5 The WYMHSC Executive and WYMHSC C-In-C will make decisions on the prioritisation and progressing of workstreams to the next stage as shown in the Decision Making Schedule and gateways (as set out in Schedule 4).

5. Risk and Gain Sharing Principles

5.1. Some WYMHSC projects developed under the workstreams will have the potential to disproportionately benefit participating WYMHSC organisations at the expense of others. The potential impact of the implementation of a project through a workstream will be established and set out within the 'Case for Change' stage (Gateway 1) and the 'risk gain share' model between the respective WYMHSC members affected by the project developed in preparation for selection of the preferred option at Gateway 3. The model will be tailored to each project and will be designed on the following principles reflecting that organisations are working for the delivery of better care and a more sustainable system for patients in the WYMHSC service area:

5.1.1. The costs of delivering the project will be met by all Parties in the proportions agreed and submitted within the submission for Gateway 3 so that the WYMHSC C-In-C can be clear when selecting the preferred option where the costs will be met from and how any losses may be reimbursed;

5.1.2. The allocation of net benefits from a project will be agreed based on one or a combination of these methods, the detail of which will be developed and agreed at Gateway 3 of decision making process :

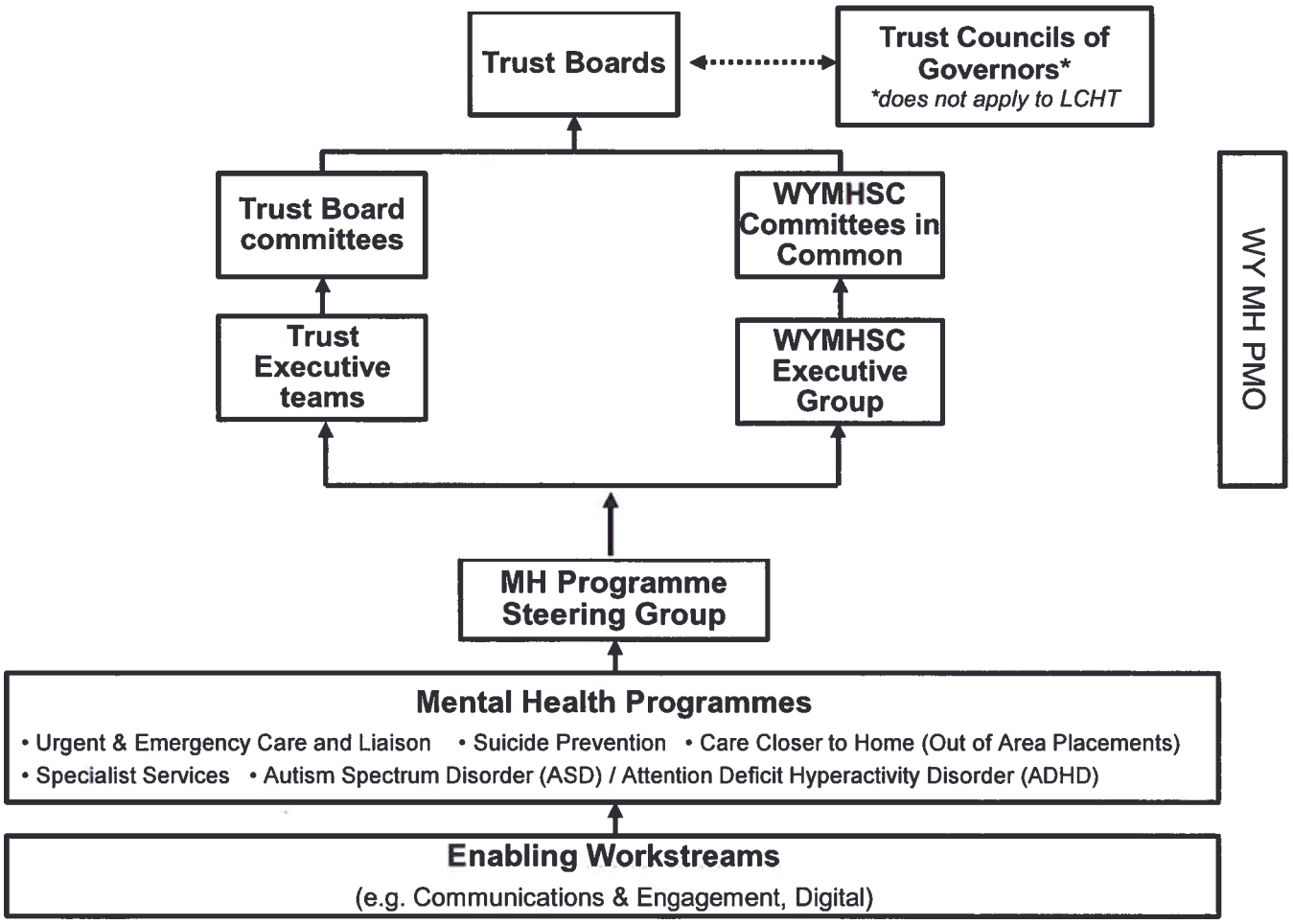
- equal gain share;
- proportional gain share; and/or
- successful contribution to the initiative.

5.1.3. The allocation of net benefits will be agreed between the relevant Parties based on the benefit and risk profile using these methods; and

5.1.4. The same principles will apply to the sharing of risks and costs in the event that a project does not deliver the anticipated net benefit.

6. High Level Programme Structure

The high level programme structure, linked to the West Yorkshire and Harrogate Health and Care Partnership (previously STP), is shown below:



SCHEDULE 3

DISPUTE RESOLUTION PROCEDURE

1. Avoiding and Solving Disputes

1.1 The Parties commit to working co-operatively to identify and resolve issues to their mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this MoU.

1.2 The Parties believe that:

1.2.1 by focusing on the agreed Key Principles underpinned by the five step approach as set out in the MoU and in Schedule 1;

1.2.2 being collectively responsible for all risks; and

1.2.3 fairly sharing risk and rewards in relation to the services in scope in the WYMHS Collaborative Programme.

they reinforce their commitment to avoiding disputes and conflicts arising out of or in connection with this MoU.

1.3 A Party shall promptly notify the other Parties of any dispute or claim or any potential dispute or claim in relation to this MoU or its operation (each a "**Dispute**') when it arises.

1.4 In the first instance the WYMHSC Programme Executive shall seek to resolve any Dispute to the mutual satisfaction of each of the Parties. If the Dispute cannot be resolved by the WYMHSC Programme Executive within 10 Business Days (a **Business Day** being a day other than a Saturday, Sunday or public holiday in England when banks in London are open for business) of the Dispute being referred to it, the Dispute shall be referred to the WYMHSC C-In-C for resolution.

1.5 The WYMHSC C-In-C shall deal proactively with any Dispute on a "Best for Meeting the Key Principles" basis in accordance with this MoU so as to seek to reach a majority decision. If the WYMHSC C-In-C reaches a decision that resolves, or otherwise concludes a Dispute, it will advise the Parties of its decision by written notice. The Parties recognise that any dispute or operation of this procedure will be without prejudice to and will not affect the statutory duties of each Party. This MoU is not intended to be legally binding save as provided in paragraph 2.4 of the MoU and, given the status of this MoU (as set out in Section 2), if a Party disagrees with a decision of the WYMHSC C-In-C or the independent facilitator, they may withdraw from the MoU at any point in accordance with section 14 of the MoU.

1.6 If a Party does not agree with the decision of the WYMHSC C-In-C reached in accordance with the above, it shall inform the WYMHSC C-In-C within 10 Business Days and request that the WYMHSC C-In-C refer the Dispute to an independent facilitator in agreement with all Parties and in accordance with paragraph 1.7 of this Schedule.

1.7 The Parties agree that the WYMHSC C-In-C, on a "Best for Meeting the Key Principles" basis, may determine whatever action it believes is necessary including the following:

1.7.1 If the WYMHSC C-In-C cannot resolve a Dispute, it may request that an independent facilitator assist with resolving the Dispute; and

1.7.2 If the independent facilitator cannot facilitate the resolution of the Dispute, the Dispute must be considered afresh in accordance with this Schedule and in the event that after such further consideration again fails to resolve the Dispute, the WYMHSC C-In-C may decide to:

(i) terminate the MoU; or

(ii) agree that the Dispute need not be resolved.

SCHEDULE 4

WYMHSC CIC DECISION MAKING

1. The Memorandum of Understanding (MoU) and Terms of Reference (TOR) for the WYMHSC Committee in Common (WYMHSC C-In-C) takes into consideration existing accountability arrangements of participating Trusts and decisions (where these apply to the services in scope in the collaborative) being made under a scheme of delegation.

2. Whilst it is recognised that some decisions taken at the WYMHSC C-In-C may not be of obvious benefit to all Parties, it is anticipated that the WYMHSC C-In-C will look to act on the basis of the best interests of the wider population investing in a sustainable system of healthcare across the WYMHSC service area in accordance with the Key Principles when making decisions at WYMHSC C-In-C meetings.

3. There are expected to be two categories of decision making:

   - **All parties will need to participate in the initiative** for reasons of interdependency, safety or financial viability. These decisions will be made on the basis of all the affected organisations reaching an agreed decision in common.

   - **Organisations will need to confirm their own commitment and involvement at key stages (Gateways)** in order to ensure the Business Case assumptions (benefits) and risks are robust, only trusts directly affected by the Case for Change (eligible constituency under paragraph 5 of this Schedule) will be able to make decisions (the Gateways) and once an organisation has committed to participate at a specific Gateway they cannot withdraw.

4. The WYMHSC 'Gateway' decision making mechanism should be used (where appropriate) to achieve agreements that will be binding across relevant members. The mechanism will follow a staged approach and unless new material comes to light, once progression has been made through the respective stages, progress will remain at the relevant stage that has been reached and will not 'fall back'. On agreement of progression through stages, members will commit to the next steps in developing the proposal.

5. All proposals brought before the WYMHSC C-In-C will require a detailed case for change. At this stage the WYMHSC C-In-C will determine if the proposal warrants further development and consideration and is appropriate to pass to the next stage of development. This stage will also consider which Parties would be directly or indirectly affected and eligible/required to vote (to be known as the eligible constituency).

6. The table below illustrates the 'Gateway Decision Making' Process:

Stage	Gateway	Outcome
Case for change (Proposal)	Gateway 1 Requires support of a simple majority	No fall back unless material new information All organisations participate in design phase
Develop Options	Gateway 2 Seek unanimous support by all parties eligible to make decisions	Options and Evaluation Framework agreed
Evaluation and selection of the preferred option	Gateway 3 Seek unanimous support by all parties eligible to make decisions	Application of agreed framework Identification of agreed option
Recommendation to Committee in Common	Gateway 4 Seek unanimous support by all parties eligible to make decisions	Proceed with formal agreements/contracts as required and implement plan

7. If a Party does not support a proposal then it will not be bound to act in accordance with that proposal as the Parties remain independent statutory bodies under the WYMHS Collaborative Programme.

8. Bilateral and Tripartite Agreements between Individual Trusts

8.1. The WYMHSC Gateway Decision Making Framework does not preclude any Party from developing bilateral or tripartite agreements with other trusts in WYMHS outside the Collaborative Programme. It is expected that there will be transparency in developing such agreements and the option for other WYMHS trusts to join an initiative and that the associated benefits and risks are appropriately considered in terms of the impact on other providers and the WYMHS Collaborative Programme.

8.2. Recognising that being part of the WYMHSC C-In-C does not preclude Parties alliances or existing relationships with other organisations.

8.3. Parties may wish to invite other organisations to be party to initiatives agreed by the WYMHSC C-In-C.

9. Forum for engaging with the wider system

9.1. The WYMHSC C-In-C could also be used as a forum to provide responses to queries and recommendations from the commissioners or the wider system (for example following a request from the WYHHCP) on specific issues.

SCHEDULE 5

WYMHSC Committees in Common -TERMS OF REFERENCE

THESE TERMS OF REFERENCE FORM PART OF THE WYMHSC MEMORANDUM OF UNDERSTANDING DEFINITIONS AND TERMINOLOGY ALIGN TO THE MEMORANDUM OF UNDERSTANDING

1. Scope

1.1. The WYMHSC C-In-C will be responsible for leading the development of the WYMHS Collaborative Programme and the workstreams in accordance with the Key Principles, setting overall strategic direction in order to deliver the WYMHS Collaborative Programme.

2. Standing

2.1. Members shall only exercise functions and powers of a Party to the extent that they are actually permitted to ordinarily exercise such functions and powers under that Party's internal governance.

3. General Responsibilities of the WYMHSC C-In-C

3.1. The general responsibilities of the WYMHSC C-In-C are:

(a) providing overall strategic oversight and direction to the development of the WYMHS Collaborative Programme;

(b) ensuring alignment of all Parties to the vision and strategy;

(c) formally recommending the final form of the collaborative programme, including determining roles and responsibilities within the workstreams;

(d) reviewing the key deliverables and ensuring adherence with the required timescales;

(e) receiving assurance that workstreams have been subject to robust quality impact assessments

(f) reviewing the risks associated with the performance of any of the Parties in terms of the impact to the WYMHS Collaborative Programme- recommending remedial and mitigating actions across the system;

(g) receiving assurance that risks associated with the WYMHS Collaborative Programme are being identified, managed and mitigated;

(h) promoting and encouraging commitment to the Key Principles;

(i) formulating, agreeing and implementing strategies for delivery of the WYMHS Collaborative Programme;

(j) seeking to determine or resolve any matter referred to it by the WYMHSC Programme Executive or any individual Party and any dispute in accordance with the MoU;

(k) approving the appointment, removal or replacement of key programme personnel;

(l) reviewing and approving the Terms of Reference of the WYMHSC Programme Executive;

(m) agreeing the Programme Budget and financial contribution and use of resources in accordance with the Risk and Gain Sharing Principles;

4. Members of the WYMHSC C-In-C

4.1. Each Party will appoint their Chair and Chief Executive as WYMHSC C-In-C Members and the Parties will at all times maintain a WYMHSC C-In-C Member on the WYMHSC C-In-C.

4.2. Each WYMHSC C-In-C member will nominate a deputy to attend on their behalf. The Nominated Deputy will be a voting board member of the respective Party. The Nominated Deputy will be entitled to attend and be counted in the quorum at which the WYMHSC C-In-C Member is not personally present and do all the things which the appointing WYMHSC C-In-C Member is entitled to do.

4.3. Each Party will be considered to be one entity within the collaborative.

4.4. The Parties will all ensure that, except for urgent or unavoidable reasons, their respective WYMHSC C-In-C Member (or their Nominated Deputy) attend and fully participate in the meetings of the WYMHSC C-In-C.

5. Proceedings of WYMHSC C-In-C

5.1. The WYMHSC C-In-C will meet quarterly, or more frequently as required.

5.2. The WYMHSC C-In-C shall meet in private where appropriate in order to facilitate discussion and decision making on matters deemed commercially sensitive and by virtue of the confidential nature of the business to be transacted across the WYMHSC members. It is agreed by the Parties that the necessary checks and balances on openness, transparency and candour continue to exist and apply by virtue of the Parties each acting within existing accountability arrangements of the Parties' respective organisations and the reporting arrangements of the WYMHSC C-In-C into the Parties' Trust Boards.

5.3. The Parties will select one of the Parties' Chairs to act as the Chair of the WYMHSC C-In-C meetings on a rotational basis for a period of twelve months. There shall also be a Deputy Chair nominated. The Deputy Chair will be the succeeding chair of the C-In-C at the end of the incumbent Chair's term.

5.4. The WYMHSC CIC may regulate its proceedings as they see fit save as set out in these Terms of Reference.

5.5. No decision will be taken at any meeting unless a quorum is present. A quorum will not be present unless every Party has at least one WYMHSC C-In-C Member present.

5.6. Members of all Parties will be required to declare any interests at the beginning of each meeting.

5.7. A meeting of the WYMHSC C-In-C may consist of a conference between the WYMHSC C-In-C Members who are not all in one place, but each of whom is able directly or by telephonic or video communication to speak to each of the others, and to be heard by each of the others simultaneously.

5.8. Each WYMHSC C-In-C Member will have an equal say in discussions and will look to agree recommendations in line with the Principles of the WYMHSC Collaborative Programme.

5.9. The WYMHSC C-In-C will review the meeting effectiveness at the end of each meeting.

6. Decision making within the WYMHSC C-In-C

6.1. Each WYMHSC C-In-C Member will comply with the existing accountability arrangements of their respective appointing organisation and will make decisions which are permitted under their organisation's Scheme of Delegation.

6.2. Recognising that some decisions may not be of obvious benefit to or impact directly upon all Parties, WYMHSC C-In-C Members shall seek to pay due regard to the best interests of the wider population in investing in a sustainable system of healthcare across the WYMHSC service area in accordance with the Key Principles when making decisions at WYMHSC C-In-C meetings.

6.3. In respect of matters which require decisions where all Parties are affected the Parties will seek to make such decisions on the basis of all WYMHSC C-In-C Members reaching an agreed consensus decision in common in accordance with the Key Principles.

6.4. In respect of the matters which require decisions where only some of the Parties are affected, then the Parties shall reference the WYMHSC Gateway Decision Mechanism at Schedule 4 of the Memorandum of Understanding.

7. Attendance of third parties at WYMHSC C-In-C meetings

7.1. The WYMHSC C-In-C shall be entitled to invite any person to attend but not take part in making decisions at meetings of the WYMHSC C-In-C.

8. Administration for the WYMHSC C-In-C

8.1. Meeting administration for the WYMHSC C-In-C will be provided by the WYMHSC Programme Office, maintaining the register of interests and the minutes of the meetings of the WYMHSC C-In-C.

8.2. The Company Secretary/Governance lead of the incumbent Chair will have responsibility for providing governance advice and finalising agendas and

minutes with the Chair.

8.3. The agenda for the meeting will be agreed by the WYMHSC C-In-C Chair. Papers for each meeting will be sent from the Programme Office to WYMHSC C-In-C Members no later than five working days prior to each meeting. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting.

8.4. The minutes, and a summary report from the Programme Director will be circulated promptly to all WYMHSC C-In-C Members as soon as reasonably practical for inclusion on the private agenda of each Parties' Board meeting. The Chair of the meeting will be responsible for approval of the first draft set of minutes for circulation to members. The Programme Director will provide a summary for sharing in the public domain.

9. Review

9.1. The WYMHSC C-In-C will review these Terms of Reference at least annually for approval by the Parties.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 June 2018
Agenda item 8.1

Title:	**Operating Plan 2018/19**
Paper prepared by:	Director of Finance and Resources
Purpose:	The purpose of this paper is to provide the Trust Board with a final copy of the operating plan submitted to NHS Improvement on 30 April 2018.
Mission/values:	Use of resources
Any background papers/ previously considered by:	Regular plan updates regularly provided to the Trust Board.
Executive summary:	➢ The draft operating plan was submitted to NHS Improvement (NHSI) on 8 March 2018 in line with what was agreed by the Trust Board. ➢ Following discussion at the April 2018 Trust Board, the final plan was approved by the Chair and Chief Executive and submitted ahead of the 30 April 2018 deadline. ➢ The agreed control total for 2018/19 is a £2.6m deficit (pre Provider Sustainability Funding of £1.5m). This is challenging but achievable based on the work carried out to date and requires delivery of a cost improvement programme of 4.6%. ➢ A letter has been received from NHS Improvement providing some feedback on the plan. It notes the planned reduction in headcount, which is largely due to CIP plans, and stresses the need to improve underlying performance for 2019/20. It also offers Trusts the opportunity to re-submit its plan by 18 June 2018 given the points raised. It is not planned to change and re-submit the plan.
Recommendation:	**Trust Board is asked to NOTE the final operating plan submitted for 2018/19 and the COMMENTS provided as feedback by NHS Improvement.**
Private session:	Not applicable.

1. Activity Planning

1.1 Approach to activity planning

Our approach to activity planning is based on a practical understanding of service pathways and the journey taken by service users. We deliver across a broad portfolio of services and communities. In each, we seek to optimise the experience of care; ensure that resources are deployed effectively by matching capacity to demand; and where necessary highlighting development requirements arising from our partnerships with commissioners and providers. As a community and mental health provider, the requirement for an activity return as part of the Operational Plan does not apply to our Trust. Nevertheless the principles are applicable and the key issues for our services are described below.

1.2 Demand and capacity modelling

Over the course of the last two years we have developed and applied a demand & capacity modelling tool. This enables us to undertake scenario planning and predict the impact of variances in demand on activity and consequential changes in the workforce. We have applied this to tenders and service reviews, and also to inform our contract negotiations with commissioners as part of the contracting process. In the year ahead we will continue to refine the approach, train more people in its application, and develop the ability to use the tool to support benchmarking for improvement.

To date we have focused on using demand and capacity modelling in such services as CAMHs, ADHD/ASD and psychology. These are areas which are experiencing levels of demand typically in excess of the contracted capacity. In addition it has been used to underpin service modelling and costing for service tenders. Furthermore the approach has been used when working with commissioners on a number of service developments such as weight management and ASD. When used it has supported a far better mutual understanding of capacity and demand requirements between provider and commissioners. Our approach to demand and capacity in ward based services is informed by our Safer Staffing programme through which we ensure all our inpatient clinical services are staffed appropriately so that they can run both safely and effectively.

1.3 Key activity planning assumptions

Our plan assumes that demographic growth and other population changes impacting on acuity and demand are reflected in contract variation settlements for 2018/19. We have based this on Office for National Statistics population projections and on the Index of Multiple Deprivation. This equates to between 0.5% and 1% growth annually

across all services, with variances within this range for specific service lines. We continue to experience demand-led growth in activity and acuity in areas such as CAMHs, Intensive Home Based Treatment, Crisis, Speech and Language Therapy, Community Nursing and our Adult Acute and Psychiatric Intensive Care Unit (PICU) mental health services. To date this additional demand has been met through productivity gains within services, but has also resulted in an increase in out of area bed placements in our mental health services. Our analysis indicates that our ability to absorb demand through improvements in productivity has largely been expended. Therefore our plan assumes that we are able to agree contractual changes with our commissioners leading to investment in services with long waits including psychology, ASD and ADHD, and CAMHs.

Changes to our service portfolio through tendering activity and managed system care pathway change have resulted in movements in activity both up and down, but with a net reduction in the current year, with a further net reduction assumed in the 2018/19 plan. This accounts for close to an £18m income reduction over two years. We anticipate impacts from the development of integrated pathways and alliance contracts aligned to emergent integrated care models. Our plan assumes a continued shift towards more community based delivery and reduced activity in bed based services. Our transformation programme for older peoples' mental health and mental health rehabilitation aims to increase the number of people who can be supported in their own home, rather than in an inpatient setting.

A major focus of our plan in 2018/19 continues to be a reduction in the use of out of area beds for mental health. Demand for adult acute and PICU beds is regularly well above commissioned levels. This reduction will be supported by improvements in length of stay, gatekeeping, and further development of alternatives to admission. We are working closely with partner organisations in this respect and have agreed a joint plan of reducing the trajectory over the course of the next three years. This will take place against a countervailing trend towards higher acuity in local mental health inpatient settings which has impacted on available internal bed capacity and average length of stay. The implementation of the Five Year Forward View (FYFV) for Mental Health and the Transforming Care agenda in learning disabilities will impact on our activity as commissioning of beds reduces with an increased focus on community care.

In 2017/18 we introduced a specialist community perinatal mental health team, adding to community activity and reducing demand for inpatient admissions. Our Improving Access to Psychological Therapies (IAPT) activity is also increasing and additional investment for 2018/19 will help meet this demand.

The local implementation of Transforming Care will enable increased community activity focused on supporting independence, and additional inpatient assessment activity to enable more people to move on from institutional settings.

1.4 Impact of system resilience planning

The 2018/19 activity plan is based on 2017/18 outturn and average over the last 3 full years' activity. Review of the last full 12 months data has also been undertaken to ensure that additional activity related to winter resilience, police liaison and hospital

based psychiatric liaison services are included. Whilst there was some limited system resilience investment into South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) services in 2017/18 there was also significant system demand throughout winter for a number of our services.

1.5 Achieving key operational standards

Activity plans will continue to support achievement of the key operational standards and delivery of the five year forward view.

New standards for early intervention in psychosis (EIP) services came into effect in April 2016. To date we have achieved the 50% target for the two week access standard for completed pathways (89.5% Jan 18).

The Trust will continue to be within the referral to treatment time (RTT) thresholds for applicable services including musculoskeletal (MSK), diabetes single point of assessment (SPA) and paediatric audiology. January 2018 performance was 98.1% within 18 weeks.

During 2017/18 the Trust has made positive progress with IAPT access standards. In March 2018 92.5% people accessed IAPT within 6 weeks (target 75%) and 99.7% people accessed IAPT within 18 weeks (target 95%). In 2018/19 we will continue to improve the achievement of IAPT recovery rates (56.5% versus 50% target in March 2018), and extend the reach of IAPT services to help more people, working with our commissioners to meet local standards. Following participation in the IST process there will be further financial investment in IAPT in Kirklees which will support meeting additional activity. However, IAPT in Barnsley will be subject to a CCG procurement tender process during 2018/19.

We have developed specific plans to respond to all of the measures used within the FYFV mental health dashboard. We are a Trust that provides prevention and wellbeing, community healthcare as well as learning disabilities and mental health services. As such there are many operational standards that are key to us in addition to those mentioned above. Some of the key areas where activity plans impact significantly on assumed income, workforce, and quality outcomes are:

- Smoking cessation – our plans reflect delivery of contracted numbers of quits and associated income. Risks regarding revised contract specifications are reflected in our mitigation plans.

- Achievement of access and throughput requirements of our MSK clinical assessment and treatment service are fundamental to whole system efficiency in the planned care system in Barnsley.

- Activity for community nursing services is currently 17% above our historical contractual requirement. Our current assumptions are that productivity gain within the current model of delivery has been exhausted. There is therefore a risk to future quality and system flow, which we are addressing through partnership work with commissioners and with primary and acute care to re-design neighbourhood nursing. We are also seeking appropriate and fair additional income from commissioners for the service.

- Activity for neuro rehabilitation services and stroke care is subject to known commissioning reductions and potential future changes. Neuro-rehabilitation beds will be reduced by 4 beds by October 2018 and the new stroke model

being developed in South Yorkshire & Bassetlaw may impact upon the stroke service in Barnsley.

There are some services where the waiting times to access assessment and treatment are too long. Where relevant we are working with commissioners to highlight these and to identify creative solutions. Through 18/19 contract discussions we are negotiating solutions regarding ADHD and ASD assessments, CAMHs, and psychology waiting times. We anticipate intensive home based treatment teams will require additional investment and activity as we manage demand for inpatient beds for acute and PICU service users. A key component of the 18/19 negotiations is prioritising Five Year Forward View priorities where investment is required to support increasing demand and activity trajectories.

The risk of increased activity and cost to the Trust as a result of decommissioning, tendering and funding shortfalls in local authorities and the third sector remains a risk.

2. Quality Planning

2.1 Our approach to quality improvement

Our executive lead for quality improvement is the Director of Nursing and Quality. Our Trust-wide improvement approach is clearly reflected in our updated Quality Strategy, which starts with our mission and values. These embed a drive to 'improve and be outstanding' enshrined in our values.

Within our strategy we describe an integrated approach to the delivery of change based on best practice. Through this we aim to ensure that quality improvement occurs as near to people who use our services as possible, and we support the delivery of change initiatives to ensure quality improvements are successfully implemented.

In 2018/19 we will focus on the development of skills for improvement throughout our Trust, working with our local Academic Health Science Network (AHSN) and others to build capacity and capability for change. Our innovation hub will mature, which supports every member of the team to identify improvement opportunities and act upon them, gaining support from colleagues where needed.

During 18/19 we are planning to introduce a quality assurance and improvement 'self- governing' assessment and accreditation model, which will provide a philosophy, process, and a set of tools for improving results for clinical teams. As a philosophy and process, the model will provide a context for a dialogue on self-governance and self- evaluation. As a series of methods and tools, it will help map the relationships between quality assurance and quality improvement and a continual source of evidence for teams to inform them how well they are performing (in relation to quality).

The aim is to foster each team's sense of responsibility for its own quality outcomes and engender optimism that the quality of service delivery can continually be improved. As part of this initiative we will develop an accreditation scheme that will be underpinned by quality measures and a quality monitoring system to recognise teams that are delivering high quality care and reward them for their efforts.

To guide our development we report on over 20 different quality indicators in our integrated performance report, including friends and family test results, infection

prevention, serious incidents, safer staffing, pressure ulcers, CQUIN performance and complaints. Each of these has a specific 'stretch' target that reflects improvement in quality, and can be viewed by team, service and trust-wide. The report is considered at the Executive Management team, the Board and its Committees. This enables us to evidence the return on our investment in quality.

We learn through a robust clinical audit programme and we participate in research and development with links to universities and AHSN. We also contribute to and learn from external benchmarking and reporting initiatives including the national confidential enquiry into homicide and suicide, mental health benchmarking and workforce numbers. We also have an active programme of quality monitoring visits to all our operational areas, from which we derive significant learning and quality assurance.

We are engaged in a cycle of delivering against our improvement plans following CQC inspections, which is focused upon actions that were already underway and actions arising from new insights CQC brings. We remain committed to ensuring that compliance is achieved through a focus on improvement.

We acknowledge that our drive for quality improvement can be put at risk if routine quality assurance measures are not in place. Therefore we have enhanced our current system to include a Clinical Governance Group focused on the delivery of our CQC action plan. This group, supplemented by our own internal inspection programme, provides a key monitoring and escalation route for action to maintain and improve quality.

Central to our approach to governance of quality and improvement is the Clinical Governance and Clinical Safety Committee (CGCSC). This is chaired by a Non-Executive Director, with the Director or Nursing and Quality as executive lead and amongst others includes the Medical Director as a member. This committee reports directly to Trust Board. Reporting in to the CGCSC is the Trust's Quality Improvement Group. The purpose of the group is to assure safe, effective, caring, responsive, innovative and well-led practice in accordance with the Trust's Quality Strategy. The functions of the group are: 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; planning and monitoring delivery against plan.

We also have the Members' Council Quality Group, which enables Governors to look in more detail at the Trust's quality performance and quality accounts and support the Trust in its approach to quality

2.2 **Summary of Quality Improvement Plan** (*including compliance with national quality priorities*)

We reviewed our quality priorities in early 2016/17 and adopted the CQC 5 key domains as our framework for developing quality approaches in the Trust. Under each domain we have identified a set of key performance indicators to monitor the quality of care. Our quality priorities reflect the needs of our service users and learning from our quality improvement systems. During 2017/18 we refreshed our Quality Strategy, revised our quality priorities and produced our Quality Account in line with required guidelines.

Our quality improvement priorities for 18/19 are described below. These include items brought forward from 17/18 where they remain relevant; as well as additional measures following the review of progress annually which updates our quality priorities. Our priorities are linked to national drivers and are well aligned to the Sustainability & Transformation Partnership plans for West Yorkshire & Harrogate and South Yorkshire & Bassetlaw. A summary is shown below:

Domain	Priority
SAFE	• Implementation of Patient safety initiatives as outlined in our Patient Safety Strategy (e.g. Prone restraint reduction, reduction of avoidable and attributable pressure ulcers) • Improve safer staffing fill rates • Improved integration of physical and mental health offer • Implementation of Suicide Prevention strategy with a zero suicide philosophy • On -going development of mortality reviews and Incident investigation system • Implementation of our safeguarding annual plan.
EFFECTIVE	• Timely assessments and reviews of care and treatment – IAPT and EIP transitions of care • Effective transitions between CAMHS and adult services • Development and implementation of outcomes measure • Recruitment and retention initiative within workforce planning
CARING	• Improve quality of clinical record keeping • Patient experience – refresh of system for capturing and acting on feedback • Staff health and wellbeing – improved Staff FFT and internal survey results • Scale up our volunteer programme
RESPONSIVE	• Improve waiting times • Complaint closure and resolution times • Zero approach to out of area beds working with partners to reduce utilisation
WELL- LED	• Introduce quality assurance and improvement 'self- governing' assessment and accreditation model • Friends and Family Test and service user feedback on co-production and access to peer support • Learning lessons –further development of systems to improve how we learn lessons from patient experience, serious incidents, audits, safeguarding reviews and share these across the trust.

2.3 Summary of quality impact assessment process

Efficiency opportunities and service improvements are identified through Trust-wide transformation initiatives, new service developments and through annual service line planning exercises. This is supported by internal and external benchmarking and market analysis. Schemes are documented on a simple standard template to aid clarity. At the time of scheme identification, service line teams undertake a self - assessed Quality Impact Assessment (QIA). This follows key lines of enquiry aligned to the CQC domains. The Impact Assessment process also involves consideration of feasibility and achievability as well as impact on quality.

A series of QIA panels review all CIP proposals using key lines of enquiry in discussion with leads for each service line. This allows self - assessed QIAs to be peer reviewed with support from clinical governance and safety experts. Panels are chaired by the Assistant Director for Nursing and Quality. RAG ratings for finance, deliverability and quality impact are brought together into an agreed overall rating, plus any mitigating actions required.

All QIAs of efficiency opportunities are specifically reviewed by the Medical Director and Director of Nursing and Quality, alongside the Director of Workforce OD and Estates, including a review of cumulative impact of CIPs in each service. Board assurance is achieved via EMT and CGCS scrutiny and then direct Trust Board approval of the Plan.

Throughout the year the Trust maintains a focus on quality including the impact of change through the weekly Operational Management Group (OMG) meeting attended by all operational directors which receives reports on key operational and quality performance from all Business Delivery Units, and ensures action is taken. This includes review of CIP progress ensuring QIAs remain valid. Any new or substitute schemes are subject to the same QIA process. Once delivered all CIPs are subject to post implementation reviews to ensure there have been no unintended consequences from the schemes. OMG escalates issues to the Executive Management Team where required and an Integrated Performance Report is reviewed by Executive Management Team each month and presented to our Trust Board meetings.

Where there have been system-wide service changes through new models of care a QIA process has been applied across that health system.

QIAs also take place at key gateway points during major service transformations and priority programmes, and at the post-implementation review point.

2.4 Summary of triangulation of quality with workforce and finance

This plan forms the basis of our integrated performance approach – a report that can be used at all levels and covers quality, performance, workforce and finance. This supports our approach to triangulation of the data that takes place at Trust Board, Executive Team, Locality and Service Line levels. Our Integrated Performance Report (IPR) will continue to directly reflect the measures in this plan. These will be finalised once contracting negotiations have been completed.

Financial budgets, activity and workforce plans have been triangulated at service level within each BDU. A cross functional approach is used to develop the plan and

test the assumptions being made, which enables this triangulation exercise to be considered robust

During 2018/19 we will build on the trust wide and place based scorecards to implement individual service level balanced scorecard to ensure that quality and performance measures are understood and used meaningfully at all levels. This will be reviewed extensively by the Executive Management Team and also discussed in public at Trust Board meetings.

The metrics used in the IPR, which aid triangulation, are multiple and include operational KPIs that also signify quality such as referral to treatment times, plus indicators of quality and effective use of workforce, such as safer staffing fill rates in ward based services, and indicators of quality and financial success such as use of out of area placements and use of agency staff. A further focus on key workforce metrics supports an understanding of current and future capacity and effectiveness, such as rates of attendance, appraisal and engagement. The IPR also draws together the feedback we receive through complaints and the Friends and Family Test describing how we are learning from feedback and sharing our learning. The Board receives the IPR on a monthly basis. It uses this information to track trends and to make specific enquiries into actions undertaken around hot-spots.

Alongside the operational issues, transformation programmes such as our recovery focused work in mental health and the reduction of out of area placements for general acute mental health in-patient needs are reported through the integrated approach. This process is informed by the full QIA process.

Throughout the year we continue to monitor the impacts on quality of our drive to always ensure safe levels of staffing, while also acting to reduce our use of agency staffing and to maximise local bed capacity to reduce use of out of area placements. Our approach is based on our belief that good quality services attract and retain excellent staff, and this will maximise benefits for service users.

3. Workforce Planning

3.1 Workforce planning

Workforce planning is an integral part of our service line and financial planning process, and is developed through a robust engagement process with clinical, operational and professional staff. Our plans build on a strong foundation of workforce transformation, including agile working, new roles for advanced and associate practitioners, and the redesign of clinical support worker roles. The Strategic Workforce Plan, which supports the Workforce Strategy is currently being refreshed and has a strong focus on delivering safe, effective services within agreed resources. The Trust will continue to deliver its Organisational Development Strategy, which aims to align systems and resources through a values based approach to workforce development.

3.2 Workforce strategy

The Trust's Workforce Strategy continues to drive forward the re-design of the workforce to ensure it is fit for purpose, affordable and sustainable. The strategy has 3 key work streams: *Workforce Development; Staff Engagement and Wellbeing; Leadership and Management Development.* Its aims are to ensure we have the right staff in the right place at the right time, that we improve quality, and improve organisational performance. The Trust recognises that significant change in the workforce is required over the next 2-5 years to meet increasing service demands and acuity levels, through maximising productivity and new ways of working. This will be driven by our operational workforce plans, transformation programmes, our CIPs, our contract tendering activity and local and national investment priorities (e.g. FYFV, CAMHs, Apprenticeships and levy).

Our workforce continues to be diverse and we need to ensure that we support diversity. This is reflected in our Equality Delivery System [EDS2] priorities and improvements in the Workforce Race Equality Standards in 2017. This is backed by active staff networks, with an active BAME network and staff driven networks for LGBTQ+ and disabled staff emerging.

Specific work streams reflected in our plans include, but are not restricted to:

Workforce Development	• Supporting workforce changes through the apprenticeship levy. • Continued redesign of the Trust's clinical support workforce to include wider professions (Pharmacy, Allied Health Professionals, Psychology) and continued implementation of band 4 Associate Practitioner roles. • A Trust wide Staff Retention Plan has been developed using identified best practice. • Pilot international recruitment of band 5 nurses from Poland. • Continued delivery of the Workforce Race and Disability Equality Standards.
Staff Wellbeing and Engagement	• Continued focus on improving staff well-being, resilience and engagement. • Developing Healthy Teams Programme. • New model for Value Based Appraisal.
Leadership and Management Development	• Building Leadership for Inclusion. • Developing Clinical Leaders. • Value Based Leadership through Values into Behaviours. • The Workforce Race Equality Standard

3.3 Workforce efficiency and transformation

The focus of the Trust's workforce transformation enhances both quality and productivity and include:

- A focused medical workforce plan that will enable a continued reduction in use of agency staff through redesign of posts including more consultant led services and the introduction of other professional roles, e.g. Advance Clinical

Practitioners, which will reduce the need for staff grades which is a particular problem area for recruitment.

- Reducing management costs through streamlining processes and devolved decision making. In addition the Trust will continue to develop strategic partnerships for collaboration in back office functions across West Yorkshire.

- The Trust's Nursing Strategy recognises the need for potential alternative delivery of newly qualified nurses following changes to nurse bursary arrangements.

- The Trust has implemented a new specialist community perinatal mental health service, supported by additional investment linked to the FYFV in 2017. Initial mobilisation was achieved via secondment of existing staff, which required backfill for operational resilience. Recruitment of specialists in this field is largely complete, and we anticipate a need to place significant emphasis on the training and development of this new team.

- Expansion of mental health liaison services to meet CORE24 standards will require additional senior nursing and therapy roles. In relation to all time limited funding through the FYFV for mental health there are risks regarding discontinuation of funding at the close of the centrally funded period. To counter this risk we have worked closely with our local commissioners to ensure that we are all aligned in our commitment to investing in mental health and to demonstrating the impact. In all of the above service areas it is essential that we engage our partners in primary and secondary care to identify and code needs and activity accurately and to share data effectively to demonstrate impact.

- Expansion/development of our workforce to meet the Early Intervention in Psychosis standards (EIP).

- Workforce transformation of our Older Peoples' Mental Health services. Development of core and enhanced workforce teams from existing staff.

- Community nursing services workforce redesign to meet new commissioning intentions (Epilepsy, District Nursing, MSK).

- Redesign/review of Stroke Unit/NRU workforce in line with partnership working With Barnsley Hospital NHS Foundation Trust (BHNFT).

- Workforce implications of a System wide review of Assisted Living Services in Barnsley during 2018/19 and co-production of a new Service model.

3.4 Addressing use of agency staff

The Trust has reduced its agency spend by over 40% in 2017/18 through strong management, clinical leadership, grip and negotiated price reduction which will continue into 2018/19. In addition the Trust is exploring, with NHS partners in West Yorkshire and NHS Professionals, possible collaboration on agency and bank staff management which has the potential to improve fill rates and deliver further cost savings.

4. Financial Planning

4.1 Financial forecasts and modelling

This section identifies how the financial plan has been developed and what our plans are to ensure it is delivered. It also clearly articulates the assumptions made when generating the plan and risks of achievement as currently identified. Given the realisation of a number of risks clearly articulated in the two year plan submission in December 2016 and March 2017 the Trust has agreed a revised control total of a £2.6m deficit pre Provider Sustainability Funding (PSF) for 2018/19. The most significant issue the Trust is facing next year is a further reduction in income given the tendering or de-commissioning of a number of services. These have tended to be high margin services and have resulted in a loss in contribution of £4m to date. There are a number of other significant cost pressures which the Trust acknowledges it needs to absorb and make efficiency savings to cover, but to cover both within a short time period would have resulted in an efficiency requirement in excess of 6%. As it stands a 4.6% efficiency saving is required to deliver the financial plan.

It is recognised that a medium term financial recovery plan needs to be developed to determine when and how the Trust can return to a financially viable position. This work will be delivered with due consideration of the partnership working that now exists in West Yorkshire & Harrogate, with colleagues in other providers of Mental Health Services facing additional pressures. The work has commenced with an initial plan due for completion during quarter two of 2018/19. This will include the consideration of radical options.

It is likely that further tendering will take place over the course of the next twelve months which will pose a further risk and until the future of all services in Barnsley is finalised there will be a degree of financial instability at the Trust.

The 2017/18 control total target was achieved. It must be emphasised this was underpinned by a range of non-recurrent measures that have been required to offset reductions in income and financial pressures created by demand for inpatient beds for acute and PICU service users. Following a fire on one of our wards in November 2016 an insurance settlement was finalised during the year and bed capacity is now back to its former levels. However inpatient demand has increased significantly; the consequences of which are being discussed with our commissioners and mutually

agreed plans are being put in place to reduce the number of out of area bed placements.

Achievement of the control total has enabled full access to the basic STF and further year-end distribution of £2.9m. The underlying position remains adverse which does impact on the opening run-rate position moving into the new financial year.

It is worthy of note that the Trust has made significant strides in reducing agency costs and at the end of March this spend was 41% lower than the corresponding period from the previous year. In addition CIPs of £7.5m (3.4%) were delivered, which is a significant achievement for a Trust operating in a block contract environment with reference costs of 95 and decreasing income. Non recurrent CIPs account for £1.6m of the total delivered and tight costs controls, particularly for non-pay, have been applied.

Throughout the course of the year the Trust has continued to liaise closely with NHS Improvement (NHSI). We have engaged in local initiatives with respect to bed management and staff retention and will continue to accept offers of support where capacity and sharing of good practice will benefit the Trust, our staff and our service users.

A full review of all assumptions has been made in developing the refreshed financial plan for 2018/19. There are a number of assumptions that are less clear, which we expect to gain traction with over the course of the year. These particularly relate to the consequences of and our roles in accountable care systems in the geographies in which we operate, further potential tendering or re-commissioning of community services and the volatility of demand for acute and PICU beds.

The Trust Board is committed to achieving the 2018/19 control total which is viewed as being challenging but deliverable, whilst acknowledging there is risk, especially in relation to the volatile demand for inpatient beds. Moving into 2018/19 out of area bed requirements are at a particularly high level which will impact on the first quarter's financial performance.

Contract variation discussions have taken place with each commissioner and have resulted in some additional investment in our services. This does provide some additional contribution which helps offset the level of cost saving required. There are further in year contract variations likely to follow based on further development taking place with respect to a number of commissioning intentions.

To achieve a deficit of £2.6m in 2018/19 will still require savings of £9.7m (4.6%) to be identified and delivered. In terms of financial assumptions these are shown in table 1 overleaf:

Table 1

	Key Assumptions
Income deflation	2.0%
Funded cost inflation	2.1%
CQUIN income	2.5%
CNST costs	30%
Pay inflation	1.0%
afc increments	0.5%
Apprenticeship levy	0.5%
Drugs costs inflation	2.0%

It must be emphasised that a number of services the Trust identified at risk of tender in the two year plan submission were tendered on an individual service basis. This is resulting in reduced income of £10m with associated contribution of £4m. Examples of services where managed system change, tendering, or de-commissioning has taken place include Intermediate Care, Diabetes, Care Navigation, Respiratory, and MSK services. There are further services at risk of either tender or re-commissioned models of care in 2018/19 which will add further short term risk to the Trust's financial position. These services include IAPT in Barnsley, Stroke and Neuro Rehab. Retention of service provision for those services potentially at risk at similar values to today is assumed within the plan, although they are clearly identified as risks. It should also be noted that a number of services commissioned by local authorities have either been de-commissioned or re-commissioned with lower funding during over the course of the last eighteen months. This trend could continue and would result in a risk of unplanned redundancy costs. It should be noted that contract discussions have resulted in some additional income and contribution which partly offset the impact of the highlighted reductions, but not to a significant extent.

Elsewhere in this plan narrative there is reference to work being undertaken in both the West Yorkshire & Harrogate STP and South Yorkshire & Bassetlaw ICS. The Trust is fully engaged with both STPs. At this point in time it is not clear exactly what impact the STP development will have on Trust service provision as this remains work in progress. Much of the work focuses on delivering more resilient services across a broader bed base. This means there are potential changes that will impact on the Trust and its specialist services, our bed based services and community services in each locality. For the purpose of this plan, we have dealt only in known changes until agreement has been reached and reflected in any contracts and it is therefore assumed that there is no change. Potential upsides will be identified as such and form part of our plan to close the financial gap.

Another key assumption is that income for mental health services will grow in line with plans established within the mental health five year forward view and in line with CCG growth as per the operating guidance. This is largely demonstrated by the results of the contract negotiations, although one CCG is still prioritising how its mental health investment will be made with confirmation scheduled by the end of the

first quarter. The impact of income deflation, provision of cost inflation, loss of or reduced service provision and growth in mental health in line with the five year forward view results in an income reduction compared to the 2017/18 plan and outturn.

Table 2 below shows a summary of key financial headlines from both the current year and the two years of the plan. This table excludes the impact of STF/PSF monies achieved which equated to £2.9m in 2017/18 and are assumed to be £1.5m in 2018/19.

Table 2				
Key Financial Headlines	**2016/17 Actual £m**	**2017/18 Plan £m**	**2017/18 Actual £m**	**2018/19 Plan £m**
Operating income	229.8	220.9	219.9	212.0
Employee expenses	(171.1)	(167.6)	(166.4)	(165.3)
Other operating expenses	(52.4)	(49.0)	(49.5)	(45.6)
Operating surplus/(deficit)	6.3	4.3	4.0	1.1
Finance income/(costs)	0.1	0.0	0.1	0.0
Other costs	(3.7)	(3.4)	(3.0)	(3.7)
Surplus/(deficit) for the year	(0.1)	1.0	1.1	(2.6)
Adjusted surplus excl impairments	3.3	2.4	2.6	(1.2)
Adjusted surplus excl STF	0.7	1.0	1.1	(2.6)

Bridges of income and cost movements are detailed within the financial schedules included within the plan. Key movements are now highlighted. The Trust has seen income fall steadily over the last three years. This is due to a number of reasons including a conscious decision to exit Barnsley 0-19 Public Health nursing services given the level of income reduction within the tender, tendering or de-commissioning of community services in Barnsley and reductions or de-commissioning in local authority commissioned services. This is a significant factor in the reduction in surplus as the income reductions do result in a degree of stranded overhead and loss of critical mass. In addition some of the service reductions have typically applied to higher margin services. To deliver the financial plan will require real income growth for mental health services as laid out in the operating guidance and an element of growth where mental health investment is below national averages. Similarly, additional demand in physical health services in community must be funded. Contract negotiations with all our CCGs have concluded for 2018/19 with a small number of important developments still in discussion. In particular, we are working on the degree of risk shared around out of area placements.

An element of the community services provided in Barnsley has transferred into an alliance contract. This contract may form the basis of further developments,
The only service developments included in the plan are those that have been confirmed such as perinatal services. Other likely new services are included as potential upsides pending confirmation of income.
Reductions in income and costs are captured where services have ceased.
Employee expenses decrease in 2018/19 given the combined effect of cost of living

increases (£1.7m), agenda for change increments (£0.5m), service reductions and CIPs. Other key movements relate to the full year effect of filling vacancies. Other operating expense movements include known cost pressures such as CNST increases, drugs costs and a planned reduction in the requirement for out of area bed placements. There is also significant pressure on IT costs such as Microsoft licences, replacement laptops, N3 replacement and revenue costs associated with the provision of wi-fi at our patient facing estate. Countering these to an extent are a range of non-pay cost improvements assumed within the plan including procurement savings and a series of CIPs. It must also be noted that an element of the CIP delivery for 2017/18 (£2.3m) was either being delivered non-recurrently or has not been achieved. This therefore adds to the financial challenge for next year. In total 4.6% of efficiency needs to be delivered in order to achieve the control total. To deliver the control total and allow for a small contingency requires a 4.7% efficiency to be delivered.

At this point in time there are no specific financial benefits identified in the plan relating to the STP, although there are potential upsides identified as a CIP relating to the provision of forensic outreach services within Learning Disabilities. There is no doubt that as plans further develop any benefits that are identified will help fill the gap we currently have. This is particularly relevant when considering bed management arrangements and opportunities across West Yorkshire. The Trust is working collaboratively within both STPs it provides services into and in particular is working closely with other providers of mental health and community services. Opportunities will be assessed for both clinical and back office synergies. These will include optimising the use of the bed base and consolidating back office service provision where it is appropriate to do so.

Achievement of the pre STF surplus in each year of the plan enables access to £2.9m of STF in 2017/18 and £1.5m of PSF in 2018/19.

The Trust has undertaken a review of current run rates, current budgets, identified cost pressures and initial cost improvement schemes in generating this financial plan. Presently the Trust has identified in excess of £5.9m savings and improvements. Further opportunities continue to be assessed at the time of writing with an additional £2.4m identified at a higher level and being developed, with a further £1m of one-off measures potentially available to support achievement of the Trust's planned deficit.

Given the current projections, based on solid assumptions, the Trust has a challenging but potentially achievable plan to enable delivery of its control total for 2018/19. As previously stated, the Board is committed to achieving the best possible financial position, whilst ensuring the delivery of safe care is imperative. This position is also based on managing a number of risks identified. The total downside risk is close to £3m, which would increase the deficit if it materialises. This is based on further tendering and re-commissioning of services and continued high demand and high acuity resulting in the extended use of out of area bed placements. Some potential mitigations could arise dependent on timing and value of asset disposals.

The Trust Board and senior management is committed to putting plans in place to deliver its CIP and overall financial plans, identifying further savings opportunities and mitigating risk. In doing so, we think it is only prudent to recognise that we are managing risks that have been clearly stated and articulated. Further work will take place in the early part of the first quarter to firm up the detail of potential additional savings and income improvements. Actions have been initiated in relation to management, operational and corporate service re-structuring, maximising income opportunities and business development opportunities, non-pay costs and non-recurrent actions. Intense focus remains on reducing the use of out of area bed placements. These will generate further assurance regarding deliverability of the plan. The financial plan assumes that sufficient additional CIPs will be identified and implemented. As part of the development of the plan consideration is given to activity plans, workforce plans and quality plans to ensure they all triangulate and align with the financial plans.

4.2 Efficiency savings for 2018/19

The Trust has a structure based on Business Delivery Units (BDUs) – Calderdale, Kirklees, Barnsley, Wakefield, Forensic and Specialist Services that are supported by a corporate Quality Academy. The BDUs and Quality Academy are accountable for their own financial performance and identify specific cost improvement schemes. These specific schemes are augmented by trust-wide schemes which are not necessarily specific to one particular service or corporate team. The Trust has a very clear principle of operating with a safety first approach. Quality Impact Assessments (QIAs) are therefore carried out on all proposed cost improvement schemes. QIAs, using the processes described in section 3, have taken place for schemes identified to date to ensure there is sufficient assurance behind the plans. Of the £5.9m CIPs identified to date confidence of delivery is strong based on the QIAs carried out.

A Director of Delivery role was appointed to in 2017, playing a leading role in the delivery of “operational excellence”. Operational excellence is one of 6 trust priorities, and has focused on such issues as agency cost and temporary staff controls, effective rostering and bed management.

For 2018/19 there are a number of key areas of focus which will help drive financial improvement. The Trust is currently experiencing a significant cost pressure which also adversely impacts on quality of care relating to an inconsistent and volatile demand for out of area bed usage. We are working closely with other Trusts locally and NHSI to identify and embed best practice and are also negotiating with commissioners where bed usage clearly outstrips the number of beds commissioned. There is also an internal bed management group that meets weekly and communicates more frequently. Risk avoidance of at least £2m can be achieved by reducing reliance on out of area beds and entering into appropriate risk share with commissioners.

Whilst expenditure on agency staff has reduced considerably, this will remain an area of clear focus as we seek to reduce costs further. Costs reduced from £9.8m to £5.8m over the course of the past 12 months. With a revised cap of £5.2m in 2018/19 the aim is to continue the reduction in agency expenditure.

There continues to be firm focus on workforce, particularly staff in non-clinical roles. Additional savings are possible and are being factored into our savings plans. Wherever possible the Trust will utilise vacancies to reduce staffing, to minimise disruption and redundancy costs. This will be either a direct saving or an opportunity

to re-structure. For some posts there are unlikely to be redeployment opportunities which may result in redundancy costs being incurred, which will impact upon the cash position.

The Trust has delivered substantial changes in the Estate based on our estates strategy, which was approved by the Board in 2012. This is providing the Trust with much improved estate, a reduced number of buildings and is an enabling factor in our agile working strategy. Having reached this stage we will maximise the use of our estate and continue to reduce the number of buildings we use. We will ensure we are operating our estate as efficiently and effectively as possible, whilst continuing to review the best way of providing estates maintenance services. An element of our CIP plans is focussed on delivering increased efficiencies within our estates and estates services.

Opportunities are being assessed for a further tranche of non-pay efficiencies either via procurement or via reducing demand for use. Favourable management information has highlighted some opportunities for drugs savings and as the Purchasing Price Index Benchmarking (PPIB) tool becomes increasingly populated it is envisaged this will identify additional opportunities for saving. Examples of non-pay savings achieved in the current year relate to patient transport and translation costs.

Historically there are some elements of our contracts which have been under-funded such as ASD/ADHD and Intensive Home Based Treatment services in some geographies. Good progress on addressing a number of these has been made through contract negotiations.

Transformation through service redesign will be a feature of our plans. We know that substituting services through alternative provision – such as Recovery Colleges and Creative Minds can provide good outcomes at lower cost. We will build on approaches to transformation that have delivered efficiencies in services to date, seeing through the full benefits of implementation.
The Trust has a history of delivering CIPs. This is in a period where it has become more difficult to deliver CIPs as the cumulative consequences of income deflation and lack of growth continue. Good achievement of CIPs includes a sub-optimal balance of recurrent and non-recurrent CIPs, which remains. Strong governance regarding CIP management remains in place including a regular in-depth review at weekly operational management meetings, regular service meetings with the Director of Finance and non-executive attendance on a monthly basis at a financial review meeting

A summary of CIP savings delivered in recent years and those required for the plan is shown in table 3. It is notable that CIPs have consistently been above the efficiency factor applied to our contracts [e.g. 2.0% in 2017/18] and the figures are as follows:

Table 3				
Cost Improvement	**2016/17 Actual**	**2017/18 Plan**	**2017/18 Actual**	**2018/19 Plan**
	£m	**£m**	**£m**	**£m**
Recurrent	7.2	7.3	5.9	7.9
Non-Recurrent	1.7	1.0	1.6	1.8
Total	9.0	8.3	7.5	9.7
% of operating cost	3.9%	3.8%	3.4%	4.6%

Table 4 below provides an indication of how the £9.7m CIP saving will be delivered. It is acknowledged there is a gap at the moment with £5.9m of saving firmly identified and planned, whilst the remainder is subject to more risk and further work.

Table 4	
Cost Improvement Delivery Breakdown	**£m**
Workforce Redesign	1.3
Contribution from additional income	1.1
Service Redesign	0.4
Admin Review	0.4
Vacancy Review	0.8
Drugs	0.3
Travel	0.1
Non Pay Savings (Including Estates recon	3.0
Structural Redesign	1.2
Additional pay opportunities	1.0
One-off measures	0.2
Total	9.7

4.3 Capital Planning

The Trust is now approaching the final phase in implementing the Estates Strategy agreed by the Board in 2012. The Estates Strategy was developed through a strong engagement process with clinical staff, service users and carers and service managers and had 3 strategic goals: *Development of the Trust's community infrastructure; Improving and modernising inpatient estate; and Disposal of properties surplus to requirements*. In terms of improving and modernising the inpatient estate the Board approved a business case for capital to redevelop the non-secure wards on the Fieldhead site. This site provides a number of inpatient facilities as well as support services. This programme of work commenced in 2016 and will conclude during 2018/19. This is therefore a pre-commitment which amounts to £4.4m in the 2018/19 plan, and constitutes the most significant proportion of the capital plan for next year.

As a consequence of the implementation of the estates strategy the Trust has much improved quality of estate, which is reflected in our PLACE assessments, and has been able to exit a number of buildings which were no longer considered fit for purpose. Agile working has been a key consideration in the design of our new community developments, which enables a more flexible workforce and a reduced estate stock. Focus continues to be applied to how estate can be reduced further and

used more efficiently. The Trust is fully participating in developing a West Yorkshire & Harrogate estates strategy as part of the STP for that area, and contributing to the South Yorkshire & Bassetlaw work in a more limited capacity.

In developing our 18/19 capital plan a full prioritisation process has taken place. With respect to estates works, focus has been applied to schemes which enable the completion of the estates strategy and high priority works covering such items as statutory requirements, patient safety and quality of care.

There has been a requirement to tender for a clinical record system for our mental health services given the end of our existing contract. This is viewed as a major change initiative and opportunity for the Trust. The opportunity is to develop a co-designed system that provides excellent access and information for our clinical staff, which will improve patient care and efficiency. The capital costs are included in the 2018/19 plan.

Other IT capital is centred on replacing aged IT infrastructure which will provide increased operational robustness as well as improved defences against cyber-crime.

Where schemes have not been included in the current financial plan a full risk assessment is taking place and mitigating actions will be identified if required. A summary of capital expenditure plans is shown in table 5 below:

Table 5

Capital Expenditure Plans	2017/18 Plan £m	2017/18 Actual £m	2018/19 Plan £m
Fieldhead Re-development	7.0	7.0	4.4
Other buildings works	1.4	1.4	1.2
Mental Health Clinical Record System	0.6	0.4	0.8
IT	1.6	1.3	1.5
Contingency	0.2		0.2
Total	10.8	10.0	8.1

The Trust will be using its own internal cash reserves to fund this expenditure. A number of building disposals are also scheduled to take place over the course of the next twelve months, but receipts have not been included in the financial plan given lack of certainty regarding exact timescales. Since 2015/16 £7.2m cash has been raised through asset disposals. (13 properties) Approximately £2.0m could be generated in the next eighteen months from planned disposals although these proceeds are excluded from the plan. The impact of the capital investment programme and other key movements on cash is that it reduced from £27.1m in March 2016 to £26.6m in March 2018. Given the impact of a net deficit, capital expenditure, timing of working capital movements and use of provisions it is projected to reduce to £18.0m by March 2019. Any proceeds from asset disposals will boost this cash balance. A summary of the cash position and overall net assets position is shown in table 6 below:

Table 6			
Balance Sheet	2017/18 Plan £m	2017/18 Actual £m	2018/19 Plan £m
Non current assets	115.2	123.8	126.2
Trade and other receivables	6.0	6.7	11.7
Cash	18.4	26.6	18.0
Other current assets	3.4	0.2	0.2
Current laibilities	(21.4)	(20.9)	(20.0)
Non current liabilities	(1.4)	(3.1)	(2.6)
Net assets employed	120.1	133.3	133.5

4.4 Summary

In summary the Trust has accepted its revised control total for 2018/19 of £2.6m deficit. This is the first time the Trust is planning for a deficit and is based on identified risk in relating to loss of contribution caused by piecemeal service tendering and de-commissioning. Delivery of the control total requires CIP delivery of 4.6%. This is a higher level than in any of the last three years. Key risks that will impact on our ability to deliver the plan in relation to service retention, resolving the issues associated with high and inconsistent demand for inpatient beds, and delivering against some more challenging savings programmes which will impact on internal capacity. Where it will add value support from NHSI continues to be welcomed and the Trust continues to engage positively and constructively with its commissioners and other partners.

5. Integrated Care Systems and Partnerships

5.1 Vision and our role

The communities we serve are largely located in South Yorkshire (Barnsley) and in West Yorkshire (Calderdale, Kirklees and Wakefield). In addition we serve the wider Yorkshire and Humber population in respect of our forensic service provision as well as place based work across a range of geographies in Yorkshire. Therefore we are actively engaged in the West Yorkshire and Harrogate Health and Care Partnership and the South Yorkshire and Bassetlaw Integrated Care System (ICS).

Our vision, mission, strategic objectives and current priorities are best demonstrated in the diagram below:

There are four clearly identified strategic ambitions which the Board has agreed and are summarised as:

- ***Regional centre of excellence*** for Specialist and Forensic Mental Health and Learning Disability services.
- ***A strong partner in mental health service provision*** across West Yorkshire and South Yorkshire ACS/HCP.
- ***A host or partner in four local integrated care partnerships*** - Barnsley, Calderdale, Kirklees and Wakefield.
- ***An innovative organisation with coproduction at its heart***, building on Creative Minds, Spirit in Mind, Recovery Colleges, Mental Health Museum and Altogether Better.

We are also fully engaged in the development of local place-based plans which are the building blocks of our partnerships. The place based plans cover each of the local authority areas within our two regional partnership footprints. We achieve this through our relationships with Health and Wellbeing Boards, Overview and Scrutiny Committees and Partnership Boards. Learning by doing also presents us with various opportunities, for example Vanguards and other local initiatives where we are developing new models of care and integrated care pathways, such as Connecting Care Wakefield.

The development of integrated care systems potentially have a significant impact on the future of the Trust clinically, operational and financially. Therefore strong engagement in all local place developments is a feature of our plan for 2018/19.

The emphasis of Integrated Care Systems on prevention and integrated holistic care is well aligned to the core strengths of our Trust. The focus on the 'triple aim' is reflected in our strategic objectives and much of our work relates to the way in which

our service provision is changing to reflect the priorities in our local health and care partnerships and their constituent place based plans.

5.2 Health and care partnerships work streams and cross cutting themes

Through our HCPs we are working with partners to deliver improvements in the following areas:

- WY&H HCP is moving towards formalising its partnership arrangements through the development of a Memorandum of Understanding (MoU).

  The mental health providers have developed a collaborative to strengthen partnership arrangements. This is now enshrined in a collaborative programme with commissioners and a committee in common between the four providers of mental health services. We are working together to address the following areas of improvement:

  - Out of Area Beds - we are working towards a shared bed base for acute inpatient beds across West Yorkshire and developing clear trajectories to reduce the use of out of area beds in 18/19.

  - The mental health and community partners have successfully received capital funding to support the development of a new CAMHs inpatient unit to address the regional shortages in in-patient care. This is part of the national New Models of Care programme and providers have agreed a risk share in return for control over the budgets. The Trust is a partner in this programme, which Leeds Community Healthcare NHS Trust leads, and is working to develop a joined up crisis response, alternatives to admission, focus on early intervention and wellbeing. This will lead to reduction in admissions, fewer out of area placements, improved access and responsiveness at all levels.

  - The partners were also successful in bidding to be part of the New Models of Care programme for specialist Eating Disorder services. These are being developed to ensure that people with eating disorders receive timely specialist support close to home across the region, with Leeds & York Partnership NHS FT leading and liaising with local services.

  - Suicide prevention – This Trust is leading this work stream within the collaboration. A new strategy was launched in November 2017 around our approach to zero suicide.

    - Improving access to ADHD and ASD assessments, working with commissioners to meet NICE standards on these, which are not in place.

    - Learning disability services, including how we ensure that Assessment and Treatment Units work across West Yorkshire. The Trust was recently awarded the contract to run the Operational Delivery Network for Yorkshire & Humber.

- The Trust is the lead provider for low and medium secure mental health and is leading a network of providers across the region – developing shared quality standards, integrated pathways from inpatients into community. We will improve quality outcomes and work towards reducing the length of stay, improve bed utilisation, and improve use of resources. This programme also has the potential to become a New Model of Care pilot.

- Mental Health Liaison – In both South and West Yorkshire where we will share standards and learning as we further enhance local liaison services. We are exploring collaboration around the training and development of acute hospital staff. This will contribute to a reduction in readmissions and support acute care system pressures. A number of our local places have developed police liaison services with staff in control rooms and triaging to ensure that people receive the right support in the right place. We will continue to work with our partners through the West Yorkshire Police and Mental Health Forum to ensure that these new models of care are sustainable. We are also developing approaches across the region to deliver training on mental health support to the police.

- Mental Health rehabilitation and out of area high cost placements for “locked rehab”– part of an alliance of providers to develop plans to sustainably reduce out of area placements in 2018/19 and beyond.

- Back office collaboration in West Yorkshire – focused on opportunities between mental health and community providers. We are focusing on opportunities such as procurement, IM&T, HR, and training.

- West Yorkshire Prevention at Scale Programme – The focus of this programme is to support the development of self-care approaches in communities, enhanced primary care teams aligned to the national Primary Care Home Model. This work stream will also bring together expertise around tobacco, alcohol and food to deliver shared campaigns, consistent commissioning and sharing of best practice. Particular relevance to smoking cessation and health coaching expertise within this Trust.

- West Yorkshire and Harrogate Harnessing the Power of Communities work stream-significant work is underway to develop support for unpaid carers across the area and the Trust is fully engaged in this work. The use of social

media and digital to change the conversations about health and care with local people and to build communities that are resilient and health producing is also a priority. Making best use of all assets within communities is an integral part of place based plans. This is particularly relevant to the approaches that the Trust has developed through Creative Minds, Spirit in Mind, Recovery colleges and Altogether Better. The Trust will be contributing to the acceleration of the implementation of the APPG taskforce recommendations on Arts and health in improving outcomes for people with mental health issues across West Yorkshire.

- Through the South Yorkshire & Bassetlaw Integrated Health and Care System we are engaged in the South Yorkshire Hyper Acute Stroke Service Review – our stroke rehab unit will ensure a smooth transition back to local place based services. We are also a key partner in the Mental Health work stream sharing best practice and learning through management and clinical networks in the development of perinatal services, IAPT, out of area placements.

5.3 Our role in local place based plans

- **Barnsley**: We are a key partner within the Barnsley Health and Care Together Integrated Care Partnership, which brings partners together leaders from across the system to develop new models of care and integrated clinical pathways e.g. diabetes, respiratory, and intermediate care, CVD, and frailty. The partnership is underpinned by a provider alliance contract that aligns providers around achievement of outcomes. The partners are working towards developing an integrated care organisation over 18/19 and 19/20.

- **Calderdale**: The system leadership have developed a single plan for Calderdale that sets out the vision to improve, health, social and economic outcomes for local residents. In 2018/19 we will be working with partners to consider how we implement the “Calderdale Cares” proposal that builds on the approach developed through the local vanguard. We will work with partners to support the development of integrated community models of care including enhanced primary care teams that will draw on learning from the national primary care at home model. Calderdale Council has also successfully secured Sports England Funding to support the development of improved physical health and activity amongst its residents. We will work with partners to enhance the development of approaches through Creative Minds such as access to the good mood football league and other physical activities that are delivered through peer support and community networks. Calderdale partners will also be a beacon site for the region on developing arts and health approaches to support health and well-being and the Trust is a key partner in this.

- **Kirklees**: In 2018/19 we will continue to improve and integrate adult’s and children's health provision working with partners. Our role will include supporting the older people’s services for Care Closer to Home and CAMHs provision as part of the holistic ‘Thrive’ model for children. We will also focus on

enabling communities to be resilient, and provide universal services that focus on early intervention and prevention. We will extend our role in prevention and wellbeing; working with commissioners and other providers to integrate the approaches developed through our recovery colleges and creative minds in integrated health and well-being services.

- **Wakefield**: The Wakefield Accountable Care Partnership has continued to progress the integration agenda through the New Models of Care Board that is underpinned by an alliance arrangement. The Trust is a key partner within this partnership. The Board has prioritised the following key areas for 18/19 that we will be involved in as key partners frailty and older people, building on the development of integrated connecting care hubs. Primary Care Home to develop enhanced integrated primary care to provide support to people in their community. End of Life Care redesign has adopted a collaborative approach to improve care for people at the end of life including those with mental health issues and dementia. The Trust will be leading the Mental Health work stream developing an alliance of mental health providers across the system and developing new models of care that will improve experience, outcomes and the use of resources starting with the Personality disorder care pathway in 18/19.

6. Membership and Elections

6.1 Our Members' Council

Our Members' Council is made up of elected representatives of our members and staff, and also nominated members from key local partner organisations such as local NHS Trusts, Local Authorities and the University of Huddersfield. There are places for 34 governors, consisting of 18 public, 7 staff and 9 appointed. One of the key roles of the Council is to make sure that the board of directors, which retains responsibility for the day-to-day running of the Trust, is accountable to their local communities through holding the non-executive directors to account for our performance.

6.2 Governor elections

The Trust holds elections each year to reflect the vacancies on its Members' Council in accordance with the Trust's Constitution. The elections are managed for the Trust by the Electoral Reform Services (ERS). The most recent election was held in April 2017 for two seats in Barnsley, one seat in Calderdale, two seats in Kirklees, two seats in Wakefield, one seat for the Rest of South & West Yorkshire and two staff seats (psychological therapies and staff in integrated teams), with candidates elected from 1 May 2017 for three years. Overseen by the Nominations Committee, the Trust sought a new Lead Governor from its publicly elected governors and the Members' Council appointed a publicly elected governor for Wakefield as Lead Governor at its meeting on 26 July 2017. The next election is taking place in April 2018. There is a vacancy of one seat in Calderdale, one seat in Kirklees and two seats in Wakefield. The public seat for the rest of South and West Yorkshire and the staff seat for social

care staff in integrated teams remain vacant. There is also one vacant stakeholder seat for Barnsley Hospital NHS Foundation Trust and the University of Huddersfield.

6.3 Governor recruitment, training, development and engagement

The Trust works with Electoral Reform Services (ERS) to publicise its elections and to encourage members to stand for election. The Trust is currently reviewing its approach to the training and development of governors to reflect governor feedback using GovernWell courses and induction support from NHS Providers, tailored as applicable. There are a number of activities to facilitate engagement between governors, members and the public, including the annual members meeting. Our Members' Council also helps us shape future strategy and is directly engaged in the development of the Annual Plan. Governors also play an important role in issues such as quality, equality and involvement and, development of our Quality Accounts through the Members Council Quality Group.

6.4 Membership strategy and supporting diversity [DN: supporting diversity looks weak in the following]

The Trust's approach to membership and engagement is set out in Membership Strategy, which is about enabling local people and staff to have a sense of ownership of the Trust, have a greater say in how services are provided in the areas the Trust serves, that services take account of local need and ensuring the Trust is accountable to local communities and the people who work for us. The Trust encourages people to take a special interest in our services, using membership as an opportunity to shape the future of health care in our areas. Membership is free, with few specific requirements (subject to the legal exemptions on eligibility and the Constitution of the Trust), has a lower age limit of 11 and no upper age limit, and service users and carers are included in the public constituency. Our public constituencies reflect our geography in proportion to the population of each area and, we aim to retain a membership which is representative of the populations we serve, with a key focus to encourage members to be engaged and involved with our Trust. The Trust evaluates progress in membership recruitment through comparison of membership with local population demographics, which allows a focus on areas of under representation. The Trust's membership plays a vital role in helping the Trust to shape its services.

Key areas for the next 12 months are:

- delivering the next phase of the membership strategy with a clear action plan
- refresh of Members' Council Objectives
- further support of staff governors who make up the core of the Freedom to Speak Up Guardian Network
- target under represented areas of membership, working with local partners
- find new ways to increase involvement and engagement of members.

We have an Equality Strategy which has the aims of:

- promoting a fair organisation with better health outcomes for all
- promoting person centred care and equal access to pathways of care
- developing and sustaining an equality competent organisation through inclusive leadership and ownership at all levels
- continuing to improve equality of opportunity for staff and our volunteers.

The Trust has an established BAME network, and recently introduced LGBT and Disability networks in support of its Equality and Diversity plan.

NHS Improvement

8 June 2018

Ian Dalton
Chief Executive
NHS Improvement
Wellington House
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London
SE1 8UG

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Tel: 0203 747 0000

www.improvement.nhs.uk/

Angela Monaghan
South West Yorkshire Partnership NHS Foundation Trust
Fieldhead
Ouchthorpe Lane
Wakefield
WF1 3SP

Dear Angela

2018/19 Operational plan feedback

I am writing to acknowlege receipt of your Board approved operational plan for 2018/19 and to highlight next steps. NHS Improvement will use the details contained within your 2018/19 Board assured activity, finance, workforce and triangulation submissions to monitor and assess your trust's delivery of the commitments you and the board have made to the patients and communities that we serve.

Your final 2018/19 operating plans have been developed in the context of on-going discussions on how to develop a sustainable, transformed health service, which highlights the importance of your strategic work to help create a sustainable organisation as part of a strong local health care system within your Shadow Integrated Care System.

It is critical that each trust meets the commitments in its annual plan to deliver safe, high quality services and the agreed access standards for patients within the resources available. This will mean maintaining an effective balance between demand and capacity and continuing to develop the workforce needed for local services.

To this end, as part of the assurance of your plan NHS Improvement has reviewed your submission and has set out below some key elements of your plan that require further review and follow up action. Please could you share this letter with your full Board for consideration. In addition to the elements of your plan described below there are some technical issues that require follow up action, these items will be picked up in detailed feedback from the appropriate NHSI lead.

Workforce

- Phasing of the plans - Within the operational workforce plan submitted on 30th April 2018 the difference between your planned March 2018 figure and April 2018 is -19.5 WTE, with a total decrease in your plan between March 2018 and March 2019 of -109.9 WTE. This means you are planning a decrease of 19.5 WTE between March 2018 and April 2018 and a further decrease of 90 WTE between April 2018 and March 2019.

NHS Improvement

Finance

It is essential trusts take action to ensure the underlying position moving into 2019/20 is better than opening 2018/19 underlying position through the delivery of recurrent measures. This will be reviewed by NHSI as part of our ongoing engagement throughout 2018/19.

Next Steps

After reviewing the issues highlighted above the trust Board may decide that amendments to the 2018/19 operating plan are required. If this is the case, NHS Improvement have put in place the facility for trusts to update all of their final 2018/19 operating plan submissions in a timely manner such that the outcome of the revised plan can be used in national reporting from month 3 onwards and will be the plan on which the Trust Board is assessed for 2018/19. NHS Improvement will communicate a deadline and detailed process for any plan resubmissions should they be required shortly. Please can you confirm if you do or do not wish to take up this opportunity to resubmit by 18 June to Beverley Bray, Delivery and Improvement Manager (beverley.bray@nhs.net).

We will continue to work with you to ensure you are able to access the necessary development support to strengthen the trust's capability and capacity for delivery. Our central commitment to delivering a strong provider landscape can only be achieved through your success and a robust set of plans. We will ensure that wherever possible we support you to deliver these ambitions. In return, our expectation is a simple one - that the commitments you make through this planning round and through locally agreed contracts are delivered in full.

If you wish to discuss the above or any related issues further, please let me or your regional director know.

Yours sincerely

Ian Dalton
Chief Executive
NHS Improvement

cc Rob Webster, Trust Chief Executive
Mark Brooks, Trust Finance Director
Lyn Simpson, Executive Regional Managing Director
Warren Brown, NHSI Delivery and Improvement Director
Jonathan Stephens, NHSI Regional Director of Finance
Beverley Bray, NHSI Delivery and Improvement Lead

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 June 2018
Agenda item 8.2

Title:	**Annual Report and accounts and Quality Account 2017/18**
Paper prepared by:	Director of Finance and Resources
Purpose:	➢ To confirm the submission of the 2017/18 annual accounts, Annual Report and Quality Account. ➢ To explain the process undertaken to generate these submissions and provide assurance regarding the governance of the process. ➢ To publically table the reports generated by the external auditors Deloitte LLP following their annual audit.
Mission/values:	The annual report, accounts and quality report form part of the Trust's governance arrangements, which support the Trust's mission and values. The annual report provides a summary of the Trust's performance against its mission and in line with our values, the accounts demonstrate financial probity and the quality report outlines the Trust's approach to quality, improvement in services and achievement of its quality priorities.
Any background papers/ previously considered by:	➢ The draft Annual Governance Statement was reviewed by the Trust Board on 24 April 2018. The final draft was included in the annual report reviewed by the Audit Committee on 22 May 2018 and approved by the Trust Board in private session on 24 May 2018. ➢ The draft Annual Report had input from executive directors and other senior managers and stakeholders, and was shared with all Board members for comment and feedback. The final draft was reviewed by the Audit Committee on 22 May 2018 and approved by the Trust Board in private session on 24 May 2018. ➢ The draft Quality Account was considered by the Member's Council Quality Group on 7 February 2018 and 17 May 2018 and by the Clinical Governance and Clinical Safety Committee on 15 May 2018 before being approved by the Trust Board in private session on 24 May 2018. ➢ The annual accounts were reviewed by the Director of Finance and Audit Committee Chair in detail, who are both qualified accountants on the Trust Board. The accounts were then reviewed in full by the Audit Committee on 22 May 2018 and approved by the Trust Board in private session on 24 May 2018.
Executive summary:	➢ In accordance with Department of Health and Social Care Group Accounting Manual 2017/18, the Annual Report and accounts including the Quality Account 2017/18 is not able to be published until after the document is laid before parliament which is due to take place in July 2018. It will be formally presented at the Annual

	Members' Meeting on 17 September 2018. ➢ All documents were submitted to NHS Improvement in line with the submission deadline. ➢ Each document was subject to significant Board scrutiny and oversight. ➢ With regard to the accounts, Deloitte issued an unmodified audit opinion with no reference to any matters in respect of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources, or the Annual Governance Statement. ➢ With regard to the Quality Account, the Trust was issued with the limited assurance report that is a requirement of the quality account process, and minor recommendations were made to further improve the quality of our data. ➢ Copies of both audit reports (accounts and Quality Account) are attached to this paper.
Recommendation:	**Trust Board is asked to:** ➢ **NOTE the update and make any further COMMENTS on the process relating the annual report, accounts and quality account process and submissions; and** ➢ **RECEIVE in public the external audit reports relating to the annual accounts and quality account and comment accordingly.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

2017/18 Annual Report, Annual Accounts and Quality Account

Introduction

In line with statutory requirements the Trust has submitted an annual report, its annual accounts and quality account to NHS Improvement. Each of these has been subject to internal scrutiny and governance, and to external audit. The documents become publicly available documents once laid before parliament, which is due to occur in July 2018 and will be formally presented at the Annual Members' Meeting in September 2018. This document explains the process undertaken and provides the external audit reports.

Annual Governance Statement

The Annual Governance Statement (AGS) was produced in line with guidance and instructions provided by NHS Improvement based on Treasury requirements. The draft AGS was reviewed by the Trust Board on 24 April and then reviewed by the Audit Committee on 22 May before being approved by the Trust Board on the 24 May 2018. The AGS contained the Head of Internal Audit overall opinion of significant assurance.

Annual Accounts

The annual accounts were produced in line with accounting standards (FRS) and followed guidance and instruction provided by NHS Improvement. The draft accounts were shared with accountants on the Trust Board for comment and feedback. Responses were provided for all questions and where appropriate amendments were made to the accounts (typically within the notes to the accounts). They were also shared with members of the Extended Management Team (EMT) for comment and feedback.

The accounts were subject to audit by Deloitte LLP and to a review at the Audit Committee on 22 May and were approved at the Trust Board on 24 May 2018. Signature took place on 25 May. A log was kept of all adjustments made from version to version. The accounts were then submitted to NHS Improvement in line with the required timescales.

Annual Report

The production of the annual report was co-ordinated by the Company Secretary and included contributions from appropriate executive directors and other senior managers. The annual report was shared with non-executive directors and the lead governor for comments. As with the annual accounts the report was reviewed at the Audit Committee on 22 May and approved at the Trust Board on 24 May 2018. Signature again took place on 25 May 2018. The report was then submitted to NHS Improvement.

Quality Account

The Quality Account 2017/18 was produced in line with the requirements of both the Department of Health, ***'Quality Account Toolkit (2010)***' and NHSI, '***Detailed requirements for quality reports'*** (2018).

The production of the quality account report is a year -long process. Quality priorities were agreed by EMT (2017), allocated a lead individual and monitored in relevant working groups throughout the year, for example, the Patient Safety Group. A bi -monthly progress report was submitted to Clinical Governance & Clinical Safety Committee, Members' Council Quality sub- group on a quarterly basis and Clinical Commissioning Groups Quality Boards, as requested.

The Quality Improvement and Assurance Team facilitate the production of the quality account report with input from BDU representatives and quality academy support teams such as finance, performance and information, information governance, human resources and contracting. A requirement of the quality account process is that our External Auditors (Deloitte) are required to undertake an audit of two mandated data items, in line with NHSI requirements set out in '***Detailed guidance for external assurance on quality reports 2017/18'.*** Following the audit the Trust were issued with the Limited Assurance report, that is a requirement of the quality account process, and minor recommendations were made to further improve the quality of our data. A copy of the External Assurance report is attached.

A draft quality account report was produced that was commented upon by EMT, Member's Council Quality sub-group and Clinical Governance & Clinical Safety Committee before sign off by the Trust Board on 24 May as part of the Annual Report. The report was submitted to NHSI in line with the required timescales. **External Audit Report**

Deloitte LLP are the Trust's external auditors. Following completion of their audit they have produced an audit report (ISA 260). A copy of the ISA 260 is attached to this report. Key points to note from the report are:

- No significant audit adjustments or disclosure deficiencies were identified
- An unmodified audit opinion was issued with no reference to any matters in respect of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources, or the Annual Governance Statement.
- There were not any identified inconsistencies between the financial statements and the FTCs.
- With regard to areas of risk identified Trust management judgements were consistent with Deloitte's expectations.

Conclusion and Recommendation

In conclusion the Trust met all its submission deadlines associated with its statutory returns covering the annual accounts, annual report and quality account. Input and feedback was regularly sought from all Board members and a range of other key stakeholders. External Audit provided an unmodified opinion in relation to the accounts.

Trust Board is asked to note the submission of the statutory returns, process undertaken to generate the accounts and reports and the assurance provided by our external auditors.

Deloitte.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

South West Yorkshire Partnership NHS FT

Final report to the Audit Committee on the 2017/18 audit

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01 Final report

02 Appendices

Director introduction
The key messages in this report

Audit quality is our number one priority. We plan our audit to focus on audit quality and have set the following audit quality objectives for this audit:

- A robust challenge of the key judgements taken in the preparation of the financial statements.
- A strong understanding of your internal control environment.
- A well planned and delivered audit that raises findings early with those charged with governance.

I have pleasure in presenting our final report to the Audit Committee for the 2017/18 audit.
I would like to draw your attention to the key messages within this paper:

Status of the audit	Our audit is complete. Our Independent Examination of EyUp! (formerly South West Yorkshire Partnership NHS Foundation Trust and Other Related Charities) is underway and will finalise this work over the next month.
Conclusions from our testing	• We have not identified any significant audit adjustments or disclosure deficiencies. Unadjusted audit misstatements would not have affected the Trust's achievement of its control total. See page 17. • Based on the current status of our audit work, we envisage issuing an unmodified audit opinion, with no reference to any matters in respect of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources, or the Annual Governance Statement. • We have not identified any inconsistencies between the financial statements and the TACs.
Financial sustainability and Value for Money	• The Trust reported an overall surplus for the year of £4.5m, including STF income of £2.9m. • CIP delivery was £7.5m against a £8.3m target; • The Trust has a Single Oversight Framework segmentation of 2 which is in line with the planned rating. It is not currently subject to any regulatory action from either NHSI or the Care Quality Commission (CQC); and • Subject to appropriate disclosure in the Annual Report and Annual Governance Statement we do not anticipate reporting any matters within our audit report in respect of the Trust's arrangements for securing the economy, efficiency and effectiveness of the use of resources.
Annual Report & Annual Governance Statement	• We have reviewed the Trust's Annual Report & Annual Governance Statement to consider whether it is misleading or inconsistent with other information known to us from our audit work. Based on our review, we consider that the Trust has followed the format prescribed by the Foundation Trust Annual Reporting Manual. We have suggested a number of minor changes to management.
Quality Accounts	• We will issue a clean quality report opinion. The findings from our work are set out in the accompanying paper, which will also be presented to the Council of Governors at their next meeting.

Responsibilities of the Audit Committee

Helping you fulfil your responsibilities as an Audit Committee

The primary purpose of the Auditor's interaction with the Audit Committee

Clearly communicate the planned scope of the financial statements audit

Provide timely observations arising from the audit that are significant and relevant to the Audit Committee's responsibility to oversee the financial reporting process

In addition, we seek to provide the Audit Committee with additional information to help them fulfil their broader responsibilities

We set out here a summary of the core areas of Audit Committee responsibility to provide a reference in respect of your responsibilities and highlight throughout the document where there is key information which helps the Audit Committee in fulfilling its remit.

Integrity of reporting

- Impact assessment of key judgements and level of management challenge.
- Review of external audit findings, key judgements, level of misstatements.
- Assess the quality of the internal team, their incentives and the need for supplementary skillsets.
- Assess the completeness of disclosures, including consistency with disclosures on business model and strategy and, where requested by the Board, provide advice in respect of the fair, balanced and understandable statement.

Oversight of external audit

- At the start of each annual audit cycle, ensure the scope of the external audit and fee are appropriate.
- Make recommendations as to the auditor appointment and implement a policy on the engagement of the external auditor to supply non-audit services.

Internal controls and risk

- Review the internal control and risk management systems (unless expressly addressed by separate board risk committee).
- Explain what actions have been, or are being taken to remedy any significant failings or weaknesses.

Oversight of internal audit

- Monitor and review the effectiveness of the internal audit activities.

Whistle-blowing and fraud

- Ensure that appropriate arrangements are in place for the proportionate and independent investigation of any concerns that are raised by staff in connection with improprieties.

Our audit explained

We tailor our audit to your business and your strategy

Identify changes in your business and environment

The Trust continues to focus on its options for sustainability in the medium term and in particular the shape and scope of services delivered in the Barnsley area. The Trust is operating in an increasingly financially challenging environment. The Trust continues to invest in a large capital programme.

Scoping

Our scope is in line with the Code of Audit Practice issued by the NAO.

Other findings

As well as our conclusions on the significant risks we are required to report to you our observations on the internal control environment as well as any other findings from the audit. These are set out on pages 13 of this report.

Determine materiality

For planning purposes we estimated materiality at £4.4m (2016/17 £4.4m) which is based on 2% of planned incoming resources as per the 2017/18 Operational Plan. At this level of materiality we have reported all misstatements in excess of £222k (2016/17 £220k) to the Audit Committee. For our final audit we updated our assessment which confirmed materiality as £4.4m and reduced the reporting threshold to above £221k.

Significant risk assessment

We identified significant audit risks in relation to income recognition and management override of controls. See page 7 of this report.

Conclude on significant risk areas

We draw to the Audit Committee's attention our conclusions on the significant audit risks. In particular the Audit Committee must satisfy themselves that management's judgements in relation to going concern are appropriate.

Our audit report

Based on the current status of our audit work, we envisage issuing an unmodified audit report.

Significant risks
Dashboard

Risk	Material	Fraud risk	Planned approach to controls testing	Controls testing conclusion	Management paper received	Consistency of judgements with Deloitte's expectations	Expected to be included in the significant issues section of the Audit Committee's report	Expected to be included as a key audit matter in our audit report	Slide no.
NHS Revenue recognition	✓	✓	D+I	Satisfactory	✓	●	✓	✓	8
Management override of controls	✓	✓	D+I	Satisfactory	✓	●	✓	✗	9

Overly prudent, likely to lead to future credit ⊖ ⊖ ● ⊕ ⊕ Overly optimistic, likely to lead to future debit.

D+I: Testing of the design and implementation of key controls
OE: Testing of the operating effectiveness of key controls

Significant audit risks

Revenue recognition in respect of CQUIN Income and Barnsley Intermediate Care

Risk identified	The risk of fraud in revenue recognition is a presumed risk under International Standards on Auditing. At the Trust the risk of revenue recognition is deemed to be applicable to the recognition of income from the Commissioning for Quality and Innovation (CQUIN) payment framework. The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. It therefore is subject to variations. Our discussions with key staff whilst planning for the audit in 2017 identified that at that time the Trust was providing services in respect of Barnsley Intermediate Care with no signed contract variation following the notice given under this service by Barnsley in June 2016 for 12 months. We considered that there was a risk in relation to the recoverability of the balance and the judgement in relation to the income accrual.
Key judgements	The key judgement in this area concerns the measurement of the Trust's performance against the agreed indicators.
Deloitte response	We are completing our work in respect of a retrospective review of accuracy of management estimation techniques used in application and allocation of CQUIN income and are challenging this. We have tested the Barnsley income recognised for accuracy following through to physical evidence. • We have assessed the design and implementation of management controls aimed at challenging, validating and agreeing the original CQUIN target measures and for reviewing progress against the target; • We have obtained evidence that CQUIN income for Q1-3 was agreed between the trust and the commissioners; ensuring that the income recognised by the Trust was in line with that which had been agreed; • We have reviewed the Q4 estimate of CQUIN income and have agreed this to supporting information from the Trust on activity performance; • We have reviewed the design and implementation of the controls covering the recognition and valuation of debts owed by Barnsley Commissioners; • For the Barnsley Intermediate Care contract we have agreed the total revenue to all invoices and confirmed receipt of cash.
Conclusion	We have completed our testing of CQUIN income, and have noted no issues in relation to this.
Draft audit report findings	We have made reference to this risk in our auditor's report as it had a significant effect upon our overall audit strategy, allocation of resources, and direction of the efforts of the team.

Significant audit risks

Management override of controls

Risk identified	In accordance with ISA 240 (UK and Ireland) management override is a significant risk. This risk area includes the potential for management to use their judgement to influence the financial statements as well as the potential to override the Trust's controls for specific transactions. The key judgments in the financial statements are those which we have selected to be the significant audit risk of revenue recognition which is where, inherently, management has the potential to use their judgment to influence the financial statements.
Key judgements	Our audit work is designed to test for instances of management override of controls.
Deloitte response	We have considered the overall sensitivity of judgements made in the preparation of the financial statements, and our work has focused on: • the testing of journals, using data analytics to focus our testing on higher risk journals; • significant accounting estimates relating to estimates discussed above in respect of NHS revenue recognition and provisioning; and • any unusual transactions or one-off transactions including those with related parties In considering the risk of management override, we: • assessed the overall position taken in respect of key judgements and estimates; and • considered the rationale for the accounting estimates and assessed these for biases that could lead to material misstatement due to fraud.
Conclusion	We have not identified any significant bias in the key judgements made by management. The control environment is appropriate for the size and complexity of the Trust. We have considered the tone at the top and note that there are no concerns we wish to draw to the attention of management or those charged with governance.
Draft audit report findings	We have not included this risk in our audit report because it did not have a significant effect upon our overall audit strategy, allocation of resources, and direction of the efforts of the team.

Other areas of audit focus

We have also identified two areas of management judgement which we consider a higher risk, which are detailed below.

Area 1 – Property Valuations

Details	The Trust is undertaking a desktop review approach to the revaluation of its estate. The Trust uses a hypothetical alternative site model. The complexities of the audit, and in the required accounting transactions, mean that there is a risk over the valuation of the property assets.
Deloitte Response	• We have reviewed the Trust's Modern Equivalent Use valuation rules and assess how these align to the strategic development and the Trust's Capital Plan. • We have challenged management's assessment that the District Valuer reported values, which we expect to be dated 31 December 2017, remain valid as at the reporting date of 31 March 2018. • We have examined the accuracy of the posting of the valuations to the general ledger and financial statements. • We will assess the impairment and the MEAV – AS assumptions recorded against Mount Vernon following the restructuring of services.
Conclusion	We have not noted any issues through our testing. We have however raised a judgemental adjustment as seen on page 17 in relation to the movement in the BCIS from 31 December 2017 to 31 March 2018.
Draft audit report findings	We have not included this risk in our audit report because it did not have a significant effect upon our overall audit strategy, allocation of resources, and direction of the efforts of the team.

Other areas of audit focus

We have also identified two areas of management judgement which we consider a higher risk, which are detailed below.

Area 2 – Provisions

Details	There are a number of judgements and provisions which will be taken by management in the financial statements for the year ended 31st March 2018, with the main judgement in provisions being in relation to the redundancy provision.
Deloitte Response	In considering the risk of management provisions and judgements, we performed the following audit procedures: • We considered the judgements and supporting evidence used in forming the provision, and corroborate its communication pre year end to the relevant parties. • We assessed the redundancy provision in relation to the managements strategic plan and also any relevant CIP schemes.
Conclusion	We have noted one error through our testing in relation to an overprovision in relation to redundancy, which is detailed on page 17.
Draft audit report findings	We do not expect to include this risk in our audit report because it did not have a significant effect upon our overall audit strategy, allocation of resources, and direction of the efforts of the team.

Value for money (VfM)

We have not identified any VfM significant risks

Value for Money

We are required to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. VfM is assessed against the following criterion, and three sub-criteria (informed decision making, sustainable resource deployment, and working with partners and other third parties):

"In all significant respects, the audited body had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people."

Our work takes account of the Annual Governance Statement and the findings of regulators. We are required to perform a risk assessment through the course of our audit to identify whether there are any significant risks to our VfM conclusion, and perform further testing where risks are identified.

Overall Financial & Quality Performance

As part of our risk assessment, we have considered how the Trust's performance compares to plan and prior year:

	Actual 2017/18	Plan 2017/18	Variance	Plan 2018/19	Actual 2016/17
Surplus before impairments and transfers	£4.0m	£2.4m	£1.6m	(£1.2m)	£0.4m
EBITDA margin	6.2%	11.6%	85.6%	3.8%	4.4%
CIP target and identified to date	£7.5m	£8.3m	90.3% identified	£9.7m	£9.0m
Single Oversight Framework segmentation	2	2	0	2	2

Risk Assessment work performed

As part of our risk assessment, we have considered information from: a combination of:

- "high level" interviews with key staff
- review of the Trust's draft Annual Governance Statement;
- consideration of issues identified through our other audit and assurance work;
- consideration of the Trust's results, including benchmarking of actual performance (including on CIP delivery as summarised below) and the 2017/18 Annual Plan;
- review of the Care Quality Commission's report on the Trust dated April 2017;
- review of NHSI's risk ratings;
- benchmarking of the Trust's performance

Conclusion

We have not identified any VfM significant risks and have provided an update on the area for monitoring identified in relation to the CIP Programme.

Area for monitoring in relation to our Value for Money Opinion

Delivery of CIP programme

Risk identified	From discussions with key members of staff as part of our planning meetings, it was noted that the Trust was performing well against its operational plan, reporting a surplus at the month 5 position. The Trust's CIP programme is not currently presenting challenges but it is noted that next year's will prove more challenging. We will review progress as part of our year end audit in relation to developing robust plans in relation to this.
Risk assessment work performed	We have undertaken a review of the Trust's medium term financial plan as well as the 2018/19 Operational Plan to assess the reliance of the Trust on the delivery of the planned CIP Programme. From this we have performed a sensitivity analysis to review the impact that differing levels of CIP delivery would have on the Trust's financial position and available cash. As well we have obtained the month 1 CIP report to review performance against plan. No residual risks have been identified from the work we have performed over the governance of the overall transformation programme.
Conclusion	Whilst there remains risk to the delivery of the cost reduction plan, the current financial position of the Trust, the governance arrangements that the Trust has in place and the history of good delivery of CIPs means that we do not consider there to be issues that would have an impact on our Value for Money opinion. We have not identified any issues which we would need to report in our audit opinion.

Other significant findings

Internal control and risk management

During the course of our audit we have identified a number of internal control and risk management findings, which we have included below for information.

Area
No significant internal control or risk management issues noted during our audit.

The purpose of the audit was for us to express an opinion on the financial statements. The audit included consideration of internal control relevant to the preparation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of internal control. The matters being reported are limited to those deficiencies that we have identified during the audit and that we have concluded are of sufficient importance to merit being reported to you.

Low Priority

Medium Priority

High Priority

Other significant findings

Financial reporting findings

Below are the findings from our audit surrounding your financial reporting process.

Qualitative aspects of your accounting practices:

There were no significant findings in relation to the accounting policies maintained by the Trust.

Liaison with Internal Audit:

The audit team, has completed an assessment of the independence and competence of the internal audit department and reviewed their work and findings. From this work we do not have any significant findings. In response to the significant risks identified, no reliance was placed on the work of internal audit and we performed all work ourselves.

We have obtained written representations from those charged with governance on matters material to the financial statements when other sufficient appropriate audit evidence cannot reasonably be expected to exist. A copy of the draft representations letter has been circulated separately.

Appendices

Purpose of our report and responsibility statement

Our report is designed to help you meet your governance duties

What we report

Our report is designed to help the Audit Committee and the Board discharge their governance duties. It also represents one way in which we fulfil our obligations under ISA 260 (UK and Ireland) to communicate with you regarding your oversight of the financial reporting process and your governance requirements. Our report includes:

- Results of our work on key audit judgements and our observations on the quality of your Annual Report.
- Our internal control observations.

What we don't report

As you will be aware, our audit was not designed to identify all matters that may be relevant to the board.

Also, there will be further information you need to discharge your governance responsibilities, such as matters reported on by management or by other specialist advisers.

Finally, our views on internal controls and business risk assessment should not be taken as comprehensive or as an opinion on effectiveness since they have been based solely on the audit procedures performed in the audit of the financial statements and the other procedures performed in fulfilling our audit plan.

We welcome the opportunity to discuss our report with you and receive your feedback.

The scope of our work

Our observations are developed in the context of our audit of the financial statements.

This report has been prepared for the Board of Directors, as a body, and we therefore accept responsibility to you alone for its contents. We accept no duty, responsibility or liability to any other parties, since this report has not been prepared, and is not intended, for any other purpose. Except where required by law or regulation, it should not be made available to any other parties without our prior written consent.

Deloitte LLP

Newcastle | 25 May 2018

Audit adjustments

Unadjusted misstatements

The following uncorrected misstatements have been identified up to the date of this report which we request that you ask management to correct as required by International Standards on Auditing (UK and Ireland). The net impact of these is an increase of £407k in the surplus for the period.

		Debit/ (credit) income statement £m	Debit/ (credit) in net assets £m	Debit/ (credit) prior year retained earnings £m	Debit/ (credit) in reserves £m	If applicable, control deficiency identified
Misstatements identified in current year						
Revaluation Movement	[1]	(£0.096m)	£0.621m		(£0.525m)	
Overprovision in relation to redundancy	[2]	(£0.494m)	£0.494m			
Management judgements in relation to the financial statements						
Over recognition of Income from NHS	[3]	£0.373m	(£0.373m)			
Over recognition of Debtors from NHS	[3]	£0.226m	(£0.226m)			
Over recognition of Creditors from NHS	[3]	(£0.255m)	£0.255m			
Aggregation of misstatements individually < £0.222m						
Misstatements less than £0.222m		(0.161m)	0.161m			
Total		**(£0.407m)**	**£0.932m**		**(£0.525m)**	

(1) Judgemental difference noted on revaluation movement indices between the valuation date (31 December) and the year end (31 March), we have also calculated a notional split based on the other in year adjustment between the revaluation reserve and the I&E for illustrative purposes.
(2) Extrapolated judgemental error in relation to redundancy provision in relation to specific CIP scheme.
(3) Variation between SWYPFT and other NHS counterparties per the Agreement of balances exercise.

Audit adjustments
Disclosures

Disclosure misstatements

The following uncorrected disclosure misstatements have been identified up to the date of this report which we request that you ask management to correct as required by International Standards on Auditing (UK and Ireland).

Disclosure	Summary of disclosure requirement	Quantitative or qualitative consideration
We have not identified any significant disclosure deficiencies in the financial statements and the deficiencies identified have been corrected by management.		

Other disclosure recommendations

Although the omission of the following disclosures does not materially impact the financial statements, we are drawing the omitted disclosures to your attention because we believe it would improve the financial statements to include them or because you could be subject to challenge from regulators or other stakeholders as to why they were not included.

Disclosure	Summary of disclosure requirement	Quantitative or qualitative consideration
We have not identified any significant disclosure deficiencies in the financial statements and the deficiencies identified have been corrected by management		

Fraud responsibilities and representations

Responsibilities explained

Responsibilities:

The primary responsibility for the prevention and detection of fraud rests with management and those charged with governance, including establishing and maintaining internal controls over the reliability of financial reporting, effectiveness and efficiency of operations and compliance with applicable laws and regulations. As auditors, we obtain reasonable, but not absolute, assurance that the financial statements as a whole are free from material misstatement, whether caused by fraud or error.

Required representations:

We have asked the Board to confirm in writing that you have disclosed to us the results of your own assessment of the risk that the financial statements may be materially misstated as a result of fraud and that you are not aware of any fraud or suspected that affects the entity or group.

We have also asked the Board to confirm in writing their responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

Audit work performed:

In our planning we identified the risk of fraud in revenue recognition and management override of controls as a key audit risk for your organisation.

During course of our audit, we have had discussions with management and those charged with governance and no instances of fraud have been identified

In addition, we have reviewed management's own documented procedures regarding fraud and error in the financial statements

We have reviewed the paper prepared by management for the audit committee on the process for identifying, evaluating and managing the system of internal financial control.

Independence and fees

As part of our obligations under International Standards on Auditing (UK and Ireland), we are required to report to you on the matters listed below:

Independence confirmation	We confirm the audit engagement team, and others in the firm as appropriate, Deloitte LLP and, where applicable, all Deloitte network firms are independent.
Fees	Details of the fees charged by Deloitte for the period have been presented below.
Non-audit services	In our opinion there are no inconsistencies between FRC's Ethical Standard and the Trust's policy for the supply of non-audit services or of any apparent breach of that policy. We continue to review our independence and ensure that appropriate safeguards are in place including, but not limited to, the rotation of senior partners and professional staff and the involvement of additional partners and professional staff to carry out reviews of the work performed and to otherwise advise as necessary. We have not carried out any non-audit services in the period 2017/18.
Relationships	We have not other relationships with the Trust, its directors, senior managers and affiliates, and have not supplied any services to other known connected parties.

Independence and fees

The professional fees expected to be charged by Deloitte for the period from 1 April 2017 to 31 March 2018 are as follows:

	Current year £	Prior year £
Audit of Trust	45,672	45,672
Total audit	**45,672**	**45,672**
Quality Accounts procedures	5,000	5,000
Independent examination of the charity	828	828
Total assurance services	**828**	**828**
Total fees	**52,500**	**52,500**

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NHS
South West Yorkshire Partnership
NHS Foundation Trust

South West Yorkshire Partnership NHS Foundation Trust

Findings and Recommendations from the 2017/18 NHS Quality Report External Assurance Review

Contents

Executive Summary

We are in the process of completing our Quality Report testing

Status of our work

- The audit is complete.
- The scope of our work is to support a "limited assurance" opinion, which is based upon procedures specified by NHS Improvement in their "Detailed Requirements for External Assurance For Quality Reports for Foundation Trusts 2017/18".
- We have signed an unmodified opinion for inclusion in your 2017/18 Annual Report.

CQC Rating "Good"

The Care Quality Commission re-inspected the Trust during the prior year and gave it an overall rating of 'Good'.

	2017/18 (Draft)	2016/17
Length of Quality Report	78 pages	78 pages
Quality Priorities	32	32

Scope of work

We are required to:

- Review the content of the Quality Report for compliance with the requirements set out in NHS Improvement's Annual Reporting Manual ("ARM").
- Review the content of the Quality Report for consistency with various information sources specified in NHS Improvement's detailed guidance, such as Board papers, the Trust's complaints report, staff and patients surveys and Care Quality Commission reports.
- Perform sample testing of three indicators.
  - The Trust has selected Early Intervention in Psychosis (EIP) and Inappropriate Out Of Area Placements as its publically reported indicators.
  - For 2017/18, all Trusts are required to have testing performed on a local indicator selected by the Council of Governors. The Trust has selected waiting times across children and young peoples' eating disorder.
  - The scope of testing includes an evaluation of the key processes and controls for managing and reporting the indicators; and sample testing of the data used to calculate the indicator back to supporting documentation.
- Provide a signed limited assurance report, covering whether:
  - Anything has come to our attention that leads us to believe that the Quality Report has not been prepared in line with the requirements set out in the ARM; or is not consistent with the specified information sources; or
  - There is evidence to suggest that the Early Intervention in Psychosis (EIP) and Inappropriate Out Of Area Placements indicators have not been reasonably stated in all material respects in accordance with the ARM requirements.
  - Provide this report to the Council of Governors, setting out our findings and recommendations for improvements for the indicators tested.

Executive Summary (continued)

We have not identified any significant issues from our work to date

Content and consistency review

We have completed our content and consistency review. From our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018 the Quality Report is not prepared in all material respects in line with the criteria set out in the ARM).

	Overall conclusion
Content Are the Quality Report contents in line with the requirements of the Annual Reporting Manual?	B
Consistency Are the contents of the Quality Report consistent with the other information sources we have reviewed (such as Internal Audit Reports and reports of regulators)?	B

Performance indicator testing

NHS Improvement requires Auditors to undertake detailed data testing on a sample basis of two mandated indicators. We perform our testing against the six dimensions of data quality that NHS Improvement specifies in its guidance.
From our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018, the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the ARM and the six dimensions of data quality set out in the "Detailed Requirements for External Assurance on Quality Reports for Foundation Trusts 2017/18".

	Early Intervention in Psychosis	Inappropriate Out of Area Placements	Local Indicator
Recommendations identified?	✓	✓	✓
Overall Conclusion	Unmodified Opinion	Unmodified Opinion	No opinion required

The six dimensions of data quality:
Accuracy Is data recorded correctly and is it in line with the methodology.
Validity Has the data been produced in compliance with relevant requirements.
Reliability Has data been collected using a stable process in a consistent manner over a period of time.
Timeliness Is data captured as close to the associated event as possible and available for use within a reasonable time period.
Relevance Does all data used generate the indicator meet eligibility requirements as defined by guidance.
Completeness Is all relevant information, as specific in the methodology, included in the calculation.

G No issues noted A Requires improvement B Satisfactory – minor issues only R Significant improvement required

Content and consistency findings

Content and consistency review findings

No issues have been noted to date in relation to the content and consistency

The Quality Report is intended to be a key part of how the Trust communicates with its stakeholders.

Although our work is based around reviewing content against specified criteria and considering consistency against other documentation, we have also made recommendations to management through our work to assist in preparing a high quality document. We have summarised below our overall assessment of the Quality Report.

Key questions	Assessment	Statistics
• Is the length and balance of the content of the report appropriate?	Yes	Length: 78 pages
• Is there an introduction to the Quality Report that provides context?	Yes	
• Is there a glossary to the Quality Report?	Yes	
• Is the number of priorities appropriate across all three domains of quality (Patient Safety, Clinical Effectiveness and Patient Experience)?	Yes	Patient Safety: 8 Clinical Effectiveness: 7 Patient Experience: 3
• Has the Trust set itself SMART objectives which can be clearly assessed?	Yes	
• Does the Quality Report clearly present whether there has been improvement on selected priorities?	Yes	
• Is there appropriate use of graphics to clarify messages?	Yes	
• Does there appear to have been appropriate engagement with stakeholders (in both choosing priorities as well as getting feedback on the draft Quality Report)?	Yes	
• Does the Annual Governance Statement appropriately discuss risks to data quality?	Yes	
• Is the language used in the Quality Report at an appropriate readability level?	Yes	

Deloitte view

Overall, the Quality Account has been prepared in all material respects with the Foundation Trust Annual Reporting Manual.

Particular areas of good practice include:

- The use of graphics throughout the report; and
- Concise presentation of information.

Possible areas for improvement next year include:

- Clearer reporting of the indicators which are subject to external audit.

Performance and Indicator Testing

Early Intervention in Psychosis ("EIP")

	Trust reported performance	Target	Overall evaluation
2017/18 (average)	88.2%	50%	B
2016/17 (average)		50%	Not subject to testing

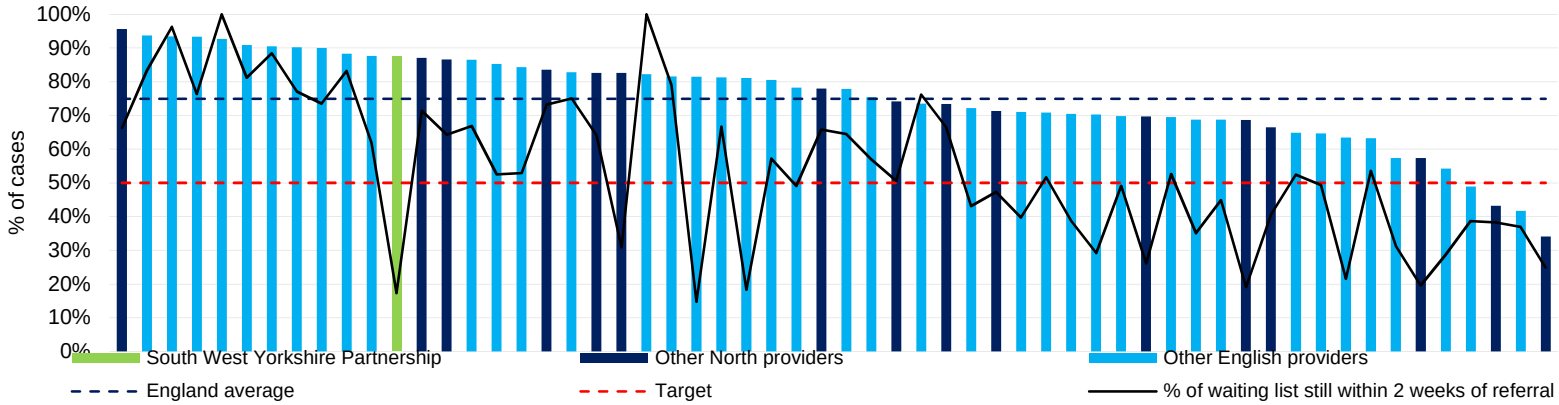
Indicator definition and process

Definition: "The proportion of people experiencing first episode psychosis or 'at risk mental state' who wait two weeks or less to start NICE recommended package of care."

National context

The chart below shows how the Trust compares to other organisations nationally for the first three quarters of 2017/18, based on the latest national data available.

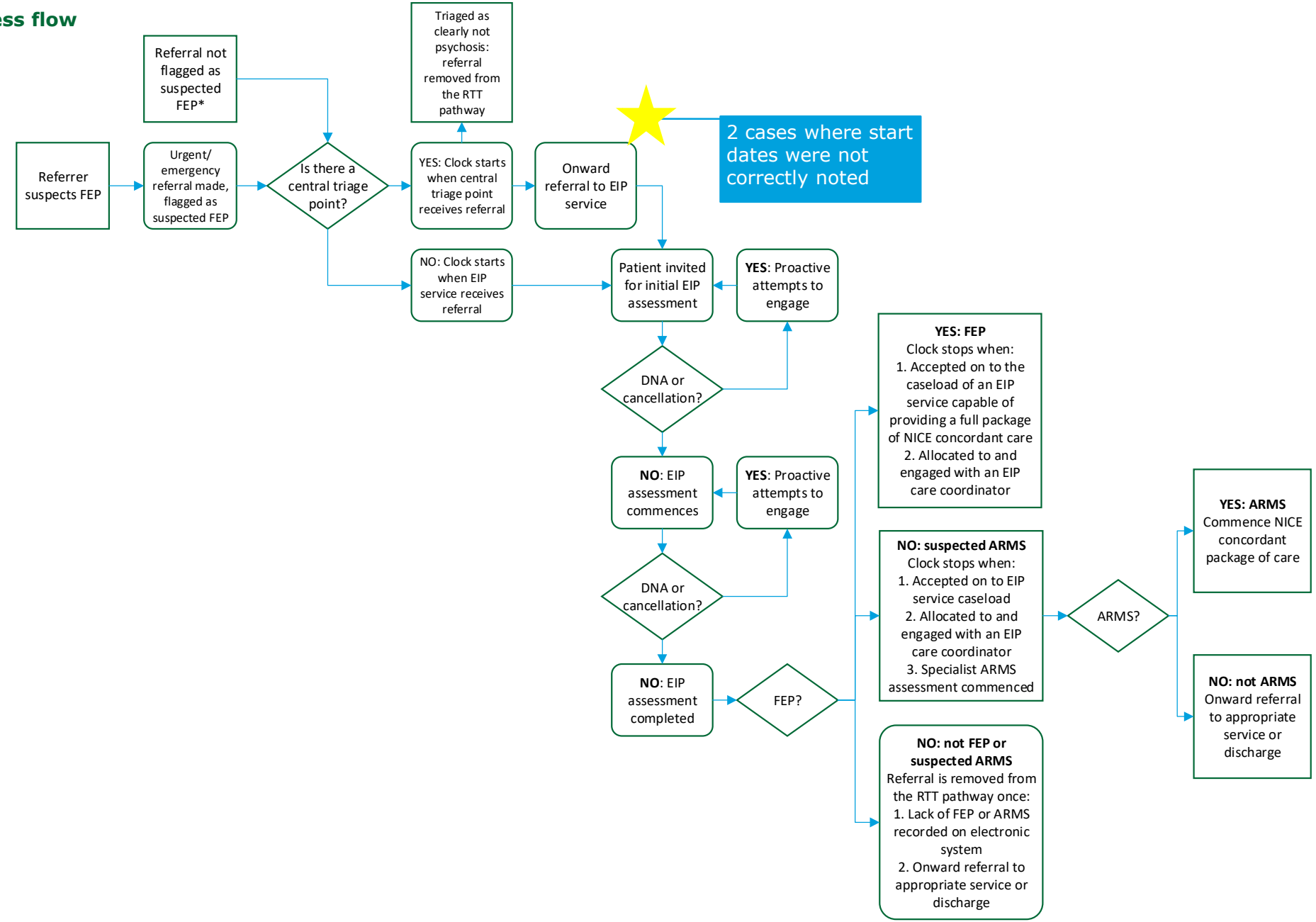
Early intervention in psychosis - starting treatment within 2 weeks - Q1-3 2017-18



Source: Deloitte analysis of NHS England data. Percentage of waiting list still within 2 weeks of referral calculated as average of month end figures.

Early Intervention in Psychosis (continued)

Process flow



Early Intervention in Psychosis (continued)

Approach

- We met with the Trust's leads to understand the process from a referral to the overall performance being included in the Quality Report. This is a newly tested indicator, and so there are no recommendations from the prior year.
- We evaluated the design and implementation of controls through the process.
- We selected a sample of 25 from 1 April 2017 to 31 March 2018 including in our sample a mixture of cases in breach and not in breach of the target.
- We agreed our sample of 25 to the underlying information held within RiO and patient notes.
- We have recalculated the indicator presented in the Quality Accounts using data provided to us.

Findings

- 2 instances where the clock start dates were incorrect based on the patient notes and information held in RiO however the difference had no impact upon the indicator.

Deloitte View:

We have completed our testing on this indicator, and have tied this item through to the reported position in the Quality Account.

Inappropriate Out of Area Placements

	Trust reported performance	Target	Overall evaluation
2017/18 Q4	1,527	Progress against trajectory	B

Indicator definition and process

Definition: "Total number of bed days patients have spent out of area" on placements assessed as inappropriate, calculated as the average of the monthly position."

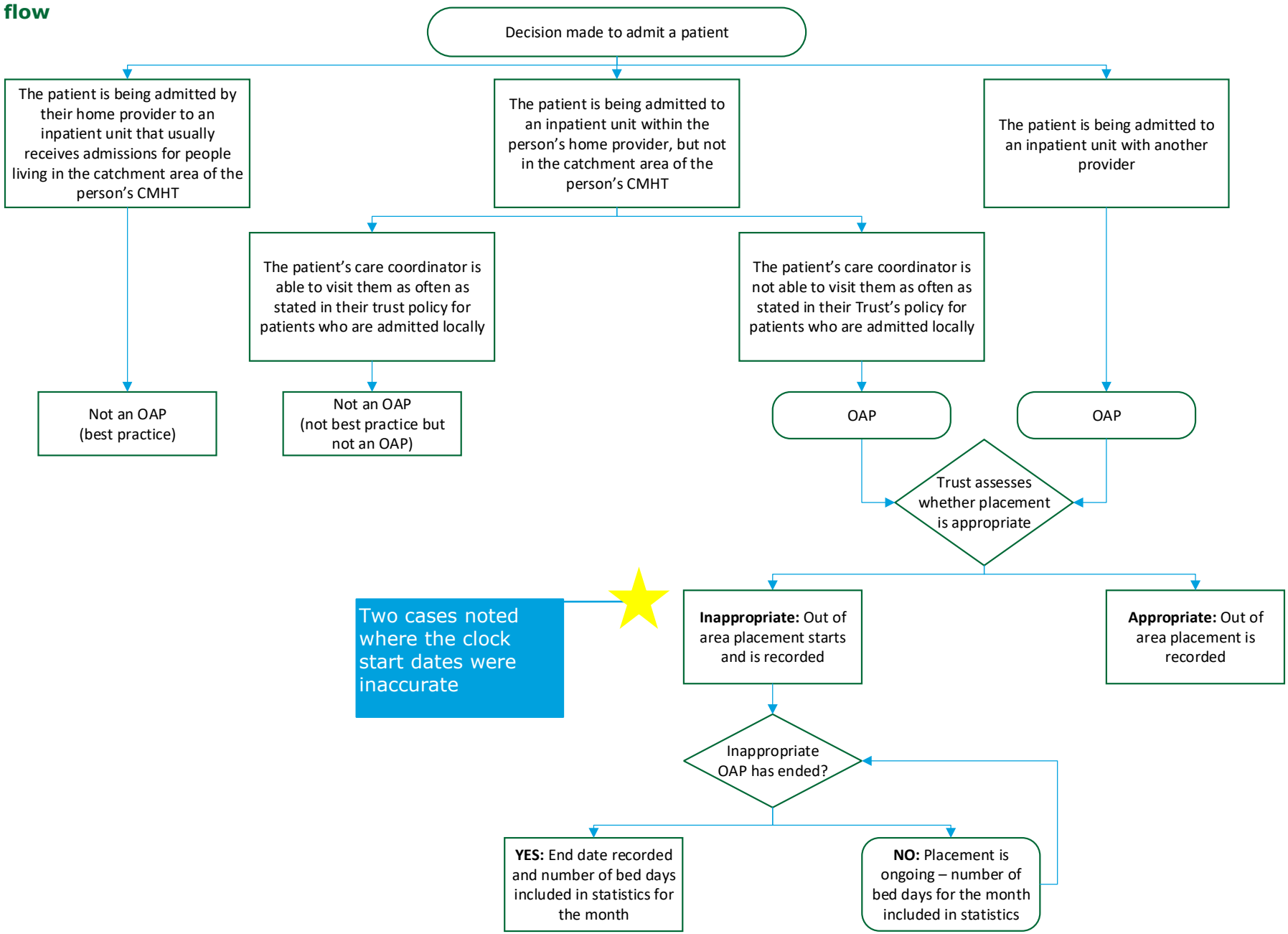
National context

Inappropriate Out of Area Placements has been mandated as an indicator for the first time this year. Due to the relatively recent inclusion in the Single Operating Framework, and so increased focus on this metric, NHS Improvement has given providers the choice for 2017/18 of reporting figures for Quarter 4 only, or for the whole year. The Trust has decided to report figures for the whole year, however, our audit is based on the Q4 position as detailed by the indicator guidance.

The indicator has a number of potentially complex judgements to assess whether an Out of Area Placement is, in fact, appropriate. We understand from NHS Improvement that over 90% of placements are reported as "inappropriate", though it is not clear whether this is due to any overall issues in reporting or identifying "appropriate" placements, or reflects the actual split of cases. However, discussions in testing across our portfolio suggest that some of this may be due to less focus on classification for the metric than just reporting overall numbers of placements.

Inappropriate Out of Area Placements (continued)

Process flow



Inappropriate Out of Area Placements (continued)

Approach

- We met with the Trust's leads to understand the process from placement through to the overall performance being included in the Quality Report. This is a newly tested indicator, and so there are no recommendations from the prior year.
- We evaluated the design and implementation of controls through the process.
- We selected a sample of 25 from 1 April 2017 to 31 March 2018.
- We agreed our sample of 25 to the underlying information held within RiO and patient notes.
- We have recalculated the indicator presented in the Quality Account using the data provided to us.

Findings

- Two cases noted where there was an incorrect start start date based on the information held within RiO and patient notes however, as the error occurred prior to 1 January 2018, it has no bearing upon the indicator.

Deloitte View:

We have completed our detailed testing of the indicator and have recalculated the percentage shown in the Quality Account.

Based on our testing we have issued an unmodified opinion.

Local Indicator

	Q3	Q4
Urgent	76.47%	69.23%
Routine	92.00%	94.44%

Indicator definition and process

Definition: Waiting times across children & young people's eating disorder (CYP-ED) pathways.

Reason for testing: Selected by Governors to validate the process of collection.

Approach

- We met with the Trust's leads to understand the process from identifying eating disorder to the overall performance being included in the Quality Report. There were no recommendations from the previous auditor's review of last year's Quality Report as this indicator was not part of the external assurance work.
- We selected a sample of 25 from 1 April 2017 to 31 March 2018.
- We agreed our sample to the underlying data held within RiO and the patient notes.
- We have recalculated the indicator presented in the Quality Report.

Findings

Inconsistent recording of the data within the RiO system where referral received dates were not consistent within the different screens of RiO. This did not affect the underlying reporting, however meant when tied to supporting evidence there were multiple referral dates on different screens in RiO.

Deloitte View:

Our testing is complete and management are asked to note the findings within the report.

Appendices

Appendix 1: Recommendation for improvement

Indicator	Deloitte Recommendation	Management Response
Early Intervention in Psychosis	**Inappropriate start dates** There should be consistency in terms of the recording of start dates the recording of referral dates where there is a referral from within the Trust.	No management response received.
Inappropriate out of area placements	**Inappropriate start dates** There should be consistency of record keeping between the referral and the acceptance of an out of area placement.	No management response received.
Local Indicator	**Completion of RiO system** There should be consistency in terms of the dates input within the RiO system. Dates should be consistently input on the relevant screens within the RiO system.	No management response received.

Appendix 2: Update on prior year recommendations

Our prior year recommendations have been addressed

Indicator	Prior year finding	Current year status
7 day follow up	Incorrectly excluded cases - We recommend the Trust research and understand the reason for the cases which were missed from the report.	Helen Smith investigated this and it was noted that the cases identified were actually correctly omitted from the report and therefore the recommendation is closed.
DTOC	Capture of MDT decisions - In line with our recommendation in the prior year, we recommend that the Trust improve the consistency of its recording of MDT decisions.	Julie Bowser has cascaded this through the teams, and reminded of the single operating procedure that is in place and is Trust policy to follow.
Wait times	Recording of direct contact – We recommend that the Trust ensure that staff are documenting outcomes consistently.	Linda Moon has taken these actions back and this has been cascaded through team meetings and also through direct supervision of the team.

Responsibility statement

Purpose of our report and responsibility statement

Our report is designed to help you meet your governance duties

What we report

Our report is designed to help the Council of Governors, Audit Committee, and the Board discharge their governance duties. It also represents one way in which we fulfil our obligations to report to the Governors and Board our findings and recommendations for improvement concerning the content of the Quality Report and the mandated indicators. Our report includes:

- Results of our work on the content and consistency of the Quality Report, our testing of performance indicators, and our observations on the quality of your Quality Report.
- Our views on the effectiveness of your system of internal control relevant to risks that may affect the tested indicators.
- Other insights we have identified from our work.

What we don't report

- As you will be aware, our limited assurance procedures are not designed to identify all matters that may be relevant to the Council of Governors or the Board.
- Also, there will be further information you need to discharge your governance responsibilities, such as matters reported on by management or by other specialist advisers.
- Finally, the views on internal controls and business risk assessment in our final report should not be taken as comprehensive or as an opinion on effectiveness since they will be based solely on the procedures performed in performing testing of the selected performance indicators.

Other relevant communications

- Our observations are developed in the context of our limited assurance procedures on the Quality Report and our related audit of the financial statements.

We welcome the opportunity to discuss our report with you and receive your feedback.

Deloitte LLP
Newcastle Upon Tyne
25 May 2018

This report is confidential and prepared solely for the purpose set out in our engagement letter and for the Board of Directors, as a body, and Council of Governors, as a body, and we therefore accept responsibility to you alone for its contents. We accept no duty, responsibility or liability to any other parties, since this report has not been prepared, and is not intended, for any other purpose. Except where required by law or regulation, it should not be made available to any other parties without our prior written consent. You should not, without our prior written consent, refer to or use our name on this report for any other purpose, disclose them or refer to them in any prospectus or other document, or make them available or communicate them to any other party. We agree that a copy of our report may be provided to Monitor for their information in connection with this purpose, but as made clear in our engagement letter only the basis that we accept no duty, liability or responsibility to Monitor in relation to our Deliverables.

Deloitte.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 June 2018
Agenda item 8.3

Title:	**Trust Board self-certification (FT4) – corporate governance statement 2017/18**
Paper prepared by:	Director of Finance Company Secretary
Purpose:	To provide assurance to Trust Board that it is able to make the required self-certifications that the Trust complies with the conditions of the NHS provider license.
Mission/values:	Good governance supports the Trust to deliver its mission and adhere to its values.
Any background papers/ previously considered by:	Trust Board received and approved the operational plan for 2017/18-2018/19 on 20 December 2016 and an update on 24 April 2018 which will be formally tabled on 26 June 2018. The Trust reviewed compliance with NHS Constitution on 20 December 2017. The first part of the required self-certification (G6/CoS7) was approved by Trust Board on 24 April 2018. The attached document has been reviewed by the Executive Management Team.
Executive summary:	**Background** NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements. As part of the annual planning arrangements, NHS Improvement requires the Trust to make a number of governance declarations. The Trust Board approved the first self-certifications (G6/CoS7) on 24 April 2018 in relation to: ➢ The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (as required by condition G6(3) of the NHS Provider Licence); and ➢ If providing commissioner requested services (CRS), the provider has a reasonable expectation that required resources will be available to deliver the designated service (as required by condition CoS7(3) of the NHS Provider Licence).

With all of us in mind.

	Further self-certifications (FT4) are required by 30 June 2018: ➢ The provider has complied with required governance arrangements (as required by condition FT4(8) of the NHS Provider Licence) (appendix 1 – Corporate Governance Statement); and ➢ The training of Governors (as required by s151(5) of the Health and Social Care Act 2012) (see below). **Self-certification - part two (FT4)** <u>Draft Corporate Governance Statement 2017/18</u> The attached paper (appendix 1) sets out the statements (numbered 1-6) Trust Board is required to make and the assurance to support self-certification against the statements. From the assurance provided, Trust Board is asked to certify that it is satisfied with the risks and mitigating actions against each area of the required six areas within the Trust's Draft Corporate Governance Statement 2018/19. <u>Training of Governors</u> Starting in 2013, the Trust has developed, through the Members' Council Co-ordination Group, a programme of training and development to ensure governors have the skills and experience required to fulfil their duties. The Trust has supported the training and development of governors in a number of ways: ➢ Each new governor had an induction meeting with the Chair and all other governors had an annual review meeting to discuss individual performance and training and development needs. ➢ The Trust offered 1:1 support and 'buddying' as part of the induction programme for new Governors. ➢ Attendance at national GovernWell training modules was also encouraged and the Trust facilitates attendance. ➢ There was an annual session to evaluate the contribution and work of the Members' Council in February 2018, facilitated by an external facilitator and included a self-assessment by governors, both individually and collectively, of their contribution and effectiveness. ➢ Most formal Members' Council meetings include a discussion item or development session, which allows governors, with the support of Trust Board, to look at a particular area of Trust services or activity in more detail. In 2014, the Members' Council signed up to the principle that there should be a level of minimum commitment and contribution from Governors at two levels: *Required* ➢ Attendance at a minimum of three out of four formal Members' Council meetings. ➢ Attendance at the annual evaluation session.

	➢ 1:1 introductory meeting with the Chair. ➢ Annual review meeting with the Chair. ➢ Attendance at the Annual Members' Meeting. *Desirable* ➢ Attendance at Trust Board meetings. ➢ Attendance at training and development sessions organised by the Trust. ➢ Attendance at the Foundation Trust Network's GovernWell modules. ➢ Membership of formal groups (currently Members' Council Co-ordination Group, Quality Group and Nominations Committee). From the assurance provided, Trust Board is asked to certify this it "***is satisfied that, during the financial year most recently ended, the Trust has provided necessary training to its governors, as required by S151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.***"
Recommendation:	**Trust Board is asked to NOTE the outcome of the self-assessments against the Trust's compliance with the terms of its Licence and with Monitor's Code of Governance and CONFIRM that it is able to make the required self-certifications in relation to:** ➢ **the Corporate Governance Statement 2017/18; and** ➢ **the training for Governors 2017/18.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 June 2018
DRAFT Corporate Governance Statement 2017/18

1. The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

The Trust continues to implement, develop and improve its arrangements to ensure it meets the principles and standards of good corporate governance and to ensure it has the systems and processes in place to meet these as well as its statutory, legal and regulatory duties and requirements. As part of this continuous improvement process, Trust Board undertook a well-led governance review during May, June and July 2015. The outcome of this review was reported to Trust Board in July 2015.

In summary, following a robust and thorough review and scrutiny of the Trust's governance arrangements, which included interviews and focus groups with Trust Board, key stakeholders, the Members' Council and staff, the review concluded that there were no 'material governance concerns'. Out of the ten areas assessed, two areas were RAG rated as green (in relation to Board engagement with patients, staff, governors and other stakeholders, and the Board having the skills and capability to lead the organisation) and eight RAG rated as amber/green. In terms of the outcome, this reflected the developmental approach taken by Trust Board and the report very much reflected Trust Board's own assessment of the Trust's arrangements. The report identified a series of areas for development around clear articulation of our strategic priorities and strengthening how these are communicated, clear monitoring and reporting against these, further development of the Board Assurance Framework (BAF), monitoring and assurance of the Trust's transformation programme, and strengthening and enhancing staff engagement. A final report on the completion of the action plan was received by Trust Board in September 2016. Internal audit undertook a review of implementation in 2016/17 which received **significant assurance**. A further internal audit was undertaken in 2017/18 on the Trust's risk management and BAF which received **significant assurance**.

Risks
The Trust does not apply or applies inconsistently good corporate governance. Mitigated by robust scrutiny through the Trust's governance and assurance processes.

The Trust was also subject to an inspection by the Care Quality Commission (CQC) in March 2016 and re-inspection in January 2017. The Trust was rated 'GOOD'' overall with some areas that require improvement. The Trust was rated as 'GOOD' for the well-led domain.

Risk
The outcome of the inspection required some areas that require improvement. Mitigated by an action plan to address areas for improvement.

There are a number of areas to provide assurance that the Trust applies the principles, systems and standards of good corporate governance.

- The Trust's Constitution underpins its governance arrangements and the Trust operates within its Constitution at all times. Where necessary, the Trust seeks external advice on any changes, and ensures amendments are approved in line with the process set out in the Constitution. A review of the Trust's Constitution was conducted in 2016/17 and the update approved by the Trust Board and Members' Council in February 2017. It is next due for review in 2019.
- The Trust complies with all relevant rights and pledges set out in the NHS Constitution with the exception of the pledge "The NHS commits to make the transition as smooth as possible where you are referred between services, and to include you in the relevant discussions". The Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care; however, there are occasions where the nature of an individual's illness makes this inappropriate. The annual self-assessment was presented to Trust Board in December 2017.
- The Trust undertakes an annual assessment of compliance against NHS Improvement/Monitor's Code of Governance which is reported to Trust Board.
- The Trust has a register of interests in place for both Trust Board and the Members' Council, which is reviewed annually and both Directors and Governors are proactively asked to update their declarations. Directors and Governors are expected to declare any additions or changes to their declarations. The Chair of the Trust reviews the declarations and considers whether there are any conflicts of interest presenting a risk to the Trust. Non-Executive Directors also make a declaration of independence on an annual basis. All Non-Executive Directors have made a positive declaration. From April 2015, members of Trust Board have also been asked to make a declaration that they meet the fit and proper person requirement introduced in response to a recommendation made in the Francis Report. All members of Trust Board have made such a declaration and the Trust undertakes appropriate enquiries to ensure that newly appointed Directors meet the requirements as well as seeking an individual declaration. All members of Trust Board and the Executive Management Team have disclosure and barring (DBS) checks in place.
- All elections made to the Members' Council are held in accordance with the Model Election Rules in the Trust's Constitution. Elections are overseen by an external organisation (currently Electoral Reform Services) to ensure independence and transparency, and to ensure the Trust meets its statutory duties.
- The Trust was awarded a Licence on 1 April 2013. The Trust ensures it meets the conditions of its Licence through a process of self-assessment. There are no major issues or risks identified in relation to the Trust's continued compliance with its Licence.

Risk

The Trust does not comply with the requirements of its Licence. Mitigated by ongoing review of Trust compliance and reporting to Trust Board as part of the NHS Improvement/Monitor requirements.

The following also provide assurance to Trust Board that the Trust has good corporate governance arrangements in place.

- The Head of Internal Audit Opinion for 2017/18 provides **significant assurance** on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.
- As Accounting Officer, the Chief Executive prepares an Annual Governance Statement. This document describes the risk and assurance processes for the Trust and meets the requirements set out in NHS Improvement's Foundation Trust Annual Reporting Manual. The Statement for 2017/18 was assessed as fit for purpose and meeting guidance as part of the audit of the Trust's annual report and accounts.
- The Trust's Board assurance framework and risk register have been assessed as appropriate as part of an internal audit of the Trust's risk management processes in 2017/18 which received **significant assurance**.

Risk
The Trust does not continue to have good corporate governance arrangements in place. Mitigated by close scrutiny of NHS Improvement performance targets by the Executive Management Team quarterly reporting to Trust Board as part of the NHS Improvement reporting process.

2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time-to-time.

The Accounting Officer and Company Secretary ensure that Trust Board is made aware of guidance on good corporate governance from NHS Improvement, an assessment of the Trust's immediate position is undertaken and any action or development required to ensure compliance is initiated.

Risk
Trust does not have regard to guidance. Mitigated by the Company Secretary having oversight of the systems and processes in place to ensure guidance is identified, captured, assessed and implemented.

3. The Board is satisfied that the Trust implements:
a) effective board and committee structures;
b) clear responsibilities for its board, for committees reporting to the board and for staff reporting to the board and those committees; and
c) clear reporting lines and accountabilities throughout its organisation.

Trust Board is clear that its role is to set the strategic direction and associated priorities for the organisation, ensure effective governance for all services and provide a focal point for public accountability. The general duty of Trust Board, and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for members of the Trust as a whole and the public. Trust Board is clear of its accountability and responsibility.

Trust Board and committee structures in place are effective and meet the requirements of the Trust's Constitution. Committees are supported by terms of reference and annual work plans and have clear reporting mechanisms to Trust Board. The Trust has five committees and one forum:

- Audit Committee;
- Charitable Funds Committee;
- Clinical Governance and Clinical Safety Committee;
- Mental Health Act Committee;
- Workforce and Remuneration Committee (previously call Remuneration and Terms of Service Committee;
- Equality and Inclusion Forum.

The committees and forum are chaired by a Non-Executive Director and, with the exception of the Audit Committee, have Non-Executive and Executive Director membership. The Audit Committee membership comprises exclusively of Non-Executive Directors. Agendas, which are risk-based, are compiled and agreed by the Chair of the committee in conjunction with the lead Director. Each committee has an annual work programme, which is incorporated into agendas as appropriate. Lead Directors are responsible for ensuring, with the Company Secretary, that papers are commissioned to meet the requirements of the committee, to provide assurance that risk is mitigated within the Trust and to provide assurance that the Trust is working to deliver and continuously

improve the services it provides whilst achieving value for money and best use of resources.

The membership of committees is reviewed regularly by the Chair of the Trust in terms of Non-Executive Directors. The committee structure is reviewed for appropriateness from time-to-time by the Chair. An update to the internal meeting governance framework was approved by Trust Board in January 2018.

Each committee is required to prepare an annual report, which is presented to the Audit Committee. This provides assurance to Trust Board that each committee is meeting its terms of reference and is seeking assurance on areas of risk in line with its terms of reference. The outcome is reported to Trust Board annually in April.

The Executive Management Team's (EMT) role is to ensure that resources are deployed to support the delivery of the Trust's plan, to ensure that the Chief Executive can discharge their accountability to best effect through effective delegation and prioritisation of work, to support each other to find appropriate linkages and synergies, to ensure performance is scrutinised and challenged, both Trust-wide and by BDU, and to ensure the work of the EMT is aligned with that of Trust Board.

Trust Board is supported by an involved and proactive Members' Council, which forms a key part of the Trust's governance arrangements. The Members' Council is clear that its role is to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors and to represent the interests of the members of the Trust as a whole and the interests of the public. The Members' Council continues to develop its skills and experience in its ability to challenge and hold Directors to account for the Trust's performance.

The Trust works within a framework that devolves responsibility and accountability throughout the organisation through robust service delivery arrangements. There are clear structures with clear responsibility and accountability below Director level. Within BDUs, deputy directors provide operational leadership and management allowing BDU Directors to focus on building and managing strategic and partner relationships and to lead the transformation agenda. BDUs are supported by arrangements at service line level where a clinical lead, general manager and practice governance coach work together and carry responsibility at ward, unit and department level to ensure excellence in service delivery and quality and to enact the service change required to achieve transformation.

BDUs are supported by the Quality Academy (corporate directorates), which provides co-ordinated support services linked to the accountabilities of executive directors. There are six domains comprising financial management, information and performance management, people management, estates management, compliance, governance and public involvement and engagement, and service improvement and development.

Risk
The Trust does not have effective structures at Trust Board level. Mitigated by annual committee review process, independent review by internal audit of effectiveness, clear view of roles and responsibilities, and clear approach to leadership and management throughout the Trust.

4. The Board is satisfied that the Trust effectively implements systems and/or processes:
- **a) to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively;**
- **b) for timely and effective scrutiny and oversight by the Board of the Licence holder's operations;**
- **c) to ensure compliance with healthcare standards binding on the Licence holder, including, but not restricted to, standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of healthcare professions;**

d) for effective financial decision-making, management and control (including, but not restricted to, appropriate systems and /or processes to ensure the Licence holder's ability to continue as a going concern); **e) to obtain and disseminate accurate, comprehensive, timely and up-to-date information for Trust Board and Committee decision-making;** **f) to identify and manage (including, but not restricted to, manage through forward plans) material risks to compliance with the conditions of its Licence;** **g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and, where appropriate, external assurance on such plans and their delivery; and** **h) to ensure compliance with all applicable legal requirements.**
As part of its annual audit, the Trust's external auditor, Deloitte, was satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources in 2017/18. There were no issues identified to report in the audit opinion. *Risk* *The Trust does not have the systems and processes to ensure compliance with its Licence. Mitigated by performance reporting arrangements to Trust Board, including exception reports on areas of risk or concern, quarterly exception reports, robust committee arrangements in place providing assurance that the systems and processes in place are effective.* The Trust's internal audit plan is risk-based to enable the Trust to identify areas where improvement is sought and to learn from best practice. The Audit Committee approved the internal audit plan for 2017/18. The plan included core reviews to inform the Head of Internal Audit Opinion relating to core financial controls, corporate governance arrangements, which will focus on risk management and board assurance framework, and information governance toolkit. This was supported by a number of cyclical and risk reviews covering transformation governance, data quality framework, Mental Health Act training, agency staffing controls and quality governance. Internal Audit also conducted a survey of all Board members in respect of governance, risk management and culture. The Trust continues to develop and implement service line reporting, which is monitored and scrutinised by the Audit Committee on behalf of Trust Board. Further work will be undertaken in the coming year to use the information to benchmark internally and learn from best practice. Trust Board receives an Integrated Performance Report (IPR) on a monthly basis. This enables Trust Board to satisfy itself that the Trust is meeting its financial and quality performance targets. Other reports to Trust Board and its committees provide further assurance that the Trust is fulfilling its purpose in an effective and efficient manner. The Trust was (and continues to be) registered with the Care Quality Commission (CQC) with no conditions. The Trust has a robust process in place to ensure that it meets the requirements of its registration. The Trust was subject to an inspection by the CQC in March 2016 and re-inspected in January 2017. Action plans were developed in response to recommendations included in the inspection reports. For 2017/18~~,~~ the Trust's programme of visits to services focused on areas 'requiring improvement' in the reports. Mental Health Act visits occur regularly and, following each visit, an action plan is submitted to the CQC to address any issues raised. The action plans and progress against these are monitored and scrutinised by the Mental Health Act and Clinical Governance and Clinical Safety Committees. Local actions have also been implemented in relation to any identified concerns arising from the Trust's own unannounced visit programme.

Based on evidence provided by finance and performance reports and the Trust's operational plan for 2018/19, supported by Audit opinion, the Trust will remain a going concern at all times. As part of its accounts audit for 2017/18, the Trust's external auditor was able to agree with management's view that the Trust could account on a going concern basis. The coming year presents a challenge to the Trust in meeting its operational and financial plans. Trust Board will review the Trust's position at its meeting in July 2018 in terms of the first three months of 'trading'.

Risk
The Trust is unable to meet the requirements of its operational and financial plans for 2018/19. Mitigated by a review at month 3 (reporting to Trust Board in July 2018) to ensure its plans provide sufficient investment in services and to consider the planned end-of-year outturn position.

The Trust has policies and procedures in place to ensure it complies with legislation both as an employer and as a provider of NHS services.

5. The Board is satisfied that:
- **a) there is sufficient capability at Trust Board level to provide effective organisational leadership on the quality of care provided;**
- **b) Trust Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;**
- **c) the collection of accurate, comprehensive, timely and up-to-date information on quality of care;**
- **d) Trust Board receives and takes into account accurate, comprehensive, timely and up-to-date information on quality of care;**
- **e) the Trust, including Trust Board, actively engages on quality of care, with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and**
- **f) there is clear accountability for quality of care throughout the Trust, including, but not restricted to, systems and/or processes for escalating and resolving quality issues, including escalating them to Trust Board where appropriate.**

The Trust continues to regularly reviews processes against governance best practice, including:

- policies developed, reviewed and in place;
- governance systems;
- the assurance framework and risk register presented to Trust Board quarterly;
- audits undertaken both internally and externally;
- the programme of unannounced visits; and
- reports submitted to Trust Board and its Committees, as well as the Members' Council.

The Trust's Quality Account for 2017/18 provides a summary of the Trust's quality achievements and challenges, demonstrating how it meets its statutory and regulatory requirements as well as how it meets the expectations of its service users, carers, stakeholders, its members and the public. The Report was externally audited. This provided the required limited assurance opinion on the content and consistency of the report, that the content was in line with the Annual Reporting Manual 2017/18 issued by NHS Improvement and consistent with documents reviewed. Minor recommendations were made to further improve the quality of our data.

The process introduced by the Director of Nursing and Quality to assess risk to and impact on quality and safety of the cost improvement and efficiency savings proposed by BDUs was again applied in 2017/18. The Quality Impact Assessment process, led by the Director of Nursing and Quality and undertaken in conjunction with clinical and general management within BDUs, provides assurance throughout the process to the Executive Management

Team (EMT) and, through regular reports, to the Clinical Governance and Clinical Safety Committee and Trust Board that cost improvements do not have an adverse effect on Trust services. In 2018/19, assessment of the impact of substitutions or mitigating action are included in the process as well as cost pressures.

The Trust's approach to quality improvement is clear that quality is the responsibility of all staff from 'ward to board'. Reporting processes and mechanisms through Trust Board, its committees, EMT and through to BDUs and their governance processes reflects this approach. Accountability for quality is also clear through the leadership and management arrangements within the Trust. BDUs continue to enable better and more rapid decision-making, as close as possible to the point of care delivery, which, in turn, enables more effective clinical engagement and leadership in service development and delivery as well as providing service users with greater access to decision-making.

The Trust's approach to clinical quality improvement is supported by the Quality Academy approach, which is based on continuous service improvement, working in innovative ways to meet local priorities, to ensure compliance with national standards and external regulation, adoption of lean systems thinking, and making the most of shared learning opportunities across the healthcare system, using quality to deliver best value. The Trust's strategic priorities and combined support service offer aligns clinical services and support functions to deliver the best care possible to those who use Trust services. The approach also links to the national Quality, Innovation, Productivity and Prevention (QIPP) agenda.

Trust Board receives regular reports, directly and through the Clinical Governance and Clinical Safety Committee, on all aspects of clinical quality and safety including management of incidents and complaints, equality and diversity, service user experience, control of infection and research and development. The Clinical Governance and Clinical Safety Committee provides assurance to Trust Board that issues and risks identified in a number of portfolio areas, such as managing aggression and violence, safeguarding adults and children, infection prevention and control, and information governance, are being addressed. where the Clinical Governance and Clinical Safety Committee identifies an area of concern which has been raised at a particular time, we scrutinise that on behalf of the board by receiving regular reports for a period.

Performance reports to Trust Board provide assurance against a range of Key Performance Indicators (KPIs_ relating to service quality and, where reports indicate underperformance, action plans are provided to and monitored by Trust Board.

The Trust has a range of arrangements in place for monitoring service user experience as an indicator of service quality. This includes surveys, consultations and engagement events. The Trust's approach to insight and service user experience is set out in its Communication, Engagement and Involvement Strategy. Regular meetings are also held in community and ward settings to receive service user and carer feedback. The Trust continues to look for innovative ways to capture service user and carer feedback at the point of contact.

The Trust is compliant with the Health Act 2006: Code of Practice for the Prevention and Control of Healthcare Associated Infection (Hygiene Code). The Trust has an Infection Control Strategy in place and the infection control annual plan and annual report are considered by the Clinical Governance and Clinical Safety Committee on behalf of Trust Board. Trust Board monitors infection control through the monthly performance reports and the quarterly compliance report. Hygiene and quality of environment are maintained through cleaning schedules and through service level agreements and regular visits to clinical areas by the Director of Nursing and Quality, include checks for cleanliness.

The Trust publishes information in relation to the Friends and Family test for service users and staff.

The Trust actively engages with its service users, their carers, staff and stakeholders on the quality of its services through the development of its Quality Accounts and in the development of its services.

The Trust has a whistleblowing policy in place, which sets out clearly staff responsibility to raise concerns and how they can do this. The policy is clear on the escalation process and who concerns should be reported to. The policy is supported by information on the Trust's intranet and in associated documentation, such as the fraud and bribery act policy, safeguarding policies, and serious incident reporting and management policy. Arrangements are scrutinised by the Audit Committee. The Trust has also appointed its staff Governors on the Members' Council as a network of Freedom to Speak Up Guardians (FTSUG) rather than one individual due of the diverse nature of services and large geographical spread of the Trust, the FTSUG provide staff with another way to raise concerns at work. Trust Board has also identified the Deputy Chair as the Senior Independent Director.

Risk
The Trust does not have the capacity and capability at Trust Board level. Mitigated by quality performance reporting to Trust Board, annual quality report, customer services processes and ongoing engagement with stakeholders, service users/carers and staff, clear process in place for whistleblowing and raising concerns, and processes in place for recruitment and selection of Trust Board members.

6. Trust Board effectively implements systems to ensure that it has in place personnel on Trust Board, reporting to Trust Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of the Trust's NHS provider licence.

Trust Board is satisfied that all Directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability.

The Chair and Non-Executive Directors have a broad base of skills and experience, including financial, commercial, marketing, legal, community engagement, and health and social care. It is the role of the Nominations Committee to assess the mix of skills and experience across Trust Board when appointing Non-Executive Directors to the Board and to ensure a balance is maintained with skills complementing those of Executive Directors. To inform this process and to ensure Trust Board retains a balance of skills and experience to operate effectively as a unitary board, a review of Trust Board skills and experience will be undertaken as part of the Trust Board development plan. The recruitment process for new members of the Trust Board incorporates testing against the values of the organisation and discussion panel including staff (with representation from staff equality networks), and service users/carers.

All new Non-Executive Directors have a detailed induction programme tailored to individual requirements and Board responsibilities. The Chair is subject to an annual assessment of performance by the Members' Council, led by the Senior Independent Director, and involving Non-Executive Directors, Executive Directors and Governors. Trust Board undertakes ongoing Board development, using external expertise where required.

The Chief Executive is subject to formal review by the Chair. Executive Directors are subject to annual appraisals by the Chief Executive, and Non-Executive Directors are subject to annual appraisal by the Chair, both of which inform individual development plans for all Board members. The outcome of the Non-Executive Director appraisals is reported to the Members' Council.

Continuous professional development of clinical staff, including medical staff, supports the delivery of high quality clinical services. The Trust has policies, processes and procedures in place to ensure all medical practitioners providing care on behalf of the Trust have met the relevant registration and re-validation

requirements. This process of assessing the organisation's readiness for medical and nursing re-validation has been scrutinised both by Trust Board and by the Clinical Governance and Clinical Safety Committee.

Trust Board satisfies itself that the management team has the necessary skills and competencies to deliver the Trust's strategic objectives. Where gaps are perceived, the Chief Executive will seek to address Trust Board concerns, supported by the Remuneration and Terms of Service Committee.

All appointments to senior management positions are subject to rigorous and transparent recruitment processes. Senior managers have objectives linked to the delivery of the strategic objectives and operational plan. The Chair and Chief Executive continue to review the capacity of senior managers within the Trust to ensure there is the required and necessary balance to deliver and maintain high quality and safe services during a time of unprecedented transformational change within the organisation and wider NHS. Professional and clinical leadership is devolved into the organisation under the leadership of the Director of Nursing and Quality, and the Medical Director.

The Trust also has a programme in place for all managers within the Trust at Bands 7 and above, Middleground, which aligns effort and resources to shared organisational goals, ensures all effort and initiatives link together to create added value, ensures behaviours and actions are aligned to the organisational vision, values and goals, and ensures behaviours help produce performance, assurance and improvement at individual, team and organisational level. The Talent Pool is now well-established to identify, nurture and develop talent within the organisation.

Risk
The Trust does not have suitably qualified individuals at all levels of the organisation. Mitigated by recruitment and selection processes for Trust Board, Director-level appointments and staff at all levels.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 June 2018
Agenda item 8.4

Title:	**General Data Protection Regulation (GDPR) implementation update**
Paper prepared by:	Director of Finance and Resources
Purpose:	To update the Trust Board on the progress being made on the implementation of GDPR
Mission/values:	Compliance with the requirements of GDPR aligns with all Trust values
Any background papers/ previously considered by:	Regular updates provided to Executive Management Team (EMT) Regular updates provided to the Audit Committee which has oversight of the implementation on behalf of the Trust Board.
Executive summary:	➢ This paper builds on previous reports to the Audit Committee on the requirements of GDPR, the plan the trust has to meet those requirements and the progress made to date on compliance. ➢ Information Governance policies have been updated approved and placed on the Trust's intranet. ➢ The Trust's public privacy notice has been updated and placed on the website. ➢ A programme of training on the completion of privacy impact assessments (PIAs) was delivered to management teams over the six months prior to the enforcement of the GDPR. ➢ Confidentiality leaflets for patients are being updated in readiness for sharing upon confirmation of a small number of points. ➢ Work is being undertaken to investigate options for data portability ➢ Work is currently being undertaken to determine the process for restricting access to personal data, both on paper and electronic, whilst the Trust investigates where an individual has notified us that the information is inaccurate or that it has been processed unlawfully or unfairly. ➢ All areas of the Trust hat hold personal data are undertaking an audit to be completed by 30 June 2018. ➢ On completion of the audit, action plans will be created by 31 July 2018 for implementation by 31 October 2018. Regular review meetings have been scheduled to ensure appropriate progress is being made, monitoring with be via EMT. **Risk appetite** This paper needs to be considered in line with the Trust risk appetite statement which aims for compliance risk of 1-6.
Recommendation:	**Trust Board is asked to NOTE the work undertaken to date and that which will be completed in the coming weeks to ensure the**

	Trust continues to strengthen its compliance with GDPR with the aim of achieving full compliance by 31 October 2018.
Private session:	Not applicable.

General Data Protection Regulation (GDPR) implementation update

1. Introduction

This paper provides an overview of and update on progress made on the implementation of the General Data Protection Regulation (GDPR).

The Data Protection Act 1998 was derived from an EU Data Protection Directive designed to regulate data protection laws across Europe. Subsequent changes to the data landscape, including increased use of the internet, social media and cloud storage, necessitated a legislative update.

The GDPR was approved by the European Parliament in April 2016 and EU member states were required to transpose its requirements into national law by 6 May 2018, with enforcement effective from 25 May 2018. The UK government confirmed in October 2016 that Brexit will not affect the implementation of the GDPR.

"There is no deadline. It's important to understand that 25th May is not the end, it is the beginning - there is a long road ahead." Elizabeth Denham, Information Commissioner, ICO.

The Information Commissioner has confirmed that the creation of the new legislation is not the end point and that, whilst it will be enforceable, it is an evolutionary process requiring evidence of commitment and ongoing effort. In addition, NHS England is still developing sector specific guidance on the application of the GDPR and the Information Commissioner's Office (ICO) has yet to update its data protection guidance. An implementation plan has been developed for Trust-wide compliance by 31 October 2018.

One of the most significant changes under the GDPR is that consent must be freely-given, explicit and verifiable: implied consent no longer applies. Other lawful bases for processing must be applied where consent is not appropriate.

Public authorities will generally be able to rely on the following lawful basis for processing patient and staff personal data:

- Article 6(1)(e) – processing is necessary for the performance of task carried out in the public interest or in the exercise of official authority vested in the controller

NHS Trusts will generally be able to apply the following conditions to processing special category data about patients and staff, which includes their health information and protected characteristics:

- Article 9(2)(b) – processing is necessary for carrying out obligations under employment, social security or social protection law
- Article 9(2)(h) – processing is necessary for the purposes of preventative or occupational medicine, for assessing the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of

health and social care systems and services on the basis of national law or a contract with a health professional

Alongside the GDPR, the final text of the Data Protection Act 2018 was approved in parliament on 23 May 2018 with enforcement also effective from 25 May 2018. The Act covers the national derogations given under the GDPR and data processing that is outside the scope of EU law, such as sharing personal data for law enforcement purposes.

2. Action plan for full compliance by 31st October 2018

Actions completed prior to enforcement

Information governance policies have been updated to incorporate the requirements of the GDPR, approved by EMT and published on the intranet:

- Acceptable Use of Communications Technology
- Access to Health Records
- Health Records Management
- Information Governance
- Non-clinical Records Management
- Safe Haven
- Service User Confidentiality and Data Protection
- Staff Confidentiality and Data Protection

The existing Information Security Policy, Agile Working Policy and Risk Management Procedure were reviewed and confirmed as GDPR compliant.

Members of the public can currently access Trust polices via Freedom of Information requests.

Resources in the Information Governance/ Health Records team were identified and re-prioritised to ensure organisational compliance can be met, including providing advice on compliance, undertaking training and raising awareness and, providing advice on assessing data protection impact.

The Trust's public privacy notice was updated on the internet (http://www.southwestyorkshire.nhs.uk/service-users-and-carers/your-rights/confidentiality/) to include the following GDPR compliant information:

- Name and contact details of the Trust's Data Protection Officer
- Why the Trust needs personal data and what it will be used for
- The lawful bases for uses of personal data
- Whether personal data is shared and, where applicable, who it is shared with
- Rights of access, rectification and erasure
- Rights to object to or restrict processing
- Right to data portability

- Right to withdraw consent where it is the legal basis for processing
- Right to complain to the ICO
- Rights in relation to automated decision-making

A programme of training on the completion of privacy impact assessments (PIAs) was delivered to management teams over the six months prior to the enforcement of the GDPR. PIAs were previously recommended by the ICO but are mandatory under the GDPR whenever change involving personal data is proposed. PIAs have been renamed data protection impact assessments (DPIAs) under the GDPR but the principles remain the same.

Work in progress against full compliance by 31st October 2018

General

The Trust's confidentiality leaflet for patients has been updated to include the GDPR compliant information in the public privacy notice prior to enforcement. However, printing and publication via the intranet has been delayed so an improvement can be made following discussion with practice governance coaches as concerns were raised that some health professionals have not accepted a referral for a current Trust patient from one team into another without evidence of patient consent. The sharing information in the leaflet is being updated to inform that personal data may be shared with a number of our teams and services as part of the delivery of a treatment plan within the Trust.

Work is currently being undertaken to determine the process for restricting access to personal data, both on paper and electronic, whilst the Trust investigates where an individual has notified us that the information is inaccurate or that it has been processed unlawfully or unfairly.

Work is also being undertaken to investigate options for data portability. Whilst this right does not extend to health information, it is possible it may apply to other personal data held by the Trust, providing it is electronically feasible.

Internal audits

All areas that hold personal data are undertaking an audit to be completed by 30 June 2018. The following are within scope, based on the implementation checklist issued by NHS Digital:

- Controls – lawfulness, fairness & transparency, individuals' rights, accountability & governance
- Security – physical security, computer & network security, data breach management
- Data Sharing – governance, record-keeping, notification, security
- Records Management – creation & maintenance, tracking & offsite storage, access controls
- Subject Access – managing requests, rights of access, management responsibility
- CCTV – installation, management, operation, public awareness & signage

On completion of the audit, action plans will be created by 31 July 2018 for implementation by 31 October 2018. Regular review meetings have been scheduled to ensure appropriate progress is being made, monitoring with be via EMT.

The starting point is a review of the Trust's asset registers. Historically information systems such as RiO, SystmOne and ESR, have been captured and the register reviewed at the Information Management & Technology Task & Action Group (IM&T TAG). It was identified during preparations for the GDPR that there is no log of paper assets or electronic assets held locally, such as in team or individual folders on network drives. Initially the IM&T TAG membership was expanded so steps could be taken to capture such assets but progress was slow. Under the GDPR organisations are required to evidence the lawful basis for processing personal data and, where the data is a special category, such as health, a condition for processing must also be identified and the asset register template has been amended to include this. The following data is captured for each asset:

- Information asset description
- Purpose for processing and business activity supported
- Lawful basis for processing
- Data subjects
- Condition for processing special category data, if applicable
- Recipients (users, systems, recipients of disclosure)
- Format
- Owner/ administrator
- Owner/ administrator contact details
- Minimum retention period for original record
- In and out-bound data flows
- Date of latest risk assessment
- Business continuity plan reference and activation period
- Applicable user/ management processes
- Additional information (access by third parties, details of networked resources, etc.)

The audits are initiated by meetings with the Information Governance (IG) Manager and engagement has been positive, with areas seeing it as an opportunity to improve records management practices and eliminate unnecessary information retention.

Direct Clinical Care

All clinical IG polices/ procedures relevant to clinical practice e.g. consent have been updated and approved as outlined above.

It should be noted that the Trust achieved Level 2 compliance in the 2017/18 toolkit, verified by internal audit which provides assurance that its systems and process for handling patient identifiable information (PID) are robust and subject to regular audit and monitoring.

The processes mapping for the implementation of the new mental health system is ongoing and the author is a member of the overarching governance group to ensure that all new processes for the recording, handling and monitoring of PID are in line with GDPR requirements and the revised toolkit when it is issued for 2018/19.

It is important for the Board to note that the Trust IM&T systems, policies and procedures for patient data are already fully compliant with Article 6(1)(e), Article 9(2)(b) and Article 9(2)(h).

Access to shared drives for the storage and retrieval of PID information is under review supported by Dr James, the clinical lead for the mental health system.

Non-clinical areas

Audits are on track to be completed by the deadline. Below is a summary of progress that has been made prior to submission of the completed audits.

An initial meeting has been held with the membership office, however the Trust senior IM&T manager is working with a number of other Trusts on an approach to management of membership under GDPR as no central guidance has been issued, this will include a change to the membership form to make consent more explicit by the deadline of 21st October 2018.

Patient Safety team data is under review and in addition the process for investigation of IG incidents is being reviewed to ensure it is in line with the new requirements. Additionally the author is working closely with CCG colleagues to ensure policies and procedures are in line.

The Occupational Health team completed the audit and action plan on 4 June 2018. The action plan has only one action outstanding as it is not currently possible to destroy electronic records held on the Cohort client information system; however, a replacement system is planned for implementation in 2019 that includes this functionality.

The Human Resources team has identified that information re the uses of staff special category data and the conditions for processing will need to provided when article 9(6)(b) does not apply. A confidentiality leaflet for staff is currently being finalised. This will be communicated to staff and provided with the new starter pack going forward.

Whilst the Pharmacy has not completed its audit yet, from discussions that have been had, it is likely they are already largely compliant as articles 9(6)(b) and (h) will apply to the processing activities and appropriate user, physical and electronic security controls are in place. However, there may an issue with retention of electronic records on the dispensing systems.

The Customer Services team already has robust processes for obtaining consent and informing individuals of the uses of the information they provide. Information assets are all held electronically in networked folders with appropriate user access controls. IG will deliver an awareness session at the team brief on 18 June 2018.

The Finance team raised an issue with sending personal data to/ from swyt email accounts, which is in breach of the Trust's Acceptable Use of Communications Technology Policy. An immediate action to create NHSnet accounts was taken. Processing activities have been identified as meeting the condition set out in article 9(6)(b). The team is working closely with IG to ensure they are progressing appropriately. IG will deliver an awareness session at the team brief on 18 June 2018.

The finance team action plan will include ensuring all linked Charities are GDPR complaint.

The Communications team have identified that, other than staff members' information held by line managers, no other personal data sets are held. Where personal data is used in media communications the lawful basis is consent. The Engagement lead has been unable to attend meetings to date but has been provided with the audit and asset register information by email. The Sugar CRM system is already captured on the asset register that is reviewed at the IM&T TAG.

Personal data held by Volunteering Services is held electronically on networked drives with appropriate access controls applied. The Head of the service is demonstrating a tremendous understanding of confidentiality and records management and the need to adapt Trust staff processes to enable volunteers to work on the same basis.

Safeguarding and incident-related information is largely unaffected by the implementation of GDPR as derogations under other legislation may be relied on where it is in the public interest to do so. Following the release of the final Data Protection Act 2018, the IG Manager is updating the guidance on when data may be shared and when other statutory or permissive legislation applies.

The Library & Resource Centre identified that, following a change last year, the current membership application form no longer includes verifiable consent. The team is working on updating this, including introducing tick boxes to provide choice on why they will be contacted, e.g. when new publications that may be of interest are released. They are also re-consenting existing members for whom verifiable consent is not currently held. A risk assessment on the uses of personal data is also being undertaken as it was identified that this has not been completed previously. The audit and action plan will be completed at the review meeting on 18 June 2018.

The Contracting & Business Development teams advised that personal data is not held permanently but, often, information is copied from other Trust sources and retained temporarily in order to conduct business activity. It was agreed that currently held information of this nature will be added to the asset register and the team must be responsible for ensuring it is updated to capture future instances. Work has already been undertaken to determine the Trust's role as data controller or data processor in existing contracts and update the confidentiality and data protection clauses.

The Integrated Change team demonstrated confidence in awareness of and accountability for processing personal and special category data for current business activities but raised an issue re retention of data used in previous change projects. A separate meeting to discuss iHub will be held as it is not clear what governance exists around re-using information that people have posted.

IT Services & Systems Development teams are working on capturing the information held on Trust servers. It is possible there may be an issue with the retention periods of such data and mechanisms for destruction. Currently records can only be removed from clinical information systems by the suppliers and at a cost to the Trust. This has been incorporated into the SystmOne mental health programme. As demonstrated from the evidence gathering

for the final submission of the IG Toolkit in March and a recent review, compliant policies and procedures for agile working, removable media, secure configuration, user access controls, system password security, malware protection, backups and restoration, patch management and firewalls are already in place.

Access to health records processes have been updated so the new timescale for compliance is set and fees are not routinely charged. Response letters have been amended to include confirmation of the lawful basis for processing the requested information. Further guidance is to follow from the ICO as it still not clear what constitutes a 'manifestly unfounded' request, for which an administrative fee may be charged, and the definition of a complex request, for which the timescale for compliance can be extended.

3. Summary & Monitoring

Audits will be completed by 30 June 2018 and action plans finalised by 31 July 2018.

Monthly monitoring meetings are being arranged to ensure appropriate progress is being made to achieve the deadline of 31st October 2018.

Arising risks and issues will be raised at the ICIG, with progress reports into the Executive Management Team and quarterly reporting to the Trust Board.

4. Conclusion and Recommendation

In conclusion the Trust has a robust approach to ensuring full compliance GDPR and has already made significant progress in this respect.

It is recommended that the Trust Board notes the work undertaken to date and that which will be completed in the coming weeks to ensure the Trust continues to strengthen its compliance with GDPR

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 June 2018

Agenda item 9 – Receipt of public minutes of partnership boards

Calderdale Health and Wellbeing Board

Date	21 June 2018
Non-Voting Member	Medical Director / District Director – Forensic, Specialist, Calderdale and Kirklees
Items discussed	➢ Single Plan for Calderdale: Calderdale Cares Update ➢ Calderdale Cares ➢ Calderdale and Greater Huddersfield Travel and Transport Review ➢ Hospital and Community Health Services Reconfiguration ➢ Active Calderdale update ➢ Calderdale Food Network
Minutes	Papers and draft minutes (when available): https://www.calderdale.gov.uk/council/councillors/councilmeetings/agendas-detail.jsp?meeting=26408

Barnsley Health and Wellbeing Board

Date	5 June 2018
Member	Chief Executive / District Director - Barnsley & Wakefield
Items discussed	➢ Local Health and Care Records Exemplar ➢ Health Protection ➢ Access to Primary Care
Minutes	Papers and draft minutes (when available): http://barnsleymbc.moderngov.co.uk/mgCommitteeDetails.aspx?ID=143

Wakefield Health and Wellbeing Board

Date	26 July 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

Kirklees Health and Wellbeing Board

Date	28 June 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

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 June 2018

Agenda item 10 – Assurance from Trust Board Committees

Audit Committee

Date	22 May 2018
Presented by	Laurence Campbell, Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	➢ Annual report and accounts and Quality Account 2017/18.
Approved Minutes of previous meeting/s for receiving	➢ To be approved at the Audit Committee meeting on 10 July 2018.

Clinical Governance and Clinical Safety Committee

Date	19 June 2018
Presented by	Charlotte Dyson, Deputy Chair / Senior Independent Director (Chair of the Committee)
Key items to raise at Trust Board	➢ Verbal update to be provided at the Trust Board meeting.
Approved Minutes of previous meeting/s for receiving	➢ Approved Minutes of the Committee meeting held on 6 February 2018 (attached). ➢ Approved Minutes of the Committee meeting held on 17 April 2018 (attached). ➢ Approved Minutes of the Committee meeting held on 15 May 2018 (attached).

Date	15 May 2018
Presented by	Charlotte Dyson, Deputy Chair / Senior Independent Director (Chair of the Committee)
Key items to raise at Trust Board	➢ Review of draft Quality Account 2018/19.

Equality and Inclusion Forum

Date	12 June 2018
Presented by	Angela Monaghan, Chair (Chair of the Committee)
Key items to raise at Trust Board	➢ Equality and diversity annual report 2017/18.
Approved Minutes of previous meeting/s for receiving	➢ Approved Minutes of the Committee meeting held on 6 March 2018 (attached).

Mental Health Act Committee

Date	15 May 2018
Presented by	Chris Jones, Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	➢ Recording of ethnicity. ➢ Bed availability and impact on our partners and patients. ➢ Lack of response of Yorkshire Ambulance Service (YAS) and Police. ➢ Section 13 increase and need to work together as Crisis Care Concordat.
Approved Minutes of previous meeting/s for receiving	➢ Approved Minutes of the Committee meeting held on 6 March 2018 (attached).

Nominations Committee

Date	20 June 2018
Presented by	Angela Monaghan, Chair (Chair of the Committee)
Key items to raise at Trust Board	➢ Verbal update to be provided at the Trust Board meeting.
Approved Minutes of previous meeting/s for receiving	➢ Approved Minutes of the Committee meeting held on 10 April 2018 (attached).

Workforce and Remuneration Committee (previously Remuneration and Terms of Service Committee)

Date	8 May 2018
Presented by	Rachel Court, Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	➢ Workforce Strategy: 2018/2019 Action Plan ➢ Organisational Development Strategy 2018/2019 Action Plan ➢ Strategic Workforce Plan – Executive Summary ➢ Human Resources Exception Report – Workforce Strategy Dashboard; Prototype
Approved Minutes of previous meeting/s for receiving	➢ Approved Minutes of the Committee meeting held on 23 March 2018 (attached).

West Yorkshire Mental Health Services Collaborative Committees in Common

Date	30 April 2018
Presented by	Angela Monaghan, Chair (member of the Committee)
Key items to raise at Trust Board	➢ Memorandum of Understanding.
Approved Minutes of previous meeting/s for receiving	➢ Not applicable as this was the first meeting of the Committee in Common.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Clinical Governance and Clinical Safety Committee held on 6 February 2018

Present:	Angela Monaghan	Chair of the Trust
	Charlotte Dyson	Deputy Chair (Chair)
	Tim Breedon	Director of Nursing and Quality
	Alan Davis	Director of Human Resources, Organisational Development and Estates
	Kate Quail	Non- Executive Director
Apologies:	Committee	
	Dr Adrian Berry	Medical Director
	Others	
	Mike Doyle	Deputy Director of Nursing
	Karen Taylor	Director of Delivery
In attendance:	Sarah Harrison	PA to Director of Nursing and Quality (author)
	Richard Norman	Project Management Office Manager
	Carol Harris	District Director – Forensic and Specialist Services, Calderdale and Kirklees
	Dave Ramsay	Deputy Director of Operations
	Sean Rayner	District Director – Barnsley & Wakefield
	Rob Webster	Chief Executive
	Julie Eskins	Assistant Director for Patient Safety
	Mike Ventress	Consultant Forensic Psychiatrist
	Karen Batty	Assistant Director of Nursing & Quality

CG/18/01 Welcome, introductions and apologies (agenda item 1)

The Chair Charlotte Dyson (CD) welcomed everyone to the meeting. The apologies, as above, were noted.

CG/18/02 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/18/03 Minutes of previous meeting held on 14 November 2017 (agenda item 3)

Charlotte Dyson (CD) asked for more focus on the discussion in the minutes. A meeting was suggested to action this.

Action: Sarah Harrison

With all of us in mind.

It was RESOLVED to APPROVE the minutes of the meeting held on 14 November 2017.

CG/18/04 Matters Arising (agenda item 4)

The action log was only on some of the Committees' Board Pads. CD asked that we ensure that the log is on all Board Pad's for future meetings. Actions from the meeting held on 14 November 17 were noted and the following matters discussed:

CG/17/90b Transition Protocol

The Committee noted the above and Angela Monaghan (AM) would welcome a discussion with Mike Doyle (MD) / Karen Batty (KB) to understand the protocol in more detail

Action: Karen Batty.

CG/17/103 Annual Reports – Safeguarding

KB informed the Committee that we are comparable with other Trusts around the Country.

CG/17/103 Ligature

Tim Breedon (TB) informed the Committee that this has been taken to EMT and actions are underway.

CG/18/05 Considerations of items from the organisational risk register relevant to the remit of the Clinical Governance & Clinical Safety Committee (agenda item 5)

CD reported that the Committee is well sighted on the 4 key risks as discussed in January Trust Board.

The Committee discussed:-

Risk ID 275. This is being picked up through the QIA report/process which will log where we think there is financial risk with the Local Authority and will be discussed in partnership forum. TB suggested further work may be needed on the stakeholder engagement position.

Risk ID 1213. AM reported that Audit Committee have some concerns and would like to be more sighted in the risk discussion to feedback

CD advised that the next Trust Board will be having a discussion regarding the differences between risk level & risk appetite, this will inform future meetings.

Action: CD to discuss with LC

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/18/06 Quality Account update (agenda item 6)

KB reported that there are some additional mandated items that we are required to report against for 2017-18, which are:

- Learning from deaths , and
- Guardian of safe working hours

In addition there is also a change to the mandated items for data quality testing. In previous years the Trust has been able to choose from 3 data items, for 17-18 mental health trusts have 4 eligible data items, early intervention in Psychosis wait times, inappropriate out of area beds, IAPT and seven day follow up. In line with the selection criteria laid out in the guidance the Trust is required to test early intervention in Psychosis wait times and inappropriate use of out of area beds. Deloitte will commence data testing week commencing 26 February (Q1-3) and finalise (Q4) in April 2018.

The local indicator that has been selected for testing is waiting times in the CAMHS Eating Disorder pathway.

Quality priorities: consultation has commenced on identifying quality priorities for 2018-19. Quality priorities from the draft Quality Strategy are being used as a 'long list' of initiatives for consultation. The Quality Improvement Group has started to discuss and develop 'meaningful measures' against these quality priorities.

Key consultations to date have been held with members of the Quality Improvement Group and Ward Managers Network. Further consultation will be undertaken in February / March. Consultation feedback will be presented to EMT with a list of quality priority recommendations.

KB advised the Committee that the Quality Account workplan is on track.

It was RESOLVED to RECEIVE the quality account progress report and NOTE the progress.

CG/18/07 Quality Strategy Development (agenda item 7)

TB informed the Committee that he had brought the latest version of the Quality Strategy for comment and challenge.

- 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 provided a framework to encourage improvement activity at all levels in the organisation.
- The section that requires most consideration is section 3, strategic objectives as it has been difficult to strike a balance between;
  a) describing our ambition and our immediate goals , and
  b) ensuring that key elements of supporting strategies have sufficient profile.
  c) keeping a simple and concise message

- Currently section 3 is closely aligned to our recent CQC quality narrative return which provides a strong summary

TB advised that the plan is to Brand the Strategy under three domains:-

- Patient Safety
- Operational Excellence
- Positive Patient Experience.

TB informed the Committee that Kate Henry (KH) as already produced some branding ideas for the Strategy. It was agreed to circulate this information

Action: Tim Breedon

AM and the Committee commented that the overall document is very good however discussed if all the details that are included are required as it remains very complex. AM also raised a query regarding the timing off priorities and if there was another way to make this clearer. TB suggested that to perhaps color code the end sections.

The Committee discussed the layout of the years and if these could be made clearer.
KB informed the Committee that the Quality Improvement Group have been considering this.

A separate implementation plan including metrics year on year would assist.

Action: Tim Breedon

AM informed the Committee that Members Council would like strengthen the service user engagement and ensure that the equality impact assessment template is followed, also to note that time is needed to address the QIA assessment. KQ agreed with the Committee that there are good system links and that Quality was threaded throughout and queried if the recommendations from the recent 360 audit were included. TB confirmed that this was the case.

Overall the Committee agreed that the Quality Strategy was a good piece of work and asked that their comments be considered and incorpoated. Committee members are invited to send any other comments to Tim Breedon.

Action: All

It was RESOLVED to RECEIVE and COMMENT on the working draft and NOTE progress to date.

CG/18/08 Transformation programme review update (agenda item 8)

Richard Norman (RN) presented the Transformation Programme update paper to the Committee. The title of this agenda item for future meetings of the committee should perhaps be titled 'Transformation and Priority Programmes Update' paper. RN informed the Committee that these update reports have developed most significantly over the last 12 months and now are wider than just transformation – it now includes transformation programme projects that are in play or nearing project completion as well as priority programmes identified in the groups of 'major transformation' and significant change' that require assessment of quality impact. This update paper also includes specific reference to benefits realisation for the Specialist Adult Learning Disability Services project and includes an updated QIA for this project. However, this report needs to gain EMT approval before submission to the committee for consideration. CH to take to EMT

Action: Carol Harris

AM queried if there was a more succinct way of presenting a summary of the QIA timetable for all the projects in the report and a RAG. RN to look into summarising the QIA schedules for all projects in one additional table in the report.

Action: Richard Norman

RW noted that we need to be careful not to go around in circles and dilute the quality of the reporting on QIAs and ensure that the committee continue to get the right information
CD requested that the post implementation review for acute & community MH comes into Committee on completion

Action: Richard Norman

It was RESOLVED to RECEIVE the report and NOTE progress.

CG/18/09 Apparent Suicide report (agenda item 9)

Mike Ventress (MV) discussed the Apparent Suicide report with the Committee. MV informed the Committee of the 27 apparent suicides reported as Serious Incidents within the Trust during the year 2016/17and explained that the purpose is to present key headline data for apparent suicide incidents to inform our understanding of what the circumstances can be for someone who tragically takes their own life. It is through better understanding and analysis that we can refine and improve the services we offer to our service users and carers. MV also provided a summary of the findings of the 2016 National Confidential Inquiry (NCI) into Suicide and Homicide.

The main findings of the 2016/17 apparent suicide analysis report are:

- The largest number of deaths (30%) occurred within the under 25 age range with 8 deaths.
- Of the acute mental health and LD providers, Kirklees has the highest rate of suicide per 100,000 service users (77.7), substantially higher than next highest, Wakefield (54) and then Barnsley (44.9).
- 48% of apparent suicides occurred within males under 35 (13 deaths).
- There has been a significant reduction of apparent suicides in females from 2014/15, although caution is needed in interpreting a single year.
- The ethnicity profile of cases has remained consistent with 70% of White British ethnic group.
- The number of service users recorded as unemployed remains high with 37% recorded as being unemployed.
- The number of service users recorded as living alone continues to be high. 27% of service users were recorded as living alone.
- The most common method of suicide continues to be hanging with 48% of deaths recorded as hanging.
- The most common location of suicide is at the patient's own home with 52% recorded at this location.
- The main diagnostic category was Schizophrenia and other delusional disorder, 22% of service users had a diagnosis of Schizophrenia, although mood disorders combined were greater than this.
- 48% of patients had a documented history of alcohol and or drug misuse.

- During 2015/16 2 inpatient deaths occurred on Trust premises.

The report is based on information gathered by the serious incident investigators and is represented in graphical and text form, with a distillation of the main themes towards the end, along with an action plan.

The findings raise questions about a number of areas, which would not ordinarily be answered by the initial information gathering and are the subject of future actions aimed at identifying areas where service provision could be improved.

These include:

- the high number of suicides by those under the age of 35. There will be a specific piece of work undertaken by the CAMHS service to understand these cases in more detail and to see whether there are any areas of service provision that can be improved as a result.

- Dr Kamal is undertaking a piece of work on drugs and alcohol, as 48% of cases had a substance misuse problem. This will relate to involvement of and liaison with misuse services.

- In line with the National Confidential Inquiry recommendation, the Trust intends to see in person those service users discharged from inpatient services within 72 hours, rather than the existing period of 7 days. The committee discussed how this might have significant resource implications for community teams, depending on the number already seen within this shorter period.

- The proportion of suicides in Kirklees is higher than would have been expected and work is underway within the BDU to examine this further. The committee agreed that it could not accept assurance in this regard until this work had been completed.

- MV also noted that over 8000 service users who are known to have suicidal ideas are in contact with the Trust on an annual basis and that an enormous amount of work goes into providing support to them and suicide prevention.

- Review of suitability of patients under IHBTTs (as per NCISH recommendations). May have resource implications if significant proportion aren't 'suitable' for care under IHBTT.

- Access to self-harm support (as per NICE guidance and NCISH recommendations). Determine clinical need and current service provided. May have resource implications if significantly less than recommended service provided currently. Linked to development of personality disorder pathway.

- Review of recently discharged patients who died by apparent suicide and specifically the quality of discharge process.

The Committee asked if other agencies are signed up to dealing with the matters raised in the report and MV informed the Committee that many other agencies are involved in suicide prevention, individually and collectively. AM queried as to whether universities are included in this. MV informed that the Local Authority have a role linking to education but was unsure if this does link into universities.

RW stated that this was a really good report but queried the figures variations by area. RW noted a missed opportunity to specifically refer to the wider context across the region of the

Care Partnership (formerly STP) suicide prevention strategy and involvement of many agencies in this regard. He advised the Committee that suicide prevention work being done across Yorkshire and Humber Alliance network – contains all agencies like local authorities and universities. MV acknowledged this wider work and that other work was ongoing in terms of the Trust suicide prevention strategy. CD asked if we link with GPs & Local Authority etc and MV indicated that in his involvement with the West Yorkshire Strategy, there had been a lack of involvement from primary care, noting that the majority of people who die by suicide are not actively under the care of mental health services.

The Committee asked when the suicide prevention strategy gets reviewed, which is December and is included in the patient safety strategy updates to the CGCSC.

A discrepancy noted on page 8 of the report, Kirklees highest rate of suicide 84.2 and table says 77.7 **(according to the figures the latter number is the correct one).**

The Apparent Suicide Analysis Report for 2016/17 has been reviewed by the Patient Safety Clinical Reference Group (for serious incidents). The Group agreed the following actions:

- An in-depth review of the patients under 35 who died by apparent suicide will be commissioned.
- Specific analysis of suicides in Kirklees will be conducted in early 2018 and the rates of suicide by BDU and presence of suicidal ideation and plans for suicide will be regular feature of reports in 2018/19.
- The cases where drug and/or alcohol was a factor will be reviewed for access to dual diagnosis services
- Review of suitability of patients under IHBTTs (as per NCISH recommendations)
- Access to self-harm support, as per NICE guidance and NCISH recommendations
- Review of recently discharged patients and specifically the quality of discharge process
- Develop a summary of themes from our report findings and those of the NCISH report 2017 for sharing within clinical services across the Trust. This has been completed.

It was RESOLVED to RECEIVE and COMMENT on the annual report on apparent suicides and NOTE the next steps identified.

CG/18/10 Waiting lists improvement plan (agenda item 10)

CG/18/10a Specialist Services -ADHD update agenda item 10.1

Carol Harris (CH) informed the Committee that this is a very high level report. CH informed the Committee that we are working with the Commissioners on the waiting lists.

There are gaps in the commissioned activity when mapped against demand in both pathways across all localities.

[redacted]

Without an increase in commissioned activity the waiting lists will expand.

AM asked about group treatments and how many were in a group as it had been reported that the numbers were quite high. CH informed the Committee that what AM was referring to had been workshop on a group treatment session and that they are voluntary attendees.

It was RESOLVED to RECEIVE and COMMENT on the report;

CG/18/10b Calderdale & Kirklees Psychological Therapy (agenda item 10.2)

[redacted]

The numbers of people referred has significantly increased and waiting times to access secondary care psychology treatment has grown as a consequence. CD asked for clarity on who has responsibility for the waiting lists and this sits SWYPFT.

AM queried if this issue was on the risk register and it was noted that it is.

Next Steps

- The CCG to lead on a whole system review of the Psychological Therapy Pathway in Calderdale to include Primary, secondary and third sector provision.
- First meeting to agree parameters of review Friday 26th January 2018
- To work with the CCG to look at referral pathways in order to the services and identify possible alternatives within the Calderdale Locality. Meeting on 8th December 2017 with CCG have now agreed an improved referral pathway between insight IAPT service and secondary care.
- Capacity now agreed to be 30 per month, effective measure now in place to manage demand from both internal and external sources.
- The trust and CCG have now agreed the profile of service users for secondary care psychology service:

  The service users who:-
  - Have complex PTSD
  - Have severe disabling OCD (obsessive compulsive disorder)
  - Suffer recurrent depression that has not responded to IAPT
  - Are ready to engage with the service

- Clarification needed on communication plan with all stakeholders

It was RESOLVED to RECEIVE and NOTE the update and planned actions.

CG/18/10c Wakefield and Barnsley Psychological Therapy (agenda item 10.3)

Barnsley

Sean Rayner (SR) Noted that there was progress in Barnsley on new referrals.

- Psychology waiting times in the Barnsley Enhanced teams have been successfully eliminated.
- An unexpected increase in referrals is noted. Expected levels are 30 referrals per month: 52 referrals per month are being received which is impacting on waiting times.

- 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 Clinical Commissioning Group (CCG) are planned to discuss this.

Wakefield

SR informed the Committee that significant progress had been made in Wakefield

- Measures implemented in Wakefield are resulting in significant improvements.
- Use of 'champions' to own the issue locally have been particularly successful.

A slight increase in waiting times in the West teams has been noted. This is due to a vacancy within the team. This has been recruited and expected to start work in April

The Committee agreed that these reports would now be received 6 monthly

It was RESOLVED to RECEIVE the NOTE the update and AGREE future report arrangements.

CG/18/11 Outcome of Care Quality Commission Inspection (agenda item 11)

KB informed the Committee on the following progress against CQC action plan:

KB identified an error in the table that she had provided. It stated that 1 should do action is red/amber and it should read 2 should do actions are red/amber.
In total 13 /15 should do actions have been completed. The 2 outstanding actions are: ILS training in Forensic services as @ 5th February the overall figure for ILS in Forensic services is 80%, however there are teams who are not meeting this target, and are rated red on the workforce performance wall, hence the amber /red rating. Significant improvement has been made on the actions in the plan between June & December. The remaining must do actions are strategic in nature. KB has discussed with Deputy Directors and the outstanding 'must do' actions are now recorded on risk registers as there are either time or resource implications required to address the issues.

The must do issues:-
3 of the 'must do' actions have been completed, the remaining 5 have action plans in place to address the issues and monitor progress.

5 outstanding actions:

- 1 action in our community services for people with learning disability or autism - Clinical risk assessments complete and accessible
- 2 actions in our acute wards for adults of working age and psychiatric intensive care units: compliance with all mandatory training and work within the guidance of MHA/MCA
- 1 action in our community mental health services for adults of working age - psychology waiting times
- 1 action in our specialist services for children and adolescent mental health services - waiting lists

All of these actions have proactive work streams in place to manage the risks and address the issues.
There is a programme of quality monitoring visits currently being undertaken to assess the application of MHA/MCA in practice. Feedback to date is that practice is variable across the

services visited. A report on the findings will be provided to MHA Committee in May 2018, however a highlight report will be available early March.

KB informed the group that as part of the well led inspection will take place between 9th- 11th April 2018. We are waiting further information from the CQC on the requirements of the inspection programme.

It was RESOLVED to RECEIVE and NOTE progress against the CQC action plan.

CG/18/12 Trust achievements (agenda item 12)

The Committee noted the considerable number of recent achievements of the Trust

The Committee suggested that any updates that are made to the document be highlighted / noted from the previous report.

Action: Jude Tipper

CG/18/13 Child and adolescent mental health services - update (agenda item 13)

The new care models work is progressing and the care navigator posts will be established from March/April 2018. Three posts will be established across the STP area and integral to ensuring the appropriateness of tier 4 admissions and the timeliness of discharge.

It was noted that work was continuing with CAMHS, adult mental health and commissioner colleagues to develop an all-age psychiatric liaison model. As part of the NHSE Winter Pressure initiative weekend working in A&E would be trialed. The intention was to base CAMHS practitioners with the mental health liaison teams to encourage joint working and ensure a more timely response to children/young people in the hospital environment.

The recent serious incidents within the service were discussed. It was noted that further work had been undertaken to ensure understanding of the procedures for prescribing unlicensed medications and for case re-allocation when consultant psychiatrist had extended periods of absence. Other actions included an audit of safeguarding practice within the Wakefield team. KQ raised a query regarding the processes for follow up of SI's and the coordination of learning. CH confirmed that each SI has a single action plan.

CYPIAPT presented an opportunity to further support professional development and skill mixing within the service. As an example Recruit to Train posts had now been established and Advanced Practitioner roles would shortly be advertised. These developments were important given ongoing difficulties in recruitment and retention.

A themed inspection of children looked after and safeguarding had recently been undertaken in Kirklees. The informal feedback had been positive with a number of good practice examples identified.

[redacted]

[redacted]

There had been a spike in referrals (including crisis referrals) across CAMHS. This placed further pressure on waiting lists. The numbers waiting more than 6 months for an intervention in Barnsley and Wakefield had increased. Although there was no national standard for CAMHS waiting times the 18 week (from referral to treatment) standard was often suggested as a proxy. At end December 2017 a total of 317 children/young people had been writing longer than 18 weeks in Barnsley and 206 on Wakefield. Only 11 Calderdale and Kirklees children/young people had been waiting for longer than 18 weeks.

RW referenced the potential value of the ORCHA App pilot and DR identified a range of other initiatives designed to improve the service offer and tackle waiting times. Dave/Carol agreed to ensure that the next update report included detail regarding the actions being taken and offer further breakdown of the waiting time data to facilitate more detailed discussion

Action: Dave Ramsay

ASC diagnostic capacity had been significantly improved in Kirklees with the service now offering 24 new assessments per month. Whilst waits were still too long there were clear signs of improvement. In Calderdale the waiting list continue to rise. An independent review of the ASC pathways had been commissioned and was expected to report in April 2018.

The excellent performance of the Barnsley service on mandatory training was noted.

It was RESOLVED to NOTE the paper.

CG/18/14 Update on topical, legal and regulatory risks (agenda item 14)

CG/18/14a Locala update (agenda item 14.1)

TB advised the Committee that he attended the Locala CQC Governance Group, Chaired by their CEO, and offered some advice. As Locala have now employed a Consultant to advise on their CQC recovery plan, future support from SWYPFT will be reduced to routine partnership advice / guidance.

CG/18/15 Issues arising from Performance Report (agenda item 15)

There were no issues to discuss regarding the IPR as already discussed at Trust Board and key items taken on this agenda.

CG/18/16 Quality Impact Assessment of cost improvement programme (agenda item 16)

TB informed the Committee that the process is well established and remains high on EMT agenda. There will be a final review in March and a more detailed report will be brought back to the next meeting in April

.

AM queried if this covers all QIA domains and TB confirmed that all domains are included.

The Committee noted the significant amount of work required to conduct the QIA in this current climate and discussed if the process could be amended without diluting the benefits. KB informed the Committee that Challenge Panels are arranged for high level QIA whilst red QIA's are discussed at OMG

The Committee asked for a more detailed report for April 2018.

Action: Karen Batty

It was RESOLVED to NOTE the update.

CG/18/17 Whistleblowing report (agenda item 17)

TB and Alan Davis (AD) gave an update on our Whistleblowing Policy which compliments the various professional codes of conduct including Freedom to Speak Up Guardians.

TB informed the Committee that we only now have one Stage 2 concern open and other matters are now closed. He explained that all who had raised a concern at stage 2 has clearly raised it for the right reason.

AD updated the Committee that he attends meeting with the Freedom to Speak up Guardians (FTSUG)regularly and that it is a learning year for us and also nationally.

There has been some good work undertaken. Caseloads are not huge with 12 people to date. All cases relate to harassment and bullying some could link to patient safety. The cases that have been raised with AD are now in other process.

The FTSUG role is to signpost and we are supporting in this. They feel comfortable with the network however finding time is proving challenging in some cases. AD agreed to look into freeing up a day a week for the Freedom to Speak up Guardians to help with this. The process is still keeping pace.

AM asked if one person leads or if there is a rotation. AD confirmed that a rotation is in place

AM informed AD that a meeting is with planned with the Governors and will make AD aware of any feedback.

Action: Angela Monaghan

It was RESOLVED to NOTE the progress to date

CG/18/18 Incident Reports update(agenda item 18)

CG/18/18a Incident report Q3 (agenda item 18.1)

Julie Eskins updated the Committee on the Quarter 3 Serious Incident Report which included the Learning from Healthcare Deaths Quarter 2 report.

Main issue is the continued increase in serious incidents in Kirklees and the BDU are undertaking a piece of work around this.

RW noted that having seen the evidence we understand the issues but need more work on understanding why Kirklees is an outlier in terms of number of apparent suicides and the Committee cannot be assured on this point at this stage.

It was agreed that a themed review of Kirklees needed to be undertaken and be brought back to the Committee

Action: Tim Breedon

Learning from Deaths Summary
The next quarter Learning from Deaths report will include a revised scope of incidents which means more will be reported, however more good practice is now coming out of the paper.

In the 2nd quarter the process will continue to be developed and refined having looked at other Trusts we are including more information throughout.

TB will be discussing the above at the DON/COO Y&H meeting where the merged approach is being reviewed.

The Committee commented that when this was first discussed at Board there was a concern of how data would be perceived publically and observed that at the moment nothing has been noted. It was noted that the HSJ sent a communication around 2 weeks ago to all trusts asking for latest data.

TB stated that he is working with the comms team in respect of reactive lines should we receive enquiries.

CD has attended the risk panel and mortality review group and is assured by the development of the process. Internal audit are reviewing the learning from healthcare deaths process and hoping to report at the end of February.

The Committee commented as follows;
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.

It was RESOLVED to NOTE the report and action required.

CG/18/18b Discussion re future SI updates (agenda item 18.2)
TB presented and shared a monthly update shown in a new format. This will then be associated with the paper sent to CD and KQ re NEDS induction. The revised approach was supported and the Committee asked TB to progress.

Action: Tim Breedon

CG/18/19 Committee Annual Report (agenda item 19)

CG18/19a Committee Annual Report (agenda item 19.1)
The Committee discussed the Annual Report which provided a summary of the Committee's activities during the financial year 2017/18 and provided assurance and evidence of its effectiveness and impact through compliance with its Terms of Reference. The Committee discussed the ToR and membership and agreed that Rachel Court could be removed as a member as she was not formally appointed as such. It was also noted that Dr Berry was to retire and that Dr Subha Thiyagesh would formally take up the position as Medical Director on the 12 April 2018. It was also noted that:

- Page 4. Equality and Inclusion CD stated that she doesn't sit on forum as Chair and needs to say member
- Learning from deaths healthcare report - the Committee queried if this was Nov 2017 and to check timing on this.
- Apparent Suicides report was received in Feb 2018

Action: Tim Breedon

CG18/19b Committee Self Assessment (agenda item 19.2)
The Committee discussed the Self-Assessment and commented on the various items and sections as follows:-

- Q4 – Review of work plan – reduce work load on the committee
- Q6 - AM - Work plan does go to board.
- Q7 - Induction for Chair and Exec Lead for Committee – needed / is it sufficient
- Members on audit and CGCS to be reviewed in the summer when membership reviewed
- Q26 Timing for meetings need to be looked at. Possible 9.30 starts.
- No don't know box – could this have been added

The information from the self assessment will inform the ToR and workplan review.

CG18/19c Work Programme (slides) (agenda item 19.3)
TB presented a draft new arrangement to the work plan with a view to sharpening our focus on improvement

He asked the Committee to consider an agenda based on the three key domains of the Quality Strategy

- Patient Experience
- Patient Safety
- Operational Excellence

The Committee was invited to think about the domains and IPR having a golden thread going through the system. A revised draft agenda was circulated and the Committee asked to feedback any comments to TB

Action: All

Committee agreed that the work plan is huge and that there is not enough time to discuss all items and potentially would like to reduce the content if possible. AD confirmed that he would like Whistleblowing and H&S to stay with CGCS.

Revised workplan to be provided at the next meeting following a discussion with the Chair of CGCS and TB

Action: Tim Breedon.

CG/18/20 Internal audit reports (agenda item 20)

CG/18/20a Quality Governance report (agenda item 20.1)

TB updated the Committee on the Quality Governance report. It is a good report and well written and assists understanding of systems in place with good links to strategies. The Committee noted the significant assurance provided by 360 thanked the team for all the work.

It was RESOLVED to RECEIVE and NOTE the positive assurance from the report.

CG/18/21 Care Quality Commission Mental Health Act visits (agenda item 21)

Process is agreed to report by exception. There were no items to report.

CG/18/22 Sub-groups – exception reporting (agenda item 22)

CG/18/22a Medicines management (agenda item 22.1)

It was RESOLVED to NOTE the report

CG/18/22b Health and Safety (agenda item 22.2

It was RESOLVED to NOTE the report

CG/18/22c Infection Prevention and Control (agenda item 22.3

TB informed that the IPC TAG may amalgamate with another group to improve attendance

It was RESOLVED to NOTE the report

CG/18/22d Safeguarding adults (agenda item 22.4)

It was RESOLVED to NOTE the report.

CG/18/22e Safeguarding children (agenda item 22.5)

It was RESOLVED to NOTE the report.

CG/18/22f Managing Aggression and Violence (agenda item 22.6)

It was RESOLVED to NOTE the report.

CG/18/22g Any feedback from other TAGs/groups (agenda item 22.7)
No update from Improving Clinical Information Group. Reported review report at the next meeting.

CG/18/23 Issues and items to bring to the attention of Trust Board (agenda item 23)

Issues were identified as:

- Quality strategy
- Apparent suicide report
- Waiting list improvement plans
- QIA CIP Position
- Audit committee review of cross committee synergies

CG/18/24 Consideration of any changes from the organisational risk register relevant to the remit of the Clinical Governance & Clinical Safety Committee (agenda item 24)

- None identified

CG/18/25 Horizon Scanning (agenda item 25)

- Well led review taking place 9-11 April 2018
- Expecting unannounced visits and will start putting together guidance and streamline the process where possible.

CG/18/26 Any other business (agenda item 26)

No further items were discussed.

CG/18/27 Date of next meeting (agenda item 27)

The next meeting will be held at 14:00 on Tuesday 17 April 2018 in Meeting room 1, Fieldhead Hospital, Ouchthorpe Lane, Wakefield WF1 3SP.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Clinical Governance and Clinical Safety Committee meeting held on 17 April 2018

Present:	Angela Monaghan (AM)	Chair of the Trust
	Charlotte Dyson (CD)	Deputy Chair (Chair)
	Tim Breedon (TB)	Director of Nursing and Quality
	Alan Davis (AGD)	Director of Human Resources, Organisational Development and Estates
	Kate Quail (KQ)	Non- Executive Director
	Dr S Thiyagesh (ST)	Medical Director
Apologies:	Committee	
	None	
	Others	
	Mike Doyle (MD)	Deputy Director of Nursing
	Karen Taylor (KT)	Director of Delivery
In attendance:	Sarah Harrison (SH)	PA to Director of Nursing and Quality (author)
	Richard Norman (RN)	Project Management Office Manager
	Carol Harris (CH)	District Director – Forensic and Specialist Services, Calderdale and Kirklees
	Sean Rayner (SR)	District Director – Barnsley & Wakefield
	Karen Batty (KB)	Assistant Director of Nursing & Quality
	Laurence Campbell (LC)	Non Executive Director
	Adrian Deakin (AD)	Forensic Security Lead/FSUG (left meeting at 2.30pm)
	Estelle Myers (EM)	Associate Practice Governance Coach/FSUG (left meeting at 2.30pm)

CG/18/28 Welcome, introductions and apologies (agenda item 1)

The Chair Charlotte Dyson (CD) welcomed everyone to the meeting. The apologies, as above, were noted.

CG/18/29 Declaration of interest (agenda item 2)

The Committee noted that there were no further declarations over and above those made in the annual return to Trust Board in March 2018 or subsequently.

CG/18/30 Minutes of previous meeting held on 6 February 2018 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the meeting held on 6 February 2018.

With all of us in mind.

CG/18/31 Matters Arising (agenda item 4)

Actions from the meeting held on 6 February 18 were noted and the action log was updated as appropriate.

CG/18/32 Considerations of items from the organisational risk register relevant to the remit of the Clinical Governance & Clinical Safety Committee (agenda item 5)

Charlotte Dyson (CD) reported that the Committee was well sighted on key risks as they had been discussed in Trust Board in some detail.

The Committee noted the 4 risks that were graded 15 and above. The Committee agreed that the risks and mitigating actions were reflected appropriately in the Clinical Governance and Clinical Safety Committee (CGCSC) agenda.

Risk ID 1078
Risk ID 1119
Risk ID 1132
Risk ID 1151

The Committee noted the risks graded 15 and below and discussed Risk 1099 (the untimely risk reports through the management reporting system for forensic CAMHS in Wetherby leading to a failure to act upon and learn from incidents). The Committee agreed this can be removed as reporting is now established.

Action: Tim Breedon

Angela Monaghan (AM) commented that the expected date of completion column has rather broad dates and would like the focus on this and be clearer on timeframes and that this applied to all risks.

Action: Tm Breedon

AM raised a query regarding out of area beds and clinical risk. AM wanted to know if this is reflected on the risk register. Tim Breedon (TB) responded to state that the impact on out of area movements should be reflected on the register which is being considered by EMT.

CD raised an issue around the implementation of the new clinical records system where the risk is assigned to the Audit Committee. CGCSC will need to understand any clinical risks that may be associated with the introduction. LC was clear that Audit Committee will be considering risks associated with performance and delivery timescales.

Action: Executive Management Team (EMT) to consider appropriate approach

LC made a general point to the Committee regarding emergent risk and spotting problems before they happen and that the risk register is backward looking. EMT will be looking to see how this can be changed or managed differently. TB advised that we have horizon scanning in CGCSC and nursing directorate to assess emerging issues.

AM reported that the risk appetite is being reviewed at Board so will have some impact on the risk register.

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/18/33 Quality Account update (agenda item 6)

TB provided a brief update to the Committee and reported that the Quality Account report is on track. Data testing is in progress and Q4 data will be available on the 23 April 2018.
The draft Quality Account was presented to the Wakefield Overview and Scrutiny Committee where positive feedback was received.

The Committee discussed the priorities at item 8 of the CGCSC agenda.

A draft of the Quality Account will be considered as a single item at the next CGCSC in May 2018.

It was RESOLVED to RECEIVE the quality account progress report and NOTE the positive progress.

CG/18/34 Planned/Unannounced Visits – Mental Capacity Act (MCA)/Mental Health Act (MHA) Quality Monitoring Visits (agenda item 7)

Karen Batty (KB) provided an overview of the paper. The purpose of this report was to look at existing care and treatment practices in supporting service users who were detained under the MHA 1983, including whether staff were working in line with recent changes to the MHA Code of Practice introduced in 2015. An overview of the findings, including areas for good practice and where improvements are needed, was included.

AM noted that there were concerns around improvement plans and would like a strong focus on this, as the CQC had picked up on this on some wards.

Committee asked to receive a progress report into future meetings via MHA Committee.

Action: Karen Batty

KB informed the Committee that the next round of planned/unannounced visits would take place within the next 6-9 months and this area will be monitored.

Good practice was noted on wards Willow and Horizon.

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

CG/18/35 Review of Quality Strategy Implementation Plan (agenda item 8)

The Quality Strategy Implementation Plan was received as part of our implementation strategy. Against each quality domain, there are a number of objectives, some of which are aspirational, and may take 2-3 years to achieve. To realise the objectives, a number of quality improvement projects, with a specified timeframe for delivery, have been identified. The progress against the projects will be revisited bi-annually, reviewed and where necessary, amended to ensure the required progress is made.

The report provides an overview of the projects. Timescales for projects will vary, depending on the availability and complexity of the improvement.

Projects will be reported into Clinical Governance Group. Progress reports will be provided into Operational Management Group (OMG) prior to being reported to Clinical Governance & Clinical Safety Committee. Projects identified for Year 1 will be monitored as part of the quality account process for 2018-19.

Quality projects will be delivered in partnership between business delivery units, support services and stakeholders. For the strategy objectives to be achieved engagement in projects from all parties is essential. A critical mass of staff will be trained, using Improvement Academy methodology, to facilitate a culture of continuous quality improvement across the organisation.

It was RESOLVED to RECEIVE the implementation plan and AGREE implementation and also AGREE priorities for the Quality Account.

CG/18/36 Care Quality Commission Action Plan and MHA Visits (agenda item 9)

The Care Quality Commission (CQC) have now visited the Trust and initial feedback has been circulated. Last week we submitted further information to the CQC to support the areas of concerns raised during their initial feedback.

The CQC will have their RAM (rating approval meeting) on the 22 May 2018 and we will review the report by w/c 29 May 2018 at the latest.

TB advised that our Relationship Manager at CQC is leaving her position and we will be gaining a new person, details to be confirmed.

The Committee extended its thanks KB and the whole team for all they did during the visits and the run up to it.

CG/18/37 Transformation & Priority Programmes Update (agenda item 10)

Richard Norman (RN) provided an update to the Committee on the Transformation and Priority Programmes report. CD thanked RN for item 10b and noted that the Committee found it useful.

RN outlined the update of quality impact assessments at the gateways as set out in the integrated change framework for each strategic priority and updated on programmes in this regard for three groups:

- 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’

As requested at the last meeting of the committee a summary of all transformation, and priority programmes (major change and significant change), that require a Quality Impact Assessment (QIA) are now presented in one summary table. This will be included in all future updates to the committee.

Carol Harris (CH) informed the Committee that a project plan for the ‘improving autism and Attention Deficit Hyperactivity Disorder (ADHD)’ priority has now been agreed and this priority will be able to report progress as from the next meeting of the committee.

CH to check the status of the out of area (OOA) priority as to whether it is a pure change project or a mix of change project/operational grip. This priority is managed through the OOA Project Board currently.

The report covers a summary of change projects through gateways but a process needs to be agreed on how to manage QIAs through those priorities that are not change related. TB to look at how these priority QIAs could be managed and reported.

Action: Tim Breedon

The Committee agreed that the Specialist Adult Learning Disability report (SALD) was a very interesting and useful report.

The Committee thanked RN for the report and the consensus was that it was very positive.

It was RESOLVED to RECEIVE the report and NOTE progress.

CG/18/38 CQC Inpatient and Community Surveys (agenda item 11)

KB informed the Committee that only the Community Survey has been produced. The national reports are published by the CQC and are publicly available. KB has replicated the report that we normally receive.

The main results indicate that overall the Trust has improved and there are no areas of risk or major concern. When comparing the results of the Trust to the national average, 68% of the results were higher, 22% were lower and 10% remained the same.

The main areas for improvement were identified as waiting times and continuity of care.

The Business Delivery Units (BDUs) have been asked to review the report, share the results of the survey and provide local action plans as appropriate.

KB to take the report through Members' Council Quality Group and BDUs after more analysis.

Action: Karen Batty

It was RESOLVED to NOTE the report and the planned actions.

CG/18/39 Trust achievements (agenda item 12)

The Committee noted the considerable number of recent achievements of the Trust, especially the Police liaison service receiving another award.

Kate Quail (KQ) asked about sharing our achievements externally and asked that our communications team (comms) ensure that our Trust Achievements are maximised with stakeholders.

Action: Communications team

CG/18/40 Issues arising from Integrated Performance report (agenda item 13)

There were no issues to discuss regarding the Integrated Performance Report (IPR) as already discussed at Trust Board and key items taken on this agenda.

CG/18/41 Update on topical, legal and regulatory risks (agenda item 14)

There were no new items to discuss from a legal perspective and MHA is being picked up within MHA Committee meeting.

TB advised the Committee that he has been invited to a national co-production workshop with CQC which will provide useful insight on any new key lines of enquiry (KLOEs).

TB advised that a discussion has taken place at the Director of Nursing/Chief Operating Officer network around the increasing acuity and demand being experienced across the system. All present agreed that it represents a real increase.

It was noted that NHS Improvement (NHSI) are alert to the shortage of psychiatric intensive care unit (PICU) beds. AM asked if this is a widespread issue as it is a problem in the North West – Rob Webster informed AM of this. TB advised that the position is similar in Yorkshire & Humber.

CG/18/42 Child and adolescent mental health services (CAMHS) - update (agenda item 15)

CH provided an introduction to the update paper and drew attention to the following;

On–call: CQC noted this issue and this has been reported previously as a challenge for CAMHS. There are actions underway to address this working with the Clinical Commissioning Groups (CCGs), hospital emergency care teams and our staff to see what service is required. Active proposals are being put forward.

CD asked how others are managing this and CH advised that contact had been made with other services, which has been incorporated.

Psychiatry on call are having similar problems where gaps are occurring - AM queried if this is attending on call, and CH confirmed this is the case. ST asked how others are managing this issue. Dave Ramsay is looking at this in detail.

The Wakefield crisis team remain challenged due to sickness and vacant posts. A new General Manager is in post and is hesitant to say that the situation has improved, but feels positive. Team has been hit hard by recent serious incidents which are subject to an external review process.

An increase in referrals was noted and requires further investigation, and the number of children waiting for an appointment is still disappointing, especially in Barnsley.

It was RESOLVED to NOTE the paper and the action planned.

CG/18/43 Quality Impact Assessment review (agenda item 16)

At the last meeting an overview was given and the Committee asked for a further report with more detail. KB has brought an example of the final QIA document which is quite in depth.

The Committee agreed that this document would be welcome at the meeting periodically, detail to be agreed.

Action: Tim Breedon/Charlotte Dyson

It was RESOLVED to NOTE the report and ongoing assessments.

CG/18/44 Annual reports (agenda item 17)

CG/18/44a Freedom to speak up Guardian annual report (agenda item 17.1)

Alan Davis (AD) gave a brief report regarding the Freedom to Speak Up Guardian (FSUG) role which has been launched nationally. When this was considered at Board it was acknowledged that a single person would not be able to manage the demands. SWYPFT decided to combine the FSUG role with that of staff governors and to review this December 2017. AD met them in January 2018 and discussed what was working and what wasn't. Adrian Deakin (staff governor and FSUG) presented the findings to Extended EMT a few weeks ago and highlighted the main issues are as follows:-

- The development of a FSUG network was felt to be the right approach
- The initial training both regionally, nationally and local was felt to be very helpful
- The dedicated page on the intranet on FSUGs was believed to be a very positive development
- The creation of a confidential email for staff was felt to be positive
- Issues raised with Chief Executive and Director of Human Resources, Organisational Development and Estates were actioned
- The role has worked, given the personal commitment of the staff governors
- The addition of a Staff Equality Network representative was felt to be positive and helpful
- Inclusion of FSUG role and names in the Trust induction was recognised as important
- Attendance at regional and national groups found to be very helpful
- Staff have been contacting the FSUGs to discuss areas of concern

Whilst the pilot on the whole was felt to be positive, there were 4 areas of concern:

- Time constraints have not allowed the proactive element of the role to develop as far as it needs to.
- Does the linking of the Staff Governors and FSUG put people off standing for the Members' Council?
- Feedback loop on returns the FSUGs make to the central team needs to improve
- Need further consideration about feedback to staff who have contacted the FSUGs

The biggest issue out of those 4 was the dedicated time to progress the role.

The outcome of the meeting was that:

- An investment of one day a week of dedicated time to be made available to one of the FSUG network from the 1st April 2018. This is designed to enable the network to develop the proactive element of the FSUG role.
- Raising concerns leaflet and Whistleblowing Policy to be updated to include FSUG network.
- Communications to support the proactive development and promotion of FSUG role
- Action plan to be developed by FSUG network for the next 6 months
- FSUG network to be reviewed again at the end of September 2018

Action: FSUG Report to CGCSC in September - Alan Davis

AM asked whether the FSUGs as a group are happy with the above and both Adrian Deakin and Estelle Myers said that the group are happy with the approach. AM thanked them for all they are doing.

It was RESOLVED to RECEIVE the report and AGREE the recommendations.

CG/18/44b Infection, Prevention & Control annual plan (agenda item 17.2)
TB updated the Committee on the Infection, Prevention & Control Annual Plan. He noted that this this report closes off the year end. TB went on to note that all policies and procedures were closed on time and that all audits had been completed. TB informed the Committee that the audit of the Antibiotic policy has been rescheduled. All training is on target and mandatory training has been maintained.

The Committee agreed that the report was well written and clear.

It was RESOLVED to NOTE the positive update and outcome.

CG/18/45 Safer Staffing update (agenda item18)

The Trust consistently meets its safer staffing requirement overall, with staffing fill rates continuing to exceed 100%, although the planned levels of registered nursing staff are not always met. This results in use of existing staff doing additional hours, bank and agency staff. Staff survey and Datix reports suggest concerns remain regarding safer staffing on wards but action throughout 2017 has resulted in increased staffing fill rates, successful recruitment of registered and non-registered staff, significant reduction in agency use and initiatives to respond quickly to areas of need.

In August 2017 NHS Improvement (NHSI) asked all trusts to complete an audit of care hours per patient day which was completed in October 2017. This will be reported monthly from May 2018. This and current plans will provide the platform from which to explore further workforce initiatives around the quality of care contact time, multi-professional approaches and use of non-registered staff.

Plans in place **to continue:**

- Building upon and improving data in exception reports
- Extending and maximising functionality within current e-rostering system as part of the centralisation programme for the trust staff bank
- Providing effective and efficient support to meet establishment templates
- Working closely with 'hotspot' wards where there is pressure on meeting staffing numbers
- Developing, managing and deploying the peripatetic workforce
- The Safer Staffing Group to monitor the action plan and new initiatives
- Working with Quality Leads to review safer staffing in the community and improve understanding and monitoring of direct care contact time
- Recruitment onto staff bank
- Aligning Safer Staffing initiatives with new Trust Workforce Strategy
- Making effective use of the awarded agency master vendor contract for both nursing and allied health professionals (AHPs).

New plans for Quarters 1 and 2 2018/19 include:

- Involvement in the development of a National acuity and staffing resource, to ensure the trust is at the forefront of any developments
- Support establishment of cohorts of staff with annualised hours within BDUs
- Develop the Medical Bank capability
- Review staff bank policy
- Expanding the bank to support other areas including admin
- Interpret and act upon NHSI Care Hours Per Patient Day (CHPPD) statistics as they are reported monthly from May 2018
- Complete establishment review and share with operational services and OMG as the basis for workforce planning going forward.
- Ensure recruitment of overseas registered staff to support the ongoing recruitment issues
- Work with OMG to review how we capitalise on opportunities arising from new national workforce initiatives (e.g. nursing associates, advanced clinical practitioners)
- Contribute to implementation of SWYPFT Retention Strategy

It was RESOLVED to NOTE the report and AGREE submission to Trust Board.

CG/18/46 Internal audit reports (agenda item 19)

CG/18/46a Learning from Deaths Internal Audit (agenda item 19.1)

TB provided a brief summary of the report. It provided the Committee with the outcome and next steps following the review by internal audit 360 Assurance. The final report was completed early April 2018 and includes the update of the learning from healthcare deaths policy. The Committee notes the position "significant assurance" provided and wanted to thank the team for all the hard work and effort that went into this. Further work is planned to improve the process further.

It was RESOLVED to RECEIVE the report and APPROVE next steps.

CG/18/47 Parliamentary and Health Service Ombudsman (PHSO) report (agenda item 20)

TB informed the Committee that this report has been to the Executive Management Team (EMT) and that this update was for information only.

EMT have already agreed to share the report throughout the Trust through BDUs to consider the learning.

The PHSO three year strategy will be announced shortly.

CG/18/48 Sub-groups – exception reporting (agenda item 21)

The Committee would like to ensure that the titles of the reports are consistent with the agenda.

Action: Sarah Harrison

CG/18/48a Medicines management (agenda item 21.1)

It was RESOLVED to NOTE the report

CG/18/48b Health and Safety (agenda item 21.2
It was RESOLVED to NOTE the report

CG/18/48c Infection Prevention and Control (agenda item 21.3
It was RESOLVED to NOTE the report

CG/18/48d Safeguarding adults & children (agenda item 21.4)
Acting named nurse complete CSEP
It was RESOLVED to NOTE the report.

CG/18/48e Managing Aggression and Violence (agenda item 21.5)
It was RESOLVED to NOTE the report.

CG/18/48e Any feedback from other Trust Action Groups (TAGs)/groups (agenda item 21.6)
No update from Improving Clinical Information Group. Review report at the next meeting.

CG/18/49 Issues and items to bring to the attention of Trust Board and other Committees (agenda item 22)

Issues for attention of the Board were identified as:

- Safer staffing
- Quality Strategy/Quality Priorities
- FSUG annual report
- Learning from deaths
- Infection prevention and control (IPC) annual report
- Out of area beds
- Internal audit

CG/18/50 Consideration of any changes from the organisational risk register relevant to the remit of the Clinical Governance & Clinical Safety Committee (agenda item 23)

- None

CG/18/52 Committee Terms of Reference (agenda item 24)

The Committee reviewed the terms of reference (ToR) and agreed some proposed minor changes. The ToR will now go to Trust Board for approval.

It was RESOLVED to APPROVE the Terms of Reference.

CG/18/52 Work Programme (agenda item 25)

It was RESOLVED to AGREE the Work Programme.

CG/18/53 Any other business (agenda item 26)

No further items were discussed.

CG/18/54 Date of next meeting (agenda item 27)

The next meeting will be held at 10.30 – 13.00 15 May 2018 in Meeting room 1, Fieldhead Hospital, Ouchthorpe Lane, Wakefield WF1 3SP. (**Quality Accounts Meeting**)

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Clinical Governance and Clinical Safety Committee meeting held on 15 May 2018

Present:	Dr Subha Thiyagesh (ST)	Medical Director
	Tim Breedon (TB)	Director of Nursing and Quality
	Charlotte Dyson (CD)	Non-Executive Director (Chair)
	Kate Quail (KQ)	Non-Executive Director
Apologies:	Members	
	Alan Davis	Director of Human Resources, OD and Estates
	Angela Monaghan	Chair
In attendance:	Karen Batty (KB)	Associate Director, Nursing and Quality
	Mike Doyle (MD)	Deputy Director, Nursing and Quality
	Carol Harris (CH)	District Director, Forensic and Specialist Services, Calderdale and Kirklees
	Sarah Millar (SM)	PA to Medical Director (author)

CG/18/55 Welcome, introduction and apologies (agenda item 1)

The Chair, Charlotte Dyson (CD) welcomed everyone to the meeting and the apologies were noted.

CG/18/56 Consideration and approval of the Quality Account 2017/2018 (agenda item 2)

Tim Breedon (TB) introduced the item and commented that due to the prescriptive nature of the requirements a public summary version would also be produced.

Action: Tim Breedon

Karen Batty (KB) presented the draft document and advised that it had been reviewed by Deloitte. KB welcomed feedback and the following was noted:

- Trajectory paper in relation to Out of Area beds to be included as a priority.
- Learning from deaths – Mike Doyle (MD) gave some background to why this had been included for this year including the recently established Mazars alliance.
- LD waiting times – Kirklees were noted as an outlier and it was agreed that this would be discussed at Clinical Governance and Clinical Safety Committee.

Action: Tim Breedon

The Committee reviewed the document and KB would make the necessary changes. The document would be checked for accuracy once all outstanding data had been included and be taken to Members' Council Quality Group on 17 May for comment. KB advised that feedback from external partners was awaited including Overview and Scrutiny, Healthwatch and the CCGs. It was noted that Angela Monaghan had provided comments prior to the meeting and these would also be taken into account.

The document would be received at Audit Committee on 22 May and at Trust Board on 24 May. The NHSI deadline is 30 May and the document would then be included on the NHS Choices website from 30 June.

It was RESOLVED, subject to the above and any minor processing amendments, to APPROVE the final draft of the Quality Account for 2017/18 and to RECOMMEND their approval to the Audit Committee as part of the Annual Report and accounts for 2017/18.

CG/18/57 Date of next meeting (agenda item 3)

The next Committee meeting will be held on Tuesday 19 June 2018 at 2.00pm in Meeting Room 1, Block 7, Fieldhead, Wakefield.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Equality and Inclusion Forum held on 6 March 2018

Present:	Angela Monaghan	Chair of the Trust (Chair)
	Tim Breedon	Director of Nursing and Quality (lead Director)
	Alan Davis	Director of Human Resources, OD and Estates
	Karen Taylor	Director of Delivery
Apologies:	Members	
	Chris Jones	Non-Executive Director
	Sean Rayner	District Director, Barnsley and Wakefield
	Rob Webster	Chief Executive
	Attendees	
	Dr Adrian Berry	Medical Director
	Aboo Bhana	Equality and Engagement Development Manager, Partnerships Team
In attendance:	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

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

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

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

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

EIF/18/03 Minutes from the meeting held on 12 October 2017 (agenda item 3)

The minutes of the previous meeting held on 12 October 2017 were approved.

EIF/18/04 Matters arising from the meeting held on 12 October 2017 (agenda item 4)

The following matters arising were discussed:

- EIF/17/30 - Zahida Mallard (ZM) advised that she has asked Aboo Bhana to consider and this could now be removed from the action log.
- EIF/17/32 - Alan Davis (AGD) advised that a list of all acting up staff across the Trust had been compiled and was being reviewed in relation to the process each had gone though. The vast majority were in clinical areas and some in in relation to maternity leave cover. The procedure around acting up in secondments would be reviewed including consideration of other career and development opportunities.

Action: Alan Davis

- EIF/17/33 - on the agenda for discussion.
- EIF/17/35 - on the agenda for discussion.
- EIF/17/38 - Tim Breedon (TB) will review with Karen Taylor (KT).

Action: Tim Breedon

- EIF/17/16 - TB advised that staff bullying and harassment incidents can be reported onto Datix, however he would need to check categories/fields for input. Claire Hartland (CHa) advised that the Forensics clinical network have been looking at Datix reports and how incidents are being reported, however it can be difficult to tell what the matter is without looking into the detail. The work of the network would inform what changes may be needed to Datix. AGD commented that some matters were being reported and recorded informally which made it hard to determine if there are themes and trends. AM commented that we need to ensure there is a clear reporting mechanism and that it is being used.

Action: Alan Davis/Tim Breedon

- EIF/17/19 - AGD advised that each Director has an element in relation to equality and inclusion within their objectives.

EIF/18/05 Feedback from BAME staff network (agenda item 5)

ZM advised that the BAME staff network was due to meet on 1 March 2018 however the meeting was cancelled due to adverse weather. The next meeting is scheduled for 31 May 2018.

AGD advised that work was underway to plan for this year's annual celebration event, including some high profile speakers. ZM commented that it would be held in black history month.

AGD advised that the first module of the Moving Forward Programme had taken place with the second one scheduled for 6 March 2018. The programme is based on the model used in Bradford. The programme is open to Mid-Yorkshire Hospital NHS Trust and Wakefield Clinical Commissioning Group staff as well as Trust staff. Feedback from the first module was really positive.

EIF/18/06 Consideration of items from the corporate/organisational risk register aligned to the Forum (agenda item 6)

TB highlighted that there was one risk on the corporate/organisational level risk register that had been aligned to the Forum to provide further assurance to the Trust Board on the controls and actions in place to mitigate the risk. This is the risk that the Trust does not have a diverse and representative workforce and fails to achieve EDS2 and WRES. AGD added that this risk was also reviewed by the Remuneration and Terms of Service Committee.

One of the issues that has been around for quite a while, and links back to the Forensic clinical network, is that BAME staff harassment and bullying from service users, carers and visitors is significantly higher than others. It is an area that stands out in the WRES and the Executive Management Team (EMT) would need to discuss and align as a workforce risk or a clinical risk.

Action: Alan Davis

ZM suggested that the establishment of the staff disability network and LGTB network be added as actions.

Action: Alan Davis

AGD commented that, through the New Horizons Project, Kirklees was where there was the greatest gap in terms of BAME staff. The project received a lot of good feedback last year. CHa commented that there was work underway with schools and through apprenticeship drives that could be added as a control.

Action: Alan Davis

TB added that the Trust also had links with universities and used to receive a report on the protected characteristics of students, however he noted that the link with the University of Huddersfield was not as strong as it was previously. Nasim Hasnie (NH) asked if the University of Huddersfield had nominated a replacement appointed governor to sit on the Members' Council. AM advised that a letter had been sent to the university following the previous governor's resignation and she would follow up on a response.

Action: Angela Monaghan

NH commented that Bradford University was ranked as one of the top universities for Nursing and Midwifery in the country and the Trust should market themselves as an employer in line with our values and policies across all of Yorkshire and Humber. AM commented that there may be opportunities to build stronger links with Bradford University in the future.

EIF/18/07 Forum annual report 2017/18, terms of reference and work programme 2018 (agenda item 7)

Annual report

EJ highlighted that when the Forum was established by the Trust Board it was initially set up as a time limited Forum. Within the Forum's Term of Reference it states that, depending on its life, the Forum should report to the Board annually on its work. The draft report has been prepared for review by the Forum prior to submission to Trust Board along with a review of its Terms of Reference and the establishment of an annual Work Programme.

The Forum discussed the annual report and requested that DES be added in addition to EDS2 and WRES.

Action: Angela Monaghan/Tim Breedon

Terms of Reference and Work Programme

EJ highlighted the Terms of Reference had been updated to reflect the current membership and align it to the wording within the Terms of Reference of the committees.

The Forum discussed and requested the following amendments:

- Noting the importance of continuing to have a dedicated Forum to discuss equality and inclusion matters, the recommendation would be to Trust Board that it becomes a standing forum rather than continuing as time limited.
- Noting the valuable contribution of NH as a governor attendee at the Forum, the recommendation to Trust Board would be that a publicly elected Governor becomes a formal member.
- DES be added in addition to EDS2 and WRES.
- NHS Equality Standards reports to be added.
- Equality Strategy update against actions to be added in October.

Action: Angela Monaghan/Tim Breedon

AGD commented that consideration would be needed on matters in relation to the Gender Pay Gap. The Forum discussed and agreed that it should be reported to the Remuneration and Terms of Service Committee and provided to the Forum for noting including any actions identified.

Action: Alan Davis

EIF/18/08 Accessible information Standard (AIS) update (agenda item 8)

TB advised that the audit against the AIS has not taken place as planned due to the Directors' Portfolio changes. It will be done as required within the calendar year and also to inform the update to the Accessible Information Policy, which is due for review in July 2018. TB will speak to Kate Henry regarding what is in the AIS as it is partly about the production of the information in different formats and also ensuring people are able to understand them.

AM asked if there were any areas where the Trust may not be meeting AIS. TB advised that an area for improvement is whether we are asking people efficiently what their needs are. ZM added that the question is on RiO and that at a EDS2 event on 5 March 2018 it was raised that the pictures used by the Trust as part of Easy Read are different to NHS England, as there is not a set standard across the system.

Action: Tim Breedon

EIF/18/09 Equality Impact Assessments update (agenda item 9)

TB reported that work has been continuing with teams to ensure EIAs are complete. EIAs can take a considerable amount of work to complete and at particular times there are several policies across the Trust that require review due to regulatory requirements, which can impact the capacity to support the process. It is important that the Trust discharges its duty as well as balancing with the amount of time it takes to complete.

ZM added that the main area for improvement is the ownership of the annual review. There are particular hot spots in Calderdale and Kirklees which may be due to there not being a local Forum. EIA can be seen by staff as a 'tick the box' exercise rather than using as a continuous improvement tool. Another area for improvement is the review of EIAs prior to policies submitted for approval.

NH commented that it was important to look at the process and compare capacity with mindset. TB advised that it would be discussed at the Operational Management Group (OMG) to provide further overview of requirement. KT commented that there was a commitment to do it and do it right and it was important to have a recap of the process so people understand the requirements.

Action: Karen Taylor

AM requested that an update on the progress be received before the next Forum.

Action: Tim Breedon / Zahida Mallard

EIF/18/10 Equality Delivery System (EDS2) update (agenda item 10)

ZM reported that the Equality Health Panel in Calderdale met on 26 February 2018, in Wakefield on 5 March 2018 and in Kirklees on 6 March 2018. The Panels were a collective of the Clinical Commissioning Groups (CCGs) and health partners working on one of the goals. This year's topic was patient experience on patient engagement. In Barnsley, an event would be held at the end of March 2018 conducted by the Trust.

The Trust had been asked for an experience or engagement activity for early insight teams to give presentations on, aiming to cover as many protected characteristics as possible. They will take these presentations to their local groups and seek feedback then come back to a grading panel. A verbal update will be provided at the next Forum meeting.

Action: Zahida Mallard/Aboo Bhana

CHa advised that a survey in relation to goals 3 and 4 had been circulate to Extended Executive Management Team members and placed in The Headlines communication to staff. The survey was open to all members of staff to take part.

AM asked what the attendance had been like at the panels that had taken place to date. ZM advised that the panels were not representatives of protected characteristics, which is a matter for commissioners. Previously the attendance had been better when the Trust organised the events as independently led. TB advised that this would be raised through the local Quality Boards.

Action: Tim Breedon

EIF/18/11 The Insight Programme update (agenda item 11)

AM advised that the current two participants of the programme run by Gatenby Sanderson finished their attachment with the Trust as of 2 March 2018. Feedback has been requested through an appraisal framework.

NH asked if feedback could be provided from participants about what they observed during their time with the Trust and what benefits the programme has had for them.

Action: Angela Monaghan

EIF/18/12 National issues and impact locally (agenda item 12)

AGD commented that the pay gap was a national issue as discussed previously.

ZM commented that NHS Employers had published a NHS Women on Boards document, which shows discrepancies including Finance Directors being low in relation to women in roles. AM commented that the last three appointments to the SWYPFT Board had all been female.

EIF/18/13 Any other business (agenda item 13)

No further items were discussed.

EIF/18/14 Consideration of any changes to the corporate/organisational risk register relevant to the remit of the Forum (agenda item 14)

No further changes were discussed.

EIF/18/15 Items to bring to the attention of Trust Board (agenda item 15)

These were agreed as:

- Annual report, terms of reference and work programme.

EIF/18/16 Date of next meeting (agenda item 16)

The next meeting will be held at 3.00pm on 12 June 2018 in Meeting room 1, Block 7, Fieldhead, Wakefield.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of the Mental Health Act Committee Meeting held on 6 March 2018

Present:	Dr Adrian Berry	Medical Director (lead Director)
	Chris Jones	Non-Executive Director (Chair)
	Laurence Campbell	Non-Executive Director
	Kate Quail	Non-Executive Director
	Salma Yasmeen	Director of Strategy
Apologies:	Members	
	Tim Breedon	Director of Nursing and Quality
	Attendees	
	Andy Brammer	Mental Health Act Professional Lead (Wakefield) – 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
	David Longstaff	Independent Associate Hospital Manager
	Victoria Thersby	Head of Safeguarding (Calderdale and Kirklees) – acute trust representative
	Stephen Thomas	MCA/MHA Team Manager (Wakefield) – local authority representative
In attendance:	Shirley Atkinson	Professional Development Support Manager (Barnsley) – local authority representative
	Julie Carr	Clinical Legislation Manager
	Yvonne French	Assistant Director, Legal Services
	Carol Harris	Director of Forensics, Specialist Services, Calderdale and Kirklees
	Sarah Millar	PA to Medical Director (author)

MHAC/18/01 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 due notice had been given to those entitled to receive it and that, with quorum present, the meeting could proceed.

There were no declarations of interest to record.

MHAC/18/02 The Act in Practice (agenda item 2)

This item was deferred to the next meeting.

MHAC/18/03 Legal update/horizon scanning (agenda item 3)

MHAC/18/03a Implementation of 135 & 136 Mental Health Act 1983 (agenda item 3.1)

Yvonne French (YF) reported that following implementation of the changes to Section 135 & 136 in December 2017, there had been a decrease in SWYPFT places of safety, however despite initial concerns of a lack of capacity, this had not been an issue. YF advised that

weekly West Yorkshire STP meetings were addressing any concerns. It was noted that there had been recent improvements in police liaison and training in both West and South Yorkshire and this had had a positive impact. YF added that there appeared to be an increase in the use of A&E in Wakefield with police using the Mental Capacity Act rather than Section 136. CJ summarised that the new rules had had unintended consequences and the Committee would continue to monitor this. The Committee could take some assurance that any issues were being addressed through formal and informal channels.

It was RESOLVED to NOTE the update.

MHAC/18/03b Trust response to Independent Review of the MHA consultation (agenda item 3.2)

Julie Carr (JC) reported that the Independent Review of the MHA 1983 was put out to consultation with a call for evidence and views. The Trust submitted a response, which has been accepted by the Independent Review.

The following were noted to be themes raised nationally:

- Rising rates of detention under the Mental Health Act
- The disproportionate number of people from black and minority ethnicities detained under the Mental Health Act
- Stakeholder concerns that some processes relating to the act are out of step with a modern mental health system
- The balance of safeguards available to patients, such as tribunals, second opinions, and requirements for consent
- The ability of the detained person to determine which family or carers have a say in their care, and of families to find appropriate information about their loved one
- That detention may in some cases be used to detain rather than treat
- The time required to take decisions and arrange transfers for patients subject to criminal proceedings.

YF added that previous minute MHAC/17/44b referred to the potential for SWYPFT to engage in the review and JC had been approached by the Royal College of Occupational Therapists. Agreement had been made with Adrian Berry (AB) that it was appropriate for JC to take a seat on the advisory panel and the initial report is due in May.

It was RESOLVED to NOTE the briefing.

MHAC/18/03c Trust response to NICE guidelines Decision-making and capacity consultation (agenda item 3.3)

JC reported that the Draft NICE Guidelines for Decision-making and Capacity were published for consultation. The Trust submitted a response, which has been accepted by NICE. It was noted that there had been the second largest number of responses to NICE on this occasion, in excess of 1,200 and the expected launch date was in May. CJ queried if there were any issues and JC indicated that it been suggested that service users and carers should be involved in delivering training. It was noted that with around 4,500 members of staff involved in mandatory training, a solution that was both realistic and fair to service users and carers was being explored including the use of statements, videos, etc.

It was RESOLVED to NOTE the briefing.

MHAC/18/03d Transforming Children and Young People's Mental Health Provision: a Green Paper (agenda item 3.4)

JC reported that on 4 December 2017, the Department of Health and Department of Education presented to Parliament the green paper outlining the government's proposals for the transformation of mental health services for children and young people. The proposal is that support will be given to local areas to adopt an ambitious new collaborative approach to provide children and young people with an unprecedented level of support to tackle early signs of mental health issues. This approach has three key elements:

- To incentivise every school and college to identify a Designated Senior Lead for Mental Health to oversee the approach to mental health and wellbeing. All children and young people's mental health services should identify a link for schools and colleges. This link will provide rapid advice, consultation and signposting.
- To fund new Mental Health Support Teams, supervised by NHS children and young people's mental health staff, to provide specific extra capacity for early intervention and ongoing help. Their work will be managed jointly by schools, colleges and the NHS. These teams will be linked to groups of primary and secondary schools and to colleges, providing interventions to support those with mild to moderate needs and supporting the promotion of good mental health and wellbeing.
- There will be a trail of a four week waiting time for access to specialist NHS children and young people's mental health services.

JC added that there had been some concerns raised in relation to funding and how four week waiting times were measured. CJ indicated that this is relevant to Clinical Governance and Clinical Safety Committee and Carol Harris (CH) agreed to include it in the paper for that Committee.

It was RESOLVED to NOTE the briefing.

MHAC/18/04 Minutes of previous meetings held on the 21 November 2017 and 19 December 2017 (agenda item 4)

It was RESOLVED to APPROVE the notes of the meetings held on 21 November 2017 and 19 December 2017 as true and accurate records of the meetings.

MHAC/18/05 Matters arising (agenda item 5)

MHAC/18/05a Action points (agenda item 5.1)

The action points were noted and three items raised:

- MHAC/17/47a – AB advised that activity levels are reported as part of the Quality Report.
- MHAC/17/47a – TB would check the status of the E&I Forum report.

Action: Tim Breedon

- MHAC/17/49a – CH was in attendance and provided an update on Audit and Compliance reports. It was noted that audit reports were available for all inpatient areas apart from Forensics, which were due. In relation to patient rights, rights are revisited and a care plan put in place for any service users who have difficulty understanding. CH added that the BDUs were broadly compliant and were addressing outstanding areas of compliance. CJ suggested that a summary report should come to Committee so members could be reassured that the Trust was compliant and plans

were in place to review compliance. CH would provide a summary report to the next meeting.

Action: Carol Harris

The Committee discussed audits and AB indicated that there were many good examples of audits of the Mental Health Act being undertaken across the Trust. CH suggested agreeing a standard programme of audits across each area, however AB indicated that a many audits are undertaken out of local interest or need although it would be useful to draw together what is being done.

LC queried how this links to clinical audits and CJ indicated that themes such as recording of assessments for capacity and patients right had been picked up through the unannounced visits programme and the CQC were aware.

CJ suggested that the Committee would welcome updates from services outside of the formal audit reporting.

MHAC/18/05b Consideration of items from the organisational risk register relevant to MHA Committee (agenda item 5.2)
AB advised that following discussion at the recent Board meeting, there were no items identified as relevant to the Mental Health Act Committee.

CJ raised staffing in general as a potential risk to the Trust's ability to discharge its responsibilities under the Mental Health Act. CH suggested that Section 17 leave represented the biggest risk, however plans were in place to manage this operationally, including managing service users' expectations. YF added that Karen Batty was developing some Standard Operating Procedure style guidance to be used alongside the Trust's guidance.

MHAC/18/06 Statistical information use of the Mental Health Act (MHA) 1983 and Mental Capacity Act (MCA) 2005 (agenda item 6)

MHAC/18/06a Monitoring information Trust Wide October-December 2017 (agenda item 6.1)
JC reported the following:

- Use of Part 2 and 3 of the MHA – it was noted that there were a couple of exception reports per quarter and consideration needed to be given to how to deal with them.
- There was one use of Section 4 in Quarter 3.
- Whilst the number of requests for Section 49 activity had appeared to decrease, the complexity had increased and multiple reports had been requested in one case.
- Hospital Managers Appeals activity continued to show a very low frequency of appeals with around half of all applications being cancelled prior to the hearing occurring and only a third achieving a hearing. Laurence Campbell (LC) queried this and JC acknowledged that there had been quite a dramatic decrease with a similar picture for Tribunals. It was unclear as to why, however length of stay was reducing so it was possible that service users were not reaching the point to make an application.
- Deprivation of Liberty – CJ queried why the total approved and refused did not total the number applied for. JC indicated that in some cases the patients were discharged or transferred prior to the assessment and there was also a backlog in the processing of responses from the local authority DOLS office. JC advised that these were being followed up as SWYPFT had a statutory obligation to report outcomes to the CQC. CJ suggested a more indepth review of DOLS applications and AB suggested waiting until

the Quarter 4 figures were available as the majority of applications related to Mount Vernon Hospital and it had now closed.

- There were 12 under 18s admitted to 136 suites in the last Quarter and YF advised that this was being addressed.
- The revised process for review of timely SOAD attendance continues to be effective but a further step in the escalation process has been agreed for timely receipt of certificates following SOAD attendance.
- Whilst internal transfer activity had reduced over Q3 there remained a high use of internal transfers, particularly in respect of the Priestley Unit and The Dales. AB added that there was the potential for activity to increase in the next Quarter although the majority of transfers were internal moves, back to their own areas. YF raised that there had been some issues with Tribunals being cancelled if service users were moved and it was agreed that this should not happen.
- 15% of people who are currently accessing The Trust's mental health services do not have ethnicity recorded (up from 12% in 2016/17 Q4). 10% of new admissions (down from 11% in Q4) and 9% of new detentions (down from 10% in Q4) did not have ethnicity recorded. (figures unchanged from Q2 report). CJ raised that this was a recurring theme and one that had the potential for ethnic minority groups to be disadvantaged. CH suggested that it was more of a systematic issue and may be addressed upon migration to SystmOne. OMG has been asked to consider a business process review of how ethnicity is recorded.

CH indicated that it would be useful for the BDUs to have sight of the Information Overview Report and YF advised that it had been copied to deputy directors in the last two Quarters for comment prior to coming to the Committee. CH will take the report to OMG.

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.**
- **MHA Committee continue to request feedback from the BDU's for insights to clinical reasons which may impact on MHA and DoLS activity.**
- **For the BDU's to consider if there are any clinical reasons to explain the decreasing trend for applications to appeal detention.**
- **Approve a review by the BDU's of internal transfer activity to and from The Dales and Priestley Unit.**

MHAC/18/06b Local Authority Information (agenda item 6.2)
The following updates were provided:

Barnsley – Shirley Atkinson (SA) reported that 5 under 18s had been admitted under Section 136 in Barnsley. SA talked about the logistics of 136 assessments and indicated that the position was being monitored.

Kirklees – YF indicated a large amount of activity in Kirklees. It was noted that no cases were reported as having community follow up by psychiatric services and 96 cases were noted as requiring no further action. AB suggested that this could be a recording issue and YF will follow this up.

Action: Yvonne French

Wakefield – YF reported that Angela Monaghan had attended a meeting in Wakefield recently on the subject of advocacy services and that Wakefield were reviewing how they

commission all advocacy services and considering one provider for all. It was noted that different local authorities go out to tender at different times.

MHAC/18/07 CQC compliance actions (agenda item 7)

MHAC/18/07a 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. West Yorkshire have agreed a document on the STP footprint.
- 136 policy – further draft dated July 2017. YF advised that this should be signed off by the next Committee in May.
- Police assistance for people undertaking MHA assessments – transporting patients policy. Draft waiting sign off by all agencies
- Joint local polices for admission to hospital – been to Clinical Governance and Clinical Safety Committee and now to OMG.
- Local Partnership arrangements to deal with people experiencing mental health crisis. 136 policy Draft and Standard Operating procedure for place of safety. It has been agreed that this would go to Clinical Governance and Clinical Safety Committee and then to OMG for final sign off.

CJ noted the good position and progress made.

It was RESOLVED to NOTE the update.

MHAC/18/07b MHA/MCA/DoLS mandatory training update (agenda item 7.2)

YF reported the current position as:

- Mental Capacity Act/DoLS training – 91.14% compliant
- Mental Health Act training – 86.63% compliant

YF had reviewed the bookings for the next three months and noted around 400 people left to train across the organisation. This was being monitored through L&D and addressed through OMG.

Future work:

- Tier 2 MCA e-learning package has been completed and is available. The potential to sell the training was noted and also to develop Section 2 training.
- Trust development of an e-learning package for Mental Health Act refresher training (there is currently no national programme). YF advised that new starters would still do face to face training then e-learning refreshers which would be available by the summer.
- A new training programme has been developed and would be available from January 2018-March 2019.
- Changes to Deprivation of Liberty are being considered by ministers – scoping out mandatory training requirements.
- Changes to Mental Health Act being considered following the Queens speech – monitoring for impact on new training programme. It was noted that if re-training is necessary, this could be done through e-learning or by leaflet depending on how significant the changes were.

CJ acknowledged the significant achievements and asked that people consider if there was anything else the Committee should be turning its attention to in relation to training. In particular, anything that represented a potential risk because we cannot evidence that people had been trained, eg local induction and seclusion.

It was RESOLVED to NOTE the update.

MHAC/18/08 Audit and Compliance Reports (agenda item 8)

MHAC/18/08a Mental Health Act Committee annual report to Trust Board (agenda item 8.1)

- Committee annual report 2017/18
  YF would provide an update to Emma Jones to include the following:
  - All Associate Hospital Managers receive a one-to-one review with a non-executive member of the Committee.
  - There had been no recruitment of Hospital Managers this year.
  - CJ suggested that it did not give a good impression to include information about changes to IR35 rules, annual pay uplift, trialling of e-expenses, etc but rather include a list of training provided to Hospital Managers.
- Committee self-assessment
  CJ requested that members who had not yet completed the self-assessment to do so.
- Committee Terms of Reference
  - Updated membership was agreed.
  - There were no sub-committees of the Mental Health Act Committee.
- Committee annual work programme 2018/19
  - YF advised that the programme included in the papers was not the most recent available and same would be circulated.

    Action: Yvonne French
  - CJ referred to recent presentations by services in relation to the Act in Practice and suggested that it would also be useful for colleagues to reflect on the audit schedule relevant to the Committee to provide assurance.

It was RESOLVED to note the annual report to Trust Board

MHAC/18/08b Section 17 Leave audit (agenda item 8.2)

Care Quality Commission (CQC) visits continue to routinely identify issues with compliance with the recording requirements of the Trust policy and the MHA 1983 Code of Practice for Section 17 leave.

The conclusions of the audit are;

- That the recording of Section 17 leave on the RiO template, as identified in the Trust policy is applied inconsistently with only 39% of leave being recorded in this manner, although this was the most frequently identified recording option.
- There was a high standard of maintenance of up to date Section17 leave forms available, with only 2/46 being identified as out of date.
- There was a consistently high standard of compliance with recording requirements by the RCs.
- There was inconsistent compliance with the recording requirements of page 2 of the Section 17 leave form. Forensic services identified that 77% of all active forms were signed by the patient and 85% signed by the nurse. This was in contrast to the acute wards reporting only 24% signed by the patient and 30% signed by the nurse.

AB raised that compared to previous audit reports and CQC reports, the position was now much stronger with a very high level of compliance with statutory reports to the CQC. The issue of not completing the second side of the Section 17 leave form, however, needed to be addressed. YF reported involvement in a Section 17 Task and Finish Group to focus on this and advised that the form was now on RiO. The doctor signs the first side and then nursing staff can do the second side electronically. Guidance notes would also be issued to staff.

JC suggested an amber risk rating given that there was a clear plan to address the issues.

The Committee RESOLVED to NOTE the audit findings and APPROVE the following recommendations:

- **That further guidance to support nursing staff to comply with the clinical requirements of the Trust policy be developed and implemented.**
- **For the BDUs to prepare action plans to ensure continued good practice of the RCs and improve practice for the nurses' recording requirements.**
- **For the Section 17 leave audit to remain on the MHA Committee annual work plan.**
- **MHA Committee support an AMBER risk rating for this audit.**

MHAC/18/08c Audit of MHA by Elaine Dower (internal audit) action plan (agenda item 8.3)

YF reported that a review had recently been completed by 360 Assurance in respect of the Trust's MHA Governance arrangements. The review examined the effectiveness of controls in place and was undertaken in accordance with the Public Sector Internal Audit Standards. It was noted that 360 Assurance were new to this Trust and the process had not been entirely straightforward, however there were some very useful themes that had come out of the report. The report provided significant assurance to the Committee with two main areas for improvement. An action plan had been developed to address these areas. The action plan would go to the next Audit Committee on 9 April.

CJ referred to the action plan and the following was noted:

- Clarity was required on how the Committee RAG rates risks and provides assurance to the Board. CJ indicated that the MHAC need to ensure a consistent approach with other committees and it was agreed that an amber rating would only be accepted if there was a clear plan to address any risk.
- In relation to partnership working and inviting police and ambulance service attendance, AB suggested that this should be by exception if the Committee required assurance and representatives could then be formally invited.

It was agreed that the Committee were content with the report and action plan. The action plan would remain as a standing item and be reviewed after Audit Committee.

The Committee RESOLVED to NOTE the summary report and action plan

MHAC/18/09 Care Quality Commission visits (agenda item 9)

MHAC/18/09a Visits and summary reports received in Quarter 3 (agenda item 9.1)

JC reported that there were 2 CQC Mental Health Act visits in Quarter 3 to; Elmdale and Ward 18.

Within the quarter, 4 MHA monitoring summary reports were received relating to visits made to; Appleton Ward (Newton Lodge), Ward 18, Elmdale and Chantry.

6 responses were submitted to the CQC; Melton Suite, Enfield Down, Appleton Ward (Newton Lodge), Ward 18, Elmdale and Chantry. Three were submitted in accordance with the timeframes set by CQC. 3 extensions were requested and the submissions made within the agreed revised timeframe.

The Committee received detailed information about the outstanding issues.

The Committee discussed that recommendations were being addressed and the current position was generally positive.

It was RESOLVED to NOTE the update.

MHAC/18/09b 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. Following the trial at Newton Lodge the Trust has been successful in gaining fast follower status for the deployment of NHS WiFi (patient/service user & public access to internet etc.) across the Trust estate. In support of this a list of sites that are considered to be in-scope for this project which has been reviewed by BDU Management. The criteria being that NHS WiFi access is to be provided in all areas where regular/frequent patient facing contact is undertaken. The fast follower status comes with tight timescales the work needs to be completed 31 March 2018.
- 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 Peoples Services.

YF reported that there are no red actions in Barnsley and Wakefield BDUs but 14 ambers including:

- Internet S
- Section 17 leave
- Environment
- Care planning
- Blanket restrictions

There was also 1 green action.

In Calderdale and Kirklees, there are no red actions but 13 amber including:

- Internet
- Care planning
- Reiteration of patients' rights
- Lockable storage
- Gender separate areas
- Perspex window in seclusion room
- Referral to an IMHA
- Lockable storage

And 6 green actions.

There are no red actions in Forensics and Specialist Services but 8 amber including:

- Internet
- Observation panel
- Auto referral to IMHA service
- Non-compliance with seclusion policy (recording and review)
- Missing treatment certificate (no paper copy with medicine card)

And 1 green action relating to cancelled Section 17 leave audit completed.

The Committee agreed that the update provided assurance that issues were being progressed operationally.

It was RESOLVED to NOTE progress.

MHAC/18/10 Partner agency update (agenda item 10)

MHAC/18/10a Hospital Managers' Forum Notes 8 December 2017 (agenda item 10.1)
There was no attendance from Hospital Managers. The forum notes were accepted by way of update.

It was RESOLVED to NOTE the update.

MHAC/18/10b Hospital Managers' Concerns – October-December 2017 (agenda item 10.2)
The concerns were noted by way of update.

It was RESOLVED to NOTE the update.

MHAC/18/10c Compliments, Complaints/Concerns in relation to the Mental Health Act, October-December 2017 (agenda item 10.3)
It was noted that one complaint had been raised in Quarter 3 by a relative of a service user. YF updated that the service user would not consent to the complainant having information and as such, the matter had not been dealt with as a formal complaint. There had been social worker involvement with the service user and full engagement with the family and service user.

It was RESOLVED to NOTE the update.

MHAC/18/11 Partner agency update (agenda item 11)

MHAC/18/11a Local Authority (agenda item 11.1)
There was no local authority update.

MHAC/18/11b Acute Health Care (agenda item 11.2)
There were no acute health care representatives present.

MHAC/18/12 Consideration of any changes to the organisational risk register relevant to the remit of the MHA Committee (agenda item 12)

There were no relevant items to note.

MHAC/18/13 Key Messages to Trust Board (agenda item 13)

The key issues to report to Trust Board were agreed as:

- Section 136 changes not affecting the Trust as expected (MHAC/18/03a)
- Recording of ethnicity (MHAC/18/06a)
- Review of internal audits – what audits come to Committee and ensure correct coverage (MHAC/18/05a)

- OMG – strengthening work of the Committee in the Trust
- Young people in 136 suites in the last Quarter (MHAC/18/06a)

CJ took the opportunity to thank AB for his support as lead director to the Committee ahead of his retirement.

MHAC/18/14 Date of next meeting (agenda item 14)

The next Committee meeting will be held on 15 May 2018 in Meeting Room 1, Block 7, Fieldhead Hospital, Wakefield from 2.00-4.30pm.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of the Nominations' Committee held on 10 April 2018

Present:	Angela Monaghan	Chair of the Trust (Chair of the Committee)
	Marios Adamou	Staff elected governor, medicine and pharmacy
	Jackie Craven	Lead Governor (Publicly elected governor, Wakefield)
	Ruth Mason	Appointed governor, Calderdale and Huddersfield NHS Foundation Trust
	Rob Webster	Chief Executive
Apologies:	Nasim Hasnie	Publicly elected governor, Kirklees
In attendance:	Alan Davis	Director of Human Resources, Organisational Development and Estates
	Emma Jones	Company Secretary (author)

NC/18/09 Welcome, introduction and apologies (agenda item 1)

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

NC/18/10 Declarations of interest (agenda item 2)

There were no further declarations over and above those made in the annual return at Trust Board in March 2017 and Members' Council in April 2017 or subsequently.

NC/18/11 Minutes of and matters arising from previous meeting held on 22 February 2018 (agenda item 3)

It was RESOLVED to APPROVE the minutes from the meeting on 22 February 2018. All matters arising from the meeting were complete.

NC/18/12 Update on Non-Executive Director (NED) recruitment (agenda item 4)

AM commented that she was pleased that the Nominations Committee had agreed at their last meeting that options for internal recruitment support could be considered, and confirmed this approach was agreed following discussion with Alan Davis (AGD). AM highlighted the following:

- Recruitment commenced from 29 March 2018 and the closing date for applications is 7 May 2018.
- The role has been advertised in the Guardian and Yorkshire Post online and through the NHS Improvement and Cabinet Office websites.
- A dedicated page on the Trust's website has been created with promotion through social media.
- An email was sent to the Board, Members' Council and stakeholders asking them to promote the vacancies with their networks.
- An email was sent to Gatenby Sanderson who run The Insight Programme who have placed information on the programme webpage.

- The first recruitment/information event was held in Kirklees at Folly Hall in Huddersfield on 3 April 2018. Three potential candidates attended and had informal discussions with members of the Board and two governors who were in attendance. The next events will take place in Calderdale at Laura Mitchell on 12 April 2018, Wakefield at Fieldhead in Wakefield on 17 April 2018, and Barnsley at Kendray in Barnsley on 24 April 2018.

AGD advised that enquiries received to date from potential candidates included whether they were able to apply if they lived outside the Trust's footprint. In accordance with the Trust's Constitution, to be eligible applicants must live within a Trust membership constituency.

AGD commented that through the discussion on an internal recruitment process, one of the gaps identified was that the Trust did not have a database of candidates to access that an external recruitment consultancy would have. It was important to continue to use our networks to promote the role wherever possible. A reminder will be sent to the Board regarding using whatever opportunities they have to promote the roles.

Action: Angela Monaghan / Emma Jones

It was RESOLVED to NOTE the update provided.

NC/18/13 Deputy Chair / Senior Independent Director recommendation to Members' Council (agenda item 5)

AM reported that the current Deputy Chair / Senior Independent Director, Charlotte Dyson, (CD) was appointed for a twelve month period from 1 August 2017. Subject to her re-appointment as a Non-Executive Director (NED), she recommended that CD be re-appointment into the role for a further two years. CD had performed well in the role and was keen to continue. CD has all the right qualities and skills to fulfil the role and has gone above and beyond the requirements including her time commitment to the Trust. The re-appointment would provide the Board with continuity.

Jackie Craven (JC) commented that CD was ideal for the job and was very approachable and personable.

Marios Adamou (MA) commented that the previous Chair wanted the Deputy Chair / Senior Independent Director to be different in personality and skills to themselves as they felt that would help them in their role as Chair, and that had influenced the appointment decision previously. However, this was their personal preference and not a requirement. AM commented that she felt there could be better challenge when there was a strong, positive relationship build on trust and open communication and she was confident that CD could challenge her as well as any of the NEDs.

RW commented that CD was good at challenging in the appropriate way and displayed all the right leadership behaviours and values. RW asked if there were considerations of whether there is a potential conflict being both Deputy Chair and a Senior Independent Director. AGD commented that, prior to 2017, there had not been a job description or a Deputy Chair, however there was a Senior Independent Director. The only criteria was that the Senior Independent Director had to be a NED and it was felt that knitting the two roles together made sense and gave seniority to the role. AM commented that an important quality was that they needed to be capable of acting independently and the wording in the job description should be updated to "is able to act independently of the Chair on behalf of the organisation" and ensure it is consistent with any wording within the Trust's Constitution. The Committee discussed and agreed that the document be called a "role description" rather than a job description.

Action: Alan Davis / Emma Jones

The Committee discussed who should complete the appraisal of the Deputy Chair / Senior Independent Director. AGD commented that the NED / Deputy Chair roles' appraisal would be conducted by the Chair, and the Senior Independent Director aspect could be led by the Lead Governor. Role description to be updated in terms of accountabilities for each part of the role.

Action: Alan Davis / Emma Jones

The Committee discussed and supported that CD meets all the essential criteria and desirable criteria, including dispute resolution.

It was RESOLVED to SUPPORT the recommendation to the Members' Council to:

- **REAPPOINT Charlotte Dyson as Deputy Chair / Senior Independent Director for a period of two years from 1 August 2018, subject to her reappointment as a Non-Executive Director; and**
- **UPDATE role description / person specification as discussed.**

NC/18/14 Any other business (agenda item 6)

No further items were discussed.

NC/18/15 Issues and items to bring to the attention of Trust Board / Members' Council (agenda item 7)

Issues were identified as:

- Update on Non-Executive Director (NED) recruitment
- Deputy Chair / Senior Independent Director recommendation to Members' Council

NC/18/016 Date of next meeting (agenda item 8)

The next meeting will be held on Wednesday 20 June 2018 from 10.30am to 12noon in Room 7, Block 7, Fieldhead, Wakefield.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of the Remuneration and Terms of Service Committee held on 26 March 2018

Present:	Rachel Court	Non-Executive Director (Chair)
	Angela Monaghan	Chair of the Trust
	Rob Webster	Chief Executive
Apologies:	Charlotte Dyson	Non-Executive Director
In attendance:	Alan Davis	Director of HR, OD and Estates
	Janice White	PA to Director of HR, OD and Estates (author)

RTSC/18/1 Welcome, Introductions and Apologies (agenda item 1)
The Chair, Rachel Court (RC) welcomed everyone to the meeting. An apology was received from Charlotte Dyson, however, RC said she had received some comments from her on some of the items.

RTSC/18/2 Declaration of Interests (verbal item)
There were no further declarations over and above those made in the annual return to Trust Board in March 2018 or subsequently.

RTSC/18/3 Minutes of the meetings held on 30th October 2017 and 19 December 2017 (agenda item 3)
It was RESOLVED to APPROVE the minutes of the meetings held on 30th October 2017 and 19th December 2017.

RTSC/18/4 Matters arising (agenda item 4)

The Committee discussed the schedule of matters arising and the following points were made:

a. RTSC/17/41 Minutes of the meeting held on 23 May 2017
RC confirmed she will provide a confidential minute of the discussion on the Chief Executive's appraisal.

Action: Rachel Court

b. RTSC/17/51 Recruitment of NEDS to sit on Appeals and Consultant Recruitment Panels
Alan Davis (AGD) confirmed the staff side very much valued Non-Executive Directors (NEDs) being the Chair of Appeal panels as they are seen to be impartial. It was suggested by the Committee that as part of their succession planning Governors could be approached to sit on Consultant recruitment panels. AGD agreed to speak to Subha Thiyagesh (ST), newly appointed Medical Director regarding this.

Action: Alan Davis

c. RTSC/17/62 ET Outcomes to come to RTSC
This is covered under a separate agenda item. It was also agreed by the Committee this be added to the Work Programme.

Action: Alan Davis

d. RTSC/17/63 Workforce Risk Register
Covered under separate agenda item

e. RTSC/17/70 Medical Director Recruitment – circulation of pay on Medical Director remuneration
This was completed and noted by the Committee

RTSC/18/5 Workforce Strategy: 2017/2020 Action Plan

It was agreed at a previous meeting to bring an update report to each meeting. AGD summarised the report. He mentioned that the one outstanding issue was coaching and that this had not progressed as quickly as would have liked and that this will roll over into quarter 1 18/19. AGD highlighted that a pilot Middleground Programme has been run with good feedback. The focus of this Middleground is healthy teams which include equality, harassment and bullying and staff engagement. RC asked if she can see an outline of the programme. AGD said that following the pilot there are some changes to the programme and once the finalised he will circulate it. It was confirmed that the Trust Board Question and Answer session will be part of the finalised Middleground Programme.

Action: Alan Davis

In relation to the Freedom to Speak Up Guardians (FSUGs) Pilot, AGD mentioned that the FSUGs met with the Executive Management Team on Thursday 22nd March and are also presenting to the Extended Executive Management Team on Thursday 29th March. The FSUGs feel the network is the right way forward but were concerned about capacity. AGD informed the Committee that it has been agreed to extend the pilot until September 2018 but with 1 day a week of dedicated time being funded for one of the guardians to develop the network. Estelle Myers, (BAME representative on the network) is going to be the FSUG undertaking the 1 day a week extra and she will be developing an action plan. There will be another review after September to see if the extra 1 day a week has enabled the FSUG network to progress. AGD informed the Committee that he will be providing a report that will go into the next Clinical Governance Committee in April and confirmed that a further report will be provided to the Committee after September. AGD mentioned that he had agreed that Paul Brown, Human Resource Manager would be available if needed for advice to the FSUGs and the network supported this. The Committee also discussed the issue of the FSUG role being part of the Staff Governor role and that this could put some staff off from becoming a Governor. The Committee felt it is important to keep this under review and for it to be part of the evaluation of the FSUG after September.

Angela Monaghan (AM) asked about the workforce development strategic goal and how are we performing against our Workforce Plan. RW felt that we had areas where there has been good work, for example, unregistered workforce but there are also areas, for example, Advice Clinical Practitioners where we need to progress with. AGD mentioned that a series of workforce development workshops had been run in partnership with BDUs to support the annual planning process. This will be used for the workforce element of the annual plan to be submitted to NHSI and to update the strategic workforce plan.

RW mentioned the importance of the NHS staff survey and that it needs to be part of our workforce strategy action plan and not seen as a separate or isolated action plan. AGD confirmed that whilst there will be an updated action plan in April it is still an integral part of the workforce strategy implementation plan. The Committee agreed the NHS Staff Survey

and action plan should come to the RTSC then Board. RC said that CD has asked her to raise if we are being ambitious enough on the equality and diversity agenda. AGD said that whilst we are doing some good work, for example, the Moving Forward Programme, the Staff Equality Networks and the Insight Programme it would be fair to say it's not leading edge. It was recognised that the Trust is making good progress in this area, however, a more innovative approach would need significant additional resources. It was confirmed that we are close to setting up a Staff Disability Network and very positive discussions are progressing on a LGBT Staff Network.

The Management and Leadership Framework has now been agreed and this will provide a strong basis for ongoing investment in staff, leaders and managers.

Action: Alan Davis

The Committee NOTED and COMMENTED on the Workforce Strategy 2017/2018 Action Plan

RTSC/18/6 HR Exception Report (agenda item 6)

a. Retention Plan

AGD informed the Committee that NHSI had commented they thought the Retention Plan was good and strong. He reported that whilst our turnover rate appeared to be above our peer group on the surface, it was clear that the decommissioning and tendering of services had played a significant role in this. Work had been undertaken to see what the underlying clinical turnover rate is taking account for decommissioning and TUPE and it seems to suggest we are about average when compared to our peers. The lessons from the first cohort on the NHSI Retention Support Programme was that good career pathways are an important reason why people come to an organisation and slick recruitment and on boarding processes are vital. It was recognised both of these areas were key features of the Trust's plan.

The Committee supported the Plan.

b. **Agency Expenditure**

It was noted that Mark Brooks (MB) will talk about agency spend at the next Trust Board. February's report was showing a higher spend due to 3 main reasons:

1) Need to deliver the commissioned CAMHs Service
2) Increase acuity in inpatient areas
3) Medical vacancies

RW said there had been a significant reduction in agency spend which was due to a lot of hard work and that it was expected we would see an increase in agency spend the last quarter.

The Committee NOTED the report and the actions planned

RTSC/18/7 Gender Pay Gap (agenda item 7)

AGD emphasised that this report is not about equal pay for work of equal value but looks globally at the average pay rates for male and female staff in the Trust. A big reason for the pay gap is that in the lower pay band roles, for example, domestics, housekeepers are predominately female staff. It was recognised some of the reasons why these roles tend to be filled by mainly female staff is a wider society issue of what is perceived to be women's roles. RW felt that we need to look at how we can attract more male staff to these roles and perhaps get some male housekeepers to promote the role. At the other end of the spectrum, amongst higher earners, there was a greater likelihood of male staff members receiving on-call payments, and also a greater preponderance of clinical excellence awards for males. There will be another report produced in June 18/19 to see if there has been any

change. RW suggested the need to make it more of a public facing document and for Communications to be involved. AGD said the results of the survey must be published on the government and Trust's website by 31st March 2018.

It was RESOLVED to NOTE the report and the action to be included as part of the 18/19 Workforce Strategy Action Plan

RTSC/18/8 Directors Remuneration Benchmarking and Link to Performance Related Pay (PRP) 17/18 (agenda item 8) - *RW and AGD left the room for this item*

The Committee discussed the report and recognised that there was a good argument for keeping the PRP scheme, based purely on the benchmarking figures. However, Directors felt the scheme was no longer appropriate and also given the Trust's current financial position, it would be hard to justify to the staff and the public no matter what the benchmarking data says.

It was RESOLVED to AGREE with the cessation of the Directors Performance Related Pay with immediate effect and that no awards will be made for 17/18. This will be kept under review for future years.

RTSC/18/9 Medical Director Appointment and Remuneration (agenda item 9)

The Medical Director Appointment and Remuneration was formally noted. AM informed the Committee that she had received confirmation of the Fit and Proper Person Test for ST.

It was **RESOLVED** to formally **NOTE** the Medical Director Appointment and Remuneration.

RTSC/18/10 Clinical Excellence Awards (agenda item 10)

AGD updated the Committee on the outcome of the national negotiations on the Consultants Local Clinical Excellence Awards which was announced by the NHS Employers on 22nd March 2018 after reaching agreement with the British Medical Association (BMA). There has been some dispute over a number of years on whether or not these awards were contractual. The Trust has been awaiting the outcome of the dispute and has held the local clinical excellence award scheme in abeyance until the matter was resolved. This means the Trust can now run a local clinical excellence award scheme which will cover 16/17 and 17/18 under the old arrangements but there will be new national arrangements from 1st April 2018. AGD said that financial provision has been made for this. RW asked if the Trust is required to run the scheme for 16/17 and 17/18. AGD confirmed that it is not clear if NHS Employers are now saying it is contractual retrospectively and agreed to clarify the position with NHS Employers on whether it should be backdated.

Action: Alan Davis

RW mentioned that one of the criteria should be the individual is living the values of the organisation and the Committee agreed this. AGD confirmed that the values of the organisation would be added to the scheme.

Action: Alan Davis

The Committee discussed the Appeals process and that CD wouldn't be able to sit on any of the panels as a further review is by the Senior Independent Non-Executive Director. AGD agreed to change the wording to say "nominated". He also confirmed that the appeal is on the process and not on the decision.

Action: Alan Davis

It was RESOLVED to NOTE the outcome of the national negotiations and seek further clarification on whether it must be backdated and that the Trust's values will be added to the scheme.

RTSC/18/11 Employment Tribunal (agenda item 11)
AGD updated the Committee on two Employment Tribunal (ET) cases:

a) Health and Wellbeing
The Trust has put in an appeal around the maternity case. The Trust's Solicitors are saying that we have a good case for appeal and identified a number of areas of challenge on the original decision. We will hear in April whether the appeal has met the standards to progress to a full hearing.

Action: Alan Davis

It was RESOLVED to NOTE the update

RTSC/18/12 Workforce Risk Register (agenda item 12)
It was felt the pay restraint risk could be removed, given the recent pay award and that most unions are recommending acceptance.

Action: Alan Davis

It was RESOLVED to agree the Workforce Risk Register, subject to the pay restraint risk being removed.

RTSC/18/13 Review of Terms of Reference (agenda item 13)
The Committee discussed the RTSC Terms of Reference. The Committee felt that we need to emphasise the workforce element of the Committee more, particularly around the Workforce Strategy and this needs adding to the terms of reference. It was also agreed the Committee's name should be changed to reflect this and recommended Workforce and Remuneration Committee (WRC)

Action: Alan Davis

It was AGREED TO RECOMMEND the change in the Committee's title and include additional elements to reflect the Committee's broader role.

RTSC/18/14 Remuneration and Terms of Service Committee Annual Report 2016/2017

a i) The Committee discussed the RTSC Annual Report and asked that Company secretary appointment and Medical director recruitment be moved to box below and to take draft off.

a ii) The Committee discussed the Self-Assessment report and commented as follows:
Page 9: Question 9 - Are Members, particularly those new to the Committee, provided with training? AM mentioned if people joined a Committee there should be a meeting with exec lead and chair to discuss any training needs.

Page 11: Question 11 – Does at least one Committee member have a financial background – RW mentioned he thought this was a Monitor request. It was discussed and agreed that a member would have some broad financial background; but not necessarily be an accountant as such.

Page 13: Question 13 - Has the Committee formally assessed whether there is a need for the support of a 'Company Secretary' role or its equivalent?
The Committee does have access to the Company Secretary.

Page 14: ***Question 14 - Does the Committee have a mechanism to keep it aware of topical, legal and regulatory issues?*** The Committee have asked for

this to be added to the **Workplan** as a standing item and also added to the **Purpose of the Committee**.

Action: Alan Davis

Page 15: Question 15 – Has the Committee formally considered how it integrates with other Committees, particularly the Audit Committee, that are reviewing risk?

It was reported that there is a standing item of ***Matters to report to the Trust Board and need to add "and other Committees"***. It was also mentioned that the Chair of the Audit Committee attends one meeting a year.

Action: Alan Davis

b) **Work Programme 2018/2019**

It was agreed the Workforce Strategy update and Workforce Plan would be added to February meeting. The ***Impact of transformation on workforce*** to be removed. Review of committee effectiveness to be added to February along with review Terms of Reference.

Action: Alan Davis

RTSC/18/15 Matters to report to the Trust Board

- Workforce Strategy
- HR Exception Reports
- Gender Pay Gap Annual Report
- Medical Director Appointment and Remuneration
- Clinical Excellence Awards
- Workforce Risk Register
- Review of TOR
- Annual Report and Work Programme
- Change of the name of the Committee to Workforce and Remuneration Committee

RTSC/18/17 Date and time of next meeting

The next meeting will be held at 14:00 on 8th May 2018 in the Chair's office, Block 7, Fieldhead Hospital.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 June 2018
Agenda item 11

Title:	**Use of Trust Seal**
Paper prepared by:	Company Secretary on behalf of the Chief Executive
Purpose:	The Trust's Standing Orders, which are part of the Trust's Constitution, require a report to be made to Trust Board on the use of the Trust's seal every quarter. The Trust's Constitution and its Standing Orders are pivotal for the governance of the Trust, providing the framework within which the Trust and its officers conduct its business. Effective and relevant Standing Orders provide a framework that assists the identification and management of risk. This report also enables the Trust to comply with its own Standing Orders.
Mission/values:	The paper ensures that the Trust meets its governance and regulatory requirements.
Any background papers/ previously considered by:	Quarterly reports to Trust Board.
Executive summary:	The Trust's Standing Orders require that the Seal of the Trust is not fixed to any documents unless the sealing has been authorised by a resolution of Trust Board, or a committee thereof, or where Trust Board had delegated its powers. The Trust's Scheme of Delegation implied by Standing Orders delegates such powers to the Chair, Chief Executive and Director of Finance of the Trust. The Chief Executive is required to report all sealing to Trust Board, taken from the Register of Sealing maintained by the Chief Executive. The seal has been used four times since the report to Trust Board in March 2018 in respect of the following: ➢ Formal lease for continued occupation of a market stall for five years between The Moor Market, Sheffield and the Trust (Stop Smoking Service). ➢ Formal lease of office occupation at Belle Vue Community Centre for three years between Agbrigg and the Trust (Health and Wellbeing and Stop Smoking services). ➢ Supplemental agreement between Calderdale Council and the Trust for public health services (Calderdale Stop Smoking Service). ➢ Sale contract and transfer for Castle Lodge between the Trust and Laurenna Homes (Sandal) Ltd.
Recommendation:	**Trust Board is asked to NOTE use of the Trust's seal since the last report in March 2018.**
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	✘	✘	✘	✘	✘	✘	✘	✘
STP / ICS 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	✘				✘			
Digital strategy (including IMT) 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
Risk assessment of performance targets, CQUINs and Single Oversight Framework and agreement of KPIs	✘							
Review of Risk Appetite Statement	✘							
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) *(recommended recovery plan July 2018, plan due in December 2018 - 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)*								

Agenda item/issue	Apr	June	July	Sept	Oct	Dec	Jan	Mar
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.	