

**Trust Board (performance and monitoring)**  
**Tuesday 25 September 2018 at 9.30am**  
**Rooms 5&6, Laura Mitchell, Great Albion St, Halifax HX1 1YR**

**AGENDA**

<b>Item</b>	<b>Approx. Time</b>	<b>Agenda item</b>	<b>Presented by</b>		<b>Time allotted (mins)</b>	<b>Action</b>
1.	9.30	<b>Welcome, introductions and apologies</b>	Chair	<b>Verbal item</b>	5	To receive
2.	-	<b>Declarations of interest</b>	Chair	<b>Paper</b>	-	To receive
3.	9.35	<b>Minutes and matters arising from previous Trust Board meeting held 31 July 2018</b>	Chair	<b>Paper</b>	5	To approve
4.	9.40	<b>Service User Story</b>	Director of Operations	<b>Verbal item</b>	10	To receive
5.	9.50	<b>Chair and Chief Executive's remarks</b>	Chair	<b>Verbal item</b>	15	To receive
			Chief Executive	<b>Paper</b>		
6.	10.05	<b>Performance reports</b>				
	10.05	6.1 Integrated performance report month 5 2018/19	Director of Finance & Resource and Director of Nursing & Quality	<b>Paper</b>	60	To receive
	11.05	<i>Break</i>			15	
	11.20	6.2 Serious incident quarter 1 report	Director of Nursing & Quality	<b>Paper</b>	10	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
<b>7.</b>	11.30	<b>Business developments</b>				
	11.30	7.1 South Yorkshire updated including South Yorkshire & Bassetlaw Shadow Integrated Care System (SYBSICS)	Director of Strategy and Director of Human Resources, Organisational Development & Estates	<b>Paper</b>	10	To receive
	11.40	7.2 West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP)	Director of Strategy and Chief Executive	<b>Paper</b>	10	To receive
	11.50	7.2i WYHHCP Memorandum of Understanding	Director of Strategy and Chief Executive	<b>Paper</b>	10	To approve
<b>8.</b>	12.00	<b>Governance items</b>				
	12.00	8.1 Appraisal / Revalidation Annual Board Report 2017/18	Medical Director	<b>Paper</b>	10	To approve
	12.10	8.2 Sustainability Annual Report 2017/18	Director of Human Resources, Organisational Development & Estates	<b>Paper</b>	5	To receive
	12.15	8.3 Health & Safety Annual Report 2017/18	Director of Human Resources, Organisational Development & Estates	<b>Paper</b>	5	To approve
	12.20	8.4 Changes to Committee membership	Chair	<b>Paper</b>	5	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
9.	12.25	<b>Receipt of public minutes of partnership boards</b>	Chair	<b>Paper</b>	5	To receive
10.	12.30	<b>Assurance and receipt of minutes from Trust Board Committees</b>	Chair of committees	<b>Paper</b>	5	To receive
		- Clinical Governance & Clinical Safety Committee 18 September 2018				
		- Mental Health Act Committee 28 August 2018				
11.	12.35	<b>Use of Trust Seal</b>	Company Secretary	<b>Paper</b>	5	To receive
12.	12.40	<b>Trust Board work programme</b>	Chair	<b>Paper</b>	5	To receive
13.	12.45	<b>Date of next meeting</b>	Chair	<b>Verbal item</b>	5	To receive
		The next Trust Board meeting held in public will be held on Tuesday 30 October 2018, Room 49, Folly Hall, St Thomas Road, Huddersfield, HD1 3LT				
14.	12.50	<b>Questions from the public</b>	Chair	<b>Verbal item</b>	10	To receive
	13.00	<i>Close</i>				

## Trust Board 25 September 2018 Agenda item 2

<b>Title:</b>	<b>Trust Board declaration of interests, including fit and proper persons declaration - additional declarations</b>
<b>Paper prepared by:</b>	Company Secretary on behalf of the Chief Executive
<b>Purpose:</b>	To ensure the Trust continues to meet the NHS rules of Corporate Governance, the Combined Code on Corporate Governance, Monitor's Code of Governance and the Trust's own Constitution in relation to openness and transparency.
<b>Mission/values:</b>	The mission and values of the Trust reflect the need for the Trust to be open and act with probity. The Declaration of Interests and independence process and the fit and proper person declaration undertaken annually support this.
<b>Any background papers/ previously considered by:</b>	Policy for Trust Board declaration and register of fit and proper persons, independence, interests, gifts and hospitality was approved by and Standards of Business Conduct Policy (conflict of interest policy).  Previous annual declaration of interest paper to the Trust Board on 27 March 2018.
<b>Executive summary:</b>	<p>The attached paper provides an update to the annual exercise reported to Trust Board on 27 March 2018 in relation to the two Non-Executive Directors appointed by Members' Council on 3 August 2018: Erfana Mahmood and Sam Young.</p> <p><b>Declaration of interests</b></p> <p>The Trust's Constitution and the NHS rules on corporate governance, the Combined Code of Corporate Governance, and Monitor/NHS Improvement require Trust Board to receive and consider the details held for the Chair of the Trust and each Director, whether Non-Executive or Executive, in a Register of Interests. During the year, if any such Declaration should change, the Chair and Directors are required to notify the Company Secretary so that the Register can be amended and such amendments reported to Trust Board.</p> <p>Trust Board receives assurance that there is no conflict of interest in the administration of its business through the annual declaration exercise and the requirement for the Chair and Directors to consider and declare any interests at each meeting. As part of this process, Trust Board considers any potential risk or conflict of interests. If any should arise, they are recorded in the minutes of the meeting.</p>

	<p>There are no legal implications arising from the paper; however, the requirement for the Chair and Directors of the Trust to declare interests is part of the Trust's Constitution.</p> <p><b>Non-Executive Director declaration of independence</b>  Monitor's Code of Governance and guidance issued to Foundation Trusts in respect of annual reports requires the Trust to identify in its annual report all Non-Executive Directors it considers to be independent in character and judgement and whether there are any relationships or circumstances which are likely to affect, or could appear to affect, the Director's judgement. This Trust considers all its Non-Executive Directors to be independent and the Chair and all Non-Executive Directors have signed a declaration to this effect.</p> <p><b>Fit and proper person requirement</b>  There is a requirement for members of Boards of providers of NHS services to make a declaration against the fit and proper person requirement for directors set out in the new fundamental standard regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which came into force on 1 April 2015. Within the new regulations, the duty of candour and the fit and proper person requirements for Directors came into force earlier for NHS bodies on 1 October 2014. Although the requirement is in relation to new Director appointments, Trust Board took the decision to ask existing Directors to make a declaration as part of the annual declaration of interests exercise. All Directors have signed the declaration stating they meet the fit and proper person requirements.</p> <p>The Company Secretary is responsible for administering the process on behalf of the Chief Executive of the Trust. The declared interests of the Chair and Directors are reported in the annual report and the register of interests is published on the Trust's website.</p> <p><b>Risk appetite</b>  The mission and values of the Trust reflect the need for the Trust to be open and act with probity. The Declaration of Interests and independence process and the fit and proper person declaration undertaken annually support this.</p>
<p><b>Recommendation:</b></p>	<p><b>Trust Board is asked to CONSIDER the attached summary, particularly in terms of any risk presented to the Trust as a result of a Director's declaration, and, subject to any comment, amendment or other action, to formally NOTE the details in the minutes of this meeting.</b></p>
<p><b>Private session:</b></p>	<p>Not applicable</p>

**Trust Board – Declaration of Interests  
25 September 2018**

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

The following declarations of interest were made by Directors in addition to those reported to Trust Board on 27 March 2018:

Name	Declaration
<b>Non-Executive Directors</b>	
Erfana Mahmood Non-Executive Director	Non-Executive Director, Chorley and District Building Society Non-Executive Director, Plexus/Omega Housing, part of Mears Group PLC Sister - employee for Guide-Line telephone helpline for Mind in Bradford
Sam Young Non-Executive Director	Director, ISAY Consulting Limited Non-Executive Director, Great Places Housing Group

**Minutes of Trust Board meeting held on 31 July 2018**  
**Small conference room, Wellbeing & learning centre, Fieldhead, Wakefield**

<b>Present:</b>	Angela Monaghan (AM)	Chair
	Charlotte Dyson (CD)	Deputy Chair
	Laurence Campbell (LC)	Non-Executive Director
	Rachel Court (RC)	Non-Executive Director
	Mark Brooks (MB)	Director of Finance and Resources
	Tim Breedon (TB)	Director of Nursing and Quality / Deputy Chief Executive (Accounting Officer)
	Alan Davis (AGD)	Director of Human Resources, Organisational Development and Estates
<b>Apologies:</b>	<u>Members</u>	
	Chris Jones (CJ)	Non-Executive Director
	Kate Quail (KQ)	Non-Executive Director
	Rob Webster (RW)	Chief Executive
	Dr. Subha Thiyagesh (SThi)	Medical Director
	<u>Other</u>	
	Carol Harris (CH)	District Director - Forensics and Specialist Services, Calderdale and Kirklees
	Kate Henry (KH)	Director of Marketing, Communications and Engagement
<b>In attendance:</b>	Sean Rayner (SR)	District Director - Barnsley and Wakefield
	Karen Taylor (KT)	Director of Delivery
	Salma Yasmeen (SY)	Director of Strategy
	Emma Jones (EJ)	Company Secretary (author)

**TB/18/59 Welcome, introduction and apologies (agenda item 1)**

The Chair, Angela Monaghan (AM) welcomed everyone to the meeting. The apologies above were noted. There were two members of the public in attendance, both Trust governors. AM reminded members of the public that there would be an opportunity at the end of the meeting for questions and comments from members of the public. Questions asked and responses would be included in the meeting Minutes going forward and a form was available for completion if questions were not able to be answered to enable a response to be provided outside of the meeting.

AM advised that it would have been the last Trust Board meeting for Chris Jones whose term as Non-Executive Director ends. He was unable to attend the meeting and had sent a letter to AM which she read to the Trust Board. The Board thanked Chris for his valuable contribution to the Trust.

**TB/18/60 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/18/61 Minutes and matters arising from previous Trust Board meeting held 26 June 2018 (agenda item 3)**

It was **RESOLVED** to **APPROVE** the minutes of the public session of Trust Board held 26 June 2018 as a true and accurate record. The following matters arising were discussed:

- TB/18/50a Integrated performance report month 3 2018/19 (PLACE assessments) - Alan Davis (AGD) commented that this year's assessments had taken place and the Head of Estates will provide the information when the next round of assessments was being organised.
- TB/18/50a Integrated performance report month 3 2018/19 (Percentage of clients in employment metric) - Tim Breedon (TB) brief narrative included in IPR
- TB/18/52d General Data Protection Regulations (GDPR) update (Policies on the website) - Salma Yasmeeen (SY) commented that the Trust would launch a new internet site within the next three months and work would take place with the Corporate Governance team to enable quicker access to Trust policies for members of the public.
- TB/18/58 Questions from the public (Visitors badges) - AGD commented that the first response that it was a one off incident and a local review has been requested. Any feedback will be circulated.

### **TB/18/62 Service User Story (agenda item 4)**

The Trust Board heard a service user story. Karen Taylor (KT) advised that the story was from a service user in Forensic Services who was encouraged to study an academic course as part of this recovery. It became evident very quickly that there was an expectation that students would have access to a computer to complete their coursework. It is not uncommon within Forensic Services to have blanket rules, particularly around technology including laptops, mobile phones and even gaming equipment that has access to the internet. In more recent times the service has been challenged to question its own restrictive practices and in 2017/18 one of the CQUIN initiatives was to reduce restrictive practices. The following is in the service user's own words:

"I have been at Bretton Centre since last year. I came from Newton Lodge and at first found moving to low secure strange as there seemed to be more rules than in medium. At the time I wanted to take an Open University course. I asked if I could have a laptop so that I could do the study in my own time but these are banned items and at first I wasn't allowed. Staff spoke with the Doctor and it was agreed that they would look at how this could be managed. Staff said that it could be managed as part of least restrictive practice. This is where patients get to have access to more things so that they can be more independent. I would have liked to have had a laptop in my own room so that I could get on with my course work but this was not possible. Instead staff said that I could access the computer when I wanted and use it in a room on the ward. I had to sign it out and return it but I could use it on my own. There was no internet so that meant that I could only use the computer for my work. I really appreciated what the staff did for me and it meant that I could get on with the course. As it turned out I couldn't finish it because I was too busy but it was good to know that staff were helping me. I think least restrictive practice is really good for patients because it means that they can do things that people in the community do."

Charlotte Dyson (CD) commented that on a recent visit to another ward, one of the observations she made was that when people's health improves it was important that they have access to things to get them ready to go back into the community, although she understands it can be difficult to get the balance right.

AM commented that previously services users had no internet access and a positive change was the national wifi programme that the Trust was taking part in. KT commented that there was access in inpatient areas however it is monitored and has restrictions in place. TB commented that there are differences in secure settings and there may be supervised access. The Trust understands the importance of the use of social media for service users in order to keep in contact with friends and relatives as part of their recovery. AGD commented that there were positive comments received from the Care Quality Commission (CQC) as part of their recent inspection that staff were testing system boundaries in order to provide the right access for service users where appropriate.

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

**It was RESOLVED to NOTE the Service User Story.**

### **TB/18/63 Chair and Deputy Chief Executive's remarks (agenda item 5)**

#### Chair's remarks

AM highlighted the following:

- One of the governors on our Members' Council sadly passed away recently. Tina Harrison was a publicly elected governor for Kirklees. A letter of condolence has been sent to her family and the Members' Council will observe a minute's silence at their meeting on 3 August 2018.
  - An extensive and robust process has taken place for the recruitment of two new Non-Executive Directors to replace Chris Jones, whose term ends today, and Rachel Court, whose term will end in the next year. The panel made a recommendation to the Nominations Committee on the candidates for appointment who have supported the recommendation, which will go to the Members' Council for approval on 3 August 2018.
  - As agreed at the last Trust Board meeting, in order to be as open and as transparent as we can about the business of the Board, the Chair will note in the public meeting those items to be discussed in private. Today, the following items will be discussed in private session:
    - One corporate/organisational risk, including whether it can now form part of the public risk register.
    - Papers relating to the Trust's financial sustainability.
    - Commercial Strategy
    - Developments in South Yorkshire including the South Yorkshire & Bassetlaw Integrated Care System.
    - Developments in West Yorkshire including the West Yorkshire & Harrogate Health & Care Partnership.
    - Minutes of private partnership boards.
    - Corporate Trustee for charitable funds items including Minutes and assurance from the Charitable Funds Committee.
- All items in the private session are scrutinised to ensure the Board discusses as much as possible in public in accordance with the guidance agreed by the Board in January 2018.

### Deputy Chief Executive's report

TB 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. Internally it represented the significant demand, pressure, and levels of acuity. Nationally, areas to keep a focus on to see whether there is any impact for the Trust are the new Secretary of State, social care green papers, and changes to deprivation of liberty legislation.

Rachel Court (RC) asked whether commissioners would respond to the increase in acuity. Mark Brooks (MB) commented that acuity can be difficult to measure specifically. General conversations with commissioners have taken place and work will continue in relation to the level of demand and acuity. CD asked if through safer staffing there were other ways to measure acuity, such as the cancellation of leave. TB commented that there were a few different measures that could be used including safer staffing, which reported to the Trust Board every six months and is subject to establishment review, the number of people on observation, length of stay, and the case workload in community. AGD commented that there was an element of e-rostering that could also help. Middle Ground programme participants had been discussing pressure in the services and felt reassured that the Board were discussing it and that it was also being discussed with commissioners. AM asked if the increase in acuity and triangulation taking place could be looked at further by the Clinical Governance & Clinical Safety Committee.

**Action: Tim Breedon**

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

### **TB/18/64 Risk and assurance (agenda item 6)**

#### **TB/18/64a Care Quality Commission (CQC) report (agenda item 6.1)**

TB highlighted the following from the report:

- The Trust was subject to a well-led inspection by the Care Quality Commission (CQC) in March & April 2018.
- Draft reports were provided to the Trust for factual accuracy checking, which was undertaken by corporate support and operational teams.
- The Trust was not required to take any immediate actions during or following inspection.
- The Trust has received its final reports, which consist of six core service reports and one overall quality report, which were published by the CQC early July 2018.
- Key findings from the reports highlight our areas of strength and improvement including our community learning disability services, our open culture with good reporting of incidents, and our established and experienced Board.
- The CQC have also provided a fair representation of the areas where we're facing significant challenges such as the level of acuity and pressure, in particular our acute and community mental health services and our child and adolescent mental health services (CAMHS), long waits in some of our services, our approach to nurse call systems across our inpatient areas, on-call arrangements in CAMHS, and restrictive practices.
- The overall rating for the Trust is 'Requires improvement', with 11 of our 14 core services rated 'Good', and all services rated 'Good' or 'Outstanding' for being caring.
- Attached to the paper is the high-level action plan submitted to CQC and a detailed action plan for 'must dos' and 'should dos' will go to the Executive Management Team (EMT) and Clinical Governance & Clinical Safety Committee in September.

LC asked how many of the actions related to policies and how much was due to performance. TB commented that the findings within the report were less to do with policy and more to do with practice and recording. Some informal questions were asked in relation to some of the approaches. AGD commented that he was keen to understand the change in stance in relation to a nurse call system, which was not seen previously as a clinical risk to the organisation and which is why it was not in place. TB commented that they have raised a question in relation to nurse call systems but not said the decision not to have one is wrong. The Trust's position in relation to inpatient nurse call systems and community based services for ligature risk would be reviewed.

CD commented that it was clear from the report that there are gaps in some areas across the system such as clinical record keeping. TB commented that the clinical governance group would have the responsibility of coordinating action plans and also to ensure there isn't significant variation of practice across the system. The action plan would be reviewed in detail by the Clinical Governance & Clinical Safety Committee. RC asked if there would be reports into the Trust Board. TB commented that the action tracker would form part of the Integrated Performance Report. Laurence Campbell (LC) asked for clarification on the role of the Operational Management Group (OMG). TB commented that the governance groups would report into OMG and the flowchart within the action plan would be updated to reflect this. AM commented that it was important to understand the reporting lines and accountability. TB commented that the terms of reference would go to the Clinical Governance & Clinical Safety Committee.

**Action: Tim Breedon**

**It was RESOLVED to:**

- **NOTE the report;**
- **SUPPORT the approach described in the CQC action plan governance framework; and**
- **CONSIDER the next steps required which were set out in the paper.**

TB/18/64b Board Assurance Framework (BAF) 2018/19 (agenda item 6.2)

MB highlighted the following from the report:

- As part of the recent inspection, the CQC gave verbal feedback that, while they recognised the structure of our BAF, they found it difficult to follow in places.
- The layout had been reviewed by MB and Emma Jones (EJ) and it was felt that by aligning the controls and assurances to the individual strategic risks it may make the document clearer.
- The previous strategic risk 1.2 - Trust plans for service transformation are not aligned to a multiplicity of stakeholder requirements - was reviewed and felt no longer to be as significant a risk given that many of the transition programmes are complete or underway and similarly much work had been carried out on the previous strategic risk 2.4 - Failure to create and communicate a coherent articulation of Trust mission, vision and values leading to inability for staff to identify with and deliver against Trust strategic objectives.
- Considering the current operating environment, two new strategic risks were identified as:
  - Strategic risk 1.2 - Impact of or differences between a multiplicity of commissioners and place based plans, and those not being aligned with Trust plans.
  - Strategic risk 2.4 - Increased demand for and acuity of service users leads to a negative impact on quality of care.
- The new format and recommended changes to the strategic risks have been reviewed and supported by the EMT and Audit Committee.

- EMT have reviewed and aligned the controls and assurance for each strategic risk and indicated an overall current assurance RAG rating of 'yellow'. The rationale and the individual risk RAG ratings are set out in the attached report.

LC commented that the changes were discussed by Audit Committee who felt the changes were a positive development. CD commented that the updated layout of the BAF was easier to navigate.

AM commented that overall the BAF shows that there has been an improvement since Quarter 4 which would be indicative of a less risky environment however she was not sure that this appropriately reflects the current position. MB commented that in the individual strategic risks only one was RAG rated as 'green' and the other differences were marginal with many areas of control and assurance in place.

AM asked if the latest CQC inspection report had been reflected in the BAF. MB commented that there is a cyclical approach to the review of the BAF on a quarterly basis and now the final CQC report had been published it would be part of the review in the next quarter along with the risk register. TB commented that now the CQC action plan had been submitted this would be considered.

**Action: Tim Breedon**

AM asked whether any gaps in control had been identified for strategic risk 2.4. TB commented in relation to the risk as a result of increase acuity and demand, it was being managed and at the moment a direct impact had not been seen. At this point it is highlighted as an area of increasing risks for focus and review.

RC asked if the clinical records system should be reflected within the BAF as given the particular risks in relation to implementation there could be a material impact on patient care.

**Action: Tim Breedon**

AM asked if the gap in control for strategic risk 3.4 was an area of assurance. SY commented that the gap was in relation to capacity and the wording would be reviewed.

**Action: Salma Yasmeen**

AM commented that some of the assurances reference past dates. TB commented that some may relate to when the last report was received and the next expected date could be added.

**Action: Mark Brooks**

**It was RESOLVED to:**

- **SUPPORT the revised format of the BAF for 2018/19;**
- **AGREE the changes recommended by EMT and supported by the Audit Committee to strategic risks 1.2 and 2.4 for 2018/19; and**
- **NOTE the controls and assurances against the Trust's strategic objectives for Q1 2018/19 and ongoing work to address gaps in control.**

TB/18/64c Corporate / organisational risk register (ORR) (agenda item 6.3)

MB reported that the ORR is reviewed on a cyclical basis which includes the review of aligned risks by the committees of the Board. The major changes made in the last quarter are identified on the front cover of the report, including a risk at the organisational level in relation to out of area placements.

CD asked in relation to Risk ID 1158 what actions had taken place to reduce the level of risk. AGD commented that some of the actions were now controls including that the recruitment and retention plan was in place, task group up and running, and the Trust was taking part in the NHS Improvement programme on recruitment and retention. CD asked if these areas were showing an initial impact. AGD commented that it was in its early stages and can show periods of fluctuation. The plans would be monitored through the Workforce and Remuneration Committee. MB commented that there may be a reduction in overreliance on agency staff rather than reliance given that the level of usage of agency staff has reduced over the past 15 months. The BDU level risk register may include risks for a couple of specific services such as CAMHs.

AGD commented that Risk ID 1155 was closed however in view of recent system pressures it might be a risk to revisit for the ORR by the Workforce and Remuneration Committee.

**Action: Alan Davis**

CD asked in relation to Risk ID 1196 what the impact was in relation to Information Governance (IG). MB commented that it did not have a direct impact and the biggest risk in relation to IG was in relation to people sending things to incorrect addresses.

AM commented in relation to Risk ID 1132 whether there was a more significant impact in relation to the people on the waiting list. MB commented that a risk in relation to the impact was on the BDU risk register which would be reviewed for potential escalation to the ORR.

**Action: Karen Taylor**

**It was RESOLVED to NOTE the key risks for the organisation.**

## **TB/18/65 Business developments (agenda item 7)**

### **TB/18/65a South Yorkshire and Bassetlaw Shadow Integrated Care System update (agenda item 7.1)**

AGD reported that the paper provided an update on the work of the South Yorkshire and Bassetlaw Shadow Integrated Care System (SYBSICS) including the Hospital Service Review (HSR) and the work in relation to stroke services which would have an impact on the Trust. A lot of good work is taking place locally and the direction of travel supports the model within the HSR. A briefing note was received and a response was sent providing general support.

SY reported that the Barnsley Clinical Commissioning Group (CCG) had been working with partners including the Trust to develop joined up integrated care. The CCG have been discussing with partner organisations, including the Trust, proposals for a new model for health care provision and commissioning for Barnsley involving an integrated care system. It was agreed by all the partner organisations that as part of the early engagement process, a series of Staff Side and Staff briefings should take place in July about the CCG proposals to develop a single integrated care organisation. A number of briefing sessions on the CCGs proposals have taken place in Barnsley and with corporate services

CD asked if there had been any concerns raised by staff in relation to Barnsley. SR commented that he had several briefings with staff and in clinical services the feedback received was generally positive and they see it as an opportunity. This is not the case in other areas, with some staff raising concern in relation to the long time scale. AGD commented that staff had also raised an issue about the amount of time that was being spent on this process which takes away from service development. There were still a lot of unknowns and staff appreciated that it was the start of the discussion.

AM commented that since the paper was produced the SYBSICS had extended the timeline on the HSR paper and further comments could be provided. The Board supported that no further response was needed.

**It was RESOLVED to NOTE the update from the SYBSICS on the Hospital Services Review and the latest position on Barnsley CCG's proposals for a new model of service provision and commissioning.**

TB/18/65b West Yorkshire and Harrogate Health and Care Partnership update (agenda item 7.2)

SY highlighted the following from the report:

- West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) draft Memorandum of Understanding continues to be updated and is due to come to Trust Board for approval in September 2018.
- Shadow Integrated Care System (ICS) governance arrangements have been reviewed to reflect the roles and there will be a chance for the Trust to reconsider its involvement in the ICS.
- A new group will be established focusing on performance and mutual accountability around key targets and deliverables which RW will lead as lead of the WYHHCP.
- Public panel workshop as part of an ongoing programme to strengthen the communication and engagement with the public.
- A second joint Non-Executive Director and Governor event for the West Yorkshire Mental Health Services Collaborate (WYMHSC) took place. There has been significant work on the mental health workstreams which is reported in the Integrated Performance Report.

AM commented that the Trust Board had not had a chance to look at the revised draft Memorandum of Understanding in detail since January and that it would be helpful before it came for approval to review it so that feedback can be provided for the final version. SY to circulate draft to LC, AM, CD and MB for review and feedback.

**Action: Salma Yasmeen**

**It was RESOLVED to RECEIVE the update on the development of the West Yorkshire & Harrogate Health and Care Partnership.**

**TB/18/66 Performance reports (agenda item 8)**

TB/18/66a Integrated performance report M3 2018/19 (agenda item 8.1)

TB highlighted the following from the report in relation to the Summary:

- Under 18 admissions - three during the month and unfortunately an issue we raise with commissioners on a regular basis. The same arrangements were in place, as for previous admissions including ensuring proper safeguards, as the least worst option. It is an area that we need to keep in focus as a longer term solution is needed across the system with Tier 4 providers.
- Out of area beds - a separate paper is included under agenda item 8.2.
- Percentage service users followed up within 7 days of discharge - noting that sometimes it is difficult to make contact with people.
- Mandatory training - new metrics in relation to managing aggression and moving and handling mandatory training have been added.
- Sickness absence - showing an increase in month.

- Information Governance (IG) - unfortunately we have another incident reportable to the Information Commissioners Office. They are issues of individual human error; and the only theme is information being sent to wrong addresses.

TB highlighted the following from the report in relation to Quality:

- Complaints - improving the rate of closure within 40 days although still work to do. There has been a reduction in the number of formal complaints which is positive by ensuring there are local resolutions.
- Medicine omissions - some good work is taking place in relation to Older Peoples Services that needs to be replicated across the Trust. Some of the underperformance relates to staff turnover and the availability of clinical pharmacy which forms part of a targeted piece of work.
- Prone restraint - is a self-set target and work is ongoing to reduce the time. All instances are reviewed by specialist advisers and further information is received by the Clinical Governance & Clinical Safety Committee.
- Falls - there has been a minor increase which will be further investigated.
- Pressure ulcer - one in month.
- Mortality - reporting of information is progressing well and information around the new structure of case reviews is showing some benefits.
- Serious incidents - number has reduced which needs to be monitored over a longer period to establish if there is a trend.
- Safer staffing – overall lessons have been maintained, however there are areas of significant pressure to maintain those levels and escalation process remains in place where planned levels are not met.

CD asked in relation to the reduction in the number of staff receiving clinical supervision if it was in specific areas. TB commented that it may have been impacted by staff receiving their annual appraisal and the level will be monitored.

CD asked in relation to incident reporting whether staff were clear on what aspects of an incident may need to be reported separately so themes can be monitored. TB commented that the important part is that people are reporting incidents, which are then reviewed by line managers and often there is a second review by a specialist manager. When incidents are recorded codes can be allocated depending on the type and there are also sub sets where various different areas can be assigned for the necessary advisers to be alerted.

LC asked in relation to mortality reporting structured judgment reviews, what the other 40% that were not rated overall care as good or excellent were rated as. TB commented that the rating would have been satisfactory. The 60% highlights those that are that are rated as good or excellent practice.

CD asked what the target was for CAMHs referral to treatment. TB commented that there is not currently a percentage target and the metric was set to monitor for any trends and then a RAG rating could be applied.

MB highlighted in relation to the National metrics that the Trust continues to typically achieve the vast majority and there was a separate paper in relation to out of area beds under agenda item 8.2.

SR highlighted the following from the report in relation to Locality:

- Barnsley - Improving Access to Psychological Therapies (IAPT) performance is holding well following the national team's support to improve performance, and the new service mobilises from 1 August 2018. Waiting times for psychological services

was noted in the CQC report, the current wait list was being addressed within acceptable parameters and discussions are ongoing with commissioners regarding funding to address backlog waits.

- Calderdale and Kirklees - areas of sickness absence.
- Specialised BDU - ongoing challenges in regard to medical recruitment and retention which flows through to agency spend.
- Wakefield BDU - discussions are taking place about acuity and the overspend in relation to bank and agency staff. In Wakefield there is now a district housing support coordinator working on the wards as part of a pilot programme. It is hoped that there will be learning from the pilot that can be applied to other wards across the patch, which will help service users and also length of stay.

AM asked if there was an opportunity to do some similar partnership work in relation to employment. SR commented that there were different schemes in place at a place based level that may not work in the same way, however the Recovery Colleges are an example of a service which has strong links with employment programmes, as well as community services.

SY highlighted the following from the report in relation to Priority Programmes:

- Out of area - separate paper under agenda item 8.2.
- Clinical records system - now in its second phase with the co-create phase successfully completed. Data testing has commenced and the outcome was far more positive than anticipated with one week of contingency gained back although still a risk. Configuration has commenced which will be an important phase to continue engagement with staff. The training approach has been coordinated with the learning and development team with staff involved in co-design and has been tested with clinical and non-clinical staff. It is a labour intensive period and risks continue in relation to developing a plan for cutover. Work is taking place on the 'go live' plan and robust contingency plan. An internal audit was completed which has assisted with identifying further actions. These particularly included putting in place a consolidated overall resource plan, to help understand all resource requirements over the coming weeks and months. A proposal on further reporting on key milestones and the gateway decision process will come to the Trust Board meeting in September 2018.
- South Yorkshire - working with partners in Barnsley to develop an integrated pathway in stroke services. A capital bid has been put in nationally which may have an impact.
- West Yorkshire - a significant amount of work taking place including in relation to eating disorders with the pathway now fully operational in all places where we are a partner.

RC commented in relation to the clinical records system that the risk identification and management processes have matured over the last couple of months and were fit for purpose and that the oversight of the programme by the programme board was more positive.

AM commented in relation to West Yorkshire that Learning Disabilities and transforming care work was added as an additional programme as part of the WYMHS. SY commented that it will be included in the reporting as the workstream is scoped out and developed.

**Action: Salma Yasmeen**

MB highlighted the following from the report in relation to Finance:

- Disappointing performance with an overspend on pay, and out of area beds contributing to the increased deficit position. Year to date the spend on out of area beds is £1.1m which is 69% over this period last year.
- Slightly below the agency cap, however the cap will reduce significantly from August onwards.
- High level of overspend on inpatient facilities, exception information has been included.
- Financial risk rating is 3, due to size of deficit in terms of our income.
- Cash levels are down at end of month, due to two slightly late payments by commissioners.
- Capital expenditure forecast is currently in line with plan. There may be additional capital requirements following the outcome of the CQC inspection.
- New model of IAPT goes live tomorrow in Barnsley with significantly lower income attached to the new model.
- The internal forecast for the full year is currently £1.5m adrift from plan.

AM asked what actions were taking place to address the difference between the plan and forecast. MB commented that actions include minimising the impact of risks and realising the potential opportunities identified. These include realising commissioning for quality and innovation (CQUIN) income, reducing out of area bed costs, completing asset disposals and reviewing asset valuation methodology.. TB commented that a key aspect was how areas of pressure can be demonstrated to commissioners to ensure it is reflected in funding.

AGD highlighted the following from the report in relation to Workforce:

- Sickness absence - is showing improvement which is a positive sign particularly when challenges in the system.
- Appraisals - support services is at 92% and the end figure at 84%, the system is seen as a crucial aspect in the retention of staff.
- Mandatory training - in relation to food handling training there is an action plan in place.

LC asked what actions were taking place in relation to staff turnover. AGD commented that focus groups were held in areas of high turnover to try to understand the issues and engage staff in what actions need to be taken. Those discussions have been fed back to OMG and will inform the recruitment and retention plan.

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

TB/18/66b Out of area placements - update report (agenda item 8.2)

KT reported that the paper brings together all of the information on work taking place grouped into three areas: increased operational focus, improvement approach, partnership approach. The changes in the system were volatile with 268 bed days in February, 730 in March, 536 in April, 284 in May, and 375 in June. There is no seen correlation between months and demand. The report includes the governance structure to see where areas are reviewed and discussed, and the areas of focus for the future with joint trajectories for improvement agreed with commissioners.

CD commended staff for the huge amount of work taking place and from talking to staff it was clear the amount of resource the work is occupying and noted that it was important to understand the community aspect to support the internal pressures. KT commented that there was a focus on both inpatient as well as community to support people getting to that stage. LC asked if there was a lack of resource in community. KT commented that it was

variable across different localities partly due to different service models and level of commissioning. TB commented that community resource is a bigger picture than purely what the Trust provides, it also includes the local authority and third sector provision, which have also been challenged financially.

RC asked how much more difference can be made on the work that has already taken place. KT commented that further work could still be done in relation to the length of stay and admission rates as they are the area that could potentially make the biggest impact in addition to six or seven other areas. Some changes are needed in relation to staff culture and clinical leadership. AM asked if there was anything further that could be done to accelerate progress. KT commented that the provision of extra resources and the release of staff to do the dedicated work required would assist.

AM commented that Sheffield had reported no out of area beds and whether lessons could be learned from their procedures. KT commented that discussions had taken place with colleagues and they are willing to share their learnings. There are various components to their performance including a high level of investment in their acute wards and staffing levels which they feel has reduced the length of stay.

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

#### **TB/18/67 Strategies (agenda item 9)**

##### TB/18/67a Estates Strategy update (agenda item 9.1)

AGD highlighted the following from the report:

- The Trust Board approved an Estates Strategy in 2012 with three key aims:
  - Modernising inpatient environments
  - Developing the Trust's community infrastructure
  - Disposing of buildings and land surplus to requirements
- Over the past 6 years there has been major capital expenditure across all our inpatient areas including a new build and adult acute wards on the Fieldhead site. The Fieldhead development has seen phase 1, the Unity Centre, open and become operational and the final phase is due to complete around March 2019.
- The development of community hubs has progressed well with the opening of Laura Mitchell, Halifax, Baghill House, Pontefract and Drury Lane, Wakefield. There still continues to be teething problems at Drury Lane and remedial work has been undertaken there. The local building user group is being supported to deal with issues and ensure the effective operation of the building.
- The attached report also provides an update on emergency planning, fire safety and health and safety where significant work has been undertaken in light of national developments. These include plans in place around heatwave which are reviewed regularly and action cards in place in relation to inpatients and community.
- The capital plan is £72k below plan with a huge amount of work taking place to keep our estates up to standard.

AM asked if there had been any incidents in relation to the recent high temperatures. TB commented that nothing had been raised through the clinical risk panel. AGD commented that there was quite a lot of guidance nationally and regionally. AM commented that she was aware of an issue in relation to the management of medication. AGD commented that it was an area that was being reviewed however in terms of patient safety there was not a risk as if the temperature was above a certain level the medication would be disposed of, which would then become a cost issue.

LC asked if there had been an assessment of the community hubs as part of a post project implementation review. AGD commented that they had been completed and would be reported to the EMT and could be included in the next update to Trust Board.

**Action: Alan Davis**

**It was RESOLVED to NOTE the update on the Estates Strategy and safety arrangements in the Trust.**

TB/18/67b Organisational Development Strategy update (agenda item 9.2)

AGD reported that the implementation plan was developed to assist in the delivery of the Organisational Development Strategy. The action plan had been reviewed in detail and supported by the Workforce and Remuneration Committee for approval by the Trust Board.

**It was RESOLVED to APPROVE the Organisation Development action plan for 2018/19.**

**TB/18/68 Governance matters (agenda item 10)**

TB/18/68a Equality and diversity annual report 2017/18 (agenda item 10.1)

TB reported that the annual report set out the work that had taken place in relation to quality and diversity in 2017/18 and had been reviewed and supported by the Equality & Inclusion Forum. As part of the work on equality and diversity it was clear that some improved coordination of the work was needed and a proposal will go to the Executive Management Team.

**It was RESOLVED to RECEIVE the Equality and Diversity Annual Report 2017/18.**

TB/18/68b Proposal for the use of e-cigarettes (agenda item 10.2)

KT reported that the proposal to amend the Trust's policy to allow service users to use e-cigarettes in ward environments had been discussed at length by the Executive Management Team. A lot of other organisations have implemented the proposed changes which gives the Trust an opportunity to learn from them, with the detail included in the report. Colleagues from health and wellbeing, fire safety, ward management, and clinical experts are in support of the proposal. This is something that the service users have been asking for as they currently are required to go outside of the hospital boundary and often need to be escorted by staff. The proposal to use e-cigarettes in our ward environments would form part of the existing policy and the Trust would still continue to support people to cease smoking. This change only related to service users and not staff.

CD asked if the change would be a step backwards in the policy implemented by the Trust and how the change would be monitored. TB commented that there was further work to be done in relation to the change if the principle was supported. KT commented that if e-cigarettes were allowed that the Trust may provide the supply to ensure safety and assist with monitoring use. AM commented that other Trusts are supplying the devices and whether service users would need to pay for them. KT commented that one of the areas being considered was the provision of one product, then further e-cigarettes would need to be purchased by the service user at cost.

RC commented that the evidence nationally was that the use of e-cigarettes could help people to quit smoking and it may also have a positive impact on managing aggression and violence (MAV). AM commented that there were a number of MAV incidents in relation to smoking. KT commented that staff would say that this is one of the biggest issues they face on a daily basis and it was a pragmatic decision about what we think could improve the situation for staff and service users.

CD asked if there would be any potential impact on service users who did not smoke who may be exposed passively to vapor. KT commented that as part of a next stage discussion would take place with service users and, if it was an issue, that use may be confined to individuals' rooms only. MB commented that EMT discussed the potential health and safety issues around the type of device and fire safety. KT commented that by supplying a certain type of device would help reduce the risk. LC commented that he felt the potential health impact of the use of vapor was still unknown. TB commented from a clinical health perspective that there had been a change in position by Public Health England since the Trust implemented the policy in 2006, and they now recommend that it is better to vape than smoke cigarettes. The Trust has listened to service users and staff and knows how difficult the current policy is to implement, and how hard it is to stop people smoking at significant times of distress. Clinically the Trust is reluctant to make changes as our organisation promotes healthy lifestyle, however people are getting distracted from their care and treatment and as long as this approach is part of the overall context of stopping smoking initiative then it makes sense. There is further work to do on detail of the changes to the policy and there is a lot of information to use nationally on others who have implemented the use of e-cigarettes.

AM commented that the Trust would still remain a smoke-free site. CD asked if staff would be able to use e-cigarettes on site. KT commented that it was not currently an area raised by staff and the starting point is that we do not allow staff to use e-cigarettes on site.

**It was RESOLVED to:**

- **SUPPORT the principle of allowing the use of e-cigarettes for service users;**
- **SUPPORT EMT to have oversight of changes to the policy and the implementation plan; and**
- **REQUEST assurance of effective implementation from the post implementation review at 6 months.**

#### **TB/18/69 Receipt of minutes of partnership boards (agenda item 11)**

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

- Barnsley Health and Wellbeing Board - SR advised that a development session was scheduled for the first week in August 2018.
- Wakefield Health and Wellbeing Board 26 July 2018 - SR advised that a colleague attended this meeting on his behalf with the Suicide Prevention Strategy agreed. Wakefield are the first Health & Wellbeing Board to sign up to the National Suicide Board.
- Kirklees Health and Wellbeing Board 28 June 2018

**It was RESOLVED to RECEIVE the updates provided.**

#### **TB/18/70 Assurance from Trust Board Committees (agenda item 12)**

Audit Committee 10 July 2018

LC highlighted the following from the meeting:

- SystemOne implementation - assurance level increased, still in a limited assurance phase:
  - workstream risk mapping
  - deadlines

- Trust Board sign-off of design - requested information to strategic Trust Board in September 2018.
- key decisions intra gateways
- transitional system during cutover
- Delivering service change - need to review some projects at points before formal Gateways.
- Risk register – growing/emergent risks such as acuity and out of area bed risk.
- Board Assurance Framework (BAF) revision – changes supported but more input on strategic risks needed.
- Triangulation report – gaps against BAF required in future.
- Recognise progress on Information Commissioners Office (ICO) and General Data Protection Regulation (GDPR) audits - both closed.
- Counter fraud plan 2018/19.
- Approved Minutes of the Committee meeting held on 10 April 2018 (attached to Trust Board papers).

#### Nominations Committee 16 July 2018

AM highlighted the following from the meeting:

- Recommended appointment of two Non-Executive Directors (NEDs) to Members' Council on 3 August 2018.
- Sub-group to be established to review the Chair and NED remuneration recommendation to Members' Council on 3 August 2018.
- Approved Minutes of the Committee meeting held on 20 June 2018 (attached to Trust Board papers).

#### Workforce and Remuneration Committee 3 July 2018

RC highlighted the following from the meeting:

- Middle Ground programme - now being delivered with a focus on developing healthy teams.
- Sickness/Absence – positive trend in the first two months and Trust currently below target.
- Recruitment and Retention :
  - Recruitment and retention action plan agreed
  - Agency Spend – reviewed current level of agency spend and noted particular pressures in Children & Adolescent Mental Health Services (CAMHS) medical staffing
- Directors structure - confirmed arrangements for Deputy Chief Executive (Directors portfolios attached to Trust Board papers).
- Risk Register reviewed – agreed that the equality and diversity and Workforce Race Equality Standards (WRES) need to be linked to the work of the Equality & Inclusion Forum as well as the Workforce & Remuneration Committee.
- Approved Minutes of the Committee meeting held on 8 May 2018 (attached to Trust Board papers).

#### West Yorkshire Mental Health Services Collaborative (WYMHSC) Committees in Common 30 July 2018

AM highlighted the following from the meeting:

- Public Health England presentation on understanding local mental health statistics and context of national statistics. This information will be shared with the EMT.  
**Action: Angela Monaghan**
- Joint Non-Executive Director/Governor event feedback.

- Integrated Care System update and high level business plan and approach to RAG rating.
- The approved Minutes of the Committee meeting held on 30 April 2018 are to follow.

**It was RESOLVED to RECEIVE the updates provided.**

**TB/18/71 Trust Board work programme 2018/19 (agenda item 13)**

AM advised that the medical appraisal/revaluation annual report will come to the next Trust Board meeting.

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

**TB/18/72 Date of next meeting (agenda item 14)**

The next Trust Board meeting held in public will be held on Tuesday 25 September 2018 in meeting rooms 5 & 6, Laura Mitchell, Halifax.

**TB/18/73 Questions from the public (agenda item 15)**

Comments and questions were invited from members of the public in attendance. A summary of the questions and responses is provided below:

*TB/18/73a - In relation to agenda item 7.2, the West Yorkshire & Harrogate Heath & Care Partnership WYHHCP) seems to be replicating the governance arrangements between the System Leadership Executive and new Partnership Board, who will set the strategy and are made up of the same people.*

SY commented that all the partners across the WYHHCP had been involved in drafting the updated Memorandum of Understanding (MoU) for the WYHHCP which is why it has taken a long time to finalise. When the WYHHCP becomes a formal Integrated Care System (ICS) the System Leadership Executive will have a different focus due to the requirements of being an ICS. AM commented that one of the reasons that the new Partnership Board is being established is to bring together the Chairs of each organisation.

*TB/18/73b - In relation to the Suicide Prevention Strategy, people have been leaving good vibe notes on the North Bridge in Calderdale. Has there been any coordination with partners on risk assessing it as by promoting it risks makes it a suicide hot spot.*

SR commented that the one referred is the joint Wakefield Suicide Prevention Strategy however there was an equivalent strategy in Calderdale. TB commented that he agreed that it was a delicate area to manage and the organisations needed to work together to minimise the means. The key risk areas include bridges, highways, railway, canals and these areas are discussed by the partnership group as part of the Suicide Prevention Strategy. Through the Strategy it has been agreed to reduce the means, raise awareness, and provide support to people. Reducing the means is a big area to address and there has been some good practice such as the enclosing of bridges.

**Signed:**

**Date:**

## TRUST BOARD 31 JULY 2018 – ACTION POINTS ARISING FROM THE MEETING

### Actions from 31 July 2018

Min reference	Action	Lead	Timescale	Progress
TB/18/63 Chair and Deputy Chief Executive's remarks	AM asked if the increase in acuity and triangulation taking place could be looked at further by the Clinical Governance & Clinical Safety Committee.	TB		
TB/18/64a Care Quality Commission (CQC) report	Laurence Campbell (LC) asked for clarification on the role of the Operational Management Group (OMG). TB commented that the governance groups would report into OMG and the flowchart within the action plan would be updated to reflect this. AM commented that it was important to understand the reporting lines and accountability. TB commented that the terms of reference would go to the Clinical Governance & Clinical Safety Committee.	TB		
TB/18/64b Board Assurance Framework (BAF) 2018/19	AM asked if the latest CQC inspection report had been reflected in the BAF. MB commented that there is a cyclical approach to the review of the BAF on a quarterly basis and now the final CQC report had been published it would be part of the review in the next quarter along with the risk register. TB commented that now the CQC action plan had been submitted this would be considered.	TB	October 2018	The BAF will be reviewed prior to the next business and risk meeting of the Trust Board in October 2018.
	RC asked if the clinical records system should be reflected within the BAF as given the particular risks in relation to implementation there could be a material impact on patient care.	TB	October 2018	The BAF will be reviewed prior to the next business and risk meeting of the Trust Board in October 2018.
	AM asked if the gap in control for strategic risk 3.4 was an area of assurance. SY commented that the	SY	October 2018	The BAF will be reviewed prior to the next business and risk meeting of the Trust Board

Min reference	Action	Lead	Timescale	Progress
	gap was in relation to capacity and the wording would be reviewed.			in October 2018.
	AM commented that some of the assurances reference past dates. TB commented that some may relate to when the last report was received and the next expected date could be added.	MB	October 2018	The BAF will be reviewed prior to the next business and risk meeting of the Trust Board in October 2018.
TB/18/64c Corporate / organisational risk register (ORR)	AGD commented that Risk ID 1155 was closed however in view of recent system pressures it might be a risk to revisit for the ORR by the Workforce and Remuneration Committee.	AGD	October 2018	The ORR will be reviewed prior to the next business and risk meeting of the Trust Board in October 2018.
	AM commented in relation to Risk ID 1132 whether there was a more significant impact in relation to the people on the waiting list. MB commented that a risk in relation to the impact was on the BDU risk register which would be reviewed for potential escalation to the ORR.	KT/CH	October 2018	The ORR will be reviewed prior to the next business and risk meeting of the Trust Board in October 2018.
TB/18/65b West Yorkshire and Harrogate Health and Care Partnership update	AM commented that the Trust Board had not had a chance to look at the revised draft Memorandum of Understanding in detail since January and that it would be helpful before it came for approval to review it so that feedback can be provided for the final version. SY to circulate draft to LC, AM, CD and MB for review and feedback.	SY		Complete. Draft reviewed and feedback provided to the West Yorkshire & Harrogate Health & Care Partnership.
TB/18/66a Integrated performance report M3 2018/19	AM commented in relation to West Yorkshire that Learning Disabilities and transforming care work was added as an additional programme as part of the WYMHSC. SY commented that it will be included in the reporting as the workstream is scoped out and developed.	SY		
TB/18/67a Estates Strategy update	LC asked if there had been an assessment of the community hubs as part of a post project implementation review. AGD commented that they had been completed and would be reported to the EMT and could be included in the next update to Trust Board.	AGD	January 2019	

<b>Min reference</b>	<b>Action</b>	<b>Lead</b>	<b>Timescale</b>	<b>Progress</b>
TB/18/68b Proposal for the use of e-cigarettes (agenda item 10.2)	The Trust Board requested assurance of effective implementation from the post implementation review at 6 months.	CH		
West Yorkshire Mental Health Services Collaborative (WYMHSC) Committees in Common 30 July 2018	Public Health England presentation on understanding local mental health statistics and context of national statistics. This information will be shared with the EMT.	AM		

#### **Outstanding actions from 26 June 2018**

<b>Min reference</b>	<b>Action</b>	<b>Lead</b>	<b>Timescale</b>	<b>Progress</b>
TB/18/50b Learning Disabilities Mortality Review (LeDeR) report	RW requested that the Executive Management Team through to the Clinical Governance & Clinical Safety Committee look at what the current arrangements are, what more do we need to do, whether a day to day lead is needed, and the training arrangements.	TB	September 2018	To be discussed at the next Clinical Governance & Clinical Safety Committee meeting in September 2018.
TB/18/50c Incident management annual report 2017/18	RW commented that in relation to Duty of Candour requirements, a number were in relation to Barnsley BDU which are still awaiting review by BDU, which is higher in comparison and asked if it was due to infrastructure or cultural issues. TB commented that it had been considered at BDU governance groups. KT commented that it was felt to be an operational issue around the capturing of information. Information to be provided to the Clinical Governance & Clinical Safety Committee for review.	TB / SR	September 2018	To be discussed at the next Clinical Governance & Clinical Safety Committee meeting in September 2018.
TB/18/52d General Data	RW asked if the Members' Council could provide additional oversight and assurance. MB to discuss	AM		

<b>Min reference</b>	<b>Action</b>	<b>Lead</b>	<b>Timescale</b>	<b>Progress</b>
Protection Regulations (GDPR) update	with AM regarding possible scheduling at a future Members' Council meeting.			

**Outstanding actions from 24 April 2018**

<b>Min reference</b>	<b>Action</b>	<b>Lead</b>	<b>Timescale</b>	<b>Progress</b>
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.

**Outstanding actions from 27 March 2018**

<b>Min reference</b>	<b>Action</b>	<b>Lead</b>	<b>Timescale</b>	<b>Progress</b>
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.

## Trust Board 25 September 2018 Agenda item 5

<b>Title:</b>	Chief Executive's report
<b>Paper prepared by:</b>	Chief Executive
<b>Purpose:</b>	To provide the strategic context for the Trust Board conversation.
<b>Mission/values/Objectives:</b>	The paper defines a context that will require us to focus on our mission and lead with due regard to our values.
<b>Any background papers/ previously considered by:</b>	This cover paper provides context to several of the papers in the public and private parts of the meeting and also external papers and links.
<b>Executive summary:</b>	<p>The Chief Executive's Report sets the context in which the Board discussion takes place. Attached to the Chief Executive's report is a copy of the Brief, both the slides and the narrative.</p> <p>The Brief gives a comprehensive overview of the issues affecting the Trust, it is circulated to all staff and board members and is followed up by face to face briefings in teams. Since the publication of the Brief there have been some notable developments:</p> <ol style="list-style-type: none"> <li>1. The new Secretary of State for Health and Social Care, Matt Hancock spoke at the NHS Expo. He used this speech to underline his commitment to digital technology and innovation in health care. This is an area which is of interest to the Trust and we have recently bid for funds in relation to our digital ambitions. The early signs are that this topic will play a full part in the new NHS 10 year plan. Details of Expo can be found <a href="#">here</a>.</li> <li>2. NHS England and NHS Improvement continue to develop a merged structure. We expect the new regional posts for the merged functions to be recruited to shortly. These posts will be a critical interface between Integrated Care Systems and the regulators. It will be important that this interface recognises the growing independence of local partnerships.</li> <li>3. Integrated Care Systems continue to develop their governance, financial and operational arrangements. The board papers cover this in more detail and the Chair and I will give a verbal update on recent developments.</li> <li>4. Our Annual Members' Meeting was an opportunity to present our <a href="#">annual report and accounts</a> and to reflect on past performance and our future plans. It was good to see governors and members from across the region in attendance. The opportunity to hear from service users and carers throughout the meeting was a</li> </ol>

	<p>visible demonstration of how we put the person first and in the centre and that families and carers matter.</p> <p>5. The Annual Members' Meeting was also an opportunity to set out our priorities for this year. The Board will continue to focus on delivering our CQC action plan, ensuring financial recovery, implementing our estates and clinical records system changes, and major strategic developments in services</p> <p>6. This is all seen in the context of needing to recruit, retain and motivate our staff. The excellence shortlists were announced this week and can be viewed here (hyperlink). The judges tell me they had a difficult job whittling down over 150 entrants to the shortlist which demonstrates the positive commitment that we have in our culture to improvement.</p> <p>Finally, this will be Karen Taylor's last Board meeting before she retires. Karen has spent 38 years in the NHS and is a visible and respected leader within the Trust. I would like to thank her for her support to me, the executive team, the Board and the Trust.</p>
<b>Recommendation:</b>	<b>Trust Board is asked to NOTE the Chief Executive's report.</b>
<b>Private session:</b>	Not applicable.

## 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](#).

### What's happening externally?

#### National and local news

- The prime minister recently called for a [long term NHS plan](#), the first five years of which have been backed by a new funding settlement. [Clinical priorities have now been announced](#) as cancer, cardiovascular and respiratory, mental health; learning disabilities and autism. [Eleven other workstreams](#) - covering issues such as efficiency and workforce - have also been announced. Our chief executive, Rob Webster, is contributing to the national clinical priority on learning disabilities.
- Struck-off Dr Hadiza Bawa-Garba [wins appeal to work again](#) – this high profile case had been of concern to doctors, in particular in relation to supervision and learning from mistakes.
- The health and care system across West Yorkshire and Harrogate is set to benefit from over £8.5m additional funding as [move to Integrated Care System pays early dividends](#). This will be spent on the development of primary care networks (£2.6m), urgent and emergency care (£4m), loneliness and social isolation (£1m), programme support, including mental health (£1m in total). The partnership has also revealed [priority funding areas for its workforce strategy](#).
- [First Civil Society strategy](#) in 15 years is launched to build stronger communities by bringing businesses, charities and public sector together.

### What's happening internally?

#### Safety and quality

We put safety first, always.

[Reporting of incidents](#) remains within expected range – please keep reporting on Datix  
In July we had:

- [1156 incidents](#) - 1022 rated [green](#) (no/low harm)
- 125 rated [yellow or amber](#)
- 9 rated as [red](#)
- [5 serious incidents](#) – 2 apparent suicides, 1 lost or stolen hardware, 1 informal patient absent without leave and 1 (grade 3) pressure ulcer

Our [CQC action plan](#) is being finalised having been co-produced with staff and it will be published by mid September. Extended EMT received a briefing and

slide deck. We all need to work together to make the quality improvements that are in the plan.

[Sign up to Safety kitchen table conversations](#) will happen across the Trust during September and help shape the review of the patient safety strategy. Conversations will take place during existing meetings. Contact the risk team for more info.

Beechdale ward in Calderdale are the first mental health team to get an Improvement Academy gold certificate – for [going 39 days without a violence and aggression incident](#). Congratulations also to Willow ward, Kendray who were awarded gold for falls reduction and silver for violence and aggression reduction. Our neuro rehab ward at Kendray were also awarded a silver certificate alongside Chantry ward at Fieldhead who gained a bronze - both for their work in reducing falls. It shows that safety huddles work. Find out more on the intranet.

We know we continue to see [increased demand and acuity](#) (acuity means how acutely unwell people are). Thank you for your continued efforts which are improving patient flow.

### Performance (July)

- **99%** of people recommend our community services
- **88%** recommend our mental health services
- **86%** of people dying in a place of their choosing
- **33%** of people in CAMHS receiving treatment within 18 weeks of referral
- **98%** follow ups within 7 days of discharge
- **99.4%** of people receiving IAPT treatment within 18 weeks of referral
- **436** “inappropriate” out of area bed days
- **76%** of prone restraint lasted ≤3mins
- **99%** of suppliers were paid in a timely manner, as demonstrated by the Better Payment Practice Code

There were **16 confidentiality breaches** during July. These were mainly due to human error. Remember your responsibilities to keep information safe and to always be accurate.

**92%** of staff are up to date with their [mandatory information governance training](#) – if you haven't done yours yet, please make it a priority.

### Staffing

- We've welcomed [two new non-executive directors](#) (NEDs), Sam Young and Erfana Mahmood. Non-executive directors are local people whose wide range of experience and skills contribute to the effective management and accountability of our trust.
- Remember – [all staff must be appraised](#) by the end of September. This is your chance to have a conversation about your aspirations, your objectives and the support you might need. A good appraisal is linked to better performance and safer organisations. Also please make sure appraisals are recorded on the intranet.
- Thanks for continued work around [sickness absence](#) – it has gone up slightly in July to 4.8%. It's now standing at 4.48% so far this year to date, just below our target of 4.5%. Remember there is support available to all staff and that appraisals now include a

conversation about health and wellbeing.

- [The flu jab](#) protects you, your family and your patients. Look out for information soon on where and when vaccinations are taking place near you this Autumn.
- We continue to develop staff networks. Both our [Black, Asian and minority ethnic \(BAME\) staff network](#) and our [disability staff network](#) are currently open for nominations for a number of roles. Please get involved.
- Our [LGBT+ network group](#) is also in development, having agreed terms of reference and key roles. To get involved see the intranet.

### Focus on: staff wellbeing survey results

Over 1700 staff completed our wellbeing survey that closed earlier this month. [Thank you for taking the time to share your views](#). We have now received the high level results, which can be viewed on the intranet.

[Overall, results for the Trust have improved since last year](#). All results are now typical of the general working population, and are, generally, at the higher end of the scale.

However, there is some [variation in levels of wellbeing across services and staff groups](#). This is something which will be explored in greater detail and which you should discuss in your teams. Many teams are doing well, some teams and professional groups are not.

It's important that we make improvements together, because [it matters to all of us](#). We'll keep a sustained focus on this work and link it to our workforce strategy.

So that we can work on this together, please come to one of our [solution groups in September](#). You'll get to understand more about the results from your service, share ideas for improvements and hear about how teams can come together to make a difference. Dates are on the intranet.

### Month 4 finances (July)



We had a [£125k deficit](#) in July, an improvement on previous months, but we need to improve further. This is the first year the Trust has been in a deficit position. Our deficit is now £1.1m so far this year.



We spent [£0.5m](#) on agency in July. We've spent £2m so far this year which is 6% higher than the same period last year. Current year end projection shows we will exceed our agency cap agreed by NHS Improvement by 17%.



We have generated [£2.7m in cost improvements](#) so far this year. We need to save £9.7m in total this year, £1m of which is still to be identified

We need everyone's help to ensure we [spend our money as wisely as possible](#). Alongside financial and staffing controls, we really want to [focus on eliminating areas of waste](#). Have conversations in your team about any areas of waste, also share your ideas on i-hub. [All of us can improve and be outstanding](#).

## Infrastructure

Did you know that holding a teleconference costs us money, yet [Skype \(previously known as Lync\)](#) is free? Wherever possible, switch to this method. We're going to review who's using Skype. So, if you don't need it your licence will be passed on to a colleague, to make sure we're making best use of resources. There'll be further info out about this soon.

From 1 October 2018 there'll be 4.5GB limit on your [Outlook mailbox](#). Ahead of this, please clear out large or old emails. More advice will be issued during September.

[Our new ESR portal](#) will officially go live on 1 October 2018. This will make it easier to access e-learning, including managing mandatory training, as well as viewing your learning history, payslips and P60 and updating personal information. You'll be able to use ESR via the web or an app.

Work continues on our [Fieldhead masterplan](#), focussing on the main entrance/visitor centre, car park and Nostell ward, which has just been connected to the IT network and will soon also have Wi-Fi for service users.

Our low secure service, The Bretton Centre, celebrated their tenth anniversary, and [they did it in style!](#)

## Focus on: [SystemOne](#)

Are you and your colleagues signed up to [SystemOne for mental health training?](#)

### **Choose the right training modules**

- Everyone should complete SystemOne: Getting Started
- After this, staff should choose one role specific module (Inpatient, Community or Admin)

### **Choose your preferred learning method**

- Sign up to classroom training AND/OR
- Use the online training materials on the intranet. Please register your intent to use these materials instead of attending classroom training
- You must pass the module competency check

Classroom training sessions run from mid-September until early January – [please don't leave it until the last minute, spaces are limited!](#)

The programme team will be in touch soon to make you aware of who has and hasn't signed up to training in your teams.

Go to the SystemOne intranet page to find out more.

## Service change

### **Barnsley services**

Last month, Barnsley CCG announced their proposal to join up and integrate services across the Borough. This proposal is still in its early days and will take around 2 years to conclude.

We've had feedback that the CCG have been asked to respond to a number of questions as part of the external assurance process from NHS England and NHS Improvement (the process is known as ISAP). The next meeting with NHSI and NHSE is likely to be in October.

Together with the council, the hospital trust and the GP Federation we've been continuing to look at how we respond to the CCG's plans, [focusing on improving care rather than structural changes](#). Recent developments around neighbourhood models of care in the Dearne Valley are a good example of what we want to achieve together. We'll keep everyone updated as things develop.

### **Barnsley Rapid Access Clinic**

Barnsley CCG are undertaking a review; looking at statistics, data and information that we've provided. They are also undertaking a [public engagement exercise](#) to inform their thinking for future commissioning proposals. A report on this work will be shared by the CCG in the autumn.

### **Suicide prevention training**

We've been successful in a bid to the Local Workforce Action Board Funding to support the West Yorkshire Suicide Prevention Strategy work, which we lead on. [£22k has been awarded to support training](#) of West Yorkshire Police and West Yorkshire Fire and Rescue Service in suicide awareness (safeTALK) and intervention (ASIST) to develop a coordinated team of first responders.

### **Older people's transformation**

Work continues to progress, including [ongoing conversations with commissioners](#) about the model and the proposals, as well as further business case development. We'll be refreshing the workstreams for both the inpatient and community models. Speak to a member of your Trio with any queries.

### **Yorkshire and Humber Forensic CAMHS Launch Event**

There's a formal launch in September of Yorkshire and Humber's new [regional forensic child and adolescent mental health service](#); a partnership between ourselves and three other trusts.

### Quality improvement and innovation

We've been shortlisted at the [Nursing Times Workforce Awards](#) in the 'Workforce team of the year' category for our work to create a sustainable workforce to meet the demands of inpatient mental health wards.

Thank you for your entries and nominations to [Excellence 2018](#), we've had over 150. Local judging for individual entries is now taking place ahead of the main judging panel on 10 September. The shortlist will be announced on Monday 17 September.

It's [Suicide Awareness Day](#) on 10 September and we are launching a 'messages of hope campaign', sharing letters written by service users. Please also [sign up to this course](#) from Zero Suicide Alliance, teaching you how to safeguard someone that may be thinking about suicide. It's free and only takes 20 minutes.

We've got a new webpage for our autism service, including the [checklist for autism friendly environments](#). There's guidance on how to complete the checklist and how to make simple changes.

Have you got an idea for a research project? Applications are now invited for the 2018-19 Research for Change award. Funding is available to backfill staff time (up to 1 day/week for 6-9 months) for small scale research projects.

### Focus on: our Annual Members' Meeting

It's important you feel connected to the Trust. [The Trust is yours](#) - our staff are members.

Our [Annual Members' Meeting](#) is taking place on Monday 17 September at the Shay Stadium, Shaw Hill, Halifax.

It's a great opportunity to network and to find out more about [how we are governed and led](#). [Meet your representatives](#) and also learn more about teams from across the Trust.

To book a place email [membership@swyt.nhs.uk](mailto:membership@swyt.nhs.uk) or call 01924 316462.

### Take home messages

1. Thank you for your continued efforts in maintaining safety and quality
2. Keep information safe and always be accurate in your recording
3. Make sure you understand your role in delivering our CQC action plan
4. Your wellbeing matters to #allofus – come to a solution group
5. Please help us eliminate waste and become as efficient as we can.  
#allofusimprove
6. Make sure you're signed up training for our new clinical system for mental health
7. The Trust is yours - have your appraisal, join a network, come to our annual members meeting

A large decorative graphic consisting of a white circle in the center, surrounded by concentric rings of blue rectangular blocks. The blocks are arranged in a pattern that resembles a stylized sun or a circular grid, with the blocks slightly overlapping and creating a sense of depth and movement.

# The Brief

## 30 August 2018

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

With **all of us** in mind.

## Our mission and values

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

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

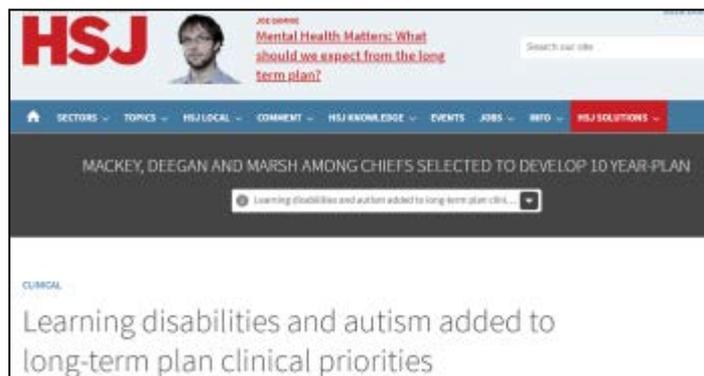
- We put people first and in the centre and know that families and carers matter
- We're respectful, honest, open and transparent
- We constantly improve and aim to be outstanding so that we're relevant today and ready for tomorrow



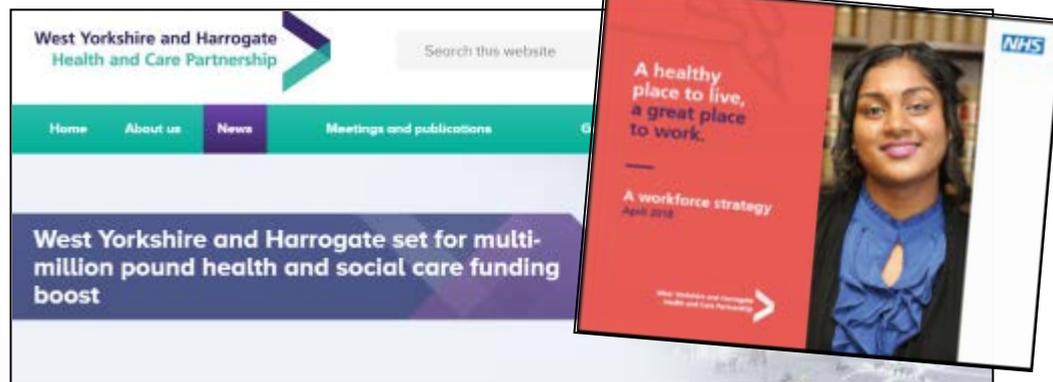
Barnsley dietitian, Sarah Armer, experiences [life with a feeding tube](#)

# What's happening externally

## National and local news



Clinical priorities for NHS plan - cancer, cardiovascular and respiratory, mental health; learning disabilities and autism



£8.5m funding for West Yorkshire and Harrogate Health and Care Partnership – who also announce priority funding for workforce strategy



Struck-off Dr Hadiza Bawa-Garba wins appeal



Civil Society strategy launched to build stronger communities



# What's happening internally

## Safety and quality

We put safety first, always. Please keep reporting.

In July we had:

- 1156 incidents - 1022 were green (no/low harm)
- 125 rated yellow or amber
- 9 rated as red
- 5 serious incidents – 2 apparent suicides, 1 lost or stolen hardware, 1 informal patient absent without leave and 1 (grade 3) pressure ulcer

Our CQC action plan is being finalised. ExEMT have been briefed. Understand what it means to you as we need to work together to make quality improvements.

We continue to see increased demand and acuity  
Thank you for your continued efforts.

Sign up to

SAFETY

Take part in  
kitchen table  
conversations  
during Sept.



Safety huddles are working – right across our Trust

With all of us in mind.

# What's happening internally

## Performance (July)

- **99%** of people recommend our community services
- **88%** recommend our mental health services
- **86%** of people dying in a place of their choosing
- **33%** of people in CAMHS receiving treatment within 18 weeks of referral
- **98%** follow ups within 7 days of discharge
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- **436** “inappropriate” out of area bed days
- **76%** of prone restraint lasted  $\leq 3$ mins
- **99%** of suppliers were paid in a timely manner, as demonstrated by the Better Payment Practice Code

There were **16 confidentiality breaches** during July. Remember your responsibilities to keep information safe and to always be accurate.



**92%** of staff are up to date with their mandatory information governance training.

## What's happening internally

### Staffing

We've welcomed **new non-executive directors**.



Sam Young and Erfana Mahmood.

Remember: **all staff should be appraised** by the end of Sept. This is your chance to discuss things with your team and line manager.

Thanks for continued work around **sickness absence** – **4.8%** in July. We are just below our target of **4.5%** across the year.

Look out for **flu jab** info, coming soon.



We continue to develop our staff networks.

**BAME and disability networks** are open for nominations.



An **LGBT+** network is also in development.

Please get more involved – these are your networks.



# What's happening internally

## Focus on: staff wellbeing survey

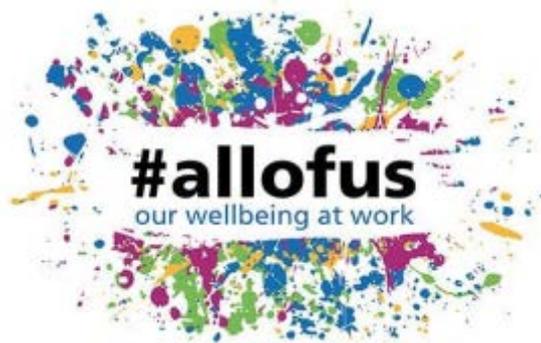
Thank you to the 1700 staff who gave their views.  
We now have the high level results.

Overall, results have improved since last year.

There's variation in levels of wellbeing across services and staff groups. This is something you should explore in greater detail with our support.

It's important we make improvements together,  
it matters to all of us.

We'll keep a sustained focus on this and link it to our workforce strategy.



Please come to a solution group.

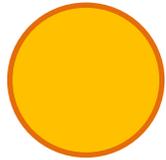
Dates are on the staff intranet.

Hear more, discuss ideas, share improvements.

With all of us in mind.

# What's happening internally

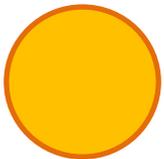
## Month 4 finances (July)



We had a **£125k deficit** in July, an improvement, but we need to improve further. This is the first year the Trust has been in a deficit position. Our deficit is now £1.1m so far this year.



We spent **£0.5m on agency** in July. We've spent £2m so far this year which is 6% higher than the same period last year. Current year end projection shows we will exceed our agency cap agreed by NHS Improvement by 17%.



We have generated **£2.7m in cost improvements** so far this year. We need to save £9.7m in total this year, £1m of which is still to be identified

We need your help to ensure we spend our money as wisely as possible.



Alongside staffing and financial controls, we want to focus on eliminating waste. Please share your ideas in your team including via ihub.

With all of us in mind.

# What's happening internally

## Infrastructure

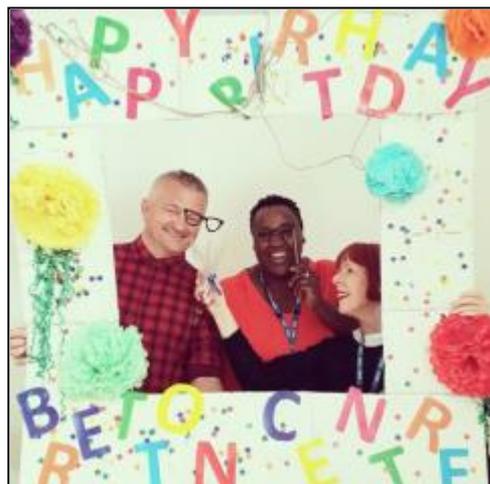
From 1 October 2018 there'll be a 4.5GB limit on your Outlook mailbox.



Did you know that holding a teleconference costs us money? Yet **Skype** (previously known as Lync) is free for those with a licence?



Wherever possible, switch to this method. If you don't need it, your licence will be passed on to a colleague.



Our low secure service, The Bretton Centre, celebrated their tenth anniversary

Our new **ESR portal** goes live on 1 October. You'll see a number of improvements and be able to use it on the web or via an app.



Work continues on our **Fieldhead masterplan**, including enabling Wi-Fi for service users on Nostell Ward.



# What's happening internally

Focus on: SystmOne for mental health

Are you and others signed up to SystmOne training?

✓ **Choose the right training modules**

- Everyone should complete SystmOne: Getting Started
- After this, you should choose one role specific module (Inpatient, Community or Admin)

✓ **Choose your preferred learning method**

- Sign up to classroom training **AND/OR**
- Use the online training materials on the intranet. Please register your intent to use this training method using the links on the intranet.
- You must pass the competency check for each module.



***Classroom training sessions run from mid-September until early January – don't leave it until the last minute, spaces are limited!***

**Visit the intranet to find out more, including who has and hasn't signed up for training in your team.**



With **all of us** in mind.

# What's happening internally

## Service change

### Barnsley services

Last month, Barnsley CCG announced their proposal to join up services, possibly through a single organisation.

The CCG are responding to a number of questions as part of the external assurance process. The next meeting is likely to be in October.



We're continuing to work with provider partners to look at what we can achieve by working together.

**Barnsley Rapid Access Clinic - CCG** are undertaking a review to inform future commissioning proposals.



**Older people's transformation** - work now focused on conversations with commissioners about the proposals.

**Suicide prevention training** – successful bid on behalf of West Yorkshire. £22k will support training of the police and fire service.



**Yorkshire and Humber Forensic CAMHS** - formal launch in September of new partnership between ourselves and 3 other trusts.

With all of us in mind.

# What's happening internally

## Quality improvement and innovation

We've had over 150 entries into Excellence 2018.  
Shortlist announced on 17 Sept.

Suicide  
Awareness Day  
on 10 Sep:  
'messages of  
hope  
campaign'.



Please also  
sign up to Zero  
Suicide Alliance  
training.

New webpage for  
our autism service,  
including checklist  
for autism friendly  
environments.



Got an idea for  
a research  
project?  
Applications  
now open for  
Research for  
Change award.

We're shortlisted in Nursing  
Times Workforce Awards for  
efforts to create an inpatient  
mental health sustainable  
workforce.



With **all of us** in mind.

# What's happening internally

## Focus on: Annual Members' Meeting

It's important you feel connected to the Trust.

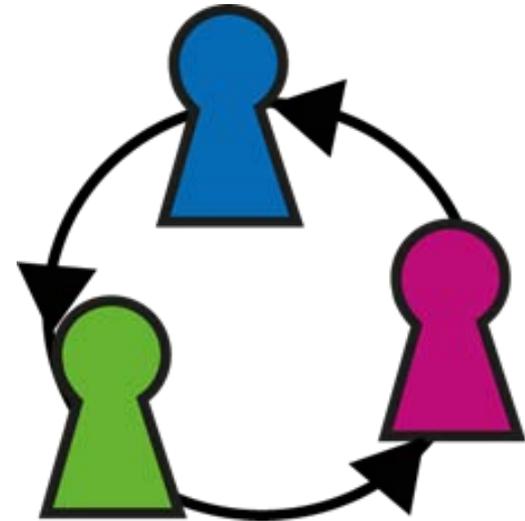
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## Take home messages

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Please help us eliminate waste and become as efficient as we can.

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Make sure you're signed up training for our new clinical system for mental health

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## Trust Board 25 September 2018 Agenda item 6.1

<b>Title:</b>	<b>Integrated Performance Report Month 5 2018/19</b>
<b>Paper prepared by:</b>	Director of Finance & Resources Director of Nursing & Quality
<b>Purpose:</b>	To provide the Board with the Integrated Performance Report (IPR) for August 2018.
<b>Mission/values/objectives</b>	All Trust objectives
<b>Any background papers/ previously considered by:</b>	<ul style="list-style-type: none"> <li>➤ IPR is reviewed at Trust Board each month</li> <li>➤ IPR is reviewed at Executive Management Team meeting on a monthly basis</li> </ul>
<b>Executive summary:</b>	<p><b>Quality</b></p> <ul style="list-style-type: none"> <li>➤ The reduction in under 18 admissions is noted, this remains the least worst option and must not become a routine position.</li> <li>➤ Safer staffing fill rates are positive overall, significant pressures still exist in relation to acuity and demand. The establishment review is being considered during the workforce planning sessions.</li> <li>➤ Seven day follow up target was narrowly missed, all efforts were made to make contact.</li> <li>➤ CQC action plan tracker shows early progress.</li> </ul> <p><b>NHS Improvement Indicators</b></p> <ul style="list-style-type: none"> <li>➤ The Trust continues to meet the majority of national performance metrics</li> <li>➤ Inappropriate out of area bed placement reduction target is currently not being achieved with the number of bed days showing a significant increase in August to 589.</li> <li>➤ The Trust narrowly missed its 7 day follow up target, achieving 94.9% compared to the target of 95%. This is the second time the threshold has not been achieved in the year.</li> <li>➤ IAPT proportion of people completing treatment and moving to recovery in-month is still above target, but only marginally in August at 50.7%.</li> <li>➤ Total bed days of Children and Younger People in adult inpatient wards reduced from 22 in July to 1 in August.</li> </ul> <p><b>Locality</b></p> <ul style="list-style-type: none"> <li>➤ Average length of stay in Barnsley and Wakefield mental health services is excess of target and is an area of focus.</li> <li>➤ The number of neuro rehabilitation beds commissioned reduces from 12 to 8 from October onwards.</li> <li>➤ A follow up meeting has taken place with the NHS England intensive support team and the CCGs in Kirklees and Calderdale in respect of the progress being made on the IAPT action plan.</li> <li>➤ Discussions taking place with the specialist commissioner in respect of forensic learning disability and medium secure bed demand and</li> </ul>

	<p>capacity.</p> <ul style="list-style-type: none"> <li>➤ Recruitment and retention of medical staff continues to be a challenge in CAMHs and learning disability services.</li> <li>➤ Medical recruitment also remains a challenge in other services and across all geographies.</li> </ul> <p><b>Priority Programmes</b></p> <ul style="list-style-type: none"> <li>➤ Criteria led discharge has been implemented in Wakefield with other locations to follow by the end of December.</li> <li>➤ Over 3,000 training sessions for SystemOne have been booked.</li> <li>➤ Commissioner engagement with regard to older people's service transformation continues.</li> </ul> <p><b>Finance</b></p> <ul style="list-style-type: none"> <li>➤ Net deficit of £139k in month which is favourable to plan. This position was boosted by a gain on disposal and a one-off VAT reclaim. As such the underlying position was a deficit of £392k.</li> <li>➤ Cumulative deficit is now £1.2m. The underlying run rate remains adverse to the full year plan.</li> <li>➤ Agency costs of £575k in month were 24% higher than the cap and represent the highest single month's expenditure since March 2017. Cumulatively spend is 6% above the cap.</li> <li>➤ Net pay savings of £0.3m year-to-date.</li> <li>➤ Out of area bed expenditure amounted to £392k which is higher than recent months. Cumulatively expenditure of £1.8m now represents 100% of the full year budget and is 62% higher than the corresponding period for 2017/18.</li> <li>➤ Year-to-date CIP delivery of £3.6m is £0.1m above plan.</li> <li>➤ Cash balance of £24.8m is slightly ahead of plan.</li> <li>➤ Financial risk rating improved to 2 given the deficit margin is slightly better than -1%.</li> </ul> <p><b>Workforce</b></p> <ul style="list-style-type: none"> <li>➤ Sickness absence increased to 4.9% in August, but remains at 4.5% year-to-date.</li> <li>➤ Staff turnover is 13.0% year-to-date.</li> <li>➤ The vast majority of training targets are being achieved.</li> <li>➤ Appraisal completion of band 6 and above stands at 92.8%, just below the 95% target.</li> </ul>
<b>Recommendation:</b>	<b>Trust Board is asked to NOTE the Integrated Performance Report and COMMENT accordingly.</b>
<b>Private session:</b>	Not applicable

# Integrated Performance Report Strategic Overview



**August 2018**

With **all of us** in mind.



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## Introduction

Please find the Trust's Integrated Performance Report (IPR) for August 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 undertook work to review and refresh the summary dashboard for 2018/19 to ensure it is fit for purpose and aligns to the Trust's updated objectives for 2018/19. All updates are now incorporated. 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.

Summary Quality National Metrics Locality Priority Programmes Finance/Contracts Workforce

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	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Year End Forecast		
Single Oversight Framework metric	2	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	Green		
<b>Improve people's health and reduce inequalities</b>	<b>Target</b>	<b>Aug-17</b>	<b>Sep-17</b>	<b>Oct-17</b>	<b>Nov-17</b>	<b>Dec-17</b>	<b>Jan-18</b>	<b>Feb-18</b>	<b>Mar-18</b>	<b>Apr-18</b>	<b>May-18</b>	<b>Jun-18</b>	<b>Jul-18</b>	<b>Aug-18</b>	<b>Year End Forecast</b>		
Total number of children & young people in adult inpatient wards 5	0	3	2	3	1	2	2	1	3	1	0	3	3	1	1		
% service users followed up within 7 days of discharge	95%	97.2%	96.1%	94.7%	98.2%	98.2%	97.2%	98.0%	95.8%	94.3%	99.2%	100%	97.7%	94.9%	4		
% clients in settled accommodation	60%	81.8%	80.8%	80.7%	80.4%	80.4%	80.1%	79.7%	79.1%	78.9%	78.5%	79.1%	78.8%	Due Oct	4		
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks 1	95%				86.8%			87.8%			86.7%		Due Oct		95%		
Out of area beds 2	Q1 940, Q2 846, Q3 752, Q4 658	362	424	467	412	407	268	613	730	536	284	375	437	589	1		
Physical Health - Cardiometabolic Assessment (CMA) - Proportion of clients with a CMA Community Inpatient 9	Community 75% Inpatient 90%											79.8%	81.1%	82.0%	82.8%	4	
												89.1%	90.6%	93.3%	91.2%	4	
Smoking Cessation - 4 week quit rate 8	tbc	Data avail Sept 18															
<b>Improve the quality and experience of care</b>	<b>Target</b>	<b>Aug-17</b>	<b>Sep-17</b>	<b>Oct-17</b>	<b>Nov-17</b>	<b>Dec-17</b>	<b>Jan-18</b>	<b>Feb-18</b>	<b>Mar-18</b>	<b>Apr-18</b>	<b>May-18</b>	<b>Jun-18</b>	<b>Jul-18</b>	<b>Aug-18</b>	<b>Year End Forecast</b>		
Friends and Family Test - Mental Health	85%	79%	85%	86%	86%	85%	85%	85%	87%	86%	75%	82%	88%	91%	85%		
Friends and Family Test - Community	98%	99%	99%	97%	98%	100%	97%	97%	99%	97%	100%	98%	99%	97%	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	28	25	28	34	26	33	37	20	26	22	22	36	34	N/A		
Safer staff fill rates	90%	109%	111.8%	112.9%	115.7%	113.4%	117.1%	117.5%	115.7%	118%	120%	118%	118%	117%	100%		
IG confidentiality breaches	<=8 Green, 9-10 Amber, 11+ Red	10	6	5	12	7	7	10	4	8	11	14	16	14			
% people dying in a place of their choosing	80%		83%	91%	89%	88%	94%	84%	87%	83%	89%	80%	85.7%	93.9%	N/A		
Proportion of people detained under the MHA who are Black, Asian & Minority Ethnic 7	trend monitor						15.1%				9.0%				15.1%	Due Oct	N/A
CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks 3	trend monitor											36.3%	37.1%	33.2%	33.1%	37.0%	N/A
<b>Improve the use of resources</b>	<b>Target</b>	<b>Aug-17</b>	<b>Sep-17</b>	<b>Oct-17</b>	<b>Nov-17</b>	<b>Dec-17</b>	<b>Jan-18</b>	<b>Feb-18</b>	<b>Mar-18</b>	<b>Apr-18</b>	<b>May-18</b>	<b>Jun-18</b>	<b>Jul-18</b>	<b>Aug-18</b>	<b>Year End Forecast</b>		
Projected CQUIN Shortfall	£4.2m	£856k	£856k	£856k	£856k	£136k	£136k	£136k	£203k	-	£160k	£252k	£379k	£379k	£379k		
Surplus/(Deficit)	In line with Plan	£226k	£6k	£158k	£235k	£551k	£635k	£1186k	£1139k	(£292k)	(£204k)	(£464k)	(£125k)	(£139k)	(£2626k)		
Agency spend	In line with Plan	£446k	£435k	£515k	£531k	£430k	£465k	£563k	£555k	£444k	£538k	£484k	£526k	£575k	£5.8m		
CIP delivery	£1074k	£2950k	£3452k	£4117k	£4815k	£5442k	£6157k	£6816k	£7475k	£619k	£1308k	£1981k	£2737k	£3615k	£9.7m		
Sickness absence	4.5%	4.9%	4.9%	4.9%	5.0%	5.1%	5.2%	5.3%	5.3%	4.6%	4.5%	4.4%	4.5%	4.5%	4.9%		
Aggression Management training	>=80%	77.0%	77.6%	76.4%	79.0%	78.0%	77.9%	78.2%	79.3%	79.3%	81.7%	81.6%	82.9%	83%	80%		
Moving and Handling training	>=80%	79.3%	79.3%	80.7%	81.6%	81.9%	84.1%	85.4%	85.5%	85.2%	85.9%	85.6%	85.7%	86.1%	80%		
Staff Turnover 6	10%	10.7%	11.7%	11.4%	12.1%	12.3%	12.4%	12.5%	12.6%	9.7%	8.5%	11.6%	12.4%	13.0%	11.0%		

NHSI Ratings Key:  
1 – Maximum Autonomy, 2 – Targeted Support, 3 – Support, 4 – Special Measures Figures in italics are provisional and may be subject to change.

**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. Under performance is generally due to waiting list issues. To mitigate this, the service have a management process in place for waiting lists across all our 4 community localities – generally, waits occur due to medium to long term absence within a specific locality discipline and as the member of staff returns to work the waits reduce. Specific issues are being addressed with locality commissioners where appropriate. The waiting lists are reviewed by leads regularly and allocated by clinical priority.  
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 days 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 has taken place to identify a suitable metric across all Trust smoking cessation services. The metric will identify the 4 week quit rate for all Trust smoking cessation services. National benchmark for 17/18 was 51%. Q1 data will be available in September 18.  
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.

#### Quality

- The reduction in under 18 admissions is noted, this remains the least worst option and must not become a routine position
- Safer staffing fill rates are positive overall, significant pressures still exist in relation to acuity and demand. The establishment review is being considered during the workforce planning sessions.
- Seven day follow up target was narrowly missed, all efforts were made to make contact.
- CQC action plan tracker shows early progress

#### NHSI Indicators

- The Trust continues to meet the majority of national performance metrics
- Inappropriate out of area bed placement reduction target is currently not being achieved with the number of bed days showing a significant increase in August to 589
- The Trust narrowly missed its 7 day follow up target, achieving 94.9% compared to the target of 95%. This is the second time the threshold has not been achieved in the year
- IAPT proportion of people completing treatment and moving to recovery in-month is still above target, but only marginally in August at 50.7%
- Total bed days of Children and Younger People in adult inpatient wards reduced from 22 in July to 1 in August

#### Locality

- Average length of stay in Barnsley and Wakefield mental health services is excess of target and is an area of focus
- The number of neuro rehabilitation beds commissioned reduces from 12 to 8 from October onwards
- A follow up meeting has taken place with the NHS England intensive support team and the CCGs in Kirklees and Calderdale in respect of the progress being made on the IAPT action plan
- Discussions taking place with the specialist commissioner in respect of forensic learning disability and medium secure bed demand and capacity
- Recruitment and retention of medical staff continues to be a challenge in CAMHs and learning disability services
- Medical recruitment also remains a challenge in other services and across all geographies

#### Priority Programmes

- Criteria led discharge has been implemented in Wakefield with other locations to follow by the end of December
- Over 3,000 training sessions for SystmOne have been booked
- Commissioner engagement with regard to older people's service transformation continues

#### Finance

- Net deficit of £139k in month which is favourable to plan. This position was boosted by a gain on disposal and a one-off VAT reclaim. As such the underlying position was a deficit of £392k
- Cumulative deficit is now £1.2m. The underlying run rate remains adverse to the full year plan
- Agency costs of £575k in month were 24% higher than the cap and represent the highest single month's expenditure since March 2017. Cumulatively spend is 6% above the cap
- Net pay savings of £0.3m year-to-date
- Out of area bed expenditure amounted to £392k which is higher than recent months. Cumulatively expenditure of £1.8m now represents 100% of the full year budget and is 62% higher than the corresponding period for 2017/18.
- Year-to-date CIP delivery of £3.6m is £0.1m above plan
- Cash balance of £24.8m is slightly ahead of plan
- Financial risk rating improved to 2 given the deficit margin is slightly better than -1%.

#### Workforce

- Sickness absence increased to 4.9% in August, but remains at 4.5% year-to-date
- Staff turnover is 13.0% year-to-date
- The vast majority of training targets are being achieved
- Appraisal completion of band 6 and above stands at 92.8%, just below the 95% target

Summary

Quality

National Metrics

Locality

Priority Programmes

Finance/Contracts

Workforce

## 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	Jun-18	Jul-18	Aug-18	Year End Forecast Position *	
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks <sup>5</sup>	Improving Health	Responsive	KT/SR/CH	TBC	Reporting Established from April 2018								37.7%	39.7%	35.0%	35.2%	37.0%	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	21% 2/7	43% 3/7	57% 8/14	1	
	% of feedback with staff attitude as an issue	Improving Health	Caring	AD	< 20%	14% 23/168	7% 12/162	18% 28/158	23% 23/195	12% 43/217	18.2% 38/208	7.7% 13/168	16% 10/64	5% 3/57	10% 5/50	12% 11/88	15% 9/60	19% 13/68	4	
Service User Experience	Friends and Family Test - Mental Health	Improving Health	Caring	TB	85%	72%	71%	71%		84%	84%	86%	86%	86%	75%	82%	88%	91%	4	
	Friends and Family Test - Community	Improving Health	Caring	TB	98%	98%	98%	99%		98%	98%	98%	98%	97%	100%	98%	99%	97%	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	75%	N/A	N/A	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	70%	N/A	N/A	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	44	27	45	N/A		
	Number of Duty of Candour applicable incidents <sup>4</sup>	Improving Health	Caring	TB	N/A	73	86	83	86			337		21	22	28	35		N/A	
	Duty of Candour - Number of Stage One exceptions <sup>4</sup>	Improving Health	Caring	TB	N/A	Reporting established from Oct 16		0	2			26		0	1	1	1		Due Oct 18	N/A
	Duty of Candour - Number of Stage One breaches <sup>4</sup>	Improving Health	Caring	TB	0	Reporting established from Oct 16	0	1	1	2	1	0	1	0	1	0	1			
	% 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%	86.2%	88.7%	86.3%	4	
	Un-outraced appointments <sup>6</sup>	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%	4.1%	3.3%	4.8%	N/A	
	Number of Information Governance breaches <sup>3</sup>	Improving Health	Effective	MB	<=8	36	25	29	36	33	22	24	21	8	11	14	16	14		
	Delayed Transfers of Care <sup>10</sup>	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%	2.6%	2.4%	2.4%	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	3065	2962	3441	1074	1087	1039	1161	994	N/A	
	Total number of patient safety incidents resulting in Moderate harm. (Degree of harm subject to change as more information becomes available) <sup>9</sup>	Improving Care	Safety Domain	TB	trend monitor					57	58	56	72	23	13	16	27	30	N/A	
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) <sup>9</sup>	Improving Care	Safety Domain	TB	trend monitor	10	19	19	20	3	8	9	7	2	1	1	5	1	N/A	
	Total number of patient safety incidents resulting in death harm. (Degree of harm subject to change as more information becomes available) <sup>9</sup>	Improving Care	Safety Domain	TB	trend monitor	73	79	73	84	12	17	24	11	1	8	5	4	3	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%	18.4%	23.2%	22.4%	3	
	Safer staff fill rates	Improving Care	Safety Domain	TB	90%					109%	111.1%	114%	116.8%	118%	118%	118%	117%	4		
Safer Staffing % Fill Rate Registered Nurses	Improving Care	Safety Domain	TB	80%					107%	94.1%	99%	98.4%	99.2%	100%	99.5%	96.4%	92.5%	4		
Number of pressure ulcers (attributable) <sup>1</sup>	Improving Care	Safety Domain	TB	N/A	98	95	78	86	82	92	71	98	30	29	29	24		N/A		
Number of pressure ulcers (avoidable) <sup>2</sup>	Improving Care	Safety Domain	TB	0	1	4	3	2	2	1	2	2	0	0	1	0		3		
Eliminating Mixed Sex Accommodation Breaches	Improving Care	Safety Domain	TB	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4		
% of prone restraint with duration of 3 minutes or less <sup>8</sup>	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%	75%	76%	73%	4		
Number of Falls (inpatients)	Improving Care	Safety Domain	TB	TBC	162	158	136	95	139	139	150	181	40	40	44	43	37	N/A		
Number of restraint incidents	Improving Care	Safety Domain	TB	N/A	Data not avail				345	424	442	589	173	211	143	192	151	N/A		
Infection Prevention (MRSA & C.Diff) All Cases	Improving Care	Safety Domain	TB	6	0	0	1	2	1	0	0	0	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	0	0	0	4		
Quality	No of staff receiving supervision within policy guidance <sup>7</sup>	Improving Care	Well Led	KT/SR/CH	80%	39.5% (March 17)			59.3%	61.0%	64.7%	86.5%	78.4%			Due Oct 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.
- 5 - 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.
- 6 - This is the year to date position for mental health direct unoutraced appointments which is a snap shot position at a given point in time. The increase in unoutraced 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 and this has continued into 18/19. There are now only a small number that require additional development.

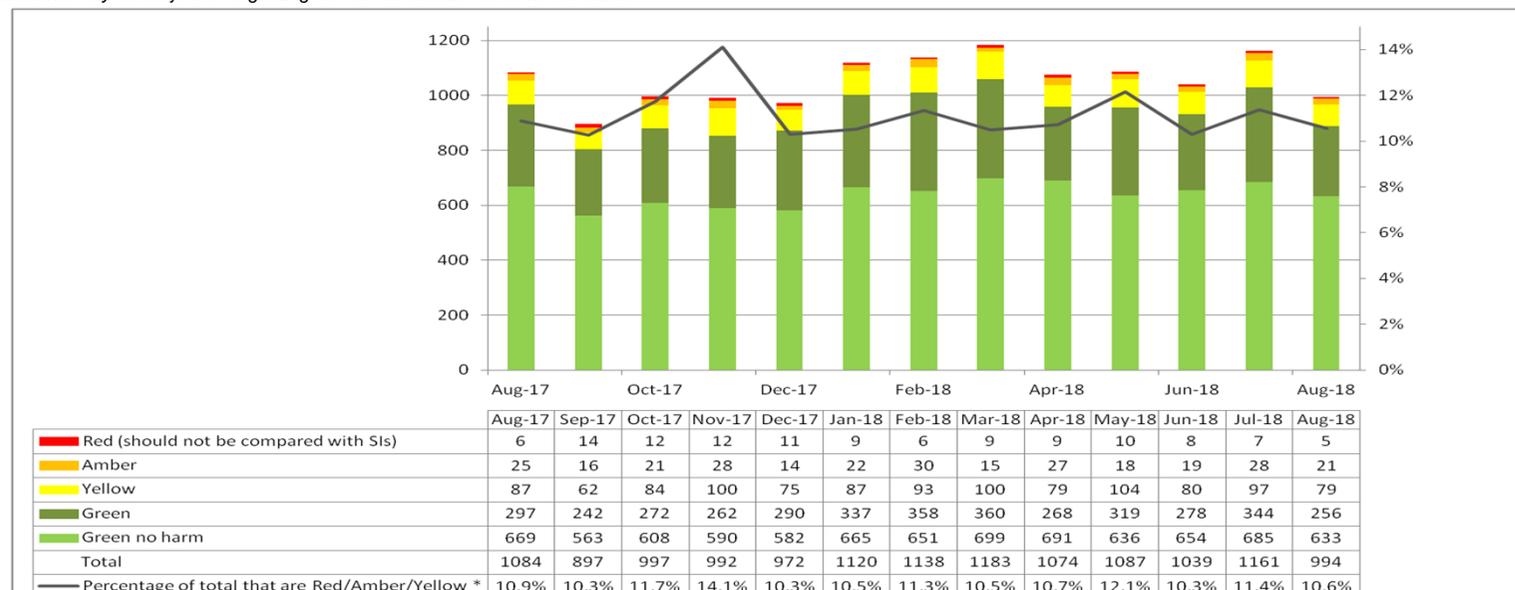
Please see the points below for indicators that are performing outside expected levels or where additional supporting information is available.

- Restraint incidents - there were 151 restraints reported with the highest proportion being in a standing position (68). This is an overall decrease on the month of July 2018 that stood at 192 total restraints. The percentage of prone restraints lasting 3 minutes or less was 73%. Wakefield remains the highest BDU for prone restraints during the month of August. These incidents relate to 28 service users, all had clear reasons for restraint. The two main factors leading to the need of restraint are danger to self or others, and at these times the clinical need to utilise intra muscular medication, against the service users will and or seclusion. Within the Wakefield BDU the highest incidents occurred on Priory 2 which has high acuity and at times significant self harming behaviour displayed by the service users and Walton which being a PICU one would expect high acuity. There have been 0 incidents resulting in injury to service users in the month of August 2018. There has been 1 incidents resulting in injury to staff resulting in Riddor in the month of August 2018.
- 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 in-patient medicine omissions in mental health trusts is just below 15%. At the end of quarter 1, SWYPFTs average was 19.6%. Older people's services have made a concerted effort to improve their patient compliance, as historically patient refusal was by far the biggest reason for medication omissions. Their combined quarter 1 rate was 15.2% which is almost at the national average. Unfortunately working age adult services remain above the national average and their combined quarter 1 average was 19.8%. Medicines omissions continue to be difficult to interpret due to changes in the way data is presented on the MHST website which no longer breaks down the reason for omission. Feedback from staff indicates that refusals are still the most common cause and this is at times high due to increased numbers of service users with diagnoses of personality disorder. As part of the CQC action plan a monthly report to BDU governance groups alongside medicines assurance checklists is planned from next month.
- Complaints closed within 40 days - for the third month there is a positive increase in the number of complaints closed within 40 days. The total number of complaints that remain open pre March 18 has reduced to 16. Both these figures demonstrate the impact of the revised complaints process and the significant contribution from both operational and customer services team.

## Safety First

### Summary of Incidents during 2017/18 and 2018/19

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



\* A high level of incident reporting, particularly of less severe incidents is an indication of a strong safety culture (National Patient Safety Agency, 2004: Seven Steps to Patient Safety). The distribution of these incidents shows 89% are low or no harm incidents.

Safety First cont...

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

	Q1 18/19	Q2 18/19 (July Aug Only)	Q3 17/18	Q4 17/18	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Total
Administration/supply of medication from a clinical area	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Death - cause of death unknown/unexplained/ awaiting confirmation	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Formal patient absent without leave	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Informal patient absent without leave	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Information disclosed in error	0	0	2	0	1	0	2	0	0	0	0	0	0	0	0	0	3
Lost or stolen hardware	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Lost or stolen paperwork	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Self harm (actual harm) with suicidal intent	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	1
Suicide (incl apparent) - community team care - current episode	4	3	14	6	3	4	5	5	2	3	1	1	3	0	2	1	30
Suicide (incl apparent) - community team care - discharged	2	1	2	0	1	1	0	1	0	0	0	0	0	2	0	1	6
Suicide (incl apparent) - inpatient care - current episode	0	0	2	2	0	0	1	1	1	0	1	0	0	0	0	0	4
Unwell/illness	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Allegation of violence or aggression	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	1
Physical violence (contact made) against staff by patient	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
Physical violence (contact made) against other by patient	0	0	1	1	1	1	0	0	0	0	1	0	0	0	0	0	3
Pressure Ulcer - grade 3	1	1	3	1	0	1	1	1	1	0	0	0	0	1	1	0	6
<b>Total</b>	<b>8</b>	<b>9</b>	<b>26</b>	<b>12</b>	<b>7</b>	<b>7</b>	<b>11</b>	<b>8</b>	<b>4</b>	<b>4</b>	<b>4</b>	<b>1</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>4</b>	<b>62</b>

- 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.
- 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 Aug 2018

Mortality - additional structure judgement reviewer training is planned for November 2018. This is a development opportunity for clinicians of Band 7 and above.

360 Assurance Internal audit actions continue to be implemented.

National Quality Board has published 'Learning from deaths: Guidance for NHS trusts on working with bereaved families and carers' <https://www.england.nhs.uk/publication/learning-from-deaths-guidance-for-nhs-trusts-on-working-with-bereaved-families-and-carers/> - A task and finish group has been arranged to take forward actions.

September is our patient safety 'kitchen table' conversation month. We are asking for suggestions about how we can improve working safely from existing meetings. Responses will feed into the development of our next patient safety strategy.

**Mortality**

**Training:** Further Structured Judgement Reviewer training is being held on 15 November 2018. Applicable to clinical staff band 7 and above.

**Assurance:** 360 Assurance Internal audit report on Learning from Healthcare Deaths has been received giving significant assurance. Mortality review group workshop has been held and actions are being implemented.

**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 is shared in 'Our Learning Journey' report for 2017/18

-Structured Judgement Reviews – learning from 2017/18 and Q1 cases is currently being collated.

60% of reviews completed to date rated overall care as good or excellent

## Safer Staffing

Overall Fill Rates: 117%

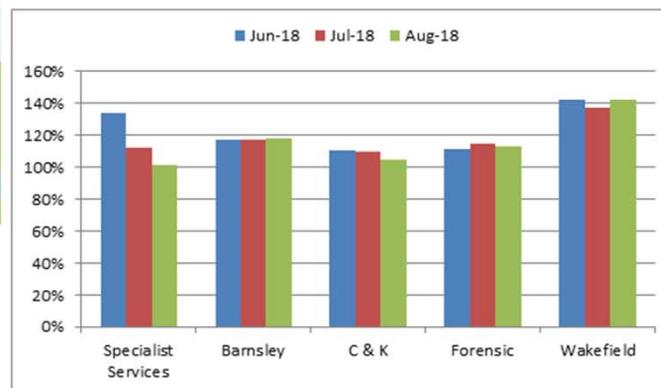
Registered fill rate: (day + night) 92.5%

Non Registered fill rate: (day + night) 141.5%

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

### BDU Fill rates - June 18 - August 18

Overall Fill Rate Unit	Month-Year		
	Jun-18	Jul-18	Aug-18
Specialist Services	134%	112%	101%
Barnsley	117%	117%	118%
C & K	110%	109%	105%
Forensic	111%	115%	113%
Wakefield	142%	138%	143%
<b>Overall Shift Fill Rate</b>	<b>118%</b>	<b>118%</b>	<b>117%</b>



#### Registered Staff:

Days 83.8 (decrease of 7.6 on July)

Nights 100.1 (decrease of 1.3 on July)

#### Registered average fill rate:

Days and nights 92.5 (decrease 3.9 on July)

#### Non Registered Staff:

Days 138.4 (increase of 4.4 on July)

Nights 143.8 (increase of 1.3 on July)

#### Non Registered average fill rate:

Days and nights 141.5 (increase of 3.3 on July)

Overall average fill rate all staff: 116.5 (decrease of 1.0 on July)

### Summary

For over a year now no ward has fallen below a 90% overall fill rate. Of the 31 inpatient areas listed 21, a decrease of 2 wards on June (67.2%) achieved greater than 100%. Indeed of these 21 areas, 11 achieved greater than 120% fill rate.

#### Registered On Days (Trust Total 83.8%)

There has been an increase in the number of wards that have failed to achieve 80%, eight wards in all (25.6%) compared to 3 (9.6%) in July. Within the forensic BDU, Appleton and Chippendale experienced the largest decrease as well as Johnson and Waterton falling below the 80% threshold. Within Wakefield, Walton and Chantry fell below as well as the Horizon Centre in specialist services. The Melton Suite in Barnsley fell just below the 80%. There were various factors cited including vacancies, sickness, maternity and the lack of willingness of bank staff to back fill (possibly on the back of a hot summer) but there was also a corresponding increase in the deployment of our health care assistant (HCA) workforce.

#### Registered On Nights (Trust Total 100.1%)

No ward has fallen below the 80% threshold. The number of wards which are achieving 100% and above fill rate on nights decreased to 60.8% (19 wards) for August.

Average fill rates for Barnsley BDU increased by 1% to 118%. Calderdale and Kirklees BDU decreased by 4% to 105%. forensic BDU was 113% a decrease of 2%. Wakefield BDU increased by 5% to 143%. Specialist services were 101% with a decrease of 11%.

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. An establishment review has been submitted which has looked at the staffing profiles across all inpatient wards. This has been discussed at OMG and accepted at EMT. We are anticipating in excess of 25 band 5 new starters across inpatient areas from September with an increase in recruitment to our HCA workforce.



**Information Governance**

There were 14 confidentiality breaches during August involving data/information lost in transit, information disclosed in error, lost or stolen hardware, lost or stolen paperwork, non secure disposal - hardware, patient healthcare record issues. This number remains constant with recent months and increased focus is being placed on effective communication.

**Commissioning for Quality and Innovation (CQUIN)**

CQUIN leads have been agreed for 2018/19. Services continue to work towards the requirements for 18/19. The Trust submitted the quarter 1 reports at the end of July to commissioners. Feedback from all commissioners has now been received and all agreed.

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 the required threshold would mean that the Trust would need to be in the top 6 of 200+ trusts nationally.
- Cardio metabolic assessment and treatment for patients with psychoses - The early intervention in psychosis element of this indicator has been rated as amber based on the 17/18 results. A number of mitigating actions are being put into place to further reduce this risk.

A new risk has been identified related to the national forensic scheme:

- Reducing restrictive practices - the detail of this is being worked through to ensure as much mitigation is in place as possible but is currently rated as green for Q1, Amber for Q2 and Red for Q3 and Q4..

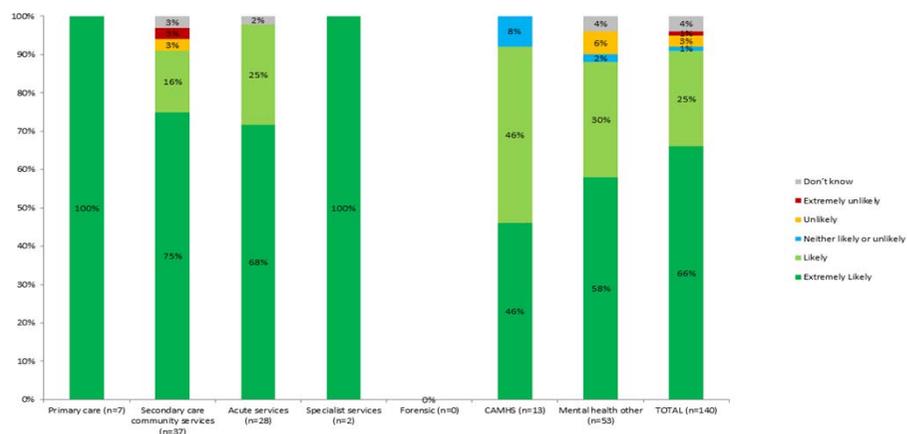
The total CQUIN value for 2018/19 is £4.4m. The Trust currently has a risk of £379k shortfall for 2018/19. CQUIN leads are working to mitigate this risk as far as possible.

**Patient Experience**

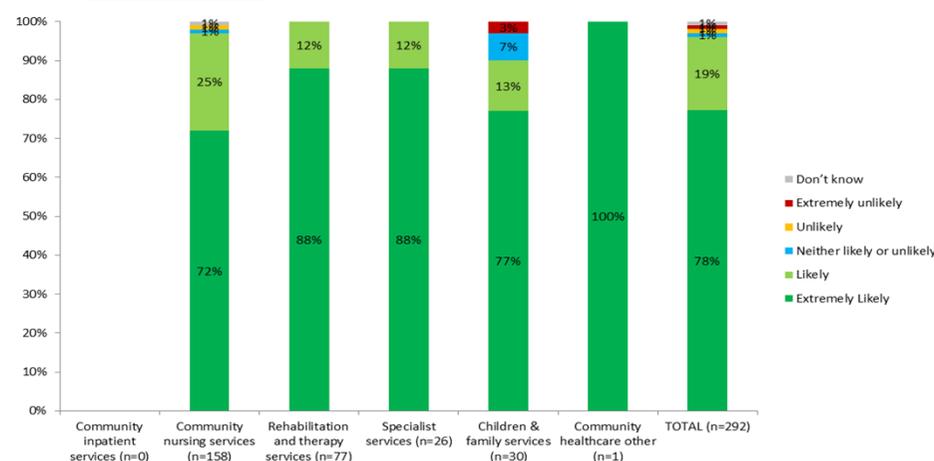
**Friends and family test shows**

- Community Services – 97% would recommend community services.
- Mental Health Services – 91% would recommend mental health services.
- Significant variance across the services in the numbers extremely likely to recommend the Trust – between 46% in CAMH services and 100% in community healthcare services
- Small numbers stating they were extremely unlikely to recommend.

**Mental Health Services**



**Community Services**



The NHS Friends and Family Test (FFT) is being reviewed by NHS England with new guidance expected for implementation in April 2019. The development of the new real time patient experience system is ongoing. Barnsley community health services were the first teams to go live in August. A roll out plan has been developed and all services will migrate to this service by the end of October 2018. The Quality Improvement & Assurance Team (QIAT) has been trained in the use of the new system and training is being rolled out. The governance framework to support FFT collection and reporting is being updated.

## Care Quality Commission (CQC)

### MHA CQC visit high level findings

There have been 5 monitoring reports received since the previous report, of these 5 reports the most common themes to emerge as areas for improvement are:

Theme	Number of reports to identify the theme
Continued use of blanket restrictions	4
Incomplete or out of date documentation (risk assessments, care plans)	4
Recording and reviewing of capacity in respect of consent to treatment under Part 4	3
Section 17 leave forms incomplete, not actioned, out of date	3
Extended periods between reiteration of rights under Section 132	2
Lack of evidence of referral to IMHA service	2
Seclusion records incomplete	2
Issues relating to AMHP reports	2

### CQC action plan

The core services that were re-visited earlier this year have developed action plans to meet any 'must' and 'should' do's identified from these visits. They will continue to provide monthly updates on how they are progressing against their actions.

### CQC engagement meeting

We held our quarterly CQC engagement meeting on 12th September 2018. This enabled us to provide updates on some of the actions we have taken since the last CQC visit. As part of this discussion CQC informed us that we will receive updates on our Insight report every two months. The Insight report provides a wide range of information and data about our services and how we are performing in comparison with other similar NHS trusts. This will help us to identify where improvements are being made, support us in understanding in which areas we need to improve; and will assist in enabling us to provide some context to the information being provided where this is appropriate.

### Registration activity

We continue to keep CQC notified about any planned changes to our services that may impact on our registration.

The RAG ratings on the action plan will be agreed within the monthly Clinical Governance Group meetings.

Blue – Action completed.

Green – On-target to deliver actions within agreed timeframes.

Amber Green – Off trajectory but ability/confident can deliver actions within agreed time frames.

Amber Red – Off trajectory and concerns on ability/capacity to deliver actions within agreed time frame

Red – Actions/targets will not be delivered

### CQC action plan headlines

Following recent CQC inspection, 11 of our 14 core services are rated Good, with all services rated Good or Outstanding for being caring, however, our overall rating went down from Good to Requires Improvement. Our aim is to return to an overall good rating ASAP and work towards outstanding.

### Our response

- We put safety first, always, and so our first priority is to address the safety issues highlighted and immediate action was taken where necessary.
- We're responding in line with our values, being open, honest and transparent and aiming to improve and be outstanding.
- We're working collaboratively to finalise our action plan, which will be published on our website via our Trust Board papers in due course.

### Monitoring of actions against our CQC action plan by the CQC

- We have developed a governance structure around the progress and management of the action plan.
- We provide EMT with a monthly update of progress against the action plan, including any areas of concern which may delay or impact on timescales being met.
- We submit our monthly action plan progress updates to CQC.
- These are also discussed within our regular engagement meetings when we meet directly with CQC and update them on our progress and improvements and about any areas where improvements are still needed.
- We provide updates when we meet with our CQC Relationship Manager (Catherine Beynon-Pindar) on a regular basis.

	Aug-18	
	MUST	SHOULD
	(n=18)	(n=47)
Blue	2	6
Green	10	37
Green Amber	5	3
Amber Red	1	1
Red	0	0
<b>Total</b>	<b>18</b>	<b>47</b>

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## Safeguarding

### Safeguarding Children

- The safeguarding nurse advisor co-presented, with the mental health in families' practitioners (local authority) the 'parental mental health' training to a multiagency audience.
- The acting named nurse for safeguarding children has provided information as part of a scoping exercise for a potential Safeguarding Practice Review (formally Serious Case Review) for a child death in Kirklees and a potential domestic homicide review in Kirklees.
- The safeguarding children's team are currently involved in two safeguarding practice reviews. One learning from local review (LLR) and one serious case review (SCR) are in final draft.
- The acting named nurse for safeguarding children and nurse advisor continue to deliver the "seen and heard" across the organisation.
- Safeguarding children's nurse adviser has attended the inpatient ward to support staff with a 17 year old who was admitted.
- Acting named nurse has completed and submitted the action plan for a SCR (child death) in Kirklees.
- Acting named nurse delivered a safeguarding adults and children presentation at the hospital managers' forum at Fieldhead, positive feedback was received.

### Safeguarding Adults

The Specialist Advisor Safeguarding Adults:

- Attended a multi-agency safeguarding meeting for a service user who was self-neglecting and had high risk physical health conditions in Barnsley. This service user has since died and this information has been gathered as part of the initial chronology of the multi-agency, multi professional involvement.
- Attended a task and finish, subgroup of the Barnsley Safeguarding Adults Board; pathways and partnerships in Barnsley. The aim was for the group to scope the non-commissioned services within Barnsley and consider their governance.
- Completed the template to evaluate the ability to deliver safeguarding education in line with the training strategy, Barnsley
- Attended a professionals' meeting to discuss the safeguarding referrals from health into the local authority and the flow of information. This was an action from a safeguarding adults review in Calderdale.
- Developed a briefing paper on self-neglect and disseminated Trust wide
- Presented the safeguarding adults training to the junior doctors and the workshop to raise awareness of Prevent
- Undertook a joint local authority and health safeguarding audit in Kirklees to consider the cases where there was a 'risk remains' outcome recorded. The findings were that the risk may still remain as there was ongoing work, that the process had been exited into another process; such as domestic abuse and the Multi-agency Risk Assessment Conference (MARAC) or for the Trust through the care programme approach process and care planning risk assessment, flexible assertive community treatment (FACT), zoning process.
- Attended one of the inpatient areas in Wakefield to support the manager with safeguarding concerns.
- Provided information regarding possible suicide cases in Barnsley and whether they were known to the Trust
- Provided comment/advice for the patients bank service user leaflet to advise the author of the inclusion of when staff may intervene/support if possible exploitation is suspected.

## Infection Prevention Control (IPC)

- Progress on the Infection Prevention and Control Annual programme 2018-19, remains on track.
- Surveillance: there has been no MRSA Bacteraemia, Clostridium difficile, or any other alert organisms, up to date. We have been recently made aware that • Barnsley BDU has a locally agreed C difficile Toxin Positive Target of 5.
- Mandatory training figures remain stable at:
  - Hand Hygiene-Trust wide Total – 90.71%
  - Infection Prevention and Control- Trust wide Total – 87.86%
- Policies and procedures remain up to date.
- Result from the PLACE audit have been released and remain above the national average.
- The planning for the Flu campaign continues to improve with peer to peer training currently taking place.
- There is still reduced capacity within the team, (1 IPC nurse vacancy has been put on hold and the Senior IPC Nurse commenced a period of planned long term sickness on 14/9/18). The team have reviewed current processes and commenced contingency arrangements.

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	Jun-18	Jul-18	Aug-18	Q1 18/19	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%	97.2%	97.1%	96.2%	97.1%	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%	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%	98.8%	98.9%	97.5%	97.6%	4	
% SU on CPA Followed up Within 7 Days of Discharge	Improving Care	Safe	SR/CH	95%	96.7%	97.8%	97.3%	97.5%	97.6%	95.5%	96.9%	96.7%	94.3%	99.2%	100%	97.7%	94.9%	97.7%	4	
Data Quality Maturity Index 4	Improving Health	Responsive	SR/CH	95%	Reporting from Nov 17					98%	98.1%	98.3%	98.3%	98.2%	98.2%	Due Oct	Due Oct		4	
Out of area bed days 5	Improving Care	Responsive	SR/CH	Q1 940, Q2 846, Q3 752, Q4 658	Reporting from April 17.				885	1127	1286	1608	536	284	375	436	589	1195	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%	57.2%	53.2%	54.0%	50.7%	54.4%	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%	88.0%	93.9%	95.9%	94.9%	91.3%	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%	100%	99.4%	99.4%	99.4%	4	
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Improving Care	Responsive	SR/CH	53%	77.5%	82.0%	82.2%	73.6%	89.2%	84.4%	89.5%	89.8%	93.5%	81.0%	70.0%	92.0%	91.4%	81.7%	4	
% clients in settled accommodation	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%	78.5%	79.1%	78.8%	Due Oct	79.1%	4	
% clients in employment 6	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%	8.6%	8.6%	Due Oct	8.6%	1	
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) inpatient wards / b) early intervention in psychosis services / c) community mental health services (people on Care Programme Approach)	Improving Care	Responsive	SR/CH		Due 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	Jun-18	Jul-18	Aug-18	Q1 18/19	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	14	22	1	16	2	
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	3	3	1	4	2	
Number of detentions under the Mental Health Act	Improving Care	Safe	SR/CH	Trend Monitor	167	174	156	168	212	221	186	180	212		Due Oct		212	N/A		
Proportion of people detained under the MHA who are BAME 2	Improving Care	Safe	SR/CH	Trend Monitor	15.0%	10.3%	10.9%	19.6%	10.8%	13.6%	15.1%	9.0%	15.1%		Due Oct		15.1%	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	Jun-18	Jul-18	Aug-18	Q1 18/19	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%	97.7%	97.5%	97.3%	Due Oct	97.5%	4	
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	Improving Health	Responsive	SR/CH	99%	99.5%	99.6%	99.7%	99.7%	99.7%	99.8%	99.8%	99.8%	99.8%	99.9%	99.9%	99.9%	Due Oct	99.9%	4	
Completion of Mental Health Services Data Set ethnicity coding for all Service Users, as defined in Contract Technical Guidance	Improving Health	Responsive	SR/CH	90%	89.6%	91.1%	94.0%	90.2%	89.3%	90.3%	90.8%	90.6%	90.7%	90.5%	90.8%	90.5%	Due Oct	90.8%	4	



\* See key included in glossary.

Figures in italics are provisional and may be subject to change.

1 - In order to provide the board with timely data, data from the IAPT dataset primary submission is used to give an indication of performance and then refreshed the following month using the refreshed dataset data.

2 - 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 and they are from one of our commissioning CCGs. 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 was taken as an agreed baseline position.

6. Clients in Employment - this shows of the clients aged 18-69 at the reporting period end who are on CPA how many have had an Employment and Accommodation form completed where the selected option for employment is '01 - Employed'

#### Areas of concern/to note:

- The Trust continues to perform well against the vast majority of NHS Improvement metrics
- The Trust narrowly missed its 7 day follow up target (94.9%). Significant attempts were made to contact all service users and typically contact was responded to just after 7 days elapsed or contact was not responded to by the service user.
- Given the hard work and focus of our staff, we continue to meet the target for proportion of people completing treatment who move to recovery within Improving Access to Psychological Therapies (IAPT), although this continues to be a challenge and achievement was only marginally above target in August.
- During August 2018, 1 service user aged under 18 years was placed in an adult inpatient ward. One 17 year old was placed in Kirklees at the end of the month, the patient has since been transferred to a Wakefield ward. Total bed days and number of children and younger people under 18 in adult inpatient wards forecast for year end has been rated as a '2 - Off trajectory and concerns on ability/capacity to deliver actions within agreed time frame' - the rationale for this is due to the fact that this is outside control of the Trust. 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. The target was not met in quarter one and there has been a further increase in the number of out of area bed days in August 2018.
- % clients in employment- the Trust is involved in a West Yorkshire and Harrogate Health & Care Partnership wave 1 three-year funding initiative, led by Bradford District Care, to promote, establish and implement an Individual Placement Support (IPS) scheme. IPS is an evidence based vocational scheme to support people with mental health problems to gain and keep paid employment. Work is currently ongoing in Calderdale to expand the opportunities we can offer people under this scheme.

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This section of the report is populated with key performance issues or highlights as reported by each business delivery unit (BDU).

#### Barnsley BDU:

##### Mental Health

###### Key Issues

- The acute service line continues to experience high demand and staffing pressures leading to ongoing bank and agency expenditure.
- Average length of stay remains in excess of target and has been identified as part of the trust wide programme of improvement in addressing demand and capacity in acute services.
- Work is ongoing with the clinical commissioning group (CCG) to address the waiting lists for psychology in the community service line. The proposal to address the 'back-waiters' in the core pathway was favourably received and we have had confirmation that this has now been approved by the CCG governing body.

###### Strengths

- Management of patient flow
- Performance around delayed transfers of care remains consistently high
- Compliance with mandatory training

###### Challenges

- Adult community consultant vacancies and gaps continue to be a pressure.
- Adult acute occupancy levels remain high
- Action plan is in place to improve performance around care plan approach reviews

###### Areas of Focus

- Admissions and discharge flow in acute adults with a current review of recent admissions and pre-admission community support.
- Continue to improve performance in service area hotspots.
- Medical recruitment to consultant psychiatry and specialty doctor posts
- Reduction of agency spend

##### Community

###### Key Issues:

- Yorkshire Smoke Free (YSF) Calderdale and Barnsley – contract runs until March 2019 – no information as yet regarding commissioning intentions
- YSF Sheffield – issue re achievement of very challenging targets. Executive management team (EMT) aware and service and contract team working with commissioners
- Rapid access clinic under CCG review

###### Strengths

- Low staff turn over
- Low sickness rates
- High performance for service against workforce key performance indicators

###### Challenges

- Future planning due to lack of clarity regarding future of services

###### Areas of Focus

- Neuro rehabilitation unit (NRU) decommissioned bed reduction from 12 to 8, may impact on winter patient flow. This has been raised with Barnsley CCG
- Stroke services – integrated working underway. Early supported discharge clinical workshop scheduled 28th September 2018
- Rapid access clinic public consultation finished 12th September 2018 – awaiting report feedback
- YSF – meetings with commissioners

##### Children's Therapy Services:

- High level of referrals into the service and waiting times are a risk therefore the commissioner has asked for a refreshed demand and capacity report.

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This section of the report is populated with key performance issues or highlights as reported by each business delivery unit (BDU).

#### Calderdale & Kirklees BDU:

##### Key Issues

- Adult Acute ward occupancy and out of area (OOA) bed use remains high on all adult wards and across the business delivery unit (BDU). Occasionally older adult beds are used for clinically relevant clients and rehab capacity at Enfield Down is utilised for patients stepping down whilst awaiting suitable accommodation. A recent review of current OOA patients identified that around 60% were not previously known to mental health services. The rest had had extensive community input prior to admission.
- NHS England intensive support team (IST) follow up meeting (jointly with the clinical commissioning group (CCG) was held on 3rd September, to inform NHSE and IST on specific action plan updates and the CCGs investment plans. David Black commended the robust action plan in place and the work undertaken to pro-actively progress the recommendations made during the IST and improving access to psychological therapies (IAPT) review meetings. It was agreed that it would be helpful to continue to update all stakeholders particularly around workshops, black and minority ethnic (BME) and long term conditions (LTC), with a follow-up progress call to be scheduled in December 2018. He recognised that we had some innovative ideas that needed testing and evidence building from an IAPT fidelity basis.
- Delayed transfers of care improved better care fund (DTCO IBCF). Monthly figures are scrutinised at Calderdale CCG level and the Kirklees local authority area has started this process. SWYPT figures continued to improve for Calderdale CCG although complex dementia care capacity in residential and nursing homes is low. Work has started with the commissioner to identify new placement providers.

##### Strengths

- Continued strong performance on mandatory training.
- Sickness levels in older adult, rehab and community service lines below 4.5% and improved in adult acute. BDU now at 4.5% Trust key performance indicator (KPI).
- Trainee doctor posts filled.
- Appraisal rate band 6 and above is 99.5%

##### Challenges

- Adult community consultant vacancies and gaps continue to be a pressure, although recruitment is underway.
- Adult occupancy levels (high above 98%).

##### Areas of Focus

- Continue to improve performance in service area hotspots.
- Recruitment to posts in community especially Kirklees IAPT, consultants and early intervention in psychosis (EIP).
- Absence in adult inpatients.
- Discharge co-ordinator capacity on wards to be rolled out.

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#### Forensic BDU:

##### Challenges

- NHS England (NHSE) have signalled an intention to close 8 learning disability (LD) beds this year. Commitment from both SWYPFT and NHSE to do further work around the demand and capacity for medium secure beds in West Yorkshire.
- Focus on reducing sickness continues with a small reduction in overall sickness noted.

##### Strengths

- Forensic outreach service LD (FOSLD) – funds available for this year £471k. Recruitment to key posts commenced. Implementation group including Leeds CCG and other key stakeholders also commenced.
- Monies available for 0.5 whole time equivalent Band 8a post to support implementation of FOLS LD.
- West Yorkshire providers have been asked to formally sign up to working as a partnership once this has been completed. NHSE have confirmed they will be in a position to share data re demand/capacity.
- Focus on reducing sickness continues with a small reduction in overall sickness noted.
- Mandatory training figures are improving.

#### Forensic Child and Adolescent Mental Health Services

##### Challenges

- High number of vacancies leading to service pressures. Recruitment taking place.
- Funding of the Wakefield community team is reduced following transformation. Work is ongoing to finalise the budget. At this stage there is not thought to be any direct impact on staff.
- Secure estate has seen a significant rise in admissions caused by rationalisation of the estate and an increase in violent crime mainly in the south. This has led to some pressure on the workload.
- Some concerns expressed by the prison re the demand/capacity of HSB (Harmful Sexual Behaviour) intervention. SWYPFT committed to working with Leeds Community Healthcare and key stakeholders to address the issue.

##### Strengths

- Sickness levels are reducing.

##### Areas of Focus

- 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.

#### Specialist BDU:

- There are significant medical staffing recruitment and retention issues across the BDU. Five agency consultants are currently working across CAMHS, and two agency consultants and one agency specialty doctor in learning disabilities. Efforts to recruit are ongoing (and supported through the medical directorate) with a number of recruitment options now being considered.

##### Child and Adolescent Mental Health Services (CAMHS)

- A Wakefield summit has been arranged for September by the CCG to consider challenges with regard to children and young people's mental health as a local system. It is anticipated this will accelerate action to improve CAMHS waiting times. An autism spectrum conditions themed summit is being arranged by Calderdale CCG. This will inform plans for additional investment in the diagnostic assessment pathway.

##### Learning Disability

- In addition to medical staffing vacancies there are 20 (11%) vacancies across community and inpatient learning disability services. A quality impact assessment (QIA) is being completed to fully assess presenting risks and set out mitigating actions.
- The STOMP initiative has been effectively implemented in Calderdale and a project plan is being developed for roll-out across all service areas. STOMP stands for 'stopping over medication of people' and particularly relates to people with a learning disability, autism or both with psychotropic medicines and is NHS England led.
- A quality impact assessment is being completed to fully assess presenting risks and set out mitigations in relation to learning disability services vacancies.

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#### Wakefield BDU:

##### Key Issues

- The acute service line continues to experience high demand and staffing pressures leading to ongoing bank and agency expenditure. Use of out of area (OOA) beds (acute and 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 decreased this month from last, but the pressures continue to have 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 trust wide programme of improvement in addressing demand and capacity in acute services.
- Medical recruitment remains a challenge

##### Strengths

- Management of patient flow and for Wakefield sustained reduction in OOA bed usage
- Performance around delayed transfers of care remains consistently high
- Care programme approach reviews performance remains high in Wakefield
- Sickness rate remains below 4.6%
- The Wakefield Engaged Leader Programme has evaluated well through qualitative feedback in appraisals. Reported benefits include; increased confidence and skills particularly around having 'crucial conversations', better understanding of team effectiveness and an increase in wellbeing through feeling valued and supported. Peer coaching groups have been established which will continue to meet after the programme has been completed

##### Challenges

- Adult community consultant vacancies and gaps continue to be a pressure.
- Adult acute occupancy levels remain high

##### Areas of Focus

- Admissions and discharge flow in acute adults with a current review of recent admissions and pre-admission community support.
- Continue to improve performance in service area hotspots.
- Medical recruitment to consultant psychiatry and specialty doctor posts
- Reduction of agency spend

#### Communications, Engagement and Involvement

- Soft launch of new Trust website. The new site uses next level web technology including HTTP2 and HTTPS which means the site is faster and more secure and means we've future-proofed the current build. Work on content population and bug fixes are ongoing
- Membership newsletter reviewed and designed
- Paper on internal social networking site, workplace, developed and discussed with HR and staffside colleagues
- Excellence awards attracted 150 entries from across the Trust
- SystemOne comms - heavy promotion to encourage staff to organise training. Engagement with stakeholders continues.



This is the August priority programme report for the integrated performance report for activity conducted on the Trust priorities for 2018/2019 and includes information to the end of August 2018. Where a priority programme is already reported in another section of the IPR, e.g. for patient safety, new business etc., then that update will not be repeated in this priority page. A summary of updates for activity conducted in August July includes:

**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 August.
- Work continues toward implementing criteria led discharge across inpatient units. Wakefield Business Delivery Unit (BDU) is first in the planned implementation with the system live on 1 September 2018. Other BDUs will follow in late 2018.
- Activity is continuing in Calderdale and Kirklees to reduce the number of admissions. As well as implementing trusted assessor processes, testing different thresholds to access IHBT and reviewing the duty system, the BDU is gathering evidence of admissions and learning what it might be able to do differently to avoid admissions in the future.

**Clinical Record System:**

- Training is progressing well with more than 3000 of the available 7000 training slots have been booked.
- Plan for the go live approach with TPP, the suppliers of SystmOne, continues as does data migration testing which is also progressing well.
- The programme team P&I analysts have co-located with the Trusts P&I team and are on track for completion of the reporting requirements form SystmOne.
- The classroom based training, online training materials and competency checks are co-designed, co-built and co-tested. The online training materials and competency checks are on the intranet and available for staff to start using.
- External communications about the migration to SystmOne has commenced.

**Older People's Services:**

- A meeting with Wakefield CCG, including GP leads and commissioners was conducted in August as part of the continued conversations with commissioners.
- A meeting with Kirklees commissioners and GPs has been re-arranged for early September and discussions with the Barnsley commissioner is scheduled for late September.

Priority	Scope	Narrative Update	Area	RAG
<b>IMPROVING HEALTH</b>				
<b>Joined Up Care</b>				
South Yorkshire Projects: Stroke Service Review	Work with our South Yorkshire partners to deliver shared objectives as described through the integrated care systems plans. This includes work on: • Stroke service review	<ul style="list-style-type: none"> <li>• Monthly Steering group meetings continue having commenced in July</li> <li>• Weekly project meetings continue with SWYPFT &amp; BHNFT</li> <li>• SWYPFT &amp; Barnsley Hospital NHS Foundation Trust (BHNFT) have nominated TAG members; and meetings are to be set up.</li> <li>• SWYPFT has drafted quality impact assessments (QIA) for transient ischemic attacks (TIA) and early supported discharge (ESD) – currently with SG at BHNFT for review/additions</li> <li>• SWYPFT are in the process of drafting an equality impact assessment (EIA) for TIA</li> <li>• Formal communications to staff were issued early September</li> <li>• A mapping session took place 30/8 in advance of the planned ESD workshop booked 28/9 which will include involvement from Jaimie Shepherd (STP), Stroke Association, BHNFT and SWYPFT.</li> <li>• BHNFT is in process of identifying TIA clinic space</li> </ul>	Progress Against Plan	Green
		Initial areas of risk include: <ul style="list-style-type: none"> <li>• Recruitment and retention</li> <li>• Finances/contracting</li> </ul>	Management of Risk	Yellow
		High level milestones currently are: <ul style="list-style-type: none"> <li>• ESD pathway mapping - September 2018</li> <li>• TIA - move to Barnsley Hospital - September/October 2018</li> <li>• ESD - detailed operating model developed - Autumn 2018</li> <li>• ESD - service model agreement - January 2019</li> <li>• ESD - implementation process - January - March 2019</li> </ul>		

Summary	Quality	National Metrics	Locality	Priority Programmes	Finance/Contracts	Workforce
South Yorkshire Projects: Neurological rehabilitation	Work with our South Yorkshire partners to deliver shared objectives as described through the integrated care systems plans. This includes work on:		<ul style="list-style-type: none"> <li>• Neurological rehabilitation</li> </ul>	<ul style="list-style-type: none"> <li>• Barnsley Clinical Commissioning Group (CCG) has informed SWYPFT that as from 1 October 2018 it proposes to reduce the number of Neuro Rehabilitation Unit (NRU) beds it commissions in Barnsley from the current twelve to eight.</li> <li>• A project team has been formed and initial meeting held to develop a plan to promote and market the NRU capacity that will be available when de-commissioning takes place.</li> <li>• Initial objectives are to conduct market analysis for these beds with a view to develop and implement a marketing strategy</li> </ul>	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 through the integrated care systems plans. This includes work on:		<ul style="list-style-type: none"> <li>• Autism and ADHD</li> </ul>	<ul style="list-style-type: none"> <li>• Initial discussions are taking place on developing a plan and determining objectives and resource implications for this priority.</li> <li>• These plans include combining this priority with the West Yorkshire and Harrogate Health &amp; Care Partnership (WY&amp;HHCP) priority for improving autism and ADHD and delivering them as one piece of work.</li> </ul>	Progress Against Plan	
	No known risks identified at this time.				Management of Risk	
	Implementation Plan is in development					
New Business	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&HHCP) to deliver shared objectives with our partners in the area of:		<ul style="list-style-type: none"> <li>• Forensics: work with NHS and private sector partners in the region to develop and deliver a co-ordinated approach to forensic care.</li> </ul>	<ul style="list-style-type: none"> <li>• New business activity within this priority is covered by the monthly bids and tenders report to EMT and is therefore not updated specifically in this priority section of the IPR.</li> </ul>	Progress Against Plan	
	No known risks identified at this time.				Management of Risk	
	Business case in development					
West Yorkshire Projects: Community Forensics CAMHS	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&HHCP) to deliver shared objectives with our partners in the area of:		<ul style="list-style-type: none"> <li>• Community Forensic CAMHS</li> </ul>	<ul style="list-style-type: none"> <li>• This priority programme is on track to plan and therefore an overall RAG for this project of Green is applied.</li> <li>• Activities completed for the reporting period of August 2018 includes: <ul style="list-style-type: none"> <li>• Due diligence continues and a meeting to finalise this is to be held with the safeguarding leads from across the footprint.</li> <li>• Further meetings have been arranged to ensure consistency across the model including with CCGs.</li> <li>• Graded introduction/communication of the service to agencies across the region continues prior to the formal launch.</li> <li>• Monthly Key performance indicators (KPIs) reporting on performance and financial tracker to NHS England (NHSE) has been submitted for July 2018</li> <li>• The next national clinical network meeting with NHSE has been scheduled for 19th October 2018 in Leeds and representatives from the Yorkshire &amp; Humber forensic CAMHS service will be attending.</li> <li>• Single point of access (SPA) referral rate continues steadily to increase</li> <li>• Sheffield Children's have now fully recruited and will begin accepting cases following the launch on 25th September</li> <li>• The formal launch of the service is scheduled for 25th September 2018, a venue has been located and planning is underway. It is anticipated around 100 attendees will attend the launch from across the region and various organisations.</li> </ul> </li> </ul>	Progress Against Plan	



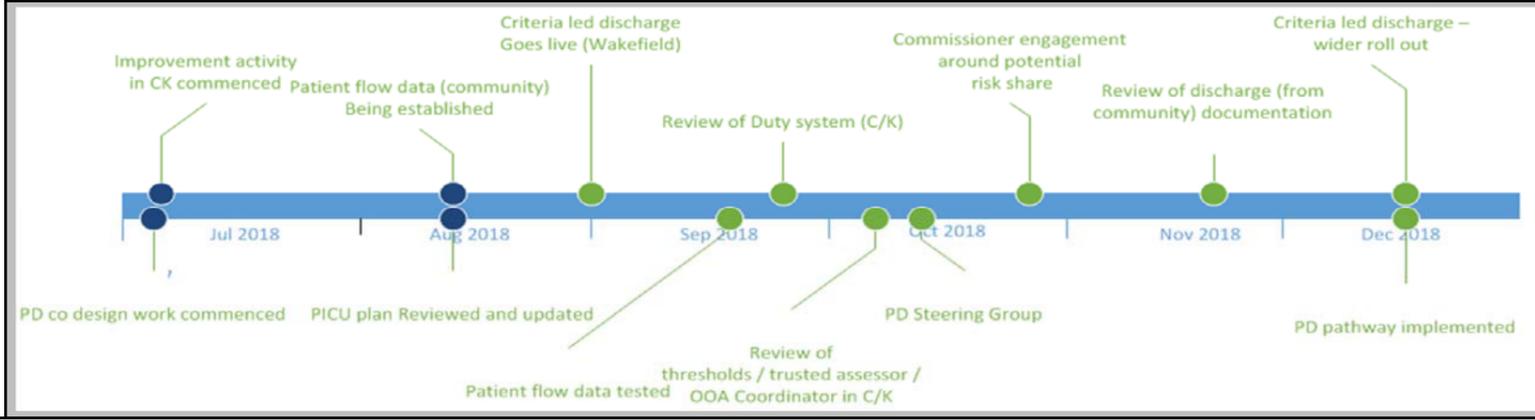
		<ul style="list-style-type: none"> <li>• There are currently no high level risks identified in this project.</li> <li>• Risk sharing agreements are being developed for the partnership</li> </ul>	Management of Risk	
West Yorkshire Projects: Forensic Community Mental Health	<p>Work across the West Yorkshire and Harrogate Health &amp; Care Partnership (WY&amp;HHCP) to deliver shared objectives with our partners in the area of:</p> <ul style="list-style-type: none"> <li>• Forensic community Mental Health</li> </ul>	<p>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.</p>	Progress Against Plan	N/A
		Not applicable	Management of Risk	N/A
		Not applicable		
West Yorkshire Projects: Forensic Community LD	<p>Work across the West Yorkshire and Harrogate Health &amp; Care Partnership (WY&amp;HHCP) to deliver shared objectives with our partners in the area of:</p> <ul style="list-style-type: none"> <li>• Forensic community LD</li> </ul>	<ul style="list-style-type: none"> <li>• SWYPFT submitted a proposal to NHS England (NHSE) 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.</li> <li>• SWYPFT were asked to provide a proposal for provision of a Community Forensic Learning Disability Service to the West Yorkshire and Harrogate Health &amp; Care Partnership (WY&amp;HHCP) which was submitted to NHSE in September 2017.</li> <li>• 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 WY&amp;HHCP, building on our original bid of September 2017.</li> <li>• NHSE have invited bids for £50k initial implementation funding for this service, which SWYPFT have submitted in March 2018.</li> <li>• We are currently awaiting confirmation of funding.</li> </ul>	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		

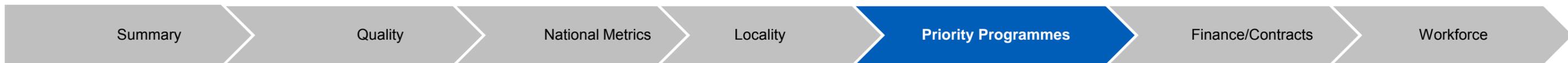
Summary	Quality	National Metrics	Locality	Priority Programmes	Finance/Contracts	Workforce
West Yorkshire Projects: Improving Autism and ADHD	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&HHCP) to deliver shared objectives with our partners in the areas of: • Improving autism and ADHD			• SWYPFT is to be lead provider for the adult autism and ADHD pathways across the West Yorkshire Mental Health collaborative. • Proposals are in place to combine this priority with the priority to deliver shared objectives with partners through the integrated care systems plans in South Yorkshire.	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&HHCP) to deliver shared objectives with our partners in the area of: • Learning Disability Organisational Development Network (ODN)			SWYPFT are taking a lead role through the Operational Delivery Network (ODN) and Transforming Care Partnership on improving services for people with a learning disability and autism across Yorkshire and Humberside from April 2018. Update on progress made in this priority in August 2018 includes: • Appointment of the Clinical Lead is progressing with interview scheduled for 13th September 2018 • Contract is finalised and in process for sign-off; 6 month contract review planned October 2019 • Priorities and supportive work-streams are being scoped; next meeting planned 20th September to further develop prior to gaining ESG sign-off • Terms of Reference and Project Plan for the ODN currently being drafted – to be signed off at next meeting on 20th September • Membership and groups currently being agreed – for ODN and virtual group • Communication tools to support better sharing and engagement across the ODN currently being scoped • Provider mapping has been completed and returned as agreed at first ODN meeting • Attendance and regular progress updates provided to ESG • Working with Inclusion North and with NHSE to agree an engagement plan and costings for user/carer co-production	Progress Against Plan	
				No risks have currently been 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 & Care Partnership (WY&HHCP) to deliver shared objectives with our partners contributing to the following areas of work across WY&HHCP: • Inpatient CAMHS			• Work continues in this priority which is focused on delivering of services for children's admissions differently 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 a pilot for two-years and SWYPFTs 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		

Summary      Quality      National Metrics      Locality      **Priority Programmes**      Finance/Contracts      Workforce

West Yorkshire Projects: Eating Disorders	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&HHCP) to deliver shared objectives with our partners contributing to the following areas of work across WY&HHCP: • Eating Disorders	<ul style="list-style-type: none"> <li>• 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.</li> <li>• The Eating Disorders West Yorkshire and Harrogate Network has SWYPFT as a partner as part of the WY&amp;HHCP.</li> <li>• Funding has been secured through the new models of care (NMoC) workstream.</li> <li>• SWYPFT are active on the new care models programme board and steering group.</li> </ul>	Progress Against Plan	Green
		Any implementation risks are with Leeds and do not transfer to SWYPFT	Management of Risk	Green
	Implementation plan in development			

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 and Harrogate to help stop all of us placing people out of area. Implement Personality disorder pathway.	<ul style="list-style-type: none"> <li>• Bed pressures remain in the system and the long term trend of high OOA placements has continued through Aug.</li> <li>• Work continues toward implementing criteria led discharge across inpatient units. Wakefield BDU is first in the planned implementation and the system is going live on 1 Sep 2018. Other BDUs will follow in late 2018.</li> <li>• Activity is continuing in Calderdale and Kirklees areas to reduce the number of admissions. As well as implementing trusted assessor processes, testing different thresholds to access IHBT and reviewing the duty system, the BDU is gathering evidence of admissions and learning what it might be able to do differently to avoid admissions in the future. The Out of Area Caseload Manager in Calderdale and Kirklees is now having some success in bringing facilitating earlier discharge and a review of impact of this role is planned for October.</li> <li>• Through September, an audit of admissions is planned which will include a focus on where the person was admitted from and what happened in the run up to admission.</li> </ul> <p>A meeting is planned with commissioners for mid September to focus on progress against the partnership plan.</p>	Progress Against Plan	Yellow
		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	Red



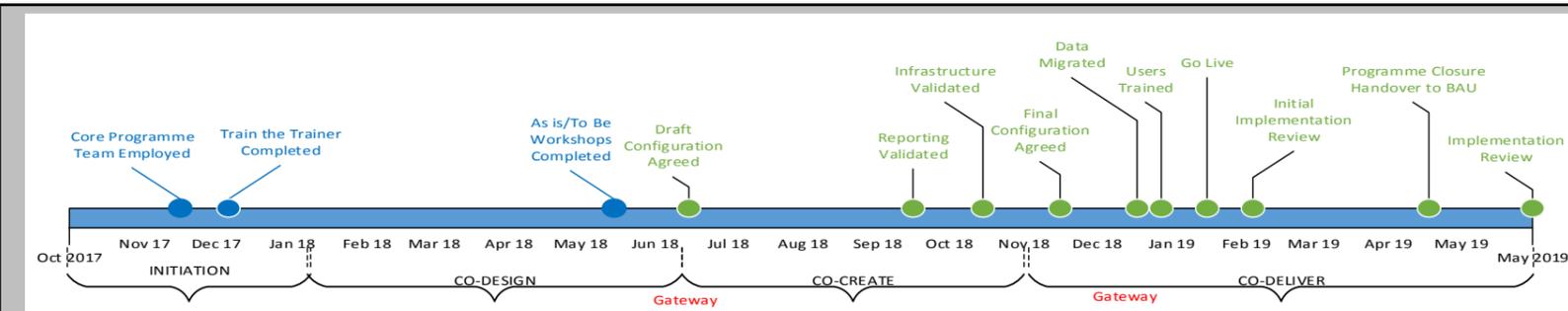


Workforce Productivity	Develop and deliver clinical support worker strategy. Develop new roles to improve rostering, reduce agency spend and enhance skill mix. Develop and deliver a retention strategy.	<p>Activity for this priority includes:</p> <ul style="list-style-type: none"> <li>• Recruitment and retention steering group now established and terms of reference agreed.</li> <li>• An action plan is now in place and activity is being taken forward.</li> <li>• Analysis has been undertaken to establish where the area are of high turnover of staff. A series of focus groups have been held to further understand risks and issues in these areas – report to follow.</li> <li>• Deep dive of wellbeing survey results is planned for the next period, following completion of the staff wellbeing survey, activity will also support the community transformation review which is taking place through the Autumn.</li> <li>• The Trust is already seeing major improvements in three key target areas of the agreed plan: <ul style="list-style-type: none"> <li>- Target against 10% turnover - Although turnover is not on target to achieve 10% (12.99%) two major workforce areas (nursing and HCA) are seeing lower turnover rates than last year and are on course to see significant reductions (11.2% and 10% respectively).</li> <li>- Nursing retire and return – Trust target of doubling nursing retire and return for the coming year would equate to 24 staff returning. In the first four months of the fiscal year already achieved almost 50% of target (11).</li> <li>- Ending employment feedback returns – Returns are far exceeding expectation following implementation of new pro-active process. Return rate for July was 33%. Overall return from April now stands at 21%. This compares to 5% return in 17/18. Next stage sees the rollout of detailed feedback reports to BDUs – in place by October.</li> </ul> </li> <li>• Collaborative working activity has already taken in place in South Yorkshire. West Yorkshire collaborative workforce planning due to start in Sep with an initial steering group scoping session with other Trusts workforce leads.</li> <li>• Nursing professional leads and workforce/L&amp;D leads have met to discuss timelines for dovetailing an updated Nursing Strategy and the refresh of the Trusts Clinical Support Workforce Strategy. The Clinical Workforce refresh will focus on further strengthening the apprenticeship model, developing clearer band 3 role design and expand the role/opportunity of band 4/TNA roles and development across the Trust with scoping of career progression from non-clinical roles into clinical roles (B4 to B5).</li> </ul>	Progress Against Plan	
	Despite ongoing work around nursing strategy and recruitment/retention, we are still seeing an increase in nurse vacancies across the whole Trust. To achieve 100% nursing establishment approx. 230 additional WTE would be required over the next 12 months. Nurse vacancies are not reducing.		Management of Risk	
	Milestones from the implementation plan for this priority (detailed timeline to be developed for the September IPR):			



Clinical record system	<p>Plan and deliver a new clinical record system which supports high quality care</p>	<p>RAG rating for this priority remains the same as the last IPR - green, indicated that the priority is on track for progress against plan. Update for progress made in August includes:</p> <ul style="list-style-type: none"> <li>• More than 3000 of the available 7000 training slots have been booked by staff. The project team will be asking staff to confirm whether they intend to complete classroom training or use the online training materials to prepare themselves for go live.</li> <li>• TPP have progressed data testing by splitting the data into the separate units that will be used at go live, e.g. inpatient, mental health community and specialist services. This allows for closer checking and validation. A number of issues have come to light and are being worked through by TPP and the programme team.</li> <li>• Plan for the go live approach with TPP continues, including user acceptance testing and cutover.</li> <li>• Since moving to within the core P&amp;I team, the programme team P&amp;I analysts have almost caught up on report specifications and are on track for completion by the end of October. This is in line with the programme schedule and moves us from specifying reports to building them.</li> <li>• Reporting database designed and built. Initial four reports are built and tested as part of prototyping. The reporting server provisioned to reporting workstream.</li> <li>• The third phase of data migration testing has been completed by the Trust and the second data cut taken by TPP.</li> <li>• The classroom based training, online training materials and competency checks are co-designed, co-built and co-tested. The online training materials and competency checks are on the intranet and available for staff to start using.</li> <li>• External communications have begun - including letters to CEO's of partner organisations.</li> <li>• The configuration workstream have drafted 64% of priority one forms.</li> </ul>	Progress Against Plan	
	<p>RAG rating for risk this priority remains the same as the last IPR - yellow</p> <p>Risks Identified (with Datix risk references notated):</p> <ul style="list-style-type: none"> <li>• 1251 CUTOVER: during the transition (cut over) period before go live if there is no electronic clinical record system to use, there will be a risk of a delay and inconvenience to patients, services and staff.</li> <li>• 1285 DATA MIGRATION: Delays to 1A impact on overall plan. Data Migration Timetable has slipped due to adaptor build issues (TPP), this has a potential to impact on Go Live if subsequent phases cannot be bought back in line with revised plan. In terms of impact on overall plan the Trust has used 4/6 weeks contingency currently built in plan.</li> <li>• 1305 CONFIGURATION: Insufficient time for system analysis Insufficient time for system analysts to create required configuration from co-design workshop outputs.</li> <li>• 1293 INFRASTRUCTURE: Lack of funding within the programme budget to fund any work required to achieve deliverables Following the assessment of the infrastructure to meet the suppliers warranted environment specification (WES), there may be insufficient funding available to comply.</li> <li>• 1223 CHANGE MANAGEMENT: Staff not engaging 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.</li> <li>• 1224 TRAINING: Staff are not trained. In the event of staff not being trained there will be a risk of staff unable to access the Clinical Records System Programme which will result in lack of visibility of the shared record</li> <li>• 1316 TESTING: Impossible to replicate live environment prior to system go-live. It is not possible to replicate the live environment in full prior to the cutover period between the 7th and 21st January. During this final testing it might reveal poor technical performance, system user authentication issues, technical unit limits being exceeded, inadequate clinical data availability and reporting.</li> <li>• 1277 REPORTING: New report requirements close to / during transition period - Ability to meet reporting requirements. - Not able to meet statutory / commissioner / local reporting requirements. End of 2 year national contracts and potential for new / additional reporting requirements.</li> <li>• 1344 RESOURCES: the team is made up from a range of temporary resources. Progress may be slower as staffs leave and replacement is recruited. Costs may go up as more skilled and experienced staff is required nearer to go live.</li> <li>• 1345 DELAYS TO GO LIVE: a range of factors may conspire to cause potential delays to the programme, to which a suitable contingency response should be available.</li> <li>• 1348 PROGRAMME RISK: ROLES AND RESPONSIBILITIES. Risk of role confusion after transfer to SystmOne with responsibilities being unclear between clinical and administrative staff.</li> </ul>	Management of Risk		

Summary Quality National Metrics Locality **Priority Programmes** Finance/Contracts Workforce

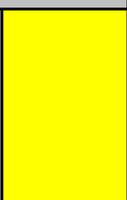


Older Peoples Services Transformation

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.

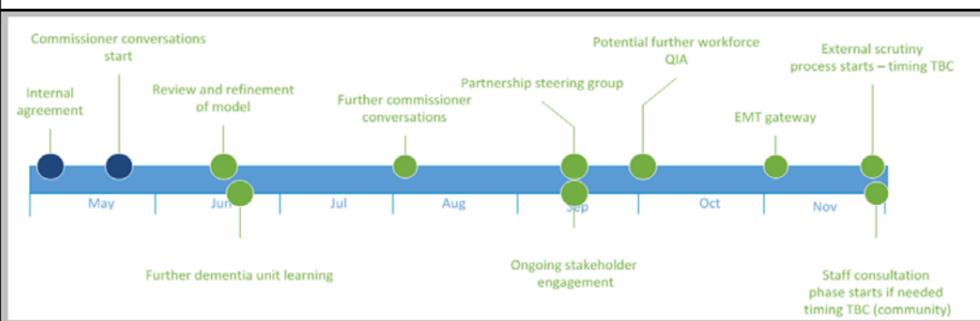
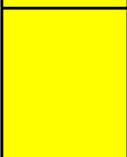
- A meeting with Wakefield CCG, including GP leads and commissioners was held in August and it was agreed that further meetings with Wakefield CCG to understand the proposals in detail is needed.
- A meeting with Kirklees commissioners and GPs has been rearranged for early September. The Barnsley commissioner meeting is now scheduled for late September and we're liaising with Calderdale about dates to meet them.
- The business case is being updated with an intention to share with commissioners soon.

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 BDUs remains, the project will need to ensure it is well resourced when moving on beyond commissioner conversations.

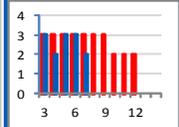
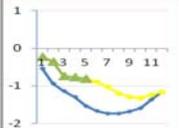
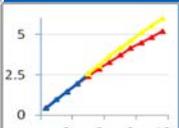
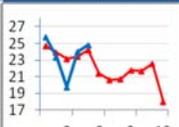
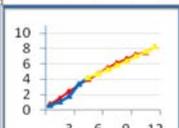
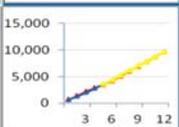
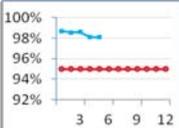
Management of Risk



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

Overall Financial Performance 2018/19

Executive Summary / Key Performance Indicators

Performance Indicator		Year to date	Forecast	Narrative	Trend
1	NHS Improvement Finance Rating	2	2	The Trust risk rating has improved from 3 to 2 in month. This is due to movement in the I & E margin metric improving to a deficit margin of 0.9%.	
2	Normalised Surplus (inc STF)	(£1.2m)	(£2.6m)	August's financial performance is a deficit of £139k pre PSF (Provider Sustainability Fund). Whilst still a deficit this is an improvement from the run rate in Quarter 1. The cumulative deficit is £1.2m. The underlying position in-month was a deficit of £0.4m, but was boosted by one-off benefits arising from asset disposals and VAT reclaims.	
3	Agency Cap	£2.6m	£6m	Agency expenditure was £0.6m in August the highest monthly spend this year. Year-to-date costs are £2.6m which is £143k (6%) above cap. Costs are 10% higher than the same period last year. Current year-end projection is to exceed our agency cap by £0.8m (15%).	
4	Cash	£24.8m	£18m	Cash remains ahead of plan in month 5. Cash of £0.7m from the sale of a Trust asset has been received in month and continues to be a key management focus.	
5	Capital	£4.2m	£8.2m	Year to date expenditure is ahead of plan primarily due to the profile of spend for the Fieldhead Non-Secure project. We continue to work closely with our construction partner to ensure we have agreed current and forecast spend profiles.	
6	Delivery of CIP	£3.6m	£9.7m	Additional identified cost reductions mean that the year to date position is ahead of plan (£114k - 3%). New schemes have been included in month; as such the required potential upside scenarios included within the forecast position has reduced from £1.0m to £0.7m.	
7	Better Payment	98%		This performance is based upon a combined NHS / Non NHS value.	

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

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## Contracting - Trust Board

### Contracting Issues - General

A series of mid-year meetings has been arranged with commissioners to review progress with Five Year Forward View, other mental health investments and any other current key pressures, specifically out of area placements.

### CQUIN

Q1 18/19 West and Barnsley clinical commissioning groups (CCGs) have confirmed full achievement, awaiting confirmation from NHS England for forensics but no delivery problems anticipated.

### Contracting Issues - Barnsley

Key strategic work areas in Barnsley continue across intermediate care, respiratory, musculo-skeletal (MSK) and stroke services. The new contract for improving psychological therapies (IAPT) services commenced 1 August 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 CCG has confirmed additional investment within adult ADHD/ASD services. The plans for additional investment in IAPT services for long term conditions has been agreed with the CCG and implementation commenced. The CCG has confirmed additional investment non-recurrently to support clearance of the backlog in adult psychology services.

### Contracting Issues - Calderdale

Key ongoing work streams include the mobilisation and implementation of the expansion of IAPT services to long term conditions, continued implementation of the perinatal service across Barnsley, Wakefield, Calderdale and Kirklees and continued implementation of the adult ASD service. Development of the THRIVE model of delivery for child and adolescent mental health services (CAMHs) in Calderdale continues between commissioners and providers. Ongoing in year priorities include early intervention in psychosis services, mental health liaison, 24/7 intensive home based treatment services and out of area placements.

### Contracting Issues - Kirklees

The current priority areas of work related to Kirklees CCGs contracts include IAPT services covering expansion to core IAPT services and long term conditions, expansion of early intervention in psychosis services, continued implementation of the perinatal service across Barnsley, Wakefield, Calderdale and Kirklees and out of area placements. Work has commenced on clearance of adult ASD backlogs.

### Contracting Issues - Wakefield

Key ongoing work streams include the full implementation of the perinatal service across Barnsley, Wakefield, Calderdale and Kirklees and out of area placements. Transformation of CAMH services remains a key priority and work stream with commissioners.

### Contracting Issues - Forensics

Following successful award of the lead provider role for the Yorkshire & Humber delivery of community forensic CAMH services work continues on implementation. Implementation of secure stairs within the forensics secure estate is ongoing. Review of bed occupancy within secure services with NHS England is ongoing.

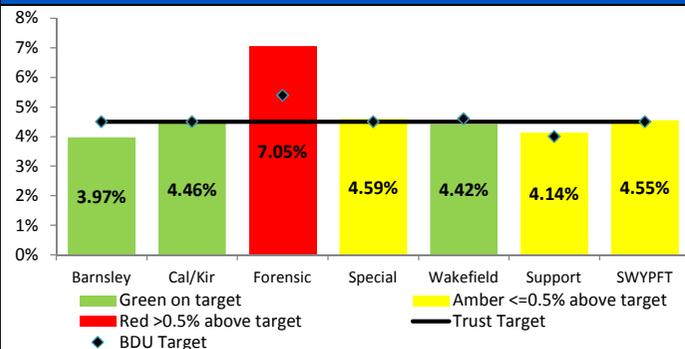
### Contracting Issues - Other

SWYPFT is leading the implementation of the Operational Delivery Network for Yorkshire and Humber for learning disability and autism following successful tender award. The contract has been finalised and signed.

Workforce

Human Resources Performance Dashboard - August 2018

Sickness Absence

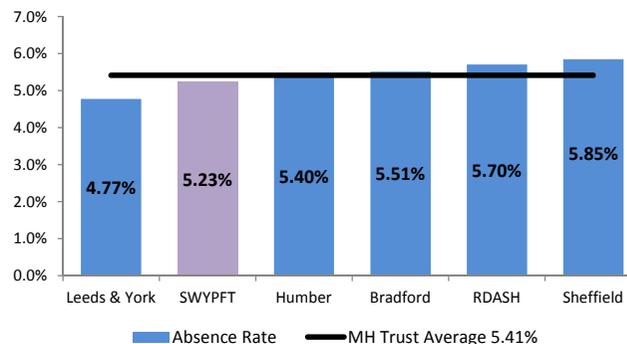


Current Absence Position and Change from Previous Month - August 2018

	Barn	Cal/Kir	Fore	Spec	Wake	Supp	SWYPFT
Rate	4.00%	3.70%	9.30%	4.20%	5.80%	4.70%	4.90%
Change	↑	↓	↑	↑	↑	↑	↑

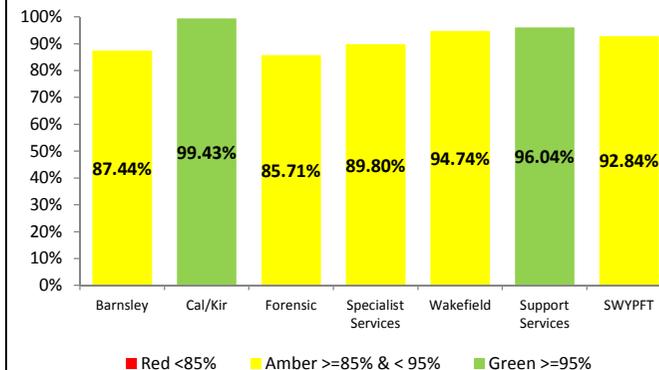
The Trust YTD absence levels in August 2018 (chart above) were just above the target at 4.55%.

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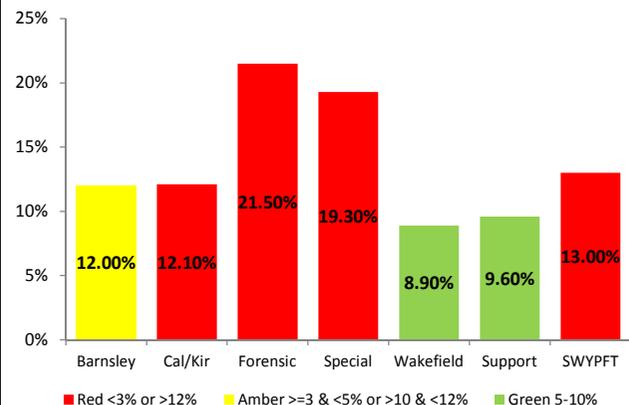
The above chart shows the YTD absence levels in MH/LD Trusts in our region for the period April 2017 to March 2018. During this time the Trust's absence rate was 5.23% which is below the regional average of 5.41%.

Appraisals - Band 6 and Above

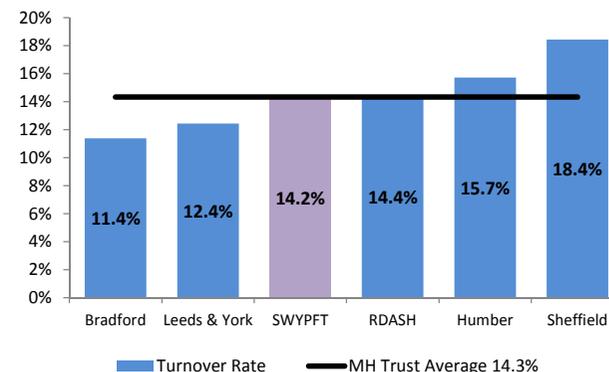


The above chart shows the appraisal rates for staff at Band 6 and above to the end of August 2018. The appraisal target is 95% and over. For staff at Band 6 and above, all appraisals should be completed by the end of June in each financial year.

Turnover and Stability Rate Benchmark

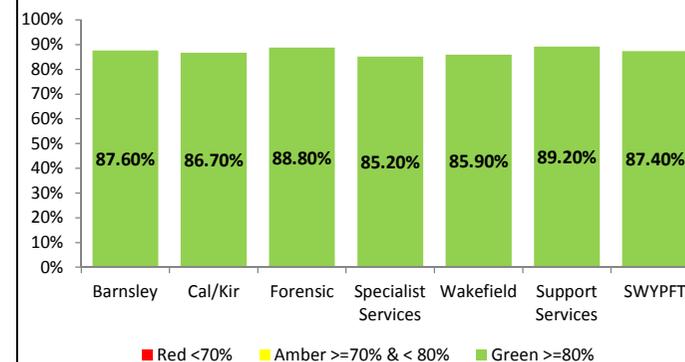


This chart shows the YTD turnover levels up to the end of August 2018. Turnover figures may look out of line with the average across the Trust but this is because of the small amount of data; the figures will level out over the new reporting year. \*The turnover data excludes recently TUPE'd services



This chart shows turnover rates in MH Trusts in the region for the 12 months ending in April 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.

Fire Training Attendance



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

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## Workforce - Performance Wall

Trust Performance Wall																	
Month	Objective	CQC Domain	Owner	Threshold	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Sickness (YTD)	Improving Resources	Well Led	AD	<=4.5%	4.9%	4.9%	5.0%	5.0%	5.1%	5.2%	5.3%	5.3%	4.5%	4.4%	4.4%	4.5%	4.5%
Sickness (Monthly)	Improving Resources	Well Led	AD	<=4.4%	5.2%	5.0%	5.2%	5.6%	5.8%	6.2%	6.0%	4.9%	4.4%	4.4%	4.4%	4.8%	4.9%
Appraisals (Band 6 and above) 1	Improving Resources	Well Led	AD	>=95%	89.0%	91.0%	92.7%	97.6%	98.1%	97.9%	97.8%	97.8%	7.3%	26.1%	84.0%	87.7%	92.8%
Appraisals (Band 5 and below)	Improving Resources	Well Led	AD	>=95%	46.2%	75.8%	82.7%	95.5%	95.7%	95.9%	95.9%	96.0%	0.8%	2.8%	9.4%	21.6%	48.1%
Aggression Management	Improving Care	Well Led	AD	>=80%	77.0%	77.6%	76.4%	79.0%	78.0%	77.9%	78.2%	79.3%	79.3%	81.7%	81.6%	82.9%	83.0%
Cardiopulmonary Resuscitation	Improving Care	Well Led	AD	>=80% by 31/3/17	71.9%	73.4%	72.8%	75.4%	76.6%	77.0%	78.5%	81.4%	82.3%	84.0%	84.5%	84.8%	83.3%
Clinical Risk	Improving Care	Well Led	AD	>=80% by 31/3/17	77.3%	79.2%	80.7%	82.3%	82.5%	83.8%	85.3%	85.1%	85.6%	85.5%	85.8%	85.9%	86.0%
Equality and Diversity	Improving Health	Well Led	AD	>=80%	87.1%	85.7%	85.4%	87.0%	86.9%	88.3%	88.9%	88.5%	89.0%	89.8%	89.7%	89.8%	90.1%
Fire Safety	Improving Care	Well Led	AD	>=80%	82.6%	82.8%	82.8%	83.3%	82.4%	83.8%	84.6%	85.4%	85.3%	86.8%	86.6%	86.6%	87.4%
Food Safety	Improving Care	Well Led	AD	>=80%	79.2%	77.0%	76.2%	78.4%	78.6%	79.3%	77.8%	77.2%	76.2%	77.2%	77.5%	80.8%	81.9%
Infection Control and Hand Hygiene	Improving Care	Well Led	AD	>=80%	83.6%	82.3%	81.8%	83.2%	83.2%	85.0%	86.5%	86.8%	87.0%	87.3%	87.3%	87.8%	88.5%
Information Governance	Improving Care	Well Led	AD	>=95%	89.1%	88.3%	86.2%	85.9%	83.8%	89.2%	95.7%	96.5%	92.4%	92.7%	92.1%	91.9%	92.2%
Moving and Handling	Improving Resources	Well Led	AD	>=80%	79.3%	79.3%	80.7%	81.6%	81.9%	84.1%	85.4%	85.5%	85.2%	85.9%	85.6%	85.7%	86.1%
Mental Capacity Act/DOLS	Improving Care	Well Led	AD	>=80% by 31/3/17	86.1%	87.6%	88.9%	90.3%	91.1%	91.0%	91.1%	90.7%	91.1%	91.4%	91.3%	92.2%	91.7%
Mental Health Act	Improving Care	Well Led	AD	>=80% by 31/3/17	80.3%	81.6%	83.4%	84.7%	86.6%	86.4%	86.0%	84.7%	85.7%	86.8%	86.5%	88.1%	87.3%
No of staff receiving supervision within policy guidance	Quality & Experience	Well Led		>=80%	61.0%		64.7%		86.5%			78.4%			Due Oct		
Safeguarding Adults	Improving Care	Well Led	AD	>=80%	86.0%	86.3%	86.3%	87.4%	87.8%	89.0%	89.8%	89.9%	90.0%	91.0%	91.3%	91.7%	91.7%
Safeguarding Children	Improving Care	Well Led	AD	>=80%	84.7%	84.8%	84.1%	85.4%	85.1%	86.7%	87.5%	87.8%	88.4%	88.6%	89.4%	90.1%	90.4%
Sainsbury's clinical risk assessment tool	Improving Care	Well Led	AD	>=80%	94.2%	94.2%	92.9%	93.4%	93.3%	93.8%	94.3%	93.4%	94.4%	95.1%	94.9%	95.8%	95.2%
Bank Cost	Improving Resources	Well Led	AD	-	£518k	£614k	£545k	£534k	£534k	£604k	£655k	£907k	£557k	£603k	£768k	£646k	£730k
Agency Cost	Improving Resources	Effective	AD	-	£446k	£435k	£515k	£531k	£430k	£465k	£563k	£555k	£444k	£538k	£484k	£526k	£566k
Overtime Costs	Improving Resources	Effective	AD	-	£12k	£12k	£7k	£10k	£8k	£11k	£13k	£6k	£8k	£13k	£5k	£11k	£5k
Additional Hours Costs	Improving Resources	Effective	AD	-	£38k	£45k	£44k	£50k	£39k	£34k	£24k	£23k	£29k	£15k	£23k	£31k	£32k
Sickness Cost (Monthly)	Improving Resources	Effective	AD	-	£527k	£499k	£547k	£550k	£594k	£633k	£532k	£483k	£430k	£443k	£417k	£463k	£478k
Business Miles	Improving Resources	Effective	AD	-	267k	283k	291k	265k	305k	271k	275k	230k	274k	264k	259k	291k	269k

1 - this does not include data for medical staffing.

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## Workforce - Performance Wall cont...

### Notes:

#### Mandatory Training

##### Green Compliance Status:

- Aggression Management – 83.01% no significant change from last month.
- Aggression Management / Physical Interventions – Clinical Level 2 – 89.63%; Aggression Management / De-escalation and Breakaway – Clinical Level 1 – 80.32%; Aggression Management / Personal Safety and Breakaway – Non Clinical Level 2 – 80.30%
- Cardio Pulmonary Resuscitation – 83.35% 1.45% decline in compliance from last month.
- Cardiopulmonary Resuscitation – Immediate Life Support – 85.93%; Cardiopulmonary Resuscitation – Basic Life Support – 82.92%
- Clinical Risk – 85.97% no significant change in compliance from last month.
- Equality and Diversity – 90.10% no significant change in compliance from last month.
- Fire Safety – 87.36% 0.8% increase in compliance from last month.
- Fire Safety – Ward based staff – 88.5%

Hotspots have been identified and a programme of training has been offered locally to meet training needs.

- Food Safety – 81.93% 1.13% increase on in compliance from last month.
- Food Safety – Level 4 – 100%; Food Safety – Level 3 – 92.31%; Food Safety – Level 2 – 82.45%; Food Safety – Level 1 – 63.89%

The review of Food Safety training continues with the implementation of the Housekeeper role into identified in-patient areas who will in future take the lead for Food handling duties. Therefore, the number of clinical staff requiring to undertake Food Safety training will reduce.

- Infection Control and Hand Hygiene – 88.54% no significant change in compliance from last month.
- Infection, Prevention and Control – 87.86%
- Hand Hygiene – 90.71%
- Mental Capacity Act – 91.69% no significant change in compliance from last month
- Mental Capacity Act / Deprivation of Liberty Safeguards – Clinical – 88.34%; Mental Capacity Act – Non Clinical – 100%; Mental Health Act – 87.29% no significant change in compliance from last month
- Mental Health Act – Registered Clinical Mental Health – Inpatient – 89.13%; Mental Health Act – Registered Clinical Mental Health – Community – 89.79%; Mental Health Act – Non Registered Clinical Inpatient and Community – 82%
- Moving and Handling – 86.13% no significant change in compliance from last month.
- Moving and Handling – Level 2 – 69.13%; Moving and Handling – Level 1 – 88.98%; Moving and Handling – Level 2 - Advisers have identified hotspots where services have not met the required targets, and have contacted individual service managers to discuss action plans for compliance. The advisers are now undertaking a Trust wide programme of in-house training sessions planned through to the end of the year, to address low rates of attendance.
- Safeguarding Adults – 91.67% no significant change in compliance from last month.
- Safeguarding Adults Level 2 – 91.24%; Safeguarding Adults Level 1 – 93.57%
- Safeguarding Children – 90.37% no significant change in compliance from last month.
- Safeguarding Children – Level 3 – 84.86%; Safeguarding Children – Level 2 – 91.24%; Safeguarding Children – Level 1 – 94.39%
- Sainsbury's Tool – 95.22% no significant change in compliance from last month.

##### Amber Compliance Status:

- Data Security Awareness Level 1 (formally IG) – 92.21% no significant change on last month.

##### Red Compliance Status:

No mandatory training subjects were in red compliance for this period.

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## Workforce - Performance Wall cont...

### Sickness

- The Trust's sickness has shown a positive downward trend since April and the year to date sickness rate remains at 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 but we have seen a slight increase during August.
- Forensic BDU, support services and specialist service BDUs have seen an increase in sickness levels for August compared to the previous month.
- Barnsley BDU continue to be the BDU with the lowest year to date sickness level. Wakefield BDU and Calderdale and Kirklees BDU remain below target levels. Specialist services, support services have seen a further increase in sickness levels and remain above the target level. Forensic have had an in month increase in sickness which has increased the year to date position to 7%, which 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.
- 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 any national guidance that may be applicable to the Trust.

### NHS.UK website changes

As part of a programme of work to improve its services, NHS Digital is rebranding the 'NHS Choices' website as the NHS website (www.nhs.uk). The NHS website will continue to provide information to help people manage their health and care online. This guidance gives information and advice on the changes organisations will need to make to their own print and digital materials when signposting patients and the public to this site.

[Click here for guidance](#)

### Academy of Medical Royal Colleges

#### Please write to me: writing outpatient clinic letters to patients

This best practice guidance aims to help and encourage doctors to write most of their outpatient clinic letters directly to patients and send a copy of the letter to the patient's general practitioner. The guidance covers general aspects of letter writing and applies to letters sent on paper and electronically. This document focuses on doctors' letters but it is relevant to all clinicians who write clinical letters.

[Click here for guidance](#)

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

[NHS outcomes framework indicators: August 2018 release](#)

[Health care workforce statistics: March 2018](#)

[NHS workforce statistics: May 2018](#)

[NHS sickness absence rates: April 2018, provisional statistics](#)

[Bed availability and occupancy: Q1 2018/19](#)

[Diagnostic imaging dataset: April 2018](#)

[NHS Improvement provider bulletin: 22 August 2018:](#)

- Managing conflicts of interest — a contractual obligation
- Health and Care Innovation Expo 2018 — keynotes and workshops
- Learning from improvement: an event for trusts in special measures for reasons of quality
- Midlands and East non-executive director (NED) networking event
- Making theory a reality: stories of improvement and transformational change
- Updates from our partners

[Statistics on NHS Stop Smoking Services in England: April 2017 to March 2018](#) - annual report by NHS Digital. presents results from the monitoring of the NHS Stop Smoking Services in England. NHS Stop Smoking Services support people to quit smoking. The results are provided at national, regional and local authority levels.

## Publication Summary

### NHS Improvement provider bulletin: 29 August 2018:

- Complaints handling — a reminder
- Health and Care Innovation Expo 2018 — keynotes and workshops
- Updates from our partners

### Quarterly hospital activity data: Q1 2018/19

#### Data on written complaints in the NHS: Q1, 2018/19

#### Data on written complaints in the NHS: 2017/18

### NHS Improvement provider bulletin: 5 September 2018:

- Contribute your ideas, experiences and insights to the long-term plan for the NHS
- Expo: find us on stand 55
- Model Hospital trust ambassadors programme relaunch
- Doctor productivity: medical job planning
- Focus on frailty — scoping event
- Well-led for the future: development for NHS board members
- Masterclass: valuing people's time towards the end of life
- Professional development events for senior children and neonatal nurses
- Improving care to the paediatric population — why are standards important?
- Updates from our partners

### Performance of the NHS provider sector for the quarter ended 30 June 2018 - NHS Improvement

#### Out of area placements in mental health services: June 2018

#### Reports on the use of Improving Access to Psychological Therapies services, England: June 2018

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

#### Mental health services monthly statistics: final June, provisional July 2018

#### Community services statistics for children, young people and adults: May 2018

#### Consultant-led referral to treatment waiting times data: July 2018

#### Monthly hospital activity data: July 2018

#### Mixed-sex accommodation breaches: July 2018

#### Early intervention in psychosis waiting times: July 2018

#### Monthly diagnostic waiting times and activity data: July 2018

#### Delayed transfers of care data: July 2018

### NHS Improvement provider bulletin: 12 September 2018:

- Performance of the NHS provider sector for quarter 1 2018/19
- Learning from last winter to plan for 2018/19
- Apply for funding to develop local non-executive community networks
- How clinicians are using patient-level costing information to improve patient care
- National workforce recruitment campaign: marketing toolkit for trusts
- Local non-executive community networks webinar
- Demand and capacity fundamentals
- Updates from our partners



South West  
Yorkshire Partnership  
NHS Foundation Trust



# Finance Report



Month 5  
(2018 / 19)  
Appendix 1



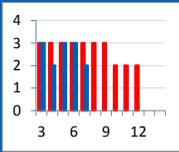
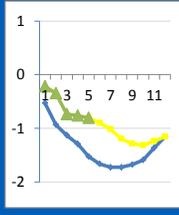
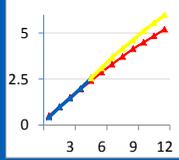
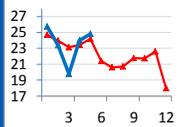
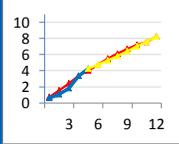
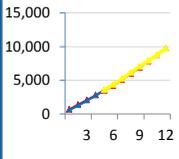
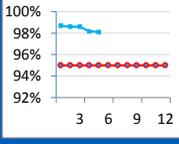
[www.southwestyorkshire.nhs.uk](http://www.southwestyorkshire.nhs.uk)

With **all of us** in mind.

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**1.0 Executive Summary / Key Performance Indicators**

Performance Indicator		Year To Date	Forecast	Narrative	Trend
1	<b>NHS Improvement Finance Rating</b>	2	2	The Trust risk rating has improved from 3 to 2 in month. This is due to movement in the I & E margin metric improving to a deficit margin of 0.9%.	
2	<b>Normalised Deficit (excl PSF)</b>	(£1.2m)	(£2.6m)	August's financial performance is a deficit of £139k pre PSF. (Provider Sustainability Fund). Whilst still a deficit this is an improvement from the run rate in Quarter 1. The cumulative deficit is £1.2m. The underlying position in-month was a deficit of £0.4m, but was boosted by one-off benefits arising from asset disposals and VAT reclaims.	
3	<b>Agency Cap</b>	£2.6m	£6m	Agency expenditure was £0.6m in August the highest monthly spend this year. Year-to-date costs are £2.6m which is £143k (6%) above cap. Costs are 10% higher than the same period last year. Current year-end projection is to exceed our agency cap by £0.8m (15%).	
4	<b>Cash</b>	£24.8m	£18m	Cash remains ahead of plan in month 5. Cash of £0.7m from the sale of a Trust asset has been received in month and continues to be a key management focus.	
5	<b>Capital</b>	£4.2m	£8.2m	Year to date expenditure is ahead of plan primarily due to the profile of spend for the Fieldhead Non-Secure project. We continue to work closely with our construction partner to ensure we have agreed current and forecast spend profiles.	
6	<b>Delivery of CIP</b>	£3.6m	£9.7m	Additional identified cost reductions mean that the year to date position is ahead of plan (£114k - 3%). New schemes have been included in month; as such the required potential upside scenarios included within the forecast position has reduced from £1.0m to £0.7m.	
7	<b>Better Payment</b>	98%		This performance is based upon a combined NHS / Non NHS value.	

<b>Red</b>	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective level	Plan	
<b>Amber</b>	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels	Actual	
<b>Green</b>	In line, or greater than plan	Forecast	

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.

Area	Weight	Metric	Actual Performance		Plan - Month 5	
			Score	Risk Rating	Score	Risk Rating
Financial Sustainability	20%	Capital Service Capacity	2.0	2	1.5	3
	20%	Liquidity (Days)	20.4	1	19.6	1
Financial Efficiency	20%	I & E Margin	-0.9%	3	-1.7%	4
Financial Controls	20%	Distance from Financial Plan	0.8%	1	0.0%	1
	20%	Agency Spend	5.9%	2	0.0%	1
<b>Weighted Average - Financial Sustainability Risk Rating</b>				<b>2</b>	<b>3</b>	

### Impact

The current finance risk rating is 2. The Trust's I & E Margin improved from 1.1% deficit to 0.9% deficit. The threshold for a rating of 4 is 1% and any individual rating of 4 caps the weighted average overall rating at a maximum of 3.

### 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	Actual £m	Variance £m	Deficit Providers
Acute	(944)	(986)	(42)	123
Ambulance	0	2	2	3
Community	1	2	1	6
Mental Health	(10)	(3)	7	21
Specialist	(20)	(14)	6	10
<b>Total - Deficit</b>	<b>(973)</b>	<b>(999)</b>	<b>(26)</b>	<b>163</b>
Uncommitted PSF	137	185	48	
<b>Adjusted Deficit</b>	<b>(836)</b>	<b>(814)</b>	<b>22</b>	

Plan £m	Forecast £m	Variance £m	Deficit Providers
(1,566)	(1,604)	(38)	88
3	3	0	5
22	23	1	4
96	97	1	10
31	31	0	5
<b>(1,414)</b>	<b>(1,450)</b>	<b>(36)</b>	<b>112</b>
896	932	36	
<b>(518)</b>	<b>(518)</b>	<b>0</b>	

NHS Improvement published Quarter 1 draft unaudited performance of the NHS Provider Sector on 11th September 2018.

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

The NHS continues to face the triple challenge of rapidly increasing demand, growing workforce shortages and continued finance pressure. Financially this is shown in the number of Trusts currently in deficit which is an increase of 61 from 102 in 17/18. Of these 6 were Mental Health providers.

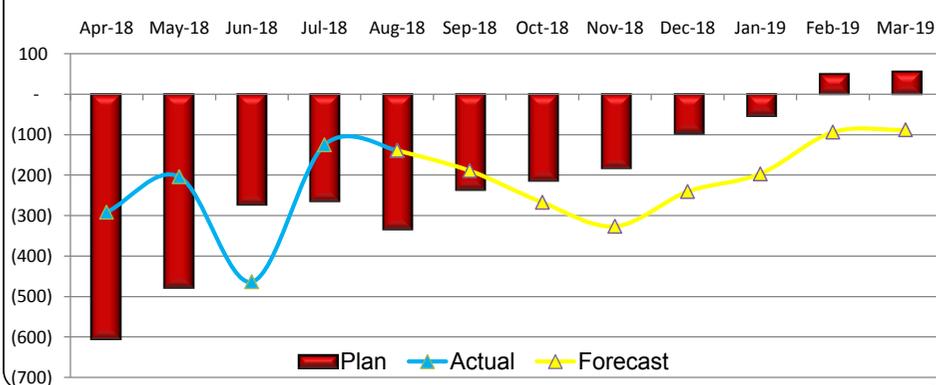
The position at Quarter 1, taking account of uncommitted PSF held centrally, is ahead of plan by £22m although this is £78m worse than the corresponding period in 2017/18. The pressures across the whole NHS continues to be related to workforce solutions to meet operational requirements, this includes both agency and bank costs although agency spend continues to reduce in absolute terms and as a percentage of overall pay.

Pressures also exist within non-pay categories with the main overspend against plan being seen in purchase of healthcare (for us Out of Area fits into this category) and premises costs. These pressures are offset by cost reductions but the whole sector is showing underperformance against recurrent savings although these have been partially offset by non-recurrent actions.

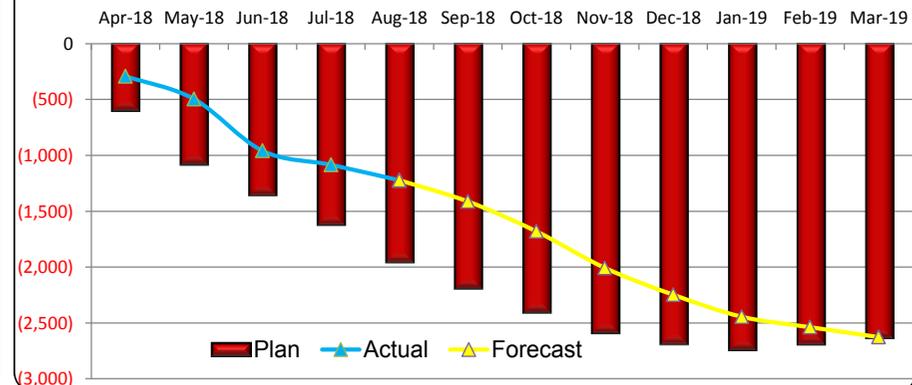
Whilst the overall position is forecast to improve it is clear that improvement of run rates and significant non-recurrent actions will be required to deliver this. On a purely pro-rata calculation the quarter 1 performance would suggest a deficit in excess of £3bn.

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
				16,745	16,707	(38)	Clinical Revenue	83,831	83,920	89	200,644	200,855	211
				<b>16,745</b>	<b>16,707</b>	<b>(38)</b>	<b>Total Clinical Revenue</b>	<b>83,831</b>	<b>83,920</b>	<b>89</b>	<b>200,644</b>	<b>200,855</b>	<b>211</b>
				1,067	1,083	17	Other Operating Revenue	5,380	5,601	220	12,679	12,757	78
				<b>17,812</b>	<b>17,790</b>	<b>(22)</b>	<b>Total Revenue</b>	<b>89,211</b>	<b>89,521</b>	<b>309</b>	<b>213,323</b>	<b>213,612</b>	<b>290</b>
4,064	4,008	(56)	1.4%	(13,960)	(13,855)	105	Pay Costs	(70,005)	(69,657)	348	(167,694)	(167,511)	183
				(3,420)	(3,582)	(162)	Non Pay Costs	(17,448)	(18,001)	(554)	(41,213)	(41,684)	(471)
				16	284	268	Provisions	195	798	604	2,310	2,314	4
<b>4,064</b>	<b>4,008</b>	<b>(56)</b>	<b>1.4%</b>	<b>(17,364)</b>	<b>(17,153)</b>	<b>211</b>	<b>Total Operating Expenses</b>	<b>(87,258)</b>	<b>(86,860)</b>	<b>398</b>	<b>(206,597)</b>	<b>(206,881)</b>	<b>(284)</b>
<b>4,064</b>	<b>4,008</b>	<b>(56)</b>	<b>1.4%</b>	<b>448</b>	<b>638</b>	<b>190</b>	<b>EBITDA</b>	<b>1,954</b>	<b>2,661</b>	<b>707</b>	<b>6,726</b>	<b>6,732</b>	<b>6</b>
				(474)	(476)	(2)	Depreciation	(2,370)	(2,375)	(5)	(5,671)	(5,694)	(23)
				(310)	(310)	0	PDC Paid	(1,552)	(1,550)	2	(3,726)	(3,725)	1
				4	10	6	Interest Received	19	40	22	45	61	16
<b>4,064</b>	<b>4,008</b>	<b>(56)</b>	<b>1.4%</b>	<b>(332)</b>	<b>(139)</b>	<b>194</b>	<b>Normalised Surplus / (Deficit) Excl PSF</b>	<b>(1,950)</b>	<b>(1,223)</b>	<b>726</b>	<b>(2,626)</b>	<b>(2,626)</b>	<b>0</b>
				98	98	0	PSF (Provider Sustainability Fund)	417	417	0	1,470	1,470	0
<b>4,064</b>	<b>4,008</b>	<b>(56)</b>	<b>1.4%</b>	<b>(234)</b>	<b>(41)</b>	<b>194</b>	<b>Normalised Surplus / (Deficit) Incl PSF</b>	<b>(1,532)</b>	<b>(806)</b>	<b>726</b>	<b>(1,156)</b>	<b>(1,156)</b>	<b>0</b>
				0	0	0	Revaluation of Assets	0	0	0	0	0	0
<b>4,064</b>	<b>4,008</b>	<b>(56)</b>	<b>1.4%</b>	<b>(234)</b>	<b>(41)</b>	<b>194</b>	<b>Surplus / (Deficit)</b>	<b>(1,532)</b>	<b>(806)</b>	<b>726</b>	<b>(1,156)</b>	<b>(1,156)</b>	<b>0</b>

Trust Monthly I &amp; E Profile (Excluding revaluation and PSF)



Trust Cumulative I &amp; E Profile (Excluding revaluation and PSF)



**August 2018 is the 5th month in a row the Trust has recorded a financial deficit. Whilst this remains better than plan action is required to secure a positive future run rate.**

### **Month 5**

The August position is a pre PSF deficit of £139k and a post PSF deficit of £41k; this is £194k favourable to plan in month. The normalised year-to-date position is a pre PSF deficit of £1,223k, which whilst favourable to plan, demonstrates a run rate which requires improvement in order to achieve our year-end control total of £2.6m deficit. The underlying monthly position excluding one off benefits is a deficit of £392k.

Non pay expenditure pressures continue to provide the greatest financial challenge with ongoing out of area bed usage (and associated costs) only being partially offset by other non-pay underspends.

### **Income**

At month 5 income is £38k behind plan, a full breakdown of income is shown on page 8.

Income risks continue to be assessed; the year to date position includes an estimate of current CQUIN risk and work continues to minimise this risk.

The only change in income in month relates to additional income relating to the Trust partnership in relation to youth offender work. This will be recharged based upon actual costs incurred by the Trust.

### **Pay Expenditure**

In August pay has underspent by £105k. This includes the April to June 2018 pay arrears (and associated budget) for the 2018/19 Agenda For Change pay award. Medical staff pay awards remain unconfirmed.

This underspend position remains possible due to the level of vacancies offsetting costs associated with temporary staffing to meet clinical and service requirements. These are often not within the same service line or locality and recruitment is actively being undertaken. As such this could lead to increased pressure going forwards. The Trust continues to work on its recruitment and retention work stream.

Inpatient wards across the Trust are reporting significant pressures. Across all inpatient wards (excluding Forensic BDU) the average overspend each month year to date is £184k due to high acuity levels, vacancies and sickness.

### **Non Pay Expenditure**

Non pay overspent by £162k in August. Out of area usage and spend remains higher than planned with actual spend of £392k in-month and is £1.8m cumulatively. At month 5 the year to date spend equals the full year budget. Drugs costs remains a pressure although overall spend has reduced from 2017/18.

### **Forecast**

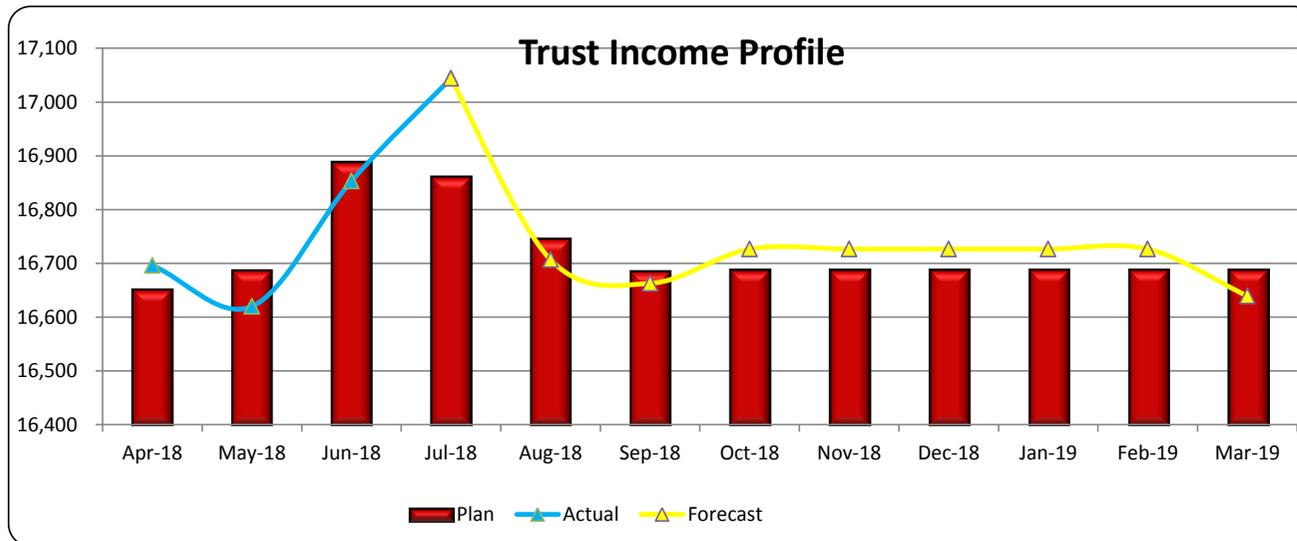
The Trust is still forecasting to achieve its year-end control total of £2.6m deficit, but given the fact a number of the risks identified at the beginning of the year and the current run rate this is at risk. Based on known risks and other information additional savings of £1.6m are required to enable achievement of the control total.

Many of the potential upsides identified to manage this position are one off / non-recurrent in nature. As such additional actions are required to ensure a positive monthly run rate going forwards. This forms the basis of discussions for the Trust future financial plans.

## Income Information

The table below summarises the year to date and forecast income by commissioner group. This is identified as clinical revenue within the Trust income and expenditure position (page 5). The majority of Trust income is secured through block contracts and therefore there has traditionally been little variation to plan.

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total	Total 17/18
	£k	£k												
<b>CCG</b>	12,132	12,012	12,286	12,453	11,924	11,927	11,927	11,927	11,927	11,927	11,927	11,840	<b>144,211</b>	<b>151,142</b>
<b>Specialist Commissioner</b>	1,946	1,946	1,946	1,946	1,872	1,957	1,957	1,957	1,957	1,957	1,957	1,957	<b>23,356</b>	<b>23,661</b>
<b>Alliance</b>	1,053	1,105	1,079	1,079	1,270	1,270	1,270	1,270	1,270	1,270	1,270	1,270	<b>14,478</b>	<b>11,478</b>
<b>Local Authority</b>	430	413	422	438	426	426	416	416	416	416	416	416	<b>5,054</b>	<b>4,851</b>
<b>Partnerships</b>	577	577	577	585	655	597	597	597	597	597	597	597	<b>7,151</b>	<b>6,838</b>
<b>Other</b>	558	567	543	543	560	485	559	559	559	559	559	559	<b>6,607</b>	<b>6,981</b>
<b>Total</b>	<b>16,696</b>	<b>16,620</b>	<b>16,853</b>	<b>17,044</b>	<b>16,707</b>	<b>16,663</b>	<b>16,727</b>	<b>16,727</b>	<b>16,727</b>	<b>16,727</b>	<b>16,727</b>	<b>16,639</b>	<b>200,856</b>	<b>204,951</b>
17/18	17,133	17,247	17,174	17,355	16,953	16,553	17,534	17,083	17,308	16,950	16,922	16,739	<b>204,951</b>	



Additional income was secured in July 2018 following agreement with commissioners. This was also subject to costs within the BDUs. (peak in the graph to the left)

Additional income has been included in month as part of our ongoing Youth Offenders partnership. Income will be reimbursed in line with actual costs incurred. This equates to an additional £350k per annum.

The current forecast position continues to assume 100% delivery of all CQUIN schemes. Although an element of risk has been identified within the internal CQUIN leads group these are being actively mitigated through internal actions and discussions with commissioners.

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 / 18 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
<b>Substantive</b>	12,595	12,598	12,593	13,290	12,529								<b>63,605</b>
<b>Bank &amp; Locum</b>	571	652	824	687	749								<b>3,484</b>
<b>Agency</b>	444	538	484	526	575								<b>2,568</b>
<b>Total</b>	<b>13,610</b>	<b>13,789</b>	<b>13,901</b>	<b>14,503</b>	<b>13,854</b>	<b>0</b>	<b>69,657</b>						
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	<b>166,257</b>
Bank as %	4.2%	4.7%	5.9%	4.7%	5.4%								5.0%
Agency as %	3.3%	3.9%	3.5%	3.6%	4.2%								3.7%

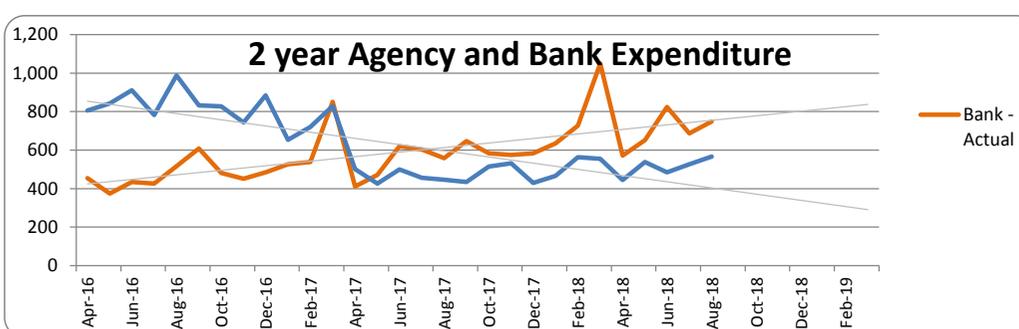
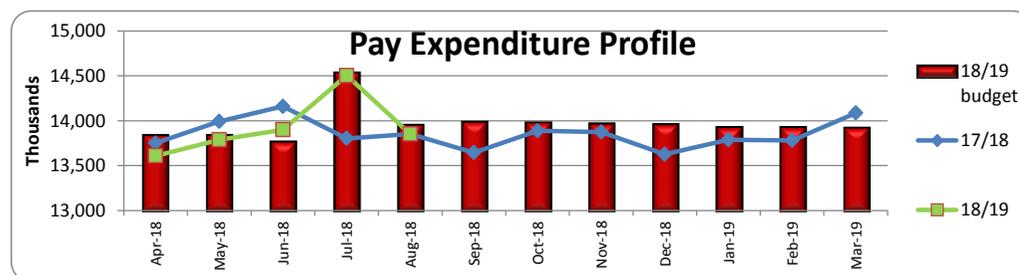
Year to Date expenditure - by staff group				
	Substantive £k	Temp £k	Agency £k	Total £k
Medical	7,344	180	1,405	8,929
Nursing Registered	22,044	1,067	234	23,345
Nursing	7,045	1,722	600	9,366
Other	16,727	255	308	17,289
Admin	10,441	275	12	10,728
<b>Total</b>	<b>63,599</b>	<b>3,499</b>	<b>2,559</b>	<b>69,657</b>

August WTE Analysis						
	Budgeted	Contracted	Bank	Agency	Variance	
Medical	209	168	1	20	(20)	
Qualified Nursing	1,364	1,221	56	10	(77)	
Unqualified Nursing	640	612	121	45	137	
Other Clinical	845	758	8	10	(69)	
A & C	806	730	26	3	(47)	
Other	316	291	8	1	(16)	
Staff Vacancy Factor	(115)	0	0	0	115	
<b>Total</b>	<b>4,064</b>	<b>3,780</b>	<b>220</b>	<b>89</b>	<b>25</b>	

### Key Messages

Pay expenditure has increased in August month due to confirmation of the 2018/19 agenda for change pay award. This pay award has been funded centrally and additional budget has been provided to the BDUs to support this. Arrears relating to April to June 2018 have been paid in August 2018, an estimate of this was included in Julys figures above.

August's cumulative expenditure on bank and agency is the highest year to date at £1.325m, this accounts for 10% of pay expenditure. Significant bank spend remains within inpatient areas (£2.1m to date) and work continues on reviewing appropriate staffing levels to support levels of activity and acuity.



## 2.1 Agency Expenditure Focus

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

**Year to date expenditure is 6% above cap**

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

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

Good progress was made in 2017/18 in terms of significantly reducing agency usage and costs from the £9.8m incurred in 2016/17. Costs now seem to have plateaued at £450k-£550k per month. The maximum agency cap established by NHSI for 2018/19 is £5.2m which is £0.6m lower than actual spend last year.

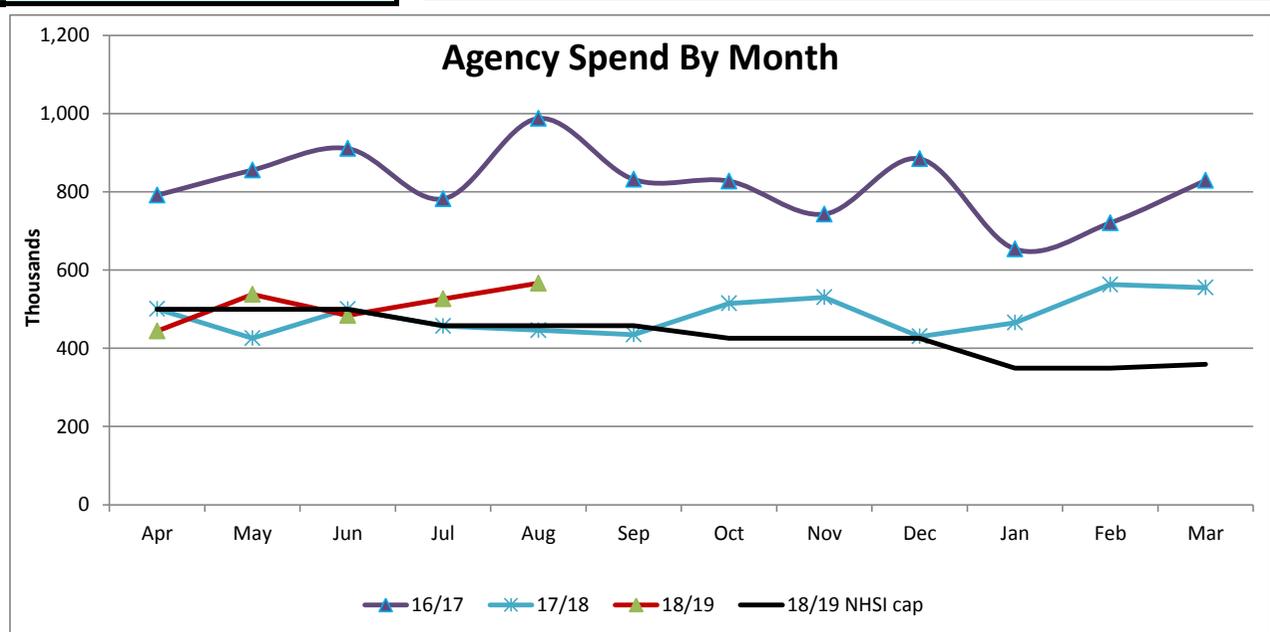
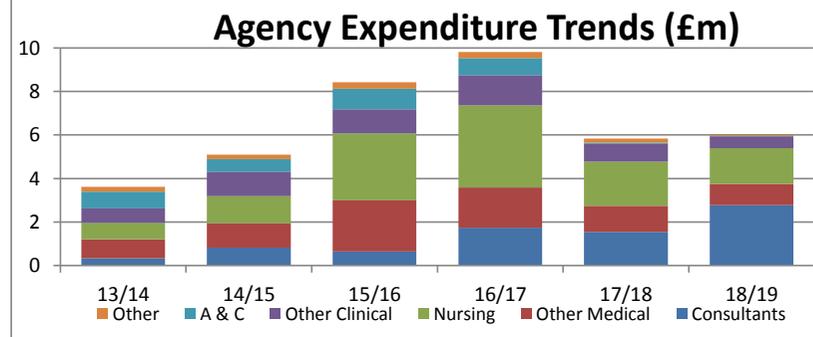
The NHS Improvement cap has been profiled to reduce spend across the year as actions have their desired impact. The cap profile reduces from £500k per month in April 2018 to £359k per month in March 2019. Actual expenditure needs to reduce to remain under this cap.

At month 5 agency spend is £575k, 24% above cap and the highest monthly expenditure level year to date and since March 2017. Overall the year to date expenditure is 6% above cap.

Agency expenditure increased by £49k between July and August, medical agency increased by £66k relating to an additional agency medic covering a new vacancy in CAMHS services, the increase was partly offset by lower nursing agency costs.

Current forecasts indicate an increased agency usage, primarily consultant medical staff, to provide service coverage for known upcoming vacancies.

Agency expenditure is subject to detailed scrutiny at all levels within the Trust. Plans continue to be progressed to reduce this level of expenditure. The Trust continues to report agency usage to NHS Improvement on a weekly basis.



## 2.1

## Inpatient Wards Pay Expenditure Focus

On an ad hoc basis additional focussed information is provided to highlight financial pressures or good practice. This provides a consolidated Trustwide view which may help to identify a whole system response.

This specific focus is on current spend and run rate for inpatient ward areas. Whilst non pay and income have been reviewed the largest pressure is pay related and as such the focus is on that area. This focus does not include forensic services and, as it considers direct ward spend only, does not include any medical input or other costs.

Inpatient wards have funded staffing establishment based upon clinically agreed safer staffing models. In line with contracts with commissioners these are based upon normal activity levels, 85% occupancy (which is the commissioned level) and normal levels of acuity.

Changes to these base assumptions, such as additional staffing to meet levels of demand, result in financial pressures.

Inpatient Type	Year to Date		
	Budget £k	Actual £k	Variance £k
Adult Working Age	4,005	4,413	(408)
Older Peoples	2,255	2,621	(366)
Rehab	339	323	16
PICU	1,180	1,264	(84)
Other	1,559	1,637	(78)
<b>Total</b>	<b>9,337</b>	<b>10,258</b>	<b>(920)</b>

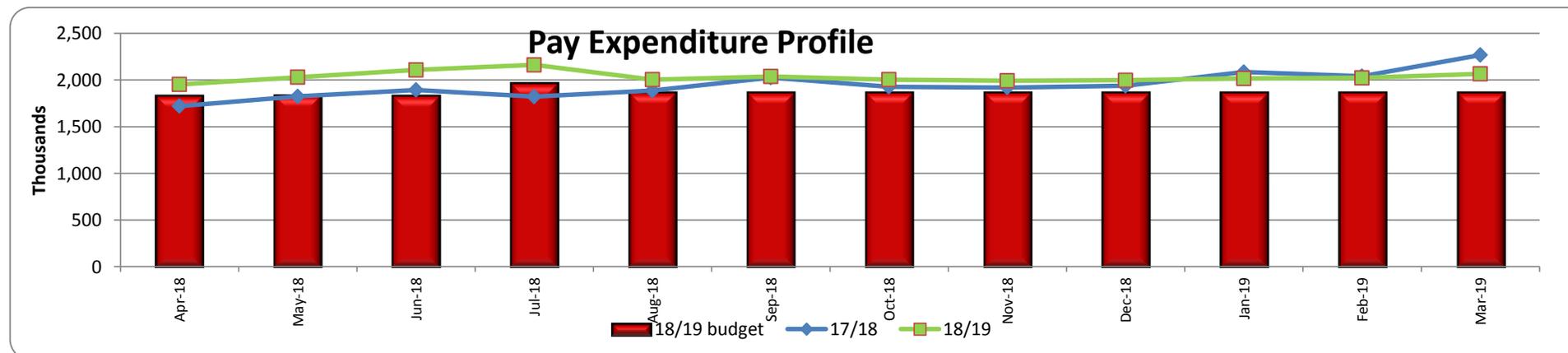
Substantive	9,337	8,216	1,121
Bank	0	1,533	(1,533)
Agency	0	508	(508)
<b>Total</b>	<b>9,337</b>	<b>10,258</b>	<b>(920)</b>

Budget	Forecast	
	Actual £k	Variance £k
9,612	10,547	(935)
5,404	6,282	(878)
814	775	39
2,831	3,028	(197)
3,741	3,762	(21)
<b>22,402</b>	<b>24,394</b>	<b>(1,992)</b>

22,402	19,621	2,780
0	3,555	(3,555)
0	1,032	(1,032)
<b>22,402</b>	<b>24,209</b>	<b>(1,807)</b>

This focus looks at 19 wards which in total are forecasting an overspend of £2.0m. Of these, 3 wards represent £1.1m (53%) of this overspend. These are wards 18 and 19 at Priestley (Male and Female) and Priory ward at Fieldhead.

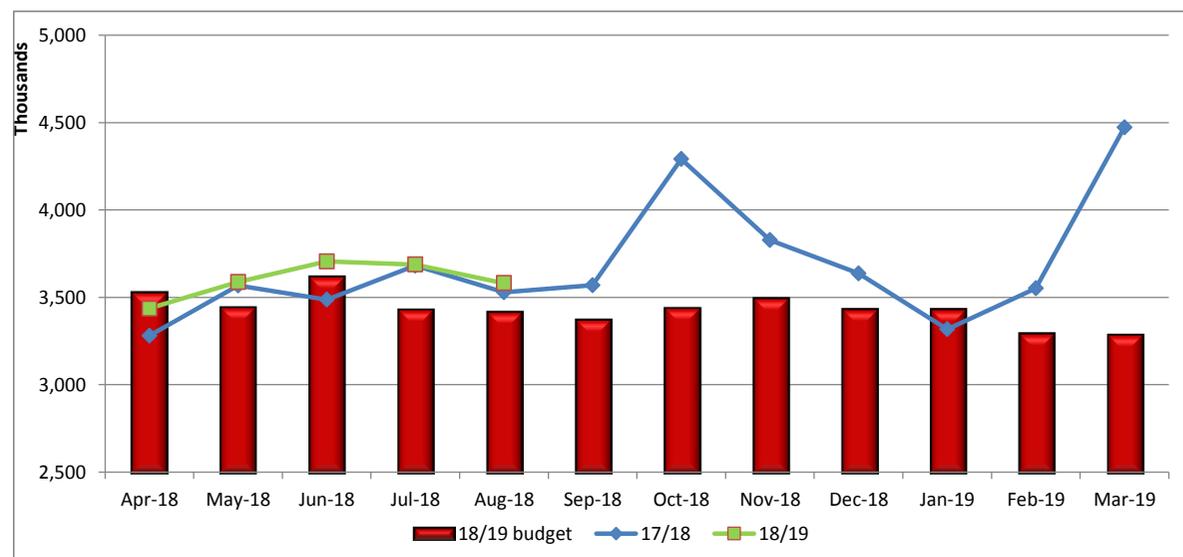
Across all wards the same themes of high acuity levels, vacancies, sickness, maternity leave and escorts are driving the high levels of overspend.



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

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total
	£k												
<b>2018 / 2019</b>	3,437	3,588	3,706	3,689	3,582								<b>18,001</b>
<b>2017 / 2018</b>	3,281	3,568	3,488	3,681	3,529	3,570	4,292	3,829	3,637	3,318	3,552	4,474	<b>44,219</b>

Non Pay Category	Budget	Actual	Variance
	YTD	YTD	
	£k	£k	£k
Clinical Supplies	1,108	1,266	(158)
Drugs	1,226	1,399	(173)
Healthcare subcontracting	2,083	2,946	(863)
Hotel Services	751	783	(32)
Office Supplies	2,109	1,911	198
Other Costs	2,020	1,725	295
Property Costs	2,790	2,819	(29)
Service Level Agreements	2,533	2,472	62
Training & Education	261	225	36
Travel & Subsistence	1,566	1,369	198
Utilities	456	504	(47)
Vehicle Costs	543	583	(40)
<b>Total</b>	<b>17,448</b>	<b>18,001</b>	<b>(554)</b>
<b>Total Excl OOA and Drugs</b>	<b>14,139</b>	<b>13,656</b>	<b>483</b>



### Key Messages

Healthcare subcontracting relates to the purchase of all non-Trust bed capacity and is overspending by £863k. As a fluctuating pressure the out of area focus provides further details on this. This is an increase in variance from month 4 as the out of area budget profile assumed reduced usage over the course of the year.

Drugs expenditure is the second highest overspend category. As at August 2018 this is £173k overspent against budget. A more detailed breakdown of drugs expenditure is included within this report on page 13.

Excluding those two key areas we continue to see good non-pay expenditure control across the majority of areas. The largest favourable variances to budget are within travel and subsistence and other costs.

## 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 (£)

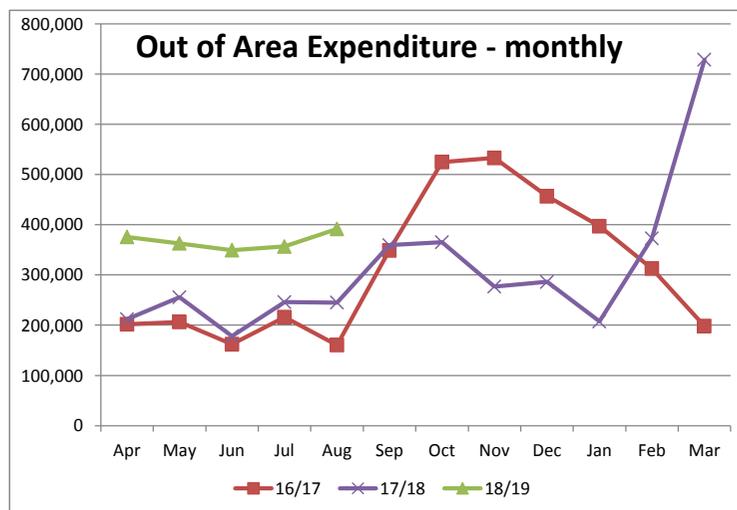
	Apr £000	May £000	Jun £000	Jul £000	Aug £000	Sep £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	Mar £000	Total £000
16/17	202	206	162	216	160	349	525	533	457	397	313	198	3,718
17/18	212	255	178	246	245	359	365	277	286	208	373	729	3,733
18/19	376	363	349	357	392								1,836

### 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	374	412	502	669								2,564

### Bed Day Information 2018 / 2019 (by category)

PICU	316	207	142	91	76								832
Acute	278	157	258	349	542								1,584
Gender	13	10	12	62	51								148
<b>Total</b>	<b>607</b>	<b>374</b>	<b>412</b>	<b>502</b>	<b>669</b>								<b>2,564</b>



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.

Acute activity in August 2018 has reached exceptionally high levels. 167 bed days were needed in one week, the highest level since weekly reporting began in October 2016.

PICU activity over the past 11 weeks has been consistently lower than in the previous 12 months. Typically 27 bed days are needed each week.

The net effect has resulted in the year to date variance increasing to £823k (£588k at month 4). Actual expenditure to date equates to the full year budget.

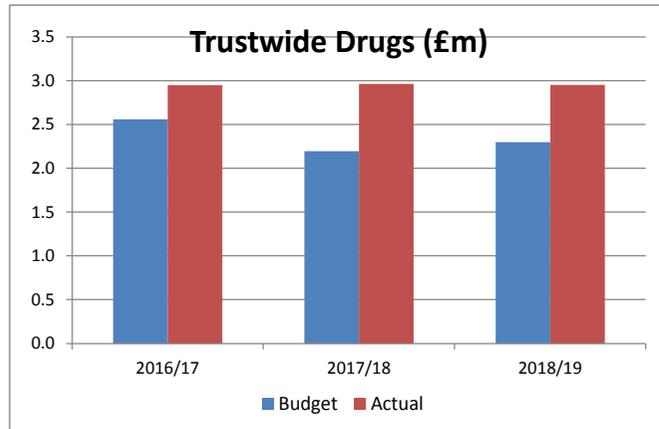
The out of area project board continue to review activity and are implementing actions to improve patient flow and ensure best value e.g criteria led discharge.

The drugs budget has overspent significantly in recent years. In 2017/18 drugs overspend was £0.8m and the current forecast for 2018/19 is an overspend of £0.7m. This page analyses and explains changes in expenditure over the past 3 years and reports on cost pressures and savings being made to achieve the 2017/18 CIP and potential future savings.

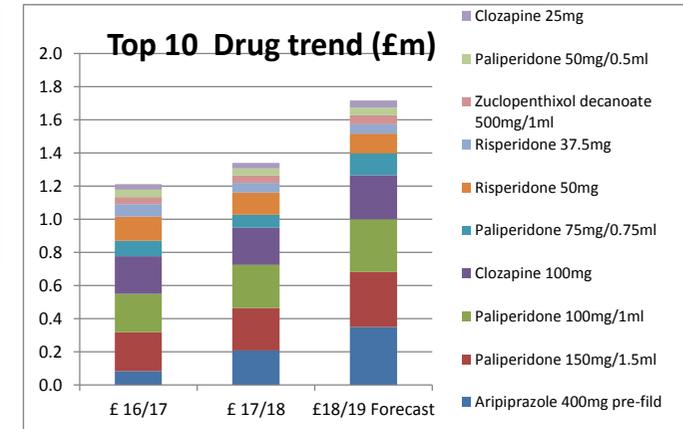
This analysis excludes drugs relating to stop smoking services.

Drugs expenditure over the last 3 years has consistently been just below £3m. During this time drugs budgets within Calderdale, Kirklees, Specialist and Forensics have remained broadly unchanged, with CIPs and new investment driving the changes. Barnsley BDU drugs budget has reduced by £254k across the three years following decommissioning and changes to service provision in intermediate care and memory services.

Drugs expenditure exceeds budget in all BDUs with the exception of forensic services.



Cost improvement programme	Full year effect (£'000s)	2018/19 Savings (£'000s)
Drug price reductions	80	15
Direct prescribing	120	0
Drug switches	45	5
Increasing shared care	60	0
Other	48	48
<b>Total Savings</b>	<b>353</b>	<b>68</b>



The table above outlines the £353k possible drugs savings identified. Using the Refine/ Define programme the Drug and Therapeutics committee have identified a number of drug preparation switches which will not impact clinically on patients. The savings are dependant on prescribers actioning the switches, quarter 1 data shows very limited progress has been made. The remaining CIPs are forecast to achieve later than planned but continue to be progressed.

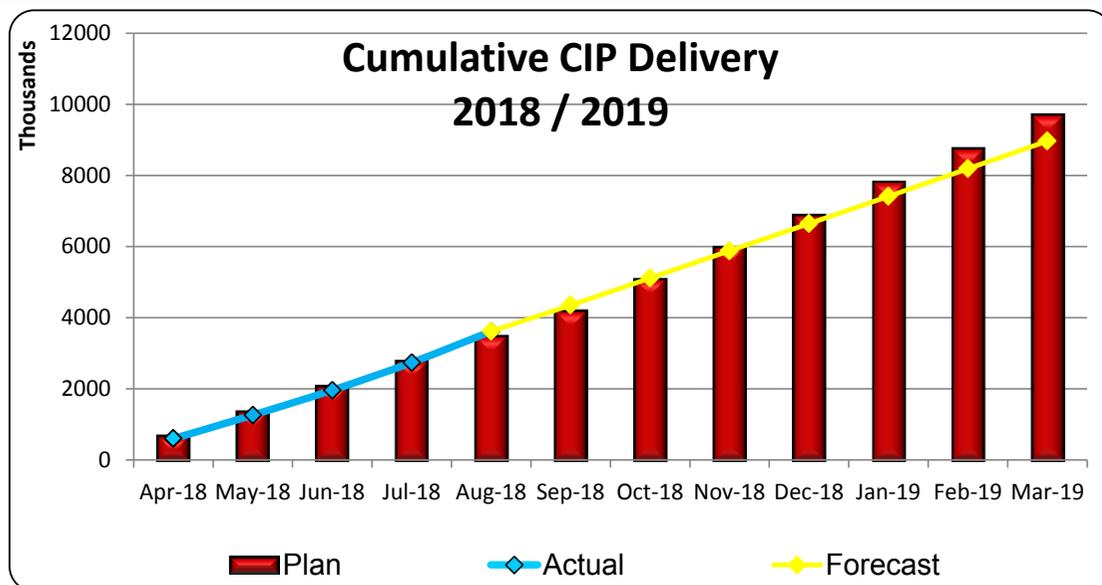
In 2018/19 circa £1.7m (60%) of expenditure is on the top 10 drugs prescribed, this includes various concentrations of the same drug. By comparison expenditure on the same 10 drugs totalled £1.2m in 2016/17. During the last few years several low cost drugs in tablet form (less than £1/day) e.g. fluphenazine have become unavailable and are being replaced by drugs at a significantly higher cost e.g. Aripiprazole (slow release injection) which costs in excess of £8/day. Expenditure on this drug has increased from £83k in 2016/17 to a forecast expenditure of £350k in 2018/19, in addition to increased demand, the cost of these drugs are increasing 4% each year. Whilst being significantly more expensive, service users benefit from using slow release drugs through fewer attendances to clinics and no daily medicine to take. Studies have evidenced the high costs of these drugs are offset by fewer inpatient and depot clinics attendances.

## 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	3,501	9,701

Delivery as originally planned	555	1,136	1,699	2,259	2,827	3,391	3,975	4,560	5,145	5,743	6,352	6,960	2,827	6,960
Mitigations - Recurrent & Non-Recurrent	39	124	260	478	788	957	1,136	1,319	1,498	1,667	1,836	2,005	788	2,005
Mitigations - Upside schemes							123	246	369	492	615	735	0	735
<b>Total Delivery</b>	<b>595</b>	<b>1,260</b>	<b>1,959</b>	<b>2,737</b>	<b>3,615</b>	<b>4,348</b>	<b>5,234</b>	<b>6,125</b>	<b>7,012</b>	<b>7,903</b>	<b>8,803</b>	<b>9,701</b>	<b>3,615</b>	<b>9,701</b>

Variance	(96)	(122)	(132)	(61)	114	145	133	128	118	80	41	0	114	0
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The Trust has a CIP requirement for 2018 / 19 totalling £9.7m. This included £1.6m of unidentified savings at the beginning of the year.

Delivery of schemes continue to be monitored. Through identified mitigations the current CIP performance is ahead of plan which is supporting the better than plan overall financial position. The currently unidentified gap is £0.7m. This is a reduction in the gap of £0.3m when compared to last month. The majority of these are schemes which hold non-clinical vacancies.

A number of opportunities are currently being finalised to support further closure of this gap. The detailed workings will validate this and confirm final values.

	2017 / 2018 Plan (YTD)		Actual (YTD)	Note
	£k	£k	£k	
Non-Current (Fixed) Assets	123,810	124,803	125,053	1
<b>Current Assets</b>				
Inventories & Work in Progress	232	232	232	
NHS Trade Receivables (Debtors)	1,388	2,007	2,425	
Non NHS Trade Receivables (Debtors)	1,867	2,977	2,040	2
Other Receivables (Debtors)	1,219	1,000	2,476	3
Accrued Income	3,660	4,650	3,129	4
Cash and Cash Equivalents	26,559	24,188	24,814	5
<b>Total Current Assets</b>	<b>34,925</b>	<b>35,054</b>	<b>35,116</b>	
<b>Current Liabilities</b>				
Trade Payables (Creditors)	(4,158)	(5,890)	(4,190)	6
Capital Payables (Creditors)	(1,142)	(1,892)	(984)	6
Tax, NI, Pension Payables	(5,782)	(6,000)	(7,303)	
Accruals	(5,799)	(6,000)	(6,526)	7
Deferred Income	(670)	(670)	(869)	
<b>Total Current Liabilities</b>	<b>(17,552)</b>	<b>(20,452)</b>	<b>(19,872)</b>	
<b>Net Current Assets/Liabilities</b>	<b>17,373</b>	<b>14,602</b>	<b>15,244</b>	
<b>Total Assets less Current Liabilities</b>	<b>141,183</b>	<b>139,405</b>	<b>140,297</b>	
Provisions for Liabilities	(6,490)	(6,240)	(6,410)	
<b>Total Net Assets/(Liabilities)</b>	<b>134,693</b>	<b>133,165</b>	<b>133,887</b>	
<b>Taxpayers' Equity</b>				
Public Dividend Capital	44,015	44,015	44,015	
Revaluation Reserve	24,938	24,938	25,328	
Other Reserves	5,220	5,220	5,220	
Income & Expenditure Reserve	60,520	58,992	59,325	8
<b>Total Taxpayers' Equity</b>	<b>134,693</b>	<b>133,165</b>	<b>133,887</b>	

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 / 18 to highlight accrued income and payables due to tax, National Insurance (NI) and pension arrangements.

1. Capital expenditure is detailed on page 17. Year to date spend is now above plan.

2. Non-NHS Debtors are lower than plan. £1m of the current balance relates to Locala, this is under 30 days and payment will be chased in due course.

3. Other Receivables includes prepayments. This is currently higher than plan and the majority relates to payment timing for licences and the lease car insurance.

4. Accrued income is currently lower than plan, invoices continue to be raised on a timely basis.

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 19.

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

7. Accruals are higher than plan due to timing of receipt of invoices.

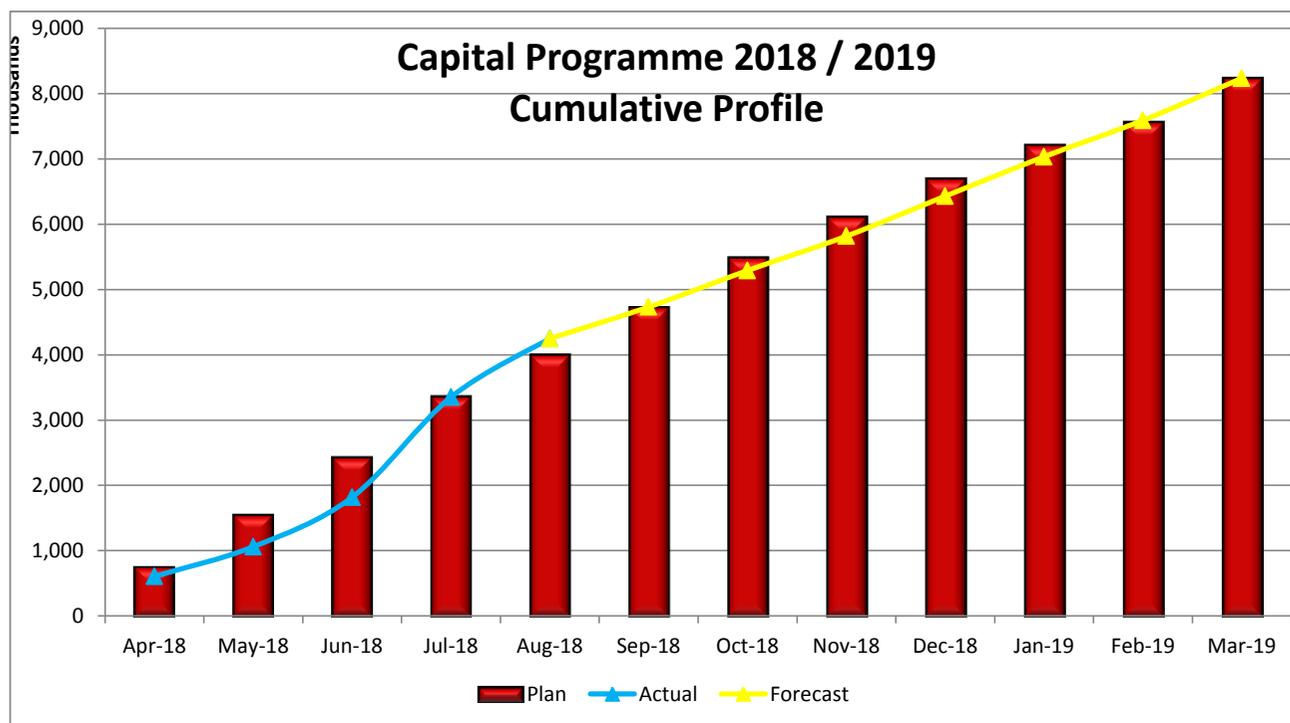
8. This reserve represents year to date surplus plus reserves brought forward.

	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
<b>Maintenance (Minor) Capital</b>							
Facilities & Small Schemes	1,628	386	318	(68)	1,731	103	3
Equipment Replacement	0	0	27	27	27	27	
IM&T	1,550	720	635	(85)	1,417	(133)	2
<b>Major Capital Schemes</b>							
Fieldhead Non Secure	4,229	2,459	3,053	594	4,229	(0)	4
Clinical Record System	828	440	269	(172)	883	55	
VAT Refunds	0	0	(52)	(52)	(52)	(52)	
<b>TOTALS</b>	<b>8,235</b>	<b>4,005</b>	<b>4,249</b>	<b>244</b>	<b>8,235</b>	<b>(0)</b>	1

The next phase of the Fieldhead non-secure project is due to open in September 2018.

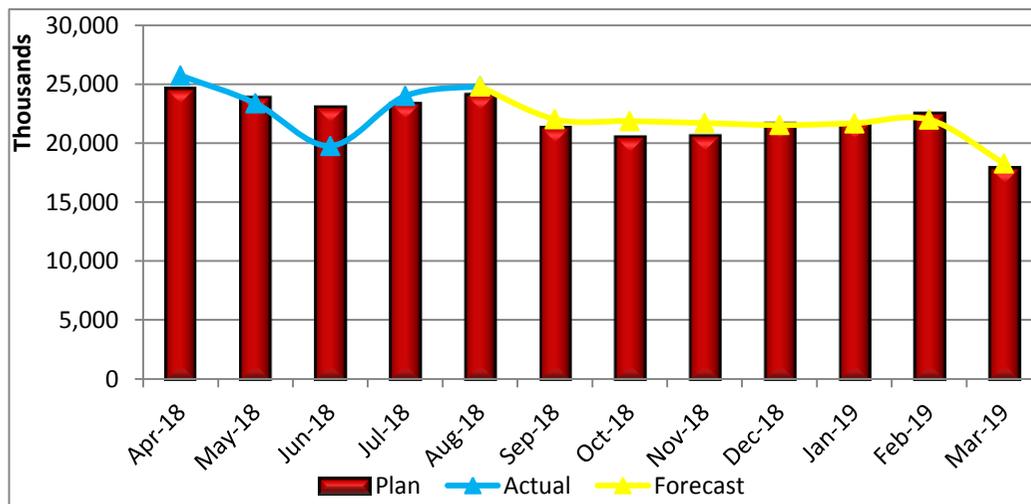
#### Capital Expenditure 2018 / 2019

- The originally agreed capital plan for 2018 / 19 was £8.1m and schemes are guided by the current estates and digital strategy. A further £135k has been added from national funding.
- IM & T schemes are progressing in line with original plans with the exception of the Business Intelligence scheme. This has been postponed pending completion of the clinical record system implementation.
- Some schemes have been delayed due to accessibility. These are still planned to be completed in year. The year to date position also reflects that schemes which have been completed have done so within original planned values.
- The main Fieldhead non secure scheme continues although the profile of expenditure is different to that originally planned.

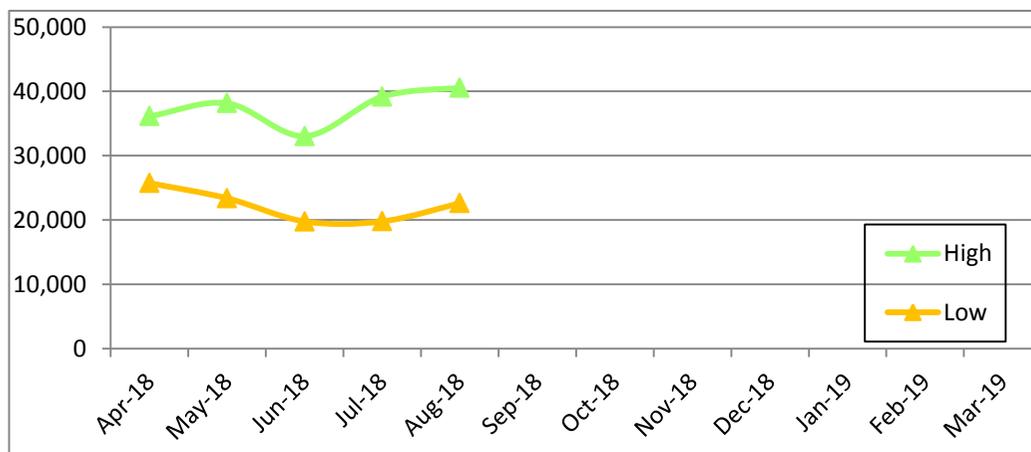


### 3.2

## Cash Flow & Cash Flow Forecast 2018 / 2019



	Plan £k	Actual £k	Variance £k
Opening Balance	26,559	26,559	
Closing Balance	24,188	24,814	626



The cash position continues to improve; monies have been received in relation to the sale of Castle Lodge.

Cash remains slightly above plan although it will reduce in September due to the payment of Public Dividend Capital (PDC) as planned. Cash was received in month for the sale of Castle Lodge (£0.7m).

A detailed reconciliation of working capital compared to plan is presented on page 19.

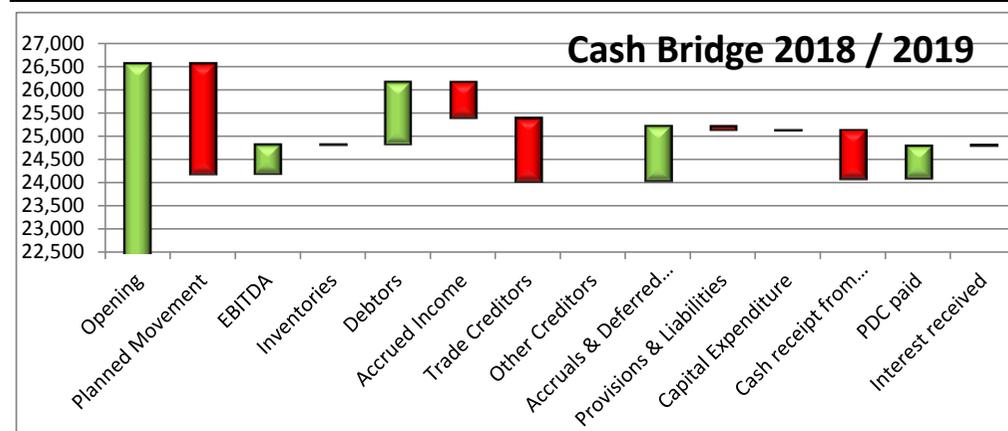
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £40.5m  
The lowest balance is: £22.6m

This reflects cash balances built up from historical surpluses.

### 3.3 Reconciliation of Cashflow to Cashflow Plan

	Plan £k	Actual £k	Variance £k	Note
<b>Opening Balances</b>	<b>26,559</b>	<b>26,559</b>	<b>0</b>	
Surplus / Deficit (Exc. non-cash items & revaluation)	2,372	3,010	638	1
<i>Movement in working capital:</i>				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	(2,500)	(1,162)	1,338	3
Accrued Income / Prepayments	0	(773)	(773)	4
Trade Payables (Creditors)	1,350	2	(1,348)	5
Other Payables (Creditors)	0	0	0	
Accruals & Deferred income	(250)	926	1,176	2
Provisions & Liabilities	0	(80)	(80)	
<i>Movement in LT Receivables:</i>				
Capital expenditure & capital creditors	(3,363)	(4,408)	(1,045)	5
Cash receipts from asset sales	0	700	700	
PDC Dividends paid	0	0	0	
PDC Dividends received			0	
Interest (paid)/ received	20	40	20	
<b>Closing Balances</b>	<b>24,188</b>	<b>24,814</b>	<b>627</b>	



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

Factors which increase the cash position against plan:

1. Whilst we are reporting an in year deficit the actual position is favourable to plan which has a positive impact on cash compared to plan.
2. Accruals are higher than plan due to the timing of invoices received. Deferred income is higher than plan primarily due to project income received for Altogether Better.
3. Debtors are lower than plan. Work has continued in August to reduce outstanding debt and the focus remains on cash management through reduction of debtors.

A number of aged debts remain and we continue to engage with all parties to resolve these.

Factors which decrease the cash position against plan:

4. Prepayments are higher than plan, mainly due to the timing of payments made for software licences and the lease car insurance. It is Trust policy to not routinely pay in advance for goods and services and therefore these are exceptional cases.
5. Creditors, and capital creditors, are lower than planned. Invoices are paid in line with the Trust Better Payment Practice Code and any aged creditors are reviewed and action plans for resolution agreed.

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

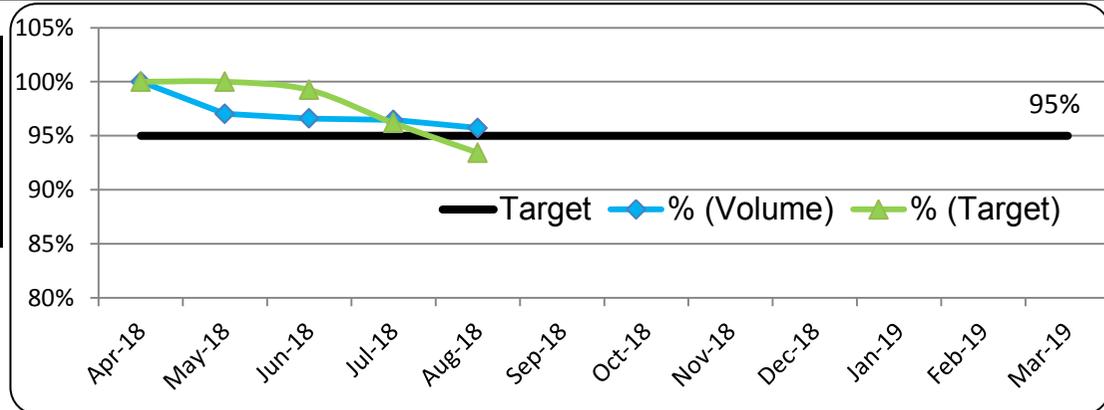
# 4.0

# Better Payment Practice Code

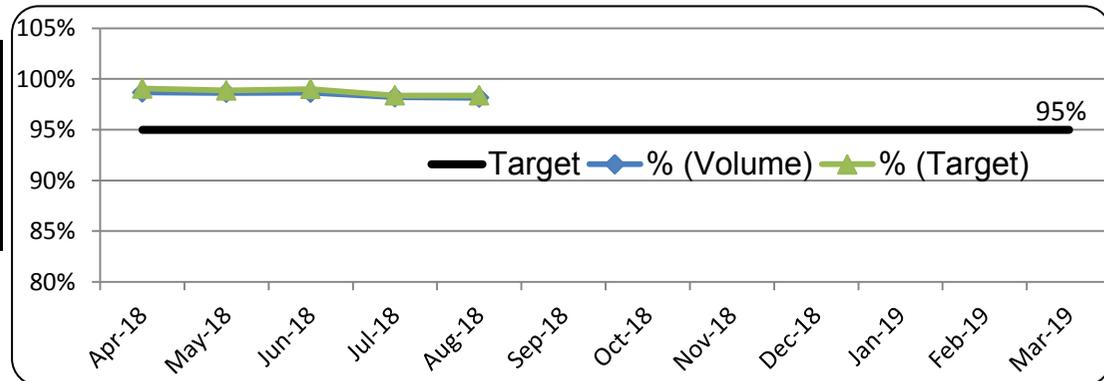
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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 July 2018	96%	96%
Year to August 2018	96%	93%



Non NHS		
	Number	Value
	%	%
Year to July 2018	98%	98%
Year to August 2018	98%	98%



## 4.1

## Transparency Disclosure

As part of the Government's commitment to greater transparency on how public funds are used the Trust makes a monthly Transparency Disclosure highlighting expenditure greater than £25,000.

This is for non-pay expenditure; however, organisations can exclude any information that would not be disclosed under a Freedom of Information request as being Commercial in Confidence or information which is personally sensitive.

At the current time NHS Improvement has not mandated that Foundation Trusts disclose this information but the Trust has decided to comply with the request.

The transparency information for the current month is shown in the table below.

Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
02-Aug-18	Property Rental	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	3079258	219,053
17-Aug-18	Legal/Prof fees	Trustwide	NHS Litigation Authority	3080663	61,855
27-Jul-18	Drugs FP10's	Trustwide	NHSBSA Prescription Pricing Division	3078620	49,347
02-Jul-18	Staff Recharge	Trustwide	Leeds and York Partnership NHS FT	3075941	48,173
07-Aug-18	Staff Recharge	Trustwide	Leeds and York Partnership NHS FT	3079488	46,731
24-Aug-18	Drugs FP10's	Trustwide	NHSBSA Prescription Pricing Division	3081108	44,715
24-Jul-18	Property Rental	Kirklees	Mid Yorkshire Hospitals NHS Trust	3078170	34,426
20-Aug-18	Training	Trustwide	The Inspiring Leaders Network Limited	3080739	26,310

- \* 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	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	5.1%	4.4%	4.2%	4.0%	4.0%	4.0%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	4.8%	4.4%	4.0%	3.8%	3.8%	4.0%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	95.7%	7.0%	25.4%	70.6%	83.5%	87.4%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	94.3%	1.0%	2.5%	6.1%	16.9%	35.6%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	77.9%	83.3%	87.3%	85.3%	85.3%	85.4%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	85.7%	86.2%	87.3%	84.3%	84.3%	85.3%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	88.3%	88.3%	88.4%	88.3%	88.3%	87.3%
Equality and Diversity	Resources	Well Led	AD	>=80%	83.3%	83.3%	84.1%	84.3%	84.3%	84.7%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	84.7%	84.2%	84.4%	84.3%	84.3%	87.3%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	63.3%	60.7%	63.2%	61.1%	65.7%	70.1%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	85.3%	85.3%	86.4%	87.1%	86.3%	87.3%
Information Governance	Resources	Well Led	AD	>=95%	95.3%	91.6%	91.9%	91.6%	91.5%	91.5%
Moving and Handling	Resources	Well Led	AD	>=80%	83.3%	82.1%	87.3%	87.4%	87.3%	87.3%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	83.3%	84.3%	84.7%	84.3%	87.3%	86.3%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	76.3%	78.9%	87.4%	85.3%	84.7%	84.3%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	86.3%	86.3%	86.3%	86.3%	86.3%	86.3%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	87.3%	86.2%	86.3%	86.3%	86.3%	86.3%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	85.3%	86.3%	86.3%	86.3%	86.3%	86.3%
Agency Cost	Resources	Effective	AD		£87k	£78k	£79k	£55k	£93k	£59k
Overtime Costs	Resources	Effective	AD		£1k	£3k	£5k	£4k	£4k	£1k
Additional Hours Costs	Resources	Effective	AD		£13k	£14k	£8k	£11k	£15k	£17k
Sickness Cost (Monthly)	Resources	Effective	AD		£132k	£116k	£120k	£105k	£105k	£118k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		166.52	79.14	92.5	91.03	91.39	71.1
Business Miles	Resources	Effective	AD		90k	96k	93k	90k	106k	102k

Calderdale and Kirklees District										
Month	Objective	CQC Domain	Owner	Threshold	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	5.3%	4.9%	4.8%	4.7%	4.7%	4.6%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	5.2%	4.9%	4.7%	4.4%	4.6%	4.7%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	95.3%	6.1%	33.8%	81.6%	95.3%	95.3%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	95.3%	0.0%	1.5%	9.4%	22.5%	54.0%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	78.5%	78.4%	82.7%	81.3%	83.7%	83.7%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	78.7%	85.3%	84.3%	85.4%	85.3%	85.7%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	86.7%	86.3%	86.3%	86.3%	86.3%	86.3%
Equality and Diversity	Resources	Well Led	AD	>=80%	87.3%	86.7%	86.3%	86.7%	86.7%	86.3%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	85.4%	84.7%	85.1%	85.3%	85.3%	86.7%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	79.6%	76.5%	78.7%	75.7%	83.3%	83.3%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	87.3%	87.3%	87.1%	87.3%	87.3%	86.7%
Information Governance	Resources	Well Led	AD	>=95%	98.3%	93.6%	93.1%	93.0%	94.1%	93.2%
Moving and Handling	Resources	Well Led	AD	>=80%	84.3%	85.3%	86.3%	86.3%	87.3%	87.3%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	82.3%	83.1%	83.3%	84.3%	83.3%	83.3%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	88.3%	83.4%	81.3%	81.3%	82.1%	83.3%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	86.3%	86.3%	86.3%	86.3%	86.3%	86.3%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	86.7%	86.3%	86.3%	86.3%	87.3%	86.3%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	86.7%	86.3%	86.3%	86.7%	86.3%	86.3%
Agency Cost	Resources	Effective	AD		£133k	£98k	£143k	£104k	£89k	£112k
Overtime Costs	Resources	Effective	AD		£4k	£3k	£8k	£1k	£4k	£3k
Additional Hours Costs	Resources	Effective	AD		£1k	£3k	£0k	£2k	£2k	£0k
Sickness Cost (Monthly)	Resources	Effective	AD		£118k	£112k	£110k	£95k	£104k	£84k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		62.79	58.91	62.81	60.56	66.97	75.42
Business Miles	Resources	Effective	AD		53k	70k	53k	58k	64k	59k

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

Forensic Services										
Month	Objective	CQC Domain	Owner	Threshold	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Sickness (YTD)	Resources	Well Led	AD	<=5.4%	6.8%	6.2%	6.1%	6.0%	6.5%	7.0%
Sickness (Monthly)	Resources	Well Led	AD	<=5.4%	7.1%	6.2%	6.0%	6.0%	7.8%	9.3%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	93.7%	14.1%	32.1%	80.0%	83.8%	85.7%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	93.7%	3.1%	8.1%	16.4%	32.3%	56.0%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	92.2%	98.7%	98.1%	97.7%	98.4%	97.3%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	92.2%	98.9%	97.3%	94.3%	98.3%	98.3%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	92.2%	98.9%	98.3%	97.7%	98.4%	98.3%
Equality and Diversity	Resources	Well Led	AD	>=80%	92.2%	98.2%	97.7%	93.7%	94.3%	98.3%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	92.2%	98.4%	92.7%	98.3%	98.3%	98.3%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	92.2%	98.4%	94.4%	97.3%	98.3%	98.3%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	92.2%	98.7%	98.3%	98.3%	97.8%	98.3%
Information Governance	Resources	Well Led	AD	>=95%	98.2%	91.9%	92.4%	92.9%	94.3%	93.0%
Moving and Handling	Resources	Well Led	AD	>=80%	92.2%	98.2%	97.2%	98.2%	98.3%	97.8%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	92.2%	98.2%	98.2%	98.7%	98.3%	97.8%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	92.2%	98.4%	98.2%	98.2%	98.2%	98.3%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	98.2%	98.2%	97.2%	98.2%	98.2%	98.3%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	98.2%	98.2%	97.2%	98.2%	97.2%	97.3%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	98.2%	97.2%	97.2%	98.2%	98.2%	98.2%
Agency Cost	Resources	Effective	AD		£35k	£41k	£39k	£39k	£54k	£51k
Overtime Costs	Resources	Effective	AD		£0k	£1k	£0k	£-1k	£0k	£0k
Additional Hours Costs	Resources	Effective	AD		£0k	£1k	£0k	£1k	£1k	£1k
Sickness Cost (Monthly)	Resources	Effective	AD		£65k	£59k	£56k	£54k	£74k	£82k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		45.42	52.45	49.26	53.13	55.59	69.76
Business Miles	Resources	Effective	AD		4k	7k	9k	6k	7k	9k

Specialist Services											
Month	Objective	CQC Domain	Owner	Threshold	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	5.6%	5.4%	5.6%	5.1%	4.7%	4.6%	
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	5.1%	5.4%	5.7%	5.1%	5.2%	5.2%	
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	98.3%	1.8%	14.7%	51.7%	72.5%	89.8%	
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	98.3%	0.0%	4.0%	7.9%	31.0%	54.1%	
Aggression Management	Quality & Experience	Well Led	AD	>=80%	75.9%	76.8%	98.9%	97.9%	98.2%	98.2%	
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	98.2%	98.2%	98.2%	98.2%	98.2%	98.2%	
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	98.2%	98.2%	98.2%	98.2%	98.2%	98.2%	
Equality and Diversity	Resources	Well Led	AD	>=80%	94.2%	98.2%	97.2%	98.2%	98.2%	98.2%	
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	98.2%	98.2%	97.2%	98.2%	98.2%	98.2%	
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	69.2%	68.0%	68.0%	69.2%	73.1%	76.9%	
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	98.2%	97.2%	98.2%	98.2%	98.2%	97.2%	
Information Governance	Resources	Well Led	AD	>=95%	98.2%	92.4%	93.6%	92.0%	91.0%	92.8%	
Moving and Handling	Resources	Well Led	AD	>=80%	98.2%	98.2%	98.2%	97.2%	98.2%	97.2%	
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	98.2%	98.2%	98.2%	97.2%	98.2%	98.2%	
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	94.2%	94.2%	97.2%	98.2%	97.2%	97.2%	
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	98.2%	98.2%	98.2%	98.2%	98.2%	98.2%	
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	98.2%	98.2%	98.2%	98.2%	98.2%	98.2%	
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	98.2%	98.2%	98.2%	98.2%	98.2%	98.2%	
Agency Cost	Resources	Effective	AD		£182k	£144k	£183k	£193k	£187k	£231k	
Overtime Costs	Resources	Effective	AD					£1k	£0k	£0k	
Additional Hours Costs	Resources	Effective	AD		£1k	£3k	£0k	£1k	£1k	£2k	
Sickness Cost (Monthly)	Resources	Effective	AD		£64k	£65k	£63k	£46k	£45k	£47k	
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		53.28	43.32	41.54	48.85	50.3	52.67	
Business Miles	Resources	Effective	AD		35k	38k	39k	39k	41k	40k	

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

Support Services										
Month	Objective	CQC Domain	Owner	Threshold	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Sickness (YTD)	Resources	Well Led	AD	<=4.0%	4.6%	3.9%	3.9%	3.9%	4.0%	4.1%
Sickness (Monthly)	Resources	Well Led	AD	<=4.0%	4.1%	3.9%	3.9%	4.4%	4.5%	4.7%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	95.9%	8.9%	17.7%	71.6%	92.2%	95.1%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	95.9%	0.2%	1.0%	10.3%	17.7%	51.7%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	77.2%	76.6%	79.5%	78.0%	78.1%	80.3%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	82.9%	82.9%	82.9%	82.9%	82.9%	82.9%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	0.0%	0.0%	0.0%	33.3%	33.3%	33.3%
Equality and Diversity	Resources	Well Led	AD	>=80%	87.9%	87.9%	87.9%	87.9%	87.9%	87.9%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	87.9%	88.9%	88.7%	88.4%	88.3%	88.2%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	88.2%	87.8%	87.3%	87.1%	86.1%	86.7%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	87.9%	87.9%	88.8%	88.8%	87.2%	86.8%
Information Governance	Resources	Well Led	AD	>=95%	95.7%	92.9%	93.7%	92.0%	89.2%	91.9%
Moving and Handling	Resources	Well Led	AD	>=80%	88.8%	88.1%	88.8%	88.8%	87.3%	88.8%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	88.8%	88.1%	88.8%	88.2%	88.3%	88.8%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	88.7%	84.8%	88.2%	88.8%	88.8%	88.7%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	87.8%	88.8%	88.8%	88.8%	88.7%	88.8%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	88.8%	88.8%	88.8%	88.8%	88.8%	88.8%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Agency Cost	Resources	Effective	AD		£1k			£0k		£-9k
Overtime Costs	Resources	Effective	AD		£0k	£1k	£0k	£0k	£1k	£1k
Additional Hours Costs	Resources	Effective	AD		£6k	£8k	£5k	£6k	£10k	£11k
Sickness Cost (Monthly)	Resources	Effective	AD		£65k	£54k	£55k	£61k	£65k	£75k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		64.78	30.78	35.33	35.6	31.96	33.31
Business Miles	Resources	Effective	AD		19k	32k	35k	30k	36k	25k

Wakefield District										
Month	Objective	CQC Domain	Owner	Threshold	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Sickness (YTD)	Resources	Well Led	AD	<=4.6%	4.9%	3.7%	3.9%	3.9%	3.1%	3.4%
Sickness (Monthly)	Resources	Well Led	AD	<=4.6%	3.9%	3.7%	3.2%	3.5%	5.8%	5.8%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	97.9%	11.7%	33.2%	77.8%	92.7%	94.7%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	98.9%	0.4%	2.6%	10.0%	24.1%	55.7%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	88.9%	77.7%	88.9%	79.5%	87.9%	88.9%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	78.9%	88.9%	88.9%	82.9%	87.9%	79.8%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	76.7%	76.8%	74.6%	74.9%	77.8%	78.9%
Equality and Diversity	Resources	Well Led	AD	>=80%	88.8%	88.8%	87.9%	87.9%	87.9%	87.9%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	88.8%	88.8%	88.8%	88.8%	88.8%	88.8%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	67.4%	64.4%	64.9%	66.2%	71.0%	72.7%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	88.8%	88.7%	88.8%	88.8%	87.9%	88.8%
Information Governance	Resources	Well Led	AD	>=95%	94.5%	91.6%	91.4%	91.7%	91.6%	91.4%
Moving and Handling	Resources	Well Led	AD	>=80%	78.3%	79.1%	88.8%	88.8%	79.9%	88.8%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	88.7%	88.8%	88.8%	88.8%	88.8%	88.7%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	84.8%	83.8%	88.7%	88.8%	88.7%	88.7%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	88.8%	88.8%	88.8%	88.8%	88.8%	88.7%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	88.8%	88.8%	88.8%	87.9%	87.9%	88.8%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	88.8%	88.8%	88.8%	88.8%	88.8%	88.8%
Agency Cost	Resources	Effective	AD		£116k	£83k	£95k	£92k	£103k	£123k
Overtime Costs	Resources	Effective	AD		£1k		£0k		£2k	£0k
Additional Hours Costs	Resources	Effective	AD		£1k	£1k	£1k	£1k	£2k	£1k
Sickness Cost (Monthly)	Resources	Effective	AD		£39k	£29k	£44k	£53k	£72k	£72k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		60.66	56.33	53.65	48.67	47.15	51.62
Business Miles	Resources	Effective	AD		29k	31k	35k	36k	37k	35k

## Glossary

ADHD	Attention deficit hyperactivity disorder	HEE	Health Education England	NK	North Kirklees
AQP	Any Qualified Provider	HONOS	Health of the Nation Outcome Scales	NMoC	New Models of Care
ASD	Autism spectrum disorder	HR	Human Resources	OOA	Out of Area
AWA	Adults of Working Age	HSJ	Health Service Journal	OPS	Older People's Services
AWOL	Absent Without Leave	HSCIC	Health and Social Care Information Centre	ORCHA	Preparatory website (Organisation for the review of care and health applications) for health related applications
B/C/K/W	Barnsley, Calderdale, Kirklees, Wakefield	HV	Health Visiting	PbR	Payment by Results
BDU	Business Delivery Unit	IAPT	Improving Access to Psychological Therapies	PCT	Primary Care Trust
C&K	Calderdale & Kirklees	IBCF	Improved Better Care Fund	PICU	Psychiatric Intensive Care Unit
C. Diff	Clostridium difficile	ICD10	International Statistical Classification of Diseases and Related Health Problems	PREM	Patient Reported Experience Measures
CAMHS	Child and Adolescent Mental Health Services	ICO	Information Commissioner's Office	PROM	Patient Reported Outcome Measures
CAPA	Choice and Partnership Approach	IG	Information Governance	PSA	Public Service Agreement
CCG	Clinical Commissioning Group	IHBT	Intensive Home Based Treatment	PTS	Post Traumatic Stress
CGCSC	Clinical Governance Clinical Safety Committee	IM&T	Information Management & Technology	QIA	Quality Impact Assessment
CIP	Cost Improvement Programme	Inf Prevent	Infection Prevention	QIPP	Quality, Innovation, Productivity and Prevention
CPA	Care Programme Approach	IPC	Infection Prevention Control	QTD	Quarter to Date
CPPP	Care Packages and Pathways Project	IWMS	Integrated Weight Management Service	RAG	Red, Amber, Green
CQC	Care Quality Commission	KPIs	Key Performance Indicators	RIO	Trusts Mental Health Clinical Information System
CQUIN	Commissioning for Quality and Innovation	LA	Local Authority	SIs	Serious Incidents
CROM	Clinician Rated Outcome Measure	LD	Learning Disability	S BDU	Specialist Services Business Delivery Unit
CRS	Crisis Resolution Service	MARAC	Multi Agency Risk Assessment Conference	SK	South Kirklees
CTLD	Community Team Learning Disability	Mgt	Management	SMU	Substance Misuse Unit
DoC	Duty of Candour	MAV	Management of Aggression and Violence	SRO	Senior Responsible Officer
DoV	Deed of Variation	MBC	Metropolitan Borough Council	STP	Sustainability and Transformation Plans
DoC	Duty of Candour	MH	Mental Health	SU	Service Users
DQ	Data Quality	MHCT	Mental Health Clustering Tool	SWYFT	South West Yorkshire Foundation Trust
DTOC	Delayed Transfers of Care	MRSA	Methicillin-resistant Staphylococcus Aureus	SYBAT	South Yorkshire and Bassetlaw local area team
EIA	Equality Impact Assessment	MSK	Musculoskeletal	TB	Tuberculosis
EIP/EIS	Early Intervention in Psychosis Service	MT	Mandatory Training	TBD	To Be Decided/Determined
EMT	Executive Management Team	NCI	National Confidential Inquiries	WTE	Whole Time Equivalent
FOI	Freedom of Information	NHS TDA	National Health Service Trust Development Authority	Y&H	Yorkshire & Humber
FOT	Forecast Outturn	NHSE	National Health Service England	YHAHSN	Yorkshire and Humber Academic Health Science
FT	Foundation Trust	NHSI	NHS Improvement	YTD	Year to Date
FYFV	Five Year Forward View	NICE	National Institute for Clinical Excellence		

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

## Trust Board 25 September 2018 Agenda item 6.2

<b>Title:</b>	<b>Incident Management Report Quarter 1 2018/2019</b>
<b>Paper prepared by:</b>	Director of Nursing and Quality
<b>Purpose:</b>	This report provides information in relation to incidents in Quarter 1 and more detailed information in relation to serious incidents.
<b>Mission/values:</b>	<ul style="list-style-type: none"> <li>➤ We are respectful, honest, open and transparent</li> <li>➤ We put the person first and in the centre</li> <li>➤ We are always improving</li> </ul>
<b>Any background papers/ previously considered by:</b>	Previous quarterly reports which have been considered by Trust Board.
<b>Executive summary:</b>	<ul style="list-style-type: none"> <li>➤ This report is produced by the patient safety support team and shows data for all incidents. Detailed Quarterly reports have been produced and shared with each BDU; this is available at service line level.</li> <li>➤ The actions from incidents are managed at BDU level. Patient safety support team produces information on completion of action plans from serious incidents and these are monitored through the operational managers group.</li> <li>➤ This report has overall figures for incident reporting – Q1 had 3169 incidents; lower than previous quarter (3441).</li> <li>➤ The annual reports show an overall trend in incident reporting is upwards in line with a good reporting culture.</li> <li>➤ Almost 88% of incidents are graded as “low” or “no harm” showing a positive culture of risk management.</li> <li>➤ Physical aggression/threat (no physical contact) by patient was the most reported category, this is a change from the previous quarter which was “physical violence (contact made) against staff by patient”.</li> <li>➤ Violence and aggression continues to be the highest reported incident. Staff report this can be linked to individual services users but also say some is linked to the trusts current smoking policy –this is being examined in more detailed and figures/information from Datix have been given to the group that has been set up.</li> <li>➤ There have been no ‘Never Events’ reported in the Trust during Q1, the last Never event reported was in 2010/11.</li> <li>➤ The total number of serious incidents reported through STEIS in Q1 (8), a decrease on Q4 (12). The range of serious incidents reported has included deaths, pressure ulcers and violence and aggression.</li> <li>➤ In Q1, the highest category of serious incident is Suicide (incl apparent) - community team care –current episode (4). This is a reduction on previous quarter (6).</li> <li>➤ The category of apparent suicide at point of reporting is similar in the rolling last 4 quarters -12, 18, 8 and 6. This is 44 for the total last 4 quarters and over level of estimated cases based on National Confidential Inquiry numbers and</li> </ul>

	<p>our population - 32/33.</p> <ul style="list-style-type: none"> <li>➤ All incidents that are graded red/amber are extracted from Datix for inclusion in the report that is reviewed at the weekly risk panel.</li> <li>➤ 23 serious incidents investigations have been submitted to the commissioner during the quarter and 27 previous serious incidents have been closed by the commissioners.</li> <li>➤ A number of reports are outside the 60 day target, all of these have agreed extensions with Commissioners. The complexity of investigations has contributed to delays.</li> <li>➤ Within the report are some examples of learning from specialist advisors.</li> </ul> <p><b>The report was scrutinised at the Clinical Governance &amp; Clinical Safety Committee meeting held on the 18 September 2018</b></p> <p>The Committee also received the “Our Learning Journey Report “, Deep Dive into apparent suicides in Calderdale &amp; Kirklees and a Suicide Prevention update.</p> <p>The Committee commented as follows:-</p> <ul style="list-style-type: none"> <li>➤ The report is of good quality.</li> <li>➤ Robust systems and processes remain in place for the reporting and investigation of incidents.</li> <li>➤ The downward trend in serious incidents is positive</li> <li>➤ The rolling total of apparent suicides over the previous 4 quarters is above the National Confidential Enquiry (NCI) estimates and remain a focus of attention and action.</li> <li>➤ The review of apparent suicides in Kirklees /Calderdale does not indicate any immediate concerns or trends and shows that the appropriate actions are in place to take any learning from the incidents.</li> <li>➤ The summary of suicide prevention work is positive and demonstrates a wide range of constructive actions.</li> <li>➤ It will be important to understand the impact of the MH Community Transformation project upon the delivery system, given the increase in demand and referrals.</li> </ul> <p><b>Risk appetite</b></p> <ul style="list-style-type: none"> <li>➤ Risk identified –the trust continues to have a good governance system of reporting and investigating incidents including serious incidents.</li> <li>➤ This report covers assurance for compliance risk for health and safety legislation and compliance with CQC standards for incident reporting. This meets the risk appetite –low and the risk target 1-3.</li> <li>➤ The clinical risk –risk to service user/public safety and risk to staff safety which is again low risk appetite and a risk target of 1-3.</li> <li>➤ The incident management process supports the drive to reduce harm and learn from incidents to reduce risk and prevent recurrence in the future.</li> </ul>
<p><b>Recommendation:</b></p>	<p><b>Trust Board is asked to NOTE the quarterly report on incident management and the assurance provided from the Clinical Governance &amp; Clinical Safety Committee.</b></p>

# **Trust wide Incident Management Report**

## **Quarter 1 2018/19**

Incorporating Serious Incidents and Learning from healthcare deaths reporting for the period 01/04/2017-31/03/18

Report prepared by Patient Safety Support Team

July 2018

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## Executive Summary

This report provides information in relation to incidents reported in Quarter 1 2018/19 and more detailed information in relation to serious incidents. A brief analysis of actions arising from completed Serious Incident investigations submitted to commissioners for the period of 1 April 2018 to 30 June 2018 is included. The report also includes the Trust's report on Learning from Healthcare Deaths to provide assurance that arrangements are in place and to provide cumulative data for the period 01/04/2017 – 31/03/2018. The learning from Healthcare Deaths report will require publication on the Trust website.

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



### Quarter 1 2018/19 Headlines

- **3169** incidents reported
- **88%** of incidents resulted in no/low harm
- **8** Serious incidents reported
- Serious Incidents account for **0.2%** of all incidents reported
- No homicides
- No Never Events



High reporting rate with high proportion of no/low harm is indicative of a positive safety culture <sup>1</sup>



- This report is produced by the patient safety support team and shows the data for incidents. Detailed Quarterly reports have been produced and shared with each Business Delivery Unit. Data are also available at service line level. All managers have access to Datix dashboards to interrogate data further.
- This report has overall figures for incident reporting. Q1 had 3169 incidents; lower than the previous quarter (3441).
- 88% of incidents are graded as “low” or “no harm” showing a positive culture of risk management (the more green incidents reported mean action taken proactively at an early stage before harm occurs).
- “Physical aggression/threat (no physical contact): by patient” was the most reported category, this is a change from the previous quarter which was “Physical violence (contact made) against staff by patient”.
- “Violence and Aggression” continues to be the highest reported incident type. Staff have reported this can be linked to individual services users but also say some incidents are linked to the trusts current smoking policy. This is being examined in more detail and figures/information from Datix have been given to the group that has been set up to consider the issues and actions.

- There have been no 'Never Events' reported in the Trust during Q4; the last Never Event reported was in 2010/11.
- The total number of serious incidents reported through Strategic Executive Information System (STEIS) in Q1 was 8; a decrease on Quarter 4 (12). The range of serious incidents reported this quarter has included deaths, pressure ulcers and violence and aggression.
- In quarter 1, the highest category of serious incident is "Suicide (including apparent suicide) community team care – current episode" (4). This is a reduction on previous quarter (6).
- The category of apparent suicide at the point of reporting is higher in the rolling last 4 quarters - 12, 18, 8 and 6. This is 44 for the total for last 4 quarters, over the estimated level based on National Confidential Inquiry numbers and our population - 32/33.
- All incidents that are graded red or amber are extracted from Datix for inclusion in a report that is reviewed at the weekly risk panel.
- 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).
- 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 Trusts strategy is complimentary to this.
- 23 serious incident investigations have been submitted to the Commissioner during the quarter and 27 previous serious incidents have been closed by Commissioners.
- The actions from incidents are managed at Business Delivery Unit level. The patient safety support team produces information on completion of action plans from serious incidents and these are monitored through the operational managers group.
- A number of investigations are outside the 60 working day target; these have agreed extensions with Commissioners. The complexity of investigations has contributed to delays. Steps are being taken to reduce the backlog although demand has remained very high in terms of frequency of serious incidents and complexity.
- Within the report are some examples of learning from specialist advisors and work streams for the highest reported incidents.

### Learning from healthcare deaths

- Scrutiny of healthcare deaths has been high on the government's agenda for some time, reports such as Francis report and the Mazars report into Southern Healthcare intensified this.
- There was a requirement for Trusts to report and publish data from Quarter 3 2017/18 onwards. When approved, our reports are made available on our website.
- Our report provides figures on deaths and the number that have been reviewed.
- From April 2017 to September 2017 the Trust started reviewing all deaths reported on Datix using an incremental approach.
- The new policy on learning from deaths came into effect from 1 October 2017, which has resulted in more deaths being in scope for review from Quarter 3 onwards.
- The Trust has adopted the three levels of scrutiny suggested in the National Quality Board guidance:
  - Death Certification
  - Case record review, including Structured Judgment Record Reviews
  - Investigation – that could be service level, serious incident reported on STEIS or other review e.g. Learning Disability Mortality Review (LeDeR), safeguarding.
- The total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of death, where the service user had had any form of contact with NHS services was 739.

- Total number of deaths reported on Datix by staff between 1/1/2018 – 31/3/2018 (by reported date, not date of death) =96
- Total reviewed =96
- Total in scope as described in report = 55
- Learning from Structured Judgement Record Reviews and Investigations completed to date is included in the report.

## 1. Introduction

This report has been prepared by the Patient Safety Support Team to bring together Trust wide information on incident activity during Quarter 1 18/19 (1 April 2018 to 30 June 2018) including reported serious incidents and learning from healthcare deaths for the period 1 January 2018 to 31 March 2018..

Please note that figures within this report may vary from the individual Business Delivery Unit reports due to movement/grading changes of incidents whilst producing the reports from a live system.

## 2. Updates from the Patient Safety Support Team

During Quarter 1, the Patient Safety Support Team our priority areas have included:

- Continuing to develop our processes for learning from healthcare deaths .
- Induction of new staff members to the team

The Patient Safety Support Team has responded to three FOI requests received between 1 April 2018 to 30 June 2018, including information related to assault, sexual/indecent assault and suicide which has been extracted from Datix.

## 3. Incident Reporting Analysis

This report has overall figures for incident reporting. Q1 had 3169 incidents similar to the levels in the previous two quarters.

88% of incidents are graded as “low” or “no harm” showing a positive culture of risk management (the more green incidents reported mean action taken proactively at an early stage before harm occurs).

## Headlines



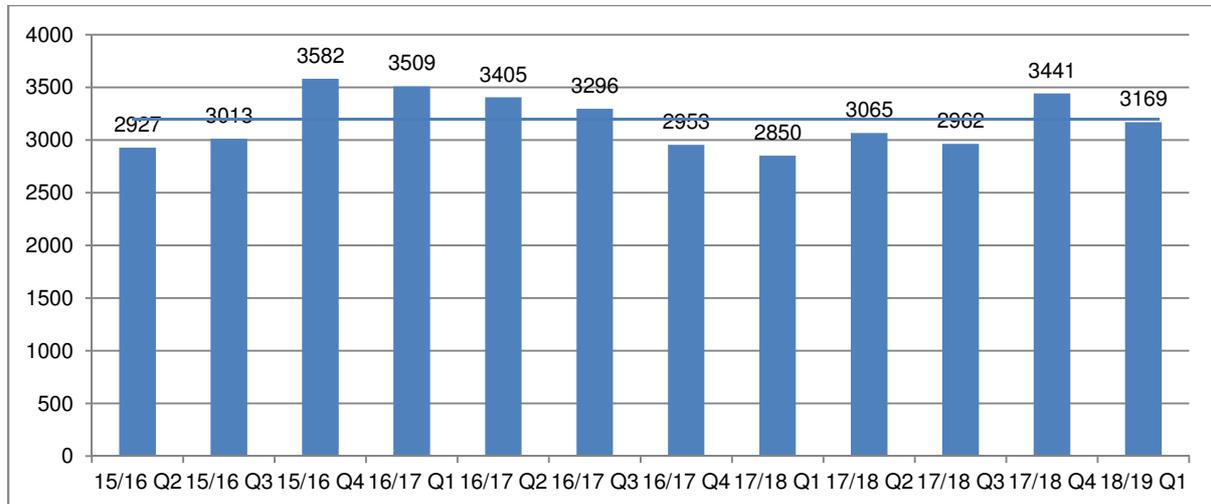
### Quarter 1 2017/18 Headlines

- **3169** incidents reported
- Decrease on reporting compared with Q4 (3441)
- **88%** of incidents remain **no/low harm**
- High reporting rate with high proportion of no/low harm is indicative of a positive safety culture



Figure 1 below shows the pattern and number of incidents reported by quarter in the Trust from Q2 15/16 to Q1 18/19. The rate fluctuates as would be expected. Quarter 1 18/19 was slightly below the average for a quarter. However with the Trust changing profile of services, direct comparisons should be viewed with caution.

Figure 1 Comparative number of incidents reported by financial quarter Q2 2015/16 to Q1 2018/19



## Severity

In Figure 2 there have been 25 red incidents reported. This data is live data at the point of producing the report. The incident may be initially graded red for a number of reasons. An example would be a death (for healthcare deaths we have been encouraging staff to report on Datix) but we later find out this is natural causes or where the individual has not been involved with Trust services for over six months so not this may be re-graded and not reported on STEIS, this can take some time to get this information. A case may be red but reported through the Commissioner onto STEIS e.g. multi-agency Serious Case Review. A red incident may also not be reportable on STEIS. Incidents graded amber may be reportable on STEIS.

Figure 2 All incidents reported Trust wide between 1/4/2017 - 30/6/2018 by severity and financial quarter

	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1
Green (no harm)	1766	1894	1780	2014	1960
Green	782	856	825	1054	854
Yellow	226	226	259	281	266
Amber	57	59	63	68	64
Red	19	30	35	24	25
<b>Total</b>	<b>2850</b>	<b>3065</b>	<b>2962</b>	<b>3441</b>	<b>3169</b>

Figure 3 All incidents reported Trust wide between 1/4/2018 - 30/6/2018 by severity and BDU

	Barnsley Mental Health	Barnsley General Community	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Corporate support services	Total
Green (no harm)	174	237	128	323	433	490	156	19	<b>1960</b>
Green	64	125	85	177	184	136	67	16	<b>854</b>
Yellow	38	14	21	53	82	32	23	3	<b>266</b>
Amber	8	37	5	5	6	3	0	0	<b>64</b>
Red	5	2	8	6	3	0	1	0	<b>25</b>
<b>Total</b>	<b>289</b>	<b>415</b>	<b>247</b>	<b>564</b>	<b>708</b>	<b>661</b>	<b>247</b>	<b>38</b>	<b>3169</b>

### Type and Category of incidents

Figure 4 shows the overarching Type of incidents reported in the Trust. 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. This report provides details of the number for Type (Figure 4) and the top 10 categories in the quarter (Figure 5).

Figure 4 Type of incident reported in Quarter 1 by BDU

	Barnsley Mental Health	Barnsley General Community Services	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Trust wide (Corporate support services)	Total
Violence and Aggression	54	13	78	191	266	319	89	3	<b>1013</b>
Care Pathway, Clinical and Pressure Ulcer Incidents	12	254	4	14	42	5	8	0	<b>339</b>
Self Harm	89	0	29	60	117	18	15	0	<b>328</b>
Medication	21	36	13	47	53	51	14	0	<b>235</b>
Health and Safety (including fire)	29	18	15	51	38	50	14	14	<b>229</b>
Legislation and Policy	4	1	17	36	47	72	1	0	<b>178</b>
All Other Incidents	14	14	19	25	24	46	17	0	<b>159</b>
Slips, Trips and Falls	7	25	17	50	34	14	6	3	<b>156</b>
Security Breaches	16	4	3	11	22	50	8	11	<b>125</b>
Missing/absent service users	6	0	16	39	28	2	3	0	<b>94</b>
Safeguarding Adults	11	7	10	8	16	22	17	0	<b>91</b>
Information Governance Incidents	3	14	3	9	7	7	23	6	<b>72</b>
Death (including suspected suicide)	10	1	11	15	9	0	6	0	<b>52</b>
Safeguarding Children	6	3	11	5	2	1	21	0	<b>49</b>
IT Related Issues	6	22	1	2	2	1	5	1	<b>40</b>
Infection Prevention/Control	1	3	0	1	1	3	0	0	<b>9</b>
<b>Total</b>	<b>289</b>	<b>415</b>	<b>247</b>	<b>564</b>	<b>708</b>	<b>661</b>	<b>247</b>	<b>38</b>	<b>3169</b>

Figure 5 Trust-wide Top 10 most frequently reported incident categories in rolling 4 quarters (1/7/2017 – 30/6/2018)

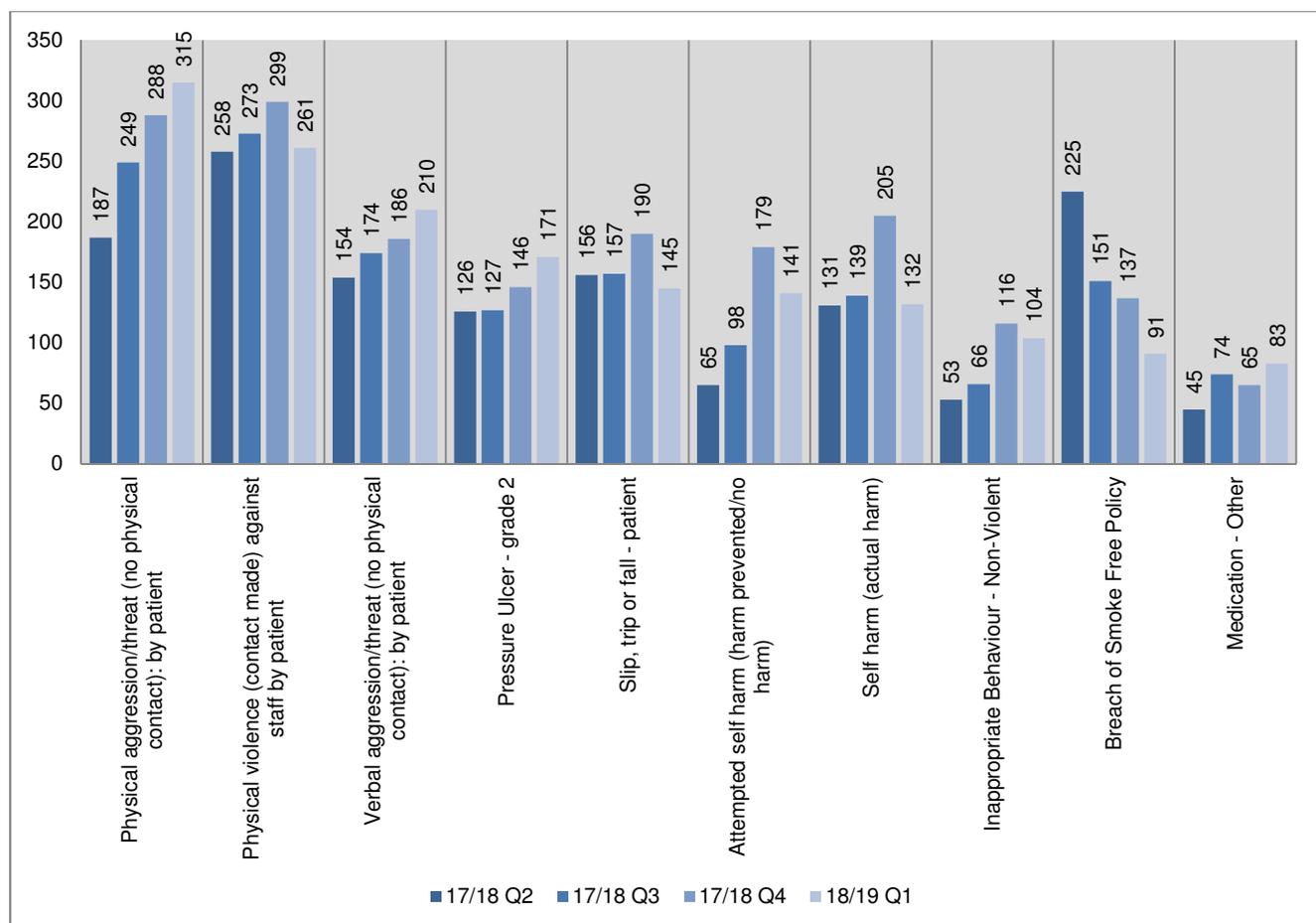


Figure 5 shows that in Quarter 1 2018/19 physical aggression/threat (no physical contact) by patient was the highest reported category of incident. Figures for previous quarters are included for comparison. The highest reported category of physical aggression/threat (no physical contact) by patient continues to increase. This demonstrates a good reporting culture of reporting situations that did not become actual physical contact.

Self harm incidents have decreased, both for actual harm and incidents where self harm has been prevented. Figures are affected by individual service user presentation.

Although the 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.

## 4. Learning from incidents

Learning from incidents is identified at all levels in the organisation. Some specialist advisors have provided the following examples.



### Safeguarding

Dr Alison Davies, Clinical Psychologist and Katie Williams, Clinical Psychology Doctoral trainee from the Wakefield Adult Learning Disability Team have completed a piece of working looking at staff responses to addressing vulnerability to sexual exploitation in adults with learning disabilities.

The findings from this work have been disseminated at Trust wide and national conferences, and within the Learning Disability governance structure.

Work is underway to develop a robust capacity assessment framework, driven by current case law, to undertake assessments looking at capacity to consent to sexual exploitation.

Champions have been identified from across the Adult LD service who will work across the 4 localities to develop work with this vulnerable client group.

Further work with NHS England is also being planned to continue to raise awareness of these issues.

### Example/s of learning from incidents

Findings from Serious Incident 2017.23460	
<b>Situation</b>	Police were called to a house fire at the service user's address. The Police confirmed that the service user was found dead as a result of the fire.
<b>Background</b>	There were safeguarding considerations in relation to possible hoarding and self-neglect. Post incident information from the Fire Service stated that the service user did not meet the criteria for the hoarding panel. The findings from the fire investigation were that the home environment was not the cause of the fire.
<b>Assessment</b>	In this case there were no direct contributing factors which could have resulted in this person's death but learning has been identified.
<b>Recommendation shared learning or change for improvement</b>	It has been identified that: <ul style="list-style-type: none"> <li>• Partnership working between SWYPFT and the West Yorkshire Fire Service can potentially provide intelligence through home visits about those who may be a fire risk.</li> <li>• There has been a rise in fire referrals for advice to the West Yorkshire Fire Service from SWYPFT following this incident.</li> <li>• The fire brigade stated in their fire report that there is a link between mental health service users and house fires. They</li> </ul>

	<p>often try to conduct visits but people are scared to let them in.</p> <ul style="list-style-type: none"> <li>When referrals are made to the fire service, details of care-coordinators / key workers should be provided so joint visits can occur to maximise fire service access. This process will form part of a partnership agreement.</li> </ul> <p>Actions that have been taken include:  The Specialist Adviser delivered the training on self-neglect and hoarding procedures to the Kirklees Core team meeting on the 2<sup>nd</sup> May 2018. This training was well attended and well received. Following the training a practitioner requested information on the Kirklees hoarding panel and contact details and information was provided to support a service user.  Work is also underway to address the issue of self-neglect is for the safeguarding team to produce a briefing paper to signpost the practitioners to the local procedures to address / manage self-neglect / hoarding.</p>
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Incident at Fox View	
<b>Situation</b>	The practitioners at Fox-view requested some support with a complex case that involved a service user who lacked capacity and potential abuse that had been covertly videoed in the service user's home.
<b>Background</b>	There were organisational safeguarding concerns about the external caring agency. Also there were concerns about the legal process.
<b>Assessment</b>	The practitioners were signposted towards the SWYPFT legal department to address the legal issues and liaised with the safeguarding consultant to ensure that information regarding Police involvement was disclosed to the team to ensure closing of the loop.
<b>Recommendation</b>	The practitioners contacted the legal team and developed a plan to ensure that the service user was safeguarded and there was a plan to ensure that the process was legal and robust.
<b>shared learning or change for improvement</b>	

Forensic homicide	
<b>Situation</b>	Following the Mental Health Homicide investigation, the Forensic team held a development day which the Safeguarding Specialist Adviser attended.
<b>Background</b>	The Specialist Adviser was able to support the process through being an author of the report and through objective oversight.
<b>Assessment</b>	The views of the Specialist Adviser were captured through the involvement in the workshop day and the Specialist Adviser's involvement was received positively.
<b>Recommendation</b> <b>shared learning or change for improvement</b>	To share the benefits of including specialist advisors in development time out.



Safeguarding Children

### Perinatal mental health presentation for safeguarding week 2018

The safeguarding team developed a training package following a team development day for the South and West Yorkshire Safeguarding weeks in June and July 2018. This was delivered as a joint training session on this subject as it covers both children and adults.

NHS England has committed to fulfilling the ambition in the Five Year Forward View for Mental Health, so that by 2020/21 there will be increased access to specialist perinatal mental health support in all areas of England, allowing at least an additional 30,000 women each year to receive evidence-based treatment, closer to home, when they need it. This includes the right range of specialist community and inpatient care.

A phased, five-year transformation programme, backed by £365m in funding, is underway to build capacity and capability in specialist perinatal mental health services, focused on improving access to and experience of care, early diagnosis and intervention, and greater transparency and openness.

#### Preparation and planning

- Developing and implementing evidence-based pathways – helping to deliver integrated services which incentivise early intervention and holistic approaches to care and recovery
- Networks – being established in all regions, as recommended in NICE guidelines, to provide leadership and expertise in the development of local services and pathways.
- Workforce development – working with partners to build the capacity and competency across the specialist workforce; to develop and deliver a workforce strategy as well as a multidisciplinary skills and competency framework.

## **The presentation covered;**

It is Possible to predict some high risk pregnancies and manage to improve outcome for woman and baby. Early detection of mental illness, clear understanding of risks, their implications and subsequent effective management can improve outcomes. Post natal depression, and the impact on the process of attachment, reduced emotional availability of mother, being in an environment with anxiety/mood swings/etc. Mum then becomes increasingly depressed because she believes she is a horrible mother and the child doesn't deserve her – estrangement.

Obsessional thoughts can respond very well to SSRI antidepressants alongside CBT, plus explanation that such thoughts are surprisingly common in mums and are not a sign of madness. Severe OCD can easily be misdiagnosed as psychosis because of perceived risks in professionals' minds. Children have been known to be taken unnecessarily into care as a result, which can have devastating effects on mum's mental health.

## **Dangers often stem from delusional ideas-**

Convinced baby is ill (e.g. is infected) or possessed (by demons), therefore mum thinks she is doing the baby a favour by ending its life – altruistic infanticide

The baby is not hers (has been replaced – Capgras symptoms), therefore baby is neglected.

The mum's delusional experiences of the world are so horrifying that she wants to protect the baby from it (and sends it to the after-life for protection), sometimes with herself Mum is so convinced she is a terrible mother and that the baby will be better off without her (potentially leading to suicide) Rapidly changing mental state, Suicidal ideation, especially of violent means, pervasive guilt or hopelessness, Significant estrangement from the infant and new or persistent beliefs of inadequacy as a mother and evidence of psychosis.

Admission to mother and baby unit should not be considered solely for purposes of parenting assessment in absence of acute mental illness requiring inpatient treatment. Mother or baby physically unwell and requiring specialist medical intervention, Mother under age of 16 (CAMHS/INSIGHT would be involved) If Children's Social Services are planning removal of the baby. In these circumstances admission should be to the local ward/PICU.

## **Domestic abuse**

30% of Domestic abuse starts in pregnancy, increasing risk of miscarriage, premature birth or stillbirth, Low birth weight, foetal injury and infection. Increased likelihood of mental illness around birth time if mum is a victim of domestic abuse.

12% women, who experience post natal depression, are victims of domestic abuse – not a proven cause, 3 x likely to have experienced it in the last year.

## **What to do when risk is identified?**

Be much more careful than with a non-perinatal woman

Ensure mum and baby are both kept safe

Regardless of the service practitioner are working in, treat as per NICE guidelines. Perinatal mental health is everyone's business; it's not just for a specialist team to do it.

Lower thresholds for acceptance into all services & prioritise

Step up care quickly to a higher appropriate level if risks are not well managed.

## Impact of the training

The training evaluated well and the future plans will be to offer it as a training package across the Trust. The training has raised the awareness of risk assessment, service user involvement and the 'think family' agenda.

## Greenlight alerts

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



Greenlight alerts are available on the [intranet](#) and below:

- Greenlight to take care with when required (PRN) medicines
- Greenlight on prescribing and administering liquid medicines
- Greenlight on valproate and haloperidol
- Greenlight on Buccolam (midazolam)
- Greenlight on paraffin
- Greenlight on clozapine

## Bluelight Alerts

Bluelight alerts have been created to provide a way to share urgent learning quickly across the Trust.



The Bluelight alerts that have already been circulated in Quarter 1 are available on the [intranet](#) and below:

- Bluelight alert 13 - 15 May 2018  
Valproate changes to license restrictions
- Bluelight alert 12 - 20 April 2018 - Fire risk with paraffin-based skin emollients or moisturisers
- Bluelight alert 11 19 April 2018-  
Assessing risk prior to inpatient leave
- Bluelight alert 10 6 April 2018 - Noose risk from the space between window panels

If you have urgent safety or learning information that needs to be shared across the Trust urgently, please discuss the information you want to share with your managers to firstly to agree if a Bluelight is the appropriate route for circulation, then follow the process on the intranet <http://www.swyt.nhs.uk/learning-from-experiences/Pages/Bluelight-alerts.aspx>

## Learning from Serious Incidents

Section 7 is the Serious Incident report. Further information on this is available in the [incident management annual report](#).

## Learning from Healthcare Deaths

Section 8 of this report contains our report on learning from healthcare deaths. This includes examples of areas for improving practice identified by the reviewers.

### 5. Incident reporting processes

#### Resources

The Datix team continue to provide a range of training options for managers. Further details of our training offer are available on the [Patient Safety intranet](#) pages.

Previous quarterly and annual reports on incidents and learning are available on the [Patient Safety intranet](#) pages.

#### Key messages regarding incident reporting processes:

##### ***Being open and learning from healthcare deaths policy***

The Patient Safety Support Team continues to receive a number of queries in relation to reporting of deaths, and they have been referred to the policy. Staff should be familiar with the learning from healthcare deaths policy to understand what to do when there is a death and which require reporting. <http://nww.swyt.nhs.uk/learning-from-deaths/Pages/default.aspx>

It doesn't have to be a Duty of Candour incident for us to write a letter and say we are sorry to hear about the death of someone we have been working with, this is just compassionate care. We should also be asking if families have any questions about the care of their family member.

This should be updated on Datix. We also need to ensure that the clinical records have been reviewed to ensure any concerns about care delivered are identified early. Again, this should be added to death of a service user section.

##### ***Manager's Investigation – outcome***

A document has been produced for managers to provide guidance on how to complete the field named 'What are the findings and outcome (to date) of your review or investigation of this incident?' within the Manager's Investigation section on Datix. The document can be found on the intranet [here](#)

### 6. Update on some improvement work

**#allofusimprove** includes Patient Safety as one of its key areas. A number of case studies have been developed to share good practice and improvement work. Several members of the patient safety strategy group will be promoting their work around patient safety in the coming months.

**Safety Huddles – the implementation of safety huddles** sits under the patient safety strategy. There are currently 9 teams actively involved with safety huddles and a further 4

considering this approach. The focus of huddles is broad, with some teams looking at reducing violence and aggression, falls, seclusion, promote safeguarding reporting. We are drawing on learning from a neighbouring trust who has shared their experiences of safety huddles in an acute ward setting. Patient safety support team has applied the same principles to introduce regular 5 minute huddles to enhance team working and communication.

**Significant event analysis (SEA)** - Work continues between patient safety support team, management of violence and aggression team and health and safety to pilot use a tool focusing on human factors following an incident of violence and aggression that has resulted in a Riddor reportable incident. Feedback so far has been positive with some systematic changes being made. A report is being prepared to summarise the learning to date. The tool has been amended following the pilot and this will be shared at the Patient Safety Strategy group to share this further with specialist advisors.

**Human Factors training** – this is now available to the Trust as Bronze training on-line training through the Improvement Academy. All lead investigators have completed this training. Silver training is available from the Improvement Academy and several staff have booked places.

**Safewards-** Most mental health and Learning Disability units are using the tools available and good practice is shared across the Trust and through Reducing Restrictive Physical Interventions training.

**Reducing Restrictive Physical Interventions Group** – The group meets 6 weekly to review Violence and Aggression across the trust. Robust representation from BDU's and other stakeholders. Amongst objectives includes incident analysis, aims to identify and analyse trends and report on training activity. Development of the use of Statistical Process Control (SPC) charts.

## 7. Trust wide Serious Incident (SI) Report<sup>1</sup> for Quarter 1 2018/19 (Data as at 3 July 2018)

### 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.”<sup>2</sup>

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*<sup>3</sup>.

Further information on reporting of SIs is available in on the intranet.

### 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

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<sup>1</sup> Please note the SI figures given in different reports can vary slightly. This report is based on the date the SIs were reported to the CCG via the Department of Health Strategic Executive Information system (StEIS).

<sup>2</sup> [NHS England. Serious Incident Framework. March 2015](#)

<sup>3</sup> [NHS Improvement. Never Event policy and framework 2018](#)

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.

## Headlines

During Quarter 1 2018/19, there were **8 Serious Incidents reported** to the relevant Clinical Commissioning Group (CCG) via the NHS England Strategic Executive Information System (StEIS).

**Never Events**<sup>4</sup> 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 Quarter 1 2018/19. 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.



### Quarter 1 Headlines

- 8 Serious incidents reported
- Serious incidents account for 0.3% of all incidents
- No homicides
- No Never Events



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<sup>4</sup> [NHS Improvement. Never Event policy and framework 2018](#)

## Serious Incident Reporting Analysis

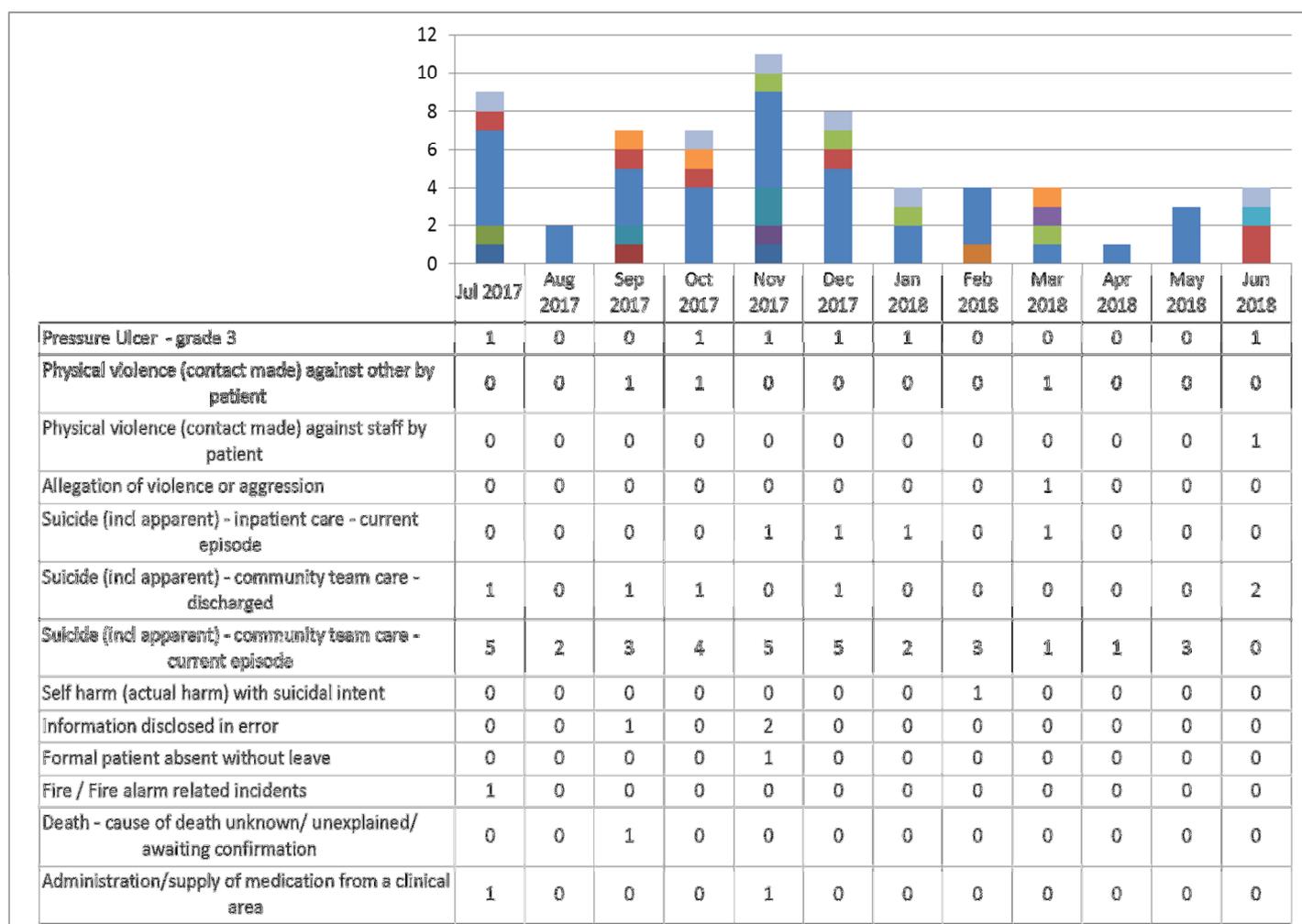
During Quarter 1 2018/19 there have been 8 serious incidents reported on STEIS, as shown in Figure 6 by financial quarter, with comparative data for previous years.

**Figure 6 Serious Incidents reported to the Commissioner by financial year and quarter up to 30/6/2018 (2014/15 - 2019/18)**

Financial quarter	14/15	15/16	16/17	17/18	18/19
Quarter 1	31	18	13	15	8
Quarter 2	24	23	13	18	
Quarter 3	30	15	15	26	
Quarter 4	21	20	24	12	
<b>Totals</b>	<b>106</b>	<b>76</b>	<b>65</b>	<b>71</b>	

Figure 7 shows a breakdown of the 64 serious incidents in a rolling 12 month period (1/7/2017-30/6/2018) by the type of incident and the month reported. 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.

**Figure 7 Types of All Serious Incidents reported on STEIS in the 12 month period (1/7/2017 – 30/6/2018 )**



As with previous quarters, the highest Type (as described on page 8) of serious incident is 'Death (including suspected suicide) totalling 4; all of these were by apparent suicide. Further breakdown is available later in this section.

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

Figures 8 and 9 show the SI reported in the quarter (8) by the team type and BDU and incident category.

**Figure 8 Serious Incidents reported by team types and BDU during Q1 2018/19**

	<b>Barnsley Mental Health</b>	<b>Calderdale</b>	<b>Kirklees</b>	<b>Wakefield</b>	<b>Total</b>
136 Suite - Calderdale	0	1	0	0	1
Core Team - Barnsley	1	0	0	0	1
Core Team - Calderdale	0	1	0	0	1
Core Team West - Wakefield	0	0	0	1	1
IAPT (Low Intensity) Calderdale/Kirklees	0	1	0	0	1
Intensive Home Based Treatment Team (IHBTT) - Wakefield	0	0	0	1	1
Intensive Home Based Treatment Team (Kirklees)	0	0	1	0	1
Poplars Unit, Wakefield	0	0	0	1	1
<b>Total</b>	<b>1</b>	<b>3</b>	<b>1</b>	<b>3</b>	<b>8</b>

**Figure 9 Serious Incidents reported by incident category and BDU during Q1 2018/19**

	<b>Barnsley Mental Health</b>	<b>Calderdale</b>	<b>Kirklees</b>	<b>Wakefield</b>	<b>Total</b>
Suicide (incl apparent) - community team care - current episode	1	2	0	1	4
Suicide (incl apparent) - community team care - discharged	0	0	1	1	2
Physical violence (contact made) against staff by patient	0	1	0	0	1
Pressure Ulcer - grade 3	0	0	0	1	1
<b>Total</b>	<b>1</b>	<b>3</b>	<b>1</b>	<b>3</b>	<b>8</b>

## Apparent Suicides

The highest category of serious incidents during Quarter 1 (Figure 9) related to apparent suicide of current service users in contact with community teams. Figure 10 shows the method used.

**Figure 9 Apparent Suicides community team care - current episode reported on STEIS between 01/01/18 – 31/03/18 by Sub-category**

	Hanging self injury	Other self poisoning	Total
Barnsley Mental Health	0	1	1
Calderdale	2	0	2
Wakefield	1	0	1
Total	3	1	4

The most common method of suicide in England<sup>5</sup> is hanging (43%), self-poisoning (25%) and jumping/multiple injuries (15%). The Trust data for quarter 4 is small in number but includes these methods.

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

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

Figure 11 shows the populations of the BDUs and some average suicide rates which would be consistent with the figures produced by the NCI.

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<sup>5</sup> National Confidential Inquiry into Suicide and Homicide 2017

Figure 10 BDU populations and average suicide rates

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

ONS – Office of National Statistics mid 2016 population estimate

NCI – National Confidential Inquiry into Suicide and Homicide by people with Mental Illness

Figure 12 Apparent Suicides reported on STEIS between 01/04/17 – 31/03/18 by Quarter and geographical area.

	Barnsley Mental Health	Calderdale	Kirklees	Wakefield	Specialist Services	Total
17/18 Q2	4	1	3	4	0	<b>12</b>
17/18 Q3	1	1	11	3	2	<b>18</b>
17/18 Q4	0	2	4	1	1	<b>8</b>
18/19 Q1	1	2	1	2	0	<b>6</b>
<b>Total</b>	<b>6</b>	<b>6</b>	<b>19</b>	<b>10</b>	<b>3</b>	<b>44</b>

The rolling 4 quarter data (Figure 12) shows that the Trust is above the expected number of suicides based on the National Confidential Inquiry figures (Figure 11) for a population the size of the Trust and patient suicide rate (27%). This figure (44) includes apparent suicides occurring in specialist services (CAMHS). Calderdale is as expected number for their respective geographical areas, Kirklees is above and Wakefield is slightly above the expected number. Barnsley is at expected level. The specialist services deaths are not allocated to a geographical area. Caution is advised with these comparisons due to the sensitivity of the figures if just one or two more incidents occur, and because the figures are not weighted by characteristics such as age, gender or socio-economic status. The financial quarters are also based upon when it was reported as a Serious Incident, not when it occurred.

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

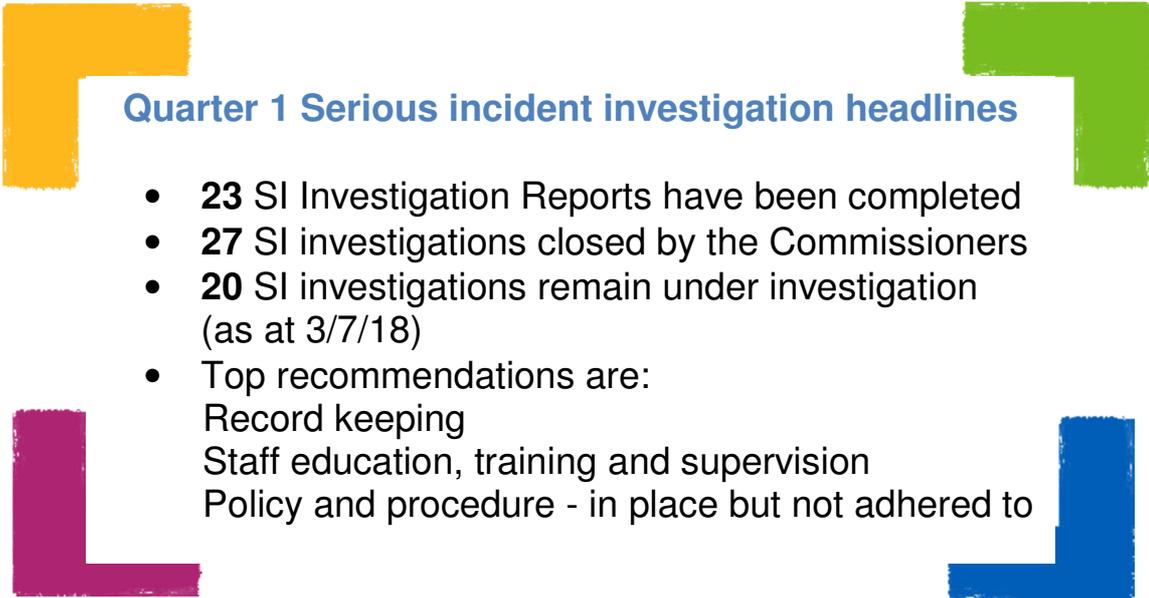
The data from the National Confidential Inquiry may not reflect trends until two years later. The Trust looks at apparent suicides on an annual basis and reports any difference between

the national data and that of the Trust. The Trust may on occasions report and investigate deaths that are later removed from the numbers as the death was not found to be due to suicide. However, when we have compared apparent suicides with results from the Coroner there is minimal data change.

### Serious Incident Investigations completed during Quarter 1 2018/19

This section of the report focusses on the 23 serious incident investigation reports that were completed and submitted to the relevant commissioner during Quarter 1 2018/19. Please note this is not the same data as those reported in this period as investigations take a number of months to complete. The term 'completed' is used in this section to describe this.

#### Headlines



### Quarter 1 Serious incident investigation headlines

- **23** SI Investigation Reports have been completed
- **27** SI investigations closed by the Commissioners
- **20** SI investigations remain under investigation (as at 3/7/18)
- Top recommendations are:
  - Record keeping
  - Staff education, training and supervision
  - Policy and procedure - in place but not adhered to

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.

Of the 20 investigations that are underway, they are at different stages of progress. 6 are within the 60 working day timeframe, and 8 are over this (Figure 13).

**Figure 11 Breakdown of SI investigations over 60 working day timescale in each quarter 2017/18 compared with the total number of investigations underway at that time (at 3/7/18)**

	Quarter 2 2017/18	Quarter 3 2017/18	Quarter 4 2017/18	Quarter 1 2018/19
Serious Incident investigations over 60 working days timeframe	12	18	22	8
Total number of ongoing SI investigations	29	45	34	20

**Figure 12 Breakdown of SI investigations that are over 60 working day timeframe (at 5/4/18)**

Commissioner extension (extension is usually for a further 20 working days)		Barnsley General Community	Barnsley Mental Health	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services - CAMHS	Total
Red	Investigation has required two or more extensions from commissioners beyond 60 working days.	1	0	2	3	0	0	0	6
Amber	Investigation has required one extension from commissioners beyond 60 working days.	1	0	0	1	0	0	0	2
<b>Total</b>		<b>2</b>	<b>0</b>	<b>2</b>	<b>4</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>8</b>

The length of time an investigation is over the 60 working days is graded. Figure 14 shows a breakdown by BDU of the 8 investigations that are over 60 working days since the incident was reported on the Strategic Executive Information system (StEIS). Serious Incident Investigation progress is monitored through the weekly patient safety support team investigators meeting, and reported through the weekly clinical risk panel. The reasons for delays varying but relate to issues such as complexity, staff availability to conduct interviews and investigation allocation delays due to capacity. Some of the investigations have involved a number of organisations and this increases complexity. Bank investigators and external investigators have been used to manage some of this pressure.

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.

## SI Action Plans

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

## Serious Incident learning and themes

During Quarter 1, the number of investigations completed and sent to the commissioners was 23 which is an increase on the previous quarter (22). A higher number of investigations have been concluded during Quarter 1. Of the 23 investigations sent to commissioners, 22 of these SI investigations had an action plan. There were 72 separate actions made to improve the system or process to prevent recurrence.

## Categorisation of recommendations

In analysing the actions, it isn't always straightforward to identify which category an action should be included in - some don't easily fit into any category, and some could be included under more than one. The analysis undertaken has included each action under the issue-theme that seemed the best match. In an attempt to gain consistency, the theming of actions is undertaken by the Lead Serious Incident Investigators.

Many actions take some time to implement. These are monitored through the operational managers group and BDU governance groups. Work to ensure monitoring and implementation of all Serious Incident action plans continues.

A standard recommendation to share learning is being embedded. This is to support learning being shared across the teams, service, BDU, Trust and wider health economy.

Figure 15 shows the action themes arising from the 23 serious incidents completed and sent to commissioners during Quarter 4. Further detail related to this is available separately. This includes a summary of the incident, the team and BDU, type of incident, learning identified through the serious incident investigation process, and recommendations for improvement.

Figure 15 Quarter 1 2018/19 completed SI investigation by action themes

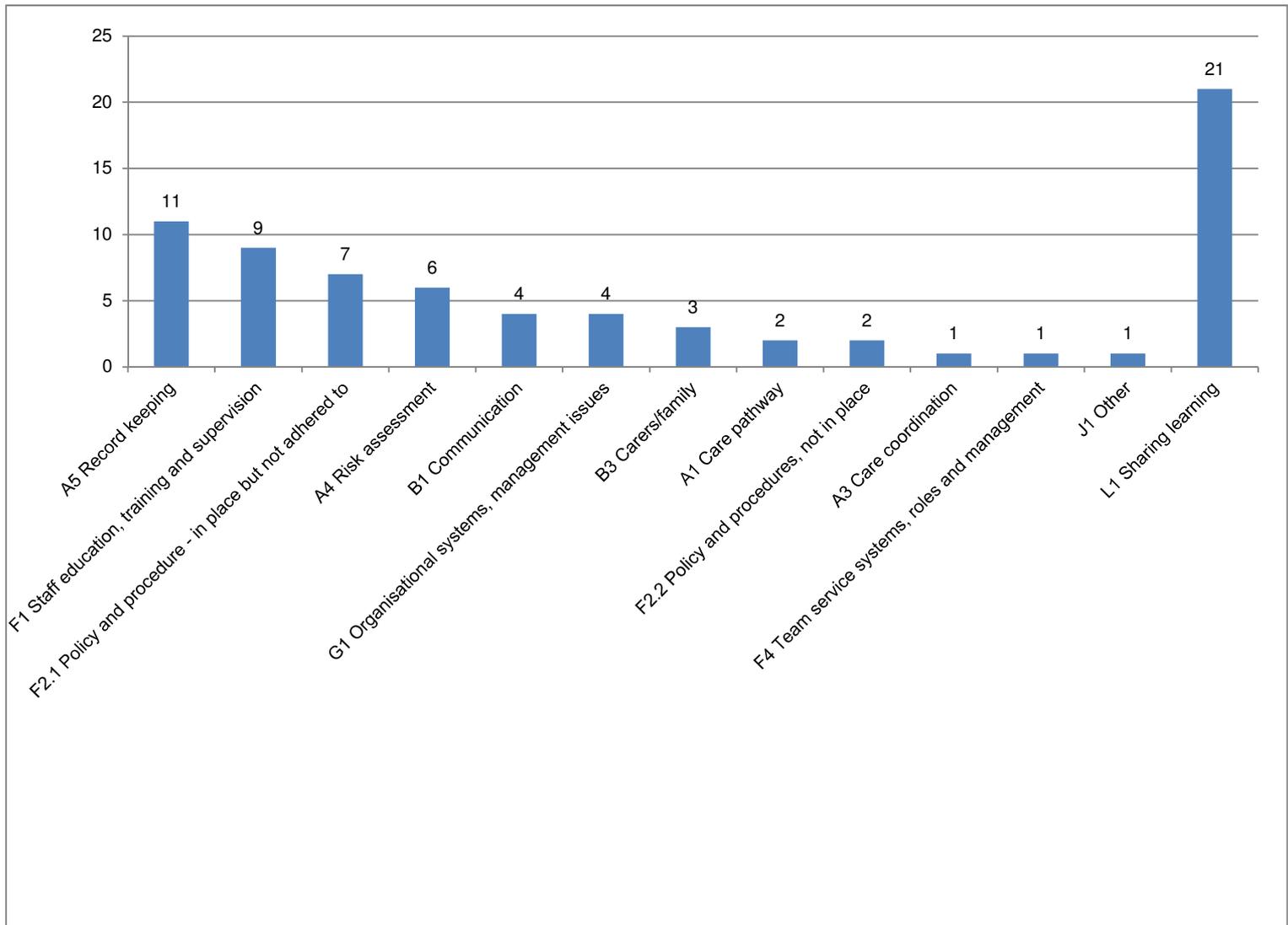
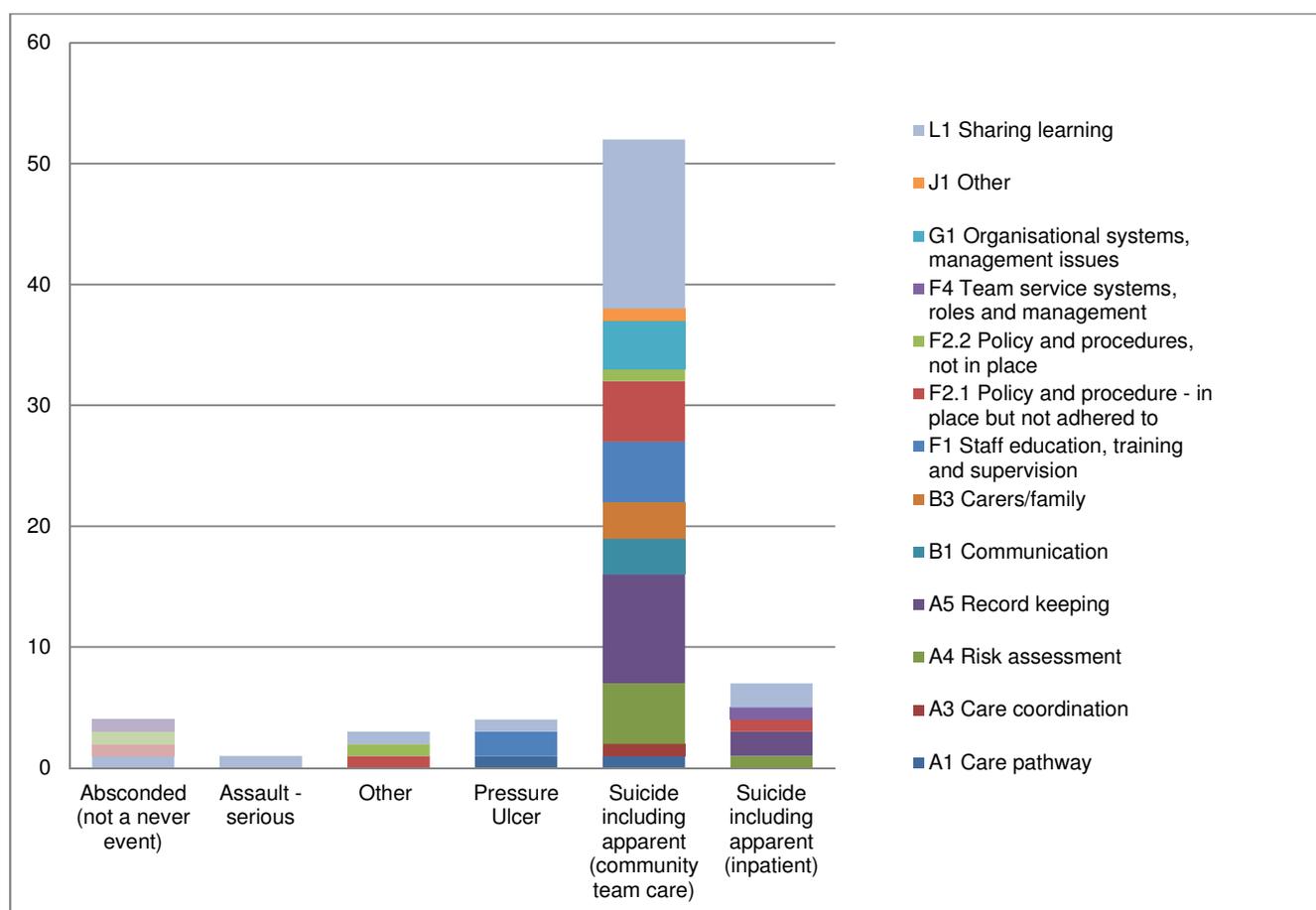


Figure 16 Comparison of action themes by incident type in Quarter 1 2018/19



As shown in Figure 16, suicide including apparent (community team care) incidents had the largest number of actions, which correlates with the number of investigations sent to the commissioners in the quarter.

In Quarter 1, 2018/19 the three most frequent<sup>6</sup> action themes were Record Keeping, 'staff education, training and supervision', and Policy and procedure - in place but not adhered to'.

To avoid duplication, analysis of the themes will be available in the Annual incident and Our Learning Journey reports for 2018/19.

### Learning within this quarter:-

- A number of individual teams have taken time to share and discuss the learning from particular incidents
- The incidents were shared in the team, service line and BDU

<sup>6</sup> Excludes recommendation to share learning

Areas for improvement from the top 3 themes are as follows:

**Record keeping:**

- All previous paper records should be scanned and archived onto the electronic care record to enable Clinicians to access the full care records of children and young people.
- The process of documentation for CAMHS Out Of Hours Consultation must be reviewed and streamlined to ensure accurate record keeping, clear clinical risk assessment formulation and risk to self.
- Next of kin details should be recorded at the time a patient is taken on. If the patient refuses to provide these details, this should also be recorded.
- Changes in risk were not documented in the case management reviews. The case management review template will be reviewed to ensure that all sections are reviewed and that updated information is clearly identified. An audit should be carried out to ensure this now takes place.
- The Sainsbury risk assessment level 1 was not completed on initial presentation to mental health services and took several weeks for this to be identified. It was missed at intervening contacts. An audit will take place to ensure this is identified.
- General Practitioner letters were saved on their local network drive and not uploaded to RiO, meaning that colleagues from other teams would not have had access to this information.
- The ward round entries were not checked by the clinician who was in the ward round and this led to errors in the recording of risk and his diagnosis
- Where an individual's care needs cannot be reasonably met there should be a simple process to record the reasons for this so it can be monitored and where necessary actions developed to militate against this.
- Ensure that all young people who are at risk of suicide have safety plans which are collaborative, written rather than verbal and shared in sufficient detail with all those required to help keep the child or young person safe.
- Consider the role of the wider MDT in formulation based assessment and care planning.

**Staff education, training and supervision:**

- No Waterlow completed on initial visit and lack of documentation in relation to skin condition
- RANE form to be reviewed and include a consent element. To deliver bespoke training across the service on consent.
- To develop bespoke training for all staff teams regards the mental capacity act. The Brief guide: capacity and competence in under 18s. Care Quality Commission. 2015 to be emailed to all individual practitioner's.
- To develop bespoke training for all staff teams regards the Caldecott Guardian role
- All CAMHS staff must complete the Sainsbury's risk assessment training prior to conducting an Emergency Assessment alone
- Guidance to be developed for staff on what to do to remove access to means of suicide
- MHA assessors (including AMHP) to take into consideration views of the Consultant Psychiatrist &/Care Coordinator prior to MHA assessment

- A team training session and briefing paper is produced to raise awareness on self-neglect and hoarding

**Policy and procedure - in place but not adhered to:**

- Compliance with the Clinical Risk, Assessment, Management and Training Policy and Procedure
- Ensure all staff are familiar with the Business Continuity plans for RiO.
- Review policy and procedure re identification of patients
- Induction for locum psychiatrists to be updated regarding out-patient appointments
- Communication with service user following a nonattendance needs to be as per the Trust Do Not Attend (DNA) policy
- Trust policy on leave and the Mental Health Act guidance were not followed
- The Business Delivery Unit must ensure teams understand the Trust's Being Open (Duty of Candour) policy

A majority of the actions 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 present learning from recommendations which is included in ['Our learning journey'](#) reports. A piece of work to strengthen learning processes has also been included in the patient safety strategy and is part of the integrated change programme.

Patient Safety Support Team  
Updated 13/07/18

## **8. Learning from healthcare deaths Report: The right thing to do Annual Cumulative Report 2017/18 covering the period 1/4/2017 – 31/3/18**

### **1. Background context**

#### **1.1 Introduction**

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

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

The Trust fully supports this approach and has developed this with other providers in the North of England as part of our collaborative approach to learning from deaths a review of the policy and learning is in the process of being planned.

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

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

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

The Trust will review/investigate deaths we have agreed are in scope through the policy. 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.

## 1.2 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.

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

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

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

This scope is further developed in the policy [Learning from healthcare deaths – the right thing to do](#).

Following the publication of the Trust policy it was expected that the total number of deaths not in scope would reduce, staff are still gaining confidence in this so we saw deaths that were not in scope being reported, but this has reduced in quarter 4. This was due to staff understanding what can be recorded on the clinical system and what needs reporting on Datixweb. The numbers of deaths in scope have risen as expected through the expansion of what is included.

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

1. Death Certification
2. Case record review, through Structured Judgment Record Review (SJRR) or Managers 48 hour review acceptance by risk panel. This latter option was introduced in early 2018.

3. Investigation – that could be service level, serious incident reported on STEIS or other review e.g. LeDeR, safeguarding.

### 1.3 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 held a workshop in June 2018 where implementation of the audit findings was agreed. 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
  - 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 part of the group working with Improvement academy with service users and carers about communication and approach following mortality. This work is nearing completion and has been shortlisted for national awards.
- 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 will provide training to increase the number of Structured Judgment Record Reviewers.

## 2. Annual Cumulative Dashboard Report 2017/2018 covering the period 1/4/2017 – 31/3/18

Table 1 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
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
Total number of deaths reported on Datix by staff (by reported date, not date of death)	158	168	146	96	568
Total number of deaths reviewed	158	168	146	96	568
Total Number of deaths reported on Datix that were in scope	27	23	62	55	167
Total Number of reported deaths not in the Trust scope (where the Trust was not the lead provider of care; and there were no concerns raised about care provided)	135	155	84	41	415
NB includes rejected incidents and those not in scope for mortality					

<sup>1</sup>Data extracted from Business Intelligence and Datix risk management systems. Data is refreshed each quarter so figures may differ from previous reports. Data changes where records may have been amended or added within live systems. Dashboard format and content as agreed by Northern Alliance group

Table 2 Breakdown of the total number of deaths reviewed by service area by financial quarter up to 31/3/2018

Total Number of Deaths reviewed	Mental Health Community	Mental Health Inpatient	General Community	General Community Inpatient	Specialist Services Learning Disability	Specialist Services CAMHS	Specialist Services ADHD	Forensic
Q1	Q1	Q1	Q1	Q1	Q1	Q1	Q1	Q1
158	143	3	0	7	4	0	1	0
Q2	Q2	Q2	Q2	Q2	Q2	Q2	Q2	Q2
168	157	3	0	0	8	0	0	0
Q3	Q3	Q3	Q3	Q3	Q3	Q3	Q3	Q3
146	126	5	0	5	8	2	0	0
Q4	Q4	Q4	Q4	Q4	Q4	Q4	Q4	Q4
96	79	4	1	0	11	1	0	0
YTD	YTD	YTD	YTD	YTD	YTD	YTD	YTD	YTD
568	505	15	1	12	31	3	1	0

Table 3 Summary of total number of deaths in scope and resulting review process by financial quarter up to 31/3/2018 (excluding learning disability deaths)

Total Number of Deaths in scope	Total Number of In-Patient Deaths	Total Number of Deaths Reviewed in Line with SI Framework***	Total Number of Deaths (other investigation)***	Total number of deaths subject to Structured Judgement Record Review**	Case Note Review (48 hour review)	Total number of deaths that were certified*
Q1	Q1	Q1	Q1	Q1	Q1	Q1
26	10	10	1	4	0	11
Q2	Q2	Q2	Q2	Q2	Q2	Q2
21	3	11	3	6	0	1
Q3	Q3	Q3	Q3	Q3	Q3	Q3
57	10	16	6	14	3	18
Q4	Q4	Q4	Q4	Q4	Q4	Q4
46	4	7	3	9	19	8
YTD	YTD	YTD	YTD	YTD	YTD	YTD
150	27	44	13	33	22	38

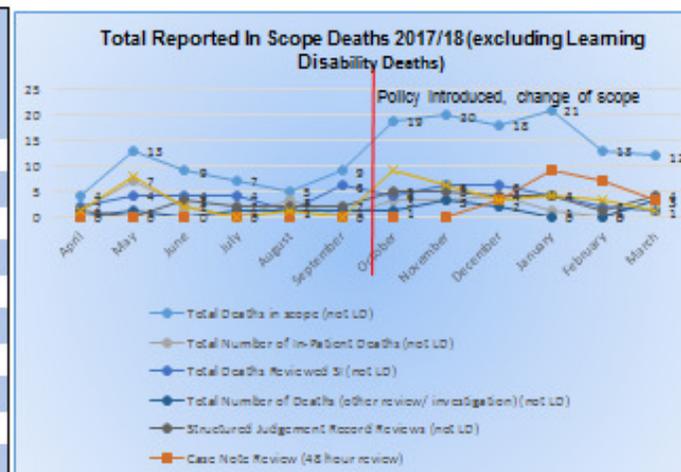


Table 4 Summary of total number of Learning Disability deaths which were in scope by financial quarter up to 31/3/2018

Total Number of Learning Disability Deaths in scope	Total Number of In-Patient Deaths	Total Number of Deaths Reviewed internally	Total Number of Deaths Reviewed in Line with SI Framework* or Structured Judgement Record Review**	Total number of deaths reported through LeDer (By S'w'YPFT)**	Total number of deaths reported through LeDer (By other organisation)**
Q1	Q1	Q1	Q1	Q1	Q1
0	0	0	0	0	0
Q2	Q2	Q2	Q2	Q2	Q2
1	0	1	0	1	0
Q3	Q3	Q3	Q3	Q3	Q3
5	0	5	0	4	1
Q4	Q4	Q4	Q4	Q4	Q4
9	0	9	0	6	3
YTD	YTD	YTD	YTD	YTD	YTD
15	0	15	0	11	4



### 3. Learning from Healthcare Death reviews and investigations

This section of the report contains a summary of learning identified from reviews and investigations that have been completed so far for deaths reported between 1/4/17 – 31/3/18. Further learning will be added as these are completed.

#### 3.1 Learning from healthcare deaths reported as Serious Incidents

This section provides information on deaths reported as Serious Incidents on Datix between 1 April 2017 and 31 March 2018.

Number of deaths that were reported as serious incidents and investigations commenced	47
Number of investigations that have been completed (at 5/4/18)	38
Number of investigations completed where there were no recommendations for improvement	4
Number of investigations completed to date resulting in recommendations	34
Number of investigations underway (learning identified through these investigations will be added at the conclusion of the investigation process).	9

### 3.1.1 Themes from completed Serious Incident investigations

From the Serious Incidents that were reported between on Datix between 1 April 2017 and 31 March 2018, 34 resulted in recommendations for improvement. The table below sets out the main themes from the resulting actions:

Action theme	Number of times theme identified	Number of SI reports where theme appears
A5 Record keeping	20	11
A4 Risk assessment	9	6
F1 Staff education, training and supervision	8	5
F2.1 Policy and procedure - in place but not adhered to	7	6
B1 Communication	6	6
G1 Organisational systems, management issues	5	4
B3 Carers/family	4	3
F2.2 Policy and procedures, not in place	3	3
F4 Team service systems, roles and management	3	3
A1 Care pathway	2	2
A2 Care delivery	2	2
A3 Care coordination	2	2
C1 Medicine management	2	2
F3 Staff attitude, conduct, professional practice	1	1
J1 Other	1	1

The top theme, record keeping, is consistent with that identified in recent annual reports, [available here](#). Further analysis of the themes emerging from Serious Incident investigations completed during 2017/18 has been prepared and included in the 2017/18 annual report, available shortly.

### 3.2 Learning from Structured Judgment Record Reviews

This section provides information on deaths reported on Datix between 1 April 2017 and 31 March 2018 which resulted in a Structured Judgment Record Review. All Structure Judgment Record Reviews that are complete are now approved by a clinical member of the Mortality Review Group before themes are entered into Datix.

Number of Structure Judgment Record Reviews that were commissioned for deaths reported between 1/4/17 – 31/3/18	32
Number of Structure Judgment Record Reviews that have been completed and approved (at 3/7/18).	20
Number of Structure Judgment Record Reviews that are underway	3
Number of Structure Judgment Record Reviews that are in the approval process	8
Number of Structure Judgment Record Reviews that have been referred for further investigation	1

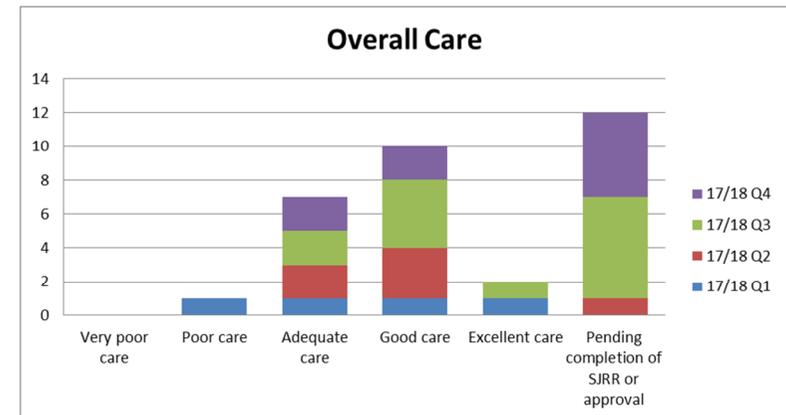
During a Structure Judgment Record Review, the reviewer assesses each phase of care and records their findings on a template under those headings. They also give a view on the care overall. Below is a summary of the rating for overall care, and examples of areas for improvement and positive practice.

## Assessment of Care Overall

60% of reviews completed to date rated overall care as good or excellent

	Very poor care	Poor care	Adequate care	Good care	Excellent care	Pending completion of SJRR or approval	Total
17/18 Q1	0	1	1	1	1	0	4
17/18 Q2	0	0	2	3	0	1	6
17/18 Q3	0	0	2	4	1	6	13
17/18 Q4	0	0	2	2	0	5	9
Total	0	1	7	10	2	12*	32

\*includes a completed SJRR which has been referred for a Service level investigation by Mortality Review Group



### 3.2.1 Areas to consider for improving practice

Due to the small number of completed structured judgement record reviews, it is difficult to identify any themes. However below are some examples of areas for improving practice identified in reviews completed and approved between 1 April 2017 and 31 March 2018. Examples will be added as more reviews are completed:

- The person was at risk of falls and died as a result of a fall at home. There was no evidence of using the skills of the whole team in mitigating risk e.g. Occupational Therapy assessment.
- Convening best interest case conference or strategy meeting to discuss service user's capacity would be valuable. Robust plan to further review their capacity in the community would also be useful.
- The severity of a service user's condition by different practitioners and services was underestimated. There appeared to be a relative lack of knowledge across different services that a man presenting in his mid 50's with severe treatment-resistant anxiety symptoms is likely to have a depressive illness of moderate to severe intensity. When reviewed by a senior practitioner, the severity was immediately noted who did a robust and well-recorded assessment. A senior review (or by someone having a higher level of training and awareness) earlier on in the episode of illness is likely to have identified the severity and risks at an earlier stage.
- Ensuring that when specific treatments cannot be provided, that this is documented clearly and explained. In this example, it appeared to lead to the service user being pre-occupied with a pathway that was not available until the point of death.
- Risk assessments need to be comprehensively documented.
- It was not clear in the documentation that any action had been taken following 7 day discharge follow up.
- Ensuring review of both physical and mental health and ensuring this is documented
- Ensuring the Trust Covert medication policy is being followed. In one case, there was no evidence of a best interest meeting, nor any documentation to support this.

- Risks were identified and detailed in the progress notes as were the care plans associated with same. However the organisation of this information could have been more clearly documented within the assessments and care plans on RIO.
- Ensuring clearly defined contingency plans are available on the clinical system to ensure colleagues are directed to the risk assessments and offered guidance to support informed decision making at times of contact with services.

### 3.2.2 Positive practice examples

It is difficult to draw themes from a small number structured judgement record reviews, however there was much more evidence of positive practice identified through the process. Below are some examples from reviews completed and approved between 1 April 2017 and 31 March 2018:

- “Overall the care was excellent. Input from a wide variety of disciplines, with regular review and regular consideration of which pharmacological options would suit him and his circumstances best. High-quality physical health care. Measures taken to increase observation/avoid falls to keep him safe. Family indicated that they were happy with his care.”
- “Advocacy contacted on his behalf.”
- “Overall the patient was cared for and time being taken to engage with her....There was a multidisciplinary approach throughout involving specialist advisors for assessment and advice.”
- “When a fall occurred they were being observed constantly. Changes to presentation were discussed with the multidisciplinary team and the family.”
- “The family were involved in the resuscitation decision. A palliative approach was taken following difficulty swallowing and deterioration in physical health.”
- “From the care record there is evidence of structured risk assessments appertaining to the community aspect of care prior to admission. These were carried out by staff who had a good therapeutic working knowledge and relationship with the patient...close working relationships and coordination between the community and inpatient teams was evident.”
- The risk triggers were identified and the plan was adhered to resulting in an informal admission to the ward. This was in a timely manner and did not escalate to a formal admission under the mental health act.
- “Discharge was being planned from an early stage in the admission with the patient being actively involved in her care arrangements...The ward team were able to facilitate escorted home leave then worked with the community teams to increase the time spent at home. Good feedback from each visit is documented and provided a basis to inform the MDT of each stage to discharge.”
- “Well documented evidence of good and collaborative joint working evident which was person-centred and responsive to the needs.”
- “Family/carer views were taken on board throughout. The team listened and acted on family concerns”
- “Individual assessments at the outset of various trust services all complied with good practice guidelines and all risk assessments were completed.”
- “The in-patient stay was excellent, detailed investigations and plans made. Collaboration with spouse and evidence of plenty of MDT working. Good planned discharge and follow up all provided in a timely fashion.”
- “During an inpatient stay in hospital...evidence of prompt and thorough assessments following falls with clear action points”
- “Consultant Physician attended for physical health review- good MDT working”

- “There is evidence that staff encouraged and involved patient in variety of OT activities. In the nursing daily reviews, the staff start off RIO entries by highlighting the MHA detention status and Nursing Level of Observations- Good practice”
- “Covert medication plan was initiated during admission due to risks of non-concordance, family were informed.”
- “Attempts were made to be collaborative in devising and agreeing a care plan that met the service user needs. There was evidence of multi-agency working and sign posting to relevant agencies to support care and treatment.”
- “The Care-coordinator had supported the patient to attend out-patient appointments, manage medication, gain new accommodation on three occasions, manage finances and had provided support on seven admissions and provided comprehensive follow up on discharge from the wards. The service user was often difficult to engage and frequently missed appointments which were always followed up by the Community Team. They had issues with alcohol and substance misuse and support was given to address. There was a pattern of relapse following increase in consumption of alcohol and/or illicit substances; when this did happen the Community Team dealt with this in a professional and non-judgemental manner. The Care-coordinator involved family members appropriately and demonstrated flexibility in order to ensure the service user received the care they needed. Every effort was made throughout the episode of care to make sure the service user was involved in decision making and their wishes around medication were taken into account and often a compromise was reached when the service user’s wishes were different to the medical recommendation.”
- “The service user’s care and treatment whilst an inpatient seemed to be compassionate and attentive. Staff responded to fluctuating needs promptly and they had good input from the MDT, including therapy staff. When the patient began complaining of transient pain in the leg with no apparent onset this was monitored for three days at which point the pain was more consistent and impacting on mobility. The patient was provided with an x-ray that showed an historic fracture that has reopened. From this point on care was delivered by general hospital staff which was appropriate”

### 3.2.3 Additional data

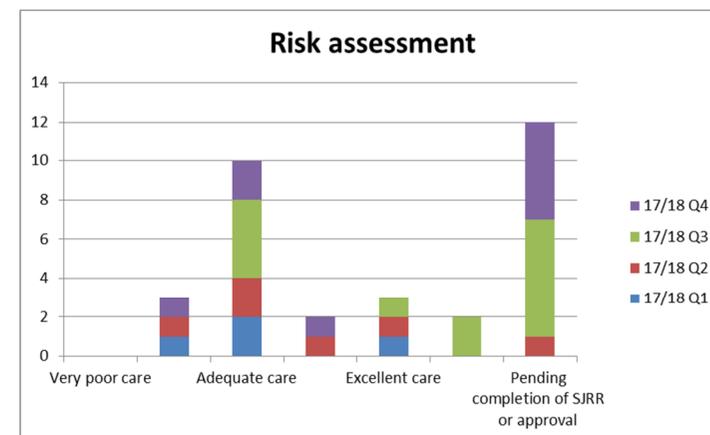
Below is a summary of the ratings given for each phase of care:-

#### Risk assessment:

25% were rated good or excellent

	Very poor care	Poor care	Adequate care	Good care	Excellent care	Not applicable	Pending completion of SJRR or approval	Total
17/18 Q1	0	1	2	0	1	0	0	4
17/18 Q2	0	1	2	1	1	0	1	6
17/18 Q3	0	0	4	0	1	2	6	13
17/18 Q4	0	1	2	1	0	0	5	9
Total	0	3	10	2	3	2	12*	32

\*includes a completed SJRR which has been referred for a Service level investigation by Mortality Review Group

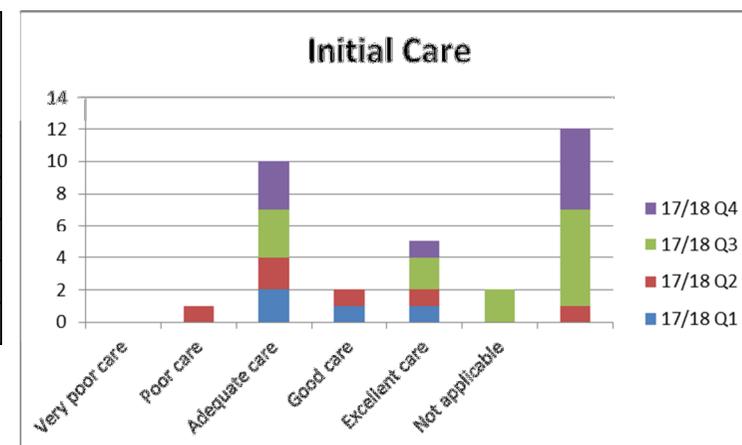


#### Allocation/ Initial Review:

35% were rated good or excellent

	Very poor care	Poor care	Adequate care	Good care	Excellent care	Not applicable	Pending completion of SJRR or approval	Total
17/18 Q1	0	0	2	1	1	0	0	4
17/18 Q2	0	1	2	1	1	0	1	6
17/18 Q3	0	0	3	0	2	2	6	13
17/18 Q4	0	0	3	0	1	0	5	9
Total	0	1	10	2	5	2	12*	32

\*includes a completed SJRR which has been referred for a Service level investigation by Mortality Review Group

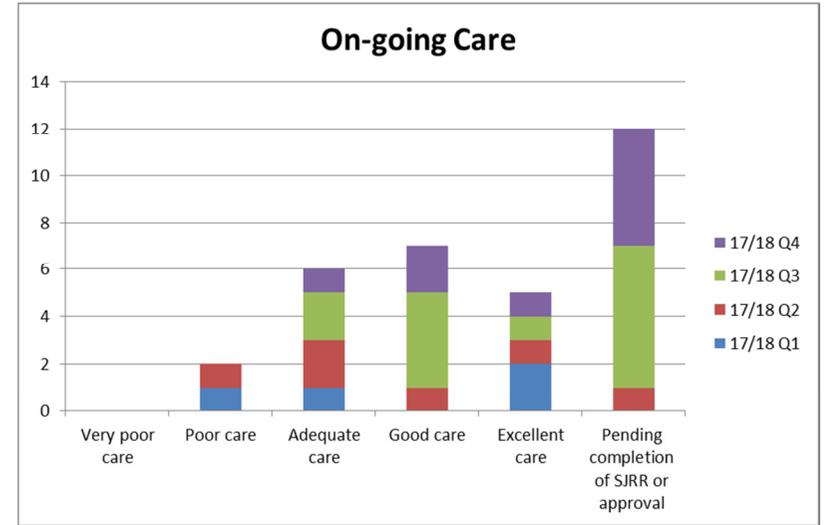


### On-going Care:

60% were rated good or excellent

	Very poor care	Poor care	Adequate care	Good care	Excellent care	Pending completion of SJRR or approval	Total
17/18 Q1	0	1	1	0	2	0	4
17/18 Q2	0	1	2	1	1	1	6
17/18 Q3	0	0	2	4	1	6	13
17/18 Q4	0	0	1	2	1	5	9
Total	0	2	6	7	5	12*	32

\*includes a completed SJRR which has been referred for a Service level investigation by Mortality Review Group

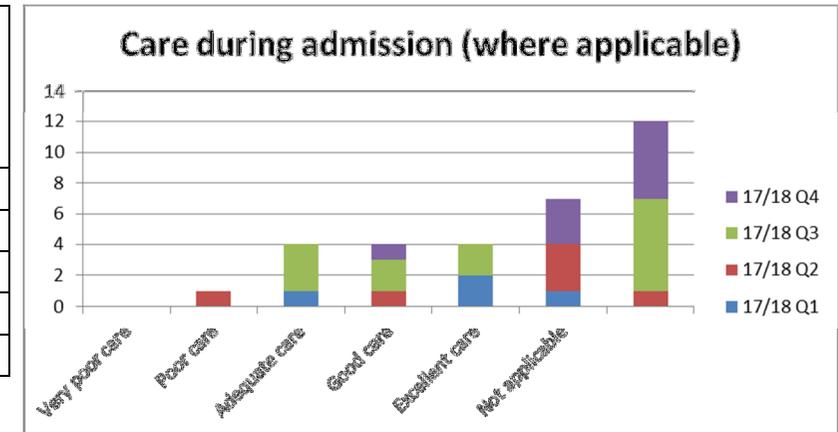


### Care During Admissions (where applicable):

62% were rated good or excellent

	Very poor care	Poor care	Adequate care	Good care	Excellent care	Not applicable	Pending completion of SJRR or approval	Total
17/18 Q1	0	0	1	0	2	1	0	4
17/18 Q2	0	1	0	1	0	3	1	6
17/18 Q3	0	0	3	2	2	0	6	13
17/18 Q4	0	0	0	1	0	3	5	9
Total	0	1	4	4	4	7	12*	32

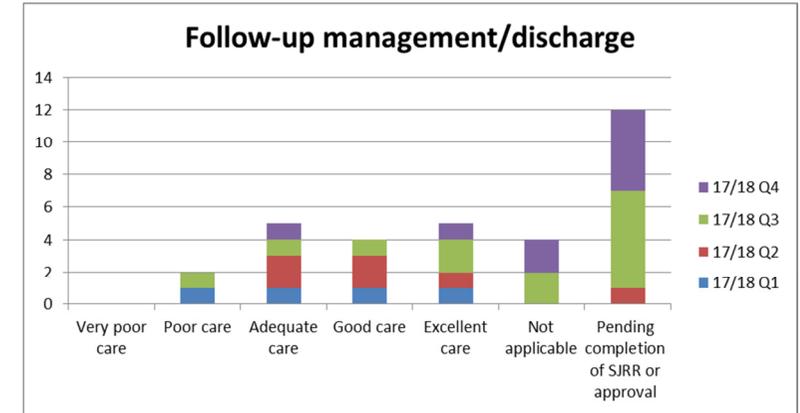
\*includes a completed SJRR which has been referred for a Service level investigation by Mortality Review Group



**Follow-up Management / Discharge:**  
**62% were rated good or excellent**

	Very poor care	Poor care	Adequate care	Good care	Excellent care	Not applicable	Pending completion of SJRR or approval	Total
17/18 Q1	0	1	1	1	1	0	0	4
17/18 Q2	0	0	2	2	1	0	1	6
17/18 Q3	0	1	1	1	2	2	6	13
17/18 Q4	0	0	1	0	1	2	5	9
Total	0	2	5	4	5	4	12*	32

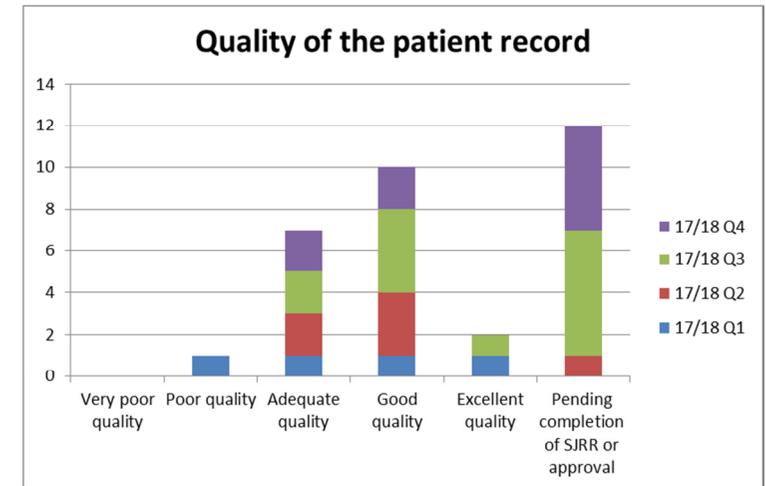
\*includes a completed SJRR which has been referred for a Service level investigation by Mortality Review Group



**Quality of the patient record in enabling good quality of care to be provided:**  
**50% were rated good or excellent**

	Very poor quality	Poor quality	Adequate quality	Good quality	Excellent quality	Pending completion of SJRR or approval	Total
17/18 Q1	0	1	1	1	1	0	4
17/18 Q2	0	0	2	3	0	1	6
17/18 Q3	0	0	2	4	1	6	13
17/18 Q4	0	0	2	2	0	5	9
Total	0	1	7	10	2	12*	32

\*includes a completed SJRR which has been referred for a Service level investigation by Mortality Review Group



### 3.3 Learning from other Investigations

#### a) Service level investigations

Of the 10 service level investigations for deaths reported between 1 April 2017 and 31 March 2018, 5 investigations have been completed (at 3/7/18).

The areas identified for improvement are summarised and themed below:

#### Care delivery

- Although teams have systems and processes there are times when an individual staff member has not taken responsibility for tasks allocated to them and care delivered was not provided as planned.

#### Risk assessment

- Ensuring Sainsbury's level 1 risk assessment is completed at the appropriate time.
- Completion of a Level 1 risk assessment at a medical review does not always happen however the formulation relating to risk is documented in the Medical Care Plan. This will be reviewed as part of the trust wide review of risk assessment documentation, in the transition to a new electronic records system. This review is underway and will give consideration to developing a more formative approach to risk assessment.
- When no face to face contact has been possible and service user contacts the team; to ensure that a qualified member of staff speaks with the service user in order to carry out a risk assessment in relation to urgency of assessment required.

#### Record keeping

- Need to check details on system at the time of taking a verbal referral e.g. GP details and address of patient.

#### Communication

- There were some communication issues between teams regarding attendance at A&E.
- Ensuring that when a patient does not attend for an outpatient appointment, that this is referred to the duty worker to follow up as per procedure.

#### b) Safeguarding reviews

During 2017/18 there have been 3 cases that were originally identified for safeguarding reviews, one has since had an Individual Management Review (IMR) completed and a Service Level Investigation has now been commissioned to explore some issues further. The two remaining safeguarding cases are currently being reviewed. Learning will be updated when this is available.

#### c) Learning disability reviews

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

### Some improvements made after reviewing deaths of people with learning disabilities

Development of better ways of taking blood from people with learning disabilities in an acute hospital



CCG commitment to fund familiar support workers when additional care is required during acute hospital admission

Breast screening service to address need to make reasonable adjustments so that equipment and facilities are accessible



Poor or unsafe discharges now highlighted to Quality Review Board

Education sessions given to care providers to ensure that support workers have the knowledge and confidence to advocate for good healthcare



A review has been undertaken to improve the quality of monitoring placements that are in unfamiliar or out of area locations

They have identified key challenges to be:-

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

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

Main findings:

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

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

## Trust Board 25 September 2018 Agenda item 7.1

<b>Title:</b>	<b>South Yorkshire and Bassetlaw Shadow Integrated Care System (SYB ICS) update</b>
<b>Paper prepared by:</b>	Director of human resources, organisational development and estates and Director of strategy
<b>Purpose:</b>	The purpose of this paper is to update the Trust Board on the developments within the South Yorkshire and Bassetlaw shadow Integrated Care System (sICS), including the Hospital Services Review and Barnsley Integrated Care developments.
<b>Mission/values:</b>	The Trust's mission to <b>enable people to reach their potential and live well in their communities</b> 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 ICS.
<b>Any background papers / previously considered by:</b>	The Trust Board have received regular updates on the progress and developments in the SYB ICS (formerly Sustainability and Transformation Partnership), including the Hospital Services Review.
<b>Executive summary:</b>	<p>The SYB ICS is one of the first Wave of formal Integrated Care systems that were established to make faster improvements in the key national deliverables, in return for additional freedoms and additional non-recurrent investment. The Trust provides services in Barnsley and is a full partner in the Barnsley Integrated Care Partnership that supports the strategic ambitions of the regional ICS. The paper provides an update on key developments including:</p> <ol style="list-style-type: none"> <li>1. Hospital Services Review</li> <li>2. Governance Review</li> <li>3. ICS Memorandum of Understanding (MoU)</li> <li>4. Draft Estate Strategy and Capital Bids</li> <li>5. SYB ICS Mental Health Workshop - 19/20 Priorities and programmes workshop</li> <li>6. Barnsley Integrated Care</li> </ol> <p><b>Risk Appetite</b></p> <p>This update supports the risk appetite identified in the Trust's organisational risk register.</p>
<b>Recommendation:</b>	<b>Trust Board is asked to NOTE the update from the SYB ICS and Barnsley Integrated Care Developments.</b>
<b>Private session:</b>	Not applicable.

**South Yorkshire and Bassetlaw Integrated Care System and  
Barnsley Integrated Care partnership - update  
Trust Board 25 September 2018**

**1. Introduction**

The purpose of this paper is to provide an update to the Trust Board on the South Yorkshire and Bassetlaw Integrated Care system (SYB ICS) and Barnsley Integrated Care partnership that is part of the wider SYB ICS.

**2. Background**

The SYB ICS is one of the first Wave of formal Integrated Care systems that were established to make faster improvements in the key national deliverables, in return for additional freedoms and additional non-recurrent investment. The Trust Board have received regular updates on the progress and developments in the SYB ICS (formerly Sustainability and Transformation Partnership), including the Hospital Services Review.

**3. Hospital Services Review**

The Board have received regular updates on the SYB Hospital Services Review. A briefing pack has been developed for Boards and governing bodies of non-Acute Trust organisations including Mental Health Trusts and Local Authorities. This pack has been circulated to Trust Board members prior to the meeting on the 25 September 2018. A summary of the update is provided below:

The Hospital Services Review (HSR) published its final report in May 2018. Boards, Governing Bodies, some Local Authorities and members of the public have now given their feedback on the recommendations in the report.

The feedback has been used to inform a Strategic Outline Case (SOC), which is the system's statement of intent around how it will take forward the recommendations of the HSR.

The SOC largely accepts the recommendations of the HSR, with two main changes:

- It emphasises the transformation of the workforce more than the HSR did.
- It outlines that the Clinical Working groups on maternity and paediatrics will be asked to explore clinical models that could satisfy interdependencies between maternity and paediatrics, as a possible alternative to moving to a Standalone Midwifery Led Unit (SMLU).

The SOC has been circulated to CCG Governing Bodies for agreement, in line with their statutory responsibility to make decisions on issues related to service change. It has also been circulated to Boards of acute providers as the organisations most directly affected. It is circulated to other provider and Local Authority members of the Collaborative Partnership Board to note. The SOC will be submitted to the next meeting of the Joint Health Overview and Scrutiny Committee (JHOSC).

The main changes in the SOC from the final report are:

- A greater focus on transformation has been introduced, in particular a stronger role for Clinical Working Groups in redesigning job roles and clinical pathways. This is now a work stream in its own right.
- The timeline has been lengthened, to allow more time to develop the transformation of the workforce roles before modelling reconfiguration and to allow more time for Boards and Governing Bodies to engage.
- On maternity and paediatrics, several organisations raised concerns about interdependencies and Standalone Midwifery Led Units. The SOC says that the Clinical Working Groups will be asked to explore alternative ways of addressing interdependencies between maternity and paediatrics, without moving to a SMLU. Any models which are proposed would be scrutinised by the Clinical Senate.
- On elective services, the HSR recommended that the next stage of work should look at some elective services. CEOs and AOs agreed that this should not be a part of the next stage of work on hospital services, although work on improving quality of elective services will continue through the elective work strand.
- In relation to Chesterfield, the SOC makes it clearer that the SYB ICS will work with the Derbyshire STP in developing proposals and mitigations.
- Where a reconfiguration option would result in some patients moving to trusts which are not within SYBND, the SOC says that the team will do due diligence around any quality issues while the options are being modelled, and the quality implications will be assessed against the evaluation criterion on quality.
- The data in the financial analysis has been slightly updated. Some updated numbers on activity levels were provided by some trusts too late to be included in the HSR. They make only a very marginal difference and do not change the decision making but in the interests of completeness they will be published alongside the SOC.
- Local Authorities requested that they should be more closely involved in the development of the next stage of work. This is being taken forward formally through the context of the wider ICS governance review and through relationships between the ICS and Local Authorities, and individual Places and Local Authorities.

- Members of the public raised a number of concerns and the detailed response to the points raised has been provided in the SOC where possible.

#### **4. Governance Review**

A review of the governance framework for the ICS is taking place over August to October 2018. The objectives of the governance review in summary are to:

- Give assurance to Boards and Governing Bodies that the ICS has robust and appropriate governance as level 2 system
- Strengthen the ICS governance system and effective decision-making
- Provide a governance system which adds value and is enabling to the direction of travel and one which supports integrated working of commissioning, providing and assuring in a system
- Supports the growing connection between the ICS and each of the five local systems
- Works within the existing legal framework working our existing statutory
- Governance including boards and governing bodies, the Joint Committee of CCGs and Committees in Common
- Is flexible enough to adapt to future changes

Key outputs will include governance options for consideration, a governance framework and terms of reference for key ICS group. The ICS governance group will act as the steering group for the review. All partners will be engaged in the review and where possible and appropriate it is proposed that existing forums will have access to support this engagement process to shape options including for example, the ICS core partnership forums and the Collaborative Partnership Board.

#### **5. ICS Memorandum of Understanding (MoU)**

**A MoU has been developed that sets out the** terms of the agreement between SYB ICS and NHSE / NHSI with a specific focus on 2018-19 including regional and national expectations. This is currently being reviewed by Governing Bodies and it is expected that a final MoU will be agreed in October.

#### **6. Draft Estate Strategy and Capital Bids**

The ICS has undertaken a process to develop and prioritise capital bids that have been submitted. It is expected that the outcomes of the capital bids submitted will be in the Autumn statement.

**7. SYB ICS Mental Health Workshop - 19/20 Priorities and programmes workshop**

The main objective of the workshop was to identify areas where there is value in taking a collective approach to achieve system efficiency (not QIPP, and not CIP). The workshop focused on three key areas reducing out of area placements, IAPT and EIP. There was recognition that there is value in collectively addressing challenges including workforce recruitment and retention and addressing the wider detriments that impact health and well-being through strengthening partnership arrangements with local authorities.

**8. Barnsley Integrated Care**

The Barnsley Clinical Commissioning Group (CCG) have been working with partners including the Trust to develop joined up integrated care. The CCG have been discussing with partner organisations, including the Trust, proposals for a new model for health care provision and commissioning for Barnsley involving an integrated care system. Partners across Barnsley continue to work together to develop integrated models of care including neighbourhood model, transforming CVD and developing an integrated model of carer for stroke and frailty.

**9. Recommendations**

Trust Board is asked to note the update from the SYB ICS and Barnsley Integrated Care developments.

## Trust Board 25 September 2018 Agenda item 7.2

<b>Title:</b>	<b>West Yorkshire &amp; Harrogate Health &amp; Care Partnership and local Integrated Care Systems update</b>
<b>Paper prepared by:</b>	Chief Executive Director of Strategy
<b>Purpose:</b>	The purpose of this paper is to provide the Trust Board 1. With an update on the development of the West Yorkshire and Harrogate Health and Care Partnership and 2. Local Integrated Care system developments.
<b>Mission/values:</b>	The development of joined up care through place-based plans is central to the <b>Trust's strategy</b> . As such it is supportive of our mission, particularly to <b>help people to live well in their communities</b> .  <b>The way in which the Trust approaches strategy and strategic developments must be in accordance with our values</b> . The approach is in line with our values - <b>being relevant today and ready for tomorrow</b> . 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.
<b>Any background papers / previously considered by:</b>	Strategic discussions and updates on place based plans have taken place regularly at Trust Board including an update to July Trust Board.
<b>Executive summary:</b>	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).  The place-based plans are being mobilised through strengthening existing partnerships and developing collaborative arrangements to commission, deliver and transform services. Progress and key developments that are summarised in the paper include:  <ul style="list-style-type: none"> <li>➤ West Yorkshire and Harrogate Health and Care Partnership</li> <li>➤ Kirklees</li> <li>➤ Calderdale</li> <li>➤ Wakefield</li> </ul> <b>Risk Appetite</b>  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.
<b>Recommendation:</b>	<p><b>Trust Board is asked to:</b></p> <ul style="list-style-type: none"> <li>➤ <b>RECEIVE</b> the update; and</li> <li>➤ <b>DISCUSS</b> and <b>COMMENT</b> on the development of Integrated Care Systems and collaborations including: <ul style="list-style-type: none"> <li>• West Yorkshire and Harrogate Health and Care Partnership</li> <li>• Wakefield</li> <li>• Calderdale</li> <li>• Kirklees</li> </ul> </li> </ul>
<b>Private session:</b>	Not applicable.

**West Yorkshire & Harrogate Health and Care Partnership and  
Local Integrated Care Systems update  
Trust Board 25 September 2018**

**1. Introduction**

The purpose of this paper is to provide an update to the Trust Board on the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP). The paper will also include a brief update on key developments in local places that the Trust provides services that are aligned to the ambitions of the WY&H HCP and the Trusts strategic ambitions.

**2. Background**

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

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

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

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

In May 2018 NHS England and NHS Improvement announced that WY&H HCP would be one of four health and care systems to join the Integrated Care System (ICS) Development Programme. This demonstrated national recognition for the way WY&H partnership works and

for the progress made. It means the partnership is at the leading edge of health and care systems, gaining more influence and more control over the way services are delivered and supported for the 2.6 million people living in our area.

### **3. Update – Progress**

#### **3.1 Development of Integrated Care System - National Memorandum of Understanding (MoU)**

As part of becoming a Shadow Integrated Care System (ICS) the ICS has been asked to sign up to the National ICS MoU. This document sets out the terms of the agreement between WY&H partnership and NHSE / NHSI with a specific focus on 2018-19. The expectation is that it will be refreshed annually. This work is now complete and will be shared with partner organisations including Trust Board.

#### **3.2 Memorandum of Understanding (MoU)**

The Partnership MoU is now going through the process of approval by Boards and governing bodies and there is a separate paper including the final MoU for Trust Board to consider.

#### **3.3 WY&H HCP revised collaborative governance arrangements**

**A new Partnership Board** will be established by April 2019 to provide formal leadership. The Board will be responsible for setting strategic direction and have oversight of all Partnership business. The Board will be made up of the chairs and CEOs of all NHS organisations, chairs of Health and Wellbeing Boards, council CEOs and senior representatives from other partner organisations. Options and process for recruiting to the Partnership chair role are being considered and explored.

**The System Leadership Executive (SLE) Group** will continue to meet and will include representation from across the partnership. This group will be responsible for overseeing delivery of the strategy of the Partnership, building leadership and collective responsibility for shared objectives.

**A new System Oversight and Assurance Group (SOAG)** will be established in 2018/19 to provide a mechanism for partner organisations to take ownership of system performance and delivery. It will be chaired by the Partnership and Trust CEO Lead Rob Webster and include representation covering each sector / type of organisation. It will regularly review a dashboard of key performance and transformation metrics and receive updates from West Yorkshire and Harrogate programme boards.

### **3.4 WY&H patient and public involvement**

This remains a key enabler to the work of the WY&H HCP and has a number of ongoing work streams to ensure there is strong engagement of the VCS, public, service users and carers through the priority programmes. In addition the System Leadership Executive group have considered proposals to develop the 'Chairs of Public Panels' group to create a Public Assurance Group that will act as advocates and constructively challenge the Partnership Board (once in place) and ensure that the public voice is at the heart of decision making.

### **3.5 Peer Challenge Process**

WY&H Health and Care Partnership will undertake a system wide peer challenge in Autumn 2018. 'Peer challenge' is a well-established process used in local government as a proven tool for improvement. The HCP will work with the Local Government Association, NHS Providers, NHSCC and NHS Confed who have been commissioned by NHS England to develop an integrated system approach to peer challenge. This is part of developing the Partnership approach to mutual accountability. The key objectives of the process include the following

- To understand the progress each 'place' is making towards integration and to make recommendations for improvement
- To understand how effective the connections between West Yorkshire and Place working are and to make recommendations for improvement
- To road test a 'place to place' peer challenge approach that can be adopted across the partnership.

It is anticipated that the Trust with partners from each place will be part of this process. Wakefield has been identified as the first place to take part in the peer review and will be part of prototyping the approach.

### **3.6 Transformation funding**

The ICS leadership has been clear that part of the deal with the national bodies for becoming an ICS must be access to greater levels of funding to support service transformation. NHSE has now confirmed the overall package of financial support that will be available for the year 2018/19. The bulk of the overall package of £34m has already been received. £25m of this comes pre-committed to specific programmes. £8.75m of discretionary funding has been made available to the ICS as a result of entering the ICS programme in 2018-19. As a shadow ICS (i.e. not operating a single control total in 2018-19) **we are not being asked to take on any greater collective financial risk as part of the arrangement.** This funding will be non-recurrent for 2018-19. Outside of the above package there will continue to be national funding pots which the shadow ICS will be eligible to bid for – for example recent success includes the Local Health and Care Integrate Record Exemplar (LHCRE) and Wave 3 capital.

The System Leadership Executive Group (SLE) agreed at its meeting in July that the £8.75 transformation funding received should be allocated to the following:

- Primary Care Network Development, as notionally earmarked by NHS England
- “WYAZ 2”: to deliver rapid implementation of improvements in urgent and emergency care delivery across the West Yorkshire and Harrogate footprint
- Harnessing the Power of Communities with a focus on loneliness
- Capacity to deliver Partnership programmes

**Transformation Funding for Winter plans 2018-19** - At its August 2018 meeting the System Leadership Executive Group confirmed the funding levels, allocation methodology and governance arrangements for the £4m identified to support system transformation and delivery. Each A&E delivery board area has now provided a return of the schemes that this funding will be used to support, including:

- The schemes that are being prioritised in 2018-19;
- The timescales for investment of the funds;
- The anticipated impact on key metrics, particularly A&E performance, DTOC
- and “super-stranded patients”.

**Transformation funding to support digital** - National investment in digital facilities to support the strategy for NHS hospital provider organisations to become paper-free, or at least paper-light, in the delivery of services to patients is being channelled through the WY&H HCP. The requirement is to produce a firm set of projects for year one and a provisional set for years two and three. The investment proposals can be submitted between **1 September and 5 October 2018** and must be endorsed by the ICS Leadership. In Year 2 the Voluntary, Community and Social Enterprise sector will also be eligible for grant funding.

### **3.7 Kings Fund offer of support to Integrated Care Systems**

As part of joining the Wave 2 Integrated Care System Programme the ICS has been offered support from the Kings Fund. The specific offer is for five days of leadership support during 2018-19. The ICS proposition is that the offer is tailored to help with the design and implementation of the new Partnership Board and mutual accountability arrangements.

### **3.8 WYMHSC Committees in Common**

The committee continues to meet and drive forward the agreed transformation areas across the system in line with the national improvements set out in the Mental Health Five Year Forward View. Draft communications plan is being developed and a communications and engagement workshop that brought together communications leads from all the partner

organisations was held. A further NED / governors event is being planned and it is anticipated that it will be held next year. Scoping of improvement work related to Dementia care across the region has commenced. Quality Improvement leads from all partner organisations will meet to discuss developing shared capacity to support Mental Health programmes.

**Mental Health programme update** - Progress is being made against all programmes as reported through the Trust Integrated Performance Report and through the Committee in Common for Mental Health Providers.

#### **4. Local Integrated Care Partnerships - key developments**

A number of the places that the Trust provides services are part of the WY&H HCP. These include Kirklees, Calderdale and Wakefield. Barnsley is part of the South Yorkshire & Bassetlaw Integrated Care System (ICS) that the Trust is a partner within. Notable developments include the following:

##### **4.1 Calderdale**

Calderdale partners are working together to deliver integrated, joined up care. Systems leaders have developed a Single Plan for Calderdale and the Calderdale Cares proposal was presented at the January Trust private Board. North Halifax primary care at home and Central Halifax prototypes for Calderdale Cares continue to develop. The Sports England Bid secured to support physical activity and well-being in Calderdale has commenced with a master class for the sponsors that was facilitated by the Design Council and Calderdale Local Authority leads. Design thinkers have been recruited and have commenced formal training. The Trust will act as the sponsor for the Mental Health group. This will involve supporting up to three members of our staff and two from other organisations to use design thinking as an approach to prototyping innovative opportunities and activities for people with mental health experiences and substance misuse to improve physical activity. Calderdale as a system has been identified as a focused implementation site for the APPG report on Arts, Health and Well Being by the WY&H HCP and the Trust is a key partner in this work.

##### **4.2 The Wakefield Integrated Care Partnership**

The Wakefield partnership has continued to progress the integration agenda through the New Models of Care Board (NMOC) that is underpinned by an alliance arrangement. Priorities for 18/19 include mental health, primary care at home, frailty and older people, End of Life Care and Cancer.

**The Wakefield Mental Health Provider Alliance** has continued to make progress on developing its governance framework and developing service pathways to improve service user outcomes and experience. All Partners (except one) have taken the document “Re-imagining mental health care: the Case for Change” through their Governing Bodies for approval. The outstanding one will be discussed at the Partner’s Governing Body later this month, and almost certainly be supported. Sean Rayner, Director of provider development, has assumed the Chair of the Provider Alliance Development Group, and chaired his first meeting on 7 September 2018.

The next phase of work will include a further iteration of the Case for Change to address the substantive issues of development and approval of a Memorandum of Understanding / Alliance Agreement; Information Sharing Agreement; Initial scope of financial envelope; establishment of a ‘Stakeholder Group’ as part of the Governance framework. The Alliance is also overseeing the review and development of service pathways for service users with personality disorder / ‘chaotic lifestyle’. This is a co-produced process and has included both service providers and service users. The outcomes of this work will be reported later in the autumn. A further iteration of the Case for Change, with more detail in respect of the issues outlined above, will be developed for discussion and agreement at Partner governing bodies including Trust Board later in this calendar year.

#### **4.3 Kirklees**

System leaders have been meeting and a provider Board has been established. A draft place based plan for health and care in Kirklees is in development. The draft plan is aligned too and supports the direction of travel and priorities set out by the WY&H HCP and the Trust strategy. The Trust is a key partner and has been involved in shaping this. The plan will be shared with Trust Board once it is complete.

### **5. Recommendations**

**Trust Board is asked to:**

- **receive the update and**
- **discuss and comment on the development of Integrated Care Systems and collaborations:**
  - **West Yorkshire and Harrogate Health and Care Partnership and**
  - **Calderdale**
  - **Wakefield**
  - **Kirklees**

## Trust Board 25 September 2018 Agenda item 7.2i

<b>Title:</b>	<b>West Yorkshire and Harrogate Health and Care Partnership (previously STP) Memorandum of Understanding</b>
<b>Paper prepared by:</b>	Director of Strategy
<b>Purpose:</b>	The purpose of this paper is to seek the Trust Board's approval for : <ul style="list-style-type: none"> <li>➤ the Memorandum of Understanding (MoU) for the West Yorkshire and Harrogate Health and Care Partnership; and</li> <li>➤ Trust Board to commit to working in partnership by authorising the Accounting Officer (Chief Executive) to sign the MoU.</li> </ul>
<b>Mission/values/objectives</b>	<p>The development of joined up care through place-based plans is central to the <b>Trust's strategy</b>. As such it is supportive of our mission, particularly to <b>help people to live well in their communities</b>.</p> <p>The development of strategic partnerships <b>supports the achievement of the Trust's strategic objectives</b> – to <b>improve health</b> and wellbeing through an enhanced focus on prevention and early intervention, <b>improve quality</b> and experience through more integrated ways of working and <b>improve the use of resources</b> across the whole system.</p> <p><b>The way in which the Trust approaches strategic developments and partnerships must be in accordance with our values.</b> The approach is in line with our values - being <b>relevant today and ready for tomorrow</b>. This MoU aims to assist the Trust Board in clarifying its role and status within the WY&amp;H HCP. The partnership is critical in ensuring the sustainability of Trust services.</p>
<b>Any background papers/ previously considered by:</b>	Updates and focused strategic discussions on placed-based plans including the WY&H HCP (STP) have formed part of most recent Trust Board meetings. The draft MoU was discussed at the private Trust Board in January 2018. The near final draft MoU was reviewed by a sub group of the Board in August 2018 and discussed by the Board in a development session on 4 September 2018.
<b>Executive summary:</b>	<p><b>Background</b></p> <p>West Yorkshire and Harrogate Health and Care Partnership (WY&amp;H HCP) was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs), in response to the <i>NHS Five Year Forward View</i>. It brings together all health and care organisations in six places: Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield, including South West Yorkshire Partnership NHS foundation Trust.</p> <p>The WY&amp;H HCP was recognised as part of the formal Integrated Care System (ICS) development programme in 2018. This is recognition of the significant progress that the ICS has made. The partnership has set out a compelling vision with a focus on delivering transformation to</p>

	<p>care and services across the region. The plans for the shadow ICS are set out in the 'Next Steps to Better Health and Care for Everyone' document that was published earlier this year.</p> <p>In October 2017 the System Leadership Executive Group agreed that a MoU should be developed to formalise working arrangements and support the next stage of development of the WY&amp;H HCP. This MoU builds on the existing partnership arrangements to establish more robust mutual accountability</p> <p><b>What it means for South West Yorkshire Partnership NHS Foundation Trust</b></p> <ul style="list-style-type: none"> <li>➤ By signing the MoU we will commit to play our full role as a member of WY&amp;H HCP and to work within the frameworks described. Accepting our share of collective responsibility will give us and our partners the opportunity to achieve greater autonomy and control over how we develop and transform our health and care services.</li> <li>➤ The partnership will be an overall collaborative framework for local Accountable Care Partnerships. This includes local partnerships in Wakefield, Calderdale and Kirklees.</li> <li>➤ 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 organisation. Instead it sits alongside and complements these frameworks, creating the foundations for closer and more formal collaboration.</li> <li>➤ As partners within the MoU we will be committing to our part in contributing to system wide shared financial control totals. We will need to understand the risks to the Trust once this aspect is clearer.</li> </ul> <p><b>Risk Appetite</b></p> <p>Supporting the development of strategic partnerships and place-based plans that enhance the Trusts sustainability are within the Trust's risk appetite. Risks to the Trust services in each place including WY&amp;H HCP will need to be reviewed and managed as the partnerships develop to assess the impact upon services, clinical and financial flows.</p>
<b>Recommendation:</b>	<b>Trust Board is asked to APPROVE the MoU and AUTHORISE the Accounting Officer (Chief Executive) to sign the MoU.</b>
<b>Private session:</b>	Not applicable.

**South West Yorkshire Partnership NHS Foundation Trust**  
**Trust Board 25 September 2018**

**A Memorandum of Understanding (MOU) for the**  
**West Yorkshire and Harrogate Health and Care Partnership**

**Introduction**

1. The purpose of this paper is to seek the Trust Board's approval for:
  - the Memorandum of Understanding (MoU) for the West Yorkshire and Harrogate Health and Care Partnership; and
  - South West Yorkshire Partnership NHS Foundation Trust Board to commit to working in partnership by authorising the [Accountable Officer / Chief Executive] to sign the MoU.

**Background**

2. West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs), in response to the NHS Five Year Forward View. It brings together all health and care organisations in our six places: Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield, including South West Yorkshire Partnership NHS foundation Trust.
3. In November 2016 the STP published high level proposals to improve health, reduce care variation and manage our finances. Since then the partnership has made significant progress to build capacity and infrastructure and establish the governance arrangements and ways of working that will enable us to achieve our collective aims.
4. The partnership has already begun to make an impact in other important areas. Our Cancer Alliance Board is a national exemplar, and has attracted £12.6m in funding to transform cancer diagnostics. We have developed a strategic case for change for stroke from prevention to after care. We have streamlined management of CCGs and established a Joint Committee of CCGs and Committee in Common for acute trusts; these will strengthen collaborative working and facilitate joint decision making. We have secured £31m in transformation funding for A&E, cancer, mental health, learning disabilities and diabetes, and £38m capital from the Autumn budget for CAMHS, pathology, telemedicine, and digital imaging.
5. In October 2017 the System Leadership Executive Group agreed that a new MoU should be developed to formalise working arrangements and support the next stage of development of the WY&H HCP. The MoU builds on the existing partnership arrangements to establish more robust mutual accountability.
6. The final draft of the MoU is attached as Annex 1 to this paper for approval.

## Purpose of the MoU

7. The MoU is an agreement between the WY&H health and care partners. It sets out the details of our commitment to work together in partnership to realise our shared ambitions to improve the health of the 2.6 million people who live in our area, and to improve the quality of their health and care services.
8. The MoU does not seek to introduce a hierarchical model; rather it provides a mutual accountability framework to underpin collective ownership of delivery. It also provides the basis for a refreshed relationship between local NHS organisations and national oversight bodies.
9. The MoU is not a legal contract, but is a formal agreement between all of the partners. It is based on an ethos that the partnership is a servant of the people in West Yorkshire and Harrogate and of its member organisations. It does not replace or override the legal and regulatory frameworks that apply to our statutory NHS organisations and Councils. Instead it sits alongside and complements these frameworks, creating the foundations for closer and more formal collaboration.
10. The draft MoU should be read in conjunction with the STP Plan, published in November 2016, the *Next Steps* (February 2018) and the Trust Strategy including local place based plans for Wakefield, Calderdale and Kirklees.
11. The MoU provides a platform for:
  - a) a refresh of the governance arrangements for the partnership, including across WY&H, and the relationship with individual Places and statutory bodies;
  - b) the delivery of a mutual accountability framework that ensures we have collective ownership of delivery, rather than a hierarchical approach
  - c) a new approach to commissioning, and maturing provider networks that collaborate to deliver services in place and at WY&H level;
  - d) clinical and managerial leadership of change in major transformation programmes;
  - e) a transparent and inclusive approach to citizen engagement in development, delivery and assurance;
  - f) better political ownership of, and engagement in the agenda, underpinned by regular opportunities for challenge and scrutiny; and
  - g) a new assurance and accountability relationship with the NHS regulatory and oversight bodies that provides new flexibilities for WY&H to assert greater control over system performance and delivery and the use of transformation and capital funds; and
  - h) the agreement an effective system of risk management and reward for NHS bodies.
12. The text of the MoU sets out details of:
  - The context for our partnership;
  - The partner organisations;

- How we work together in WY&H, including our principles, values and behaviours;
- The objectives of the partnership, and how our joint priority programmes and enabling workstreams will improve service delivery and outcomes across WY&H;
- Our mutual accountability and governance arrangements, including how we will move towards a new approach to assurance, regulation and accountability with the NHS national bodies;
- Our joint financial framework;
- The support that will be provided to the Partnership by the national and regional teams of NHSE and NHSI;
- Which aspects of the agreement apply to particular types of organisation.

### **Becoming an Integrated Care System**

13. In May 2018 NHS England and NHS Improvement announced that WY&H HCP would be one of four health and care systems to join the Integrated Care System (ICS) Development Programme. This demonstrated national recognition for the way our WY&H partnership works and for the progress we have made. It means we can join the leading edge of health and care systems, gaining more influence and more control over the way we deliver services and support for the 2.6 million people living in our area.
14. The importance of joining up services for people at a local level in Bradford District and Craven; Calderdale; Harrogate and Rural District; Kirklees; Leeds; and Wakefield is at the heart of our local plans and our WY&H programmes. All decisions on services are made as locally and as close to people as possible. Our move to becoming an ICS is predicated on this continuing to be the case.
15. This integrated approach to health and care will continue to support much closer working between our organisations. The MoU will provide a firm foundation for this. It reflects and builds on the current ways of working and agreed principles for the partnership and maintains an ethos of the primacy of local Place.

### **Progress to Date**

16. Over recent months drafts of the MoU have been discussed in development sessions by members of the Boards and Governing Bodies of partner organisations and by members of Health and Wellbeing Boards and the WY&H Joint Overview and Scrutiny Committee.
17. Feedback from these discussions has directly influenced the development of the final draft, which has now been agreed by the WY&H HCP System Leadership Executive Group.
18. Updates and focused strategic discussions on placed-based plans including the WY&H HCP have formed part of most recent Trust Board meetings. The early draft MoU was reviewed and discussed at the private session of the January Trust Board. A sub group of the Trust Board has reviewed the near-final draft MoU In August 2018 and the outcomes of this review was made available for the discussion at the September Trust Board development day with the final MoU.

19. The HCP core team has sought a legal opinion on the text of the MoU, on behalf of all Partner organisations. The lawyers were able to provide helpful suggestions to improve clarity and remove elements of ambiguity. They also confirmed that the MoU was sound, and was not inconsistent with statutory or regulatory frameworks, or with the powers and duties of individual partners.

### **What it means for South West Yorkshire Partnership NHS Foundation Trust**

20. By signing the MoU we will commit to play our full role as a member of WY&H HCP and to work within the frameworks described. Accepting our share of collective responsibility will give us and our partners the opportunity to achieve greater autonomy and control over how we develop and transform our health and care services.
21. The partnership will be an overall collaborative framework for local Accountable Care Partnerships that the Trust is a partner in including Wakefield, Calderdale and Kirklees.

### **Next steps**

22. Each Partner organisation is being asked to approve and sign the MoU. It is expected that this process will be completed over the summer.

### **Recommendations**

23. Members of the Trust Board are asked to:
  - a) Approve the MoU; and
  - b) Authorise the Accountable Officer / Chief Executive to sign the MoU.



West Yorkshire and Harrogate  
Health and Care Partnership



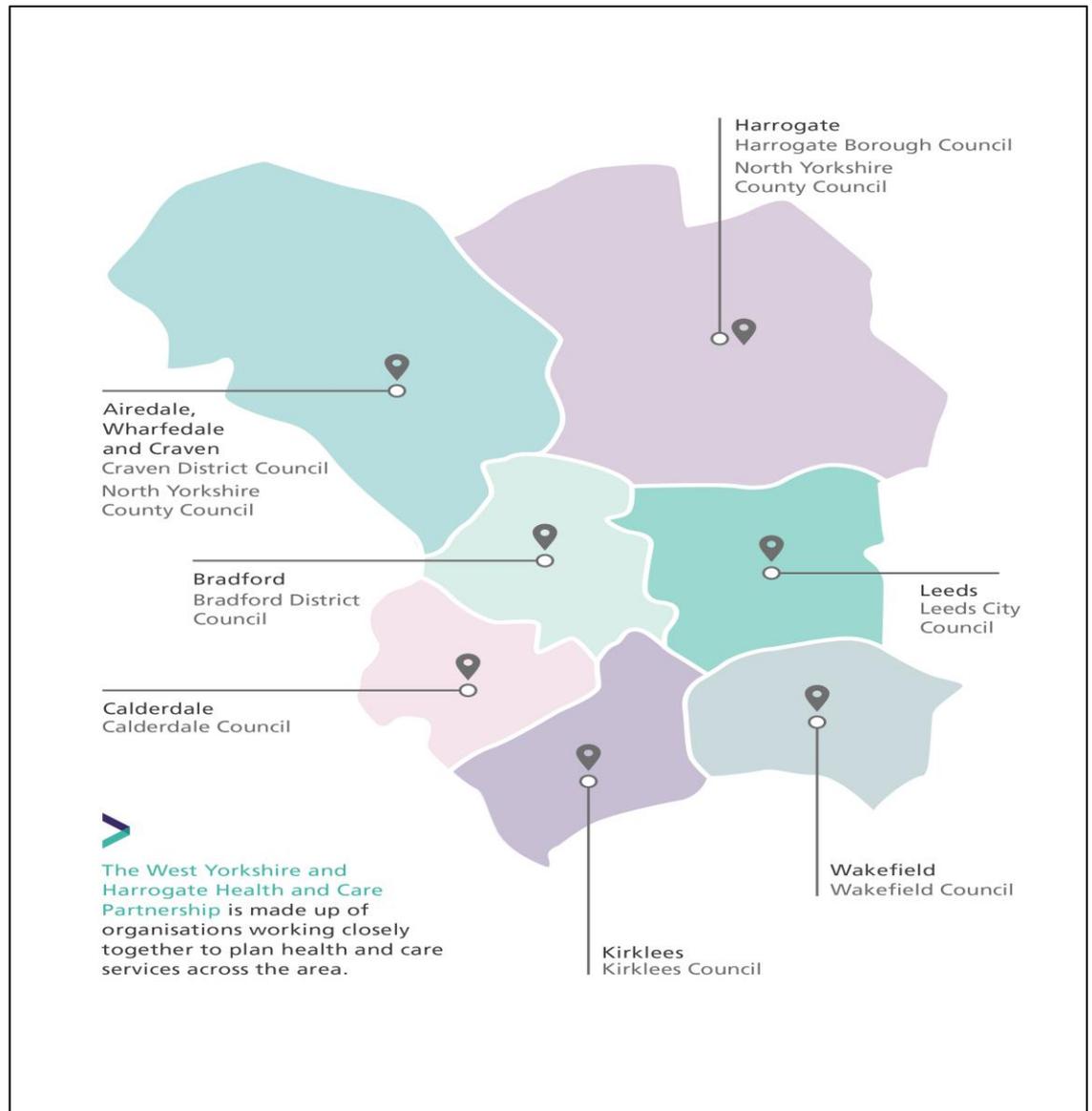
# West Yorkshire and Harrogate Health and Care Partnership

Developing our  
Memorandum of  
Understanding

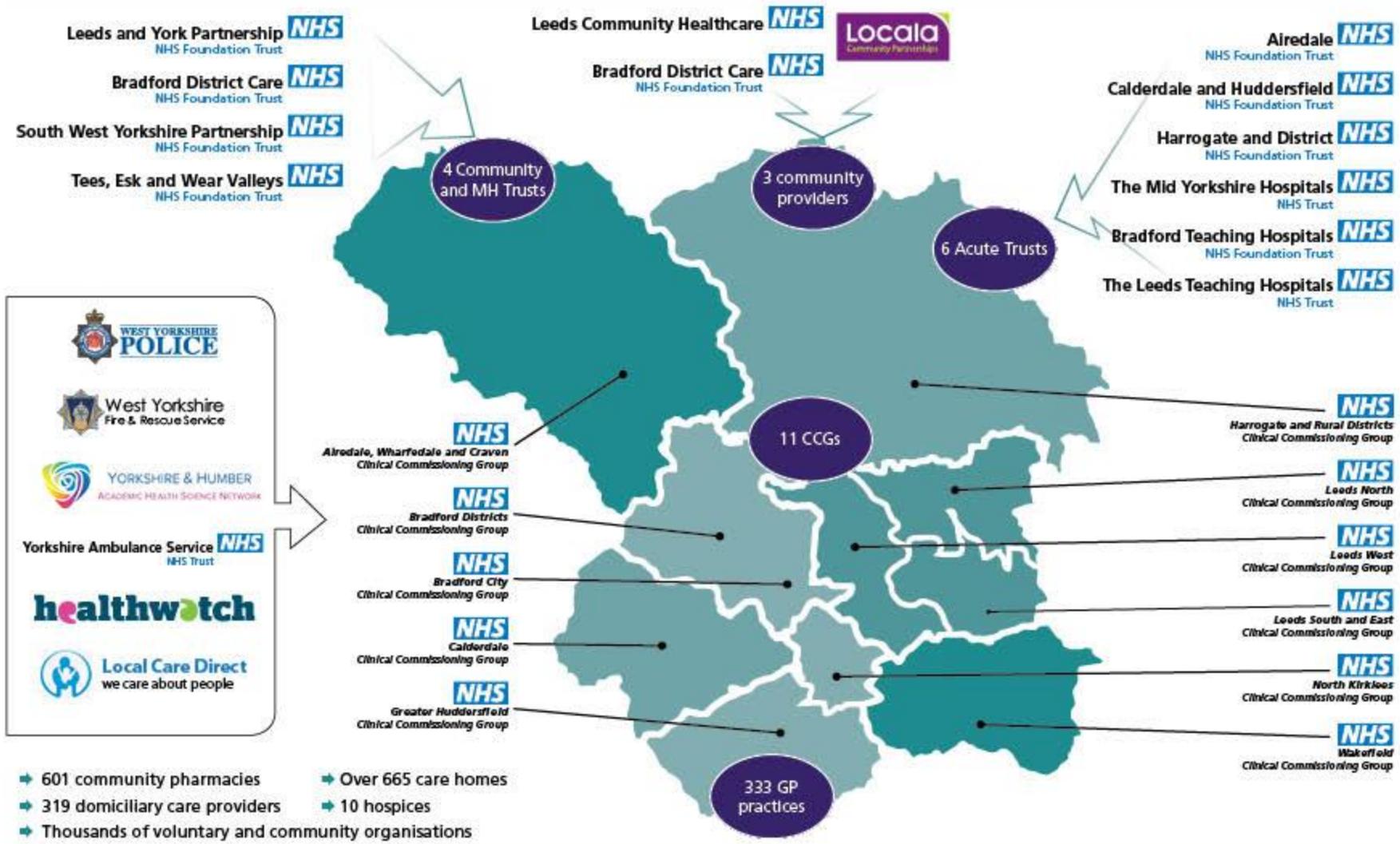
June 2018

# West Yorkshire and Harrogate Health and Care Partnership area

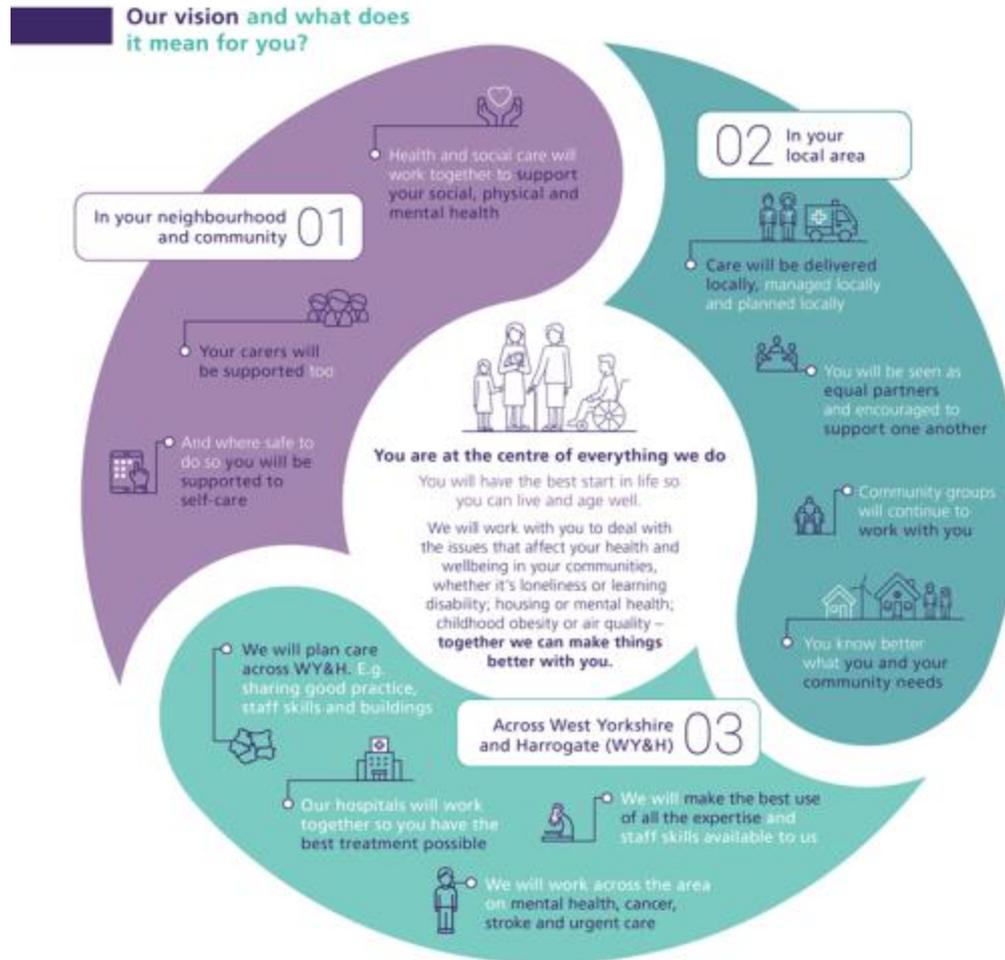
2nd largest in the country in terms of population – 2.6m people, over £5bn of health and care funding.



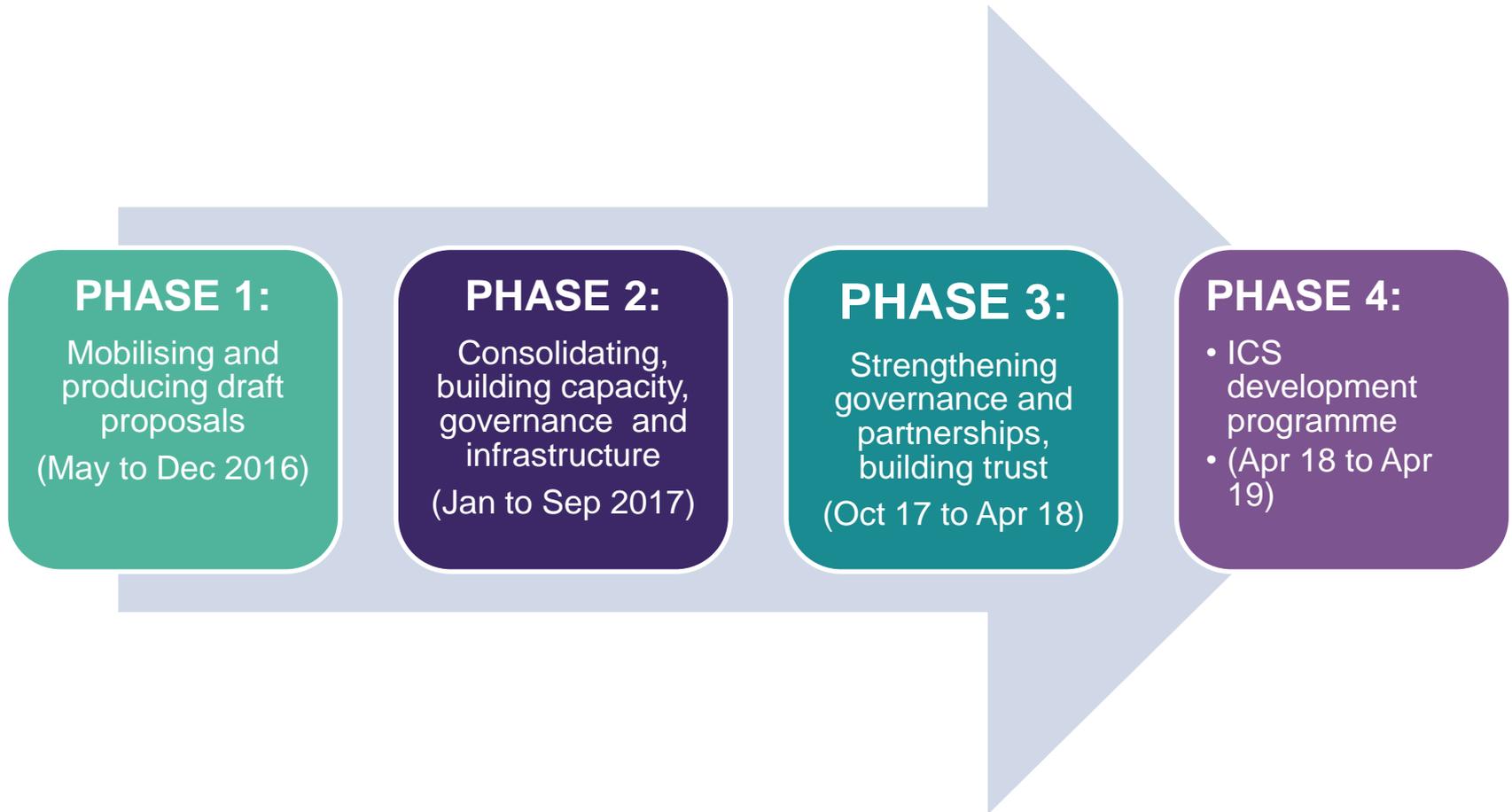
# We are one of the biggest health and care partnerships



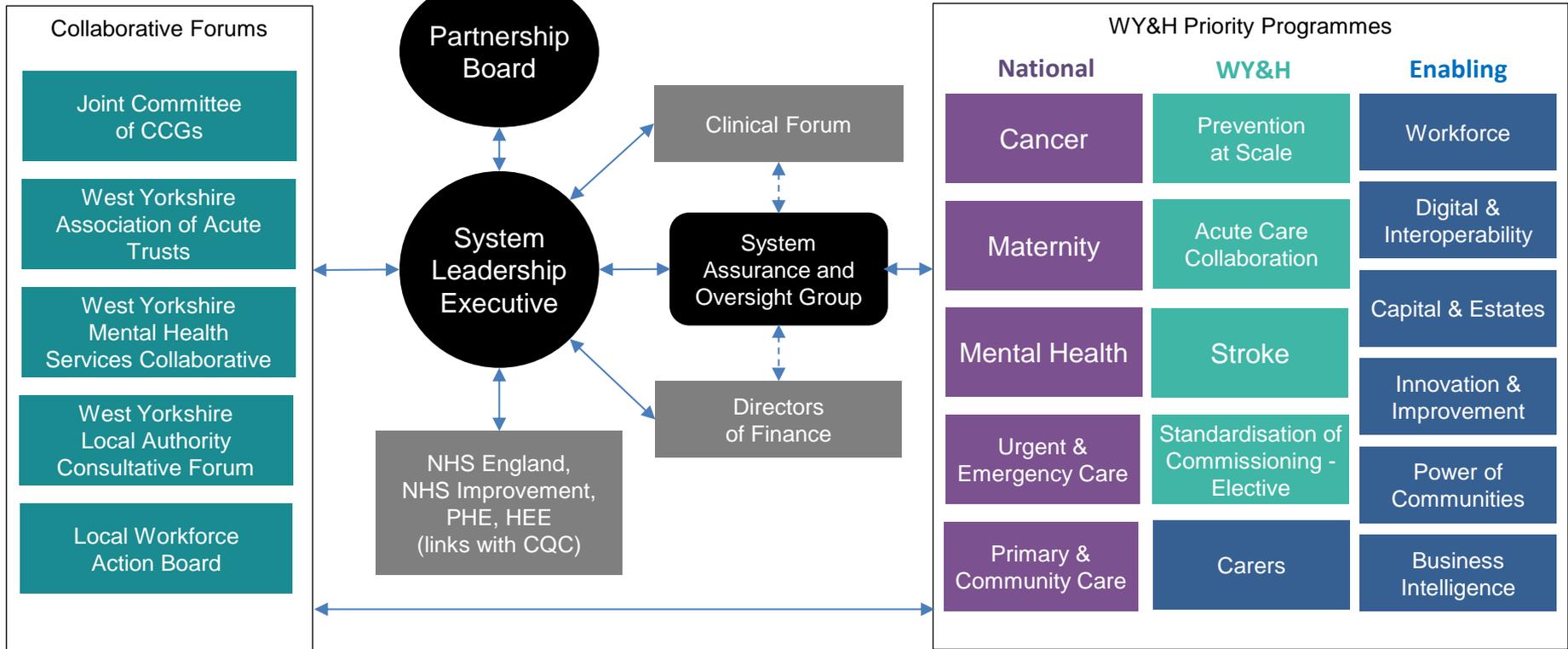
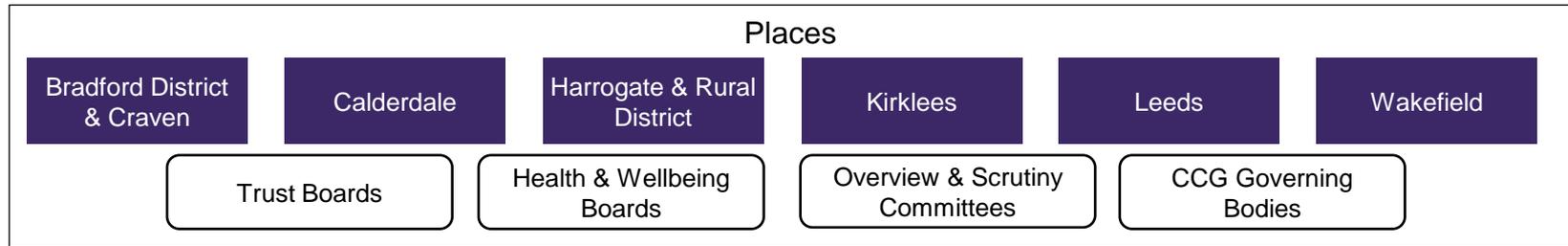
# The work we are doing to realise our vision



# Our partnership is evolving



# We are developing collaborative governance and accountability arrangements **[please note this is draft and work in progress]**



# This includes... developing a memorandum of understanding [MoU]

This has been discussed with:

- WY&H executive group
- Member of the Boards and Governing Bodies of partner organisations
- Health and Wellbeing Boards
- WY&H Joint Overview and Scrutiny Committee.

Feedback from these discussions has directly influenced the development of the final draft, which has now been agreed by the WY&H HCP System Leadership Executive Group.



# Why do we need a MoU?

- In October 2017 the WY&H **Executive Group agreed that a new MoU** should be developed to formalise working arrangements and support for the next stage of our development work
- The MoU **builds on our existing partnership arrangements** to establish more robust mutual accountability
- It is an **agreement** between the WY&H health and care partners
- It sets out the details of our **commitment to work together** in partnership to realise our shared ambitions to improve the health of the 2.6 million people living across the area.



# What will having an MoU offer?

- **Having an MoU will provide a mutual accountability framework** that ensures we have collective ownership of delivery, rather than a hierarchical approach
- It will offer new model for assurance and **accountability with national organisations such as NHS England, NHS Improvement**
- **It will help** assert greater control over performance management and intervention, allocation of transformation funding
- An effective system of risk and reward for a **single NHS financial control total** and the associated arrangements
- A new **commissioning framework**, clarifying what functions will be undertaken at local or WY&H level.



# It will also provide a platform for...

- A **refresh of the governance arrangements for the partnership**, including across WY&H, and the relationship with our local areas [Bradford District and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield]
- **Clinical and managerial leadership** of change in major transformation programmes
- A continued open approach to community engagement in development, delivery and assurance
- **More political ownership** of, and engagement in the agenda, underpinned by regular **opportunities for challenge and scrutiny**
- The **agreement of an effective system of risk management and reward** for NHS bodies.



## &....

- All decisions will continue to be made as locally and as close to people as possible. Having an MoU is predicated on this continuing to be the case.
- Our integrated approach to health and care will continue to support much closer working between our organisations. The MoU will provide a firm foundation for this. It reflects and builds on the current ways of working and agreed principles for the partnership and maintains an ethos of the primacy of our local places.



## Most importantly we are.....

- Working to improve people's health with and for them
- Working to improve people's experience of health and care
- Making every penny in the pound count so we offer best value to the taxpayer
- Making the most of valuable staff, their skills and expertise
- It is our role to help keep people well and make life better for those we serve.



Proud to be part of the local  
partnership and West Yorkshire and  
Harrogate work.

Watch this short [film](#) to find out more



# Further information

- **Local details**
- Visit [www.wyhpartnership.co.uk](http://www.wyhpartnership.co.uk)
- Weekly blog [www.wyhpartnership.co.uk/blog](http://www.wyhpartnership.co.uk/blog)
- 'Our Next Steps' [www.wyhpartnership.co.uk/next-steps](http://www.wyhpartnership.co.uk/next-steps)
- Follow: @wyhpartnership



DRAFT

West Yorkshire and Harrogate  
Health and Care Partnership



# Memorandum of Understanding

DRAFT

August 2018



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## Foreword

Since the creation of West Yorkshire and Harrogate Health and Care Partnership in March 2016, the way we work has been further strengthened by a shared commitment to deliver the best care and outcomes possible for the 2.6 million people living in our area.

Our commitment remains the same and our goal is simple: we want everyone in West Yorkshire and Harrogate to have a great start in life, and the support they need to stay healthy and live longer. We are committed to tackling health inequalities and to improving the lives of the poorest fastest. Our commitment to an NHS free at the point of delivery remains steadfast, and our response to the challenges we face is to strengthen our partnerships.

The proposals set out in our plan are firming up into specific actions, backed by investments. This is being done with the help of our staff and communities, alongside their representatives, including voluntary, community organisations and local councillors. Our bottom-up approach means that this is happening at both a local and WY&H level which puts people, not organisations, at the heart of everything we do.

We have agreed to develop this Memorandum of Understanding to strengthen our joint working arrangements and to support the next stage of development of our Partnership. It builds on our existing collaborative work to establish more robust mutual accountability and break down barriers between our separate organisations.

Our partnership is already making a difference. We have attracted additional funding for people with a learning disability, and for cancer diagnostics, diabetes and a new child and adolescent mental health unit.

However, we know there is a lot more to do. The health and care system is under significant pressure, and we also need to address some significant health challenges. For example we have higher than average obesity levels, and over 200,000 people are at risk of diabetes. There are 3,600 stroke incidents across our area and we have developed a strategic case for change for stroke from prevention to after care and are identifying and treating people at high risk of having a stroke.

We all agree that working more closely together is the only way we can tackle these challenges and achieve our ambitions. This Memorandum demonstrates our clear commitment to do this.

Rob Webster

**West Yorkshire and Harrogate Health and Care Partnership Lead  
CEO South West Yorkshire Partnership NHS FT**



## 1. Parties to the Memorandum

1.1. The members of the West Yorkshire and Harrogate Health and Care Partnership (the **Partnership**), and parties to this Memorandum, are:

### Local Authorities

- City of Bradford Metropolitan District Council
- Calderdale Council
- Craven District Council
- Harrogate Borough Council
- Kirklees Council
- Leeds City Council
- North Yorkshire County Council<sup>1</sup>
- Wakefield Council

### NHS Commissioners

- NHS Airedale, Wharfedale and Craven CCG
- NHS Bradford City CCG
- NHS Bradford Districts CCG
- NHS Calderdale CCG
- NHS Greater Huddersfield CCG
- NHS Harrogate and Rural District CCG
- NHS Leeds CCG
- NHS North Kirklees CCG
- NHS Wakefield CCG
- NHS England

### NHS Service Providers

- Airedale NHS Foundation Trust
- Bradford District Care NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Calderdale and Huddersfield NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Leeds Community Healthcare NHS Trust
- The Leeds Teaching Hospitals NHS Trust
- The Mid Yorkshire Hospitals NHS Trust

- South West Yorkshire Partnership NHS Foundation Trust<sup>1</sup>
- Tees, Esk, and Wear Valleys NHS Foundation Trust<sup>1</sup>
- Yorkshire Ambulance Service NHS Trust<sup>1</sup>

### Health Regulator and Oversight Bodies

- NHS England
- NHS Improvement

### Other National Bodies

- Health Education England
- Public Health England
- Care Quality Commission [TBC]

### Other Partners

- Locala Community Partnerships CIC
- Healthwatch Bradford and District
- Healthwatch Calderdale
- Healthwatch Kirklees
- Healthwatch Leeds
- Healthwatch North Yorkshire
- Healthwatch Wakefield
- Yorkshire and Humber Academic Health Science Network<sup>1</sup>

1.2. As members of the Partnership all of these organisations subscribe to the vision, principles, values and behaviours stated below, and agree to participate in the governance and accountability arrangements set out in this Memorandum.

1.3. Certain aspects of the Memorandum are not relevant to particular types of organisation within the partnership. These are indicated in the table at **Annex 1**.

### Definitions and Interpretation

1.4. This Memorandum is to be interpreted in accordance with the Definitions and Interpretation set out in Schedule 1, unless the context requires otherwise.

### Term

1.5. This Memorandum shall commence on the date of signature of the Partners, and shall continue for an initial period of three (3) years and thereafter subject to an annual review of the arrangements by the [Partnership Board].

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<sup>1</sup> These organisations are also part of neighbouring STPs.

## Local Government role within the partnership

1.6. The West Yorkshire and Harrogate Health and Care Partnership includes eight local government partners. The five Metropolitan Councils in West Yorkshire and North Yorkshire County Council lead on public health, adult social care and children's services, as well as statutory Health Overview and Scrutiny and the local Health and Wellbeing Boards. The Metropolitan Councils, Harrogate Borough Council and Craven District Council lead on housing. Together, they work with the NHS as commissioning and service delivery partners, as well as exercising formal powers to scrutinise NHS policy decisions.

1.7. Within the WY&H partnership the NHS organisations and Councils will work as equal partners, each bringing different contributions, powers and responsibilities to the table.

1.8. Local government's regulatory and statutory arrangements are separate from those of the NHS. Councils are subject to the mutual accountability arrangements for the partnership. However, because of the separate regulatory regime certain aspects of these arrangements will not apply. Most significantly, Councils would not be subject a single NHS financial control total and its associated arrangements for managing financial risk. However, through this Memorandum, Councils agree to align planning, investment and performance improvement with NHS partners where it makes sense to do so. In addition, democratically elected councillors will continue to hold the partner organisations accountable through their formal Scrutiny powers.

## Partners in Local Places

1.9. The NHS and the Councils within the partnership have broadly similar definitions of place. (The rural Craven district is aligned with Bradford for NHS purposes, but is seen as a distinct local government entity in its own right within North Yorkshire.)

1.10. All of the Councils, CCGs, Healthcare Providers and Healthwatch organisations are part of their respective local place-based partnership arrangements. The extent and scope of these arrangements is a matter for local determination, but they typically include elements of shared commissioning, integrated service delivery, aligned or pooled investment and joint decision-making. Other key members of these partnerships include:

- GP Federations
- Specialist community service providers
- Voluntary and community sector organisations and groups
- Housing associations.
- other primary care providers such as community pharmacy, dentists, optometrist
- independent health and care providers including care homes

## 2. Introduction and context

2.1. This Memorandum of Understanding (Memorandum) is an understanding between the West Yorkshire and Harrogate health and care partners. It sets out the details of our commitment to work together in partnership to realise our shared ambitions to improve the health of the 2.6 million people who live in our area, and to improve the quality of their health and care services.

2.2. West Yorkshire and Harrogate Health and Care Partnership began as one of 44 Sustainability and Transformation Partnerships (STPs) formed in 2016, in response to the *NHS Five Year Forward View*. It brings together all health and care organisations in our six places: Bradford District and Craven<sup>2</sup>, Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

2.3. Our partnership is not a new organisation, but a new way of working to meet the diverse needs of our citizens and communities. NHS services have come together with local authorities, charities and community groups to agree how we can improve people's health and improve the quality of their health and care services.

2.4. We published our high level proposals to close the health, care and finance gaps that we face in November 2016. Since then we have made significant progress to build our capacity and infrastructure and establish the governance arrangements and ways of working that will enable us to achieve our aims.

### Purpose

2.5. The purpose of this Memorandum is to formalise and build on these partnership arrangements. It does not seek to introduce a hierarchical model; rather it provides a mutual accountability framework, based on principles of subsidiarity, to ensure we have collective ownership of delivery. It also provides the basis for a refreshed relationship with national oversight bodies.

2.6. The Memorandum is not a legal contract and is not intended to be legally binding and no legal obligations or legal rights shall arise between the Partners from this Memorandum. It is a formal understanding between all of the Partners who have each entered into this Memorandum intending to honour all their obligations under it. It is based on an ethos that the partnership is a servant of the people in West Yorkshire and Harrogate and of its member organisations. It does not replace or override the legal and regulatory frameworks that apply to our statutory NHS organisations and Councils. Instead it sits alongside and complements these frameworks, creating the foundations for closer and more formal collaboration.

2.7. Nothing in this Memorandum is intended to, or shall be deemed to, establish any partnership or joint venture between the Partners to the

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<sup>2</sup> Whilst Craven is organisationally aligned with the NHS in Bradford, it is a distinctive place in its own right, forming part of North Yorkshire.

Memorandum, constitute a Partner as the agent of another, nor authorise any of the Partners to make or enter into any commitments for or on behalf of another Partner.

2.8. The Memorandum should be read in conjunction with the Partnership Plan, published in November 2016, the Next Steps (February 2018) and the six local Place plans across West Yorkshire and Harrogate.

### Developing new collaborative relationships

2.9. Our approach to collaboration begins in each of the 50-60 neighbourhoods which make up West Yorkshire and Harrogate, in which GP practices work together, with community and social care services, to offer integrated health and care services for populations of 30-50,000 people. These integrated neighbourhood services focus on preventing ill health, supporting people to stay well, and providing them with high quality care and treatment when they need it.

2.10. Neighbourhood services sit within each of our six local places (Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield). These places are the primary units for partnerships between NHS services, local authorities, charities and community groups, which work together to agree how to improve people's health and improve the quality of their health and care services.

2.11. The focus for these partnerships is moving increasing away from simply treating ill health to preventing it, and to tackling the wider determinants of health, such as housing, employment, social inclusion and the physical environment.

2.12. These place-based partnerships, overseen by Health and Wellbeing Boards, are key to achieving the ambitious improvements we want to see. However, we have recognised that there also clear benefits in working together across a wider footprint and that local plans need to be complemented with a common vision and shared plan for West Yorkshire and Harrogate as a whole. We apply three tests to determine when to work at this level:

- to achieve a critical mass beyond local population level to achieve the best outcomes;
- to share best practice and reduce variation; and
- to achieve better outcomes for people overall by tackling 'wicked issues' (ie, complex, intractable problems).

2.13. The arrangements described in this Memorandum describe how we will organise ourselves, at West Yorkshire & Harrogate level, to provide the best health and care, ensuring that decisions are always taken in the interest of the patients and populations we serve.

## Promoting Integration and Collaboration

2.14. The Partners acknowledge the statutory and regulatory requirements which apply in relation to competition, patient choice and collaboration. Within the constraints of these requirements we will aim to collaborate, and to seek greater integration of services, whenever it can be demonstrated that it is in the interests of patients and service users to do so.

2.15. The Partners are aware of their competition compliance obligations, both under competition law and, in particular (where applicable) under the NHS Improvement Provider Licence for NHS Partners and shall take all necessary steps to ensure that they do not breach any of their obligations in this regard. Further, the Partners 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 Monitor/NHS Improvement and will keep this position under review accordingly.

2.16. The Partners understand that no decision shall be made to make changes to services in West Yorkshire and Harrogate or the way in which they are delivered without prior consultation where appropriate in accordance with the partners statutory and other obligations.

### 3. How we work together in West Yorkshire and Harrogate

#### Our vision

3.1. We have worked together to develop a shared vision for health and care services across West Yorkshire and Harrogate. All proposals, both as Partner organisations and at a Partnership level should be supportive of the delivery of this vision:

- Places will be healthy - you will have the best start in life, so you can live and age well.
- If you have long term health conditions you will be supported to self-care through GPs and social care services working together. This will include peer support and via technology, such as telemedicine.
- If you have multiple health conditions, there will be a team supporting your physical, social and mental health needs. This will involve you, your family and carers, the NHS, social care and voluntary and community organisations.
- If you need hospital care, it will usually mean going to your local hospital, which works closely with others to give you the best care possible
- Local hospitals will be supported by centres of excellence for services such as cancer and stroke
- All of this will be planned and paid for together, with councils and the NHS working together to remove the barriers created by planning and paying for services separately. For example community and hospital care working together.
- Communities and staff will be involved in the development and design of plans so that everyone truly owns their health care services.

#### Overarching leadership principles for our partnership

3.2. We have agreed a set of guiding principles that shape everything we do through our partnership:

- We will be ambitious for the people we serve and the staff we employ
- The West Yorkshire and Harrogate partnership belongs to its citizens and to commissioners and providers, councils and NHS so we will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on people's health and wellbeing.
- We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict
- We will undertake shared analysis of problems and issues as the basis of taking action
- We will apply subsidiarity principles in all that we do – with work taking

place at the appropriate level and as near to local as possible

### Our shared values and behaviours

3.3. We commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire and Harrogate;
- We support each other and work collaboratively;
- We act with honesty and integrity, and trust each other to do the same;
- We challenge constructively when we need to;
- We assume good intentions; and
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery.

### Partnership objectives

3.4. Our ambitions for improving health outcomes, joining up care locally, and living within our financial means were set out in our STP plan (November 2016, available at: <https://wyhpartnership.co.uk/meetings-and-publications/publications>). This Memorandum reaffirms our shared commitment to achieving these ambitions and to the further commitments made in *Next Steps for the West Yorkshire and Harrogate Health and Care Partnership*, published in February 2018.

3.5. In order to achieve these ambitions we have agreed the following broad objectives for our Partnership:

- i. To make fast and tangible progress in:
  - enhancing urgent and emergency care,
  - strengthening general practice and community services,
  - improving mental health services,
  - improving cancer care,
  - prevention at scale of ill-health,
  - collaboration between acute service providers,
  - improving stroke services, and
  - improving elective care, including standardisation of commissioning policies.
- ii. To enable these transformations by working together to:
  - Secure the right workforce, in the right place, with the right skills, to deliver services at the right time, ensuring the wellbeing of our staff ,

- Engage our communities meaningfully in co-producing services,
  - Use digital technology to drive change, ensure systems are interoperable, and create a 21st Century NHS,
  - Place innovation and best practice at the heart of our collaboration, ensuring that our learning benefits the whole population,
  - Develop and shape the strategic capital and estates plans across West Yorkshire and Harrogate, maximising all possible funding sources and ensuring our plans support the delivery of our clinical strategy, and
  - Ensure that we have the best information, data, and intelligence to inform the decisions that we take.
- iii. To manage our financial resources within a shared financial framework for health across the constituent CCGs and NHS provider organisations; and to maximise the system-wide efficiencies necessary to manage within this share of the NHS budget;
- iv. To operate as an integrated health and care system, and progressively to build the capabilities to manage the health of our population, keeping people healthier for longer and reducing avoidable demand for health and care services;
- v. To act as a leadership cohort, demonstrating what can be achieved with strong system leadership and increased freedoms and flexibilities.

### Delivery improvement

3.6. Delivery and transformation programmes have been established to enable us to achieve the key objectives set out above. Programme Mandates have been developed for each programme and enabling workstream. These confirm:

- The vision for a transformed service
- The specific ambitions for improvement and transformation
- The component projects and workstreams
- The leadership arrangements.

3.7. Each programme has undergone a peer review ‘check and confirm’ process to confirm that it has appropriate rigour and delivery focus.

3.8. As programme arrangements and deliverables evolve over time the mandates will be revised and updated as necessary.

## 4. Partnership Governance

4.1. The Partnership does not replace or override the authority of the Partners' Boards and governing bodies. Each of them remains sovereign and Councils remain directly accountable to their electorates.

4.2. The Partnership provides a mechanism for collaborative action and common decision-making for those issues which are best tackled on a wider scale.

4.3. A schematic of our governance and accountability relationships is provided at **Annex 2** and terms of reference of the Partnership Board, System Leadership Executive and System Oversight and Assurance Group are provided at **Annex 3**.

### Partnership Board

4.4. A Partnership Board will be established to provide the formal leadership for the Partnership. The Partnership Board will be responsible for setting strategic direction. It will provide oversight for all Partnership business, and a forum to make decisions together as Partners on the range of matters highlighted in section 7 of this Memorandum, which neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum.

4.5. The Partnership Board is to be made up of the chairs and chief executives from all NHS organisations, elected member Chairs of Health and Wellbeing Boards, one other elected member, and chief executives from Councils and senior representatives of other relevant Partner organisations. The Partnership Board will have an independent chair and will meet at least four times each year in public.

4.6. The Partnership Board has no formal delegated powers from the organisations in the Partnership. However, over time our expectation is that regulatory functions of the national bodies will increasingly be enacted through collaboration with our leadership. It will work by building agreement with leaders across Partner organisations to drive action around a shared direction of travel.

### System Leadership Executive

4.7. The System Leadership Executive (SLE) Group includes each statutory organisation and representation from other Partner organisations. The group is responsible for overseeing delivery of the strategy of the Partnership, building leadership and collective responsibility for our shared objectives.

4.8. Each organisation will be represented by its chief executive or accountable officer. Members of the SLE will be responsible for nominating an empowered deputy to attend meetings of the group if they are unable to do so personally. Members of the SLE will be expected to recommend that their organisations support agreements and decisions made by SLE (always subject to each Partner's compliance with internal governance and approval procedures).

### System Oversight and Assurance Group

4.9. A new system oversight and assurance group (SOAG) will be established in 2018/19 to provide a mechanism for Partner organisations to take ownership of system performance and delivery and hold one another to account. It will:

- be chaired by the Partnership Lead;
- include representation covering each sector / type of organisation;
- regularly review a dashboard of key performance and transformation metrics; and
- receive updates from WY&H programme boards.

4.10. The SOAG will be supported by the partnership core team.

### West Yorkshire and Harrogate programme governance

4.11. Strong governance and programme management arrangements are built into each of our West Yorkshire and Harrogate priority and enabling programmes (the **Programmes**). Each programme has a Senior Responsible Owner, typically a Chief Executive, accountable officer or other senior leader, and has a structure that builds in clinical and other stakeholder input, representation from each of our six places and each relevant service sector.

4.12. Programmes will provide regular updates to the System Leadership Executive and System Oversight and Assurance Group. These updates will be published on the partnership website.

### Other governance arrangements between Partners

4.13. The Partnership is also underpinned by a series of governance arrangements specific to particular sectors (eg commissioners, acute providers, mental health providers, Councils) that support the way it works. These are described in paragraphs 4.14 to 4.29 below.

### The West Yorkshire and Harrogate Joint Committee of Clinical Commissioning Groups

4.14. The nine CCGs in West Yorkshire and Harrogate are continuing to develop closer working arrangements within each of the six Places that make up our Partnership.

4.15. The CCGs have established a Joint Committee, which has delegated authority to take decisions collectively. The Joint Committee is made up of representatives from each CCG. To make sure that decision making is open and transparent, the Committee has an independent lay chair and two lay members drawn from the CCGs, and meets in public every second month. The Joint Committee is underpinned by a memorandum of understanding and a work plan, which have been agreed by each CCG.

4.16. The Joint Committee is a sub-committee of the CCGs, and each CCG retains its statutory powers and accountability. The Joint Committee's work plan reflects those partnership priorities for which the CCGs believe collective decision making is essential. It only has decision-making responsibilities for the West Yorkshire and Harrogate programmes of work that have been expressly delegated to it by the CCGs.

#### **West Yorkshire Association of Acute Trusts Committee in Common**

4.17. The six acute hospital trusts in West Yorkshire and Harrogate have come together as the [West Yorkshire Association of Acute Trusts](#) (WYAAT). WYAAT believes that the health and care challenges and opportunities facing West Yorkshire and Harrogate cannot be solved through each hospital working alone; they require the hospitals to work together to achieve solutions for the whole of West Yorkshire and Harrogate that improve the quality of care, increase the health of people and deliver more efficient services.

4.18. WYAAT is governed by a memorandum of understanding which defines the objectives and principles for collaboration, together with governance, decision making and dispute resolution processes. The memorandum of understanding establishes the WYAAT Committee in Common, which is made up of the Chairs and Chief Executives of the six trusts, and provides the forum for working together and making decisions in a common forum. Decisions taken by the Committee in Common are then formally approved by each Trust Board individually in accordance with their own internal procedures.

#### **West Yorkshire Mental Health Services Collaborative**

4.19. The four trusts providing mental health services in West Yorkshire (Bradford District Care Foundation Trust, Leeds Community Healthcare NHS Trust, Leeds and York Partnership Foundation Trust and South West Yorkshire Partnership Foundation Trust) have come together to form the West Yorkshire Mental Health Services Collaborative (WYMHSC). The trusts will work together to share best practice and develop standard operating models and pathways to achieve better outcomes for people in West Yorkshire and ensure sustainable services into the future.

4.20. The WYMHSC is underpinned by a memorandum of understanding and shared governance in the form of 'committees in common'.

4.21. Tees, Esk and Wear Valleys NHS Foundation Trust provides mental health services to the Harrogate area.

#### **Local council leadership**

4.22. Relationships between local councils and NHS organisations are well established in each of the six places and continue to be strengthened. Complementary arrangements for the whole of West Yorkshire and Harrogate have also been established:

- Local authority chief executives meet and mandate one of them to lead on

health and care partnership;

- Health and Wellbeing Board chairs meet;
- A Joint Health Overview and Scrutiny Committee
- West Yorkshire Combined Authority
- North Yorkshire and York Leaders and Chief Executives

## **Clinical Forum**

4.23. Clinical leadership is central to all of the work we do. Clinical leadership is built into each of our work programmes, and our Clinical Forum provides formal clinical advice to all of our programmes.

4.24. The purpose of the Clinical Forum is to be the primary forum for clinical leadership, advice and challenge for the work of the partnership in meeting the Triple Aim: improving health and wellbeing; improving care and the quality of services; and ensuring that services are financially sustainable.

4.25. The Clinical Forum ensures that the voice of clinicians, from across the range of clinical professions and partner organisations, drives the development of new clinical models and proposals for the transformation of services. It also takes an overview of system performance on quality.

4.26. The Clinical Forum has agreed Terms of Reference which describe its scope, function and ways of working.

## **Local Place Based Partnerships**

4.27. Local partnerships arrangements for the Places bring together the Councils, voluntary and community groups, and NHS commissioners and providers in each Place, including GPs and other primary care providers, to take responsibility for the cost and quality of care for the whole population. Each of the six Places in West Yorkshire and Harrogate has developed its own arrangements to deliver the ambitions set out in its own Place Plan.

4.28. These new ways of working reflect local priorities and relationships, but all provide a greater focus on population health management, integration between providers of services around the individual's needs, and a focus on care provided in primary and community settings.

4.29. There are seven local health and care partnerships (two in Bradford District and Craven and one in each other place) which will develop horizontally integrated networks to support seamless care for patients.

## 5. Mutual accountability framework

5.1. A single consistent approach for assurance and accountability between Partners on West Yorkshire and Harrogate system wide matters will be applied through the governance structures and processes outlined in Paragraphs 4.1 to 4.12 above.

### Current statutory requirements

5.2. NHS England has a duty under the NHS Act 2006 (as amended by the 2012 Act) to assess the performance of each CCG each year. The assessment must consider, in particular, the duties of CCGs to: improve the quality of services; reduce health inequalities; obtain appropriate advice; involve and consult the public; and comply with financial duties. The 2012 Act provides powers for NHS England to intervene where it is not assured that the CCG is meeting its statutory duties.

5.3. NHS Improvement is the operational name for an organisation that brings together Monitor and the NHS Trust Development Authority (NHS TDA). NHS Improvement must ensure the continuing operation of a licensing regime. The NHS provider licence forms the legal basis for Monitor's oversight of NHS foundation trusts. While NHS trusts are exempt from the requirement to apply for and hold the licence, directions from the Secretary of State require NHS TDA to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate. This includes giving directions to an NHS trust where necessary to ensure compliance.

### A new model of mutual accountability

5.4. Through this Memorandum the Partners agree to take a collaborative approach to, and collective responsibility for, managing collective performance, resources and the totality of population health. The partners will:

- Agree ambitious outcomes, common datasets and dashboards for system improvement and transformation management;
- work through our formal collaborative groups for decision making, engaging people and communities across WY&H; and
- identify good practice and innovation in individual places and organisations and ensure it is spread and adopted through the Programmes.

5.5. The Partnership approach to system oversight will be geared towards performance improvement and development rather than traditional performance management. It will be data-driven, evidence-based and rigorous. The focus will be on improvement, supporting the spread and adoption of innovation and best practice between Partners.

5.6. Peer review will be a core component of the improvement methodology. This will provide valuable insight for all Partners and support the identification and adoption of good practice across the Partnership.

5.7. System oversight will be undertaken through the application of a continuous improvement cycle, including the following elements:

- Monitoring performance against key standards and plans in each place;
- Ongoing dialogue on delivery and progress;
- Identifying the need for support through a clinically and publically-led process of peer review;
- Agreeing the need for more formal action or intervention on behalf of the partnership; and
- Application of regulatory powers or functions.

5.8. The Programmes will, where appropriate, take on increasing responsibility for managing this process. The extent of this responsibility will be agreed between each Programme and the SLE.

5.9. A number of Partners have their own improvement capacity and expertise. Subject to the agreement of the relevant Partners this resource will be managed by the Partner in a co-ordinated approach for the benefit of the overall Partnership, and used together with the improvement expertise provided by national bodies and programmes.

### Taking action

5.10. The SOAG will prioritise the deployment of improvement support across the Partnership, and agree recommendations for more formal action and interventions. Actions allocated to the SOAG are to make recommendations on:

- agreement of improvement or recovery plans;
- more detailed peer-review of specific plans;
- commissioning expert external review;
- the appointment of a turnaround Director / team; and
- restrictions on access to discretionary funding and financial incentives.

5.11. For Places where financial performance is not consistent with plan, the Partnership Directors of Finance Group will make recommendations to the SOAG on a range of interventions, including any requirement for:

- financial recovery plans;
- more detailed peer-review of financial recovery plans;
- external review of financial governance and financial management;
- organisational improvement plans;
- the appointment of a turnaround Director / team;

- enhanced controls around deployment of transformation funding held at place; and
- reduced priority for place-based capital bids.

### **The role of Places in accountability**

5.12. This Memorandum has no direct impact on the roles and respective responsibilities of the Partners (including the Councils, Trust Boards and CCG governing bodies) which all retain their full statutory duties and powers.

5.13. Health and Wellbeing Boards (HWB) have a statutory role in each upper tier local authority area as the vehicle for joint local system leadership for health and care and this is not revised by the Partnership. HWB bring together key leaders from the local Place health and care system to improve the health and wellbeing of their population and reduce health inequalities through:

- developing a shared understanding of the health and wellbeing needs of their communities;
- providing system leadership to secure collaboration to meet these needs more effectively;
- having a strategic influence over commissioning decisions across health, public health and social care;
- involving councillors and patient representatives in commissioning decisions.

5.14. In each Place the statutory bodies come together in local health and care partnerships to agree and implement plans across the Place to:

- Integrate mental health, physical health and care services around the individual
- Manage population health
- Develop increasingly integrated approaches to joint planning and budgeting

### **Implementation of agreed strategic actions**

5.15. Mutual accountability arrangements will include a focus on delivery of key actions that have been agreed across the Partnership and agreement on areas where Places require support from the wider Partnership to ensure the effective management of financial and delivery risk.

## National NHS Bodies oversight and escalation

5.16. As part of the development of the Partnership and the collaborative working between the Partners under the terms of this Memorandum, NHS England and NHS Improvement will look to adopt a new relationship with the Partners (which are NHS Bodies) in West Yorkshire and Harrogate in the form of enacting streamlined oversight arrangements under which:

- Partners will take the collective lead on oversight of trusts and CCGs and Places in accordance with the terms of this Memorandum;
- NHS England and NHS Improvement will in turn focus on holding the NHS bodies in the Partnership to account as a whole system for delivery of the NHS Constitution and Mandate, financial and operational control, and quality (to the extent permitted at Law);
- NHS England and NHS Improvement intend that they will intervene in the individual trust and CCG Partners only where it is necessary or required for the delivery of their statutory functions and will (where it is reasonable to do so, having regard to the nature of the issue) in the first instance look to notify the SLE and work through the Partnership to seek a resolution prior to making an intervention with the Partner.

## 6. Decision-Making and Resolving Disagreements

6.1. Our approach to making Partnership decisions and resolving any disagreements will follow the principle of subsidiarity and will be in line with our shared Values and Behaviours. We will take all reasonable steps to reach a mutually acceptable resolution to any dispute.

### Collective Decisions

6.2. There will be three levels of decision making:

- **Decisions made by individual organisations** - this Memorandum does not affect the individual sovereignty of Partners or their statutory decision-making responsibilities.
- **Decisions delegated to collaborative forums** - some partners have delegated specific decisions to a collaborative forum, for example the CCGs have delegated certain commissioning decisions to the Joint Committee of CCGs. Arrangements for resolving disputes in such cases are set out in the Memorandum of the respective Joint Committee and not this Memorandum. There are also a specific dispute resolution mechanisms for WYATT and the WYMHC.
- **Whole Partnership decisions** - the Partners will make decisions on a range of matters in the Partnership which will neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum, as set out in Paragraphs 6.3 below.

6.3. Collaborative decisions on Partnership matters will be considered by the Partnership Board. The Partnership Board has no formal powers delegated by any Partner. However, it will increasingly take on responsibility for co-ordinating decisions relating to regulatory and oversight functions currently exercised from outside the WY&H system and will look to reach recommendations and any decisions on a Best for WY&H basis. The terms of reference for the Partnership Board will set out clearly the types of decision which it will have responsibility to discuss and how conflicts of interest will be managed. The Partnership Board will initially have responsibility for decisions relating to:

- The objectives of priority HCP work programmes and workstreams
- The apportionment of transformation monies from national bodies
- Priorities for capital investment across the Partnership.
- Operation of the single NHS financial control total (for NHS Bodies)
- Agreeing common actions when Places or Partners become distressed

6.4. SLE will make recommendations to the Partnership Board on these matters. Where appropriate, the Partnership Board will make decisions of the Partners by consensus of those eligible Partnership Board members present at a quorate meeting. If a consensus decision cannot be reached, then (save for decisions on allocation of capital investment and transformation funding) it may

be referred to the dispute resolution procedure under Paragraph 6.6 below by any of the affected Partners for resolution.

6.5. In respect of referring priorities for capital investment or apportionment of transformation funding from the Partnership, if a consensus cannot be reached at the SLE meeting to agree this then the Partnership Board may make a decision provided that it is supported by not less than 75% of the eligible Partnership Board members. Partnership Board members will be eligible to participate on issues which apply to their organisation, in line with the scope of applicable issues set out in Annex 1.

### Dispute resolution

6.6. Partners will attempt to resolve in good faith any dispute between them in respect of Partnership Board (or other Partnership-related) decisions, in line with the Principles, Values and Behaviours set out in this Memorandum.

6.7. Where necessary, Place or sector-based arrangements (the Joint Committee of CCGs, WYAAT, and WYMHSC as appropriate) will be used to resolve any disputes which cannot be dealt with directly between individual Partners, or which relate to existing schemes of delegation.

6.8. The Partnership will apply a dispute resolution framework to resolve any issues which cannot otherwise be agreed through these arrangements.

6.9. As decisions made by the Partnership do not impact on the statutory responsibilities of individual organisations, Partners will be expected to apply shared Values and Behaviours and come to a mutual agreement through the dispute resolution process.

6.10. The key stages of the dispute resolution process are

- i. The SOAG will seek to resolve the dispute to the mutual satisfaction of each of the affected parties. If SOAG cannot resolve the dispute within 30 days, the dispute should be referred to SLE.
- ii. SLE will come to a majority decision (i.e. a majority of eligible Partners participating in the meeting who are not affected by the matter in dispute determined by the scope of applicable issues set out in Annex 1) on how best to resolve the dispute based, applying the Principles, Values and Behaviours of this Memorandum, taking account of the Objectives of the Partnership. SLE will advise the Partners of its decision in writing.
- iii. If the parties do not accept the SLE decision, or SLE cannot come to a decision which resolves the dispute, it will be referred to an independent facilitator selected by SLE. The facilitator will work with the Partners to resolve the dispute in accordance with the terms of this Memorandum.
- iv. In the unlikely event that the independent facilitator cannot resolve the dispute, it will be referred to the Partnership Board. The Partnership Board will come to a majority decision on how best to resolve the dispute in accordance with the terms of this Memorandum and advise the parties of its decision.

## 7. Financial Framework

7.1. All NHS body Partners, in West Yorkshire and Harrogate are ready to work together, manage risk together, and support each other when required. The Partners are committed to working individually and in collaboration with others to deliver the changes required to achieve financial sustainability and live within our resources.

7.2. A set of financial principles have been agreed, within the context of the broader guiding Principles for our Partnership. They confirm that we will:

- aim to live within our means, i.e. the resources that we have available to provide services;
- develop a West Yorkshire and Harrogate system response to the financial challenges we face; and
- develop payment and risk share models that support a system response rather than work against it.

7.3. We will collectively manage our NHS resources so that all Partner organisations will work individually and in collaboration with others to deliver the changes required to deliver financial sustainability.

### Living within our means and management of risk

7.4. Through this Memorandum the collective NHS Partner leaders in each Place commit to demonstrate robust financial risk management. This will include agreeing action plans that will be mobilised across the Place in the event of the emergence of financial risk outside plans. This might include establishing a Place risk reserve where this is appropriate and in line with the legal obligations of the respective NHS body Partners involved.

7.5. Subject to compliance with confidentiality and legal requirements around competition sensitive information and information security the Partners agree to adopt an open-book approach to financial plans and risks in each Place leading to the agreement of fully aligned operational plans. Aligned plans will be underpinned by common financial planning assumptions on income and expenditure between providers and commissioners, and on issues that have a material impact on the availability of system financial incentives

### NHS Contracting principles

7.6. The NHS Partners are committed to considering the adoption of payment models which are better suited to whole system collaborative working (such as Aligned Incentive Contracting). The Partners will look to adopt models which reduce financial volatility and provide greater certainty for all Partners at the beginning of each year of the planned income and costs.

### Allocation of Transformation Funds

7.7. The Partners intend that any transformation funds made available to the Partnership will all be used within the Places. Funds will be allocated through collective decision-making by the Partnership in line with agreed priorities. The method of allocation may vary according to agreed priorities. However, funds will not be allocated through expensive and protracted bidding and prioritisation processes and will be deployed in those areas where the Partners have agreed that they will deliver the maximum leverage for change and address financial risk.

7.8. The funding provided to Places (based on weighted population) will directly support Place-based transformation programmes. This will be managed by each Place with clear and transparent governance arrangements that provide assurance to all Partners that the resource has been deployed to deliver maximum transformational impact, to address financial risk, and to meet the efficiency requirements. Funding will be provided subject to agreement of clear deliverables and outcomes by the relevant Partners in the Place through the mutual accountability arrangements of the SLE and SOAG and be subject to ongoing monitoring and assurance from the Partnership.

7.9. Funding provided to the Programmes (all of which will also be deployed in Place) will be determined in agreement with Partners through the SLE, subject to documenting the agreed deliverables and outcomes with the relevant Partners.

### Allocation of ICS capital

7.10. The Partnership will play an increasingly important role in prioritising capital spending by the national bodies over and above that which is generated from organisations' internal resources. In doing this, the Partnership will ensure that:

- the capital prioritisation process is fair and transparent;
- there is a sufficient balance across capital priorities specific to Place as well as those which cross Places;
- there is sufficient focus on backlog maintenance and equipment replacement in the overall approach to capital;
- the prioritisation of major capital schemes must have a clear and demonstrable link to affordability and improvement of the financial position;
- access to discretionary capital is linked to the mutual accountability framework as described in this Memorandum.

### Allocation of Provider and Commissioner Incentive Funding

7.11. The approach to managing performance-related incentive funds set by NHS planning guidance and business rules (e.g. the 2018/19 Provider Sustainability Fund and Commissioner Sustainability Fund) is not part of this Memorandum. A common approach to this will be agreed by the Partnership as part of annual financial planning.

## 8. National and regional support

8.1. To support Partnership development as an Integrated Care System there will be a process of aligning resources from ALBs to support delivery and establish an integrated single assurance and regulation approach.

8.2. National capability and capacity will be available to support WY&H from central teams including governance, finance and efficiency, regulation and competition, systems and national programme teams, primary care, urgent care, cancer, mental health, including external support.

## 9. Variations

9.1. This Memorandum, including the Schedules, may only be varied by written agreement of all the Partners.

## 10. Charges and liabilities

10.1. Except as otherwise provided, the Partners shall each bear their own costs and expenses incurred in complying with their obligations under this Memorandum.

10.2. By separate agreement, the Parties may agree to share specific costs and expenses (or equivalent) arising in respect of the Partnership between them in accordance with a "Contributions Schedule" to be developed by the Partnership and approved by the Partnership Board.

10.3. Partners shall remain liable for any losses or liabilities incurred due to their own or their employee's actions.

## 11. Information Sharing

11.1. The Partners will provide to each other all information that is reasonably required in order to achieve the Objectives and take decisions on a Best for WY&H basis.

11.2. The Partners have obligations to comply with competition law. The Partners will therefore make sure that they share information, and in particular competition sensitive information, in such a way that is compliant with competition and data protection law.

## 12. Confidential Information

12.1. Each Partner shall keep in strict confidence all Confidential Information it receives from another Partner except to the extent that such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised

disclosure by a Partner. Each Partner shall use any Confidential Information received from another Partner solely for the purpose of complying with its obligations under this Memorandum in accordance with the Principles and Objectives and for no other purpose. No Partner shall use any Confidential Information received under this Memorandum for any other purpose including use for their own commercial gain in services outside of the Partnership or to inform any competitive bid without the express written permission of the disclosing Partner.

12.2. To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Partner or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Partner may have in respect of such Confidential Information.

12.3. The Parties agree to procure, as far as is reasonably practicable, that the terms of this Paragraph (Confidential Information) are observed by any of their respective successors, assigns or transferees of respective businesses or interests or any part thereof as if they had been party to this Memorandum.

12.4. Nothing in this Paragraph will affect any of the Partners' regulatory or statutory obligations, including but not limited to competition law.

### 13. Additional Partners

13.1. If appropriate to achieve the Objectives, the Partners may agree to include additional partner(s) to the Partnership. If they agree on such a course the Partners will cooperate to enter into the necessary documentation and revisions to this Memorandum if required.

13.2. The Partners intend that any organisation who is to be a partner to this Memorandum (including themselves) shall commit to the Principles and the Objectives and ownership of the system success/failure as set out in this Memorandum.

### 14. Signatures

14.1. This Memorandum may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Memorandum, but all the counterparts shall together constitute the same document.

14.2. The expression "counterpart" shall include any executed copy of this Memorandum transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

14.3. No counterpart shall be effective until each Partner has executed at least one counterpart.

[INSERT SIGNATURE PAGES AFTER THIS]

## Schedule 1 - Definitions and Interpretation

1. The headings in this Memorandum will not affect its interpretation.
2. Reference to any statute or statutory provision, to Law, or to Guidance, includes a reference to that statute or statutory provision, Law or Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced.
3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.
4. References to Annexes and Schedules are to the Annexes and Schedules of this Memorandum, unless expressly stated otherwise.
5. References to any body, organisation or office include reference to its applicable successor from time to time.

### Glossary of terms and acronyms

6. The following words and phrases have the following meanings in this Memorandum:

<b>ALB</b>	Arm’s Length Body A Non-Departmental Public Body or Executive Agency of the Department of Health and Social Care, eg NHSE, NHSI, HEE, PHE
<b>Aligned Incentive Contract</b>	A contracting and payment method which can be used as an alternative to the Payment by Results system in the NHS
<b>Best for WY&amp;H</b>	A focus in each case on making a decision based on the best interests and outcomes for service users and the population of West Yorkshire and Harrogate
<b>CCG</b>	Clinical Commissioning Group
<b>CEO</b>	Chief Executive Officer
<b>Committee in Common</b>	
<b>Confidential Information</b>	All information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Memorandum
<b>CQC</b>	Care Quality Commission, the independent regulator of all health and social care services in England

<b>GP</b>	General Practice (or practitioner)
<b>HCP</b>	Health and Care Partnership
<b>Healthcare Providers</b>	The Partners identified as Healthcare Providers under Paragraph 1.1
<b>HEE</b>	Health Education England
<b>Healthwatch</b>	Independent organisations in each local authority area who listen to public and patient views and share them with those with the power to make local services better.
<b>HWB</b>	Health and Wellbeing Board
<b>ICP</b>	Integrated Care Partnership The health and care partnerships formed in each of the
<b>ICS</b>	Integrated Care System
<b>JCCCG</b>	Joint Committee of Clinical Commissioning Groups - a formal committee where two or more CCGs come together to form a joint decision making forum. It has delegated commissioning functions.
<b>Law</b>	any applicable statute or proclamation or any delegated or subordinate legislation or regulation; any enforceable EU right within the meaning of section 2(1) European Communities Act 1972; any applicable judgment of a relevant court of law which is a binding precedent in England; National Standards (as defined in the NHS Standard Contract); and any applicable code and “Laws” shall be construed accordingly
<b>LWAB</b>	Local Workforce Action Board sub regional group within Health Education England
<b>Memorandum</b>	This Memorandum of Understanding
<b>Neighbourhood</b>	One of c.50 geographical areas which make up West Yorkshire and Harrogate, in which GP practices work together, with community and social care services, to offer integrated health and care services for populations of 30-50,000 people.
<b>NHS</b>	National Health Service
<b>NHSE</b>	NHS England Formally the NHS Commissioning Board
<b>NHS FT</b>	NHS Foundation Trust - a semi-autonomous organisational unit within the NHS

<b>NHSI</b>	NHS Improvement - The operational name for an organisation that brings together Monitor, the NHS Trust Development Authority and other functions
<b>Objectives</b>	The Objectives set out in Paragraph 3.5
<b>Partners</b>	The members of the Partnership under this Memorandum as set out in Paragraph 1.1 who shall not be legally in partnership with each other in accordance with Paragraph 2.7.
<b>Partnership</b>	The collaboration of the Partners under this Memorandum which is not intended to, or shall be deemed to, establish any legal partnership or joint venture between the Partners to the Memorandum
<b>Partnership Board</b>	The senior governance group for the Partnership set up in accordance with Paragraphs 4.4 to 4.6
<b>Partnership Core Team</b>	The team of officers, led by the Partnership Director, which manages and co-ordinates the business and functions of the Partnership
<b>PHE</b>	Public Health England - An executive agency of the Department of Health and Social Care which exists to protect and improve the nation's health and wellbeing, and reduce health inequalities
<b>Places</b>	One of the six geographical districts that make up West Yorkshire and Harrogate, being Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield, and "Place" shall be construed accordingly
<b>Principles</b>	The principles for the Partnership as set out in Paragraph 3.2
<b>Programmes</b>	The WY&H programme of work established to achieve each of the objectives set out in paras 4.2,i and 4.2,ii of this memorandum
<b>SOAG</b>	System Oversight and Assurance Group
<b>STP</b>	Sustainability and Transformation Partnership (or Plan) The NHS and local councils have come together in 44 areas covering all of England to develop proposals and make improvements to health and care
<b>System Leadership Executive or SLE</b>	The governance group for the Partnership set out in Paragraphs 4.7 and 4.8

<b>Transformation Funds</b>	Discretionary, non-recurrent funding made available by NHSE to support the achievement of service improvement and transformation priorities
<b>Values and Behaviours</b>	shall have the meaning set out in Paragraph 3.3 above
<b>WY&amp;H</b>	West Yorkshire and Harrogate
<b>WYAAT</b>	West Yorkshire Association of Acute Trusts
<b>WYMHC</b>	West Yorkshire Mental Health Collaborative

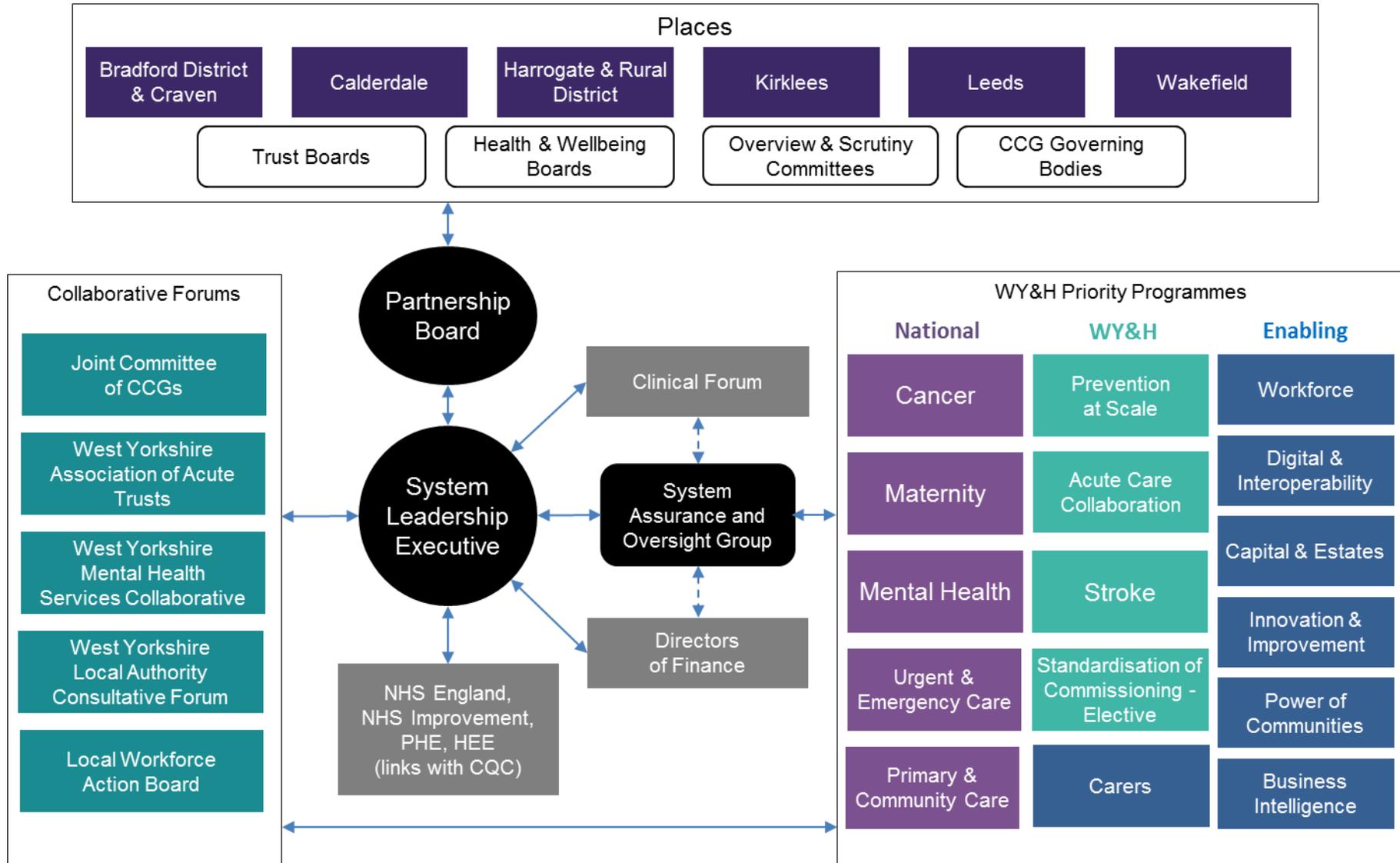
## Annex 1 – Applicability of Memorandum Elements

	CCGs	NHS Providers <sup>3</sup>	Councils	NHSE and NHI	Healthwatch	Other partners
Vision, principles, values and behaviour	✓	✓	✓	✓	✓	✓
Partnership objectives	✓	✓	✓	✓	✓	✓
Governance	✓	✓	✓	✓	✓	✓
Decision-making and dispute resolution	✓	✓	✓	✓	✓	✓
Mutual accountability	✓	✓	✓	✓		
Financial framework – financial risk management	✓	✓		✓		
Financial framework – Allocation of capital and transformation funds	✓	✓	✓	✓		
National and regional support	✓	✓	✓	✓		

<sup>3</sup> All elements of the financial framework for WY&H, eg the application of a single NHS control total, will not apply to all NHS provider organisations, particularly those which span a number of STPs.

Locala Community Partnerships CIC is a significant provider of NHS services. It is categorised as an 'Other Partner' because of its corporate status and the fact that it cannot be bound by elements of the financial and mutual accountability frameworks. This status will be reviewed as the partnership continues to evolve.

## Annex 2 – Schematic of Governance and Accountability Arrangements



## **Annex 3 - Terms of Reference**

**Part 1: Partnership Board**

**Part 2: System Leadership Executive**

**Part 3: System Oversight and Assurance Group**

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West Yorkshire and Harrogate  
Health and Care Partnership



# Partnership Board Terms of Reference

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June 2018

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## 1. Introduction and context

- 1.1. West Yorkshire and Harrogate Health and Care Partnership was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs), in response to the *NHS Five Year Forward View*. It brings together all health and care organisations in our six places: Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield.
- 1.2. The Partnership is not a new organisation, but a new way of working to meet the diverse needs of our citizens and communities. NHS services have come together with local authorities, charities and community groups to agree how we can improve people's health and improve the quality of their health and care services.
- 1.3. The Partnership Board is a key element of the leadership and governance arrangements for the West Yorkshire and Harrogate Health and Care Partnership.

### Purpose

- 1.4. The Partnership Board will provide the formal leadership for the Partnership. It will be responsible for setting strategic direction. It will provide oversight for all Partnership business, and a forum to make decisions together as Partners on the matters highlighted in the Partnership Memorandum of Understanding, which neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum.
- 1.5. The Partnership Board has no formal delegated powers from the organisations in the Partnership. However, over time the regulatory and oversight functions of the NHS national bodies will increasingly be enacted through collaboration with our leadership.
- 1.6. The Partnership Board will work by building agreement with leaders across Partner organisations to drive action around a shared direction of travel.
- 1.7. These Terms of Reference describe the scope, function and ways of working for the Partnership Board. They should be read in conjunction with the Memorandum of Understanding for the West Yorkshire and Harrogate Health and Care Partnership, which describes the wider governance and accountability arrangements.

## 2. How we work together in West Yorkshire and Harrogate

### Our vision

- 2.1. We have worked together to develop a shared vision for health and care services across West Yorkshire and Harrogate. All of our plans support the realisation of this vision:
- Places will be healthy - you will have the best start in life, so you can live and age well.
  - If you have long term health conditions you will be supported to self-care through GPs and social care services working together. This will include peer support and via technology, such as telemedicine.
  - If you have multiple health conditions, there will be a team supporting your physical, social and mental health needs. This will involve you, your family and carers, the NHS, social care and voluntary and community organisations.
  - If you need hospital care, it will usually mean going to your local hospital, which works closely with others to give you the best care possible
  - Local hospitals will be supported by centres of excellence for services such as cancer, stroke, and mental health.
  - All of this will be planned and paid for together, with councils and the NHS working together to remove the barriers created by planning and paying for services separately. For example community and hospital care working together.
  - Communities and staff will be involved in the development and design of plans so that everyone truly owns their health care services.

### Principles for our Partnership

- 2.2. The Partnership Board operates within an agreed set of guiding principles that shape everything we do through our Partnership:
- We will be ambitious for the people we serve and the staff we employ
  - The West Yorkshire and Harrogate Partnership belongs to its citizens and to commissioners and providers, councils and NHS
  - We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict
  - We will undertake shared analysis of problems and issues as the basis of taking action
  - We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible
  - We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on people's health and wellbeing.

## Our shared values and behaviour

2.3. Members of the Partnership Board commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire and Harrogate
- We support each other and work collaboratively
- We act with honesty and integrity, and trust each other to do the same
- We challenge constructively when we need to
- We assume good intentions.
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery

## 3. Role and Responsibilities

3.1. The Partnership Board will provide the formal leadership for the Partnership. It will be responsible for setting strategic direction and providing strategic oversight for all Partnership business. It will make joint decisions on a range of matters which do not impact on the statutory responsibilities of individual organisations and have not been delegated formally to a collaborative forum. Its responsibilities are to:

- i. agree the broad objectives for the Partnership;
- ii. consider recommendations from the System Leadership Executive Group and make decisions on :
  - The objectives of priority Partnership work programmes and workstreams
  - The apportionment of transformation monies from national bodies
  - Priorities for capital investment across the Partnership
  - Operation of the single NHS financial control total (for NHS bodies)
  - Common actions when systems become distressed
- iii. act as a leadership cohort, demonstrating what can be achieved with strong system leadership and increased freedoms and flexibilities;
- iv. provide a mechanism for joint action and joint decision-making for those issues which are best tackled on a wider scale;
- v. oversee financial resources of NHS partners within a shared financial control total for health across the constituent CCGs and NHS provider organisations; and maximise the system-wide efficiencies necessary to manage within this share of the NHS budget;
- vi. support the development of local partnership arrangements which bring

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together the Councils, voluntary and community groups, and NHS commissioners and providers in each Place;

- vii. ensure that, through partnership working in each place and across WY&H, there is a greater focus on population health management, integration between providers of services around the individual's needs, and a focus on care provided in primary and community settings;
- viii. oversee a mutual accountability framework which provides a single, consistent approach for assurance and accountability between partners;
- ix. reach agreement in relation to recommendations made by other governance groups within the Partnership on the need to take action in relation to managing collective performance, resources and the totality of population health;
- x. adopt an approach to making joint decisions and resolving any disagreements which follows the principle of subsidiarity and is in line with the shared values and behaviours of the partnership;

## 4. Membership

4.1. The membership will comprise:

- An independent, non-executive Chair
- the Partnership lead CEO
- CCG Clinical Chairs
- CCG Accountable Officers
- Council leaders
- Council chief executives
- Chairs of Health and Wellbeing Boards of each Place
- Chairs of NHS Trusts, NHS Foundation Trusts and other providers of NHS services which are formal partners
- Chief executives of NHS Trusts, NHS Foundation Trusts and other providers of NHS services which are formal partners
- One representative of NHS England
- One representative of NHS Improvement
- One representative of Health Education England
- One representative of Public Health England
- One representative of Healthwatch organisations
- The chief executive of Yorkshire and Humber Academic Health Science Network
- The chair of the WY&H Clinical Forum
- [Non-executive/Lay members – TBC]

4.2. A deputy Chair will be agreed from among the non-executive members.

4.3. A list of members is set out at **Annex 1**.

#### **Deputies**

4.4. If a member is unable to attend a meeting of the Partnership Board, s/he will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and sufficient understanding of the issues to be considered to represent their organisation, place or group effectively. Deputies will be eligible to vote.

#### **Additional attendees**

4.5. Additional attendees will routinely include:

- The WY&H Partnership Director
- The WY&H Partnership Finance director.

4.6. At the discretion of the Chair, additional representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues. Such additional representatives may include:

- Senior Responsible Officers and programme leads for WY&H programmes
- Representatives of Partner organisations, who are not part of the core membership.
- Members of the WY&H Partnership core team and external advisers.

## **5. Quoracy and voting**

5.1. The Partnership Board will be quorate when 75% or more of Partner organisations are present, including at least one representative from each place. The Partnership Board will generally operate on the basis of forming a consensus on issues considered, taking account of the views expressed by members. It will look to make any decisions on a Best for WY&H basis. The Chair will seek to ensure that any lack of consensus is resolved amongst members.

5.2. Partnership Board members will be eligible to participate on issues which apply to their organisation, in line with the scope of applicable issues set out in Annex 1 of the Partnership Memorandum of Understanding. If a consensus decision cannot be reached, then (save for decisions on allocation of capital investment and transformation funding set out at 5.3 below) it may be referred to the dispute resolution procedure under Paragraph 6.6 of the Partnership Memorandum of Understanding by any of the affected Partners for resolution.

5.3. In respect of priorities for capital investment or apportionment of transformation funding from the Partnership, then the Partnership Board may make a decision provided that it is supported by not less than 75% of the eligible Partnership Board members present at a quorate meeting. In such cases, each eligible Partner organisation shall have one vote.

## 6. Accountability and reporting

- 6.1. The Partnership Board has no formal powers delegated by Partner organisations. However, it will increasingly take on responsibility for decisions relating to regulatory and oversight functions currently exercised from outside the system.
- 6.2. The Partnership Board has a key role within the wider governance and accountability arrangements for the WY&H partnership (see **Annex 2** for a description of these arrangements). The minutes, and a summary of key messages will be submitted to all Partner organisations after each meeting.

## 7. Conduct and Operation

- 7.1. The Partnership Board will meet in public, at least four times each year. An annual schedule of meetings will be published by the secretariat.
- 7.2. Extraordinary meetings may be called for a specific purpose at the discretion of the Chair. A minimum of seven working days notice will be given when calling an extraordinary meeting.
- 7.3. The agenda and supporting papers will be sent to members and attendees and made available to the public no less than five working days before the meeting. Urgent papers will be permitted in exceptional circumstances at the discretion of the Chair.
- 7.4. Draft minutes will be issued within 10 working days of each meeting.

### Managing Conflicts of Interest

- 7.5. Each member must abide by all policies of the organisation it represents in relation to conflicts of interest.
- 7.6. Where any Partnership Board member has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member may participate and/or vote in meetings (or parts of meetings) in which the relevant matter is discussed.
- 7.7. Where the Chair decides to exclude a member, the relevant organisation represented by that member may send a deputy to take the place of the conflicted member in relation to that matter.

### Secretariat

- 7.8. The secretariat function for the Partnership Board will be provided by the WY&H Partnership core team. A member of the team will be responsible for arranging meetings, recording notes and actions from each meeting, preparing agendas, and agreeing these with the Chair.

## 8. Review

- 8.1. These terms of reference and the membership of the Partnership Board will be reviewed at least annually. Further reviews will be undertaken in response to any material developments or changes in the wider governance arrangements of the Partnership.

## **Annex 1 – Members**

### **Health and Wellbeing Boards**

Bradford , Airedale and Wharfedale	✓
Calderdale	✓
Kirklees	✓
Leeds	✓
North Yorkshire	✓
Wakefield Council	✓

### **Local Authorities**

	Leader	Chief Executive
City of Bradford Metropolitan District Council	✓	✓
Calderdale Council	✓	✓
Craven District Council	✓	✓
Harrogate Borough Council	✓	✓
Kirklees Council	✓	✓
Leeds City Council	✓	✓
North Yorkshire County Council	✓	✓
Wakefield Council	✓	✓

### **CCGs Clinical Chairs**

	Chair	Accountable Officer
NHS Airedale, Wharfedale and Craven CCG	✓	✓
NHS Bradford City CCG	✓	✓
NHS Bradford Districts CCG	✓	✓
NHS Calderdale CCG	✓	✓
NHS Greater Huddersfield CCG	✓	✓
NHS Harrogate and Rural District CCG	✓	✓
NHS Leeds CCG	✓	✓
NHS North Kirklees CCG	✓	✓
NHS Wakefield CCG	✓	✓

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### NHS Service Providers

	Chair	Chief Executive
Airedale NHS Foundation Trust	✓	✓
Bradford District Care NHS Foundation Trust	✓	✓
Bradford Teaching Hospitals NHS Foundation Trust	✓	✓
Calderdale and Huddersfield NHS Foundation Trust	✓	✓
Harrogate and District NHS Foundation Trust	✓	✓
Leeds and York Partnership NHS Foundation Trust	✓	✓
Leeds Community Healthcare NHS Trust	✓	✓
The Leeds Teaching Hospitals NHS Trust	✓	✓
Locala Community Partnerships CIC	✓	✓
The Mid Yorkshire Hospitals NHS Trust	✓	✓
South West Yorkshire Partnership NHS Foundation Trust	✓	✓
Tees, Esk, and Wear Valleys NHS Foundation Trust	✓	✓
Yorkshire Ambulance Service NHS Trust	✓	✓

### Heath Regulator and Oversight Bodies

NHS England	✓
NHS Improvement	✓

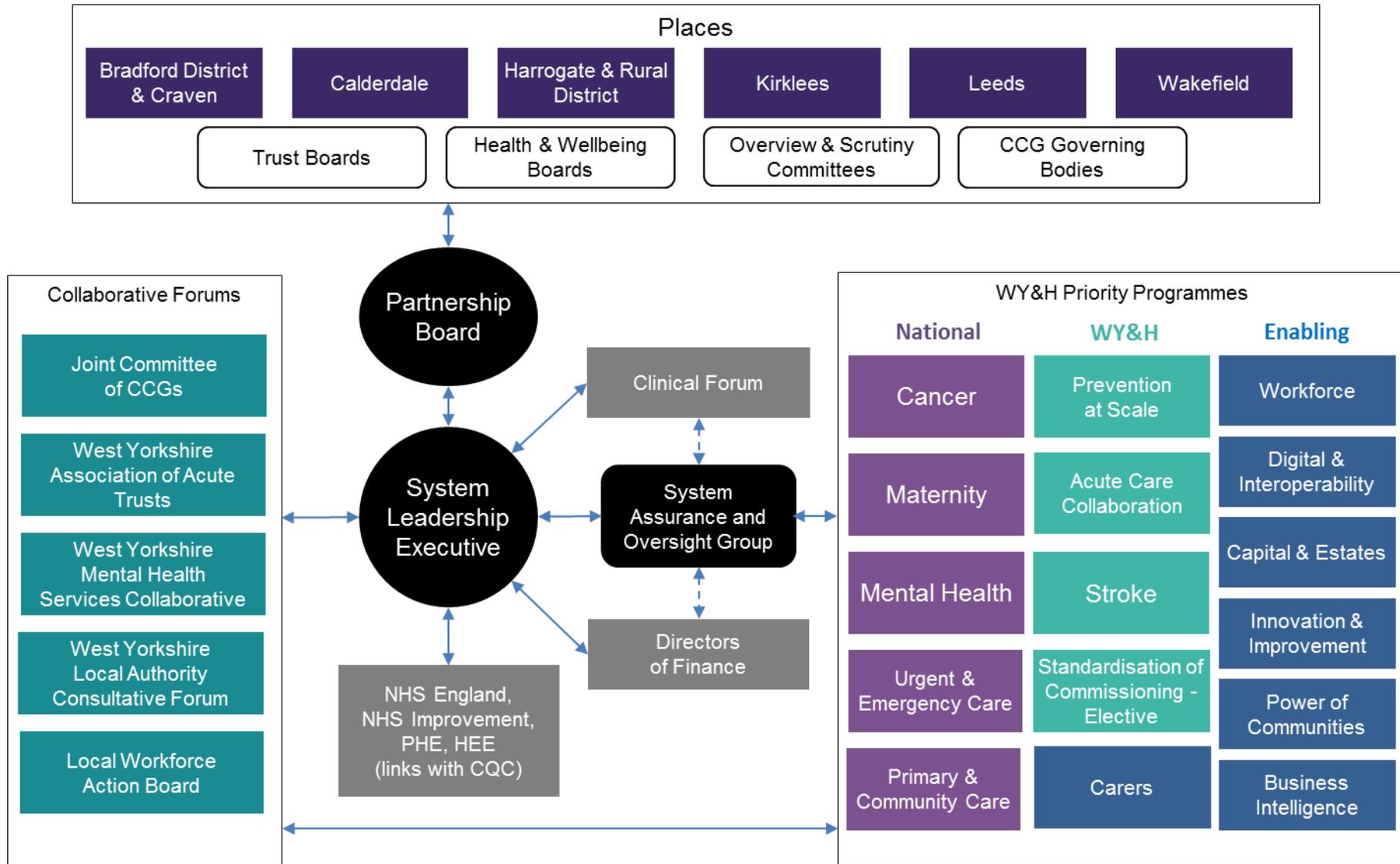
### Other National Bodies

Health Education England	✓
Public Health England	✓
Care Quality Commission [TBC]	✓

### Other Partners

Healthwatch representative	✓
Yorkshire and Humber Academic Health Science Network	✓

## Annex 2 – Schematic of Governance and Accountability Arrangements



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West Yorkshire and Harrogate  
Health and Care Partnership



# System Leadership Executive Group Terms of Reference

DRAFT

June 2018

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## 1. Introduction and context

- 1.1. West Yorkshire and Harrogate Health and Care Partnership was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs), in response to the *NHS Five Year Forward View*. It brings together all health and care organisations in our six places: Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield.
- 1.2. The Partnership is not a new organisation, but a new way of working to meet the diverse needs of our citizens and communities. NHS services have come together with local authorities, charities and community groups to agree how we can improve people's health and improve the quality of their health and care services.
- 1.3. The System Leadership Executive Group ('SLE') is a key element of the leadership and governance arrangements for the West Yorkshire and Harrogate Health and Care Partnership.

### Purpose

- 1.4. The SLE will support the Partnership Board to lead and direct the Partnership and will have overall executive responsibility for delivery of the Partnership plan.
- 1.5. The SLE will make decisions and recommendations to the Partnership Board on the matters highlighted in the Partnership Memorandum of Understanding, which neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum.
- 1.6. The SLE has no formal delegated powers from the organisations in the Partnership. However, over time the regulatory and oversight functions of the NHS national bodies will increasingly be enacted through collaboration with our leadership.
- 1.7. The SLE will work by building agreement with leaders across Partner organisations to drive action around a shared direction of travel.
- 1.8. These Terms of Reference describe the scope, function and ways of working for the SLE. They should be read in conjunction with the Memorandum of Understanding for the West Yorkshire and Harrogate Health and Care Partnership, which describes the wider governance and accountability arrangements.

## 2. How we work together in West Yorkshire and Harrogate

### Our vision

- 2.1. We have worked together to develop a shared vision for health and care services across West Yorkshire and Harrogate. All of our plans support the realisation of this vision:
- Places will be healthy - you will have the best start in life, so you can live and age well.
  - If you have long term health conditions you will be supported to self-care through GPs and social care services working together. This will include peer support and via technology, such as telemedicine.
  - If you have multiple health conditions, there will be a team supporting your physical, social and mental health needs. This will involve you, your family and carers, the NHS, social care and voluntary and community organisations.
  - If you need hospital care, it will usually mean going to your local hospital, which works closely with others to give you the best care possible
  - Local hospitals will be supported by centres of excellence for services such as cancer, stroke, and mental health.
  - All of this will be planned and paid for together, with councils and the NHS working together to remove the barriers created by planning and paying for services separately. For example community and hospital care working together.
  - Communities and staff will be involved in the development and design of plans so that everyone truly owns their health care services.

### Principles for our Partnership

- 2.2. The SLE operates within an agreed set of guiding principles that shape everything we do through our Partnership:
- We will be ambitious for the people we serve and the staff we employ
  - The West Yorkshire and Harrogate partnership belongs to its citizens and to commissioners and providers, councils and NHS
  - We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict
  - We will undertake shared analysis of problems and issues as the basis of taking action
  - We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible
  - We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on people's health and wellbeing.

## Our shared values and behaviour

2.3. Members of the SLE commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire and Harrogate
- We support each other and work collaboratively
- We act with honesty and integrity, and trust each other to do the same
- We challenge constructively when we need to
- We assume good intentions.
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery

## 3. Role and Responsibilities

3.1. The SLE will take overall executive responsibility for delivery of the Partnership plan. It will make recommendations to the Partnership Board and make joint decisions on a range of matters which do not impact on the statutory responsibilities of individual organisations and have not been delegated formally to a collaborative forum. Its responsibilities are to:

- i. make recommendations to the Partnership Board on:
  - The objectives of priority Partnership work programmes and workstreams
  - The apportionment of transformation monies from national bodies
  - Priorities for capital investment across the Partnership.
  - Operation of the single NHS financial control total (for NHS bodies)
  - Agreeing common action when systems become distressed
- ii. progressively build the capabilities to manage the health of our population, keeping people healthier for longer and reducing avoidable demand for healthcare services;
- iii. act as a leadership cohort, demonstrating what can be achieved with strong system leadership and increased freedoms and flexibilities;
- iv. provide a mechanism for joint action and joint decision-making for those issues which are best tackled on a wider scale;
- v. manage financial resources of NHS partners within a shared financial control total for health across the constituent CCGs and NHS provider organisations; and maximise the system-wide efficiencies necessary to manage within this share of the NHS budget;

## DRAFT

- vi. support the development of local partnership arrangements which bring together the Councils, voluntary and community groups, and NHS commissioners and providers in each Place;
- vii. ensure that, through partnership working in each place and across WY&H, there is a greater focus on population health management, integration between providers of services around the individual's needs, and a focus on care provided in primary and community settings;
- viii. oversee the development and implementation of a mutual accountability framework which provides a single, consistent approach for assurance and accountability between partners;
- ix. reach agreement in relation to recommendations made by other governance groups within the partnership on the need to take action in relation to managing collective performance, resources and the totality of population health;
- x. adopt an approach to making joint decisions and resolving any disagreements which follows the principle of subsidiarity and is in line with the shared values and behaviours of the partnership;

## 4. Membership

4.1. The membership will comprise:

- A Chair – the Partnership lead CEO
- CCG Accountable Officers
- Council chief executives
- Chief executives of NHS Trusts, NHS Foundation Trusts and other providers of NHS services which are formal partners
- One representative of NHS England
- One representative of NHS Improvement
- One representative of Health Education England
- One representative of Public Health England
- One representative of Healthwatch organisations
- The chief executive of Yorkshire and Humber Academic Health Science Network
- The chair of the WY&H Clinical Forum

4.2. A deputy Chair will be agreed from among nominated members. A list of members is set out at **Annex 1**.

### Deputies

4.3. If a member is unable to attend a meeting of the SLE, s/he will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and sufficient understanding of the issues to be considered, to

represent their organisation, place or group effectively. Deputies will be eligible to vote.

### Additional attendees

4.4. Additional attendees will routinely include:

- The WY&H Partnership director
- The WY&H Partnership finance director.

4.5. At the discretion of the Chair, additional representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues. Such additional representatives may include:

- Senior Responsible Officers and programme leads for WY&H programmes
- Representatives of Partner organisations, who are not part of the core membership.
- Members of the WY&H Partnership core team and external advisers.

## 5. Quoracy and voting

5.1. The SLE will be quorate when 75% or more of Partner organisations are present, including at least one representative from each place. The SLE will generally operate on the basis of forming a consensus on issues considered, taking account of the views expressed by members. It will look to make any decisions on a Best for WY&H basis. The Chair will seek to ensure that any lack of consensus is resolved amongst members.

5.1. Members will be eligible to participate on issues which apply to their organisation, in line with the scope of applicable issues set out in Annex 1 of the Partnership Memorandum of Understanding. If a consensus cannot be reached, then decisions will be made by 75% majority of the Group present and voting at a quorate meeting. In such cases, each eligible Partner organisation shall have one vote.

## 6. Accountability and reporting

6.1. The SLE will be accountable to the Partnership Board, which provides the formal leadership of the WY&H Partnership. The SLE has no formal powers delegated by Partner organisations. However, it will increasingly take on responsibility for decisions relating to regulatory and oversight functions currently exercised from outside the system.

6.2. The SLE has a key role within the wider governance and accountability arrangements for the WY&H Partnership (see **Annex 2** for a description of these arrangements). The minutes will be submitted to each meeting of the Partnership Board. The minutes, and a summary of key messages will also be submitted to all Partner organisations after each meeting.

## 7. Conduct and Operation

- 7.1. The SLE will normally meet monthly. An annual schedule of meetings will be published by the secretariat.
- 7.2. Extraordinary meetings may be called for a specific purpose at the discretion of the Chair. A minimum of seven working days notice will be given when calling an extraordinary meeting.
- 7.3. The agenda and supporting papers will be sent to members and attendees no less than five working days before the meeting. Urgent papers will be permitted in exceptional circumstances at the discretion of the Chair.
- 7.4. Draft minutes will be issued within 10 working days of each meeting.

### Managing Conflicts of Interest

- 7.5. Each member must abide by all policies of the organisation it represents in relation to conflicts of interest.
- 7.6. Where any SLE member has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member may participate and/or vote in meetings (or parts of meetings) in which the relevant matter is discussed.
- 7.7. Where the Chair decides to exclude a member, the relevant organisation represented by that member may send a deputy to take the place of the conflicted member in relation to that matter.

### Secretariat

- 7.8. The secretariat function for the SLE will be provided by the WY&H Partnership core team. A member of the team will be responsible for arranging meetings, recording notes and actions from each meeting, preparing agendas, and agreeing these with the Chair.

## 8. Review

- 8.1. These terms of reference and the membership of the SLE will be reviewed at least annually. Further reviews will be undertaken in response to any material developments or changes in the wider governance arrangements of the Partnership.

## **Annex 1 – Members**

### **Local Authorities**

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

### **NHS Commissioners**

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

### **Healthcare Providers**

Airedale NHS Foundation Trust	
Bradford District Care NHS Foundation Trust	
Bradford Teaching Hospitals NHS Foundation Trust	
Calderdale and Huddersfield NHS Foundation Trust	
Harrogate and District NHS Foundation Trust	
Leeds and York Partnership NHS Foundation Trust	
Leeds Community Healthcare NHS Trust	
The Leeds Teaching Hospitals NHS Trust	
Locala Community Partnerships CIC	
The Mid Yorkshire Hospitals NHS Trust	

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South West Yorkshire Partnership NHS Foundation Trust	
Tees, Esk, and Wear Valleys NHS Foundation Trust	
Yorkshire Ambulance Service NHS Trust	

### Heath Regulator and Oversight Bodies

NHS England	
NHS Improvement	

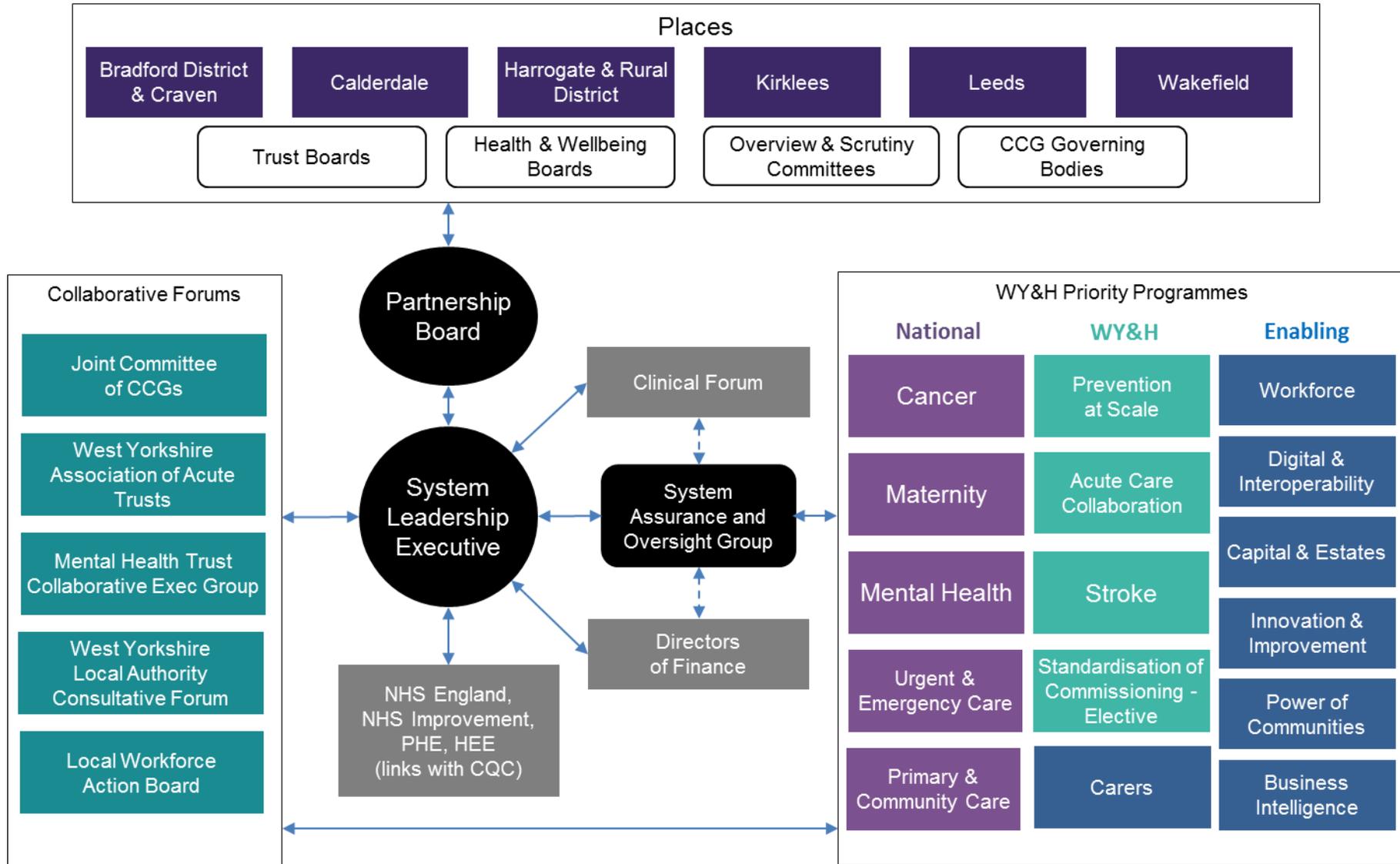
### Other National Bodies

Health Education England	
Public Health England	
Care Quality Commission [TBC]	

### Other Partners

Clinical Forum Chair	
Healthwatch representative	
Yorkshire and Humber Academic Health Science Network	

## Annex 2 – Schematic of Governance and Accountability Arrangements



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West Yorkshire and Harrogate  
Health and Care Partnership



# System Oversight and Assurance Group Terms of Reference

DRAFT

June 2018

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## 1. Introduction and context

- 1.1. West Yorkshire and Harrogate Health and Care Partnership was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs), in response to the *NHS Five Year Forward View*. It brings together all health and care organisations in our six places: Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield.
- 1.2. The Partnership is not a new organisation, but a new way of working to meet the diverse needs of our citizens and communities. NHS services have come together with local authorities, charities and community groups to agree how we can improve people's health and improve the quality of their health and care services.
- 1.3. The System Oversight and Assurance Group is a key element of the leadership and governance arrangements for the West Yorkshire and Harrogate Health and Care Partnership.

### Purpose

- 1.4. The Partnership has agreed to adopt a new integrated approach to leading performance development and culture change, encompassing operational performance, quality and outcomes, service transformation, and finance.
- 1.5. This new approach will feature:
  - a single framework, covering individual places, and West Yorkshire and Harrogate as a whole;
  - an increasing focus on making judgements about a whole place, while understanding the positions of individual organisations;
  - a strong element of peer review and mutual accountability;
  - a clear approach to improvement-focused intervention, support and capacity building.
- 1.6. The purpose of the System Oversight and Assurance Group is to be the primary governance forum to oversee the Partnership's mutual accountability arrangements. It will take an overview of system performance and progress with delivery of the Partnership's plan
- 1.7. These Terms of Reference describe the scope, function and ways of working for the System Oversight and Assurance Group. They should be read in conjunction with the Memorandum of Understanding for the West Yorkshire and Harrogate Health and Care Partnership, which describes the wider governance and accountability arrangements.

## 2. How we work together in West Yorkshire and Harrogate

### Our vision

- 2.1. We have worked together to develop a shared vision for health and care services across West Yorkshire and Harrogate. All of our plans support the realisation of this vision:
- Places will be healthy - you will have the best start in life, so you can live and age well.
  - If you have long term health conditions you will be supported to self-care through GPs and social care services working together. This will include peer support and via technology, such as telemedicine.
  - If you have multiple health conditions, there will be a team supporting your physical, social and mental health needs. This will involve you, your family and carers, the NHS, social care and voluntary and community organisations.
  - If you need hospital care, it will usually mean going to your local hospital, which works closely with others to give you the best care possible
  - Local hospitals will be supported by centres of excellence for services such as cancer, stroke, and mental health.
  - All of this will be planned and paid for together, with councils and the NHS working together to remove the barriers created by planning and paying for services separately. For example community and hospital care working together.
  - Communities and staff will be involved in the development and design of plans so that everyone truly owns their health care services.

### Principles for our partnership

- 2.2. The System Oversight and Assurance Group operates within an agreed set of guiding principles that shape everything we do through our Partnership:
- We will be ambitious for the people we serve and the staff we employ
  - The West Yorkshire and Harrogate partnership belongs to its citizens and to commissioners and providers, councils and NHS
  - We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict
  - We will undertake shared analysis of problems and issues as the basis of taking action
  - We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible
  - We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on people's health and wellbeing.

## Our shared values and behaviour

2.3. Members of the System Oversight and Assurance Group commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire and Harrogate
- We support each other and work collaboratively
- We act with honesty and integrity, and trust each other to do the same
- We challenge constructively when we need to
- We assume good intentions.
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery

## 3. Role and Responsibilities

3.1. The System Oversight and Assurance Group will provide oversight, and challenge to the delivery of the aims and priorities of the Partnership. In support of this, its responsibilities are to:

- i. lead the development of a dashboard of key performance, quality and transformation metrics for the Partnership;
- ii. take an overview of performance and transformation at whole system, place and organisation levels in relation to Partnership objectives and wider national requirements;
- iii. take an overview of programme delivery;
- iv. receive reports from WY&H programmes and enabling workstreams on issues which require escalation;
- v. develop and maintain connections with other key groups and organisations which have a role in performance development and improvement, including:
  - Care Quality Commission
  - Quality Surveillance Groups
  - Place-based transformation boards
  - A&E Delivery Boards
  - WY&H Directors of Finance Group
  - WY&H Clinical Forum;
- vi. lead the development of a framework for peer review and support for the Partnership and oversee its application;

- vii. make recommendations to the System Leadership Executive, in consultation with WY&H programme boards, and national NHS bodies, on the deployment of improvement support across the Partnership, and on the need for more formal action and interventions. Actions will include the requirement for:
- agreement of improvement or recovery plans;
  - more detailed peer-review of specific plans;
  - commissioning expert external review;
  - the appointment of a turnaround Director / team;
  - agreement of restrictions on access to discretionary funding and financial incentives.

## 4. Membership

4.1. The membership of the System Oversight and Assurance Group will include representation from each sector of the partnership, ie providers, commissioners, Councils, national bodies, Healthwatch.

4.2. The membership will comprise:

- A Chair – the Partnership lead CEO
- Acute sector – chair of WYAAT
- Mental health sector – chair of Mental Health Services Collaborative
- CCGs – nominated lead accountable officer
- A representative of community / primary care providers
- Local authorities – lead CEO for health
- One representative of NHS England
- One representative of NHS Improvement
- One representative of Healthwatch

4.3. A deputy Chair will be agreed from among nominated members. A list of members is set out at **Annex 1**.

### Deputies

4.4. If a member is unable to attend a meeting of the System Oversight and Assurance Group, s/he will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and sufficient understanding of the issues to be considered, to represent their organisation, place or group effectively.

### Additional attendees

4.5. Additional attendees will routinely include:

- The WY&H Partnership director
- The WY&H Partnership finance director.

4.6. At the discretion of the Chair, additional representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues. Such additional representatives may include:

- Senior Responsible Officers and programme leads for WY&H programmes
- Representatives of Partner organisations, who are not part of the core membership.
- Members of the WY&H Partnership core team and external advisers.

## 5. Quoracy and voting

5.1. The System Oversight and Assurance Group will not be a formal decision making body. The Group will operate on the basis of forming a consensus on issues considered, taking account of the views expressed by members. The Group will not take votes and will not require a quorum of members to be present to consider any business.

5.2. The Chair will seek to ensure that any lack of consensus is resolved amongst members.

5.3. Under exceptional circumstances any substantive difference of views among members will be reported to the System Leadership Executive Group.

## 6. Accountability and reporting

6.1. The Group does not have any powers or functions formally delegated by the Boards or governing bodies of its constituent organisations. However, NHS England and NHS Improvement will, where appropriate, enact certain regulatory and system oversight functions through the Group.

6.2. The Group has a key role within the wider governance and accountability arrangements for the WY&H partnership (see **Annex 2** for a description of these arrangements).

6.3. The System Oversight and Assurance Group will formally report, through the Chair, to the System Leadership Executive Group. It will make recommendations, where appropriate to the System Leadership Executive Group.

## 7. Conduct and Operation

- 7.1. The Group will normally meet monthly. An annual schedule of meetings will be published by the secretariat.
- 7.2. Extraordinary meetings may be called for a specific purpose at the discretion of the Chair. A minimum of seven working days notice will be given when calling an extraordinary meeting.
- 7.3. The agenda and supporting papers will be sent to members and attendees no less than five working days before the meeting. Urgent papers will be permitted in exceptional circumstances at the discretion of the Chair.
- 7.4. Draft minutes will be issued within 10 working days of each meeting.

### Managing Conflicts of Interest

- 7.5. Each member must abide by all policies of the organisation it represents in relation to conflicts of interest.
- 7.6. Where any Group member has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member may participate and/or vote in meetings (or parts of meetings) in which the relevant matter is discussed.
- 7.7. Where the Chair decides to exclude a member, the relevant organisation represented by that member may send a deputy to take the place of the conflicted member in relation to that matter.

### Secretariat

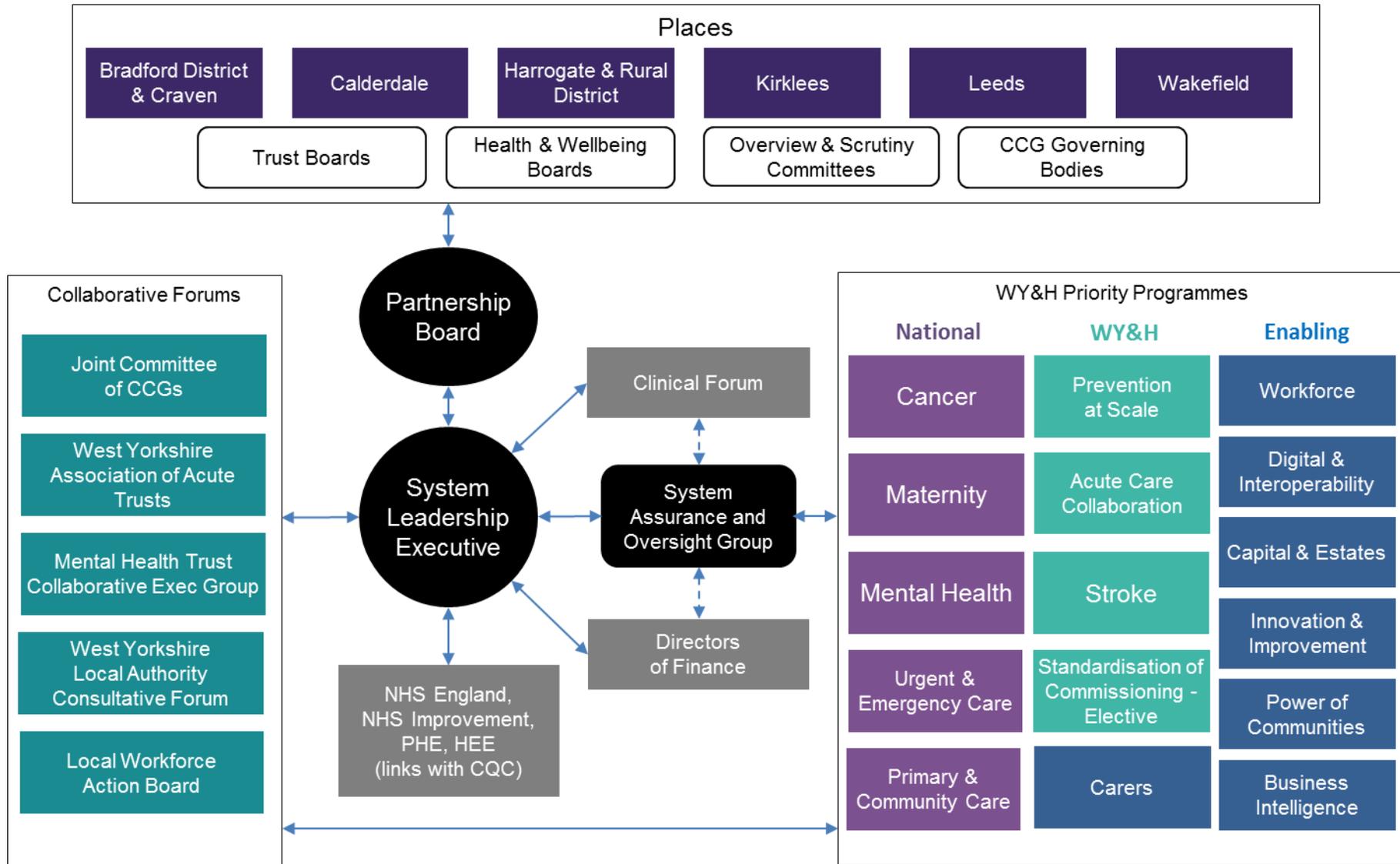
- 7.8. The secretariat function for the System Oversight and Assurance Group will be provided by the WY&H Partnership core team. A member of the team will be responsible for arranging meetings, recording notes and actions from each meeting, preparing agendas, and agreeing these with the Chair.

## 8. Review

- 8.1. These terms of reference and the membership of the Group will be reviewed at least annually. Further reviews will be undertaken in response to any material developments or changes in the wider governance arrangements of the Partnership.

**Annex 1 – Members**

## Annex 2 – Schematic of Governance and Accountability Arrangements





# Clinical Forum Terms of Reference

April 2018

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## 1. Introduction and context

1.1. West Yorkshire and Harrogate Health and Care Partnership was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs), in response to the *NHS Five Year Forward View*. It brings together all health and care organisations in our six places: Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

1.2. The partnership is not a new organisation, but a new way of working to meet the diverse needs of our citizens and communities. NHS services have come together with local authorities, charities and community groups to agree how we can improve people's health and improve the quality of their health and care services.

1.3. The Clinical Forum is a key element of leadership and governance arrangements for the West Yorkshire and Harrogate health and care partnership.

### Purpose

1.4. The purpose of the Clinical Forum is to be the primary forum for clinical leadership, advice and challenge for the work of the partnership in meeting the Triple Aim: improving health and wellbeing; improving care and the quality of services; and ensuring that services are financially sustainable.

1.5. The Clinical Forum ensures that the voice of clinicians, from across the range of clinical professions and partner organisations, drives the development of new clinical models and proposals for the transformation of services. It also takes an overview of system performance on quality.

1.6. These Terms of Reference describe the scope, function and ways of working for the Clinical Forum. They should be read in conjunction with the Memorandum of Understanding for the West Yorkshire and Harrogate Health and Care Partnership [**forthcoming**], which describes the wider governance and accountability arrangements.

## 2. How we work together in West Yorkshire and Harrogate

### Our vision

2.1. We have worked together to develop a shared vision for health and care services across West Yorkshire and Harrogate. All of our plans support the realisation of this vision:

- Places will be healthy - you will have the best start in life, so you can live and age well.
- If you have long term health conditions you will be supported to self-care through GPs and social care services working together. This will include peer support and via technology, such as telemedicine.
- If you have multiple health conditions, there will be a team supporting your

physical, social and mental health needs. This will involve you, your family and carers, the NHS, social care and voluntary and community organisations.

- If you need hospital care, it will usually mean going to your local hospital, which works closely with others to give you the best care possible
- Local hospitals will be supported by centres of excellence for services such as cancer, stroke, and mental health.
- All of this will be planned and paid for together, with councils and the NHS working together to remove the barriers created by planning and paying for services separately. For example community and hospital care working together.
- Communities and staff will be involved in the development and design of plans so that everyone truly owns their health care services.

### Principles for our partnership

2.2. The Clinical Forum operates within an agreed a set of guiding principles that shape everything we do through our partnership:

- We will be ambitious for the people we serve and the staff we employ
- The West Yorkshire and Harrogate partnership belongs to its citizens and to commissioners and providers, councils and NHS
- We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict
- We will undertake shared analysis of problems and issues as the basis of taking action
- We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible
- We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on people's health and wellbeing.

### Our shared values and behaviour

2.3. Members of the Clinical Forum commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire and Harrogate
- We support each other and work collaboratively
- We act with honesty and integrity, and trust each other to do the same
- We challenge constructively when we need to
- We assume good intentions.

- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery

### 3. Role and Responsibilities

3.1. The Clinical Forum will provide clinical leadership, oversight, and challenge to the development and delivery of the aims and priorities of the partnership. In support of this, its responsibilities are to:

- i. lead the development of a clinical strategy and narrative for West Yorkshire and Harrogate
- ii. ensure that all plans within the West Yorkshire and Harrogate health and care partnership are clinically led, evidence based, and configured to improve patient outcomes;
- iii. ensure the voice of the patients, service users and citizens is heard and reflected in all plans;
- iv. maintain and embed clinical co-production as a core principle of the partnership;
- v. support collaboration and strengthen partnerships between clinical colleagues;
- vi. exhibit clinical leadership and galvanise professional colleagues and partner organisation to agree models of care which support delivery to close the three gaps (health, care and finance) in West Yorkshire and Harrogate
- vii. champion change and evidence-based innovation within their own organisations and Place, with peers, professional colleagues and networks;
- viii. support transition to new models of care, where appropriate.
- ix. make recommendations to the System Leadership Executive Group on proposals developed by priority workstreams and local place-based partnerships;
- x. provide oversight and alignment of all clinical initiatives across West Yorkshire and Harrogate;
- xi. support regular communication and engagement with all stakeholders;
- xii. support through review the evaluation and impact of all workstreams and plans
- xiii. provide innovative solutions to system-wide challenges, particularly where there are dependencies between workstreams (including enablers) and local plans;
- xiv. provide input and assurance to the clinical representation on each of the workstreams;

- xv. ensure a robust framework for quality impact assessment of change is established and implemented;
  - xvi. review system performance on the quality of health and care services and provide a mechanism for partner organisations to hold each other to account on quality, making appropriate links with the Quality Surveillance Forum.
- 3.2. Members of the group should ensure that all groups of clinicians within their organisations are engaged with the work of the Clinical Forum as appropriate.

## 4. Membership

- 4.1. The membership of the Clinical Forum will reflect the engagement of all Places and partner organisations.
- 4.2. Members will be senior clinicians (normally clinical commissioners, provider GPs, medical directors, directors of nursing, senior allied health professionals) nominated by the relevant organisation or partnership group.
- 4.3. The membership will comprise:
- A Chair
  - One clinical commissioner representative from each of the six places
  - One representative from each mental health and community trust
  - One representative from each acute Trust
  - One representative from Yorkshire Ambulance Service
  - One medical representative from NHS England and NHS Improvement
  - One Nursing and Quality Lead
  - One Allied Health Professional representative
  - One Community Pharmacist representative
  - Two representatives of primary care federations
  - One Director of Adult Social Services
  - One Director of Public Health
  - The Clinical Director for the West Yorkshire Association of Acute Trusts
  - One representative from Yorkshire Academic Health Science Network
- 4.4. A deputy Chair will be agreed from among nominated members.
- 4.5. A list of current members is set out at **Annex 1**. (Arrangements for future changes to the role of Chair and nominated members will be confirmed with the Forum).
- 4.6. Additional representatives may be requested to attend meetings of the Clinical Forum from time to time to participate in discussions or report on particular issues. Such additional representatives may include:

- clinical leads for each of the West Yorkshire and Harrogate priority programmes and enabling workstreams
- Local Medical Committee representatives.

### Additional attendees

4.7. A representative of Healthwatch, members of the WY&H partnership core team, external advisers, and other individuals may be invited to attend for all or part of any meeting as and when appropriate, at the discretion of the Chair.

### Deputies

4.8. If a member is unable to attend a meeting of the Clinical Forum, s/he will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and sufficient understanding of the issues to be considered, to represent their organisation, place or group effectively.

## 5. Accountability and reporting

5.1. The Clinical Forum will not be a formal decision making body. It does not have any powers or functions formally delegated by the Boards or governing bodies of its constituent organisations.

5.2. The Clinical Forum has a key role within the wider governance and accountability arrangements for the WY&H partnership (see **Annex 2** for a description of these arrangements).

5.3. The Clinical Forum will formally report, through the Chair, to the System Leadership Executive Group. The Chair will be a core member of this group.

5.4. The Forum will make recommendations, where appropriate to the System Leadership Executive Group.

## 6. Conduct and Operation of the Clinical Forum

6.1. The Forum will operate on the basis of forming a consensus on issues considered, taking account of the views expressed by members.

6.2. The Forum will not take votes and will not require a quorum of members to be present to consider any business.

6.3. The Chair will seek to ensure that any lack of consensus is resolved amongst members.

6.4. Under exceptional circumstances any substantive difference of views among members will be reported by the Chair to the System Leadership Executive Group.

## Secretariat

6.5. The secretariat function for the Clinical Forum will be provided by the WY&H partnership core team. A member of the team will be responsible for arranging meetings, recording notes and actions from each meeting, preparing agendas, and agreeing these with the Chair.

6.6. The secretariat will collate papers and circulate them to members and attendees no less than five days before the meeting. Late papers will be permitted in exceptional circumstances at the discretion of the Chair.

## 7. Frequency of meetings

7.1. The Clinical Forum will usually meet each month. An annual schedule of meetings will be confirmed by the secretariat.

7.2. Additional or extraordinary meetings may be called for a specific purpose at the discretion of the Chair.

7.3. Members will normally be given a minimum of six weeks' notice of any meeting of the Forum.

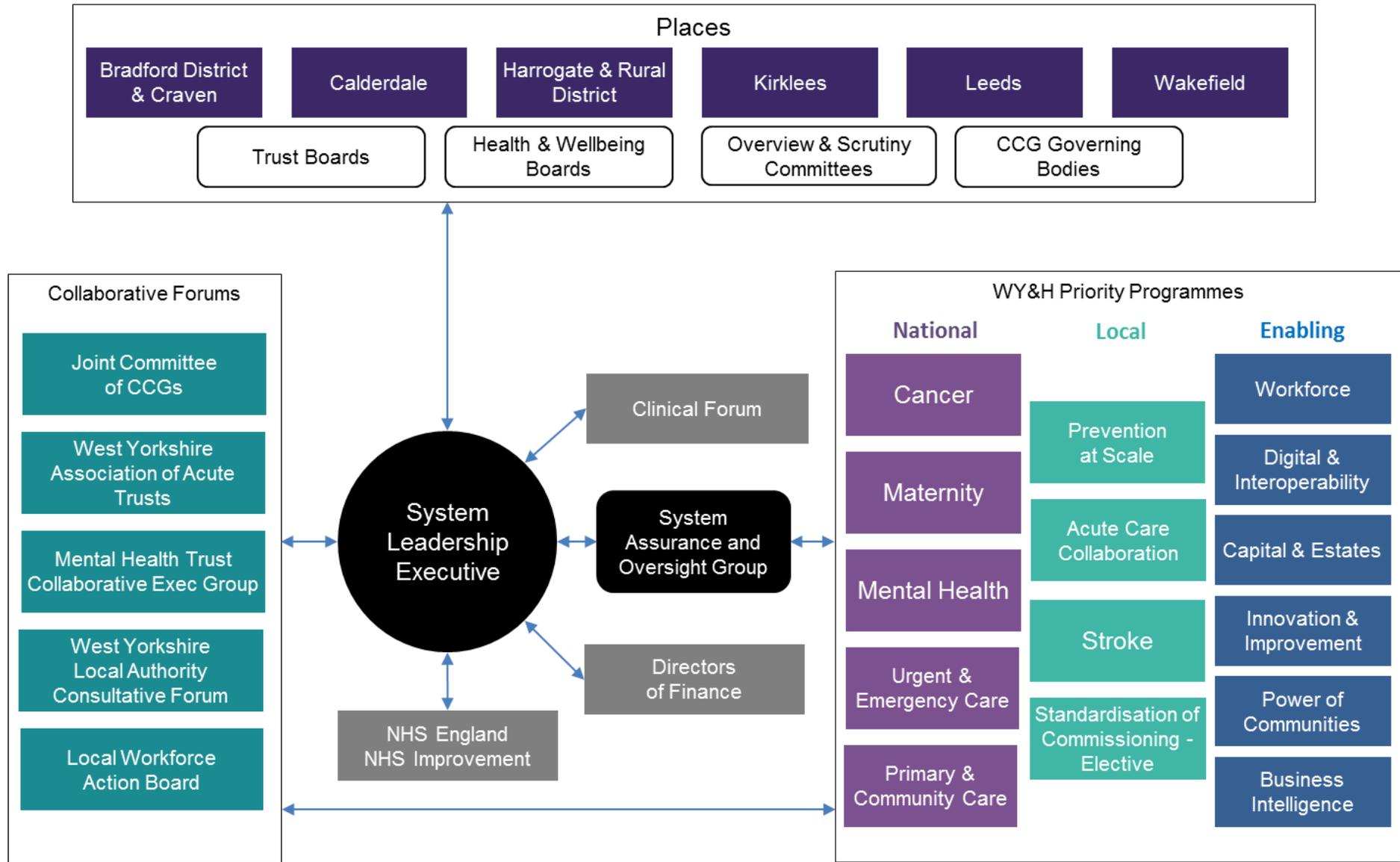
## 8. Review

8.1. These terms of reference and the membership of the Forum will be reviewed at least annually. Further reviews will be undertaken in response to any material developments or changes in the wider governance arrangements of the partnership.

## Annex 1 – Nominated members of the Clinical Forum

	Nominee
Chair	Dr Andy Withers
<b>CCGs / Places</b>	
Bradford District and Craven	Dr James Thomas
Calderdale	Dr Steven Cleasby
Harrogate and Rural District	Dr Bruce Willoughby
Leeds	Dr Gordon Sinclair
North Kirklees and Greater Huddersfield	Dr David Kelly
Wakefield	Dr Phil Earnshaw
<b>Acute Trusts</b>	
Airedale NHS Foundation Trust	Jill Asbury
Bradford Teaching Hospitals NHS Foundation Trust	Dr Bryan Gill (Deputy Chair)
Calderdale and Huddersfield NHS Foundation Trust	Brendan Brown
Harrogate and District NHS Foundation Trust	David Scullion
The Leeds Teaching Hospitals NHS Foundation Trust	Dr Yvette Oade
The Mid Yorkshire Hospitals NHS Foundation Trust	David Melia
<b>Mental Health and Community Providers</b>	
Bradford District Care NHS Foundation Trust	Dr Andy McElligott
Leeds and York Partnership NHS Foundation Trust	TBC
South West Yorkshire Partnership NHS Foundation Trust	Tim Breedon
Leeds Community Healthcare NHS Trust	Marcia Perry
<b>Others</b>	
NHS England	Dr Yasmin Khan
Allied Health Professional	TBC
Community Pharmacist	Ruth Buchan
GP Providers x 2	TBC
Social Care	TBC
Public Health representative	Andrew O'Shaughnessy
WYAAT Clinical Lead	Robin Jeffrey
Yorkshire Ambulance Service	Julian Mark
Nursing & Quality Lead (and QSG link)	Jo Harding
AHSN	Mike Potts (interim)

## Annex 2 – Schematic of Governance and Accountability Arrangements



## Trust Board 25 September 2018 Agenda item 8.1

<b>Title:</b>	<b>Appraisal / Revalidation Annual Board Report 2017-18</b>
<b>Paper prepared by:</b>	Responsible Officer
<b>Purpose:</b>	<p>This report is presented to the Board:</p> <ul style="list-style-type: none"> <li>➤ For assurance that the statutory functions of the RO role are being appropriately and adequately discharged.</li> <li>➤ To inform of progress in medical appraisal and revalidation during 2017/18.</li> <li>➤ To support the signing of the Statement of Compliance (see Appendix 5 in report).</li> </ul>
<b>Mission/values:</b>	Ensuring that all medical staff are fit to practice and up to date supports the Trust's mission to enable people to reach their potential and live well in the community.
<b>Any background papers/ previously considered by:</b>	None.
<b>Executive summary:</b>	<ul style="list-style-type: none"> <li>➤ 133 doctors had a prescribed connection with the Trust as at 31<sup>st</sup> March 2018. <ul style="list-style-type: none"> <li>- 93% successfully completed the appraisal process during 2017/18, an increase of 4% on 2016/17.</li> <li>- 7% had an agreed postponement in line with the medical appraisal policy, a reduction of 3.5% on 2016/17. These postponements were approved by either the AMD for Revalidation or Responsible Officer as appropriate.</li> </ul> </li> <li>➤ 16 revalidation recommendations were required from 1<sup>st</sup> April 2017 to 31<sup>st</sup> March 2018. <ul style="list-style-type: none"> <li>- 14 doctors had positive recommendations made.</li> <li>- 2 doctors had a recommendation of deferral. The deferral was recommended after the Responsible Officer had consulted with the GMC Liaison Employment Advisor.</li> <li>- All recommendations made were upheld by the GMC.</li> </ul> </li> <li>➤ The Trust continues to strengthen its appraisal and revalidation processes.</li> </ul> <p>The required 5 yearly peer review was undertaken in November 2017. This was undertaken with Leeds York Partnership NHS FT and the learning identified is being acted upon.</p> <p>The voluntary status of the appraisers and their importance to our system is noted each year. It continues to be a concern that, if under pressure from other areas of work, doctors could withdraw from this role, thus threatening the appraisal process.</p> <p>Also there remains an expectation that the revalidation process will</p>

	<p>become more robust and place new demands on existing resources. If it transpired that additional resources are required, the MD will present this to the EMT on behalf of the RO.</p> <p>The Trust's statutory duties relating to equality and diversity have been met and an Equality Impact Assessment was undertaken on the Medical Appraisal Policy which underpins the appraisal and revalidation process.</p>
<b>Recommendation:</b>	<b>Trust Board is asked to RECEIVE the report and APPROVE the statement of compliance confirming that the organisation as a designated body is in compliance with the regulations.</b>
<b>Private session:</b>	Not applicable.

## **MEDICAL APPRAISAL / REVALIDATION ANNUAL BOARD REPORT 2017-18**

### **1. Executive Summary**

- 1.1** 133 doctors had a prescribed connection with the Trust as at 31<sup>st</sup> March 2018.
- 93% successfully completed the appraisal process during 2017/18, an increase of 4% on 2016/17.
  - 7% had an agreed postponement in line with the Medical Appraisal Policy. These were approved by either the Associate Medical Director (AMD) for Revalidation or Responsible Officer (RO) as appropriate. This is a reduction of 3.5% on 2016/17
- 1.2** 16 revalidation recommendations made between 1<sup>st</sup> April 2017 and 31<sup>st</sup> March 2018.
- 14 doctors had positive recommendations made.
  - 2 doctors had a recommendation of deferral. The deferrals were recommended after the RO had consulted with the General Medical Council (GMC) Liaison Employment Advisor.
  - All recommendations made were upheld by the GMC.
- 1.3** The Trust continues to strengthen its appraisal and revalidation processes.

### **2. Purpose of Paper**

This report is presented to the Board:

- 2.1** For assurance that the statutory functions of the RO role are being appropriately and adequately discharged.
- 2.2** To inform of progress in medical appraisal and revalidation during 2017/18.
- 2.3** To support the signing of the Statement of Compliance (see Appendix 5).

### **3. Background**

- 3.1** 2017/18 was the sixth year of medical revalidation. Launched in 2012 to strengthen the way that doctors are regulated, the aim is to improve the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical profession.
- 3.2** Each doctor must have a RO who must oversee a range of processes including annual appraisal, and who will at five yearly intervals make a recommendation to the GMC in respect of the doctor's revalidation.
- 3.3** The RO is appointed by the Board of the organisation, termed a Designated Body, to which the doctor is linked by a Prescribed Connection.

- 3.4** Provider organisations have a statutory duty to support their RO in discharging their duties under the Responsible Officer Regulations and it is expected that provider boards / executive teams will oversee compliance by:
- 3.4.1 Monitoring the frequency and quality of medical appraisals in their organisation.
  - 3.4.2 Checking there are effective systems in place for monitoring the conduct and performance of their doctors.
  - 3.4.3 Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors.
  - 3.4.4 Ensuring that appropriate pre-employment background checks (including pre-employment for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.
- 3.5** Compliance with the Responsible Officer Regulations forms part of the Care Quality Commission inspection.

## **4. Governance**

### **4.1 Trust's Revalidation Team**

- Responsible Officer – Dr Adrian Berry
- Associate Medical Director for Revalidation – Dr Gerard Roney
- Business Manager, Medical Directorate – Julie Hickling
- Medical Directorate Administrator – Debbie Hellowell (until 1.7.17) / Charlotte Lyons (from 23.10.18)
- HR Business Partner with responsibility to support Revalidation – Andrea Horton

### **4.2 Policy and Guidance Update**

- Medical Appraisal Policy – updated March 2018

### **4.3 Main Tools Utilised Centrally**

- MyL2P (web based) – e-appraisal system
- Datix (Trust system) – provision of incident, complaints and compliments data
- HR Online (Trust system) – provision of sickness data and mandatory training
- GMC Connect (web based) – designated body list

### **4.4 Designated Body List**

The Business Manager and Administrator ensure that the designated body list of doctors is accurate. The formal list of the Trust's prescribed connections is recorded on the GMC Connect portal. As individual doctors are able to add themselves to this list, it is regularly checked to ensure that all the prescribed connections are appropriate. To facilitate this, a regular starters and leavers report is run from Electronic Staff Record.

#### 4.5 External Oversight

The Trust is subject to the oversight of the NHS England Revalidation Team. During 2017/18, due to the Trust's continuing successful record in attaining satisfactory engagement in appraisal, an email response from the RO was the only quarterly reporting requirement. This confirms that the Trust is still on target to achieve the planned appraisal trajectory for the quarter and the year as a whole. The final year Annual Organisational Audit was still a requirement and was completed and submitted May 2018.

#### 4.6 Internal Oversight

- 4.6.1 The AMD and Business Manager meet fortnightly to oversee the day-to-day running of the appraisal and revalidation processes.
- 4.6.2 The RO, AMD and Business Manager meet monthly to ensure that there is regular communication with the RO and that any issues are highlighted and acted upon. Where a meeting is not possible, email and telephone conversations take place to ensure matters are dealt with in a timely manner.
- 4.6.3 The Revalidation Team have Revalidation Review meetings to formally consider those doctors with a revalidation recommendation required within the following 12 months.

#### 4.7 Independent Verification

- 4.7.1 Independent verification is required to be undertaken every 5 years. In November 2017 a Revalidation Peer to Peer Review was undertaken with Leeds and York Partnerships NHS Foundation Trust. The resulting report (see Appendix 6) for the Trust highlighted areas of good practice and also areas of learning. The areas of learning have been incorporated in sections 11.3 and 11.4 of this report.

### 5. Medical Appraisal

#### 5.1 Appraisal and Revalidation Data

	Consultant		SAS* & Trust Grade		Fixed Term	
Number of doctors as at 31 <sup>st</sup> March 2018 who have a prescribed connection to the Trust	79		44		10	
Number of completed appraisals during 2017/18:	75 consultants completed 77 appraisals	95%	43 SAS doctors completed 45 appraisals	98%	6 fixed term doctors completed 7	60%



					appraisals	
Number of missed/incomplete appraisals during 2017/18:	4	5%	1	2%	4	40%
Number of doctors in remediation:	0	0%	0	0%	0	0%
Number of doctors in disciplinary processes	0	0%	0	0%	0	0%

\*SAS - Staff Grade, Specialty and Associate Specialist doctors  
 See Appendix 1; Audit of missed/incomplete appraisals

## 5.2 Appraisers as at 31<sup>st</sup> March 2018

### 5.2.1 Number of appraisers – 22 (18 consultants, 4 SAS doctors)

- Three appraisers stepped down from the role during 2017/18; one citing the reason being for an improved work life balance, one due to retirement and the third did not provide a reason.
- Two new appraisers were recruited.

### 5.2.2 Support activities undertaken:

- A full day new appraiser training session was provided on 14.6.17, for the 2 new appraisers.
- A half day refresher training session was provided on 11.10.17 for 4 appraisers.
- On 31.1.18 a new format combined new appraiser/refresher training session was undertaken. The new appraisers attended the morning session and the existing appraisers joined them for the afternoon session. This session involved appraisers from other regional healthcare organisations. Six of the Trust's appraisers attended for the refresher training.
- Training sessions are facilitated by at least 2 of appraiser trainers, who are experienced Trust appraisers – Dr Mark Radcliffe, Dr Ruth Stockill, Dr Isaura Gairin and Dr Sara Davies.
- Appraisers Forums were held on 12.7.17 and 8.11.17. The Forums continue to provide an opportunity for appraisers to share good practice and discuss areas of concern/difficulty. Continuous improvement of the appraisal process in the Trust is also an important topic for discussion in the Forums.

### 5.3 Quality Assurance Processes

- 5.3.1 There is a portfolio minimum data set required for appraisal and the appraisers are required to check that this is uploaded or an adequate reason provided for non-inclusion.
- 5.3.2 The Trust utilises the multisource feedback tool embedded within MyL2P. This automatically flags with the doctors when they are required to undertake the colleague and patient feedbacks (required to be undertaken every 3 years, unless new to the Trust then required within first year). The reports are then not released to the doctor unless they have gained the minimum number of responses (and undertaken their self-assessments) or their request for release to the Revalidation Team is upheld.
- 5.3.3 The Revalidation Team inform the doctor if they are required to change their appraiser for their next appraisal (required to change after every third consecutive appraisal with same appraiser).
- 5.3.4 The AMD reviews all submitted appraisals (excluding those where he was the appraiser). Checks are made on appraisal inputs (appraisal portfolio), appraisal outputs (Personal Development Plan (PDP), appraisal summary and sign-off) and where appropriate, the AMD will request further work be undertaken prior to him recommending to the RO that annual appraisal is satisfactory. Those appraisals where the AMD was appraiser, the RO reviews and checks inputs and outputs.
- 5.3.5 The RO also reviews the appraisals on receiving the AMD's recommendation and either concurs or requests further clarification.
- 5.3.6 Each doctor is asked to provide feedback about the system and appraiser after their appraisal has been submitted (see section 5.6). This is a system that is embedded in the overall MyL2P system. This feedback is combined with other objective measures and subject to impression of the AMD who aspires to feed back in writing on an annual basis. If any issues arise in the course of the year, the AMD will liaise with individual appraisers.
- 5.3.7 There is on-going feedback to the doctors being appraised and appraisers, at the time that appraisal submissions are being reviewed. This takes the form of email correspondence or telephone conferences with the relevant doctors. The aim of this is to improve the quality of the appraisal submissions and to ensure there is satisfactory engagement.
- 5.3.8 The reviews undertaken by the AMD and RO also often raise agenda items for the Appraiser Forums, where for example inconsistencies are identified.
- 5.3.9 The appraisers receive further group feedback during Appraiser Forum meetings.
- 5.3.10 Issues also discussed at the refresher training that appraisers are required to attend every 2 years.

## 5.4 Access, security and confidentiality

- 5.4.1 The e-appraisal system (MyL2P) is required to be used by all doctors. No breaches to the system or individual portfolios were recorded during 2017/18.
- 5.4.2 Access to individual appraisals on MyL2P is restricted by login to the doctor, their appraiser, RO, Medical Director (MD), AMD and the Revalidation Team and any other person the doctor provides access to (via their own login).
- 5.4.3 Doctors are made aware via the MyL2P system that patient identifiable information should not be included in their appraisals. This is also stated in the Trust's Medical Appraisal Policy.

## 5.5 Clinical Governance

- 5.5.1 All doctors are provided with a PDF formatted record (including a nil response if appropriate) of their Incidents, Complaints and Sickness for their appraisal year from the Revalidation Team. This data is directly uploaded to the doctor's appraisal record on MyL2P. Doctors are required to reflect on their involvement in incidents and complaints, both those included in the reports and any others that they are aware of but may not have been linked to them via Datix.
- 5.5.2 The minimum requirement for their appraisal portfolio is provided in a Portfolio Minimum Data Set which is reviewed every year.
- 5.5.3 The doctor is required to complete a checklist prior to submitting their appraisal to their appraiser and where key information (predominately the minimum data set) is missing, they are required to provide a reason for its absence.

## 5.6 Appraisal feedback

Of the 136 feedback questionnaires completed by doctors after their appraisal, the following is a selection of the feedback given:

Was your appraisal useful for:	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Your personal development	40%	52%	7%	1%	0%
Your professional development	47%	49%	4%	0%	0%
Your preparation for revalidation	53%	47%	0%	0%	0%
Promoting quality improvements in your work	42%	50%	8%	0%	0%
Improving patient care	43%	44%	11%	0%	1%

Number of hours	<1	1-2	2-3	3-4	>4
Duration of appraisal	1%	62%	26%	7%	4%

discussion					
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	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
The appraisal was satisfactory	63%	34%	1%	0%	2%
I was able to collect all the necessary supporting information from the organisation	54%	40%	2%	1%	2%

99% of the doctors either agreed or strongly agreed that they would be happy to have the same appraiser again. 1% were neutral on this.

## 6. Revalidation Recommendations (1.4.17 to 31.3.18)

Number of recommendations	16
Recommendations completed on time	16
Positive recommendations	14
Deferral requests	2
Non engagement notifications	0

- 6.1** The Revalidation Review Group meet monthly and consider those revalidation recommendations due to be made in the following 12 months. This allows time for any further requirements to be actioned to enable a positive revalidation recommendation to be made.
- 6.2** As an outcome of this process, 100% of recommendations due in 2017/18 were submitted on time.
- 6.3** Of these, all but 2 were positive recommendations, the remaining two were for deferral.
- 6.4** All positive recommendations were approved by the GMC and the doctors subsequently revalidated. In the case of the deferral, the proposed new recommendation date was accepted by the GMC.
- 6.5** No recommendations were made late (within GMC category of late 7 days and under).

*See Appendix 3; Audit of revalidation recommendations*

## 7. Recruitment and engagement background checks

### 7.1 Substantive and Fixed Term appointments

During 2017/18, 11 substantive doctors were employed and 9 doctors were employed on temporary contracts.

- 7.1.1 During the application and interview process, doctors are assessed to ensure they have the qualifications and experience in order to fulfil the duties of the post.

- 7.1.2 For consultants, all interviewees are required to complete a 16PF (16 personality factors) questionnaire and the resulting assessment report is considered by the Advisory Appointment Committee.
- 7.1.3 For consultants, an assessment centre is held if more than 1 candidate for the role is to be interviewed.
- 7.1.4 Where appropriate, Medical HR check the national database for Approved Clinician and Section 12 status. GMC registration is also checked.
- 7.1.5 Reference checks from the previous 3 years of employment are undertaken by Medical HR and the Appointing Officer confirms that they are satisfied with the references. The references will be checked for the correct dates and that the person giving them is the relevant person to provide.
- 7.1.6 Medical HR will meet with the doctor to verify their ID using the acceptable documents list. They request the original documents which are copied and used to process the Disclosure and Barring Service (DBS) check.
- 7.1.7 The Medical Directorate request information from the doctor's current/last RO, where the doctor has had one. This includes information about the doctor's last appraisal date, whether there are any concerns about the doctor's practice, conduct or health and if there are any outstanding investigations. The information received is checked by the Trust's RO, prior to final offer being made. Where this information is not received prior to the final offer being made\*, the offer remains subject to satisfactory RO information or satisfactory Annual Review of Competence Progression (ARCP) outcome for those doctors joining the Trust straight from a training programme.
- 7.1.8 The MD checks and approves the final offer letter prior to sending.
- 7.1.9 If a doctor is recruited with GMC conditions, further information from the GMC is requested.  
\* if requests for RO information have not been responded to after 4 weeks, the Trust's RO will contact the GMC Employment Liaison Advisor to flag but recruitment will continue to ensure posts are filled as soon as possible.

## **7.2 Agency Locum appointments**

- 7.2.1 Agency locum doctors do not have a prescribed connection to the Trust. Their connection is with their locum agency. It is the agency's responsibility to ensure their doctors are appraised and revalidated however the Trust's processes to engage locums, does include appraisal and revalidation checks.
- 7.2.2 During 2017/18 the Trust had a primary supplier agreement with Athona Recruitment.
- 7.2.3 The Medical Clinical Lead/Medical Manager usually leads on the securing of locum doctors for their areas.
- 7.2.4 Athona provides suitable CVs and references through an online portal.

- 7.2.5 If a locum doctor's appraisal is over 24 months overdue, then it is recommended the doctor is not engaged.
- 7.2.6 If a booking is taken forward, a checklist is sent via email confirming the doctor has a DBS, Occupational Health clearance, Right To Work etc.
- 7.2.7 In line with the Trust guidance on booking locum doctors, the internal lead is then required to undertake a telephone interview prior to commencement.
- 7.2.8 In line with Trust guidance on booking locum doctors, on their first day a locum doctor's identification should be verified through the checking of their passport or photo-card driving licence.
- 7.2.9 Athona provide a regular list of the locum doctors working within the Trust. This includes the doctor's appraisal status. This is then checked by the Business Manager and if an appraisal is overdue, the agency is connected for further information.

## **8. Monitoring Performance**

- 8.1 Doctors are generally monitored through their team management structures.
- 8.2 In addition, a doctor's performance is monitored via the appraisal system which includes a requirement for feedback from service users and 360° feedback from colleagues on a three yearly basis.
- 8.3 Information in relation to whether a doctor is involved in serious untoward incidents or subject to complaint is also included in the appraisal system.
- 8.4 Serious untoward incidents are investigated using the Trust investigation procedures carried out by the trained investigators.
- 8.5 In the event that any concerns are raised, these are referred to the MD who can instigate various levels of investigation and take to the Responding to Concerns Advisory Group as appropriate.

## **9. Responding to Concerns and Remediation**

- 9.1. The Trust has a Responding to Concerns and Remediation Policy which was approved in January 2015. The reviewed policy will go to Executive Management Team for approval during Q2 2018
- 9.2. As at 31.3.18 the Trust had 2 trained Case Managers and 3 trained Case Investigators, all of whom are medical consultants.
- 9.3. A Responding to Concerns Advisory Group meets monthly wherever possible/required. It is chaired by the RO and is also attended by the Medical Director, Director of Human Resources, Organisational Development and Estates, the AMD for Revalidation, Director of Nursing and Quality, Medical Directorate Business Manager and HR Business Partner with responsibility to support Revalidation. Relevant general management representatives attend as and when required. This approach ensures there is a consistent and open approach taken across the Trust in the investigation of concerns in relation to doctors. The group's terms of reference are

included in the Responding to Concerns and Remediation Policy and were reviewed during 2017/18.

- 9.4.** Remediation, when identified, is carried out on an individual basis, being tailored to the individual's needs.

## **10. Risk and Issues**

The following are areas of potential difficulty for the Trust:

**10.1** The voluntary status of the appraisers and their importance to our system is noted annually. It remains a concern that, if under pressure from other areas of work, doctors could withdraw from this role, thus threatening the appraisal process.

**10.2** There is a continuing expectation that there will be further development demands on the revalidation process which will place increasing demands on resources. If it transpired that additional resources are required, the RO will present this to the appropriate for a in the Trust.

## **11. Actions, Improvements and Next Steps**

An action plan for medical appraisal/revalidation is regularly reviewed and updated by the AMD and Business Manager and periodically reviewed with the RO.

### **11.1 2015-16 Actions**

11.1.1 Consideration to be given to undertaking a peer review with a neighbouring Trust to comply with the requirement for independent verification every 5 years.

**Update 16/17:** It is anticipated this will be completed during 2017/18.

**Update 17/18:** This was undertaken 20<sup>th</sup> November 2017 and the report agreed and a copy provided to NHS England (NHSE).

11.1.2 Ensuring that appraiser time is reflected in the job plans of appraisers.

**Update 16/17:** This has been partially successful. However the development of the e-job planning system should support this.

**Update 17/18:** E-job planning is being fully implemented during 2018/19 and an exercise will be undertaken to check data is being captured.

### **11.2 2016-17 Actions**

11.2.1 Review the Responding to Concerns & Remediation Policy for Medical Staff.

**Update:** Policy has been reviewed and awaiting Executive Management Team (EMT) approval. A delay in EMT approval has occurred due to consultation with the Local Negotiating Committee.

11.2.2 Review the Medical Appraisal Policy.

**Update:** Policy has been reviewed and received EMT approval March 2018

- 11.2.3 Review the training of new and existing appraisers to ensure still fit for purpose and making an efficient use of resources.  
**Update:** A change in appraiser training delivery was agreed based on the experience of the trainers. The revised programme includes a full day for new appraisers and half a day for existing appraisers, wherever possible, this being delivered by joining the new appraisers in their afternoon session. This enables the new appraisers to gain insight both from the trainers and the existing appraisers.
- 11.2.4 Present a paper on appraisal and revalidation to the Members' Council.  
**Update:** A delay in presenting last year's Board Report resulted in the RO agreeing to not present to Members' Council. Subsequently, the RO, after participating in discussions at the north RO network meetings, decided to develop a Revalidation Oversight Group (see 11.4.3) which would include lay representation. The RO felt that as there would always be an issue with the timeliness of presenting a paper to Members' Council, this group would provide the lay presentation instead..
- 11.2.5 Increase the number of medical case investigators.  
**Update:** Reviewed and judged sufficient considering the number of investigations historically required.
- 11.2.6 Review and amend the recruitment checks undertaken for employing substantive and fixed term doctors.  
**Update:** The processes were reviewed in conjunction with Medical Staffing Team and appropriate changes made.
- 11.2.7 Undertake a continuous review of the resources required to adequately support the appraisal/revalidation process.  
**Update:** The current demands were considered and at the present time it was concluded that resources were sufficient. The revalidation team are conscious of the changing environment and the regular external reviews of the medical revalidation process which could lead to further developments required. As such, resource requirements will be reviewed as changes/demands are made.

### 11.3 Additional Improvements

- 11.3.2 An outcome of the peer review undertaken in November 2017 was to consider reviewing those coming up to revalidation 12 months ahead of their revalidation date. Although reviews of those within 3 months of revalidation were being undertaken, it was agreed that it would be good practice to review 12 months in advance and this was immediately implemented.
- 11.3.3 Changes to Health Education England responses to requests for RO to RO information led to a change in pre-employment checks. Final contracts for those doctors joining the Trust straight from a training programme are subject to satisfactory ARCP outcome.

### 11.4 Next Steps (2017-18 Actions)

- 11.4.1 A further outcome of the peer review was to consider if invalid detentions data would be appropriate to include in the appraisal minimum data set. This is being considered in collaboration with the Trust's Legal Services Department.
- 11.4.2 To review the current process for requesting RO to RO information and consider if it can be included in the standard online reference request process (excluding those joining the Trust straight from a training programme).
- 11.4.3 To implement a Revalidation Oversight Group to meet on a 4 monthly basis. Role will include reviewing the NHSE Annual Organisation Audit, review appraisal/revalidation performance, provide input into the annual report, assist in the development of strategy and policy, assist in responding to national guidance/regulation and ensure continuous improvement of the appraisal and revalidation processes. Membership would include RO, MD, AMD, Business Manager, and representation from medical appraisers, non appraiser doctors and lay representative.

## **12. Recommendations**

- 12.1** The Board is asked to receive this report noting that it will be shared, along with the Annual Organisational Audit, with the Tier 2 Responsible Officer at NHS England.
- 12.2** The Board is further asked to recognise that the resource implications of medical revalidation are likely to continue to increase year on year.
- 12.3** The Board is finally asked to approve the Statement of Compliance attached as Appendix 5 of this report confirming that the Trust, as a Designated Body, is in compliance with the regulations.

**APPENDIX 1  
AUDIT OF MISSED / INCOMPLETE APPRAISALS DURING 2017/18**

<b>DOCTOR FACTORS</b>	<b>CONSULTANT</b>	<b>SAS/TRUST GRADE</b>
Maternity Leave during the majority of the appraisal period	1	0
Sickness Absence during the majority of the appraisal period	1	0
Prolonged Leave during the majority of the appraisal period	0	0
Suspension during the majority of the appraisal period	0	0
New starter	0	2
Postponed due to incomplete portfolio / insufficient supporting information	0	0
Lack of time of doctor	1	0
Lack of engagement of doctor	0	0
Other doctor factor (describe)	0	0
<b>APPRAISER FACTORS</b>	<b>NUMBER</b>	
Unplanned absence of appraiser	0	0
Lack of time of appraiser	0	0
Other appraiser factor (describe)	0	0
<b>ORGANISATION FACTORS</b>	<b>NUMBER</b>	
Administration or management factors	4	0
Failure of electronic information systems	0	0
Insufficient numbers of trained appraisers	0	0
Other organisational factors (describe)	0	0

Four doctors have appraisals reported as incomplete for organisational factors. This is due to their appraisal period being logged on MyL2P as April 17 - March 18, resulting in their appraisal meeting not being due until after the appraisal year i.e. April 2018. This will be addressed for 2018/19 appraisal year.

4 APPENDIX 2  
**QUALITY ASSURANCE AUDIT OF APPRAISAL INPUTS AND OUTPUTS**

<b>TOTAL NUMBER OF APPRAISALS COMPLETED - 129</b>		
	<b>NUMBER OF APPRAISAL PORTFOLIOS AUDITED (1.4.17-31.3.18)</b>	<b>NUMBER OF APPRAISAL PORTFOLIOS DEEMED TO BE ACCEPTABLE AGAINST THE STANDARDS</b>
<b>APPRAISAL INPUTS</b>		
Scope of work	129	129
Is continuing professional development compliant with GMC requirements?	129	129
Is quality improvement activity compliant with GMC requirements?	129	129
Has a patient feedback exercise been completed?	129	129
Has a colleague feedback exercise been completed?	129	129
Have all complaints been included and appropriately reflected on?	129	129
Have all significant events been included and appropriately reflected on?	129	129
Is there sufficient supporting information from all the doctor's roles and places of work?	129	129
Is the portfolio sufficiently complete for the stage of the revalidation cycle?	129	129
Other reason	129	126 <ul style="list-style-type: none"> <li>• Whole scope of work</li> <li>• SI reflection</li> <li>• Medical educator</li> </ul>
<b>APPRAISAL OUTPUTS</b>		
Appraisal summary	129	129
Appraiser statement	129	129
PDP	129	129

All deficits were either addressed satisfactorily after the appraisal had been referred back, or agreement given that it would be addressed in the doctor's next appraisal.  
 Some appraisals were referred back for multiple reasons.



**APPENDIX 3****AUDIT OF REVALIDATION RECOMMENDATIONS (1<sup>st</sup> April 2017 to 31 March 2018)**

Recommendations completed on time (within GMC recommendation window)	16
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
<b>TOTAL</b>	<b>16</b>
<b>PRIMARY REASON FOR LATE/MISSED RECOMMENDATIONS</b>	
No Responsible Officer in post	0
New starter / new prescribed connection established within 2 weeks of revalidation due date	0
New starter / new prescribed connection established more than 2 weeks of revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible Officer error	0
Inadequate resources or support for the Responsible Officer role	0
Other (describe)	0
<b>TOTAL (sum of late and missed)</b>	<b>0</b>

**APPENDIX 4**  
**AUDIT OF CONCERNS ABOUT A DOCTOR'S PRACTICE**

<b>CONCERNS</b>	<b>HIGH LEVEL</b>	<b>MEDIUM LEVEL</b>	<b>LOW LEVEL</b>	<b>TOTAL</b>
<b>NUMBER OF DOCTORS WITH CONCERNS ABOUT THEIR PRACTICE IN THE LAST 12 MONTHS</b>				
Capability concerns (as primary category)	0	0	0	0
Conduct concerns (as primary category)	0	0	0	0
Health concerns (as primary category)	0	0	0	0
<b>REMEDIATION/RESKILLING/RETRAINING/REHABILITATION</b>				
Number of doctors who have undergone formal remediation				0
Consultants (permanent, employed staff)				0
Staff grade, associate specialist, specialty doctor (permanent, employed staff)				0
Temporary or short term contract holders				0
<b>OTHER ACTIONS / INTERVENTIONS</b>				
<b>LOCAL ACTIONS</b>				
Number of doctors who were suspended/ excluded (commenced or completed between 1.4.17 and 31.3.18)				0
Number of doctors who have had local restrictions placed on their practice in the last 12 months				0
<b>GMC ACTIONS</b>				
Number of doctors referred to the GMC between 1.4.17 and 31.3.18				0
Number of doctors who underwent or undergoing GMC Fitness to Practice procedures between 1.4.17 and 31.3.18				1
Number of doctors who had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1.4.17 and 31.3.18				0
Number of doctors who had their registration / licence suspended by the GMC between 1.4.17 and 31.3.18				0
Number of doctors who were erased from the GMC register between 1.4.17 and 31.3.18				0
<b>NATIONAL CLINICAL ASSESSMENT SERVICES (NCAS) ACTIONS</b>				
Number of doctors about whom NCAS has been contacted between 1.4.17 and 31.3.18				0
Reason for contacts:				
For advice				
For investigation				
For assessment				
Number of NCAS investigations performed				
Number of NCAS assessments performed				



## Designated Body statement of Compliance

The board of South West Yorkshire Partnership NHS Foundation Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

Yes, this being Dr Adrian Berry

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

Yes, this is maintained by the Trust's Medical Revalidation Team utilising GMC Connect and MyL2P

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

Yes, as of 31<sup>st</sup> March 2018 there are 22 appraisers for 133 doctors with a prescribed connection to the Trust. The Medical Appraisal Policy requires appraisers to undertake between 3 and 7 appraisals per year.

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

Yes, this is achieved by attendance at appraisal training every 2 years, appraisers' forum (2 during 2017-18), receiving feedback for the role and receiving direct feedback from the AMD for Revalidation on quality issues.

5. All licensed medical practitioners<sup>1</sup> either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

Yes, see annual report

<sup>1</sup> Doctors with a prescribed connection to the designated body on the date of reporting.

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners<sup>1</sup>, which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

Yes, see annual report

7. There is a process established for responding to concerns about any licensed medical practitioners<sup>1</sup> fitness to practise;

Yes, as specified within the Trust's Responding to Concerns and Remediation Policy

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Yes, there is a requirement through the appraisal process that supporting information regarding a doctor's full scope of practice is incorporated and reviewed.

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners<sup>1</sup> have qualifications and experience appropriate to the work performed; and

Yes, the Trust's HR procedures are followed

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Yes, a regularly reviewed action plan is in place to continue to development the quality and management of the appraisal and revalidation processes.

Signed on behalf of the designated body

Name: \_\_\_\_\_

Signed: \_\_\_\_\_

[chief executive or chairman]

Date: \_\_\_\_\_

**APPENDIX 6**

**PEER REVIEW OF SOUTH WEST YORKSHIRE PARTNERSHIP  
 NHS FOUNDATION TRUST  
 MEDICAL REVALIDATION AND APPRAISAL PROCESSES  
 By LEEDS AND YORK PARTNERSHIP NHS FOUNDATION  
 TRUST**

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) provided Leeds and York Partnership NHS Foundation Trust (LYPFT) with a pack of pre-visit information which consisted of the following:

- Appraisal Board Report
- Medical Appraisal Policy
- SWYPFT Annual Organisational Audit (AOA) end of year questionnaire 16/17
- Responding to concerns and remediation policy
- Medical revalidation review group terms of reference
- Responding to Concerns advisory group terms of reference

This information was reviewed by LYPFT prior to the review and key themes were collated for further discussion.

**IN ATTENDANCE AT THE REVIEW:**

<b>SWYPFT</b>	<b>LYPFT</b>
Adrian Berry, Responsible Officer	Claire Kenwood, Responsible Officer
Gerry Roney, Associate Medical Director for revalidation	Douglas Fraser, Associate Medical Director for medical appraisal and CPD
Julie Hickling, Medical Directorate Business Manager	Gina White, Medical Directorate Manager
Charlotte Lyons, Medical Directorate Administrator	Joanne Chapman, Medical Directorate Administrator

The agenda for the peer review is provided in Appendix A. On the day the prepared templates were used as the framework for the review and discussion. Exchanged information is provided in Appendix B. Key points noted at the peer review were

**APPRAISAL AND REVALIDATION RECOMMENDATIONS**

At 31.3.17 there were 141 prescribed connections, 125 appraisals were completed, 15 were incomplete/ missed appraisals and there was one unapproved incomplete/missed appraisal equating to an 88.65% completion rate.

3 month forward look of revalidation recommendations i.e. doctors under notice



In the absence of SAS doctor specific data the consultant's data is provided.

Job plan is informed by activity data therefore at appraisal reflection is on the job plan

Doctors expected to make statement about indemnity arrangements and medical educator role

AMD checks information provided has been reflected on, notes have been addressed. RO may return appraisal form to the doctor if not felt to be good enough.

Appraiser recruitment and training scheduled. Regular training provided to new and established appraisers.

**Learning:** Consider 12 month horizon scan of forthcoming revalidation recommendations to allow any gaps to be rectified

**Good practice:** Providing the number of sickness days is so that the appraiser can discuss the impact of absence regarding completing CPD and Quality Improvement activities

## PERFORMANCE

Data sources allow triangulation.

Culturally need to create an organisation that is willing to listen. Known reluctance of non-medical staff to raise concern about doctors.

Multi Source Feedback (MSF) in place.

**Learning:** Consider including invalid detentions in minimum dataset

**Good Practice:** Contact with a coroner is flagged with the doctor by the Revalidation Team

## OTHER TEAM PROCESSES

Managing concerns covered by procedures.

Annual medical leadership development conference. This has been widened this year to a multi professional event that evaluated well.

Employment processes managed by HR. RO expected to be one of the referees

**Good Practice:** Director of HR and Director of Nursing (Lead Director for clinical governance) attend responding to concerns advisory group

**Good Practice:** RO expected to be one of the referees

## GENERAL

Appraisals are included in job plan .25 PA for 6-8 appraisals and related CPD

Succession planning for RO was not discussed.

AMD briefs council of governors based on annual report

Case investigators in place and expected to complete CPD for this role.

## **CALIBRATION**

Case used was a doctor that had 3 questions on the MSF responded to negatively including probity. Approach taken matched with approach that would be taken by LYPFT.

MD, Business Manager and AMD checked other sources of data and there was no other evidence to support concern. Check made probity declaration completed

AMD contacted supervising consultant and again no concerns raised

MSF question design reviewed for potential to produce false negatives

Case discussed with RO. Appraisal reviewed as satisfactory.

## **SUMMARY**

Good practice noted includes

- Providing the number of sickness days is so that the appraiser can discuss the impact of absence regarding completing CPD and Quality Improvement activities
- Contact with a coroner is flagged with the doctor by the Revalidation Team
- Director of HR and Director of Nursing (Lead Director for clinical governance) attend responding to concerns advisory group
- RO expected to be one of the referees in recruitment process

Learning identified by SWYPFT from the process was

- Consider 12 month horizon scan of forthcoming revalidation recommendations to allow any gaps to be rectified
- Consider including invalid detentions in minimum dataset

NHS England to consider the good practice and learning from the review for sharing at network events

## Trust Board 25 September 2018 Agenda item 8.2

<b>Title:</b>	<b>Sustainability report 2017/18</b>
<b>Paper prepared by:</b>	Director of Human Resources, Organisational Development and Estates
<b>Purpose:</b>	<p>The purpose of this paper is to provide the Board with an overview on performance on sustainability based mainly on the impact the Trust is having in reducing its environmental impact. It covers how we buy, use and dispose of resources and the impact this has on our carbon footprint. It also looks at how people within the organisation travel and the impact of new ways of working and technology which can assist in reducing energy usage.</p> <p>The green travel plan currently in its review process gives detail on how Trust staff are being supported in helping them to plan different ways of travelling either to get to their place of work or during their work activities.</p>
<b>Mission/values:</b>	This report is in line with the Trusts ambition to be a positive contributor to society overall. And to allow people to live their life to the full
<b>Any background papers/ previously considered by:</b>	Sustainability Strategy 2015/16 – 2019/20 and associated policy.
<b>Executive summary:</b>	<p>The report evidences the excellent performance of the Trust in driving down energy consumption and carbon emissions through a combination of estate rationalisation, Investment in energy saving processes and equipment and good housekeeping. The report also addresses actions in key areas as follows:-</p> <ul style="list-style-type: none"> <li>➤ Reducing the use of vehicles.</li> <li>➤ Promoting the use of technology</li> <li>➤ Responsible procurement</li> <li>➤ Waste and recycling</li> <li>➤ Promotion of agile working and hot desking</li> <li>➤ Green travel plans</li> <li>➤ Sustainable building</li> </ul> <p><b>Risk Appetite</b></p> <p>This report forms part of the annual information process for Board for the sustainability agenda.</p>
<b>Recommendation:</b>	<b>Trust Board is asked to NOTE the content of this report.</b>
<b>Private session:</b>	Not applicable.



South West  
Yorkshire Partnership  
NHS Foundation Trust

# Sustainability

## Summary report

### 2017/18

September 2018

With **all of us** in mind.

## Introduction

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

## Sustainability Strategy

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

- A healthier environment – including reducing pollution and carbon emissions
- Resilience – for changing times and climates.
- Responsible sourcing of goods and services.

The Trust is working to a five year sustainability strategy covering the period 2015/16 - 2019/20. The strategy provides the framework to ensure the integration of resource sustainability into Trust operations and in engagement with staff, service users and other parties we work with.

The sustainability strategy covers the national goals and delivers on our energy and carbon management, procurement, transport, travel and access, water, waste, designing the built environment and adaptation.

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

## Sustainable Development and Carbon Management

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### **Trusts Carbon Management Plan:**

The Trust carbon emissions for 2017-18 have been updated and the comparisons of both the base year 2010-11 and last year 2016-17 are detailed below:

**DEFINITION:** Greenhouse gas emissions are categorised into three groups or 'scopes' by the most widely-used international accounting tool, the Greenhouse Gas (GHG) Protocol. While scope 1 and 2 cover direct emissions sources (e.g., fuel used in company vehicles and purchased electricity), scope 3 emissions cover all indirect emissions due to the activities of an organisation.

The Carbon Management Tool covers **Stationary** (Electricity and Gas Consumption) **Transport** (Business Transport) and **Further Sources** (Water and Waste) with all these inputs converted into CO2 emissions

## Carbon Emissions – Data Analysis

### Data

Carbon Emissions			
	CO2 (tonnes) 2010-11 Baseline Emissions	CO2 (tonnes) 2015-16	Overall %Reduction
Stationary	11,515	8,336	-27.61%
Transport	1,404	1,127	-19.73%
Further Sources	452	64	- 86.72%
	<b>13,373</b>	<b>9,527</b>	<b>-28.76%</b>

### Sustainability Strategy

The Trust set an original Carbon Reduction Target of 18% (2,407 Tonnes (CO2) based on its Carbon Emissions in 2010-11 Tonnes **13,373** (CO2) this ambition reduction in Stationary, Transport and Further Sources committed the Trust to actively pursue areas of specific improvements and through a targeted operational and energy efficiency investments plan coupled with the Trust's Estates Strategy that recognises service change with agile working and estates rationalisation, has resulted in the planned reduction being exceeded.

### New Carbon Reduction Targets of 34% by 2020

The focus and challenge of reducing the Trust's Carbon Emissions has resulted in a significant improvement in our Carbon Footprint and therefore going forward and to align the Trust's sustainability goals, the original planned 5 year target has been extended to 2020 with a new target reduction of 34% that in total will require the Trust to reduce its Carbon Emissions by 4,547 Tonnes CO2.

Trust Updated Carbon Reduction Target (2020) – 34%.  
Overall Planned Reduction **4,547** Tonnes (CO2).

## Trusts Carbon Management Plan: 2017-18 Update

Source - ERIC Data for 2017-18; Carbon Trust assessment tool

### Baseline Analysis – 2010-11 to 2017-18 Carbon Reduction 4,830 Tonnes (CO2)

Data

	Carbon Emissions		
	CO2 (tonnes) 2010-11 Baseline Emissions	CO2 (tonnes) 2017-18	Overall %Reduction
Stationary	11,515	7,367	-36.02%
Transport	1,404	1,133	-19.30%
Further Sources	452	43	-90.48%
	<b>13,373</b>	<b>8,543</b>	<b>-36.18%</b>

### Annual Analysis – 2016-17 to 2017-18

Data

	Carbon Emissions		
	CO2 (tonnes) 2016-17	CO2 (tonnes) 2017-18	Overall %Reduction
Stationary	8,273	7,367	-10.95%
Transport	683	1,133	+65.88%
Further Sources	52	43	-17.30%
	<b>9,009</b>	<b>8,543</b>	<b>-5.17%</b>

Actual Reduction in 2017-18 – 466 Tonnes (CO2) - 5.17%

## Carbon Emissions – Analysing Data

The Trust's Sustainable/Carbon Reduction Plan aims to reduce its Carbon Emissions in three categories Stationary (Electricity & Gas), Transport (Fuel) and Further Sources (Water & Waste) and this year's reduction of 466 Tonnes (CO<sub>2</sub>) 5.17% have come from a reduction in Stationary and Further Resources producing a combined reduction of 915 Tonnes (CO<sub>2</sub>) however, the Trust's Business Transport Miles has increased from 3,584,609 to 3,937,771 miles, this increase of 353,162 miles is due to the reporting requirements/definition in the Trust's mandatory Estates Returns Information Collection ERIC Returns which now includes Other Travel/Transport Miles - **628,436 Miles**.

### Calculated using the following definition

The total business mileage undertaken by staff via other modes of transport such as public transport, trains, taxis, tram, underground and cycling. If the Trust had a travel booking service they would be able to provide travel distance data. An alternative method would be to use these indicative costs per mile for each mode of transport to calculate the distance based on cost:

Cycling = 20p/mile (Agenda for Change rate)

Taxi (non-London) = 283p/mile (using standard 9am - 5pm Monday to Friday rates for different journey distances based on several councils published tariffs)

Taxi (London) = up to 542p/mile (using standard 5am - 8pm (tariff 1) Monday to Friday rates for different journey distances based on TfL published rates)

Coach/Bus = 12p / mile (based on some indicative mid-range prices)

Rail/train = 38p/mile (based on some indicative mid-range prices)

The inclusion of the above has resulted in an increase of 450 Tonnes (CO<sub>2</sub>) in 2017-18.

## Sustainable Development and Carbon Management Plan

The Trust's ongoing commitment to reducing carbon emissions is crucial to delivering the Sustainable Development and Carbon Management Plan with targeted investment in Energy Efficiency Improvements. A robust approach to monitoring and the contribution made through the implementation of the Trust's Estates Strategy by the rationalisation of the property portfolio, supported by agile working, have contributed to an impressive overall reduction of **4,830 Tonnes (CO<sub>2</sub>) 36.18%** from the Base Year **2010-11** and therefore the targeted reduction of 34% has been achieved though the significance of continually striving to reduce the Trust's Carbon Footprint linked to both consumption/cost reduction is becoming increasingly more important as the Commodity prices are increasing with market volatility alongside additional (Non Commodity) Government taxes rises with transport and distribution costs also increasing the cost of Electricity, Gas and Water and so we are and will be seeing significant increases over the coming years. Therefore, it is essential that every opportunity to ensure energy and water is been effectively purchased, used and utilised has become business critical.

## Procurement

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

The main procurement challenges for the coming months include:

- To monitor environmental and sustainability in all goods and service tenders
- To work with suppliers who are environmentally aware and hold the relevant accreditations
- To undertake large contracting exercises
- To identify purchasing Cost Improvement Plans
- To develop skills in the procurement team to enable positive change
- To update the Sustainable Procurement Strategy
- To update the Trusts Procurement Strategy which will include the recommendations detailed in the Carter Report (February 2016) where applicable to the Trust
- To update the departments operating procedures and policies with the long term aim of achieving level 3 of the NHS Procurement Standards

## Sustainable Travel & Agile Working

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

### **Green Travel**

To support further reduction in business mileage the Trust has developed a green travel plan to minimise the impact of travel on the environment within the context of running an efficient business. The plan includes a range of measures aimed at promoting sustainable travel choices and reducing reliance on car travel. If effective, this will bring environmental, social and health benefits to both staff and to our communities.

The travel plan will ensure:

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

***For staff, an effective travel plan should offer:***

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

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

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

The plan will also aim to improve the accessibility of the Trust's estate, improve road safety on or near sites, preserve valuable land and avoid the costs of providing too much parking.

The objective is to further reduce the number of personal and business miles and increase the use of public transport by 5% by 2020. The plan will include targets and baseline measurement and evaluation.

As the Trust's use of buildings and estate changes, site specific plans are developed and the Trust's vehicle fleet reviewed.

### **Baseline assessment**

To assist development of a green travel plan, a detailed understanding of the current position is required. Travel surveys at Fieldhead and Kendray, undertaken in early 2017 have been repeated in 2018 to provide continued intelligence from which to better understand demand.

We know that staff use cars for convenience and to undertake other activities on the way to and from work. Time and cost savings are also major factors.

In respect of business miles travelled, on the base year of 2014/15 an average monthly total of 310,000 business miles was recorded through payroll. The annual business mileage in 2015/16 was 3,735,911 for the Trust as a whole (excluding white fleet). In 2016/17 the figure was 3,584,609 a reduction of 4%. Definition changes in 2017/18 have increased that figure to: 3,937,771 miles but this does include **628,436** of previously unreported mileage this shows that the Trust has continued to reduce its overall reliance on vehicles by 275,274 miles. Access to public transport is varied across the Trust. Comprehensive assessment was undertaken 4 years ago and there are plans to refresh this in 2018. Car share and cycling schemes are already in place and publicised to staff, with cycle storage available at larger sites.

The following is included in the Green Travel Plans:

- Providing public transport information on the intranet and the Trust's website, ensuring this is regularly updated
- Bike to Work and staff cycle incentive schemes, with reminders about safe cycle storage
- Staff invited to join task and finish groups for specific pieces of work, providing a forum to consult staff on the implementation of the Travel Plan and to develop ideas for further improvement.
- Survey of staff travel to work choices
- Explore alternative messages and methods of communication to encourage a reduction in business mileage, evidencing a 4% reduction
- Re-launch of the car sharing schemes with Liftshare
- Work with local bus companies to provide better public transport links, for example, to community hubs.
- Publicise that staff can access the Mid Yorkshire bus services to Pinderfields and Pontefract Hospitals, following recent negotiations

### **Examples of positive practice in agile working and use of technology:**

A range of initiatives have been implemented in support of enabling an agile workforce:

- The Trust's agile working team continues to support teams to become agile across the Trust. Typically this involves workshops tailored for individual teams and equipment deployment.
- The agile working team has worked with partners to support reciprocal Wi-Fi sharing arrangements to allow staff to work from partner sites rather than return to base during and after meetings.

The locations are:

- Barnsley Hospital NHS Foundation Trust
- Huddersfield Royal Infirmary
- Calderdale Royal Hospital
- Broad Lea House, Bradley
- Batley Health Centre

- Becksid Court, First Floor
  - Cleckheaton Health Centre
  - Dewsbury Health Centre
  - Eddercliffe Health Centre
  - Fartown Health Centre
  - White Rose House, Wakefield
  - Mill Hill Health Centre
  - Holme Valley Memorial Hospital
- Skype for Business Audio Conferencing Facilities available at:
- Fieldhead Hospital
  - Kendray Hospital
  - Folly Hall
  - Laura Mitchell Health & Wellbeing Centre
  - Drury Lane Health & Wellbeing Centre
  - Baghill House Health & Wellbeing Centre
  - Priestly Unit Dewsbury
- Skype for Business Video Conferencing Facilities available at:
- Folly Hall
  - Laura Mitchell Health & Wellbeing Centre
  - Priestly Unit Dewsbury
- Skype for Business Video Conferencing Facilities will soon be available at:
- Fieldhead Hospital
  - Kendray Hospital
  - Becksid Court
  - Ravensleigh Resource Centre
- Over 2500 laptops are in use across the Trust by agile workers
- There are significant numbers of staff using Mobile Broadband which supports working in community settings and in people’s homes
- There are more than 1900 agile workers with VPN enabling home working and other otherwise unsecured Wi-Fi connections
- There are over 1900 Skype for Business users, having access to both audio and video conferencing facilities via laptop/desktop computers regardless of location (provided there is network connection)
- Hot desking is available at the following locations to support staff in reducing travel:

Barnsley	Calderdale	Kirklees	Wakefield
Kendray Hospital	Laura Mitchell	Folly Hall	Baghill House
Worsbrough LIFT	The Dales	Becksid Court	Drury Lane
Apollo Court MC	Hope Street Resource Centre	Priestly Unit	Fieldhead
Cudworth LIFT	Hebden Bridge HC	Ravensleigh Resource Centre	
Goldthorpe LIFT			
Hoyland LIFT			
Athersley Roundhouse			
Mount Vernon Hospital			

## Recycling furniture

Rationalisation of Trust premises resulted in large amounts of furniture becoming surplus to requirements. A plan was initiated to maximise furniture sent for re-use which included:

- An 'open day' at Mount Vernon Hospital, creating the opportunity for staff to view equipment/furniture which was available for re-use
- Sharing listed items with local Trusts and public bodies
- Surplus equipment was offered to charities via the Furniture re-use Network
- Remaining items not suitable for re-use or sale by charities were sent by skips to a mixed recycled facility where the materials were segregated and sent for recycling.

## Waste Management Procedure Policy

The Trust's Waste Management Procedure Policy is subject to update in line with developments in environmental and waste legislation.

All employees generating waste are responsible for the correct segregation of waste. Where staff treat or care for a person in their own home, any waste produced is considered to be produced by that care professional. Part of the Duty of Care is to ensure that the waste is dealt with appropriately, from point of production to final disposal.

Barnsley Metropolitan Borough Council (BMBC) has advised its residents to dispose of offensive waste alongside general waste, which may not be appropriate for some offensive healthcare waste. As a result the Community Healthcare Waste Manual has been produced in partnership with the community nurses to ensure healthcare waste produced in domestic premises is disposed of appropriately.

- Carry out activity specific waste assessment and procedures for hazardous waste.

## Designing the Built Environment and Adaptation

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The Trust's Estates Strategy, approved by Trust Board and monitored through the Estates Trust Action Group, is to move from smaller properties, which do not offer a functional space, to purpose built Hubs which offer an optimal environment from which to deliver healthcare. This includes improving high quality green space and biodiversity on our estate, promoting physical health & wellbeing.

Integrating health and sustainable development considerations in our built environment is part of all new build projects and adaptations, with continued investment in energy reduction technologies, renewable energy and future proofing. The Trust works closely with local strategic partnerships and stakeholders to promote the delivery of health and sustainability outcomes when planning the built environment. The Trust's Estates Strategy is shared with partner organisations and

there is joint work with local Health and Wellbeing Boards and other partners to ensure that adaptation (the ability to respond in extreme circumstances) is a key part of local planning processes.

The Trust works to the Climate Change Mitigation and Adaptation Plan and BDUs are supported to embed resilience activity into their operations. The Trust aims to be a leading exemplar in the management of major and extreme events and has incorporated the impacts of climate change into the scenarios utilised for testing our plans.

In addition the Trust has invested in the redevelopment of the Fieldhead site for non-secure services with the completed development being occupied in May 2019. This building incorporates high levels of insulation together with photo voltaic electricity panels and natural stack ventilation to reduce the consumption of fossil fuels.

## Summary / Next Steps

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Work continues to deliver the Trust's Sustainability Strategy and to monitor performance

Changes in director portfolios have resulted in the transfer of responsibility for this agenda from the Director of Corporate Development to the Director of Human Resources, Organisational Development and Estates. Actions will continue to be monitored and update provided to Trust Board on an annual basis.

**Trust Board 25 September 2018  
Agenda item 8.3**

<b>Title:</b>	<b>Health and Safety Annual Report 2017/18 and action plan 2018/19</b>
<b>Paper prepared by:</b>	Director of Human Resources, Organisational Development and Estates
<b>Purpose:</b>	The Trust Board has a duty to ensure that the health, safety and welfare of service users, staff and visitors remains a high priority within the organisation and as far as reasonably possible, risks are mitigated or reduced. This paper is devised to give assurance that the Trust has the systems and processes, so far as practicable, to ensure the health, safety and welfare for service users, carers, staff and visitors.
<b>Mission/values:</b>	Safety and effectiveness in a complex caring environment is vital to ensuring carers can have confidence individuals receive care that enables them to live well in their communities.
<b>Any background papers/ previously considered by:</b>	The Clinical Governance and Clinical Safety Committee receives regular health and safety updates including a report for the health and safety Trust Action Group at each meeting. The Committee also receives and scrutinises the Safety Services Annual Report and action plan which is attached to this paper. The Executive Management Team has also considered and agreed the attached Safety Services Annual Report and action plan.
<b>Executive summary:</b>	<p>The role and responsibilities of the Trust Board for health and safety is set out in the Health and Safety Policy approved by the Board. The policy states that the responsibility of the Board is to ensure, so far as reasonably practicable:</p> <p>‘That all steps are taken to ensure the health, safety and welfare of all staff, partners, service users, visitors and others’</p> <p>To discharge its responsibilities the Trust has well established and robust management and governance arrangements for health and safety management. These arrangements include:</p> <ul style="list-style-type: none"> <li>➤ The Clinical Governance and Clinical Safety Committee having delegated responsibility for the regular oversight of health and safety management within the Trust. The Committee agrees and signs off the annual health and safety programme, receives and scrutinises the annual health and safety report, receives an update at each meeting from the health and safety Trust Action Group as well as receiving ad hoc reports.</li> <li>➤ An executive director on the Trust Board, Director of Human Resources, Organisational Development and Estates has been appointed as the lead for health and safety.</li> </ul>

- The Trust has an established and well attended Health and Safety, Emergency Preparedness Trust Action Group supported by two locality based sub-groups. These groups provide a strong management system, in line with national guidance, for ensuring that effective health and safety management is embedded across the Trust. To ensure strong engagement, these groups consist of specialist advisers, managers, clinicians and staff side representatives and there has been good attendance throughout the year.
- An annual health and safety audit is undertaken each year to ensure compliance with health and safety and fire safety related policies. This enables the Trust to identify any potential gaps requiring immediate action and/or use it as a base to inform the annual programme.
- The Trust runs significant safety training programmes and monitors attendance.
- Health and Safety performance is measured regularly through the analysis of a number of data sources including:
  - Datix Reports
  - Specialist Advisers reports
  - Annual monitoring returns
  - Ad hoc health and safety visits
  - Any external reports e.g. CQC
  - Sickness reports
- The Trust's capital programme prioritises schemes related to health and safety and fire compliance.

The attached Safety Services report is designed to provide an update of the key actions related to the above for 2017/2018. The report also details the high level priorities for 2018/2019 which have been signed off by the EMT and Clinical Governance and Clinical Safety Committee, the key themes are:

- Continue to embed a robust risk based monitoring and audit programme.
- Refine the set of performance indicators
- Continue to deliver and improve health and safety training.
- Develop regular communications framework for health and safety.
- Ensure the Trust responds to ongoing learning from the Grenfell fire
- Revise the Trust's Health and Safety Policy
- Trust Board training following recent NHS corporate manslaughter cases

#### **Risk appetite**

Risk identified – the Trust continues to have a good governance system of proactive safety support to all levels of service.

This report covers assurance for compliance of risk for health and safety and other safety related issues i.e. Fire, Security and

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

# Safety Services

## Annual Report 2017/2018

April 2018 Nick Phillips, Head of Estates & Facilities

Produced in conjunction with Safety Service Advisers

## **Contents**

1. Executive Summary
2. Introduction
3. Health & Safety
4. Fire Safety
5. Security
6. Emergency Preparedness
7. Conclusion

## **Appendices**

1. Health & Safety Action Plan 2018/2019
2. Security Management Action Plan 2018/19
3. NHS England Core Standards for Emergency Preparedness, Resilience & Response Action Plan 2018/19
4. Key Performance Indicators
5. Safety Related Training Performance
6. Health and Safety Action Plan 2017/18 Final report

## 1. Executive Summary

This report is designed to update the wider Trust on activity during the previous year and plan for the forthcoming year the activity of the Safety, Security and EPRR functions in the Trust.

It is part of the overall assurance to Board that the duties incumbent on them are being discharged in a proper manner and that the Trust is operating in a safe and secure manner and is discharging its duties under legislation governing this field.

This has been a challenging year with the changes to teams and redistribution of staff following the closure of Mount Vernon Hospital there has been a need to undertake interim reviews of many procedures for health and safety, fire safety and EPRR throughout the Barnsley BDU, this has been achieved whilst ensuring that the provision to the rest of the Trust has remained at a high standard:

- For the second year running, health & safety management across the Trust has improved. The Trust utilise an electronic questionnaire, (Survey Monkey) for managers and teams to conduct a self-audit of their safety provision within their areas of control. Compliance questions include baseline risk assessments, training, reporting of accidents/incidents. A programme of audits has been established to ensure continued improvement is maintained;
- Partnership working with third party trusts, Local Authorities and the Health & Safety Executive (HSE) continues to work well, with established working relationships with various CCG's, police forces and fire & rescue services is now embedded within our safety culture;
- Strong interdepartmental links and partnership working, involving specialist advisers and staff side across the Trust;
- The Health, Safety & Emergency Preparedness TAG has been a success and subsequently renamed as the Safety & Resilience TAG to better reflect the workings of the Group. This TAG now has a robust agenda that captures Trust key safety and resilience topics;
- The Health & Safety Sub Groups have merged into one group and meet on a bi-monthly basis;
- The successful delivery of the flu campaign which has seen the Trust obtain full flu CQUIN delivery for the second year running;
- Support to staff moving into new premises following transformation and closure of properties;
- Achieving compliance against the NHSBA Security Standards. The Trust has maintained a programme of works based on the former security standards implemented by NHSBA now that NHS Protect has been dissolved;
- Achieving full compliance against the NHS England Core Standards for Emergency Preparedness, Resilience and Response. This is an improvement on 2016/17 when the Trust declared substantial compliance.
- Delivery of the 2017/18 action plan (Appendix 6)

The 2018/2019 action plans build on the previous years and are designed to:

- Continue to embed a robust risk based monitoring and audit programme;
- Review and implement all policies and procedures for safety and resilience whilst ensuring they continue to be fit for purpose;
- Identify and implement a programme of fire safety works which ensures retrofit work such as the installation of sprinklers systems to existing patient sleeping areas, is fit for purpose, maintains patient safety and complies with fire safety requirements;
- Maintain the Trust standards on fire safety in accordance with a changing legislative landscape.
- Further review all risk assessments following building closures and departmental relocations;
- Continue to strengthen EPRR links and business continuity plans by way of table top exercises, audits and inspections.

## **2. Introduction**

This report is designed to provide an overview of the key achievements from all respective areas of health & safety, security, fire safety and emergency preparedness, during 2017/2018, and any areas of development within 2018/2019. Areas of development will be provided by way of action plans and added as appendices to this document.

The report furnishes the Executive Management Team (EMT) with an up to date summary on Trust activities during the previous financial year including confirmation that the agreed action plan has been implemented and defines proposed work streams for 2018/2019.

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

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

### 3. Health & Safety

2017/18 has proved to be very challenging year for the Health and Safety Team major changes in the Barnsley BDU saw a requirement to undertake a very rapid reassessment of a number of plans and to provide support to teams who had relocated to new premises. The 2017/18 annual action plan provided a solid platform for the prioritisation of strategic goals but the pressure on routine activity has been very high throughout the latter part of the year. The 2017 /18 plan was delivered in full. Both these key issues have gone some way in identifying potential risks that will need to be addressed via the 2018/2019 annual action plan, all of which are noted below.

The Quality Improvement and Assurance Team (QIAT) was commissioned by Roland Webb, trust health & safety manager, on behalf of the former Health, Safety & Emergency Preparedness Trust Action Group, (now Safety & Resilience TAG) to undertake an annual audit of health and safety provisions, of all Trust premises and teams. The health and safety provisions included baseline risk assessments, training and reporting of accidents/incidents.

The audit results were received and analysed by key specialist advisers; any gaps in health & safety assurance were highlighted and a plan of action established by the Health & Safety Manager.

#### Achievements

Key achievements outside the annual plan in 2017/2018 include:

- Results from the health & safety monitoring programme have shown an increase in compliance;
- Partnership working with third party organisations continues to function well, with robust working arrangements now established;
- Partnership working with internal functions, including staff side, specialist advisers and Trust functions continues to grow stronger, this being especially important as part of the change management process;
- The Health, Safety & Emergency Preparedness TAG continues to meet on a quarterly basis under the new name of the Safety & Resilience TAG. The sub groups have also merged into one group and meet on a bi-monthly basis. The revision into one group has seen a rise in attendance and a much more engaged group;
- Excellent uptake of safety related training at mandatory/core training days, including fire safety, health & safety awareness and lone worker training (see Appendix 5);
- health & safety presence at Trust Induction “Welcome Days”.

## **Key Risks during the Current Financial Year**

### *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)*

The number of RIDDOR reportable incidents within the Trust has decreased by 6 from 2016/17. Of those incidents 29 were reportable on Datix under violence and aggression.

### *Mount Vernon Hospital*

Prior to the closure of Mount Vernon Hospital an exit plan strategy was established. Within this plan the relocation of staff, operational change of working in different locations and the need for revised information, instruction and training was identified. As a result of this, increased health & safety support and guidance has been made available to all staff and services.

## **Key Risks for 2018/2019**

The HSE are building tools to help employers better assess and review how workplace stress and musculoskeletal disorders affect their workforce. Frameworks for both areas are set to be implemented by the HSE during 2018. A Trust piece of work will be identified and form part of the annual action plan. The Health & Wellbeing Group, staff surveys and the wellbeing centre will help provide a good foundation to build on this.

## **Priority Actions for 2018/2019**

Three priority actions have been identified for the health & safety team to focus on during 2018/19, these being:

1. Undertake audits and inspections, based on the outcomes of the 2017 Annual Monitoring Tool, providing support to teams where required;
2. Review health and safety policies and procedures to ensure that they remain fit for purpose;
3. Identify programme of works that ensures appropriate arrangements are in place to manage and monitor stress and musculoskeletal Injuries in the workplace.

## **4. Fire Safety**

The fire safety team continues to ensure that the Trust and its employees remain protected against the impact of fire. The team have continued to work closely with the capital planning team with regards to major new developments at Fieldhead Hospital, in particular the phases of the Unity Building project, together with building works to support the re-allocation of services following the closure of Mount Vernon Hospital.

The team has reduced by 2 whole time equivalent staff members this year, however gained a new trainee in December. The addition of this staff member will ensure that training and inspections continue to be delivered effectively.

There were 2 reportable fires during this reporting year where the Fire & Rescue Service attended and fire fighting action was required. The incidents occurred on Ward 18, Priestley Unit and Ashdale Ward; both incidents were suspected deliberate ignition by clients. The fire on Ward 18 resulted in minor damage to a bedroom; however the Ashdale ward did result in extensive damage to a bedroom. It is a point of note that there was an excellent response to the incidents by staff.

### **Achievements**

Key achievements noted in 2017/18 are noted below:

- There were 113 fire alarm activations recorded on Trust managed sites during the reporting year; this was a decrease on the 156 reported in the previous year. Of the 113 activations, 20 required attendance by the Fire & Rescue Service and 93 were classified as false alarms;
- 12 minor incidents of fire were reported on Datix; all of which were dealt with internally by staff, without intervention from the Fire & Rescue Service. These incidents include suspected deliberate fires using contraband lighters or matches and 1 incident detailed deliberate damage to an iPad by a service user which resulted in the equipment setting on fire. The fire totals exclude burn marks or damage to furniture or bedding as a result of non-compliance to the Trust Smoke Free Policy;
- The delivery of training across the Trust has been successful with targets for the financial year being achieved.

### **Key Risks for 2018/2019**

Three areas of risk have been identified during the current financial year, however continues to remain a risk in the following financial year. These risks are as follows:

- Significant risk to property and service users as a result of deliberate ignition together with non-compliance of the Trust Smoke Free Policy, where service users have access to contraband lighters or matches;
- Risk of arson prior to disposal of unoccupied premises such as Keresforth, Mount Vernon Hospital, Castle Lodge and Ossett Health Centre.

### **Priority Actions for 2018/2019**

Three priority actions have been noted for 2018/2019, which are as follows:

- Provide sufficient training sessions in order to maintain and exceed the attendance target;
- Achieve a higher training attendance compliance figure to demonstrate year on year compliance for inpatient services;
- Review and update fire risk assessments to take account of re-location of staff following closure of premises;
- Identify and implement a programme of fire safety works which ensures retrofit work such as the prioritised installation of sprinklers systems to existing patient sleeping areas is fit for purpose, maintains patient safety and complies with fire safety requirements.

## 4. Security

### *NHS Protect*

During 2017/18, NHS Protect dissolved; however the Trust continues to work towards its security standards so that original Key Performance Indicators can be maintained. It is anticipated that a new governing stakeholder will take over the security standards and oversee, monitor and audit achievement across the NHS. With this in mind the security team continued to work towards achieving the NHS Protect security standards as required. Out of these standards 2 main areas of work focussed staff efforts in 2017/18; including the Security Incident Reporting System (SIRS) and also the provision of assessment reviews across all Trust premises.

### *Car Parking*

As part of the Estates Strategy a number of Trust premises have either been sold or vacated. This has placed an increased pressure on parking availability on a number of Trust premises.

A car parking group has been established to look at various strategies to improve accessibility to car parking provision. As a result, a significant number of additional parking bays have been created in a number of car parks across the Trust so to alleviate this pressure.

## **Achievements**

Key achievements in 2017/18 include:

- Implementation of a new external security contract with Active Response Security Ltd, in November 2017. The new supplier provides key holding, alarm response and patrol services to numerous properties across the Trust geographical footprint. Initial KPI reviews indicate a successful implementation and continuous meeting of targets. These have been achieved while making significant cost savings and providing added value;
- Maintained the security of unoccupied premises to ensure smooth handover to new owners. Premises include Castleford, Normanton and District Hospital (CNDH), Ossett Health Centre, Keresforth Centre and Mount Vernon;
- Continued partnership working with the capital planning team to address any potential security issues that may occur during the implementation of schemes;
- Security assessments throughout the Trust have identified certain issues, notably environmental weaknesses within the Dales Unit, allowing ongoing absent without leave (AWOL's). This is currently being reviewed;
- Supporting the Estates Strategy and capital planning team, in the relocation of staff to hubs, main hospital sites and clinics, following transformation; remedying things such as access control, CCTV and general security.

## Key Risks during 2017/2018

A number of risks have been identified during 2017/18:

- The ongoing security of buildings after closure such as Keresforth, Mount Vernon Hospital and Ossett Health Centre continues to be risk and cost pressure for the department. Active Response Security and trust security guards are utilised to monitor and maintain security, reporting any instances of intrusion/property damage to estates and facilities so that they can be remedied in good time;
- Lone worker devices are not being utilised as required within numerous teams across the Trust, in particular CAMHS and high risk mental health teams. A report providing a detailed breakdown of usage was provided to the December 2017 Health, Safety & Emergency Preparedness TAG, where it was agreed the lack of usage needed to be escalated to BDU Governance Groups;
- It has been noted that there is an increase in self presenters at community premises. This is causing regular concerns and safety issues for all stakeholders utilising these premises. Short term solutions have been implemented and capital bids made to increase safety measures;
- Car parking issues across Trust premises have increased over the financial year following the closure of buildings in Barnsley and the continuation of building works at Fieldhead. Car parking at Kendray following the closure at Mount Vernon Hospital has become complicated, resulting in many parking in the local streets behind the hospital. This in turn has caused concern with the local public and as such works with the local policing unit has increased so to remedy any issues about parking. A significant number of additional parking bays have been created in a number of car parks across the Trust in particular Fieldhead and Kendray Hospital in order to alleviate this pressure.

## Priority Actions for 2018/2019

Five priority actions have been noted for 2018/2019, which are as follows:

- Improve lone worker device usage across the Trust; this will be achieved by improving communication with Business Delivery Unit (BDU) governance leads; implementing more robust reporting mechanisms in conjunction with the key account manager at Reliance and arranging refresher training to those areas that advise of need. In addition to this regular reports are to be provided to the Safety & Resilience TAG, BDU governance groups and deputy directors so that usage can be better monitored;
- Review the approach to lone worker protection completely and revise any processes/policies accordingly (this to be done in conjunction with the health and safety adviser) ;
- Implementation and installation of air lock security measures at the Dales Unit, to ensure reduction of AWOL's from wards;

- Ongoing support to community premises to address safety concerns when self-presenters attend sites;
- Implementation of SIRS module on the Datix system.

## 5. Emergency Preparedness

Every year the core standards for EPRR increase. Whilst works to comply with standards should roll over year on year, the emergency planning team must review and ensure standards continue to be achieved and cater works to implement and achieve new standards. In 2017/2018, new standards relating to governance were implemented relating to assurances of business continuity within the Trust, including the provision of an annual report, implementation of a suitable delivery group to oversee emergency preparedness and business continuity and also attendance at regional emergency preparedness meetings.

### Achievements

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

- Full compliance declared against the 2017/18 NHS England Core Standards for Emergency Preparedness, Resilience and Response;
- Successful implementation and achievement of the annual flu campaign;
- Testing of business continuity plans and table top exercises undertaken across the Trust, allowing the sharing of lessons learned to improve plans;
- EPRR being built into SUI reports to show the importance of having robust plans in place.

### Key Risk for 2017/2018

The following key risk has been identified during 2017/18:

- Not all BDU managers and business continuity leads are fully aware of emergency planning responsibilities. Managers and business continuity leads need to identify operational resilience risks and implement appropriate strategies to address these risks within their areas of control. To support managers and leads, the following actions have and continue to be implemented by the emergency planning and safety team; training provision on various emergency planning strands; 1-2-1 support; group table top sessions and testing of plans and regular evaluation reports provided to the Safety & Resilience TAG and various BDU governance groups and managers.

### Priority Actions for 2018/2019

To continue to fulfil the NHS England Core Standards for Emergency Preparedness, Resilience and Response, the emergency planning and safety team need to continue to monitor systems that are already in place.

## Priority Actions for 2018/19

- To continue a programme of works that ensures appropriate information, instruction, training, supervision and management of Trust BCP's;
- The live simulated test of internal "SILVER" command to be run in April. Learning following this event will be shared Trust wide;
- Table top exercises to be run across all BDU's, so that senior managers have assurances that services can operate in an emergency situation/incident;
- All new employees and existing staff to receive EPRR training. Discussions are underway with Learning and Development as to how this can be facilitated.
- Ensure the smooth transition of duties following the resignation of the existing EPRR adviser to a new postholder

## **6. Conclusion**

2017/2018 has been a productive and challenging year across the safety service function, with a number of notable achievements recognised from each work stream. The success of the Health & Safety Monitoring Tool roll out; the fire safety specialist adviser involvement and input into the major low secure new build facility at Fieldhead Hospital; the commissioning and implementation of a new external security contract; and achieving full compliance against NHS England Core Standards for Emergency Preparedness, Resilience and Response, are a number of key achievements discussed within this report.

The changes that the Trust has gone through in 2017/18 has put additional pressure on the department at a time of reducing resources due to staff leaving the organisation, this has highlighted the need for the team to continue to provide a multi- disciplinary approach to the safety agenda in order to both provide internal and external resilience to the team and wider Trust

2018/2019 will be just as challenging if not more for staff within the function, with need to redesign training packages to meet the changing workforce; the creation of suitable support mechanisms for community premise staff and service users and also the implementation of new standards to achieve compliance against. New targets will be implemented to enable the teams to meet the requirements of the Trust, its staff and external standards throughout the next reporting year.

**Appendix 1**

**Health & Safety Action Plan 2018/2019**

<b>Task/objective</b>	<b>Lead Director/ Senior Manager</b>	<b>Lead Officer(s)</b>	<b>Rationale</b>	<b>Target Date</b>	<b>Comments</b>
Audit/Inspection spreadsheet held by Health & Safety Team to be updated from results of H&S 17/18 Monitoring programme. Visits To be planned for 18/19	Alan Davis/Nick Phillips	Roland Webb/Alan Ryding/Steph Bates	To ensure support can be accurately and promptly targeted to services & teams	Q1	Planned audits, inspections and visits to teams are a fundamental element of the Trust's approach to HSG65.
Revise & Update Trust Health & Safety Policy	Alan Davis/Nick Phillips	Roland Webb	A written Health & policy is a legal requirement. – The present policy is due for formal review in May 2018	Q1	Revised policy will take into account transformation and reflect Governance arrangements for 2018.
Revise & Update Trust COSHH Policy	Alan Davis/Nick Phillips	Roland Webb	COSHH provides a legal framework to protect people against health risks arising from hazardous substances used or encountered at work.	Q2	This Policy details SWYPFT's approach to meeting its legal and moral and moral duties
Revise & Update Trust Environmental Policy & Guidance	Alan Davis/Nick Phillips	Roland Webb	The Environmental Policy & Guidance document is a guide on the environmental aspects to be considered in Trust activities to minimise the environmental impacts by reducing wastage of energy, water, resources, and establishing compliance with environmental legislation as the minimal level of performance.	Q2	The Policy will complement the Green Transport plan, also being developed during 18/19 supporting the Trust in bids for new business, where environmental safety is increasingly becoming a prerequisite of commissioners.
Revise & Update Trust Health & Safety Risk Assessment Policy	Alan Davis/Nick Phillips	Roland Webb	The Trust Health & Safety Risk Assessment approach supports a reasonable and pragmatic approach to continued safe working practices	Q3	The Trust Health & safety Trust Risk Assessment Policy details SWYPFT's approach to meeting its legal and moral and moral duties and is due for review in November 2018
Revise & Update Trust First Aid Policy	Alan Davis/Nick Phillips	Roland Webb	The HSE have issued minor guidance updates in April 2018 towards First Aid Provision	Q4	The Trust First Aid Policy details SWYPFT's approach providing effective First Aid cover and is due for review in January 2019
Implement and complete audit/inspection programme by end of March and prepare for 2019/2020 monitoring programme	Alan Davis/Nick Phillips	Roland Webb/Alan Ryding/Steph Bates	Ensure effective Trust wide approach to health & safety monitoring/inspections for Trust Board assurance.	Q4	The annual health & safety monitoring programme, including the audit and inspection schedule all underpin Trust Board re-assurance of effective health & safety measures within the Trust.
Update Health & Safety Intranet pages and ensure policies and all H&S Information is current with correct contact details	Alan Davis/Nick Phillips	Roland Webb	To ensure Trust staff have reliable and pertinent access to Health & Safety Information	Q4	As the roll out of new services evolve and working practices modernised Health & Safety information will be updated as required.

**Appendix 2**

**Security Management Action Plan 2018/19**

<b>Task/objective</b>	<b>Lead Director/ Senior Manager</b>	<b>Lead Officer(s)</b>	<b>Rationale</b>	<b>Target Date</b>	<b>Comments</b>
Complete SRT on behalf of the Trust and submit to the LSMS Working Group	Martin Brandon	John Sanderson/ Johan Celliers	To ensure that the Trust is compliant with the NHS Standard contract and meet CQC requirements and general good practice	Q1	
Complete Crime Reduction Surveys on all Trust premises as per the 3 year schedule.	Martin Brandon	Johan Celliers/ John Sanderson	Meet SRT actions and to support the Estates Strategy and agenda.	Q4	
Improve lone worker device usage across the Trust by improving communication with BDU Governance leads; implementing more robust reporting mechanisms in conjunction with the Key Account Manager at Reliance and arranging refresher training to those areas that advise of need	Martin Brandon	Johan Celliers/ John Sanderson/ Emma Hilton	Supporting risk assessed teams in transformation and lone working.	Q3	
Implementation and installation of air lock security measures at the Dales Unit, to ensure reduction of AWOL's from wards	Martin Brandon	Johan Celliers/ John Sanderson	To reduce clinical risk by way of environmental and operational changes	Q1	
Ongoing support to community premises to address safety concerns when self-presenters attend sites	Martin Brandon	Johan Celliers/ John Sanderson	To reduce clinical risk by way of environmental and operational changes	Q3	
Implementation of SIRS module on the Datix system.	Martin Brandon	Johan Celliers/ John Sanderson/ Emma Hilton	To ensure that the Trust is compliant with the NHS Standard contract and meet CQC requirements and general good practice	Q2	

**Appendix 3**

**Emergency Preparedness Action Plan 2018/2019**

<b>Task/objective</b>	<b>Lead Director/ Senior Manager</b>	<b>Lead Officer(s)</b>	<b>Rationale</b>	<b>Target Date For Completion</b>	<b>Comments</b>
All new employees and existing staff to receive EPRR training. Discussions are underway with Learning and Development as to how this can be facilitated.	Alan Davis	Martin Brandon	Links to core standards that staff on induction receive training	May 2018	
Fulfil the NHS England Core Standards for Emergency Preparedness, Resilience and Response,	Alan Davis	Alan Davis	the Emergency Planning and Safety team need to continue to monitor systems that are already in place and further embed more documentation into the individual standards for a more robust evidenced response	March 19	
Table top exercises to continue be run across the BDU's, so that Senior Managers have assurances that services can operate in an emergency situation/incident;	Alan Davis	Martin Brandon	Through the regular testing of plans allows learning to be evaluated and shared with other areas to try and ensure that the Trust becomes as resilient as possible over time	March 19	

## Appendix 4

### Key Performance Indicators

#### INCIDENTS/EVENTS

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

RIDDOR requires the Trust to report all over seven day injuries to the Health & Safety Executive; a total of 39 such incidents were reported during 2017/2018. This was a 13% reduction from 2016/17, with violence and aggression related incidents being the major incident factor.

##### *Safety Related Incidents*

A total of 5607 of safety related incidents were recorded in 2017/2018, up 13% (635 incidents) from 2016/2017, with violence and aggression accounting for 64% of incidents reported.

##### *Slips, Trips & Falls*

A total of 720 reports of Slips, Trips and Falls (a 9% increase from 2016/2017), were recorded across the Trust. The majority of reported incidents affected clients within the clinical setting, followed by staff members sustaining injury whilst undertaking their daily tasks.

##### *Security Related Incidents*

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

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

## Appendix 5

### Safety Related Training Statistics

A total of 5502 staff members received a form of safety related training during 2017/2018. Fire Safety is the only mandatory training session listed within the table below. Total attendance for all fire safety training for the year was 84.64% which exceeds the minimum attendance target of 80%.

Training is offered to all staff with the option to deliver face to face training; pre organised events and also attendance at team meetings is available to provide a training session. During 2017/2018 a total of 320 face to face training sessions were provided by the Safety Services Team.

Training Type	Number of Participants
Business Continuity	19
Conflict Resolution	18
Conflict Resolution Refresher	16
Conflict Resolution E-learning	3
COSHH Workbooks	100
Fire Safety Training	3484
Fire Safety E-learning	581
First Aid	117
HAZMAT	6
Health & Safety Awareness	319
Health & Safety E-learning	8
Health & Safety Workbooks	81
Lone Worker Training (Identicom Device Training)	212
Media Training	64
Project Griffin	44
Trust Welcome Day	429
Risk Assessment	1

## Trust Board 25 September 2018 Agenda item 8.4

<b>Title:</b>	<b>Changes to Trust Board committee and forum membership</b>
<b>Paper prepared by:</b>	Company Secretary on behalf of the Chair
<b>Purpose:</b>	The purpose of this paper is to formally note and support the changes to the membership and attendance of the committees and the forum of the Board.
<b>Mission/values:</b>	A strong and effective Board and committee structure enables the Trust to achieve its vision and goals, and maintain a sustainable and viable organisation.
<b>Any background papers/ previously considered by:</b>	The last update to the Terms of Reference of the committees and the forum were approved by Trust Board on 24 April 2018.
<b>Executive summary:</b>	<p>Trust Board committees are responsible for scrutiny and providing assurance to Trust Board on key issues within their Terms of Reference (TOR). The TOR are reviewed annually as part of the annual reporting process including the names of members and attendees. The TOR were last reviewed and approved by Trust Board on 24 April 2018.</p> <p>Within the TOR it sets out the membership and attendance. In July 2018, changes were made to some Directors portfolios and on 3 August 2018 the Members' Council approved the appointment of two Non-Executive Directors. As part of these changes, the Director and Non-Executive Director membership and attendance across the committees and the forum have been reviewed. The attached document sets out these changes from 25 September 2018. The names of the members and attendees will be updated in the TOR when they are next reviewed.</p>
<b>Recommendation:</b>	<b>Trust Board is asked to SUPPORT the changes to the Trust Board committee and forum membership from 25 September 2018.</b>
<b>Private session:</b>	Not applicable.

Trust Board Committee and Forum membership  
(proposed as from 25 September 2018)

	Audit Committee	Clinical Governance & Clinical Safety Committee	Mental Health Act Committee	Workforce & Remuneration Committee	Charitable Funds Committee	WYMHSC Committee in Common	Equality & Inclusion Forum	Other
Angela Monaghan	-	Member	-	Member	Member	Member	Chair	-
Charlotte Dyson	-	Chair	-	Member	Chair	-	-	-
Laurence Campbell	Chair	-	Member	-	-	-	-	-
Rachel Court	Member	-	-	Chair	-	-	-	CRS Prog. Board
Erfana Mahmood	Member	-	Member	-	-	-	Member	-
Kate Quail	-	Member	Chair	-	Member	-	-	-
Samantha Young	Member	-	-	Attends	-	-	Member	Attends CRS Prog. Board
Rob Webster	-	-	-	Member (NV)	-	Member	Member	-
Tim Breedon	-	Member (LD)	Member	-	Member	-	Member (LD)	-
Mark Brooks	Attends (LD)	-	-	-	-	-	-	-
Dr Subha Thiyagesh	-	Member	Member (LD)	-	-	-	Attends	-
Alan Davis	-	Member	-	Attends (LD)	-	-	Member	-
Emma Jones	Attends	-	-	-	-	-	-	-
Carol Harris	-	Attends	-	-	-	-	-	-
Sean Rayner	-	Attends	-	-	-	-	Member	-
Karen Taylor*	-	Attends	-	-	-	-	Member	-
Salma Yasmeen	-	-	Member	-	Member (LD)	-	-	-
<b>QUORUM</b>	<b>2 NEDs</b>	<b>2 NEDs &amp; 2 EDs</b>	<b>2 NEDs &amp; 2 EDs</b>	<b>2 NEDs</b>	<b>3 Members</b>	<b>1 Member</b>	<b>1/2 Members</b> inc. 1 NED & 1 ED	-

	Non-Executive Director (NED)
	Executive Director
	Other Director
	Company Secretary

LD Lead Director  
 NV Non-voting committee member  
 \* Director of delivery post in place until October 2018

Members' Council Group membership and attendance  
(as at 1 August 2018)

	Members' Council	Members' Council Coordination Group	Members' Council Quality Group	Nominations' Committee
Angela Monaghan	Chair	Attends	-	Chair
Charlotte Dyson	Attends	Attends	Attends	-
Laurence Campbell	Attends	-	-	-
Rachel Court	Attends	-	-	-
Erfana Mahmood	Attends	-	-	-
Kate Quail	Attends	-	-	-
Samantha Young	Attends	-	-	-
Rob Webster	Attends	-	-	Attends
Tim Breedon	Attends	-	Attends	-
Mark Brooks	Attends	-	-	-
Dr Subha Thiyagesh	Attends	-	-	-
Alan Davis	Attends	-	-	Attends
Emma Jones	Attends	Attends	--	Attends
Carol Harris	Attends	-	-	-
Sean Rayner	Attends	-	-	-
Salma Yasmeen	Attends	-	-	-
Karen Taylor*	Attends	-	-	-

	Non-Executive Director (NED)
	Executive Director
	Other Director
	Company Secretary

LD Lead Director  
 NV Non-voting committee member  
 \* Director of delivery post in place until October 2018

Trust Board 31 July 2018

Agenda item 9 – Receipt of public minutes of partnership boards

Calderdale Health and Wellbeing Board

<b>Date</b>	9 August 2018
<b>Non-Voting Member</b>	Medical Director / Director of Operations
<b>Items discussed</b>	<ul style="list-style-type: none"> <li>➤ The First 1000 Days – Progress Review</li> <li>➤ New: Director of Public Health Report - Healthy Ageing</li> <li>➤ Transforming Outpatient Appointments</li> <li>➤ Vulnerable Adults</li> <li>➤ Wicked Issues Forum</li> <li>➤ Emotional Health and Wellbeing of Children</li> <li>➤ Single Plan for Calderdale – Calderdale Cares Update</li> </ul>
<b>Minutes</b>	Papers and draft minutes (when available): <a href="https://www.calderdale.gov.uk/council/councillors/councilmeeting/s/agendas-detail.jsp?meeting=25856">https://www.calderdale.gov.uk/council/councillors/councilmeeting/s/agendas-detail.jsp?meeting=25856</a>

Barnsley Health and Wellbeing Board

<b>Date</b>	Next meeting scheduled for 2 October 2018 (last update from meeting 5 June 2018, 7 August 2018 was cancelled)
<b>Member</b>	Chief Executive / Director of Operations
<b>Items discussed</b>	➤ To be confirmed.
<b>Minutes</b>	Papers and draft minutes (when available): <a href="http://barnsleymbc.moderngov.co.uk/mgCommitteeDetails.aspx?ID=143">http://barnsleymbc.moderngov.co.uk/mgCommitteeDetails.aspx?ID=143</a>

Wakefield Health and Wellbeing Board

<b>Date</b>	To be confirmed (last update from meeting 26 July 2018)
<b>Member</b>	Chief Executive / Director of Provider Development
<b>Items discussed</b>	➤ To be confirmed
<b>Minutes</b>	Papers and draft minutes are available at: <a href="http://www.wakefield.gov.uk/health-care-and-advice/public-health/what-is-public-health/health-wellbeing-board">http://www.wakefield.gov.uk/health-care-and-advice/public-health/what-is-public-health/health-wellbeing-board</a>

Kirklees Health and Wellbeing Board

<b>Date</b>	6 September 2018
<b>Invited Observer</b>	Chief Executive / Director of Operations
<b>Items discussed</b>	<ul style="list-style-type: none"> <li>➤ Kirklees Health &amp; Wellbeing Plan</li> <li>➤ Update on Integration of Health and Social Care Commissioning and Service delivery</li> </ul>

	<ul style="list-style-type: none"><li>➤ Integrated Care System Development</li><li>➤ Director of Public Health Annual Report</li><li>➤ Winter Review</li></ul>
<b>Minutes</b>	Papers and draft minutes (when available): <a href="https://democracy.kirklees.gov.uk/mgCommitteeDetails.aspx?ID=159">https://democracy.kirklees.gov.uk/mgCommitteeDetails.aspx?ID=159</a>

**Trust Board 25 September 2018**

**Agenda item 10 – Assurance from Trust Board Committees**

**Clinical Governance & Clinical Safety Committee**

<b>Date</b>	18 September 2018
<b>Presented by</b>	Charlotte Dyson, Non-Executive Director (Chair of the Committee)
<b>Key items to raise at Trust Board</b>	<ul style="list-style-type: none"> <li>➤ Learning Lessons report</li> <li>➤ Suicide deep dive</li> <li>➤ Care Quality Commission (CQC) action plan</li> <li>➤ Child &amp; Adolescent Mental Health Services (CAMHS) update</li> <li>➤ Freedom to Speak Up Guardian business case</li> <li>➤ Patient Led Assessment of the Care Environment (PLACE) report</li> </ul>
<b>Approved Minutes of previous meeting/s for receiving</b>	<ul style="list-style-type: none"> <li>➤ Approved Minutes of the Committee meeting held on 19 June 2018 (attached)</li> </ul>

**Mental Health Act Committee**

<b>Date</b>	28 August 2018
<b>Presented by</b>	Kate Quail, Non-Executive Director (Chair of the Committee)
<b>Key items to raise at Trust Board</b>	<ul style="list-style-type: none"> <li>➤ To be confirmed</li> </ul>
<b>Approved Minutes of previous meeting/s for receiving</b>	<ul style="list-style-type: none"> <li>➤ Approved Minutes of the Committee meeting held on 15 May 2018 (attached).</li> </ul>

**West Yorkshire Mental Health Services Collaborative Committees in Common**

<b>Date</b>	Next meeting scheduled for 1 October 2018
<b>Presented by</b>	Angela Monaghan, Chair (member of the Committee)
<b>Key items to raise at Trust Board</b>	<ul style="list-style-type: none"> <li>➤ To be confirmed.</li> </ul>
<b>Approved Minutes of previous meeting/s for receiving</b>	<ul style="list-style-type: none"> <li>➤ To be confirmed.</li> </ul>

**Minutes of Clinical Governance and Clinical Safety Committee held on  
19 June 2018  
Meeting room 1, Fieldhead, Wakefield**

**Present:** Angela Monaghan (AM) Chair of the Trust  
Charlotte Dyson (CD) Deputy Chair (Chair of the Committee)  
Kate Quail (KQ) Non- Executive Director  
Tim Breedon (TB) Director of Nursing and Quality (lead Director)  
Alan Davis (AGD) Director of Human Resources, Organisational Development and Estates

**Apologies:** Committee  
Dr S Thiyagesh (SThi) Medical Director

Others  
Carol Harris (CH) District Director – Forensic and Specialist Services, Calderdale and Kirklees  
Sean Rayner (SR) District Director – Barnsley & Wakefield

**In attendance** Mike Doyle (MD) Deputy Director of Nursing  
Sarah Harrison (SH) PA to Director of Nursing and Quality (author)  
Chris Lennox (CL) Acting Deputy Director for Barnsley & Wakefield  
Richard Norman (RN) Project Management Office Manager  
Dave Ramsay (DR) Deputy Director for Barnsley & Wakefield  
Karen Taylor (KT) Director of Delivery

**CG/18/58 Welcome, introductions and apologies (agenda item 1)**

The Chair Charlotte Dyson (CD) welcomed everyone to the meeting. The apologies, as above, were noted. A query was raised whether a deputy should be in attendance for Dr S Thiyagesh (SThi), at present Dr Thiyagesh does not have a deputy in place.

**Action: Emma Jones**

**CG/18/59 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/18/60 Minutes of previous meeting held on 17 April 2018 and 15 May 2018 (agenda item 3)**

17 April 2018 Minutes

Angela Monaghan (AM) asked that agenda item CG/18/7 is included as an additional item for the work plan. Sarah Harrison (SH) to check the work plan.

**Action: Sarah Harrison**

15 May 2018 Minutes

CG/17/29 Quality accounts - Public summary to be produced.

**Action: Jude Tipper**

Kirklees LD waiting times to be reviewed by Clinical Governance & Clinical Safety Committee (CGCS)

**Action: Tim Breedon**

**It was RESOLVED to APPROVE the minutes of the meeting held on 17 April and 15 May 2018.**

**CG/18/61 Matters Arising (agenda item 4)**

Actions from the meeting held on 17 April 2018 and 15 May 2018 were noted and the action log was updated as appropriate.

**CG/18/62 Consideration of items from the organisational risk register relevant to the remit of the Clinical Governance & Clinical Safety Committee (agenda item 5)**

TB introduced the paper outlining the current changes in respect of the risk register noting that there are now no risks aligned to the Clinical Governance & Clinical Safety Committee (CGCS) graded 15 and above. This was agreed at Trust Board on 24 April 2018. CD reported that the Committee was well sighted on key risks as they had been discussed in Trust Board in some detail.

A discussion then took place around the changes to the register and AM commented in particular in relation to Risk 1078 that whilst the likelihood was reduced due to mitigating actions, this does not change the overall risk. TB advised that he felt there were two separate issues in play.

1. The impact of delay in starting treatment.
2. Reputational risk to the Trust due to long waits.

Dave Ramsay (DR) confirmed that any waiting list is constantly being reviewed and support mechanisms are in place should the risks increase whilst on the list.

Committee felt that there is two elements and would like Executive Management Team (EMT) to look at the risk register again to ensure it adequately reflect the risks above.

**Action: Tim Breedon**

The Committee then discussed the need to include the outcome of the recent Care Quality Commissioner (CQC) Well Led review. It was agreed to consider this in the first instance at EMT once the report has been received prior to publication and then at CGCS.

**Action: Tim Breedon**

The Committee noted that the out of area bed usage risk will be added to the register after consideration of the appropriate rating by EMT. Karen Taylor (KT) stressed the importance of separating the clinical impact of out of area placements from the financial impact upon the Trust.

The Committee asked that once this risk is articulated that a full report is received at Board.

**Action Tim Breedon**

AM queried the need to consider the recent increase in suicides as a potential risk register item. Following discussion it was agreed to consider the position following the Kirklees apparent suicides deep dive review at the next meeting. AM also noted the importance on ensuring that entries have completion dates.

TB referred the Committee to the recommendation within the paper in relation to Risk ID 1119 and explained the rationale for moving this from organisational to BDU level ownership. The Committee supported EMT recommendation to Board. Kate Quail (KQ) raised some concern around the color coding of the risk appetite which will be discussed at Board.

**It was RESOLVED to NOTE the changes in the current Trust-wide Corporate risk register and that there are no risks are no risks aligned to the Clinical Governance & Clinical Safety Committee graded 15 and above.**

### **CG/18/63 Apparent Suicide Update (agenda item 6)**

Annual report and Kirklees suicide update report.

Mike Doyle (MD) introduced the 17/18 Apparent Suicide report main findings and actions.

MD advised that the deep dive in relation to Kirklees suicide rates, as discussed at the previous meeting, is now available but unfortunately was not produced in time for the Committee. The high level findings are included in the report.

MD drew attention to the following:-

- 43 apparent suicides reported as serious incidents during 2017/18, compared with 2016/17 (27) and 2015/16 (41).
- Kirklees deep dive shows an increase in GP referrals 25% across SWYPFT, Calderdale and Kirklees is at 50%.
- The increase in numbers of suicides showing is in relation to Wakefield, Calderdale and Kirklees and not in Barnsley. Depression workshops have been established in Kirklees where biggest rise can be seen.
- There is also a review of the Sainsburys risk assessment tool underway it will be formulation informed and a draft will be piloting before SystemOne is introduced.
- A new text message follow up system is also being used which has been successful in other areas
- The initial review of CAMHS suicides does not show any immediate concern or trends.

MD also informed the Committee that Safety huddles are continuing to taking place across the Trust and that Peer Review workshops in CAMHS are being well received.

AM queried whether the actions in the report can be measured and link to the Patient Safety Strategy. MD replied that the next step is to review the report and check that all actions are included in the current Strategy, if not they will be included.

The Committee queried the ethnicity reporting. MD informed that on occasions it is not known or has not been stated and that the issue with the recording of these is being addressed. SystemOne will address this as you will not be able to progress on the system if these details are not inputted. The Committee requested that the ethnicity recording issue be discussed at the E&I forum.

**Action: Tim Breedon**

CD acknowledged that the Kirklees Suicide update and the themed review on CAMHS are included but the full reports must be received for the Committee to confirm assurance.

Both to be added to September CGCS

**Action: Sarah Harrison**

**It was RESOLVED to RECEIVE the Apparent Suicide report and NOTE the next steps.**

**CG/18/64 Clinical Audit and Practice Effectiveness (CAPE) Annual Plan 18/19 (agenda item 7)**

MD updated the Committee on the plan for 18/19. The Directorates and BDUs have prioritised 82 clinical audits and 8 service evaluations but this is expected to increase as the year progresses. The majority of projects are prioritised by the directorates, however most of these are trust-wide and the BDUs will be participating.

There are 15 national projects included in the CAPE plan this year. The national projects, specifically the POMH quality improvement project will require identified project leads in each BDU.

There are more audits planned in Barnsley primarily related physical health systems.

AM asked if the MP related audit of consent is included in the programme TB advised that it has been commissioned but is not yet included on this schedule.

**It was RESOLVED to NOTE the plan for 18/19.**

**CG/18/65 Planned / Unannounced Visits –Quality Monitoring (agenda item 8)**

MD updated the Committee on the results of the Planned / Unannounced visits which have shown that a great deal of good work has been carried out that has led to significant improvements in many areas of practice. It has also shown there are areas where further improvements are needed if we are going to maintain progress. Our findings have also helped us to identify where we have taken actions to make sure people's rights and entitlements are protected when they are detained under the Mental Health Act (MHA) or in our care on an informal (voluntary) basis. It should be noted that, we continue to have shortfalls within this area and further improvements to make.

The findings from the visits are then fed back to BDU governance groups and action plans are developed and monitored.

We are still in the process of planning the structure of the 2018/2019 programme. Careful consideration will be given to which areas we need to prioritise. This may mean we re-visit some of our focus from this year's programme. For example, we may decide to look again at whether the necessary improvements in our MHA/MCA practices have been made

MD informed the Committee that a draft schedule of visits has been put together for 18/19. CD enquired as to whether the visits linked to the CQC visits and MD informed that they are considered and also take account of the MHA visits in this process. The choice of where we visit is also driven by the CQC reports.

AM requested that when planning this years visits if as much notice as possible is given to allow attendance from the Non Executive Directors (NEDS).

**Action: Mike Doyle**

AM asked as to whether Governors and Members of the Members Council Quality Board could also be part of the visits and the Committee agreed that they could. Alan Davis informed the Committee that no DBS is required by the Governors or Members Council Quality Board for visits.

**Action Mike Doyle**

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

**CG/18/66 BDU Governance Groups Annual Reports (agenda item 9)**

Karen Taylor (KT) introduced the report. BDU Governance Groups undertook 'self-assessment' governance reviews in 2014/2015 and then during 2015/16, there was a move away from the annual self-assessment process, to a continuous quality improvement model, where BDU's regularly review and seek to improve the quality of their care. Improvements are shared with colleagues across the Trust on a quarterly basis at the Quality Improvement Group (QIG).

During 2016/17 and 2017/18 the movement to a continuous quality improvement model, where BDU's regularly review and improve the quality of their care has continued. Throughout this time period the role of the Clinical Governance Group was strengthened by reviewing the terms of reference.

Although the BDU Governance Groups may cover a diverse and very different range of services their focus and aims remain constant, the provision of a quality clinical service and a cycle of continuous service improvement.

The Governance Groups have met challenges and identified areas of good practice, innovation and improvement.

The Committee noted that this was a very useful report but agreed there was a lot of detail and wanted to know more about the processes and attendance etc. Karen Taylor (KT) informed the Committee that work is underway on this for the next report.

The Committee also required assurance around the action planning process and links to the Risk Register.

**Action: Karen Taylor**

**It was RESOLVED to RECEIVE the report and NOTE the themes.**

**CG/18/67 Consideration of External Audit Report in Trust Quality Accounts (agenda item 10)**

The Committee agreed to defer this item until the next Committee meeting in September as the final report is not complete. However TB confirmed that the only outstanding issue related to agreement with Deloitte's over a specific point in relation to the action plan.

**Action: Sarah Harrison**

**CG/18/68 Transformation & Priority Programmes Update (agenda item 11)**

Richard Norman (RN) attended the Committee to give an update which included the new Trust 2018/19 priorities as well as former transformation programme projects that require continued assessment of quality.

The summary table in the report doesn't list all 2018/19 priorities but priorities which are still being scoped and therefore are no gateway dates for these, they will be included at a later date. Some projects previously reported are removed from this update but a summary is provided

The Acute and Community transformation – Post implementation review stage is expected early 2019, commencing September 18.

CD questioned the current status of the Older peoples MH

The business case recently went to EMT to enquire if older peoples MH remains a priority and it was agreed it was. It is with Commissioners now to see if they agree the model.

#### Perinatal Mental Health

AM asked if there was a project closure report template. Richard Norman (RN) advised that the associated paper for the project closure of the Perinatal Mental Health project followed the agreed format.

AM asked for an update on clinical and operational model given the achievement date of December. RN informed the Committee that this service was handed over to operational management and an update will be included in the next report. Post implementation review is scheduled for March 2019

AM asked if we have an update on the achievement of mandated national target, number of mothers supported target 547 -performance 522. RN to include on next update.

**Action: Richard Norman**

Committee queried if perinatal MH should be on the IPR, to be discussed at EMT

**Action Tim Breedon**

AM – request end of year update at Q4 on performance. RN to include in future update

**Action: Richard Norman**

Kate Quail (KQ) commented that the Equality Impact Assessment (EIA) assessment was quite generic and would have liked to have seen more detail for example the impact on families and how the service is addressing these issues. Chris Lennox advised that family and carer issues are taken account of within the service and acknowledge that the EIA could be improved. TB confirmed that the quality of the Equality impact assessments is being considered in the equality and inclusion forum.

The Committee thanked RN and agreed the report was developing well.

**It was RESOLVED to RECEIVE the report and NOTE progress.**

#### **CG/18/69 Care Quality Commission Action Plan and MHA Visits (agenda item 12)**

The Trust received the draft reports on 25 May 2018. The 10 day period for factual accuracy checking then followed. We received an evidence document (293 pages), which detailed the information the CQC has considered, 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 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 identified as “required improvement”, to consider our evidence.

A letter detailing the areas the Trust requested the CQC to reconsider was discussed by the Committee and the approach was supported.

**Timeline for next steps:**

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 already 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.

CD enquired regarding the “MUST DO’s” and TB confirmed that no immediate action was required by the CQC.

**It was RESOLVED to RECEIVE the update and note the potential publication date.**

**CG/18/70 Trust achievements (agenda item 13)**

The Committee noted the considerable number of recent achievements of the Trust especially the Our Year leaflet and thanks the team for an excellent booklet.

**CG/18/71 Waiting List Improvement Plan (agenda item 14)**

ADHD

Committee noted update.

**It was RESOLVED to RECEIVE the update and note progress**

LD

DR asked that the Committee notes the positive progress made on waiting times since the previous inspection. With particular reference to the improvement in Kirklees.

**It was RESOLVED to RECEIVE the update.**

Calderdale Psychological Therapies

CD commented on Group therapies to minimise waiting lists which has now been discussed at the Members Council Quality Group (MCQG). The Committee were in support of the approach.

**It was RESOLVED to RECEIVE the update.**

Wakefield and Barnsley Psychological Therapies

Committee noted update.

**It was RESOLVED to RECEIVE the update.**

AM asked if the Committee can do more to assist with Commissioners. KT advised, not at the moment but advised that the position is in hand at present however support may be required during September.

### **CG/18/472 Issues arising from Performance report (agenda item 15)**

MD provided an update on the following:-

#### Restraints

There has been a spike in restraints in Q4 that are outside our expected limit. These were both related to acuity and to two patients in particular which accounts for the rise above our anticipated limits.

#### Complaints

There is a mapping process underway in customer services. Performance looks poor at the moment but progress is evident. The number of formal complaints has started to reduce as clinical teams make contact with potential complainants and take greater ownership of the process.

#### Patient Experience

Development of a new patient experience report is underway re- friends and family etc. The Committee would like to receive early sight when available.

**Action: Mike Doyle**

There were no further issues to discuss regarding the IPR as already discussed at Trust Board and key items taken on this agenda.

### **CG/18/73 Update on topical, legal and regulatory risks (agenda item 16)**

TB updated the Committee on two issues:-

- NHS long term funding announcement – The Trust will need be clear in the event of any funds arriving as to the associated expectations.
- CQC - sexual safety in wards. CQC are publishing further information later this month and providing guidance and good practice which we need to be alert to. We were included in the consultation events.

AM informed the Committee that the Carter Review in Mental Health and Community has been published.

### **CG/18/74 Child and adolescent mental health services - update (agenda item 17)**

DR provided an overview of the key points from the report. The draft CQC report had identified a number of areas of good practice within the service and there were also areas that required attention. The most pressing issue relates to the provision of the out of hours on call service, a robust action plan is being developed and will be reported to the next Committee. DR confirmed that all areas of concern identified by the CQC have been subject to review and a plan is in place. DR highlighted the importance of sustaining an out of hour on call rota through the move to an all age psychiatric liaison service, this work is underway.

DR highlighted that the proposal, will remove the requirement for on call staff to attend A&E out of hours as a telephone only service is being proposed. Kate Quail expressed a concern about this approach and DR confirmed that the proposal would be subject to a quality and safety review though EMT prior to any implementation.

The recommendations from the recent serious incidents were discussed and it was confirmed that the themed review would be brought back to the next meeting. DR advised the Committee of the impending Ofsted inspection at Wakefield and reminded the Committee that SWYPFT has been fully engaged with the Wakefield services child improvement plan. AM asked DR about our ability to compare performance with similar services and DR advised that there is limited data available. AM also commented on the positive areas of practice picked up by the CQC and acknowledged the importance of the improvement worked. AM also queried the increase in the Barnsley sickness rate and DR advised that there is no apparent trend but the position continues to be monitored. AGD commented of the importance of appraisals to support staff during pressured times and the importance of ensuring that mandatory training levels are sustained. DR confirmed that this is a focus amongst service managers.

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

#### **CG/18/75 Quality Impact Assessment review (agenda item 18)**

TB updated the Committee on the interim report for June 2018 and gave a brief overview of the Quality Impact Assessment position. A number of CIPs have an impact on other agencies and thus they are rated as red. Process continues to work well.

**It was RESOLVED to RECEIVE and NOTE the update.**

#### **CG/18/76 Serious Incidents Quarterly Reports and Annual Report (agenda item 19)**

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.

Key actions from Apparent Suicide report to come into this report

**Action:- Mike Doyle**

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

### **CG/18/77 Internal Audit Reports (agenda item 20)**

#### 360 Internal Audit Plan

The Committee agreed to defer to the next Committee Meeting and agenda setting

**Action: Sarah Harrison**

### **CG/18/78 NICE Annual Report (agenda item 21)**

MD introduced the report and noted the significant work to maintain our position. The Committee commented that the report is of good quality and thanked the team involved.

**It was RESOLVED to RECEIVE the summary report and NOTE the plans for 2018/19.**

### **CG/18/79 Mandatory Training Annual Report (agenda item 22)**

Alan Davis (AGD) updated the Committee on the Mandatory training throughout the Trust. It is monitored through Integrated Performance Report (IPR). Service lines are being monitored and alerts have been set up to flag at risk areas.

AM raised a query regarding fire safety for inpatient wards and the targets to achieve the new threshold. AGD informed the Committee that a target of 95% for all available staff is being set. This is a local target for 18/19 and we should see results after the 2<sup>nd</sup> quarter.

The Committee agreed that this report was to stay with the CGCS rather than be moved to Workforce and Remuneration Committee (WRC).

**It was RESOLVED to NOTE the Mandatory and Statutory Training Annual Report and its recommendations.**

### **CG/18/80 Sub-groups – exception reporting (agenda item 23)**

#### Drug & Therapeutic (agenda item 23.1)

The Committee asked for clarification on Blue Lights and Green lights and how this is disseminated throughout the Trust. TB informed that this should be an email. Committee asked for Dr S Thiyagesh to confirm

**Action Subha Thiyagesh**

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

#### Safety & Resilience (agenda item 23.2)

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

Infection Prevention and Control (agenda item 23.3)

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

Safeguarding adults & children (agenda item 23.4)

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

Managing Aggression and Violence (agenda item 23.5)

AM noted that the recording of training needs to be more robust as updates are not coming through correctly.

Self-generated dashboards seem to be working well for the Trust and helping with this issue.

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

Any feedback from other TAGs/groups (agenda item 23.6)

No update from Improving Clinical Information Group as it has not met.

### **CG/18/81 Issues and items to bring to the attention of Trust Board and other Committees (agenda item 24)**

Issues were identified as:

- Equality Impact Assessment completion to be considered at Equality Inclusion forum
- Risk Register queries to be considered at EMT
- Apparent Suicide and Serious Incidents reports position
- CAMHS Review

Board asked for a report on the national LeDeR report that has just been published. This is going to Board next week and therefore has not been into Committee. TB advised that the Learning from Deaths report has a section that includes a brief overview.

### **CG/18/55 Consideration of any changes from the organisational risk register relevant to the remit of the Clinical Governance & Clinical Safety Committee (agenda item 25)**

Discussion as per agenda item CG/18/62 refers.

### **CG/18/82 Work Programme (agenda item 26)**

**It was RESOLVED to AGREE the Work Programme and NOTE changes.**

### **CG/18/83 Any other business (agenda item 27)**

No further items were discussed.

### **CG/18/84 Date of next meeting (agenda item 28)**

The next meeting will be held at 14.00 on 18 September 2018 in Meeting room 1, Fieldhead Hospital, Ouchthorpe Lane, Wakefield WF1 3SP.

**Minutes of the Mental Health Act Committee Meeting held on  
15 May 2018**

<b>Present:</b>	Dr Subha Thiyagesh Chris Jones Tim Breedon Kate Quail Salma Yasmeen	Medical Director (lead Director) Non-Executive Director (Chair) Director of Nursing and Quality Non-Executive Director Director of Strategy
<b>Apologies:</b>	<u>Members</u> Laurence Campbell	Non-Executive Director
	<u>Attendees</u> Shirley Atkinson	Professional Development Support Manager (Barnsley) – local authority representative
	Andy Brammer	Mental Health Act Professional Lead (Wakefield) – local authority representative
	Terry Hevicon-Nixon	Operations Manager - Working Age Mental Health (Calderdale) – local authority representative
<b>In attendance:</b>	Julie Carr Yvonne French Carol Harris	Clinical Legislation Manager Assistant Director, Legal Services Director of Forensics, Specialist Services, Calderdale and Kirklees
	Anne Howgate David Longstaff Victoria Thersby	AMHP Team Leader (Kirklees) – local authority Independent Associate Hospital Manager Head of Safeguarding (Calderdale and Kirklees) – acute trust representative
	Stephen Thomas	MCA/MHA Team Manager (Wakefield) – local authority representative
	Sarah Millar	PA to Medical Director (author)

**MHAC/18/15 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/18/16 The Act in Practice (agenda item 2)**

MHAC/18/16a Learning Disability Service (agenda item 2.1)

Presentation from Dr Manoj Narayan (MN) on the interface of the Mental Health Act and Mental Capacity Act in Learning Disability Services. Dr Narayan was accompanied by Enzo Harris, Advanced Nurse Practitioner and Dr David Ingle.

The Committee thanked MN for his presentation.



### **MHAC/18/17 Legal update/horizon scanning (agenda item 3)**

#### MHAC/18/17a Deprivation of Liberty in Hospital Settings (agenda item 3.1)

Julie Carr (JC) reported that in June 2015, Barristers who specifically deal with the Court of Protection produced guidance for hospitals in relation to identifying Deprivation of Liberty cases. It was noted that this document was significantly revised in February 2018. JC assured the Committee that the Trust guidance note for clinicians had been reviewed and is in line with the national guidance.

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

#### MHAC/18/17b Reform of the Deprivation of Liberty Safeguards (agenda item 3.2)

JC reported that the DoLs framework had been widely criticised for being overly complex and bureaucratic and to no longer provide a safeguard for those people who lack capacity. In response, the Government had asked the Law Commission to look at ways to reform the legislation. The Commission published its final report in March 2017 calling for DoLs to be replaced as a matter of urgency with a new scheme called the Liberty Protection Safeguards (LPS). To progress the reform, the Joint Committee on Human Rights have opened their Inquiry: The Right to freedom and safety: Reform of the Deprivation of Liberty Safeguards.

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

#### MHAC/18/17c CQC Annual Report – Monitoring the Mental Health Act 2016/17 (agenda item 3.3)

JC reported that the most recent CQC annual report on the application of the Mental Health Act 1983 published on 28 February 2018 noted that there had been limited or no improvement in key areas raised in the reports of previous years. In particular, they found:

- No improvement in the recording in care plans of evidence of patient involvement, of the views of patients about their care, or of whether clinicians had considered the least restrictive options for care.
- No reduction in the number of patients whose physical health had not been assessed through examination on admission.
- No reduction in the number of records examined that showed that patients had not been informed of their legal rights on admission.
- That 15% of the records examined showed that patients were not automatically referred to advocacy services where they lacked capacity to decide whether to do so themselves.

Yvonne French (YF) advised that the report had been to the Clinical Governance Sub Group and Practice Governance Coaches had been asked to consider the key points although it was noted that there were no records of patients not being informed of their legal rights on admission to SWYPFT and the new clinical records system would record referrals to advocacy services. YF added that the annual report was a good indicator of what the CQC would be looking at over the next 12 months.

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

MHAC/18/17d Final Government Response to the Law Commission's review of Deprivation of Liberty Safeguards and Mental Capacity (agenda item 3.4)

JC reported that on 14 March 2018, the Government published its response to the Law Commission's Mental Capacity and Deprivation of Liberty report. It was noted that the Government had mostly accepted the recommendations although it was anticipated that the Independent Mental Health Act review would be taken into consideration. It was further noted that the Government had declined to look at the matter of statutory codification of DoLs for children.

JC advised that the independent review had only been received today. There was no recommendation for a fusion act but a number of changes had been suggested. JC would arrange for a working group to consider these changes and prepare a briefing for the next Committee meeting.

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

MHAC/18/17e Place of Safety Briefing (agenda item 3.5)

YF reported an update from the Place of Safety trust wide group that meets on a quarterly basis. There had been discussion around the ages of some of the under 18's on this report and the number of times the same patient presented. It was agreed to raise this matter at the interface meeting with CAMHS and a CAMHS representative had been requested to join the 136 Suite group.

YF advised of a couple of recent situations where there were issues with the use of 136 that had been escalated to director level and Carol Harris (CH) gave an example of one of these cases which had resulted in a learning event with the police.

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

**MHAC/18/18 Minutes of previous meeting held on the 6 March 2018 (agenda item 4)**

**It was RESOLVED to APPROVE the notes of the meeting held on 6 March 2018 as a true and accurate record of the meeting.**

**MHAC/18/19 Matters arising (agenda item 5)**

MHAC/18/19a Action points (agenda item 5.1)

The action points were noted and two items raised:

- MHAC/18/05a – TB confirmed that this would be taken to the June 2018 meeting.
- MHAC/18/06b – Anne Howgate (AH) provided an update and advised that there had been a drive on prevention and each request for a Mental Health Act assessment was being logged but not necessarily taking place. There had been a lot of referrals that were not really appropriate for the Mental Health Act and some other cases where Mental Health Act assessments had taken place but no doctor had been available at that point to prescribe. CJ thanked AH for the update and agreed that the Committee could take assurance from this.

MHAC/18/19b Consideration of items from the organisational risk register relevant to MHA Committee (agenda item 5.2)

Subha Thiyagesh (ST) advised that following discussion at the recent Board meeting, there were no items identified as relevant to the Mental Health Act Committee.

**MHAC/18/20 Statistical information use of the Mental Health Act (MHA) 1983 and Mental Capacity Act (MCA) 2005 (agenda item 6)**

MHAC/18/20a Monitoring Information Trust Wide January-March 2018 (agenda item 6.1)

JC reported the following:

- There had been a reduction in the use of the Mental Health Act in the previous quarter. It was noted, however that P&I had confirmed a longer average length of stay for that period.
- There had been a decrease in the number of Tribunals and Manager's Hearings and there was no clear reason for this. It was suggested that advocacy services could be approached for a view.
- 15% of people who are currently accessing The Trust's mental health services do not have ethnicity recorded (unchanged from Q3 and up from 12% in 2016/17 Q4). 13% of new admissions and 12% of new detentions did not have ethnicity recorded, up from 10% and 9% respectively in Q3.
- Length of wait for a SOAD to provide the certificate of authorisation for treatment remains within the time frame agreed by the Trust with CQC of 4 weeks from request.
- There were two instances of patients being made subject to a s.5(2) multiple times within a short period before being detained under s.2.
- There was one exception report for CTOs in the last Quarter.
- There was one exception report for Tribunals that should be noted in relation to a patient in an out of area placement who wished to be transferred to the Trust in their home area.
- There had been a reduction in the number of DoLs applications since the loss of physical health services in Barnsley although it was noted that they were still not being completed prior to the patient being discharged in a large number of cases. People were now being asked to consider the likelihood of the patient still being there in 3-4 weeks.
- There were 8 Section 49 orders in the last Quarter and it was noted that one of these had resulted in 5 separate reports. The Committee discussed the large amount of clinical time required that the Trust was simply not commissioned for. It had been agreed that if there had been no previous knowledge of a person or the last contact was more than two years ago, it was not appropriate for SWYPFT to provide a report. CJ suggested that evidence of time spent should be collected and JC added that in some cases, legal services time was also quite considerable. It was queried if this was a matter for the Committee or a resource issue. ST will pick up data recording and CH suggested that the data be considered in OMG and then escalated to EMT.

**Action: Subha Thiyagesh/Carol Harris**

The Committee discussed the system issues that had been identified as contributing to lack of ethnicity reporting. Whilst this would be rectified on SystemOne with a mandatory field, CJ indicated frustration that this had been an issue for the last two years and advised that it would continue to be raised at Trust Board until someone took ownership. CH assured the Committee that patients were receiving the correct care despite ethnicity not always being recorded.

AH queried the decrease in use of Sections 2 and 3 and whether this coincided with an increase in out of area placements. CH confirmed a spike in out of area placements. AH raised an issue with the recording of patients detained out of area as the responsibility lies where the patient is detained which may skew the figures. The Committee discussed the possibility of tracking out of area placements. YF indicated that this would be a massive piece of work but could be considered outside of the meeting. There was also the issue of some outside agencies not having RiO access.

CJ added that the summary was useful to the Committee and contained some powerful messages.

**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.**
- **MHAC continue to request feedback from the BDU's for insights to clinical reasons which may impact on MHA and DoLS activity.**
- **MHAC request feedback from the BDU's for insight into reasons for decline in s.136 activity.**
- **MHAC seek views from BDU's to explain the decreasing number of Appeals (Tribunals and Hospital Managers) and those that are resulting in a hearing.**

MHAC/18/20b Local Authority Information (agenda item 6.2)

The following updates were provided:

**Kirklees** – AH reported several unusual 136s. Although the numbers had reduced, the police appeared to be behaving differently, eg arresting someone at home for a breach of the peace then transferring them to 136.

**Wakefield** – Stephen Thomas (STh) also reported a reduction of around 1/3 in 136s which had previously been around 20/24 per month. The number of people presenting at Pinderfields had increased.

STh added that there had been some serious cases where people were potentially getting away with what they had done because they required a MHA assessment. It had got to the point where Wakefield AMHPs were being advised not to attend when a serious crime had been committed.

AH indicated that there was further work to do with police liaison as a lot of what had been previously discussed was not being put into practice. YF advised that SWYPFT were working with the police around PACE and the Mental Health Act and were clear that just because someone had a mental disorder, this did not mean that they should not be charged with a crime and that mental health services could be accessed through the criminal justice system.

STh referred to difficulties with bed availability and delays together with the increase in A&E admissions. AH added that in Kirklees, time between an initial assessment and duplicate assessment which would take place when a bed became available, was counted as a delay. There were also significant delays in waiting times for ambulances. CJ queried if there was a process for managing this and CH referred to the Crisis Care Concordat. YF advised that a Conveyancing Policy had been developed with partner agencies although AH indicated that Yorkshire Ambulance Service (YAS) were yet to sign off on this as they may not be able to deliver. A full response is awaited.

Salma Yasmeen (SY) referred to a quarterly West Yorkshire wide meeting involving the police, YAS, mental health services, etc and that this forum might be a good place to discuss the issues.

**Barnsley** – There was no representative present, however YF indicated that she would clarify the figure of 64 admitted to a non-Trust bed with Shirley Atkinson.

**Action: Yvonne French**

## **MHAC/18/21 CQC compliance actions (agenda item 7)**

### **MHAC/18/21a MHA Code of Practice action plan (agenda item 7.1)**

YF provided an update on the development of policies to ensure compliance with the Code of Practice:

- Place of Safety Standard Operating procedure had been approved by OMG.
- Transporting patients under the Act – YF would pick up the YAS issue described at MHAC/18/20b with a general manager in Kirklees prior to forwarding to OMG for approval.
- Outstanding policies related to multi-agency:
  - 136 MHA policy – this had been approved from an STP point of view. SY advised that more work would need to be done in relation to other organisations including West and South Yorkshire Police. Consideration had been given to a SWYPFT Footprint Multi-agency Group and MHA Committee agreed that this would be appropriate. It was noted that this would be progressed at the next 136 group meeting.

**Action: Yvonne French**

- Joint local policies for admission to hospital
- Local Partnership arrangements to deal with people experiencing mental health crisis.

**It was RESOLVED to NOTE the update and to ACCEPT that the Standard Operating procedure for Trust wide place of safety had been approved at OMG.**

### **MHAC/18/21b MHA/MCA/DoLS mandatory training update (agenda item 7.2)**

YF reported the current position as:

- Mental Capacity Act/DoLS training – 91% compliant
- Mental Health Act training – 85% compliant

There had been a 1% decrease in MHA training figures and it was suggested that this may have been due to a gap in the new training programme which was now full. The local authority were providing training which was very well attended. It was agreed that the figures would continue to be monitored with a view to achieving 100%.

Future work:

- Trust development of e learning package for Mental Health Act refresher training (currently no national programme) – JC was working on this.
- Changes to Deprivation of Liberty being considered by ministers – scoping out mandatory training requirements.
- Changes to Mental Health Act being considered following Queen's speech – monitoring for impact on new training programme.

**It was RESOLVED to NOTE the level of compliance with mandatory training target and plans for future training.**

### MHAC/18/21c CQC internal compliance visits (agenda item 7.3)

Tim Breedon (TB) advised that the full report had been to Clinical Governance and Clinical Safety Committee (CGCSC) along with details of actions required and progress monitoring. It had come to MHA Committee for completeness as it related to the Mental Health Act.

Two key points had been identified by CGCSC for follow up and action:

- Good practice had been identified 'in pockets' and needed to be spread across the system.
- Routine of record keeping.

CJ indicated that he had read the full report that went to CGCSC and thought it helpful to have just one action plan and one place for monitoring progress.

It was noted that each team was responsible for the monitoring of their action plan and CJ added that this represented a team based approach to a Trust wide challenge. TB advised that the Clinical Governance group had oversight of all plans and would ensure standardisation.

CJ concluded that there should be a good balance of ownership and accountability but with oversight and consistency. Assurance would be through OMG and monitoring of actions through CGCSC. CH suggested reviewing assurance at MHA Committee and CH/TB would discuss this outside the meeting.

**Action: Carol Harris/Tim Breedon**

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

### **MHAC/18/22 Audit and Compliance Reports (agenda item 8)**

#### MHAC/18/22a Audit of Seclusion within the Forensic services (agenda item 8.1)

CH presented the Local Audit Activity for Seclusion in relation to Forensic Services. The Committee agreed that the paper summarised the work done and supported the recommendation that the MAV TAG review the audit tool and adjust in order to lead on an appropriate Trust wide audit. This would then inform MHA Committee of any further work required prior to full assurance being agreed.

**It was RESOLVED to RECEIVE the audit report and SUPPORT the recommendation.**

#### MHAC/18/22b Section 132 Patients' Rights (agenda item 8.2)

CH presented the Local Audit Activity for Section 132/133 Patients' Rights. It was noted that hospital managers have a duty to provide certain information to patients and in order to fulfil their statutory duties should ensure that correct information is given, accurate records are kept and regular checks are made. CJ queried if the MHA Committee could take assurance that this was happening and it was noted that whilst it is implicit in care plans, it is not always explicit that a patient has understood their rights. It was noted that developments in SystemOne would provide an opportunity for improved recording of rights to incorporate revisiting and rechecking that rights were understood. YF advised that the 132 form had also recently been added to RiO. The Committee considered the summary, conclusions and recommendations.

The Committee **RESOLVED** to **NOTE** the audit findings and **APPROVE** the following recommendations:

- **Note the content of the report and the actions in place to address local issues.**
- **Request a similar report in 6 months with specific assurance on rights being revisited.**

### **MHAC/18/23 Care Quality Commission visits (agenda item 9)**

#### MHAC/18/23a Visits and summary reports received in Quarter 4 (agenda item 9.1)

JC reported that there were 3 CQC Mental Health Act visits in Quarter 4 to; Beechdale, Beamshaw and Waterton wards.

Within the quarter, 3 MHA monitoring summary reports were received relating to visits made to; Beechdale, Beamshaw and Waterton wards.

2 responses were submitted to the CQC; Beechdale and Beamshaw wards. Both were submitted in accordance with the timeframes set by CQC.

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/18/23b Outstanding Actions/Progress Report (agenda item 9.2)

YF reported that the following 4 actions have been outstanding for above 12 months:

- **WIFI access**  
There had been significant progress with WIFI access. It had been installed in Wards 18 and 19 in Dewsbury although there were issues with connectivity.
- **Poplars**  
Refurbishment of garden area at Poplars – costings now received, for completion May 2018.
- **Newton Lodge**  
The CQC continued to raise concerns in relation to curtains on the observation panels. A funded plan was in place to address this and the Committee were assured by this. CJ raised that during the CQC well-led visit, directors and non-executive directors had been questioned extensively in relation to restrictive practices. TB indicated that these had involved specific issues rather than blanket issues raised previously. CH added that there was the potential to add a field to Datix to indicate where restrictions had been put in place. TB suggested the need to consider actual scenarios and to act when we have detail.
- **Poplars**  
Environmental review – this is part of the transformation work for Older Peoples Services.

YF reported that there were no red actions in any of the BDUs. There were 10 amber and 14 green in Barnsley and Wakefield BDUs, 4 amber and 10 green in Calderdale and Kirklees and 7 amber and 7 green actions in the Forensic and Specialist Services BDUs.

The Committee agreed that the update provided assurance that issues were being progressed operationally.

**It was RESOLVED to NOTE progress.**

### **MHAC/18/24 Monitoring Information (agenda item 10)**

#### MHAC/18/24a Hospital Managers' Forum Notes 10 April 2018 (agenda item 10.1)

David Longstaff (DL) reported on the excellent training on Medicines Management. DL indicated that he had attended the CQC independent charity feedback and CJ thanked him for his contribution. It was noted that Angela Monaghan would be attending the June meeting. CJ acknowledged that Bula Chakraborty had retired as a Hospital Manager and asked DL to pass on his best wishes and thanks for their enthusiasm.

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

#### MHAC/18/24b Hospital Managers' Concerns – January-March 2018 (agenda item 10.2)

DL raised that it was frustrating when hearings had to adjourn because professionals did not attend, for various reasons. It was noted, however, that there were no specific instances in the last quarter.

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

#### MHAC/18/24c Compliments, Complaints/Concerns in relation to the Mental Health Act, January-March 2018 (agenda item 10.3)

It was noted that there had been no complaints received in the previous quarter and only two concerns.

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

### **MHAC/18/25 Partner agency update (agenda item 11)**

#### MHAC/18/25a Local Authority (agenda item 11.1)

**Kirklees** – AH reiterated that the impact on no bed being available when a Mental Health Act assessment had taken place was huge. There were also issues with YAS and the police not attending. One implication of this is that some people wait a long time and then deteriorate and end up having a lengthy stay. SY queried if the Intensive Home Based Treatment Team (IHBTT) were doing all they could to manage people in the community and AH advised that whilst IHBTT were engaged, there were cases where they were no longer able to manage people in the community. CJ asked for a sense of how many people were waiting for beds and AH gave some examples, indicating a real pressure in the system.

**Wakefield** – STh reported a similar issue in Wakefield and also noted the impact on resource of multiple assessments where no bed was available, which could be unpleasant for the person and onerous on the AMHP team.

CJ agreed to raise these issues at Trust Board.

#### MHAC/18/25b Acute Health Care (agenda item 11.2)

Victoria Thersby (VT) advised that reporting arrangements on activity in relation to the Mental Health Act was through the Safeguarding Committee then to Board. There was also a section in the Trust Board report this year on the Mental Health Act.

VT reported that the CQC well led visit had taken place the previous week although there was little raised in relation to mental health, 136, etc.

It was noted that there had been a reduction in DoLs over the winter pressure period but figures had remained stable since then. There were no detentions in April.

VT advised that Calderdale and Kirklees were working on a Mental Health Strategy for next year and were working closely with the liaison team to develop a Mental Health Policy.

**MHAC/18/26 Consideration of any changes to the organisational risk register relevant to the remit of the MHA Committee (agenda item 12)**

CJ agreed to raise the issues of bed access and out of area placements not being recorded on our systems as potential risks.

**MHAC/18/27 Key Messages to Trust Board (agenda item 13)**

The key issues to report to Trust Board were agreed as:

- Recording of ethnicity (MHAC/18/20a)
- Bed availability and impact on our partners and patients (MHAC/18/20b and MHAC/18/25a)
- Lack of response of YAS and Police (MHAC/18/20b and MHAC/18/25a)
- 136 – increase and need to work together as Crisis Care Concordat (MHAC/18/21a).

CJ advised the MHA Committee that this would be his last meeting as Chair and members thanked him for his valued contribution.

**MHAC/18/28 Date of next meeting (agenda item 14)**

The next Committee meeting will be held on 28 August 2018 in Meeting Room 1, Block 7, Fieldhead Hospital, Wakefield from 2.00-4.30pm.

## Trust Board 25 September 2018 Agenda item 11

<b>Title:</b>	<b>Use of Trust Seal</b>
<b>Paper prepared by:</b>	Company Secretary on behalf of the Chief Executive
<b>Purpose:</b>	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.
<b>Mission/values:</b>	The paper ensures that the Trust meets its governance and regulatory requirements.
<b>Any background papers/ previously considered by:</b>	Quarterly reports to Trust Board.
<b>Executive summary:</b>	<p>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.</p> <p>The seal has been used two times since the report to Trust Board in June 2018 in respect of the following:</p> <ul style="list-style-type: none"> <li>➤ Renewal lease to formalise the occupation of the Stop Smoking Service in Scot Lane, Doncaster between the Trust and Beech House Pension Trust.</li> <li>➤ Contract for the sale of freehold land with vacant possession at Keresforth Close, Barnsley between the Trust and Barnsley Metropolitan Borough Council.</li> </ul>
<b>Recommendation:</b>	<b>Trust Board is asked to NOTE use of the Trust's seal since the last report in June 2018.</b>
<b>Private session:</b>	Not applicable.

Trust Board annual work programme 2018-19

Agenda item/issue	Apr	June	July	Sept	Oct	Dec	Jan	Mar
<b>Standing items</b>								
Declaration of interest	x	x	x	x	x	x	x	x
Minutes of previous meeting	x	x	x	x	x	x	x	x
Chair and Chief Executive's report	x	x	x	x	x	x	x	x
Business developments	x	x	x	x	x	x	x	x
STP / ICS developments	x	x	x	x	x	x	x	x
Integrated performance report (IPR)	x	x	x	x	x	x	x	x
Assurance from Trust Board committees	x	x	x	x	x	x	x	x
Receipt of minutes of partnership boards	x	x	x	x	x	x	x	x
Question from the public	x	x	x	x	x	x	x	x
<b>Quarterly items</b>								
Corporate/organisational risk register	x		x		x		x	
Board assurance framework	x		x		x		x	
<i>Customer Services quarterly report (now patient experience report included in IPR from quarter 1)</i>	x		x		x		x	
<i>Guardian of safe work hours (now included in IPR)</i>	x		x		x		x	
Serious incidents quarterly report		x		x		x		x
Use of Trust Seal		x		x		x		x
Corporate Trustees for Charitable Funds# (annual accounts presented in July)	x		x		x		x	
<b>Half yearly items</b>								
Strategic overview of business and associated risks	x				x			
Investment appraisal framework (private session)	x				x			
Safer staffing report	x				x			
Digital strategy (including IMT) update	x				x			
Estates strategy update			x				x	
<b>Annual items</b>								
Draft Annual Governance Statement	x							

Agenda item/issue	Apr	June	July	Sept	Oct	Dec	Jan	Mar
Audit Committee annual report including committee annual reports	x							
Compliance with NHS provider licence conditions and code of governance - self-certifications <i>(date to be confirmed by NHS Improvement)</i>	x							
Risk assessment of performance targets, CQUINs and Single Oversight Framework and agreement of KPIs	x							
Review of Risk Appetite Statement	x							
Annual report, accounts and quality accounts - update on submission		x						
Health and safety annual report		x						
Customer Service annual report		x						
Serious incidents annual report		x						
Equality and diversity annual report			x					
Medical appraisal/revalidation annual report			x					
Sustainability annual report				x				
Workforce Race Equality Standard (WRES)					x			
Assessment against NHS Constitution						x		
Eliminating mixed sex accommodation (EMSA) declaration								x
Information Governance toolkit								x
Strategic objectives								x
Trust Board annual work programme								x
Operational plan (two year) <i>(next due in December 2018 - date to be confirmed by NHS Improvement)</i>						x		
<b>Policies and strategies</b>								
Constitution (including Standing Orders) and Scheme of Delegation							x	
Risk Management Strategy							x	
Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies)							x	
Policies/strategies for future review:								
<ul style="list-style-type: none"> <li>Trust Strategy <i>(reviewed as required)</i></li> <li>Standing Financial Instructions <i>(reviewed as required)</i></li> <li>Membership Strategy <i>(next due for review in April 2019)</i></li> <li>Communication, Engagement and Involvement strategy <i>(next due for review in December 2019)</i></li> <li>Organisational Development Strategy <i>(next due for review in December 2019)</i></li> <li>Treasury Management Policy <i>(next due for review in January 2020)</i></li> <li>Workforce Strategy <i>(next due for review in March 2020)</i></li> <li>Customer Services Policy <i>(next due for review in June 2020)</i></li> <li>Equality Strategy <i>(next due for review in July 2020)</i></li> </ul>								

Agenda item/issue	Apr	June	July	Sept	Oct	Dec	Jan	Mar
<ul style="list-style-type: none"> <li>• Standards of Conduct in Public Service Policy (conflicts of interest) <i>(next due for review in October 2020)</i></li> <li>• Learning from Healthcare Deaths Policy <i>(next due for review in October 2020)</i></li> <li>• Digital Strategy <i>(next due for review in January 2021)</i></li> <li>• Quality Strategy <i>(next due for review in March 2021)</i></li> <li>• Trust Board declaration and register of fit and proper persons, interests and independence policy <i>(next due for review in March 2021)</i></li> <li>• Estates Strategy <i>(next due for review in July 2022)</i></li> </ul>								
	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.								