South West Yorkshire Partnership NHS Foundation Trust

Trust Board (performance and monitoring)
Tuesday 26 March 2019 at 9.30am
Rooms 3 & 4, Laura Mitchell Health and Wellbeing Centre, Great Albion Street, Halifax HX1 1YR

AGENDA

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
1.	**9.30**	**Welcome, introductions and apologies**	Chair	**Verbal item**	2	To receive
2.	**9.32**	**Declarations of interest**	Chair	**Verbal item**	3	To receive
3.	**9.35**	**Minutes and matters arising from previous Trust Board meeting held 29 January 2019**	Chair	**Paper**	5	To approve
4.	**9.40**	**Service User Story**	Director of Operations	**Verbal item**	10	To receive
5.	**9.50**	**Chair and Chief Executive's remarks**	Chair Chief Executive	**Verbal item** **Paper**	15	To receive
6.	**10.05**	**Performance reports**				
	10.05	6.1 Integrated performance report M11 2018/19	Director of Finance & Resource and Director of Nursing & Quality	**Paper**	60	To receive
	11.05	6.2 Staff survey results	Director of HR, OD & Estates	**Paper**	10	To receive
	11.15	*Break*				

With **all of us** in mind.

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	11.30	6.3 Clinical Records System update	Director of Strategy	**Paper**	10	To receive
	11.40	6.4 Freedom to Speak Up Guardians update	Director of HR, OD & Estates	**Paper**	5	To receive
7.	**11.45**	**Business developments**				
	11.45	7.1 South Yorkshire update including South Yorkshire & Bassetlaw Integrated Care System (SYBICS)	Director of HR, OD & Estates and Director of Strategy	**Paper**	10	To receive
	11.55	7.2 West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP)	Director of Strategy	**Paper**	10	To receive
8.	**12.05**	**Strategies and policies**				
	12.05	8.1 Updates to Learning from Healthcare Deaths Policy	Director of Nursing & Quality	**Paper**	5	To approve
9.	**12.10**	**Governance matters**				
	12.10	9.1 Eliminating mixed sex accommodation (EMSA) declaration	Director of Nursing & Quality	**Paper**	5	To receive
	12.15	9.2 Data Security and Protection toolkit	Director of Finance & Resources	**Paper**	10	To receive
	12.25	9.3 Update on: - Financial and business planning - Integrated performance report - Board assurance framework	Director of Finance & Resources and Director of Nursing & Quality	**Paper**	10	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	12.35	9.4 Brexit contingency plan	Director of HR, OD & Estates	**Paper**	10	To receive
10.	**12.45**	**Receipt of public minutes of partnership boards**	Chair	**Paper**	5	To receive
11.	**12.50**	**Assurance and receipt of minutes from Trust Board Committees** - Clinical Governance & Clinical Safety Committee 12 February 2019 - Equality & Inclusion Forum 5 March 2019 - Mental Health Act Committee 12 March 2019 - West Yorkshire Mental Health Collaborative Committees in Common 4 March 2019 - Workforce and Remuneration Committee 12 February 2019	Chairs of committees	**Paper**	5	To receive
12.	**12.55**	**Use of Trust Seal**	Chair	**Paper**	5	To receive
13.	**13.00**	**Trust Board work programme**	Chair	**Paper**	3	To approve
14.	**13.03**	**Date of next meeting** The next Trust Board meeting held in public will be held on Tuesday 30 April 2019, Room 49/50, Folly Hall, St Thomas Road, Huddersfield HD1 3LT	Chair	**Verbal**	2	To note
15.	**13.05**	**Questions from the public**	Chair	**Verbal**	15	To receive
	13.20	*Close*				

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 March 2019
Agenda item 2

Title:	**Trust Board declaration of interests, including fit and proper persons declaration**
Paper prepared by:	Company Secretary on behalf of the Chief Executive
Purpose:	To ensure the Trust continues to meet the NHS rules of Corporate Governance, the Combined Code on Corporate Governance, Monitor's Code of Governance and the Trust's own Constitution in relation to openness and transparency.
Mission/values:	The mission and values of the Trust reflect the need for the Trust to be open and act with probity. The Declaration of Interests and independence process and the fit and proper person declaration undertaken annually support this.
Any background papers/ previously considered by:	Previous annual declaration of interest papers to the Trust Board. Policy for Trust Board declaration and register of fit and proper persons, independence, interests, gifts and hospitality approved by Trust Board in March 2018.
Executive summary:	**Declaration of interests** The Trust's Constitution and the NHS rules on corporate governance, the Combined Code of Corporate Governance, and Monitor / NHS Improvement require Trust Board to receive and consider the details held for the Chair of the Trust and each Director, whether Non-Executive or Executive, in a Register of Interests. During the year, if any such Declaration should change, the Chair and Directors are required to notify the Company Secretary so that the Register can be amended and such amendments reported to Trust Board. Trust Board receives assurance that there is no conflict of interest in the administration of its business through the annual declaration exercise and the requirement for the Chair and Directors to consider and declare any interests at each meeting. As part of this process, Trust Board considers any potential risk or conflict of interests. If any should arise, they are recorded in the minutes of the meeting. There are no legal implications arising from the paper; however, the requirement for the Chair and Directors of the Trust to declare interests is part of the Trust's Constitution. **Non-Executive Director declaration of independence** Monitor's Code of Governance and guidance issued to Foundation Trusts in respect of annual reports requires the Trust to identify in its annual report all Non-Executive Directors it considers to be

	independent in character and judgement and whether there are any relationships or circumstances which are likely to affect, or could appear to affect, the Director's judgement. This Trust considers all its Non-Executive Directors to be independent and the Chair and all Non-Executive Directors have signed a declaration to this effect. **Fit and proper person requirement** There is a requirement for members of Boards of providers of NHS services to make a declaration against the fit and proper person requirement for Directors set out in the new fundamental standard regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which came into force on 1 April 2015. Within the new regulations, the duty of candour and the fit and proper person requirements for Directors came into force earlier for NHS bodies on 1 October 2014. Although the requirement is in relation to new Director appointments, Trust Board took the decision to ask existing Directors to make a declaration as part of the annual declaration of interests exercise. All Directors have signed the declaration stating they meet the fit and proper person requirements. The Company Secretary is responsible for administering the process on behalf of the Chief Executive of the Trust. The declared interests of the Chair and Directors are reported in the annual report and the register of interests is published on the Trust's website. In February 2017, NHS England released new guidance on Managing Conflicts of Interest in the NHS including a model policy which took effect from 1 June 2017. The Standards of Business Conduct Policy (conflict of interest policy) for staff was updated to align with the model policy and approved by Trust Board in October 2017. A revised version of the Policy for Trust Board declaration and register of fit and proper persons, independence, interests, gifts and hospitality was approved in March 2018, with minor amendments to align it to the staff policy. **Risk appetite** The mission and values of the Trust reflect the need for the Trust to be open and act with probity. The Declaration of Interests and independence process and the fit and proper person declaration undertaken annually support this.
Recommendation:	**Trust Board is asked to CONSIDER the attached summary, particularly in terms of any risk presented to the Trust as a result of a Director's declaration, and, subject to any comment, amendment or other action, to formally NOTE the details in the minutes of this meeting.**
Private session:	Not applicable

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 March 2019

Register of interests of the directors (Trust Board) from 1 April 2019 to 31 March 2020

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 have been made by the Trust Board:

Name	Declaration
Chair	
MONAGHAN, Angela Chair	Spouse - Strategic Director at Bradford Metropolitan District Council. Spouse - Non-Executive Director of the National Association for Neighbourhood Management.
Non-Executive Directors	
CAMPBELL, Laurence Non-Executive Director	Director, Trustee and Treasurer, Kirklees Citizens' Advice Bureau and Law Centre, includes NHS complaints advocacy for Kirklees Council.
COURT, Rachel Non-Executive Director* (*term ends 31 March 2019)	Director and Chair, Leek United Building Society. Chair, Invesco Pensions Ltd. Director, Invesco UK Ltd. Director, Leek United Financial Services Ltd. Chair, PRISM. Governor, Calderdale College. Magistrate. Chair, NHS Pension Board.
DYSON, Charlotte Deputy Chair / Senior Independent Director	Independent Marketing Consultant, Beyondmc (including consultancy for Royal College of Surgeons of Edinburgh). Lay Chair, Leeds Teaching Hospitals NHS Trust Advisory Appointments Committee for consultants (occasional). Lay member, Leeds Teaching Hospitals NHS Trust Clinical Excellence Awards Committee (CEA). Lay member, Bradford Teaching Hospitals NHS Trust Clinical Excellence Awards Committee (CEA). Lay member, Advisory Committee Clinical Excellence Awards, Yorkshire and Humber Sub-Committee. Lay member, Royal College of Surgeons of Edinburgh, MRSC Part B OSCE.

Name	Declaration
MAHMOOD, Erfana 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.
QUAIL, Kate Non-Executive Director	Owner / Director of The Lunniagh Partnership Ltd, Health and Care Consultancy.
YOUNG, Sam Non-Executive Director	Owner / Director, ISAY Consulting Limited. Non-Executive Director, Great Places Housing Group.
Chief Executive	
WEBSTER, Rob Chief Executive	Independent Chair of Panel for assessing clinical commissioning group learning disability commissioning (NHS England). Visiting Professor, Leeds Beckett University. Honorary Fellow, Queen's Nursing Institute. Honorary Fellow, Royal College of General Practitioners. Lead Chief Executive, West Yorkshire and Harrogate Health and Care Partnership (Integrated Care System).
Executive Directors	
BREEDON, Tim Director of Nursing and Quality / Deputy Chief Executive	Son - works in the Trust's Occupational Health Service as a Registered Nurse.
BROOKS, Mark Director of Finance and Resources	No interests declared.
DAVIS, Alan Director Human Resources, Organisational Development and Estates	Spouse - Employed by Blackpool Teaching Hospitals NHS FT as the Managing Director for NHS North West Leadership Academy.
THIYAGESH, Dr Subha Medical Director	No interests declared.
Other Directors (non-voting)	
HARRIS, Carol Director of Operations	Spouse - Engineering Company has contracts with NHS providers including Mid Yorkshire Hospitals NHS Trust.
RAYNER, Sean Director of Provider Development	No interests declared.
YASMEEN, Salma Director of Strategy	Board member, PRISM charity in Bradford.

Note, Kate Henry, Director of Marketing, Communication and Engagement is on maternity leave until her contract ends in August 2019. No interests have been previously declared.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Trust Board meeting held on 29 January 2019
Small conference room, Wellbeing & learning centre, Fieldhead, Wakefield

Present:	Angela Monaghan (AM)	Chair
	Charlotte Dyson (CD)	Deputy Chair / Senior Independent Director
	Rachel Court (RC)	Non-Executive Director
	Kate Quail (KQ)	Non-Executive Director
	Erfana Mahmood (EM)	Non-Executive Director
	Sam Young (SYo)	Non-Executive Director
	Rob Webster (RW)	Chief Executive
	Mark Brooks (MB)	Director of Finance and Resources
	Dr. Subha Thiyagesh (SThi)	Medical Director
	Tim Breedon (TB)	Director of Nursing and Quality / Deputy Chief Executive
	Alan Davis (AGD)	Director of Human Resources, Organisational Development and Estates
Apologies:	Laurence Campbell (LC)	Non-Executive Director
In attendance:	Carol Harris (CH)	Director of Operations
	Sean Rayner (SR)	Director of Provider Development
	Salma Yasmeen (SY)	Director of Strategy
	Emma Jones (EJ)	Company Secretary (author)

TB/19/01 Welcome, introductions and apologies (agenda item 1)

The Chair, Angela Monaghan (AM) welcomed everyone to the meeting. Apologies as above were noted. At the commencement of the meeting there were two members of the public in attendance which included one governor and one member of staff. AM reminded the 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 members of the public preferred to raise their questions in that way and to enable a response to be provided outside of the meeting.

TB/19/02 Declarations of interest (agenda item 2)

The following declaration was made and considered by Trust Board.

Name	Declaration
Non-Executive Directors	
Tim Breedon Director of Nursing & Quality / Deputy Chief Executive	Son - works in the Trust's occupational health service as a registered nurse.

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

It was RESOLVED to formally NOTE the Declaration of Interest. It was noted that the Chair had reviewed the declaration made and concluded that it does not present a risk to the Trust in terms of conflict of interests.

TB/19/03 Minutes and matters arising from previous Trust Board meeting held 18 December 2018 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 18 December 2018 as a true and accurate record. The following matters arising were discussed:

- TB/18/106 Service User Story - AM advised that she had held individual meetings with both carers to provide feedback from the Board and both were positive and constructive conversations. Carol Harris (CH) and Dr. Subha Thiyagesh (SThi) are also following up on some areas raised.
- TB/18/110a Assessment against NHS Constitution (piloted staff app) - Salma Yasmeen (SY) commented that it was hoped the app could be launched in April 2019 following a meeting with Staff Side. It would be a free base level product which will enable the Trust to communicate key messages to staff.
- TB/18/110c Emergency Preparedness, Resilience & Response (EPRR) Compliance - Alan Davis (AGD) advised that the evidence against all standards would be circulated for the Trust Board briefing session on 29 March 2019.

  Action: Alan Davis
- TB/18/78 Chair and Chief Executive's remarks (new legislation covering violence against NHS staff) - AGD commented that the policy would be updated and conversations were taking place with the local police with an aim to agree by end of the financial year.
- TB/18/81a Appraisal / Revalidation Annual Board Report 2017/18 - SThi commented that the advisory group would provide the Responsible Officer with any feedback. If any issues arose the Responsible Officer would pick these up. The Responsible Officer and Medical Director had interface meetings with a clear agenda to ensure all complaints and concerns are picked up. The processes in place would ensure compliance with guidance.

TB/19/04 Service User Story (agenda item 4)

The Trust Board heard a combined staff member and service user story in relation to the impact of agile working. Carol Harris (CH) advised that the story was from a Community Matron in Barnsley, with whom she had attended a home visit, who wanted to explain the difference it had made to their working life as well as the service users. After the initial pilot in July 2017 the matron service in Barnsley began agile working. The following was an extract from feedback given in the staff member's own words:

> "As a Community Matron, agile working allows me to be empowered to work where, when and how I choose, enabling flexibility, which helps optimise patient care and staff performance. As a systems leader in the Neighbourhood Nursing Service, agile working enables me to keep in contact with staff by means of emails, instant messaging or Skype calls, without having to drive across town to attend a face-to-face meeting and breaking away from patient care. It offers the ability to access work whilst out and about, enabling work to be scheduled according to the demands of that particular work day and activities."

CH outlined the advantages highlighted by the member of staff included that it immediately provides increased responsiveness, ability to complete patient records in their own homes and communicate with GPs, increased job satisfaction and personal productivity, training apps that can be watched with the patient. There were however some disadvantages, which included reduced cover and 4G access and the need to be strict because sometimes it was hard to switch off from work.

CH outlined a case study in relation to an elderly service user who lived with their partner and the positive impact of the staff member's agile working on their support to the service user. This included consultations performed in the service user's home, which made them and their partner feel actively involved with the planning of care, the ability to make changes to prescribed medications directly into the system so they were up to date and other records reflecting the service user's changing needs. If paramedic services were needed an Acute Care Plan was implemented, including preemptive rescue medication with all paramedics able to see this on the service user's record and the ability for them to be treated at home rather than requiring a hospital admission. Advance care planning was implemented toward end of life and the service user consented to share this information, therefore it was available for other visiting professionals to see if the Community Matron was off duty, as the service user did not like talking about their prognosis and found it extremely difficult discussing the topic of resuscitation. Unfortunately the service user has passed away, however the plans in place enabled them to do so as they chose, at home with their family.

The Board reflected on the story noting that it highlighted the importance of the timeliness and access to information across services, assisting service users in being actively involved in care planning by seeing the records taken, and preventing service users being asked the same questions repetitively.

Charlotte Dyson (CD) commented that it would be good to have videos of some service user stories to enable them to be shared more widely. RW commented that there were many filmed stories available on the internet which could be updated.

CH commented that the story moved her as she had heard about the service user's condition prior to the visit and had pictured a hospital scene. However when she visited it was someone in their own setting and highlighted the importance of someone being able to receive care at home with their family to support them with quality of life.

Rachel Court (RC) commented that staff not feeling able to switch off was a concern and asked whether there was guidance or safeguards in place to ensure staff did not work extended hours. CH commented that clinical supervision was the best safeguard to work through these areas with staff, including their responsibilities for care and to themselves, as well as through management supervision, team meetings, and general discussions.

Sam Young (SYo) asked if the partner's perspective was known in relation to being a carer. CH commented that they were much involved in the care planning, as well as their own self-care and support, and the plan provided support to both.

Rob Webster (RW) commented that a positive aspect of the implementation of Systmone was that records could be accessed across services, with West Yorkshire and Harrogate being one of the local health care record exemplar (LHCRE) pilot areas. The next stage would be giving people access to their own records.

The Board thanked the staff member and service user for sharing their stories.

It was RESOLVED to NOTE the Service User Story.

TB/19/05 Chair and Chief Executive's remarks (agenda item 5)

Chair's remarks

AM highlighted the following:

- The next Members' Council meeting will be held on 1 February 2019 at the Barnsley Football Club commencing at 9.30am.
- The Members' Council election process for 2019 was about to commence with nominations opening on 1 February 2019 until 1 March 2019. This year there were seats available for public governors in Barnsley, Calderdale, Kirklees and Wakefield and staff governors for Nursing support and Social care staff working in integrated teams. The election would be conducted by the Electoral Reform Services (ERS) on behalf of the Trust.
- The Board will be discussing the following items in private session today, which are considered as commercial in confidence:
  - Corporate/organisational level risk register – one specific risk
  - Those aspects of financial performance considered to be commercial in confidence, including draft financial sustainability plans.
  - Draft operational plan 2019/20, which includes the Trust's proposed control total.
  - Update on implementation of the new Clinical Records System (CRS), in particular the governance arrangements for cutover and go live dates.
  - Commercially confidential business developments in West Yorkshire and South Yorkshire including the Integrated Care Systems (ICSs) and an End of Life Alliance agreement in Wakefield.
  - Minutes of private partnership board meetings.

Chief Executive's report

RW commented that there was no edition of "The Brief" communication to staff at the end of December which would have normally been included with the paper. Therefore a separate Chief Executive's report provided a more detailed update on the local and national context than normal, as well as what was happening across the organisation, and highlighted the following:

- Brexit dominates the headlines with 60 days until the UK is due to leave the EU. There was an item agenda in relation to contingency planning.
- There was a lot of planning taking place in response to the NHS Long Term Plan and Trust's Operational Plan with items on the agenda. At the same time commissioners are responding, their five year allocations.
- Within the NHS Long Term Plan there was a significant amount of focus on wellbeing, mental health, community services and primary care, which are in line with the Trust's strategy, and there was continued focus on the health and wellbeing of staff.
- Local allocations had improved in terms of accuracy and place-based needs of local people. Previously, it had been felt that there was further needed in relation to mental health and this has now been factored into the allocations' formula.
- There was still a significant amount of detail missing in terms of planning guidance. There would be two phases of business planning: a one-year plan for 2019/20 for final submission in April 2019, and a five-year plan to be agreed by the ICSs in the autumn.
- Local government social care and public health and NHS workforce budgets were still to be set, and a green paper on social care was still expected.
- Giving the importance of workforce in delivering plans, Julian Hartley, who is currently Chief Executive of Leeds Teaching Hospitals NHS Trust, has been asked to lead the new workforce implementation plan for the NHS
- There would be 20% less infrastructure on commissioning which would affect our partners and focusing on a digitally enabled NHS would support plans.
- The Workforce Race Equality Standard (WRES) data had been published as previously discussed at Trust Board. There were some areas on which the Trust had

improved, and some we had not. The Trust needed to demonstrate the work that was taking place to improve and keep in view.

- In relation to ICSs it was positive that the Trust was operating within two and the NHS Long Term Plan states that all places must be within an ICS in the future. It was important to recognise that the ICS is a system, rather than an organisation with a structure and a hierarchy.

CD asked when the green paper on social care was expected, noting the importance of local authorities to get support and funding in place, as it could impact on the Trust's ability to deliver services. RW commented that it had been expected at the same time as the NHS Long Term Plan but had yet to emerge. He also noted that it was important as a sustainable solution was needed to social care funding. The local authorities in each of the Trust's main places were in the process of setting their three-year budgets and, as they form part of the ICS, the Trust would be able to understand their plans and priorities.

CD asked if it was known who would replace Diana Terris as the Chief Executive Officer of Barnsley Council when she steps down later this year. AM commented that the recruitment process had commenced.

SYo commented that the different levels of planning across the system could create less certainty and asked if there was sufficient capacity in the Trust to react accordingly. Mark Brooks (MB) commented that the turnaround time for submission of the Trust's plans was short, however the processes were in place and have worked fairly effectively in previous years. The agenda item on the NHS Long Term Plan outlines the enormity of the planning process, and it was recommended for a separate discussion in a Trust Board strategic session to agree on which areas to focus. RW commented it would be important to agree the areas of focus in relation to capacity.

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

TB/19/06 Risk and assurance (agenda item 6)

TB/19/06a Board Assurance Framework (BAF) (agenda item 6.1)

MB reported that both the Board Assurance Framework (BAF) and Corporate/Organisational Risk Register (ORR) were reviewed on a cyclical basis by the Executive Management Team (EMT) prior to reporting to Trust Board. In Quarter 3, EMT felt there had been no significant changes which would change the RAG rating. The cover page identifies the changes that have been made since the last report to Trust Board. There are some areas that could change next quarter, including capacity for the Trust to complete the priorities and strategic objectives set and through the review of the NHS Long Term Plan, and recognising the financial challenge, which could move the RAG rating from green to amber. This quarter, following recommendation from the internal auditors, a key had been added to indicate whether assurance was positive or negative and internal or external. At this stage it appears that assurance is very dependent on internal areas and further work is needed to ensure external areas are reflected. The Trust Board would consider whether any strategic risks should change for 2019/20 at a strategic session.

SYo commented, in relation to strategic risk 2.2, that it includes reference to the work taking place nationally on the NHS workforce as well as that taking place by the Trust, such as the quality improvement training addressing areas that lack capacity. CD commented that as well as the quality improvement reference, the work that the Trust is doing to be outstanding needs to be reflected.

Action: Alan Davis

Kate Quail (KQ) commented that she found it difficult at times to determine how the current assurance level had been decided. Emma Jones (EJ) suggested that, as it was discussed by the EMT prior to Trust Board, Non-Executive Directors raise any areas of concern for full Board discussion.

RC commented, in relation to strategic risk 3.1, that the work taking place on the NHS Long Term Plan, financial sustainability plan, and strategic plans needs to be captured. AGD commented that one of the limiting factors around the NHS Long Term Plan was workforce. It was important that the right number of people with the right skills and expertise were in place to deliver the ambitions.

Action: Mark Brooks

RC commented that it was helpful to show the RAG ratings over the year to track progress and suggested a comparison be made over a longer period of time to see what had changed.

Action: Mark Brooks

SYo commented, in relation to strategic risk 3.4 that, while it was RAG rated green overall, there were areas of concern under the surface. MB commented that that the RAG rating of that strategic risk was one of the ones most debated at EMT meetings. AM asked if the cover page of the report could reflect the discussion of EMT in future.

Action: Mark Brooks

MB commented that it was important there was appropriate ownership of each strategic risk to ensure they are updated appropriately to provide assurance to Trust Board. RW commented that any gaps in assurance could be discussed as part of agenda setting. An area for specific consideration as part of the BAF in 2019/20 may be in relation to workforce.

Action: Rob Webster/Angela Monaghan

It was RESOLVED to NOTE the controls and assurances against the Trust's strategic objectives for Q3 2018/19 and actions in place to address the gaps in control.

TB/19/06b Corporate/organisational risk register (ORR) (agenda item 6.2)

MB reported that the cover paper identifies the red risks scored above 15 and those which are outside of risk appetite, including the updates that have taken place over the last quarter. A patient safety risk has been discussed by the Executive Management Team (EMT), and would be discussed further by the Clinical Governance & Clinical Safety Committee, then reported to Trust Board.

Action: Tim Breedon/CGCSC

The triangulation of risk, performance and governance report to Audit Committee noted some areas within the Integrated Performance Report (IPR) which were RAG rated as red and did not have a specific risk on the ORR. In relation to complaints it was included as part of learning and incorporated into the patient safety risk.

AM asked which committee would discuss any risk relation to the percentage of clients in employment which is RAG rated as red on the IPR. TB commented that this could be considered by the Equality & Inclusion Forum with a draft dashboard under development for review by the Forum in March 2019.

Action: Tim Breedon/E&I Forum

Erfana Mahmood (EM) asked if there was a point when the Trust Board would be asked to decide if the level of ongoing risks were unacceptable. MB commented that some risks by their very nature would remain on the risk register however the Trust Board may consider how long a risk should remain outside of the risk appetite. The challenge sometimes was

escalating risks from BDU level to the ORR quickly enough. TB commented that it was sometimes difficult to get balance between transient/emerging risks and ongoing risks, however it was important to make sure that both were covered. RW commented that Non-Executive Director challenge and review of aligned ORR risks at committees was important for feedback and assurance to Trust Board.

CD commented that the Clinical Governance & Clinical Safety Committee had a standing agenda item in relation to CAMHS to provide further assurance on the actions taking place to mitigate the risk. Linking with the IPR the Committee has requested extra assurance in relation to the use of restrictive practices which would be received at the next meeting. RC commented that the Workforce & Remuneration Committee received reports relating to agency staff and recruitment challenges as well as in-depth information on the workforce plans in place. Some risks may continue due to system wide issues. KQ commented that while there were no specific risks on the ORR aligned to the Mental Health Act Committee the Committee still discussed areas of potential risk and mitigations. SThi commented that any risks identified would be raised and discussed by the EMT to consider for inclusion on the ORR.

CD asked, in relation to communication on the delivery of the NHS Long Term Plan and Trust sustainability plans, was the right level of resource in place to understand the key messages and communicate them to staff and partners. SY commented that communication has been discussed at an EMT timeout in relation to the Trust's priorities and priority programmes. Communications and workforce engagement underpins the delivery and the key messages needed were clear. EM asked if a separate risk was needed in relation to capacity. MB commented that is was a strategic risk within the BAF.

KQ asked, in relation to Risk ID 1153, whether the loss of dual trained staff with knowledge and expertise to support service users with long term conditions was adequately reflected as well as potential to rotate staff within the Trust to assist. AGD commented that at a workforce planning workshop for inpatient areas it had been raised and the role of the nursing associate assisted with the skill mix of teams as their training was more acute focused. RW commented that one of the areas agreed in the ICS was a work passport for acute staff so they could more easily move between organisations and it may be an area that could be considered for mental health services.

AM commented in relation to Risk ID 1157 that a further control could be added in relation to the WRES and DES.

Action: Alan Davis

AM commented in relation to Risk ID 1080 that further areas could be incorporated from the recent Trust Board training.

Action: Mark Brooks

AM asked in relation to Risk ID 1214 if the publication of the NHS Long Term Plan would mean that the likelihood of tendering would decrease. MB commented that the risk could be updated following the publishing of the plan.

Action: Mark Brooks

AM asked if the risk grading matrix could be included with future reports to assist with understanding the scoring of risks.

Action: Mark Brooks

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

TB/19/06c Contingency planning for "no deal" Brexit (agenda item 6.3)

AGD highlighted the following:

- At the end of 2018 new guidance was released on actions that needed to be taken.
- The Trust's action plan has been updated in accordance with the guidance.
- Nationally a lot of work was taking place in relation to drug supply and it was felt this was relatively secure. The Trust has service users that require unlicensed drugs that it may need to build sufficient stock in accordance with national guidance.
- It was important to consider any impact on the system before actions are taken and the Trust was working with trusts across West Yorkshire & Harrogate.

EM asked if the number of staff who are EU citizens was known. AGD commented that approximately 25 staff had identified themselves as EU citizens and would be supported by the Trust. There may be a greater medium to long term effect across the system as it was unknown what regulations would be put into place on EU citizens working in the UK.

AM asked if reassurance had been provided to service users and staff through communications in relation to contingency plans. AGD commented that reassuring messages had been provided to staff through staff communications. SY commented that a direct message for staff had also been include on payslips. AGD commented that the service user element may need to be considered.

Action: Alan Davis / Salma Yasmeen

It was RESOLVED to NOTE the content of the report.

TB/19/07 Business developments (agenda item 7)

TB/19/07a NHS Long Term Plan (agenda item 7.1)

MB reported that the paper provided a summary of the NHS Long Term Plan, with language directly used from the plan. It was recommended that the Long Term Plan be discussed in further detail at a strategic session of Trust Board.

TB commented that the summary show areas of alignment to the Trust's plans.

The Board commended that the summary was helpful and supported further discussion at a strategic session.

It was RESOLVED to:

- **REVIEW and COMMENT on the report; and**
- **AGREE to discuss in further depth at a Trust Board strategy meeting which will enable the Board to agree a series of next steps to articulate and define what the long term plan means to the Trust and services it provides.**

TB/19/07b South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYBICS) (agenda item 7.2)

AGD reported that SYBICS partnership board meeting in January and February 2019 had been cancelled. Interim governance arrangements were expected to be announced and the paper in the private session of Trust Board included an update from the leader of the ICS. The performance dashboard for the ICS showed that overall it was performing well, however there were still challenges such as cancer target that needed further work. Mental health related targets were all RAG rated green and the Trust plays a significant role in this area.

SYo asked about the transformation funding in relation to a Children & Young People's Service. SY commented that a small amount of funding had been provided to assist with

areas that were already being working on. The Trust is involved in work taking place with schools.

SY commented that the mental health alliance work was showing the positive benefits of working in partnership including ASD/ADHD learning from the work taking place in West Yorkshire and Harrogate. Individual placement and support services are variable across the places within the SYBICS and a bid has been placed to fund an expansion and work was taking place with commissioners and partners to develop a model. In relation to suicide prevention, the SYBICS had secured £0.5m funding with Barnsley Council leading the steering group and the Trust strongly involved in shaping the work. Funding has also been provided to support winter pressures in Barnsley and the Trust was part of the discussions and proposals.

AM asked if the dashboard was published. AGD to provide the website link.

Action: Alan Davis

It was RESOLVED to NOTE the update from the SYBICS and Barnsley integrated care developments.

TB/19/07c West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) (agenda item 7.3)
SY highlighted the following:

- The System Oversight and Assurance Group (SOAG) is looking at areas of concern and hotspots as well as updates from each work programme.
- The WYHHCP received a significant amount of the national budget allocation including capital and £12m to support mental health rehab and recovery and the Trust would work with partners to develop proposals.
- Work is taking place on New Models of Care for CAMHS and Adult Eating disorders as noted by SOAG.
- A workshop was led by the Kings Fund to start planning for the five year ICS plans.
- Place-based planning has leads identified which is positive, with work taking place to develop the plan together, supported by an editorial group.
- The ICS supported the "I will be heard" campaign about Child Sexual Exploitation and, as a Trust, we supported the campaign too with activity over January 2019.
- NHS England, NHS Improvement and NHS Digital visited the ICS to look at areas of best practice to share with the wider system.

It was RESOLVED to RECEIVE and NOTE the updates on the development of Integrated Care Partnerships and collaborations including:

- **West Yorkshire and Harrogate Health and Care Partnership**
- **Wakefield**
- **Calderdale**
- **Kirklees**

TB/19/08 Performance reports (agenda item 8)

TB/19/08a Integrated performance report (IPR) Month 9 2018/19 (agenda item 8.1)
TB highlighted the following in relation to Summary and Quality:

- Under 18 admissions to acute wards have reduced for the month, and work continues to ensure this is eliminated.

- Safer staffing fill rates are positive overall, however some very significant local pressures remain.
- Complaints turnaround remains a challenge, additional support is in place and backlog continues to reduce.
- Out of area placements showing a reduction.
- Information Governance (IG) training compliance is below target with further work to be done to ensure the 95% target is achieved.
- Friends & Family Test (F&FT)
- New data on risk assessments -need to look at setting a suitable metric.
- Medicines omissions has been a data collection issue as information was taken on Boxing Day when a number of staff were on leave. SThi stated the next stage of collection is due tomorrow, spread variation across wards, area with maximum is in Wakefield but may be in relation to data collection which will be reviewed.
- Prone restraint position is positive for December and will be an area of focus at the next Clinical Governance & Clinical Safety Committee meeting.
- Falls was showing an increase in frailty.
- Staff supervision reporting has reduced and will be addressed during the final quarter. CH commented that the Operational Management Group (OMG) had agreed to review to ensure all supervision had been included in the data.
- Safety first was showing a slight reduction in the reporting of incidents which will be updated in the Quarter 3 report.
- Apparent suicide looking at the overall trend over the past two years. Important it is linked with the work on prevention.
- Care Quality Commission (CQC) action plan was making positive progress. There will be a dedicated quality improvement meeting in February 2019 to review further. Positive messages had been received from the CQC relationship manager who attended a Clinical Governance & Clinical Safety Committee meeting in relation to how it was conducted and the areas discussed. Whilst focus is on the action plan, high profile work is being started in preparation for the next well-led inspection.

CD asked, in relation to the national concern around child sexual exploitation, how the Trust would support individuals if needed. TB commented that a small working group had met to look at the best approach as the support would need to be bespoke to individuals. It is important that, if they contact the Trust, the services understand they come under this area so the Trust can respond appropriately. At this stage some assumptions have been made on what type of support and intervention would be needed and from early information it was felt the services would be able to meet any potential demand.

KQ asked, in relation to the increase in falls, how it was known that it was due to an increase in frailty. TB commented that they related back to the falls risk assessment tool (FRAT).

RC asked how long the additional resources would be in place to support responding to complaints. TB commented that an internal audit showed the Trust had the systems and processes in place, however it was the capacity that needed focus. As the Trust continues to improve the system including embedding in operational areas it can add additional pressure on workforce. Work was taking place on Datix to support improved reporting and in a month there should be a clear trajectory. SYo commented that the internal audit report had been received by the Audit Committee. TB commented that the internal audit report would also go to the Clinical Governance & Clinical Safety Committee for discussion.

SYo asked, in relation to safer staffing, where local pressures are discussed. TB advised that they are discussed at the staffer staffing group, Operational Management Group (OMG), Clinical Governance & Clinical Safety Committee, and reported half yearly to Trust Board. There is also a report published on a monthly basis on the Trust's website. TB to provide the link to the monthly report.

Action: Tim Breedon

CD asked, in relation to Information Governance (IG) incidents, if there were any themes. MB commented that the only theme was they typically related to individual human error. CH commented that the learning from IG incidents was discussed by the OMG agenda to assist in sharing the learning across the organisation.

AM commented, in relation to risk assessment, although not currently a metric, this was steadily increasing for community but not for inpatient, and structured judgement reviews were showing only 35% of risk assessments were rated good or excellent. CH commented that, for each, work was taking place with wards through teams and named nurses to understand if there were any issues in completing the risk assessments. TB commented that there was ongoing clinical risk assessment training and it was a key line of enquiry through quality visits. It was not necessarily that they were not taking place, it was that they may have not completed them within the timeframe.

AM asked, in relation to cardio metabolic assessments, what actions were taking place to mitigate any risk. TB commented that work was taking place in relation to operational rigour and to ensure all the necessary equipment was available.

AM asked, in relation to the percentage of clients in employment, what actions were taking place. MB commented that the national metric only related to those on the Care Programme Approach (CPA). CH commented that the OMG were checking whether meaningful activity in volunteering could be included.

RW asked, in relation to patient safety incidents resulting in serve harm and death, if it was known what caused the increase in November 2018. TB commented that in November 2018 there had been a cluster of incidents, some related to Kirklees, that were going through a detailed independent review with respect to apparent suicides. No particular trends or themes were identified and, in terms of data, the local population size needed to be considered. CH commented that, in comparison to deaths per hundred thousand, Kirklees was not an outlier.

CD asked, in relation to the review of the transformation of community services, the number of complex cases in core services, the impact on enhanced teams, and if any trends or themes had been identified. TB commented that the report for the Clinical Governance & Clinical Safety Committee identified no trends or themes that required immediate action, however the Committee wanted to understand the impact of the transformation in the long term.

MB highlighted the following in relation to NHS Improvement Indicators:

- The Trust breached the maximum 6-week wait for diagnostics target of 99% in December 2019, leading to the quarter 3 performance of 98.6%. CH commented that the breach related to one incident involving twins and therefore recorded as two around following up the family to see they wanted a revised appointment. This was offered and the family cancelled. This has provided learning for the Trust in terms of timeliness of follow up contact.
- Improving Access to Psychological Therapies (IAPT) looks like it has been marginally achieved for people moving to recovery.

CH highlighted the following in relation to Locality:

- Musculoskeletal (MSK) referrals well above expected levels working with commissioners.

- Pulmonary rehab work is taking place with commissioners.
- Closure of neuro rehab beds.
- The Trust was successful in a recent tender exercise to provide liaison and diversion services across South Yorkshire.
- Adult occupancy on Calderdale and Kirklees wards remains high.
- Final report on independent review at Wetherby Youth Offender Institute (YOI) and working with Leeds Community Health as lead providers.
- CAMHS recent suicides serious case review.
- CAMHS are establishing a senior oversight group.
- Wakefield continue to have no out of area placements.
- Acute inpatient has staffing pressures due to high demand and reporting requirements.

RW commented on the two areas where there was commissioner and partner engagement in responding to concerns. The independent review at Wetherby YOI included, alongside the clinical issues, areas to consider in relation to leadership behaviors and reputation, which would be worked through appropriately with Leeds Community Health as the lead provider. Similarly, in relation to CAMHS suicides in Kirklees and a recent suicide in Wakefield, it was a difficult time for the services and work was taking place in partnership with commissioners. AM asked if the reports would be discussed by the Clinical Governance & Clinical Safety Committee. TB to confirm the dates for the Committee conversations.

Action: Tim Breedon

SY highlighted the following in relation to Priority Programmes:

- Detailed updates on the Clinical Records System (CRS) and out of area placements would be discussed in the private session of Trust Board.
- Older peoples' community services have shared an updated transformation business case with commissioners and further conversations are planned regarding how to take the model forward.

MB highlighted the following in relation to Finance:

- Finance Subgroup meeting held last Thursday with most of the Board in attendance.
- Pre-Provider Sustainability Funding (PSF) surplus of £158k in December taking the cumulative position to £795k deficit.
- Additional non-recurrent income from Barnsley Clinical Commissioning Group (CCG) was the driving factor behind this improved performance.
- Agency staffing costs of £530k in month were broadly the same as previous month and cumulatively these costs are now 13% above the agency cap.
- The cumulative position does include a number one-off benefits including asset disposal gains of over £0.6m.
- Expenditure on out of area beds reduced in-month to £268k meaning cumulative spend is now £3.1m, already £1.4m adverse to full year plan.
- Cumulative net savings on pay amount to £1.2m through the level of vacancies masks overspend on inpatient wards and savings in other areas.
- The cash balance remains in relative health at £26.2m.

AGD highlighted the following in relation to Workforce:

- Sickness absence improved to 5.7% in December and cumulatively has increased to 5.0%. Based on past trends this was anticipated with a reduction in the final quarter. Wellbeing groups are being established in all the BDUs and wellbeing champions being identified.

- Staff turnover has reduced slightly in all areas except Wakefield and overall is slightly lower than the previous month. Work continues on the retention plan to reduce turnover particularly in clinical roles, with actions being fed back into OMG.
- The majority of training targets continue to be achieved although Information Governance has fallen below the 95% target, which needs to be addressed before the end of March.

AM asked whether the ward based fire safety target was on track for year end. AGD commented that the overall Trust target, which remained at 85%, was being met. However, a further local target, which had been set at 95% for face-to-face training, was not being met. It was a stretch target that the Trust would continue to work towards achieving.

It was RESOLVED to NOTE and COMMENT on the Integrated Performance Report.

TB/19/09 Strategies (agenda item 9)

TB/19/09a Estate Strategy progress update (agenda item 9.1)

AGD highlighted the following:

- There would be a refresh of the Estate Strategy to note the work that had taken place and what long term plans were needed. Areas to review would be in relation to The Dales, forensic services, and the estate in North Kirklees.
- Twelve month technical reviews have taken place at Baghill House and Drury Lane and more detailed reviews would now be undertaken. At Drury Lane there had been more difficulties in the change of estate than the other hubs due to a mixture of issues that need to be resolved. An action plan was agreed at the building user group meeting on 28 January 2019.

EM commented that the update showed good progress against the strategy and asked whether, in relation to future disposal of surplus estate, the impact of Brexit had been considered. AGD commented that majority of disposals had been completed. There was one which was now at preferred buyer stage and the Trust was working with them in relation to the site and planning permission.

It was RESOLVED to NOTE the content of the report.

TB/19/10 Governance items (agenda item 10)

TB/19/10a Operational plan 2019/20 (agenda item 10.1)

MB highlighted the following:

- Final planning guidance was issued in January 2019, following on from the outline planning guidance provided in December 2018, with key milestones and timescales identified.
- Control totals remain in place for 2019/20, which have been re-based.
- Financial settlement is a net 2.7% (3.8% uplift less 1.1% efficiency requirement) uplift prior to additional investment in mental health, learning disability and community health services.
- Mental health investment to be at least in line with growth in commissioner allocations.
- The Trust was required to submit a draft plan by 12 February 2019. The outline timetable within the paper should allow the Trust to reach a reasonable draft and then allows more time for the Trust Board to agree the final version at end of March 2019 for submission on 4 April 2019.

RW asked about the role of the ICSs in the plan development. MB commented that as the process developed over the next month in relation to delivery of control totals it would then also need to be considered on an aggregated ICS basis.

It was RESOLVED to:

- **REVIEW and COMMENT on the paper, recognising the requirements and guidance associated the annual operational plan development and submission; and**
- **CONFIRM the governance and approval arrangements outlined in the paper.**

10.2 Review of the Trust Constitution (including Standing Orders) and Scheme of Delegation (agenda item 10.2)

MB reported that the Trust Constitution (including Standing Orders) and Scheme of Delegation were now due for review. It was requested that this review takes place in quarter 2 to take into account any changes required as a result of national guidance. An update to the Scheme of Delegation would be planned prior to consider changes to financial approval levels for staff and any required reference to the West Yorkshire Mental Health Services Collaborate (WYMHSC) Committees in Common.

It was RESOLVED to SUPPORT the proposal to review the Constitution (including the Standing Orders) and Scheme of Delegation at the end of quarter 2 2019/20.

10.3 Update to the Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies) (agenda item 10.3)

MB reported that the policy was the overarching policy, based on which all policies are developed and reviewed. The policy was due for review and included some minor amendments. Following feedback from clinical leads the updated policy would be approved for one year to allow for further discussion in relation to the processes for corporate and clinical policies.

SYo suggested that a reference be included in relation to the consideration of digitally-enabled care in the development and review of policies.

Action: Mark Brooks / Emma Jones

It was RESOLVED to APPROVE the update to the policy.

TB/19/11 Receipt of public minutes of partnership boards (agenda item 11)

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

- Wakefield Health & Wellbeing Board 11 January 2019 - Sean Rayner (SR) commented that the healthy hearts item had good discussion. The Chair of Wakefield Clinical Commissioning Group (CCG) made a good point in relation to the difficult to reach communities not just being geographical, it can also be people with learning disabilities or mental health conditions. In relation to cancer, the Trust provides the smoking cessation service and the commissioner said they were proud to commission such a great service as reduction rates have been significant. In relation to the Public Health Annual Report, work would take place in terms of public messages.

RW commented that the role of each Health & Wellbeing Board was currently being reviewed.

It was RESOLVED to RECEIVE the updates provided.

TB/19/12 Assurance and receipt of minutes from Trust Board Committees (agenda item 12)

Audit Committee 8 January 2019

The following were highlighted in the paper:

- Data breaches - The Committee asked management for a deep dive on Information Governance (IG) breaches and to look at new ways to improve our performance in avoiding the often serious consequences of these breaches;
- Cyber risk - review of cyber risks and mitigations in the light of the matters raised in the Board training session of 8 January 2019;
- Triangulation report - There were three areas in the Integrated Performance Report (IPR) and not the organisational level risk register for consideration by the Executive Management Team (EMT);
- Committee annual self-assessment - two new questions added for the Audit Committee's self-assessment focusing on effective coverage of Terms of Reference and the effectiveness of division of duties between committees;
- Clinical risk - possible quality risk in relation to community service staffing levels;
- Complaints Internal Audit (Limited Assurance) - Issues around Datix fit-for-purpose question, key performance indicator (KPI) coverage and possible solutions at other Trusts;
- Clinical records system (SystmOne) - Internal Audit phase 2 report required before go-live.

Workforce & Remuneration Committee 18 December 2019

RC highlighted the following:

- Ratification of Clinical Excellence Awards.
- Will circulate a note on confidential items to NEDs.

It was RESOLVED to RECEIVE the updates provided.

TB/19/13 Trust Board work programme (agenda item 13)

AM advised that the update to the Risk Management Strategy had been deferred to April 2019 after review by the Audit Committee.

It was RESOLVED to NOTE the work programme and move the update to the Risk Management Strategy to April 2019.

TB/19/14 Date of next meeting (agenda item 14)

The next Trust Board meeting held in public will be held on Tuesday 26 March 2019, Room 3/4, Laura Mitchell Health and Wellbeing Centre, Great Albion St, Halifax HX1 1YR

TB/19/15 Questions from the public

TB/19/15a - Are there any issues with restricted practice keys with people having to ask someone to lock and unlock rooms.

CH commented that she was not aware of any issue and would check and confirm. Some service users use wrist bands or fobs to operate the doors.

Action: Carol Harris

The following questions were received in advance of the meeting:

TB/19/15b - *Will it be possible to celebrate Trust anniversary similar to 70 years NHS anniversary?*
Angela Monaghan (AM) commented that she was not aware of what has been considered to date. Alan Davis (AGD) commented that in 2002 the Trust became the South West Yorkshire NHS Mental Health Trust, in 2009 the South West Yorkshire Partnership NHS Foundation Trust, and in 2011 merged with Barnsley. Emma Jones (EJ) suggested that the 10 year anniversary of becoming a foundation trust could be incorporated into the Annual Members' Meeting (AMM) in September 2019. This was supported by the Trust Board.

Action: Angela Monaghan

AGD added, in relation to the Estate Strategy, that part of the Trust becoming a foundation trust was to generate a surplus to allow for investment in services.

TB/19/15c - Will it be possible for the Trust Board meeting to have not only service user story, but story from:

- *Volunteer of the Trust?*
- *Learner of the Trust recovery colleges?*
  - AM commented that topics for service users stories were considered as part of agenda setting, including volunteer and learner stories. A previous story in September 2018 was from a service user who had used the recovery college as part of their recovery and was a volunteer for the Trust.

TB/19/15d - *Initiative about future New Optimal Health Care Model for the Trust with the specific focus on Prevention:*

- *Promoting Mandatory Health Science Literacy for the general public (information and education)*
- *Increase role of patient in self-care and lifelong self-education.*

Tim Breedon (TB) took the question on notice for response.

Action: Tim Breedon

Signed: **Date:**

South West Yorkshire Partnership NHS Foundation Trust

TRUST BOARD 29 JANUARY 2019 – ACTION POINTS ARISING FROM THE MEETING

= completed actions

Actions from 29 January 2019

Min reference	Action	Lead	Timescale	Progress
TB/19/06a Board Assurance Framework (BAF)	SYo commented, in relation to strategic risk 2.2, that it includes reference to the work taking place nationally on the NHS workforce as well as that taking place by the Trust, such as the quality improvement training addressing areas that lack capacity. CD commented that as well as the quality improvement reference, the work that the Trust is doing to be outstanding needs to be reflected.	AGD	April 2019	
TB/19/06a Board Assurance Framework (BAF)	RC commented, in relation to strategic risk 3.1, that the work taking place on the NHS Long Term Plan, financial sustainability plan, and strategic plans needs to be captured. AGD commented that one of the limiting factors around the NHS Long Term Plan was workforce. It was important that the right number of people with the right skills and expertise were in place to deliver the ambitions.	MB	April 2019	A separate workforce objective is being considered. Once agreed the BAF will be updated to reflect this risk
TB/19/06a Board Assurance Framework (BAF)	RC commented that it was helpful to show the RAG ratings over the year to track progress and suggested a comparison be made over a longer period of time to see what had changed.	MB	April 2019	This will be incorporated in the next Board report
TB/19/06a Board Assurance Framework (BAF)	SYo commented, in relation to strategic risk 3.4 that, while it was RAG rated green overall, there were areas of concern under the surface. MB commented that that the RAG rating of that strategic risk was one of the ones most debated at EMT meetings. AM	MB	April 2019	This will be incorporated in the next Board report

Min reference	Action	Lead	Timescale	Progress
	asked if the cover page of the report could reflect the discussion of EMT in future.			
TB/19/06a Board Assurance Framework (BAF)	MB commented that it was important there was appropriate ownership of each strategic risk to ensure they are updated appropriately to provide assurance to Trust Board. RW commented that any gaps in assurance could be discussed as part of agenda setting. An area for specific consideration as part of the BAF in 2019/20 may be in relation to workforce.	AM/RW	April 2019	Discussed and agreed that the revised BAF would be agreed at the April Board meeting. This would then be used to help set the Board work plan and agenda for the year.
TB/19/06b Corporate/organisational risk register (ORR)	MB reported that the cover paper identifies the red risks scored above 15 and those which are outside of risk appetite, including the updates that have taken place over the last quarter. A patient safety risk has been discussed by the Executive Management Team (EMT), and would be discussed further by the Clinical Governance & Clinical Safety Committee, then reported to Trust Board.	TB/CGCSC	April 2019	Discussed at Clinical Governance & Clinical Safety Committee and specific patient safety risk refined and logged on ORR
TB/19/06b Corporate/organisational risk register (ORR)	The triangulation of risk, performance and governance report to Audit Committee noted some areas within the Integrated Performance Report (IPR) which were RAG rated as red and did not have a specific risk on the ORR. In relation to complaints it was included as part of learning and incorporated into the patient safety risk. AM asked which committee would discuss any risk relation to the percentage of clients in employment which is RAG rated as red on the IPR. TB commented that this could be considered by the Equality & Inclusion Forum with a draft dashboard under development for review by the Forum in March 2019.	TB/E&I Forum	April 2019	Key indicators to form dashboard identified for E&I forum, including • Recruitment data (applicants, shortlisting and appointments) by protected characteristic) • Delivery and outcome measures in the Equality Strategy (Staff element of the F&F test, Wellbeing survey results and NHS staff survey results) • Clinical indicators including engagement, incidents, MHA detention, experience and equality impact assessments

Min reference	Action	Lead	Timescale	Progress
TB/19/06b Corporate/organisational risk register (ORR)	AM commented in relation to Risk ID 1157 that a further control could be added in relation to the WRES and DES.	AGD	April 2019	
TB/19/06b Corporate/organisational risk register (ORR)	AM commented in relation to Risk ID 1080 that further areas could be incorporated from the recent Trust Board training.	MB	April 2019	The actions identified at the Board cyber training will be incorporated in the next iteration of the risk register
TB/19/06b Corporate/organisational risk register (ORR)	AM asked in relation to Risk ID 1214 if the publication of the NHS Long Term Plan would mean that the likelihood of tendering would decrease. MB commented that the risk could be updated following the publishing of the plan.	MB	April 2019	Currently tendering remains in place. This point will be regularly monitored and the risk updated accordingly.
TB/19/06b Corporate/organisational risk register (ORR)	AM asked if the risk grading matrix could be included with future reports to assist with understanding the scoring of risks.	MB	April 2019	This will be included in the next Board report
TB/19/06c Contingency planning for “no deal” Brexit	AM asked if reassurance had been provided to service users and staff through communications in relation to contingency plans. AGD commented that reassuring messages had been provided to staff through staff communications. SY commented that a direct message for staff had also been included on payslips. AGD commented that the service user element may need to be considered.	AGD/SY	March 2019	Update to be given as part of Trust Board presentation on EPRR
TB/19/07b South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYBICS)	AM asked if the dashboard was published. AGD to provide the website link.	AGD	March 2019	Confirmed with South Yorkshire and Bassetlaw ICS that the Dashboard is not published on the Internet site
TB/19/08a Integrated performance report (IPR) Month 9 2018/19	SYo asked, in relation to safer staffing, where local pressures are discussed. TB advised that they are discussed at the staffer staffing group, Operational Management Group (OMG), Clinical Governance & Clinical Safety Committee, and reported half yearly to	TB	March 2019	Picked up in safer staffing meetings and OMG and immediate support offered within teams and form across the Trust via Bank and specialist advisor

Min reference	Action	Lead	Timescale	Progress
TB/19/08a Integrated performance report (IPR) Month 9 2018/19	Trust Board. There is also a report published on a monthly basis on the Trust's website. TB to provide the link to the monthly report. RW commented on the two areas where there was commissioner and partner engagement in responding to concerns. The independent review at Wetherby YOI included, alongside the clinical issues, areas to consider in relation to leadership behaviours and reputation, which would be worked through appropriately with Leeds Community Health as the lead provider. Similarly, in relation to CAMHS suicides in Kirklees and a recent suicide in Wakefield, it was a difficult time for the services and work was taking place in partnership with commissioners. AM asked if the reports would be discussed by the Clinical Governance & Clinical Safety Committee. TB to confirm the dates for the Committee conversations.	TB		Key issues from IPR and serious incidents discussed and noted at Clinical Governance and Clinical Safety Committee meetings
TB/19/10 Governance items 10.3 Update to the Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies)	SYo suggested that a reference be included in relation to the consideration of digitally-enabled care in the development and review of policies.	MB/EJ	July 2019	This will be considered in conjunction with the Director of Nursing & Quality to ensure it is introduced in an effective and meaningful way
TB/19/15 Questions from the public *TB/19/15a - Are there any issues with restricted practice keys with people having to ask someone to lock and unlock rooms.*	CH commented that she was not aware of any issue and would check and confirm. Some service users use wrist bands or fobs to operate the doors.	CH	March 2019	CH checked with the services and confirmed that patients have access to wrist bands or fobs to operate their bedroom doors. Risk assessment and care planning guides the decision making in relation to these and where these aren't suitable, for example for people with dementia, staff provide additional support

Min reference	Action	Lead	Timescale	Progress
TB/19/15b - *Will it be possible to celebrate Trust anniversary similar to 70 years NHS anniversary?*	Board Angela Monaghan (AM) commented that she was not aware of what has been considered to date. Alan Davis (AGD) commented that in 2002 the Trust became the South West Yorkshire NHS Mental Health Trust, in 2009 the South West Yorkshire Partnership NHS Foundation Trust, and in 2011 merged with Barnsley. Emma Jones (EJ) suggested that the 10 year anniversary of becoming a foundation trust could be incorporated into the Annual Members' Meeting (AMM) in September 2019. This was supported by the Trust.	AM	September 2019	
TB/19/15d - *Initiative about future New Optimal Health Care Model for the Trust with the specific focus on Prevention:* • *Promoting Mandatory Health Science Literacy for the general public (information and education)* • *Increase role of patient in self-care and lifelong self-education.*	Tim Breedon (TB) took the question on notice for response.	TB	April 2019	

Outstanding actions from 18 December 2018

Min reference	Action	Lead	Timescale	Progress
TB/18/108a Finance report Month 8 2018/19	LC commented that it would be good to have some overall Board visibility on the agency initiatives taking place. RW commented that the Board had to complete a self-certification in December 2016 and it might we worth using this to review progress made. This is an area that is reviewed by the Workforce &	SThi / MB	March 2019	To be updated at the meeting

Min reference	Action	Lead	Timescale	Progress
	Remuneration Committee. RC suggested that an update is provided to the Board after the next Committee meeting in February 2019.			
TB/18/110c Emergency Preparedness, Resilience & Response (EPRR) Compliance	LC commented that, in relation to some areas, it looked like all providers were doing what they needed to do and asked why it was not rated as fully compliant. AGD commented that the report was triangulated with West Yorkshire partners and agreed that it should remain partial at this stage until all evidence was in place. AM asked where the Board could see the evidence against all the standards. AGD to circulate.	AGD	March 2019	To be circulated for the separate briefing session scheduled for the Trust Board in March 2019.
	The Board discussed whether all members felt informed enough on future plans to provide challenge and requested: ➢ that the Health & Safety session planned for the Trust Board in March 2019 include EPRR and the communication process; and ➢ that the full copy of the plan be circulated to the Trust Board.	AGD / SY	March 2019	Separate briefing session scheduled for the Trust Board in March 2019.

Outstanding actions from 30 October 2018

Min reference	Action	Lead	Timescale	Progress
TB/18/93a Strategic overview of business and associated risks	The Board discussed whether the level of detail within the report was useful and requested the following areas be considered: ➢ Whether enough was being done to capitalise on the strengths and opportunities that were in the Trust's control. ➢ Highlight key areas on the front cover, including what would be done as a result of the analysis and any actions identified. ➢ Inclusion of the last review date within the report. ➢ Whether data sharing in relation to the Clinical Records System and safety issues from the CQC inspection were prominent enough, as raised by the Shadow Board.	SY	April 2019	

Min reference	Action	Lead	Timescale	Progress
	➢ Further areas to be reflected in the report including universal credit rollout, legal regulatory framework through the Health & Safety Executive with a focus on managing aggression and violence (MAV) and manual handling, changes to NHS England and NHS Improvement. ➢ Importance of horizon scanning and whether the external stakeholder survey could be refreshed and repeated to assist with providing an external view.			

Outstanding actions from 25 September 2018

Min reference	Action	Lead	Timescale	Progress
TB/18/78 Chair and Chief Executive's remarks (Chief Executive's report)	AM commented that she had seen new legislation had recently been brought into effect which meant stiffer sentences for people who assault emergency workers, including NHS staff. AGD commented that the guidance would be reviewed to ensure the Trust had the right tolerance level and balance within the services it provides. *29 January 2019 update:* AGD commented that the policy would be updated and conversation was taking place with the local Police with an aim to agree by end of the financial year.	AGD	April 2019	
TB/18/81c Health & Safety Annual Report 2017/18	RW commented that the report provided a sequential view however the new priorities were being received formally half way through the financial year. RW asked if the Board could consider the priorities annually in March. AGD commented that the action plan could be separated from the annual report.	AGD	March 2019	Separate briefing session scheduled for the Trust Board in March 2019.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 March 2019
Agenda item 5

Title:	**Chief Executive's report**
Paper prepared by:	Chief Executive
Purpose:	To provide the strategic context for the Trust Board conversation.
Mission/values/Objectives:	The paper defines a context that will require us to focus on our mission and lead with due regard to our values.
Any background papers/ previously considered by:	This cover paper provides context to several of the papers in the public and private parts of the meeting and also external papers and links.
Executive summary:	The Brief, provided monthly to all staff and cascaded through the Extended Executive Management Team, delivers a summary of the Trust's context, performance and finances. This is attached. Since the publication of the Brief, we have seen: • **The Spring Statement in health or care, with no additional resourcing of health and care.** This is not a surprise as the Autumn Statement is now being used for spending announcements. Public satisfaction in the NHS fell in the most recent British Household Survey. • **Given the lack of a funding settlement for social care or any sight of the social care green paper**, the NHS Confederation has pulled together a network of national bodies lobbying for a social care settlement. Details of Health for Care are available here: https://www.nhsconfed.org/news/2019/03/health-for-care-launch • **Changes to the leadership of NHS Improvement and NHS England**, with further consolidation of the senior teams of the organisations. This means the removal of the Chief Executive role in NHS Improvement and the Deputy Chief Executive role in NHS England. Further simplification of the arrangements should be welcomed as we move to a focus on integration. The Board should note that the changes will not affect the regional structures that have already been published. • **National planning for 2019/20 has continued, with associated contractual and service developments.** This year, our two integrated care systems [ICS] have been more heavily involved in coordinating plans across West Yorkshire & Harrogate and South Yorkshire & Bassetlaw. This involves a role in mediation, support and triangulation of plans. The Board will be discussing the Trust's operational plan, financial plan and regulatory requirements in private today. This work has been substantial.

	• **This enhanced role for ICS is reflected in potential changes to legislation.** These changes are subject to a number of factors, and require parliamentary time. A briefing is attached at **(ANNEX 3)** for information. • **The introduction of situation reporting on Brexit preparations.** This is covered in more detail in the Brexit report to Board and reflects the usual rigour that applies to issues that affect business continuity in the NHS. • **The Care Quality Commission [CQC] published a report into the Mental Health Act [MHA] (ANNEX 1).** This showed nationally that there have been improvements in the adherence to the MHA in 2017/18, especially in elements of care planning and involvement. Legal rights, safety on acute wards and higher quality care planning were themes that are of concern. The themes around legal rights and care planning can be seen in some of the reports of MHA inspections of some of our services by the CQC. The MHA Committee has a role in assuring the Board that we are compliant with the MHA or making appropriate improvements. This is a focus of the Executive and the Medical Director explicitly. A briefing on the report is attached and will be discussed at the MHA Committee to compare the Trust's position and the national findings. • **The CQC has also published a report into learning from deaths (ANNEX 2).** This shows a range of improvements across the country and areas where progress is still required. Again, a review will be conducted and presented to the MHA Committee. A briefing is attached for information on the national report. • **Details of early thinking on the national workforce plan have been shared by Baroness Harding and Julian Hartley in a letter to Chief Executives.** The early findings focus on recruitment in areas like nursing and general practice, retention through making the NHS a great place to work and delegation of responsibility to Integrated Care Systems. As a Trust, we have contributed to a response from the 7 northern systems, the West Yorkshire & Harrogate ICS, the South Yorkshire & Bassetlaw ICS, the Mental Health Collaborative and our own organisation. Details will be shared with the Workforce and Remuneration Committee. • **SystmOne has gone live in our mental health and learning disability services.** Thanks to good preparation we have seen a successful transition from RiO to SysmOne as our new clinical record system. We have seen some issues emerge along the way, which have been dealt with effectively through the support arrangements in place from our staff, Daisy and TPP, the system supplier. Thanks to all the staff involved to date. Following a period of stabilisation we will be moving to optimisation of the system. The Executive Management Team will be overseeing the resourcing of this work.

	• **Submission of our Prior Information Request to the CQC.** This was made on the same day as SysmOne went live. This is a credit to the staff involved and to my colleagues in the director team. The submission is a very substantial piece of work that required input from staff across the Trust. • **Continuing development of local systems and services that will impact on the Trust.** This ranges from welcome investment in services like children's therapies and mental health for young people, to joined up care in neighbourhoods linked to clusters of GP practices. This is clear from the papers on the agenda. The Board should note that the Trust continues to face financial and service pressures in a fluctuating local context. Part of our role is to bring clarity to the staff and our partners on priorities and focus of our work in the coming year. In doing so, our values will guide us and good analysis will be essential to inform decision making.
Recommendation:	**Trust Board is asked to NOTE the Chief Executive's report.**
Private session:	Not applicable.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

The Brief

28 Feb 2019

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

Our go-live support team

Thank you to everyone for your amazing efforts on implementing SystmOne for mental health.
We've worked hard together
getting ready for tomorrow.

With **all of us** in mind.

Safety and quality

NHS
South West Yorkshire Partnership
NHS Foundation Trust

In January we had:

- 1087 incidents - 944 rated green (no/low harm)
- 126 rated yellow or amber
- 17 rated as red
- 8 serious incidents – all of which were apparent suicides.

Datixweb has reached 100,000th incident report: thank you for reporting incidents and near misses, providing learning on preventing harm occurring.

Numbers have continued to increase each year, with 89% being no/low harm.

High reporting rate + high proportion of no/low harm = positive safety culture. Please keep reporting.

Our whistleblowing policy has been updated.

Always feel comfortable reporting concerns about safety and quality.

This is one of a range of ways - also includes Freedom To Speak Up guardians.

With **all of us** in mind.

South West Yorkshire Partnership NHS Foundation Trust

Focus on: Care Quality Commission (CQC)

Provider Information Return (PIR)

155 data requests

121 universal requests
20 specific to mental health
14 specific to community

All returned to the CQC, thank you.

Next steps: At least one of our core services will be visited, and we'll have our annual well-led review. Service visits could start as early as late April 2019.

Service user, carer and staff focus groups: CQC want to speak directly to service users, carers and staff. Find out when sessions are and please go along.

We have a detailed CQC action plan. Understand your role and that of your service.

Important areas of improvement remain which we must focus on.

We have a lot to be proud of as well as many areas where we have made improvements.

With **all of us** in mind.

Our performance in January

- **100%** follow ups within 7 days of discharge
- **97%** of inpatients with a Cardiometabolic Assessment
- **97%** of people recommend our community services
- **87%** recommend our mental health services
- **80%** of people dying in a place of their choosing
- **31.5%** of people in CAMHS receiving treatment within 18 weeks of referral
- **82%** of prone restraint lasted less than 3 minutes
- **23.5%** medicines omissions, above a target of 17.7%
- **96%** of staff have completed their information governance training

Medicines omissions performance has worsened.

It's reduced by 9% over the past 3.5 years.

However, our performance is still not good enough.

There were 10 confidentiality breaches. Please remember to always double check details and stay focussed. How would you want your personal information looked after?

With **all of us** in mind.

Staffing

NHS South West Yorkshire Partnership NHS Foundation Trust

Sickness absence was 6% in January – now 5.1% year to date. There's wellbeing support for #allofus

Kate Dewhirst has recently been appointed as our chief pharmacist.

Our freedom to speak up guardians are always available. Book a confidential call.

Keep up with latest recruitment news via The Update

We are currently hitting all our targets for mandatory training, thank you to all staff. Always keep up with your compliance, don't wait to be prompted.

An EU exit group continues to meet, we're following national guidance and looking at how best to prepare.

Our Black Asian Minority Ethnic (BAME) network is hosting a number of events, open to all.

There's also a new BAME network member case study.

With all of us in mind.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Focus on: staff survey results

2018 survey results

The NHS Staff Survey provides extremely important feedback on your experience of working for the Trust.

Positives

- % of staff reporting discrimination has reduced
- % of staff satisfied with support from their manager has improved
- % of staff reporting bullying has reduced
- % of staff satisfied with how the Trust deals with incidents has improved

Areas for improvement

- % of staff satisfied with the quality of care they provide to service users has reduced
- % of staff experiencing violence from service users/members of the public has increased
- % of staff saying appraisal helped them to do their job has reduced

40% response rate

1643 staff views

We'll plan actions in line with our **workforce strategy** and incorporating our **wellbeing at work** feedback. Key areas include bullying and harassment, staff engagement, workforce equality/diversity and development.

With **all of us** in mind.

Our finances explained

NHS
South West Yorkshire Partnership
NHS Foundation Trust

This financial year, we'll have spent £2million more than we're given. You can help bring this number down.

January update

Significant pressures continue, for example, demand on wards.

This means our costs are higher than our income.

We spent over £317,000 on beds outside our area because we didn't have enough for our service users.

This extra cost means we need to save money elsewhere.

What can you do?

Ask yourself:

Am I spending our money the best way I can?

How can I improve?

What can my service do differently to reduce inefficiency and waste?

South West Yorkshire Partnership NHS Foundation Trust

Infrastucture

SystmOne for mental health – we're live!

Inpatient teams successfully went live on SystmOne on **Monday 25 February.** Community and other teams go live on **Tuesday 5 March.**

Thank you to all staff who have worked hard to get your teams ready for this change.

Where to find help and support:

- The intranet – how to guides, FAQs, training videos and more
- Speak to your super user
- Ask the go live support team
  - Systmone.golivehelp@swyt.nhs.uk
  - 01924 316059

With **all of us** in mind.

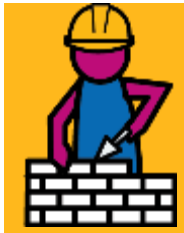
Service change

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Thank you to everyone who was involved in our workforce planning workshops. They are a key part of developing our operational plans and looked at a range of solutions whilst fully understanding the challenges.

The older people's services project is moving forward, seeking to make improvements to community services in advance of any proposed inpatient changes.

Further conversations are planned in each locality.



We've had positive meetings with partners in Barnsley and Calderdale around social prescribing.

It's a priority for the wider NHS, as well as for the South Yorkshire and Bassetlaw Integrated Care System and the West Yorkshire and Harrogate Health and Care Partnership..

Our forensics services are providing training for community staff to feel more confident in caring for people from secure settings.

With **all of us** in mind.

#allofusimprove
and be outstanding

NHS
South West Yorkshire Partnership
NHS Foundation Trust

If you see something that can be improved, take action.
It doesn't matter what role you're in or whether you're trying to reduce waste, improve efficiency or have a quality improvement idea.

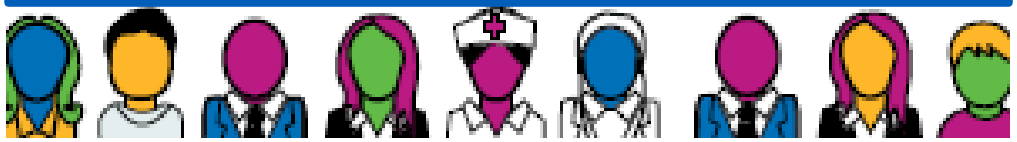
Join the #allofusimprove network and become an improvement champion.

Use the toolkit on the intranet or email the helpdesk for support.

Speak to your manager if you're interested in completing specialist improvement courses.

Institute for Healthcare Improvement

There's support available to help **#allofusimprove.**



Looking out for our neighbours

Do you live in West Yorkshire or Harrogate? Are you involved with any community groups?

A new campaign led by West Yorkshire and Harrogate Care Partnership, launches in March and aims to help prevent loneliness. Choose your support, from displaying posters or handing out packs, to promoting the campaign on social media. Find out more on our intranet or via Twitter.

With **all of us** in mind.

Take home messages

NHS
South West Yorkshire Partnership
NHS Foundation Trust

We'll be visited by the CQC. We have a lot to be proud of and this is our chance to show it, as well as learn how we can further improve.

Thanks for the hard work on SystmOne for mental health; it's a huge achievement.

We must always keep a focus on quality and safety, regardless of what is going on around us.

We all need to take action on our staff survey results, which we're aligning to our workforce strategy. We want to make improvements for #allofus.

Our freedom to speak up guardians can be contacted at any time, by anyone.

Get involved with #allofusimprove and help us reduce waste, manage our finances and improve clinical quality.

Please help a community organisation pledge support for our look out for our neighbours campaign.

With **all of us** in mind.

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

28 February 2019

South West Yorkshire Partnership NHS Foundation Trust

The Brief

Our mission and values

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

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

Why not take a couple of minutes in your team to talk about a positive example of where an individual or team has demonstrated the values of our Trust?

Have you got a news story or an example of how you're living our values? Shout about it with the help of comms@swyt.nhs.uk or by calling 01924 316391.

Safety and quality

We put safety first, always.

Reporting of incidents remains within expected range – please keep reporting on Datix
In January we had:

- 1087 incidents - 944 rated green (no/low harm)
- 126 rated yellow or amber
- 17 rated as red
- 8 serious incidents – all of which were apparent suicides.

Thank you for your hard working in always ensuring quality and safety come first.

Our whistleblowing policy has recently been reviewed and updated, please always feel comfortable reporting concerns about safety and quality. This is one of a range of ways available to you, which also includes freedom to speak up guardians.

Datixweb reaches 100,000th incident report on web system

Our senior leadership and patient safety support team would like to thank everyone for reporting incidents and near misses, providing learning on preventing harm occurring. Numbers have continued to increase each year, with approximately 89% being no or low harm. A high reporting rate with high proportion of no/low harm is indicative of a positive safety culture. Please always keep reporting.

With all of us in mind.

South West Yorkshire Partnership NHS Foundation Trust

Focus on: Care Quality Commission (CQC)

We were last visited by the CQC in March 2018. As a learning organisation, we value our relationship with the CQC and we have kept doing the things they found to be 'Good' and 'Outstanding' whilst improving in areas that needed focus.

To help us do this we have a detailed CQC action plan; view a summary of action we are taking in response to the findings of our last inspection.

We have a lot to be proud of in our Trust, alongside many areas where we have made significant improvements. Some important areas for improvement remain; we must ensure that they are addressed within the agreed timescales.

Provider Information Return (PIR)

At the start of February we received our PIR request from the CQC. This included 155 data requests in total (121 universal requests, 20 specific to mental health and 14 in relation to our community health services).

We have returned all this information and other documents to the CQC, thank you to all staff for your hard work and responsiveness in gathering this data.

Next steps

The PIR triggers a process that will lead to at least one of our core services being visited and our annual well-led review. Service visits could start as early as late April 2019 and our well-led review will take place within the next 6 months. We'll keep you updated as soon as we find out more.

Service user, carer and staff focus groups

The CQC will be checking whether our services are safe, caring, effective, responsive and well led. To do this they want to speak directly to service users, carers and staff so we have arranged a number of sessions across Barnsley, Calderdale, Kirklees, Wakefield and our forensic services.

Performance (January)

- **100%** follow ups within 7 days of discharge
- **97%** of inpatients with a Cardiometabolic Assessment (CMA)
- **97%** of people recommend our community services
- **87%** recommend our mental health services
- **80%** of people dying in a place of their choosing
- **31.5%** of people in CAMHS receiving treatment within 18 weeks of referral
- **82%** of prone restraint lasted less than 3 minutes
- **23.5%** medicines omissions, above a target of 17.7%
- **96%** of staff have completed their information governance training

Medicines omissions performance has got worse. We've been focussing on reducing medication omissions on inpatient areas for the past 3 and half years and overall there has been a reduction of 9%. However, the mental health safety thermometer's national data has shown that the Trust has been an outlier when benchmarked. In the short-term, our pharmacy team will feed back to quality and governance leads and they will share medicines administration checklist. In the long-term, procurement of Electronic Prescribing & Medicines Administration (EPMA) system will prevent omissions.

There were 10 confidentiality breaches during January involving patient healthcare record issues and information disclosed in error and non-secure disposal. We continue to see a reduction in the number of incidents being reported, however this is still 10 incidents too many. These are frequently down to human error. Please remember to always double check address details and stay focussed on the task in hand when working with people's personal data and information. Think about how you would want your information looked after.

Staffing

- Sickness absence was **6%** in January. It's now standing at **5.1%** so far this year to date, above our target of **4.5%,** though this is slightly lower than this time last year**.** Remember there is wellbeing support available to #allofus.
- Kate Dewhirst has been appointed as our chief pharmacist.
- Our freedom to speak up guardians are always available. Book a confidential call via
- 07768 043998 or email guardian@swyt.nhs.uk.
- Keep up with latest recruitment news in our Trust by reading The Update from recruitment, available on the intranet.
- We are currently hitting all our targets for mandatory training, thank you to all staff. Please keep up with training when reminded to do so, rather than waiting for it to expire. We should always be meeting our training targets.
- Our Black Asian Minority Ethnic (BAME) network is hosting a number of opportunities including lunchtime chats and an event, which is open to all staff, that is looking at equality in patient centered care. There's also a new BAME network member case study.
- An EU exit group continues to meet, which includes reps from emergency planning, estates, pharmacy, workforce, professions, HR, procurement, IT and communications. We're following national guidance and looking at how we can best prepare.

Focus on: staff survey results

What it's telling us and what we need to do

Between October and December 2018 the annual national NHS survey was sent to all staff and over 1600 people took the time and effort to give feedback on what it feels like to work for the Trust. The aim of the survey is to use this feedback to improve the working lives of staff to enable them to either support or directly provide better care for service users.
It's important that the survey doesn't just lie on the shelf and is forgotten about. We all have to take responsibility to listen to what you have said and work together to make the Trust the best possible place to work and deliver services.

What we all need to do over the next few weeks is:

- Look at the results for your service area and discuss what they are telling you about working for the Trust with your team and/or colleagues

- Engage with your staff about what we can do to improve working lives
- Learn from other areas in the Trust where the results are better
- Start to develop your own action plan to improve – don't wait for a Trust plan

The results are telling us as that on the whole, we are not as good an employer as we need to be and this is a challenge for all leaders and managers. There are services where the results are very positive but others where they are a concern. This leaves us overall average compared to similar organisations. There are four key areas which research has been shown to impact on quality of care that we need a strong focus on:

- Improving staff engagement – we are below average compared to similar Trusts
- Preventing bullying and harassment
- Improving the quality of appraisal
- Improving staff health and wellbeing

If we get these things right then staff and service user experience will improve.

Everyone can get involved by joining a BDU workplace wellbeing group and helping to improve staff experience in your area. Workplace wellbeing groups are held in:

- Forensic services BDU
- Kirklees and Calderdale BDU
- Barnsley BDU
- Wakefield BDU
- Specialist services

Please contact Ashley Hambling, HR business manager for more information.

Our finances explained

What's the current financial position?

This financial year, we'll have spent £2million more than we're given - you'll also hear this being described as being in deficit, which is what we forecast for this year. Not overspending before the end of March by more than £2m, to achieve our forecast, remains challenging but it's achievable thanks to additional one-off income we received and through a revaluation of Trust assets.

Delivering what we said we will (a £2m deficit) means that the Trust will then receive an additional £1.2m of national funding which can be used to support future investment in our estate and technology.

How did we do in January (Month 10)?

Our financial performance in January 2019 is a surplus of £714k. This is possible due to the positive outcome of the Trust revaluation of assets exercise; excluding this we would have reported a deficit of £265k. This means we've had more money coming in (income) than what we've needed to spend. Our cumulative position is breakeven for the first 10 months of the year; this means we have spent all of the income we have received. We're concerned that our costs are higher than our income and know this is a challenge which we all need to address.

What were are key financial pressures?
We spent over £317k on beds outside our area because we didn't have enough for our service users - this equals 361 bed days. We continue to closely monitor and review the situation.

The use of agency staff also remains a key pressure with £596k spent in January, bringing our year to date total to £5.3m. Overall, including bank and agency, we have spent £12.5m on staff who are on temporary or fixed term contracts (non-substantive staff).

What can you do?
To support our current position and the development of our next financial plan we must keep the focus on making sure we work as efficiently as possible. Keep asking, how can I improve? What can my service do differently to reduce inefficiency and waste? Are there areas where we can reduce our spend?

The Trust's financial position is directly linked to the decisions and actions we all make every day. All of us have a role to play in how we spend our money, get involved with #allofusimprove.

Infrastructure: SystmOne for mental health

Go live update
Inpatient teams successfully went live on SystmOne on Monday 25 February. A huge thank you to everyone who has worked hard over the past few days and weeks to help get your teams ready for this change, including ward staff, managers, super users and support services.

Community and other teams go live on Tuesday 5 March.

Where to go for help and support
The intranet – how to guides, FAQs, training videos and more
Speak to your super user
Ask the go live support team:

- Systmone.golivehelp@swyt.nhs.uk
- 01924 316059
- Please do not contact the IT Service Desk

What's next?
On 13 March, some of the missing information from Feb 11 – March 4 (assessments, progress notes and scanned documents for existing patients as at 10 Feb) will appear in SystmOne. Full details of forms included can be found on the intranet.

Service change

Workforce planning workshops
Thank you to everyone who was involved in our workforce planning workshops. The workshops were a key part of developing our operational plans and we

looked at a range of solutions whilst fully understanding the challenges. This included identifying development roles in teams for nurse associates, advanced clinical practice roles and physician associates alongside looking at workforce risk and training needs analysis and leadership development. Your operational, professions and service leads will be happy to feedback from their workshops and keep you informed of plans and developments in your area.

Out of area

Work has now concluded with the external consultants which focussed on the root causes of the out of area situation and established change and improvement work. Eight work streams have been identified and findings from this work are being aligned with the emerging findings from the community mental health transformation review.

Working with our partners on social prescribing

We've had positive meetings with partners in Barnsley and Calderdale around social prescribing, which means connecting people to others in their community and to creativity, arts and meaningful activities that enable them to reach their potential and improve their health and wellbeing. Creative Minds, Spirit in Mind and Recovery Colleges are great examples of this. The NHS long term plan talks about increasing social prescribing with over 2.5 million more people set to benefit from it within the next five years. It's a priority for the wider NHS, as well as for the South Yorkshire and Bassetlaw Integrated Care System and the West Yorkshire and Harrogate Health and Care Partnership, led by our chief executive Rob Webster.

Learn more about forensics

Community staff who work with adults with mental health problems are invited to attend training to feel more confident caring for service users from a secure setting. The next training session is focused on social supervision and has been rearranged to Friday 22 March, 9am – 4pm. To find out more or to register, contact Mandy Kidney.

Older people's services

The older people's services project is now moving forward, seeking to make improvements to community services in advance of any proposed inpatient changes. Further conversations are planned in each locality to shape the local programme. Patient stories will be developed to show how the future community systems will lead to improvements and how they will be delivered. It is envisaged that local plans will be established before local community improvements are taken forward during 2019.

#allofusimprove

If you see something that can be improved, take action. It doesn't matter what role you're in or whether you're trying to reduce waste, spend our money better or make a change to improve efficiency.

It may be that you have a great idea to improve quality, finances or service delivery and you're not sure what to do next.

There's support available to help #allofusimprove.

- Use the toolkit on the intranet or email the helpdesk for support.
- Join the #allofusimprove network and become an improvement champion. Thank you to those of you already involved.
- Speak to your manager if you're interested in completing specialist improvement courses.
- If you're already signed up, please start completing the modules.
- Email allofusimprove@swyt.nhs.uk if you're a manager and want to nominate someone to complete the course.

Pledge your support to the 'Looking out for our neighbours' campaign
Do you live in West Yorkshire or Harrogate? Are you involved with or know of any community groups or organisations?

This new campaign led by West Yorkshire and Harrogate Care Partnership, launches in March and aims to help prevent loneliness in our communities by encouraging people to look out for one another. People can choose how they support the campaign - from displaying posters or handing out packs, to promoting the campaign on social media or directing people to the website. Find our more details about the campaign or pledge your support.

Take home messages

1. *We'll be visited by the CQC. We have a lot to be proud of and this is our chance to show it, as well as learn how we can further improve.*
2. *Thanks for the hard work on SystmOne for mental health; it's a huge achievement.*
3. *We must always keep a focus on quality and safety, regardless of what is going on around us.*
4. *We'll be taking action on our staff survey results, aligned to our workforce strategy. We want to make improvements for #allofus.*
5. *Our freedom to speak up guardians can be contacted at any time, by anyone.*
6. *Get involved with #allofusimprove and help us reduce waste, manage our finances and improve clinical quality.*
7. *Please help a community group or organisation pledge support for our look out for our neighbours campaign.*

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

The next issue will start on 28 March 2019.

26 February 2019

on the day BRIEFING

NHS Providers

Care Quality Commission's Monitoring the Mental Health Act in 2017/18

Today the Care Quality Commission (CQC) has published Monitoring the Mental Health Act in 2017/18, under its statutory duty to provide Parliament with an annual review of how health services in England apply the Mental Health Act. This briefing summarises the report's key findings, but for a comprehensive overview of challenges facing improvement in applying the Act with appropriate regard to individual's rights and preferences, we encourage providers to read the report in full.

Key points:

- There has been an overall improvement in some aspects of care in 2016-2018 compared with findings in 2014-2016, which is commendable at a time of rising demand and increased pressure on mental health services.
- In particular, there has been improvement in the quality of care planning and patient involvement. A higher proportion of care plans are detailed, comprehensive and developed in collaboration with patients and carers. However, there is still considerable room for further improvement.
- The provision of information about legal rights to patients and relatives is still the most frequently raised issue from CQC visits. In many cases, patients may struggle to understand information given to them on admission because they are most ill at this point.
- The greatest concern from Mental Health Act monitoring visits is about the quality and safety of mental health wards; in particular acute wards for adults of working age.

Part 1: Key findings from CQC Mental Health Act activities

National figures on the use of the Mental Health Act

- NHS Digital reported just over 49,500 new detentions in hospital under the Mental Health Act (MHA) during 2017/18. Of these, 27,971 took place at the point of admission to hospital, 2,983 following assessment under section 136 of the MHA, 18,349 following informal admission to hospital, and 257 revocations of community treatment orders.
- Available data continues to show overrepresentation of black and minority ethnic (BME) groups in the detained population. 'Black or black British' has the highest rate of detention (288.7 per 100,000 population), more than four times that of the broad 'White' group, which has the lowest rate (71.8 per 100,000 population).
- Repeat admissions of the same people are not a major factor in the rising levels of detention in England. 84.6% (33,680) of people were detained only once in 2017/18; 2.4% (966) of people were detained three

or more times in the year. People from 'black' and 'mixed' BME groups had the highest rates of repeated detention (18.4% and 18.1% of people were detained more than once, respectively, compared with 15.3% in the 'white' group).

MHA visits

- CQC made 1,165 MHA visits in 2017/18. The number of visits has reduced in recent years.
- A major factor in the reduction in visits is that there are fewer wards open to visit. Some of the change could also relate to changes to the way MHA reviewers work with inspection teams and record activity, and MHA reviewer time being spent on activities other than visits.

Key issues found in people's experiences of the Mental Health Act

Providing information to patients

- How information is being provided to patients accounted for 14% of actions raised from non-individual patient issues in 2017/18, with varying degrees of concern. This is the most frequently raised area of practice from CQC analysis of records during visits.
- CQC has seen some progress in this area and an overall improvement in services meeting the code's expectations in 2016-18, compared with findings in 2014-16.
- There has been an increase in evidence of patients being provided with this information in an appropriate format from 89% to 94%.
- There has been an increase in further attempts to explain rights, or to explain rights to nearest relatives, from 83% to 85%.
- There has been an improvement in rates of discussions about rights and assessments of the patient's levels of understanding from 91% to 93%.

Involving people in care planning

- Care planning is still one of CQC's greatest concerns, based on the frequency with which it is raised by MHA reviewers. Specifically, CQC continue to find issues with recording adequate evidence of whether patients consent to treatment, discharge planning and involving patients in care planning.
- However, this is also an area that has shown the most improvement when comparing results from 2016-18 and 2014-16. There has been an increase in evidence of patients' involvement in care plans (from 73% to 83%) and an increase in care plans showing consideration of the person's view about their treatment (from 75% to 80%).
- Evidence of consideration of the person's diverse needs in care plans and evidence of consideration of minimum restrictions to liberty have also increased – from 91% to 95%, and 91% to 94% respectively.
- CQC has found an increasing amount of care planning is detailed, comprehensive and developed with patients and carers being involved. However, a substantial proportion of the care plans it has examined are still of a poor quality.

Accessing independent mental health advocacy

- Patients state they have some degree of access to independent mental health advocates (IMHAs) on almost every ward CQC visits, as has been the case for the last three years. Exceptions (less than 1% of visits) appear to reflect short term breakdowns in provision during retendering contracts for advocacy services, or handovers from one provider to another when contracts change.
- CQC found an increasing majority of services appear to be following the code of practice's advice around referring an incapacitated patient to an IMHA.
- However, CQC still hear from service user groups that advocacy services are not as fully available and responsive as they would like, and of concerns over the quality of advocacy.

Challenging restrictive practices

- CQC MHA reviewers commonly raise concerns about restrictive practices. It is a concern that 'long-term segregation' (LTS), an intervention once thought of as extreme and usually limited to higher-security forensic hospitals, is now viewed to be much more commonplace.
- CQC said that the physical fabric of wards, which are often located in old and unsuitable buildings, a lack of access to the full range of care interventions, and problems with staffing – both number and level of expertise – are underpinning problems.
- CQC is currently carrying out a thematic review of the use of restraint, prolonged seclusion and long-term segregation on people with mental health problems, a learning disability or autism. An interim report will be published in May 2019 and a final report published by spring 2020. CQC will share learning with partner organisations as the review progresses.

Identifying physical health issues on admission

- There has been an increase in evidence of physical health checks being carried out in 2016-18 (98%) compared with findings in 2014-16 (95%).
- There has been an increase in the number of hospital wards where staff, when asked on visits, report no difficulty with access to GP services in the period 2016-18 (93%) compared with 2014-16 (90%). However, 110 wards CQC visited reported problems in the period 2016-18.

Second opinion appointed doctor service

- In 2017/18, second opinion appointed doctor (SOAD) service carried out 14,503 visits. This is similar to the number carried out during the previous three years.
- This year, SOAD reviews resulted in 27% of all treatment plans considered being changed, which is similar to the previous year's figure of 26%. Treatment plans for electroconvulsive therapy (ECT) or community treatment order (CTO) patients were more likely to be left unchanged in 2017/18 than medication (detained) patients.
- SOAD visits appear to be marginally more likely to change treatment proposals where the patient is refusing to give consent, which is consistent with previous years' findings.

- CQC is working with government to evaluate the potential resource impacts of shortening the three-month period before which a SOAD authorisation is required where a detained patient receives medication for mental disorder without consent.

Equalities data and SOAD visits

- 59.9% (8,688) of SOAD visits in 2017/18 were made to men, 40% (5,800) to women, and 0.1% (12) to transgender people.
- In 2017/18, SOAD visits for women were over two times more likely to be for ECT than is the case for men. For 2016/17 this was three times more likely.
- Plans for younger adults (18 to 40) were changed in 33% of 2017/18 visits, which is more often than other age groups. This continues the trend of 2016/17. Plans for people aged 61 and over were changed in 20% of 2017/18 visits, making this age group the least likely to have their plan changed following a SOAD visit.
- 10,766 (77%) of the SOAD visits with ethnicity recorded in 2017/18 were made to white people with 3,180 (23%) made to people from BME groups.
- SOAD visits to consider ECT are almost twice as likely to be for white patients than for patients from BME groups, although this may reflect the older demographic of patients usually referred for ECT.
- The older patients are, the more likely that the SOAD visit involves the use of ECT (20% of visits are to people aged 61 and over).
- Treatment plans for white people (21%) were changed slightly less during 2017/18 than that of people from BME groups (26%).

Individualised risk assessments

- There has been an increase in identified risks being matched by the care plan judged to be appropriate by the MHA reviewer, from 92% in 2014-16 to 95% in 2016-18.
- 92% of care plans are being re-evaluated following changes to care needs in 2016-18, compared with 88% in 2014-16.

Supporting people in discharge planning

- There has been an improvement in care plans showing evidence of discharge planning in 2016-18 (80%) compared with findings in 2014-16 (69%).

Part 2: CQC and the Mental Health Act

- In 2017/18, CQC carried out 1,165 visits, met with 3,993 patients and required 6,049 actions from providers.
- Second opinion appointed doctor service carried out 14,503 visits to review patient treatment plans, and changed treatment plans in 27% of their visits.

- CQC was notified of 189 deaths of detained patients by natural causes, 48 deaths by unnatural causes and 10 yet to be determined verdicts.
- CQC was told about 11 deaths that occurred within seven days of restraint being used. CQC's review of these deaths had not identified any deaths during or immediately (within 24 hours) following restraint by staff.
- CQC received 2,319 complaints and enquiries about the way the MHA was applied to patients. Common themes for complaints and concerns were: medical treatment, staff attitude, communication, diagnosis, and availability of leave.
- CQC were notified of 714 absences without leave from secure hospitals, which is 72 more than were recorded in 2016/17. Around three-quarters (74%) of incidents were recorded by low secure units, as in the previous year.
- In 2017/18, there was a 22% fall in the number of notifications received by CQC of a person under 18 years old being placed in a psychiatric ward or unit intended for adults for a continuous period of more than 48 hours, compared with 2016/17.
- Data provided by the Tribunal Service shows that there was a slight fall in applications, and a proportionate fall in absolute discharges, for both detained and CTO patients.

NHS Providers media statement

Further improvement in mental health services must be supported by front line investment

Responding to Monitoring the Mental Health Act in 2017/18 by Care Quality Commission, the deputy chief executive of NHS Providers, Saffron Cordery said:

"We are pleased to see that Care Quality Commission has noted the improvements in care for mental health patients made over the last year.

"There is further to go, but it is a credit to the efforts and dedication of trusts and front line staff who have worked incredibly hard against rising demand, financial pressures and staffing challenges to provide a good level of care for patients at their most vulnerable.

"It is vital that investment earmarked for the sector reaches the frontline if we are to meet growing need and improve quality. Mental health services must receive an appropriate share of capital funding to invest in the specialised facilities they need. We also need urgent action to address a severe shortage of mental health staff.

"We were pleased to contribute to and welcome the recommendations put forward by Professor Sir Simon Wessely's independent review of the Mental Health Act. These changes will strengthen the voice of patients and improve variation in care across services. We look forward to seeing progress."

Contact: Ella Fuller, Senior Policy Officer ella.fuller@nhsproviders.org

19 March 2019

on the day BRIEFING

NHS Providers

Care Quality Commission's Learning from deaths – a review of the first year of NHS trusts implementing the national guidance

Introduction and summary

The Care Quality Commission (CQC) has today published Learning from deaths – a review of the first year of NHS trusts implementing the national guidance. The report reviews CQC inspectors' observations from the first year of assessing how well trusts are implementing national guidance on learning from deaths. National guidance for trusts on a standardised approach to learning from deaths and working with families were introduced in response to the findings of CQC's 2016 thematic review Learning, candour and accountability, which made a number of recommendations to help to improve the quality of investigations into patient deaths. This briefing summarises key findings from today's report, but for a comprehensive overview of the enablers and barriers to putting the guidance into practice, we encourage providers to read the report in full.

Key points:

- CQC's review finds that awareness of the guidance is high. Inspections have found evidence of some trusts having taken action to revise policies and establish more robust oversight of the investigation process to ensure learning is shared and acted on.
- Overall, CQC found that the key to enabling good practice is: an open and learning culture; clear and consistent leadership; values and behaviours that encourage engagement with families and carers; positive relationships with other organisations; and the ability to support staff with training and the wider resources needed to carry out thorough reviews and investigations.
- However, progress made to date varies between trusts and some organisations have found it harder than others to make the changes needed. In particular, improving engagement with bereaved families and carers is an area where some providers have struggled.
- Issues such as fear of engaging with bereaved families, lack of staff training, and concerns about repercussions on professional careers, suggest that cultural issues within some organisations may be a barrier to putting the guidance into practice.
- The report includes a case study analysis of three NHS hospital trusts – West Suffolk NHS Foundation Trust, Greater Manchester Mental Health NHS Foundation Trust and Norfolk Community Health and Care Trust – that have demonstrated areas of good practice in implementing changes to improve investigations and learning when patients in their care die.

- Following this review CQC has committed to further strengthening its assessment of how trusts are investigating and learning from patient deaths and to providing additional support and training for inspection staff involved in monitoring and inspecting trusts progress.
- CQC also set out where the challenges lie for the Learning from Deaths programme to continue to support implementation, and to make sure that learning from deaths remains a priority for the NHS so there is the necessary investment made by trusts.

How well are trusts implementing the guidance?

- How trusts are implementing the learning from deaths guidance varies. Trusts are at different stages of implementing the guidance, with some finding it more difficult than others to make the changes needed.
- Awareness of the national guidance is high, and some trusts are taking action to revise policies and establish oversight of learning from deaths.
- However, there is some, albeit limited, evidence to suggest that the guidance is better suited to acute trusts rather than mental health or community services.

Enablers and barriers to good practice

This chapter looks at the themes that CQC found were supporting or inhibiting trusts' ability to improve. In addition to the factors highlighted below, CQC identified existing capabilities, good governance and oversight, and the financial resources of a trust as other contributing factors.

Values and behaviours that encourage engagement with families and carers and support for staff

- There was variation in how well trusts are engaging meaningfully with bereaved families and carers. CQC saw ad hoc engagement with families and carers in some trusts, where contact with families and carers had only taken place after a serious incident or complaint. More needs to be done to make sure that bereaved families and carers are involved from the start.
- CQC inspection staff found that staff can sometimes be fearful of engaging with bereaved families and carers. The reasons for this could be linked to a lack of skills or confidence to contact bereaved families, a fear of adding to families' distress and grief, a culture of blame and concerns about potential repercussions on professional careers. Trusts need to invest and support their staff so they have the appropriate skills and resources to engage with bereaved families and carers in a meaningful and compassionate way.
- However, CQC has seen some examples of positive engagement with families and carers, where trusts had clear pathways of contact, an open and transparent approach to engagement, and showed compassionate communication with families.

Clear and consistent leadership and governance

- CQC's first year of inspecting trusts' implementation of the guidance suggests that having a specific person, at a reasonably high level in the trust, responsible for leading on the learning from deaths agenda is key to driving the work forwards.
- Clarity over who is responsible, 'churn' in the leadership team and support from the board were potential influences on trusts' ability to implement the national guidance.
- CQC saw evidence that strong existing governance and processes, such as review groups and systems for learning from deaths, was also a factor.
- CQC has seen that challenge and interest at board level are important to make sure that these governance arrangements are robust and well adhered to. CQC found good governance is also important in ensuring that the lessons learned from reviews are shared and acted on.

Open and learning culture

- CQC found that the existing culture of an organisation can be a key factor in trusts' ability to implement the guidance on learning from deaths. CQC inspection staff observed a difference between an open, transparent, no-blame culture that is focused on learning, and an inward-looking, fearful culture, which can manifest in defensiveness and blame.
- As highlighted in the section on engagement with families and carers, negative cultural factors can include a fear of litigation, public perception, or confrontation with families, and a failure to engage staff with the trust's cultural values or empower them to raise concerns.
- To truly learn from serious incidents in the NHS, there needs be a culture where staff, patients and leaders all feel able to speak up and work collaboratively to learn.
- Positive cultural factors observed by the CQC included staff at all levels feeling able to speak up, a working environment that feels like "a collaborative team, rather than a directional board downwards team", strong patient focus, engagement of medical staff (particularly consultants), and a desire to learn as a central value of the organisation. It can also have an effect on how quickly processes are put in place and how likely any learning from reviews of deaths is shared.
- CQC found that culture can also influence other factors in learning from deaths, including how a trust works with partner organisations who share the responsibilities for caring for that person, and how a trust involves bereaved families in the review, investigation and learning process.

Providing staff with resources, training and support

- Having sufficient resource (in terms of staff capacity and capability, support and training) is an important factor in a trust's ability to deliver effective reviews and investigations. Not all trusts are in an equally good position to allocate appropriate resource to learning from deaths. CQC has seen that trusts can face challenges in providing support and training, allowing staff time away from clinical duties and protecting time to carry out reviews.

- Factors that influence trusts' ability to allocate resources include funding and commissioning, competing priorities – such as those brought about by organisational restructures – and the willingness of the board to provide adequate resources to learning from deaths.
- Where CQC has seen good practice, this has been related to freeing people up from clinical commitments to take responsibility, protected time for reviews and training, and support from board and clinical commissioning groups (CCGs) for resource, such as a medical examiner or mortality technician.

Engaging with partner organisations delivering care

- There was some evidence that the quality of existing relationships between organisations can affect how well trusts are working with partners on investigations into deaths. A lack of incentive or support for building relationships between system partners can be a barrier to collaborative investigations into deaths.
- Difficulties in sharing information can also be a barrier. This was mentioned about obtaining information from GPs, a lack of established systems or routes for sharing information, and working across multiple CCGs.
- Inspection staff felt that CCGs could play a bigger role in encouraging learning to be shared and collaboration, but noted that differences in approach and levels of support can be a problem, particularly for trusts that work with multiple CCGs.
- CQC heard concerns about data protection when sharing information could be a barrier. Trusts need to be confident that they understand the data protection rules and regulations, and that these are being appropriately applied when implementing the national guidance on learning from deaths.
- However, CQC has seen pockets of good practice, for example one trust had begun to build relationships with primary care colleagues, which included starting to work with GPs about the standard judgement framework.
- Other inspection staff felt that CCGs were in a position to enable relationships between trusts and primary care, but felt that this would only be possible where they covered the hospital and the GP practice.

Learning, next steps and recommendations

Actions for NHS trusts

- CQC are at the beginning of the implementation of the learning from deaths guidance, but a first look at this early stage suggests that implementation of the guidance by trusts is variable.
- CQC's findings have highlighted a lot of the same issues that were raised in its original Learning, candour and accountability report, and have shone a light on the need for NHS providers to act now to build on the key drivers for change. These include:
  - encouraging values and behaviours that enable engagement with families and carers as well as support for staff.

  - providing clear and consistent leadership at a senior level with challenge and oversight from non-executives.
  - creating a positive, open and learning culture where people who use services, and staff, feel confident to speak out.
  - providing staff with the time, support and training to carry out robust reviews and investigations of deaths.
  - developing positive working relationships with partner organisations to share information and learning following the deaths of people for whom they have provided care.
- There is no one factor that guarantees good practice, with enablers and barriers to implementing the guidance interrelated. However, the existing culture of an organisation can be a key factor in trusts' implementation of guidance, and could be preventing trusts from making the progress needed.
- Where CQC has seen examples of good practice, trusts have built on existing processes, cultures and expertise in reviewing, investigating and learning from sources of feedback. This means that when trusts do not have these characteristics in place at the start, they need to take a long-term view to start to invest and build the necessary capabilities and capacities over the next few years.

Actions for the Learning from Deaths Programme Board and CQC

- There are actions that others, including the Learning from Deaths Programme Board and CQC, need to take to provide further support to NHS providers and families and carers in developing their approach to learning from deaths.
- There has been comment about what the Learning from Deaths programme needs to do next to continue to support implementation, and to make sure that learning from deaths remains a priority for the NHS so there is the necessary investment made by trusts. These challenges include:
  - how to align the work with related policy initiatives on introducing medical examiners, safety improvement, complaints and concerns so there is coherence and consistency in the approach.
  - the need to further develop a system-wide view on learning from deaths that includes clarity on which organisation leads on a death that occurs outside of a hospital, and how to encourage information sharing across providers (including GPs), when investigating the death of a person who receives care from different NHS or other organisations.
  - the need for a focused assessment of the progress made on reviews and investigations of deaths of people with mental health problems or a learning disability (working with partners such as the Learning Disabilities Mortality Review (LeDeR) programme).
  - improved support from a single set of consistent guidance for staff that is agreed across national bodies, including NHS Improvement and Healthcare Safety Investigation Branch, that helps them to carry out robust reviews and investigations of deaths and serious incidents. This should include children, people with a learning disability, people with mental ill-health and mothers.
  - the need to analyse and monitor the investment made by NHS providers in resources in learning from deaths, in terms of training and support and dedicated staff time to carry out reviews and investigations.

- CQC are committed to providing further support and training for CQC inspection and other staff in understanding what good reviews and investigations look like, as well as how to engage sensitively with bereaved families and carers to hear the learning from their experiences of care. CQC will continue to monitor progress by trusts through its monitoring and inspection processes.

NHS Providers media statement

Responding to Learning from deaths – a review of the first year of NHS trusts implementing the national guidance by Care Quality Commission, Miriam Deakin, NHS Providers Director of Policy and Strategy, said:

"When a person dies under NHS care it is vital to ensure that opportunities to learn and improve care are not missed.

"It is encouraging to see that trusts' awareness of new national guidance on learning from deaths is high, and that some – though not all – have made good progress.

"We welcome this report which offers practical examples of good practice by trusts, together with useful insights on the changes needed to support a better approach."

Contact: Ella Fuller, Senior Policy Officer ella.fuller@nhsproviders.org

Proposals for possible changes to legislation

The NHS long term plan sets out NHS England's and NHS Improvement's (NHSE/I) view that the current policy direction towards collaboration and integration within local systems can "generally" be achieved within the current statutory framework, but that "legislative change would support more rapid progress". The plan included an overview of barriers to collaborative working which NHSE/I would like to address via legislative change. They have now published an engagement document, *Implementing the NHS long term plan: proposals for possible changes to legislation*, setting out their top level proposals for change. These were described in terms of the plan depending "mainly on collective endeavour", with local and national NHS bodies needing to work together to redesign care around patients.

There is an eight week period in which to submit responses to the proposals. This briefing document summarises NHSE/I's proposals and gives NHS Providers' initial analysis, as well as our press statement. We have also set out a number of questions for members, and would be grateful for your views and experiences – **please send any comments to Ferelith Gaze (ferelith.gaze@nhsproviders.org) by 22 March** to ensure they can be properly reflected in our response. You may also want to submit your own response – we suspect that different members may have different views on some of the proposals, depending on their particular circumstances.

NHS Providers' overall view

The passage of these proposals will unfold against the backdrop of a number of difficult realities facing NHS legislation. There is the practical issue of Brexit dominating the parliamentary timetable for some time to come. There is the political sensitivity for the Conservative government in bringing forward health legislation after the Lansley reforms. There is also the tension between wishing to avoid further upheaval for the frontline, even while current structures may be presenting unnecessary barriers.

The long term plan, and the Secretary of State, have been keen to argue that any proposals should come from the NHS itself, rather than be politically driven, and that there should be a consensus in taking them forward. For the same reason, the proposals make piecemeal rather than wholesale changes to NHS legislation.

However, NHS legislation on issues of integration (and therefore competition) and on the scale proposed here need detailed, robust and transparent scrutiny. In particular, we would note that the proposals introduce the potential for both greater integration, but also greater intervention by the NHS arm's length bodies. We also need to consider whether alternative, non-legislative approaches would, in some cases, be more reasonable and proportionate. Where legislation is the appropriate response, given the complexity and sensitivity of NHS legislation, further consideration is needed as to how to avoid unintended

consequences. This will be particularly important since any individual changes on particular issues need to work within and maintain the clarity and consistency of the existing wider legal framework which will remain unchanged.

NHS Providers would therefore welcome member views on the overall direction of travel of these proposals.

Summary and initial analysis of proposals

Below we summarise each of the proposals and give our initial analysis. We will develop this analysis in the coming weeks as we consider the implications of changes. We are seeking member feedback on the proposals, and your experiences of current legislation and regulations to develop the evidence base for our formal response to NHSE/I. We will also continue to seek to influence proposals, and involve trusts, over the coming weeks and months through a range of avenues. We are pleased that the document makes specific reference to the important of NHS Providers' involvement in the drafting process (para 41).

Collaboration and competition

Summary of proposals

NHSE/I are concerned that current competition requirements act as a drag on efforts to improve collaboration between NHS bodies and provide integrated care. The Competition and Markets Authority (CMA) has powers to investigate and intervene in proposed NHS mergers. As the NHS is a publicly funded service, democratically accountable to the Secretary of State and to Parliament, NHSE/I consider that the NHS should be able to make its own decisions in relation to mergers, taking into account the potential benefits for patients.

PROPOSAL 1: removing the CMA's duty to review foundation trust mergers

NHS Improvement has concurrent powers with the CMA to apply UK and EU competition law to the provision of healthcare services in England. NHSE/I do not think it necessary for these powers to be held in parallel, and their removal would allow greater focus on oversight of and support for improvement. NHS Improvement would still be able (through licence conditions) to prevent anti-competitive behaviour in certain circumstances where it is against patients' interests.

PROPOSAL 2: removing NHS Improvement's competition powers and duty to prevent anti-competitive behaviour

Under the 2012 Act, where there are sufficient objections to proposed licence conditions or the national tariff payment system, NHS Improvement must either refer the relevant proposals to the CMA or consult on a revised set of proposals. NHSE/I consider that NHS Improvement (with NHS England in the case of the tariff) should be able to reach final decisions on these matters without referral to the CMA, provided it has consulted on the proposals and given any concerns raised proper consideration.

PROPOSAL 3: removing the requirement for NHS Improvement to refer contested licence conditions or national tariff provisions to the CMA

NHS Providers initial analysis

NHS Providers' view is that while competition can, in some circumstances, be one driver of quality and service improvement in the NHS, it must be applied carefully and sensibly to the ultimate benefit of patients. In other circumstances, over rigid application of competition principles can operate against the interest of patients. For example, a number of providers have been seeking to undertake mergers or acquisitions to address workforce challenges, enable better patterns of service delivery and drive efficiencies. However, the CMA's involvement in the merger approval process has, in the view of many providers, added unnecessary duplication, cost and complexity into the transaction process. We therefore think it likely that most providers will find it helpful to remove the CMA's duty to review provider mergers, as an overly stringent application of competition requirements to the NHS .

However, this proposal should be read in conjunction with proposal 10 (where NHS Improvement seeks the power to direct foundation trust mergers and acquisitions – see later in this document for our analysis). An unintended consequence could be that weakening the role of competition in the NHS also weakens provider board autonomy in the longer term, because the process of deciding service/institutional configurations is centrally directed rather than negotiated and there is no recourse to an independent third party

With regards to the proposal to remove the CMA's potential involvement in licence and tariff objections, this removes a final recourse for providers, albeit one mediated by NHS Improvement. The question to consider here is whether the presence of this backstop has the effect of encouraging robust and reasonable working practices by NHSE/I. It is worth remembering the scale of disagreement between the provider sector and NHSE/I on the framing of the tariff a few years ago when providers triggered the formal tariff objection mechanism. The Government has now amended the terms of that mechanism to make it much more difficult for providers to trigger. We assume members might want to try to secure a "quid pro quo" for the loss of the right of CMA referral, in the form of clear guarantees of what NHSE/I means when it says that it will seriously consider any objections.

Questions for members on proposals 1 to 3

- What elements of the presence of the CMA in the mergers process have been a) beneficial and b) disadvantageous?
- How concerned are you by the proposal to remove the requirements on NHS Improvement to refer to the CMA (a) contested licence conditions and (b) contested national tariff provisions?
- Please could you let us know about any occasions that you have contested, or considered contesting, your licence conditions.
- Do you have any further comments or concerns about these proposals?
- Would you agree with the idea of securing a "quid pro quo" for loss of the right of CMA referral?

Procurement rules

Summary of proposals

Procurement of healthcare services in the NHS is carried out under two sets of regulations: the Procurement, Patient Choice and Competition Regulations (PPCC regulations; made under powers in the 2012 Act), and the Public Contracts Regulations 2015 (implementing EU rules on public procurement).

NHSE/I consider that NHS commissioners should be able to arrange for NHS providers to provide services without necessarily seeking expressions of interest from the wider market. Under the current system, protracted procurement processes incur potentially wasteful legal and administrative costs, and it can be difficult for NHS organisations to collaborate and use their collective resources in the most effective way.

NHSE/I propose that, rather than a necessary procurement process, it would, instead, be for commissioners to use their discretion. The key test in awarding a contract would be whether NHS commissioners were: obtaining "best value" from their resources, in terms of the likely impact on quality of care and health outcomes; whether they were acting in the best interests of patients; and whether they were actively considering relevant issues in making any decisions.

PROPOSAL 4: regulations made under section 75 of the Health and Social Care Act 2012 should be revoked and the powers in primary legislation under which they are made should be repealed and replaced by a best value test

PROPOSAL 5: removing NHS commissioners and NHS providers from the scope of Public Contracts Regulations, and instead making NHS commissioners subject to a best value test, supported by statutory guidance

The way in which the Public Contracts Regulations 2015 can be changed will depend in part on how the UK exits the EU. It will also depend on other legislative proposals which affect the nature of arrangements between NHS commissioners and NHS providers.

In rescinding the PPCC regulations, requirements in relation to patient choice are intended to continue under the standing rules given to commissioners and licence conditions for providers. The power to set standing rules in primary legislation would also be explicitly amended to require inclusion of patient choice rights.

NHS Providers initial analysis

Careful analysis of these regulations is required. It would seem that greater commissioner discretion in procurement processes would be helpful in reducing the burden on trusts, particularly for community and mental health trusts whose services are more regularly subject to tendering. Yet further clarification is required in a number of areas. For example, there is considerable uncertainty about the nature of the amendments to the Public Procurement Regulations, and more widely, the extent to which competition rules will still apply to day-to-day procurement. The definition of and guidance around the "best value test"

will also need further clarification and consideration. Meanwhile, we should be mindful of the role of patient choice and how this would be enacted in absence of the regulations.

Questions for members on proposals 4 and 5

- Rescinding these regulations seems likely to reduce the burden on trusts for retendering, but please let us know if you are aware that there are any elements of these regulations that are beneficial and would otherwise be lost.
- Do you have any further comments or concerns about these proposals? Are you, for example, happy with a return / move to greater commissioner discretion on whether to tender or not?

National NHS payment systems

Summary of proposals

Changes to the national tariff have been made for 2019/20 with the stated objectives of supporting providers and commissioners to work more collaboratively and develop a more aligned system of payments and incentives. The national tariff also already provides for a degree of flexibility, with providers and commissioners able to agree local payment approaches. However, NHSE/I consider that legislative changes could help further this approach.

PROPOSAL 6: on the tariff: (a) national prices can be set as a formula rather than a fixed value; (b) a power for national prices to be applied only in specified circumstances; and (c) allow in-year adjustments without consultation to some treatments within the tariff

Currently, providers can apply to NHS Improvement to make changes to tariff prices if agreement with local commissioners on modifications cannot be reached. NHSE/I view this as out of keeping with moves towards integrated care systems (ICSs) where commissioners and providers take shared responsibility for managing their collective financial resources.

PROPOSAL 7: once ICSs are fully developed, the power to apply to NHS Improvement to make local modifications to tariff prices should be removed

It is not currently possible to set national tariff prices for section 7a public health services commissioned by NHS England or CCGs on behalf of the Secretary of State. This has created difficulties where these services are part of a patient pathway for a particular service, for example, screening newborn babies' hearing as part of their mothers' maternity care.

PROPOSAL 8: national tariff can include prices for section 7a public health services

NHS Providers initial analysis

We would question any broad power to adjust treatments in the tariff without any consultation, and will seek further clarification here. We will also consider further how the payment system would work in practice if prices are set as a formula rather than a fixed value and with national prices for certain circumstances.

We would also question whether it is an appropriate point to remove NHS Improvement's role in resolving disputes over local modifications to prices, even when ICSs are fully developed, as we can still foresee potential for provider / commissioner disagreement as long as there are separate, distinct, statutory entities. We would welcome member views on this. We agree with the ambition that modifications should be agreed locally. However, an emphasis on collaboration over competition and a drive towards integrated care systems are not sufficient drivers to ensure that disputes will not arise in the future. We are also aware that some trusts (for example University Hospitals Morecambe Bay) have used the local modification process to identify where a trust has a structural deficit that commissioners ought to be taking account of in its contracted pricing. We assume that this process will, in future, be part of each individual trust's discussion with NHSE/I on access to the new Financial Recovery Fund (FRF). But some might regard it as premature to remove this avenue for identifying a provider structural deficit before we can be sure that the FRF process will achieve a similar objective.

Questions for members on proposals 6 to 8

- Please let us know your views on proposal 6, and in particular, national prices being set as a formula, and the power for national prices to be applied only in specified circumstances.
- Please could you let us know of any occasions where you have applied to NHS Improvement to make local modifications to tariff prices and the result of this application.
- Do you have any further comments or concerns about these proposals?

Integrated care trusts

Summary of proposals

The integrated care provider (ICP) contract provides for a situation where local health systems wish to bring some services together under the responsibility of a single provider organisation, supported by a single contract and a combined budget. However, in some cases, it may be difficult for commissioners to identify an existing organisation that could take on responsibility for a contract of this kind. It could be that a group of local GP practices and a provider of community, mental health and/or hospital services wished to come together. However, the existing legislative framework doesn't lend itself to these circumstances as a new NHS foundation trust cannot be established from scratch and the 2012 Act did not envisage the creation of new NHS trusts. NHSE/I therefore propose that the Secretary of State be given the power to be able to set up new integrated care trusts.

PROPOSAL 9: Secretary of State to be able to set up new integrated care trusts

Integrated care trusts would only be established where local commissioners wished to bring services together under a single contract and where it is necessary to establish a new special purpose organisational vehicle to do so, and where there has been appropriate local engagement. The resulting ICP would:

- Have a contractual duty to deliver and improve health and care for a defined population
- Act as a provider of integrated care with the freedom to organise resources across a range of services

- Be run in a way that involves the local community and the full range of health care professionals
- Be accountable to commissioners for its performance

Taken together with the procurement proposals, this power to establish a new trust would also support the expectation in the long term plan that the ICP contract should be held by public statutory providers.

NHS Providers initial analysis

While we understand that this proposal could create some helpful flexibility within the system, we are cautious about its implementation. Whether created from existing entities or newly formed, establishing a new trust is a considerable undertaking. We need to be clear on when this would be pursued, and how this would be driven, and what consideration would be given to potentially valid alternatives (such as a merger). We would be keen to have assurances that new trusts would not be set up without the explicit support of all partners in the local health economy in question. There also need to be appropriate protections for existing NHS providers serving the area. There might, for example, be a possibility that the threat of creation of a new integrated trust could be used as leverage to get an existing trust to behave in a particular way. In our discussions with NHSE/I over this clause we asked for specific protection for providers but this has been translated as "appropriate local engagement".

The duties, autonomy, governance and accountabilities of a new form of trust require careful consideration, not least since the proposal is to create a new type of trust rather than a foundation trust, and enabling vertical integration between secondary and primary care may mean establishing an organisation with a different composition from the current model. We will also explore how these trusts will be able to integrate services across a local system, with primary care particularly in mind.

Questions for members on proposal 9

- To what extent do you think this proposal presents your local system with an opportunity, particularly to develop more integrated models of care?
- What provisions or protections for NHS trusts and foundation trusts would you consider important as part of taking this proposal forward?
- Do you have any further comments or concerns about these proposals?

Mergers and acquisitions

Summary of proposals

In some circumstances, NHSE/I believe that plans to improve the management of local health services through mergers and acquisitions can be frustrated by the reluctance of one local trust to consider such a change. NHS Improvement can already direct NHS trusts in this respect. However, it can only take equivalent action in relation to NHS foundation trusts in the event of trust special administration – that is, where there is a serious failure or risk of failure.

PROPOSAL 10: NHS Improvement to have targeted powers to direct mergers or acquisitions involving NHS foundation trusts, in specific circumstances only, where a clear patient benefit has been shown

NHSE/I are proposing that NHS Improvement should have the power to direct NHS foundation trusts to:

- Enter into arrangements to consider and/or to prepare for a merger or acquisition with an NHS trust or other NHS foundation trust
- Merge with an NHS trust or other NHS foundation trust
- Be acquired by another NHS foundation trust

Such an approach would change organisational accountability in a local system, and is distinct from changes to service provision. Decisions on service changes would remain a matter for local commissioners and providers, subject to national tests (such as strong patient engagement, preservation of patient choice, a clear clinical benefit, and support from local clinical commissioners).

NHS Providers initial analysis

In our view, any proposal for NHS Improvement to hold a broad power of direction over foundation trust mergers and acquisitions would cut across the ability of FT boards to carry out their responsibilities and be held properly accountable to the public for the quality of care they provide. That said, we know there are circumstances in which some members would welcome greater direction from the centre with regard to the structure of the local providers in their area, particularly if circumstances arise where one trust is unreasonably preventing a change in organisational form that every other member of a local system supports.

We have been debating the scope of this power with NHSI for some time. We argued that a general power to direct was wholly inappropriate. The proposals therefore talk about a targeted power for use in specific circumstances only. We recognise, however, that some members are likely to still have concerns.

We believe that greater clarity is needed as to the circumstances under which this power would be used (for example, how is the need for a merger or acquisition determined and how does NHS Improvement become involved). Would the power, for example, be more acceptable, if NHSE/I committed that it would only be used after a trust had been given the opportunity to determine for itself whether it was sustainable in a standalone form, and NHSI and all other providers in the area disagreed with the answer. It therefore feels important to explore alternatives have been considered, and whether would it be more effective and appropriate for NHS Improvement to hold a role more akin to arbiter in the event of local system dispute than director of that system).

This proposal also needs to be considered in conjunction with a number of other proposals. These include proposal 1, as the CMA would not have a role in investigating and intervening such changes; proposal 9, and the ability to create new integrated care trusts; and proposal 11, relating to NHS Improvement's direction of FT capital spending given the further impact on governance and control.

Questions for members on proposal 10

- We would argue strongly against a broadly drawn power for NHS Improvement to direct mergers and acquisitions on the basis that it interferes with appropriate trust autonomy and accountability. Please could you tell us:
  - If you agree with that stance
  - If there are alternative approaches to such a power, such as an arbitration role for NHS Improvement, which you would consider to be more helpful in your local system
  - The circumstances, if any, under which you would consider an 'in extremis use' of this power to be appropriate
- Do you have any further comments or concerns about these proposals?

Capital spending

Summary of proposals

There is an urgent need to invest in NHS buildings and facilities, and a more coordinated and collaborative approach to planning capital investment is required to support this. NHSE/I see that, while parliament approves an annual financial envelope for capital expenditure across the Department of Health and Social Care and the NHS, the lack of mechanisms to set capital spending for NHS foundation trusts is a barrier to a more collective approach. It can therefore be that, because of uncertainty around foundation trust capital spending, it is necessary to constrain or delay capital spending by trusts that may be more urgent or address higher priority needs. The inability of NHSE/I to control capital spend by FTs and, they argue, the inaccurate forecasting of such spend, also means that the risk of the NHS breaking its overall capital spending limit, is too great.

PROPOSAL 11: NHS Improvement to have powers to set annual capital spending limits for NHS foundation trusts

NHSE/I say they would want to avoid, where possible, cutting across the freedoms that FTs have to build up funding reserves or borrow money. The power to set annual spending limits would not prevent FTs from using their funding reserves for capital investment, but it would mean that they would need to agree with NHS Improvement, working with local health systems, when to make large capital investments.

NHS Providers initial analysis

Capital maintenance and investment is a key part of service delivery, and we question the circumstances under which NHS Improvement would be better placed to make a decision here than the trust board, especially bearing in mind that the consequences for under-investment will sit with the trust. Whilst we recognise the risks around breaking capital limits, we would argue that this risk has been elevated by the poor quality and opaqueness of the capital allocation process operated by NHSE/I and the Department of Health and Social Care. It is this, rather than trust failings, that is the largest contributor to inaccurate trust capital spend forecasting.

Subject to member views, NHS Providers intends to oppose this proposal. While appropriate controls over capital spending are necessary, we would question whether a legislative response which blurs trust autonomy and accountability is appropriate, especially when more proportionate and collaborative approaches could be pursued. For example, NHS Providers has argued for some time that a more robust capital bidding and prioritisation regime is needed in order to give trusts certainty over the coming years and frame their investments within a set of strategic priorities.

Questions for members on proposal 11

- Please could you let us know of any instances within your local system where there have been disputes around capital spending?
- Please could you let us know of any instances in your local area where NHS Improvement has used its powers in relation to NHS trusts (as opposed to NHS foundation trust) capital spending, and the results of this?
- What complications or opportunities do you foresee central direction of capital creating for your trust and/or local system?
- If there is a need for greater accuracy in forecasting capital expenditure to reduce the risk of exceeding the aggregate NHS capital limit, are there other ways in which this could be achieved that avoid the need for NHSI to have a power of direction over FT capital spending?
- Do you have any further comments or concerns about these proposals?

Provider and commissioner joint working

Summary of proposals

NHSE/I want NHS organisations to work with each other as ICSs to jointly plan and improve care delivery. However, they believe that establishing ICSs as distinct, new organisational entities would involve a complex reassignment of functions that currently sit with CCGs and trusts. Instead, they propose to change primary legislation to remove barriers to collaboration, and make legal provisions to allow CCGs and NHS providers to take joint decisions.

PROPOSAL 12: NHS providers and CCGs to be able to create joint committees

PROPOSAL 13: NHS England to be able to publish guidance on joint committee governance and appropriate delegation

Joint committees would not remove the existing responsibilities of CCGs and NHS providers. Joint committees would be required to act openly and transparently, and would need to work in a way that avoids conflicts of interests (for example, a commissioner would not be able to delegate to decisions on purchasing services to a joint committee).

NHSE/I also view it as sensible to allow NHS providers to form their own joint committees (CCGs can already do so). These could include representation from other bodies, such as primary care networks, GP practices or the voluntary sector. These committees could bring local care providers together to set up clinical services networks, a single estates strategy or shared IT, HR and pharmacy services.

Legislation currently specifies that CCG governing bodies must include a registered nurse and a doctor who is not a GP, neither of whom should be working for a provider where the CCG has commissioning arrangements. NHSE/I view it as inconsistent to allow GPs to sit on governing bodies but prevent the designated nurse and doctor from working for other local providers, and see this rule as too limiting for CCGs to plan services effectively.

PROPOSAL 14: allowing CCGs more freedom to have governing body members who work as clinicians for local providers

Joint roles may be a way of improving integrated care. While joint appointments can already be made, NHSE/I recognise that the legislation is ambiguous and organisations can leave themselves open to challenge in the future for the appointments they make.

PROPOSAL 15: making it easier for CCGs and NHS providers to make joint appointments

NHS Providers initial analysis

The NHS is clearly in transition from a system focussed on individual CCGs / providers to one focussed on integrated local health and care systems. In the absence of legislation creating local health and care systems as formal legal entities to replace trusts and CCGs, we recognise the potential power of joint committees to help speed this transition. We believe there are currently two main uses of the joint committee approach: to bring groups of providers together into a common decision making structure; and as a means of cross system decision making covering both CCGs and providers in more advanced local systems.

However, as we understand the current proposals, the creation of a joint committee would mean that a trust could then be bound, potentially against its will, to decisions made by that committee even while the trust retains its accountability for those decisions. There will be some who are concerned by such a lack of clarity over how responsibilities are held, not least given the level of risk managed at trust level. Others might also highlight the potential absence of challenge within this model, as otherwise provided by non-executive directors (NEDs) within a trust's unitary board. The value of NEDs is recognised – and has been consistently strengthened over time – within the governance codes for the private sector, and we would encourage the same within the NHS.

We are therefore keen to understand how different members see the balance of benefit / risk here, weighing up the benefit of being able to speed the transition to integrated local systems against the risk of losing the clarity of accountability of current unitary trust boards. NHSE/I's proposals provide the protection that the creation of joint committees is a matter for local discretion. It would be helpful to understand if this is sufficient protection or whether this needs further definition (e.g. what happens if one member of a local system refuses to accept a joint committee all other members of that system support).

Regarding steps to enable joint provider-commissioner appointments, while we recognise the intention here to support system working, we need to be equally mindful that the purchaser-provider split is being maintained. Whether and where a joint appointment creates conflicts for the incumbent, or blurs board accountability, needs careful consideration.

Questions for members on proposals 12 to 15

- Have you explored the creation of a joint committee? If so, for what purpose and to what benefit? Equally, have you tried and failed to set up such a committee and if so, why did it fail?
- Are there any circumstances under which you can envisage your trust creating a joint committee (in any given combination of other trust(s) or CCG(s))? And what protections do you think are needed?
- Have you sought to make any joint appointments with a CCG to date? If so, please could you outline the key considerations for your trust in doing so.
- Do you have any further comments or concerns about these proposals?

Shared duties for providers and commissioners

Summary of proposals

NHS bodies are already bound by strong duties to provide or arrange high quality care and financial stewardship as individual organisations. However, NHSE/I do not believe that these are sufficient to ensure local systems plan and deliver care across organisational boundaries in ways that secure the best possible quality of care and health outcomes for local communities.

PROPOSAL 16: a shared duty for CCGs and NHS providers to promote the triple aim of better health for everyone, better care for all patients, and efficient use of NHS resources, both for their local system and for the wider NHS

NHSE/I believe that this change would support the goal of strengthening the chain of accountability for managing public money within and between NHS organisations. The legal duties that currently apply might be amended or extended to ensure consistency and support this triple aim.

NHS Providers initial analysis

We suspect that whilst most members will be supportive of the policy intent of this proposal, some might have reservations about it being added to existing duties, even recognising that they may be refined in parallel. A shared duty in this manner might, to some, seem to be in tension with trust boards' accountabilities for their organisation and organisational delivery. Further general duties may generate conflicts and it may be prudent to re-emphasise existing legislation and its policy intent rather than adding an extra layer.

Questions for members on proposals

- If your existing duties remained as they are, do you foresee any conflicts arising from the addition of a triple aim duty shared across local systems, including with CCGs?
- Do you have any further comments or concerns about these proposals?

Joined up commissioning

Summary of proposals

Commissioning responsibilities are split across CCGs, NHS England and local authorities, meaning that public health, primary care, hospital care and specialist services are organised by different bodies. NHSE/I want to join up commissioning without major organisational restructuring.

PROPOSAL 17: removing the barriers that limit the ability of CCGs, local authorities and NHS England to work together and take decisions jointly

NHSE/I identify barriers to joined up commissioning as including:

- The inability of CCGs holding delegated functions (for example, commissioning primary medical care on behalf of NHS England) to then enter into formal joint decision-making arrangements for that function with neighbouring CCGs or local government (as this would constitute unlawful double delegation)
- The public health functions carried out by NHS England on behalf of the Secretary of State (such as national screening and immunisation programmes) cannot be jointly commissioned by NHS England and one or more CCGs, making it harder to take account of local issues
- CCGs working together cannot currently make joint decisions other than by formally merging.

PROPOSAL 18: (a) NHS England can allow groups of CCGs to collaborate to arrange services for their combined populations; (b) CCGs can carry out delegated functions as if they were their own; and (c) groups of CCGs in joint and lead commissioner arrangements can make decisions and pool funds across their functions

PROPOSAL 19: NHS England can commission, or jointly commission, or delegate to groups of CCGs, section 7a public health functions

These changes would empower CCGs to make joint decisions and promote integration, although NHS England would retain its overall responsibilities. NHS England would also be required to consult on any plans to delegate services to CCGs.

Services that form part of care pathways can include services commissioned variously by NHS England, CCGs or local authorities. For example, CCGs commission services for patients with kidney disease, NHS England for patients with kidney failure. Such splits can hinder efforts to organise care around the needs of patients, as has been the case in integrating specialist mental health services with community-based mental health and social care services. NHSE/I believe that CCGs should be more involved in decisions around specialised services, but the only mechanism currently available is for full responsibility for individual services to be transferred to all CCGs. Yet this would not be appropriate for services which need to be planned on a larger population scale.

PROPOSAL 20: NHS England can enter into formal joint commissioning arrangements with CCGs

NHS Providers initial analysis

NHS Providers has raised a number of concerns around fragmented commissioning pathways, especially relating to mental health and specialised services. We also note the success of pilots to transfer responsibility for specialised commissioning of some forensic mental health services to providers and the desire to speed up and extend this approach. We would therefore welcome steps to streamline commissioning and support improvements to patient care. Wee are also mindful of other concurrent changes taking place, particularly the closer working of NHS England and NHS Improvement with the appointment of joint regional directors, and the potential growing role for providers in undertaking tactical commissioning or lead provider roles. We will be interested to understand how powers would be shared between CCGs, local authorities and NHS England, and also to understand the impact of these proposals on the commissioner-provider relationship at every level. We will also urge that providers are appropriately consulted as CCGs work more closely together to promote service integration.

Questions for members on proposals

- If you have experienced joint commissioning by NHS England and a CCG, do you have any concerns arising from that process which may be relevant here? Have there been any benefits or lessons learned to feed into these changes?
- Do you have any further comments or concerns about these proposals?

National leadership

Summary of proposals

There are limits on how far NHS England and NHS Improvement can work together. For example, there is no provision to formally carry out functions jointly, there are constraints on sharing board members, and they have separate accountability arrangements to the Secretary of State. This causes unhelpful and cumbersome bureaucracy for both organisations. NHSE/I are instead looking to go further in speaking with one voice, setting consistent expectations across the health system, developing a single oversight and support framework, bringing together national work programmes, and using collective resources more efficiently.

PROPOSAL 21: NHS England and NHS Improvement should be brought together more closely beyond the limits of the current legislation, whilst clarifying the accountability to Secretary of State and Parliament

PROPOSAL 22: closer working should be achieved by: either (a) creating a single organisation which combines all the relevant functions of NHS England and NHS Improvement; or (b) leaving the existing bodies as they are, but provide more flexibility to work together, including powers to carry out functions jointly or to delegate or transfer functions to each other, and the flexibility to have non-executive Board members in common

At present, there are different legislative arrangements for the accountability between the Secretary of State and each of NHS England, Monitor and the Trust Development Authority. If a single body were created, accountability would need to be appropriately defined. Moreover, the Health and Social Care

Select Committee has recommended that all national NHS arm's length bodies (ALBs) act in a more joined-up way, particularly on priority areas such as prevention of ill-health and workforce education and training. Responsibility for these issues sits in different organisations, specifically Public Health England and Health Education England.

PROPOSAL 23: enable wider collaboration between ALBs by establishing new powers for the Secretary of State to transfer, or require delegation of, ALB functions to other ALBs, and create new functions of ALBs

NHS Providers initial analysis

These proposals are a further significant shift in the way the NHS is led at a national level, with important implications for trusts and their leaders. While increased coordination and consistency is welcome, there remain significant risks within this approach which need careful consideration. These include the importance of understanding provider needs, risks and the task set for them, as well as a proportionate approach to regulation and support which take account of continuing lines of provider autonomy and accountability. There are also some who believe that the formal merger of NHSE/I would create a single organisation that was too large to function effectively and, potentially, represented too great a concentration of power. We are therefore interested in members' views on whether full; merger or greater working together is seen as preferable. We will seek greater clarity around these proposals and how NHSE/I would envisage their future relationship with the sector, whether they are acting as a single or more aligned entity.

While there is a logic for giving the Secretary of State greater power to transfer responsibility between arms length bodies we would be keen to hear from members if they think such an approach would bring increased risks or disadvantages.

Questions for members on proposals

- What is important for your trust in its relationship with NHS Improvement to see maintained in the future closer working arrangements of NHSE/I?
- Where would you see increased coordination and alignment as most beneficial to your trust?
- Would you prefer to see NHSE/I to fully merge or work more closely together, and why?
- What risks or disadvantages can you see to the Secretary of State having greater power to transfer responsibilities between arms length bodies?
- Do you have any further comments or concerns about these proposals?

Our press statement

Responding to the consultation on proposed legislative changes, the chief executive of NHS Providers, Chris Hopson said:

"The NHS has spent the last five years trying to find ways to create integrated local health and care systems within a legislative framework based on competition and individual institutions. This isn't a straightforward

task. It adds risk, uncertainty and complexity to the job of frontline leaders already grappling with significant financial, demand and workforce challenges.

"As the service works to fulfil the ambitions of the NHS long term plan, it makes sense to review whether we can make enabling changes through legislation, recognising that there are other possible ways of addressing the tensions between the current legislative framework and the desired direction of future travel.

"It is vital that we consider any changes carefully, work through the detail and co-create any changes with those affected, as the Health and Social Care Select Committee has suggested. We therefore welcome NHS England's and NHS Improvement's first step in announcing this engagement exercise and their commitment to a process of co-production.

"We will consult NHS foundation trusts and trusts, but we think there are proposals here that the provider sector will welcome and find helpful. We will wish to explore with providers the cumulative effect of the proposals, and we will want to talk to our members about two particular areas.

"First, the principle of trust boards being completely accountable for all that happens within their trust, and having the appropriate power and freedom to discharge that responsibility effectively, is central to the way the NHS currently works. It is the key governance mechanism to manage the level of safety, clinical, operational and financial risk inherent in the frontline delivery of hospital, mental health, community and ambulance services. As much as we all support integrated care within local health and care systems, we must approach anything that cuts across this clear trust board accountability with caution. We will therefore want to look very carefully at the proposals for NHSE/I to take powers to direct trust level merger and acquisition activity and set their capital limits.

"The second is how we manage the transition from an NHS legal framework based on competition and individual institutions to one of collaborative, integrated local health and care systems. The changes proposed are targeted as they seek to avoid a wholesale restructure and another top down re-organisation. However, they do create something of a halfway house and we must ensure that this half way house would deliver more effectively for patients than what we currently have, and that it would be robust, appropriate and consistent. We will therefore want, for example, to carefully consider proposals such as joint committee decision making between commissioners and providers and the ability of the Secretary of State to create new integrated trusts in this context."

Contact: Ferelith Gaze, senior public affairs manager Ferelith.Gaze@nhsproviders.org

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 March 2019
Agenda item 6.1

Title:	**Integrated Performance Report (IPR)**
Paper prepared by:	Director of Finance & Resources and Director of Quality & Nursing
Purpose:	To provide the Board with the Integrated Performance Report (IPR) for February 2019.
Mission/values/objectives	All Trust objectives
Any background papers/ previously considered by:	➢ IPR is reviewed at Trust Board each month ➢ IPR is reviewed at Executive Management Team meeting on a monthly basis
Executive summary:	**Quality** ➢ Significant reduction in medication omissions to below national average following targeted action plan ➢ Two under 18 admissions to adult wards due to lack of alternative CAMHS beds. Appropriate safeguards put in place ➢ No duty of candour breaches since May 2018 and only one recorded in 2018/19 ➢ Staffing levels remain above 100% overall but significant staffing challenges remain in response to increased acuity **NHSI Indicators** ➢ The majority of national metrics continue to be achieved ➢ The Trust has achieved the threshold for maximum six week wait for diagnostic procedures following under-achievement in the last two months ➢ 15 days occupied by two young people under 18 in adult wards, which is higher than recent months **Locality** ➢ Support to contract negotiations taking place in each locality, with focus on activity, performance targets and new investments ➢ Focus on the stroke pathway in Barnsley with the aim of introducing an early supported discharge service ➢ Consideration being given to results of the staff survey in each place with actions being identified ➢ Demand and capacity is a challenge in Barnsley community mental health services ➢ Anti-ligature work has taken place in the ward 18 garden area ➢ Recruitment is taking place to the new learning disability forensic outreach service ➢ Mobilisation for the introduction of the South Yorkshire liaison and diversion service is taking place in readiness for April 1st start ➢ Out of area bed usage in Wakefield remains at nil through intense work

	Priority Programmes ➢ SystmOne for mental health went live as planned ➢ Work is taking place to establish work streams based on the recommendations made in the SSG report. Bed pressures remain **Finance** ➢ Pre Provider Sustainability Funding (PSF) deficit in February of £244k taking the cumulative position to a £325k deficit ➢ Included in the February position it non-recurrent income of £0.4m for out of area bed usage from Kirklees CCG. There were also non-recurrent costs incurred of a slightly higher number leaving an underlying deficit position of circa £160k ➢ The cumulative position is £1.8m favourable to plan and includes a significant saving in capital charges (£1.4) from a revised calculation for asset valuations, as well as one-off asset disposal gains of £0.5m and non-recurrent income support of £0.9m ➢ Expenditure on out of area beds of £191k takes the cumulative spend to £3.6m ➢ Cumulatively net savings on pay amount to £1.1m through the level of net vacancies, with a £0.2m saving recorded in February. Inpatient ward costs are overspent by £2.4m year-to-date ➢ Agency staffing costs were £545k in month, which is 56% higher than our cap. The full year projection of £6.4m is close to breaching the NHS Improvement cap by 25%. This would have adverse implications on our financial risk rating. ➢ CIP delivery of £9.7m is £0.9m above plan with performance boosted by the reduction in capital charges. ➢ The cash balance remains in relative health at £27.6m ➢ The achievement of the year-end control total of £2m remains probable with a possibility of bettering it. **Workforce** ➢ Year to date sickness absence rate remains at 5.1% in February. The monthly sickness absence rate reduced to 5.2% from 6.0% in January. ➢ Staff turnover remains at 12.0%. Work continues on the retention plan to reduce turnover particularly in clinical roles. ➢ Completion of training remains good and above target across the Trust
	Trust Board is asked to NOTE the Integrated Performance Report and comment accordingly.
Private session:	Not applicable

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report
Strategic Overview

February 2019

With **all of us** in mind.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Table of Contents

Introduction

Please find the Trust's Integrated Performance Report (IPR) for February 2019. 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.

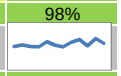
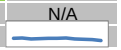
The integrated performance strategic overview report is a key tool to provide assurance to the Board that the strategic objectives are being delivered and to direct the Board's attention to significant risks, issues and exceptions and will contribute towards streamlining the number of different reports 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.

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	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Year End Forecast
Single Oversight Framework metric	2	2	2	2	2	2	2	2	2	2	2	2	2	2
CQC Quality Regulations (compliance breach)	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
Improve people's health and reduce inequalities	**Target**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Year End Forecast**
Total number of children & young people in adult inpatient wards [5]	0	3	1	0	3	3	1	2	2	3	1	1	2	1
% service users followed up within 7 days of discharge	95%	95.8%	94.3%	99.2%	100%	97.7%	94.9%	98.4%	96.9%	99.0%	95.4%	100%	Due April 19	4
% clients in settled accommodation	*60%*	79.1%	78.9%	78.5%	79.1%	78.7%	78.8%	79.0%	78.5%	78.2%	78.5%	*78.0%*	*78.2%*	4
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks [1]	95%	87.8%		86.7%			84.6%			84.2%		Due April 19		95%
Out of area beds [2]	Q1 940, Q2 846, Q3 752, Q4 658	730	531	282	368	437	589	384	165	389	269	299	199	1
Physical Health - Cardiometabolic Assessment (CMA) - Proportion of clients with a CMA Community	Community 75% Inpatient 90%			79.8%	81.1%	82.0%	82.8%	84.1%	84.5%	84.5%	83.8%	83.3%	83.2%	4
Inpatient [9]				89.1%	90.6%	93.3%	91.2%	90.1%	91.0%	92.5%	95.3%	97.4%	96.6%	4
Smoking Cessation - 4 week quit rate [8]	tbc			63%			65%			Due April 19			Due July 19	N/A
Improve the quality and experience of care	**Target**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Year End Forecast**
Friends and Family Test - Mental Health	85%	87%	86%	75%	82%	88%	91%	88%	89%	86%	90%	87%	84%	85%
Friends and Family Test - Community	98%	99%	97%	100%	98%	99%	97%	98%	100%	97%	99%	97%	98%	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	20	24	20	19	32	23	19	31	38	22	40	28	
Safer staff fill rates	90%	115.7%	118%	120%	118%	118%	117%	116%	116%	119%	118%	119%	119%	100%
IG confidentiality breaches	<=8 Green, 9 -10 Amber, 11+ Red	4	8	11	14	16	14	15	14	20	11	10	13	
% people dying in a place of their choosing	80%	86.8%	82.8%	88.5%	92.9%	85.7%	90.0%	89.2%	90.9%	83.3%	87.9%	80.0%	92.0%	N/A
Proportion of people detained under the MHA who are Black, Asian & Minority Ethnic [7]	trend monitor	9.0%		15.1%			14.1%			13.0%		Due April 19		N/A
CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [3]	trend monitor		38.1%	39.8%	34.9%	35.6%	37.9%	37.0%	39.1%	34.4%	33.4%	31.5%	26.7%	
Improve the use of resources	**Target**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Year End Forecast**
Projected CQUIN Shortfall	£4.2m	£203k	-	£160k	£252k	£379k	£379k	£261k	£204k	£204k	£204k	£204k	£204k	£204k
Surplus/(Deficit)	In line with Plan	£1139K	(£292k)	(£204k)	(£464k)	(£125k)	(£139k)	£424k	(£73k)	(£80k)	£158k	£714k	(£244k)	(£2026k)
Agency spend	In line with Plan	£555K	£444k	£538k	£484k	£526k	£575k	£522k	£537k	£536k	£530k	£596k	£545k	£6.4m
CIP delivery	£1074k	£7475k	£619k	£1308k	£1981k	£2737k	£3615k	£4452k	£5234k	£6015k	£6779k	£8764k	£9669k	£9.7m
Sickness absence	4.5%	5.3%	4.4%	4.4%	4.4%	4.5%	4.5%	4.6%	4.8%	4.9%	5.0%	5.1%	5.1%	4.9%
Aggression Management training	>=80%	79.3%	79.3%	81.7%	81.6%	82.9%	83.0%	82.2%	81.3%	81.4%	82.5%	83.1%	82.9%	80%
Moving and Handling training	>=80%	85.5%	85.2%	85.9%	85.6%	85.7%	86.1%	87.2%	87.3%	88.6%	89.0%	87.8%	88.9%	80%
Staff Turnover [6]	10%	12.6%	9.7%	8.5%	11.6%	12.4%	13.0%	12.8%	12.5%	12.3%	12.0%	12.0%	12.0%	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. Q2 data is currently with services to validate and will be included in next months report.
2 - Out of area beds - From April 18, in line with the national indicator this identifies the number of inappropriate out of area bed days during the reporting month - the national definition for out of area bed is: is a patient that is admitted to a unit that does not form part of the usual local network of services. This is for inappropriate admission to Adult Acute and PICU Mental Health Services only.
3 - CAMHS Referral to treatment - the figure shown is the proportion of clients waiting for treatment as at the end of the reporting period who at that point had waited less than 18 weeks from their referral receipt date. Data refreshed back to April 18 each month.
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 September18.
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
• Significant reduction in medication omissions to below national average following targeted action plan.
• Two under-18 admissions to adult wards due to lack of alternative CAMHS beds. Appropriate safeguards put in place.
• No duty of candour breaches since May 2018 and only one recorded in 2018/19.
• Staffing levels remain above 100% overall but significant staffing challenges remain in response to increased acuity.

NHSI Indicators
• The majority of national metrics continue to be achieved
• The Trust has achieved the threshold for maximum 6 week wait for diagnostic procedures following underachievement in the last two months.
• 15 days occupied by 2 young people under 18 in adult wards, which is higher than recent months.
• Inappropriate out of area bed admissions of 199 which continues to mean the Trust remains well above target.

Locality
• Support to contract negotiations taking place in each locality, with focus on activity, performance targets and new investments
• Focus on the stroke pathway in Barnsley with the aim of introducing an early supported discharge service
• Consideration being given to results of the staff survey in each place with actions being identified
• Demand and capacity is a challenge in Barnsley community mental health services
• Anti-ligature work has taken place in the ward 18 garden area
• Recruitment is taking place to the new learning disability forensic outreach service
• Mobilisation for the introduction of the South Yorkshire liaison and diversion service is taking place in readiness for April 1st start
• Out of area bed usage in Wakefield remains at nil through intense work

Priority Programmes
• SystmOne for mental health went live as planned
• Work is taking place to establish work streams based on the recommendations made in the SSG report. Bed pressures remain

Finance
• Pre Provider Sustainability Funding (PSF) deficit in February of £244k taking the cumulative position to a £325k deficit
• Included in the February position it non-recurrent income of £0.4m for out of area bed usage from Kirklees CCG. There were also non-recurrent costs incurred of a slightly higher number leaving an underlying deficit position of circa £160k
• The cumulative position is £1.8m favourable to plan and includes a significant saving in capital charges (£1.4) from a revised calculation for asset valuations, as well as one-off asset disposal gains of £0.7m and non-recurrent income support of £0.9m
• Expenditure on out of area beds of £191k takes the cumulative spend to £3.6m
• Cumulatively net savings on pay amount to £1.1m through the level of net vacancies, with a £0.2m saving recorded in February. Inpatient ward costs are overspent by £2.4m year-to-date
• Agency staffing costs were £545k in month, which is 56% higher than our cap. The full year projection of £6.4m is close to breaching the NHS Improvement cap by 25%. This would have adverse implications on our financial risk rating.
• CIP delivery of £9.7m is £0.9m above plan with performance boosted by the reduction in capital charges.
• The cash balance remains in relative health at £27.6m
• The achievement of the year-end control total of £2m remains probable with a possibility of bettering it.

Workforce
• Trust continues to achieve above 80% compliance in all the mandatory training areas.
• Sickness rate in February has fallen compared to January and the projection is that annual rate will be lower than last year.
• Turnover continues to be an area of focus and the Trust has agreed action.

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 2018-19.

Section	KPI	Objective	CQC Domain	Owner	Target	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Year End Forecast Position *
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	Improving Health	Responsive	CH	TBC	Reporting commenced April 18				38.1%	39.8%	34.9%	35.6%	37.9%	37.0%	39.1%	34.4%	33.4%	31.5%	26.7%	N/A
Complaints	Complaints closed within 40 days	Improving Health	Responsive	TB	80%	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	50% 7/14	13% 2/16	40% 4/10	20% 2/10	22% 2/9	25% 3/12	1
	% of feedback with staff attitude as an issue	Improving Health	Caring	AD	< 20%	19.8% 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	19% 10/53	12%	21% 16/76	11% 4/35	25% 3/12	10% 1/10	4
Service User Experience	Friends and Family Test - Mental Health	Improving Health	Caring	TB	85%	84%	84%	86%	86%	86%	75%	82%	88%	91%	88%	89%	86%	90%	87%	84%	4
	Friends and Family Test - Community	Improving Health	Caring	TB	98%	98%	98%	98%	98%	97%	100%	98%	99%	97%	98%	100%	97%	99%	97%	98%	4
Quality	Staff FFT survey - % staff recommending the Trust as a place to receive care and treatment	Improving Health	Caring	AD	80%	74%	75%	N/A	76%	N/A		75%	N/A	N/A	71%	N/A	N/A	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	60%	64%	N/A	67%	N/A		70%	N/A	N/A	58%	N/A	N/A	N/A	N/A	N/A	N/A
	Number of compliments received	Improving Health	Caring	TB	N/A	81	113	148	64	26	109	44	27	45	48	63	26	60	49	10	N/A
	Number of Duty of Candour applicable incidents [4]	Improving Health	Caring	TB	N/A	337				*21*	*22*	*28*	*35*	*24*	*15*	*34*	43	20	25		N/A
	Duty of Candour - Number of Stage One exceptions [4]	Improving Health	Caring	TB	N/A	26				0	1	*1*	*1*	*2*	*2*	*1*	1	2	0	Due April 19	N/A
	Duty of Candour - Number of Stage One breaches [4]	Improving Health	Caring	TB	0	1		2	1	0	1	0	0	0	0	0	0	0	0		
	% Service users on CPA given or offered a copy of their care plan	Improving Care	Caring	CH	80%	85.2%	85.6%	85.0%	84.9%	86.3%	85.8%	86.2%	88.7%	86.3%	86.4%	86.6%	86.5%	87.5%	*87.5%*	Due April 19	4
	Un-outcomed appointments [6]	Improving Health	Effective	CH	TBC	4.3%	3.3%	2.5%	2.5%	5.4%	4.3%	4.1%	3.3%	3.2%	3.0%	3.0%	2.9%	2.8%	2.3%	2.4%	N/A
	Number of Information Governance breaches [3]	Improving Health	Effective	MB	<=8	33	22	24	21	8	11	14	16	14	15	14	20	11	10	13	
	Delayed Transfers of Care [10]	Improving Care	Effective	CH	7.5% 3.5% from Sept 17	1.6%	2.3%	2.7%	3.7%	2.7%	2.1%	2.6%	2.4%	2.4%	1.5%	1.6%	1.9%	1.7%	1.8%	1.6%	4
	Number of records with up to date risk assessment - Inpatient [11]	Improving Care	Effective	CH	TBC	Reporting commenced April 18				82.9%	85.0%	87.5%	78.5%	84.9%	91.0%	86.5%	84.3%	83.2%	89.3%	Due April 19	N/A
	Number of records with up to date risk assessment - Community [11]									75.7%	78.4%	78.3%	74.6%	77.5%	78.4%	81.7%	86.2%	93.8%	92.9%		N/A
	Total number of reported incidents	Improving Care	Safety Domain	TB	trend monitor	2849	3065	2962	3441	1074	1090	1039	1168	1004	862	1085	1108	982	1099	1032	N/A
	Total number of patient safety incidents resulting in Moderate harm. (Degree of harm subject to change as more information becomes available) [9]	Improving Care	Safety Domain	TB	trend monitor	57	58	56	72	22	13	15	24	21	13	21	29	19	28	21	N/A
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) [9]	Improving Care	Safety Domain	TB	trend monitor	3	8	9	7	2	1	1	4	0	4	5	5	1	1	1	N/A
	Total number of patient safety incidents resulting in death harm. (Degree of harm subject to change as more information becomes available) [9]	Improving Care	Safety Domain	TB	trend monitor	12	17	24	11	0	6	3	4	2	2	5	4	2	11	6	N/A
	MH Safety thermometer - Medicine Omissions	Improving Care	Safety Domain	TB	*17.7%*	18.2%	24.3%	16.5%	20.5%	19.9%	20.6%	18.4%	23.2%	22.4%	22.1%	17.8%	22.0%	29.8%	23.5%	13.9%	3
	Safer staff fill rates	Improving Care	Safety Domain	TB	90%	109%	111.1%	114%	116.8%	118%	120%	118%	118%	117%	116%	116%	119%	118%	119%	119%	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%	93.7%	98.3%	99.1%	96.6%	98.7%	97.5%	4
	Number of pressure ulcers (attributable) [1]	Improving Care	Safety Domain	TB	N/A	82	92	71	98	30	29	29	26	21	30	34	29	30	30	30	N/A
	Number of pressure ulcers (avoidable) [2]	Improving Care	Safety Domain	TB	0	2	1	2	2	0	0	1	0	1	0	0	0	0	0	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	0	0	4
	% of prone restraint with duration of 3 minutes or less [8]	Improving Care	Safety Domain	CH	80%	74.7%	79.5%	77.0%	75.7%	80.0%	61.3%	75.0%	76.3%	72.7%	72.7%	88.6%	81.3%	90.9%	82.4%	80.6%	4
	Number of Falls (inpatients)	Improving Care	Safety Domain	TB	TBC	139	139	150	181	40	40	44	43	37	52	40	41	49	39	48	N/A
	Number of restraint incidents	Improving Care	Safety Domain	TB	N/A	345	424	442	589	173	211	143	192	151	134	190	201	136	165	168	N/A
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	Improving Care	Safety Domain	TB	6	1	0	0	0	0	0	0	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	0	0	4
Quality	No of staff receiving supervision within policy guidance [7]	Improving Care	Well Led	CH	80%	59.3%	61.0%	64.7%	87.6%	82.6%			83.6%			81.5%			Due April 19		4

Quality Headlines

** 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 and categorisation of incidents has been updated in the year to reflect the requirements of the General Data Protection Requirements (GDPR)
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 unoutcomed appointments which is a snap shot position at a given point in time. The increase in unoutcomed appointments in April 17 is due to the report only including at 1 months worth of data.
7- This shows the clinical staff on bands 5 and above (excluding medics) who were employed during the reporting period and of these, how many have received supervision in the last 12 months. Please note that services only been fully using the system since December 2016.
8 - The threshold has been locally identified and it is recognised that this is a challenge. From June 17, the monthly data reported is a rolling 3 month position.
9 - Data is extracted from a live system, and correct at the time of reporting. The degree of harm is initially recorded based on the potential level of harm and is subject to change as further information becomes available eg 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 Trust's contracts have not been varied to reflect this, however the Trust now monitors performance against 3.5%.
11. Number of records with up to date risk assessment - data now available for April 18 onwards. Criteria used is - Inpatients, we are counting how many Sainsbury's level 1 assessments were completed within 48 hours prior or post admission and for community services for service users on care programme approach we are counting from first contact then 7 working days from this point whether there is a Level 1 Sainsbury's risk assessment.

Quality Headlines

During 2017/18 the Trust undertook some work to develop the key quality measures and this has continued into 18/19.

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

• Number of restraint incidents - the number of restraint incidents during February was 168. The highest proportion of incidents are in the standing position (93). The Trust continues to ensure that during training the emphasis on non-physical interventions remains paramount and when it comes to teaching and discussing prone restraint the course continues to inform staff of the risks associated with the prone position and the need to move from any prone restraint position as soon as possible. The Trust target of 80% of prone restraints being under 3 minutes is discussed at length and the importance of striving to maintain this is strongly emphasised.

• % of prone restraint with duration of 3 minutes or less - during February there were a total of 31 incidents recorded. 6 of those incidents lasted greater than 3 minutes:

- 1 incident lasted 4-5 minutes - 136 Suite Wakefield, level of aggression and risk;
- 1 incident lasting 5-10 minutes - Walton PICU in Wakefield to administer intra muscular meds and to facilitate seclusion exit.
- 1 incident lasting 9-10 minutes - Elmdale Ward, due to level of aggression displayed and to administer I.M. meds.
- 1 incident 10-15 minutes - Walton PICU, Wakefield, due to level of aggression and to manage infection control risks.
- 2 incidents over 15 minutes - 1 incident Elmdale ward, 20 minutes. Due to level of aggression displayed; 1 incident, 136 Suite Wakefield. Used intermittently over a 3 hour period. Due to level of aggression and to manage.

• NHS Safety Thermometer - medicines omissions – performance has significantly improved this month compared to previous months and stands at 13.9% for February. This 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 and overall there has been a reduction of 9%. However, the mental health safety thermometer's national data has shown that the Trust has been an outlier when benchmarked. Over the last month, there has been a focus for improvement on medicines omissions at all levels of the organisation. Wards and pharmacy teams have been working closely together on the causes and solutions to include in everyday practice. Some wards have included medicines omissions in safety crosses and others are reviewing each day. A "medicines refused? Refer to pharmacy" campaign was started during February. Ward breakdowns have also been provided giving more information to operational services. As we have previously reported, long-term plans include the procurement of Electronic Prescribing & Medicines Administration (EPMA) system which will prevent omissions.

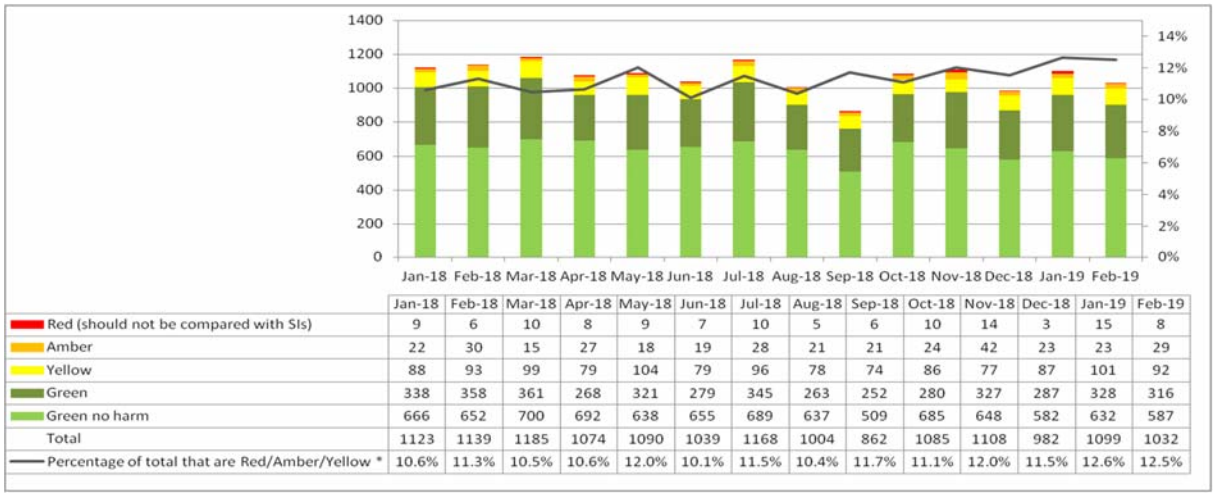
• Number of falls (inpatients) - February saw an increase in fall incidents during the month compared to previous months; this was attributed to increases in Forensic and Calderdale and was due to an increase in service users with very complex physical health issues which has led to a high level of incidents reported during the month.

• % people dying in a place of their choosing - the Trust has been monitoring data for this indicator since April 2018 and has shown an improving trend which in some part is due to work undertaken to improve the collection and recording of this data.

Safety First

Summary of Incidents during 2017/18 and 2018/19

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



	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Red (should not be compared with SIs)	9	6	10	8	9	7	10	5	6	10	14	3	15	8
Amber	22	30	15	27	18	19	28	21	21	24	42	23	23	29
Yellow	88	93	99	79	104	79	96	78	74	86	77	87	101	92
Green	338	358	361	268	321	279	345	263	252	280	327	287	328	316
Green no harm	666	652	700	692	638	655	689	637	509	685	648	582	632	587
Total	1123	1139	1185	1074	1090	1039	1168	1004	862	1085	1108	982	1099	1032
Percentage of total that are Red/Amber/Yellow *	10.6%	11.3%	10.5%	10.6%	12.0%	10.1%	11.5%	10.4%	11.7%	11.1%	12.0%	11.5%	12.6%	12.5%

** 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 86% 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	Q3 18/19	Q4 18/19 Jan & Feb only	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Total
Death - cause of death unknown/ unexplained/ awaiting confirmation	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	1
Informal patient absent without leave	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Information disclosed in error	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Lost or stolen hardware	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Lost or stolen paperwork	0	1	1	0	0	0	0	0	0	1	0	1	0	0	0	0	2
Self harm (actual harm) with suicidal intent	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	1
Suicide (incl apparent) - community team care - current episode	4	3	4	9	1	1	3	0	2	1	0	2	1	1	6	3	21
Suicide (incl apparent) - community team care - discharged	2	1	0	2	0	0	0	2	0	1	0	0	0	0	2	0	5
Suicide (incl apparent) - inpatient care - current episode	0	0	1	0	1	0	0	0	0	0	0	1	0	0	0	0	2
Unwell/Illness	0	1	1	0	0	0	0	0	0	1	0	0	0	1	0	0	2
Allegation of violence or aggression	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Physical violence (contact made) against staff by patient	1	0	1	0	0	0	0	1	0	0	0	1	0	0	0	0	2
Physical violence (contact made) against other by patient	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Pressure Ulcer - Category 3	1	1		0	0	0	0	1	1	0	0	0	0	0	0	0	2
Total	8	9	10	12	4	1	3	4	5	4	0	6	2	2	8	4	43

SJR Themes
Risk assessment: 35% of cases reviewed were rated good or excellent
Allocation/initial review: 46% of cases reviewed were rated good or excellent
On-going care: 56% of cases reviewed were rated good or excellent
Care during admissions (where applicable): 57% of cases reviewed were rated good or excellent
Follow-up management / discharge: 56% of cases reviewed were rated good or excellent
End of life care: 100% of relevant cases in inpatient care were rated good or excellent
51% of reviews completed to date rated the quality of the patient record as good or excellent
The learning from healthcare deaths report includes examples of areas for improving practice identified by the reviewers, and also good practice examples.
Work to embed recording the SJR within Datix has been completed which will aid extraction of themes.

- Incident reporting levels have been checked and remain within the expected range.
- Degree of harm and severity are both subject to change as incidents are reviewed and outcomes are established.
- Reporting of deaths as red incidents in line with the 'learning from healthcare deaths' has increased the number of red incidents. Deaths are re-graded upon receipt of cause of death/clarification of circumstances.
- All serious incidents are investigated using systems analysis techniques. Further analysis of trends and themes are available in the quarterly and annual incident reports, available on the patient safety support team intranet pages.
See http://nww.swyt.nhs.uk/incident-reporting/Pages/Patient-safety-and-incident-reports.aspx
- Risk panel remains in operation and scans for themes that require further investigation. Operational Management Group continues to receive a monthly report, the format and content is currently being reviewed.
- No never events reported in February 2019
- Patient safety alerts not completed by deadline of February 2019 - None

Mortality

A new clinical mortality review group will take effect from 29/3/19 to focus on learning and action from outcomes from learning from deaths reviews.
Training: Structured Judgement Reviewer (SJR) training took place on 31 January 2019. Eight people were trained.
Policy: The revised Learning from Healthcare Deaths policy was approved by EMT in January 2019. This is now available on the intranet and website.
Reporting: The Trust's Learning from Healthcare Deaths information is reported through the quarterly incident reporting process. The latest report is available on the Trust website. This includes 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 Q1-2 cases is included in the latest report.
56% of reviews completed to date rated overall care as good or excellent

Safer Staffing

Overall Fill Rates: 119%
Registered fill rate: (day + night) 97.5%
Non Registered fill rate: (day + night) 140.4%

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

BDU Fill rates - November 18 - February 19

Overall Fill Rate	Month-Year		
Unit	Dec-18	Jan-19	Feb-19
Specialist Services	165%	180%	156%
Barnsley	120%	121%	123%
C & K	107%	109%	109%
Forensic	114%	116%	114%
Wakefield	130%	130%	135%
Overall Shift Fill Rate	**118%**	**119%**	**119%**

The figures (%) for February 2019:
Registered Staff - Days 89.2% (a decrease of 2.7% on the previous month); Nights 105.9% (an increase of 0.3% on the previous month)
Registered average fill rate - Days and nights 97.5% (a decrease of 1% on the pervious month)
Non Registered Staff - Days 139.5% (an increase of 3.2% on the previous month); Nights 141.4% (a decrease of 2.9% on the previous month)
Non Registered average fill rate - Days and nights 140.4% (an increase of 0.4% on the previous month)
Overall average fill rate all staff: 119.2% (a decrease of 0.3% on the previous month)
Overall fill rates for staff for the all inpatient areas remain at 90% or above.

Summary
There has again been no ward fell below a 90% overall fill rate. Of the 31 inpatient areas 24, a decrease of one on the previous month, (76.8%) achieved greater than 100%. Indeed of these 24 areas, 13 achieved greater than 120% fill rate. This was consistent with the previous month.
Registered On Days (Trust Total 89.2%)
The number of wards that have failed to achieve 80% increased by three wards to five (16%) on the previous month. There were three wards within the Forensic BDU (Chippendale, Priestley and Johnson). The others were Poplars within the Wakefield BDU and Ward 19 Male within Calderdale and Kirklees. There were various factors sited including vacancies, sickness and supporting acuity across the BDU.
Registered On Nights (Trust Total 105.9%)
No ward has fallen below the 80% threshold. The number of wards who are achieving 100% and above fill rate on nights remained at 20 wards (64%) from the previous month.
Average fill rates for most areas increased in February. Barnsley BDU increased by 2% to 123%. Calderdale and Kirklees BDU remained at 109%. Forensic BDU were 116% a decrease of 2%. Wakefield BDU increased to 135%. Specialist services were 156% with a decrease of 24%. Overall fill rate for the trust remained at 119%.
Despite the achievement and above of expected fill rates, significant pressures remain on inpatient wards due various influences including demands arising from acuity of service user population, vacancies and sickness.

Information Governance

A slight increase from last month with 13 breaches reported, related to 8 information disclosed in error, 2 to lost or stolen paperwork and 3 were patient healthcare record issues.

No incidents were reported to the information commissioner's office.

Commissioning for Quality and Innovation (CQUIN)

Services continue to work towards the requirements for 18/19 and are now completing the final year end requirements which are due to be submitted to the commissioner at the end of April.

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 means that the Trust would need to be in the top 6 of 200+ trusts nationally. The Trust has agreed some additional local measures related to staff health and wellbeing which reduces the total amount of risk associated with this indicator.
• 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.
• 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 £204k shortfall for 2018/19. CQUIN leads are working to mitigate this risk as far as possible.
• Flu vaccinations - the Trust exceeded the 75% threshold and therefore achieved all income associated with this indicator. Final overall % performance for vaccination uptake is awaited.

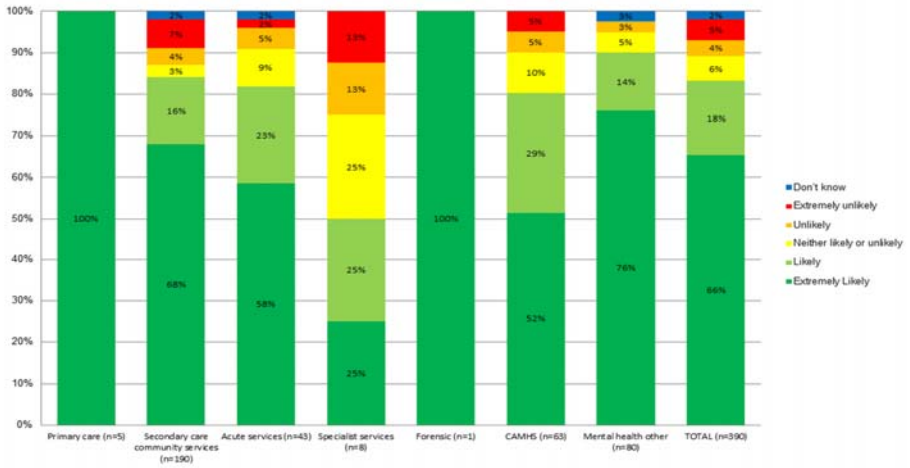
The 19/20 national CQUIN schemes have been recently published, the Trust is working with its commissioners to agree the applicable indicators for each contract. The rules state there must be a maximum of 5 indicators per contract, overall value of the scheme as reduced to 1.25% of contract value.

Patient Experience

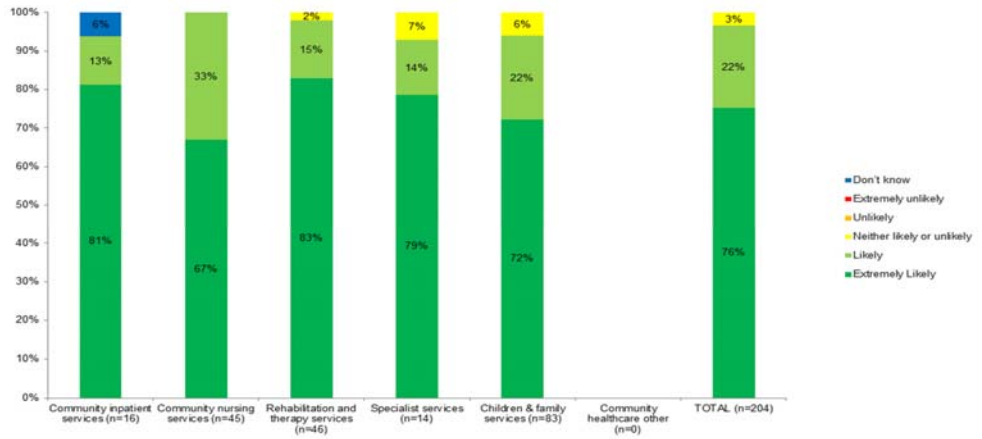
Friends and family test shows

- Community Services – 98% would recommend community services.
- Mental Health Services – 84% would recommend mental health services.
- Significant variance across the services in the numbers extremely likely to recommend the Trust – between 25% in specialist services and 100% in primary care
- Small numbers stating they were extremely unlikely to recommend.

Mental Health Services



Community Services



Care Quality Commission (CQC)

Following the March 2018 core service visits, the CQC issued the Trust with 18 MUST do and 47 SHOULD do actions. These included one MUST do and six SHOULD do Trust wide actions. At February 2019 -72.5% of MUST DO actions and 87% of SHOULD DO have either being completed or making good progress.
An extra ordinary workshop is being held on 27.3.19 to review the CQC action plan in detail, assess the risks to successful completion and identify additional actions required to expedite actions that are behind anticipated completion dates. The action plan progress will be updated and a more frequent and enhanced monitoring system will be implemented from 1st April 2019

Safeguarding

Safeguarding children's activity February 2019

- The named nurse for safeguarding children has attended a number of external training opportunities including 'sexual safety on mental health wards', the learning from the training will be incorporated into the Trust Policy, briefs for staff, service users and carers and updating the current safeguarding children training packages.
- The safeguarding team continue to provide training as part of the safeguarding board offer and are currently preparing presentations for the upcoming safeguarding weeks in June and July.
- The safeguarding team have contributed to a number of external information gathering requests including a cross-border safeguarding practice review.
- The safeguarding team have contributed and attended the initial multi-agency pregnancy liaison advisory group multi-agency meeting in Wakefield which assesses the risk of individuals who are pregnant and may have mental health concerns and / or alcohol and substance misuse.

Safeguarding adult activity February 2019

- The specialist advisor safeguarding adults has contributed to a number of external information gathering requests for safeguarding adult reviews, domestic homicide reviews and a suicide panel.
- Additional support and supervision has been provided to a number of internal complex cases thus ensuring appropriate risk assessment and relevant external agencies are involved in a timely manner.
- Amended and re circulated the safeguarding adults policy, the sexual relationships policy and the threats to kill guidance document
- Data requests for performance dashboards for the safeguarding boards has been completed.

Infection Prevention Control (IPC)

• Progress on the Infection Prevention and Control annual programme 2018-19, has been good, all objectives in Q3 have been completed. Progress in Q3 is good and there are no areas at risk of non-completion.
• Surveillance: there has been no MRSA Bacteraemia, Clostridium difficile, or any other alert organisms. Barnsley BDU has a locally agreed C difficile toxin positive target of 5. There has been a MRSA Bacteraemia, which relate to a person in Urban House. We have been involved in the care of this person. A MRSA bloodstream infection: post infection review is being undertaken by Kirklees CCG. Outcome expected soon. There may be some learning for SWYFT. This will not be on SWYFT surveillance figures.
• There has been an outbreak of gastroenteritis (Jan 2019) on Beechdale affecting 16 (9 patient 7 staff), ward closed 7 days. To note norovirus and respiratory viruses are circulation in the communities, this is a national picture.
• Q3 - Wakefield - 6, Barnsley (mental health and community) - 0, Forensics - 2, Calderdale/Kirklees – 4, Specialist Services - 0 and Corporate Support Services - 1.
• Incident breakdown – 4 sharp related incidents, 2 sharp related not needlestick, 2 disposal of sharp, 2 outbreak restrictions in place (not outbreak), 2 exposure to infection and 1 contact with urine.
• Severity rating – 11 incidents were risk rated green and 1 yellow.
• Mandatory training figures are healthy:
Hand Hygiene-Trust wide Total – 90%
Infection Prevention and Control- Trust wide total – 86%
• Policies and procedures are up to date.

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.
• Due to the requirements of staff to support the SystmOne go live, not all performance data is available this month at the time of report submission.

NHS Improvement - Single Oversight Metrics - Operational Performance

KPI	Objective	CQC Domain	Owner	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Q1 18/19	Q2 18/19	Q3 18/19	Year End Forecast Position *	Trend
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Improving Care	Responsive	CH	92%	97.1%	97.3%	97.2%	97.1%	96.2%	97.2%	98.0%	99.0%	99.3%	99.8%	98.2%	97.1%	97.2%	98.6%	4	
Maximum 6-week wait for diagnostic procedures	Improving Care	Responsive	CH	99%	100%	100%	100%	100%	100%	100%	100%	100%	97.9%	98.9%	100%	100%	100%	98.6%	4	
% Admissions Gate kept by CRS Teams	Improving Care	Responsive	CH	95%	*95.5%*	98.3%	98.8%	98.9%	97.5%	97.0%	99.0%	98.8%	97.6%	95.5%	Due April 19	97.6%	97.9%	98.9%	4	
% SU on CPA Followed up Within 7 Days of Discharge	Improving Care	Safe	CH	95%	94.3%	99.2%	100%	97.7%	94.9%	98.4%	96.9%	99.0%	95.4%	100%	Due April 19	97.7%	97.1%	97.1%	4	
Data Quality Maturity Index [4]	Improving Health	Responsive	CH	95%	98.3%	98.2%	98.2%	98.2%	98.2%	98.2%	98.3%	98.2%	98.1%	*98.1%*	*98.1%*	98.2%	96.8%	98.1%	4	
Out of area bed days [5]	Improving Care	Responsive	CH	Q1 840, Q2 846, Q3 752, Q4	531	282	368	437	589	384	165	389	267	299	199	1181	1410	821	1	
IAPT - proportion of people completing treatment who move to recovery [1]	Improving Health	Responsive	CH	50%	52.9%	57.2%	53.2%	54.0%	52.1%	47.1%	50.8%	50.1%	57.8%	55.1%	*57.1%*	54.4%	51.1%	*52.8%*	3	
IAPT - Treatment within 6 Weeks of referral [1]	Improving Health	Responsive	CH	75%	91.6%	88.0%	93.9%	93.9%	94.8%	94.0%	94.6%	96.9%	91.1%	92.3%	*88.3%*	91.3%	94.3%	*94.4%*	4	
IAPT - Treatment within 18 weeks of referral [1]	Improving Health	Responsive	CH	95%	100%	98.7%	100%	99.7%	99.5%	99.6%	99.7%	99.7%	99.4%	99.3%	*98.8%*	99.4%	99.6%	*99.6%*	4	
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Improving Care	Responsive	CH	53%	93.5%	81.0%	70.0%	92.0%	91.4%	90.3%	94.2%	94.7%	88.6%	85.1%	85.3%	81.7%	90.3%	92.6%	4	
% clients in settled accommodation	Improving Health	Responsive	CH	*60%*	78.9%	78.5%	79.1%	78.7%	78.8%	79.0%	78.5%	78.2%	78.5%	78.0%	*78.2%*	79.1%	78.8%	*78.2%*	4	
% clients in employment [6]	Improving Health	Responsive	CH	*10%*	9.0%	8.7%	8.6%	8.5%	9.5%	8.9%	8.6%	9.0%	9.3%	9.2%	Due April 19	8.6%	8.8%	9.3%	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	CH		Due June 19														2	

Mental Health Five Year Forward View	Objective	CQC Domain	Owner	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Q1 18/19	Q2 18/19	Q3 18/19	Year End Forecast Position *	Trend
Total bed days of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	*TBC*	2	0	14	22	1	22	8	29	2	4	15	16	45	39	2	
Total number of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	*TBC*	1	0	3	3	1	2	2	3	1	1	2	4	6	6	2	
Number of detentions under the Mental Health Act	Improving Care	Safe	CH	*Trend Monitor*	212			192			184			*Due April 19*		212	192	184	N/A	
Proportion of people detained under the MHA who are BAME [2]	Improving Care	Safe	CH	*Trend Monitor*	15.1%			14.1%			13.0%			*Due April 19*		15.1%	14.1%	13.0%	N/A	

NHS Standard Contract	Objective	CQC Domain	Owner	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Q1 18/19	Q2 18/19	Q3 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	CH	90%	97.4%	97.7%	97.5%	98.8%	98.5%	99.1%	98.9%	97.0%	98.7%	98.8%	*98.8%*	97.8%	98.8%	98.1%	4	
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	Improving Health	Responsive	CH	99%	99.8%	99.9%	99.9%	99.9%	100.0%	99.9%	100.0%	99.9%	99.9%	99.9%	*99.9%*	99.9%	99.9%	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	CH	90%	90.7%	90.5%	90.8%	90.5%	95.5%	95.1%	91.0%	90.9%	90.8%	90.4%	*90.7%*	90.8%	91.1%	90.9%	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 majority of NHS Improvement metrics
- The proportion of people completing treatment who move to recovery within Improving Access to Psychological Therapies (IAPT) is above threshold for February This is provisional data and the final data will be reported in next month's report.
- During February 2019, the number of service users aged under 18 years placed in an adult inpatient ward increased to 2 - this related to the admission of two 17 year olds to Wakefield BDU during the month. Total bed days and number of children and younger people under 18 in adult inpatient wards forecast for year end has been rated as '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. 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, two or three, an overall reduction in the number of bed days can be seen but this continues to be above trajectory and therefore not achieved. Focus remains on reducing the levels of bed days out of area.
- % 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 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.

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

Barnsley BDU:

Key Issues
• Pulmonary rehabilitation formal joint investigation work ongoing in response to performance targets.
• Activity profiles for 19\20 submitted to CCG to inform contract negotiations
• Bed usage for Barnsley registered patients in neurological rehabilitation is currently above the bed days commissioned from Barnsley CCG. Discussions with integrated care system (ICS) regarding use of uncomissioned beds has commenced.
• Sickness level for Trust (year to date) is 5.1% against a target of 4.5%. Barnsley district is at 5.5% for February which has reduced from January figure of 6.3%.

Strengths
• Doncaster smoke free (YSF) commissioner has indicated they will be using underspend and CQUIN money to develop and deliver smoke free services in acute settings through the Doncaster team.
• YSF Calderdale acting manager, Jan Spencer, was runner up in the Wakefield College's student of year award 2019.
• Friends and Family Test (FFT) remains excellent for the majority of health and wellbeing services
• Nova have been given funding from the commissioner for a further full time band 5 equivalent post for Wakefield live well due to the increased volume of work coming into the service
• Children's FFT excellent results
• Children's speech and language therapy (SALT) team have commented on the benefits of in house mindfulness training and the health and well-being checks that are available
• Dietetics - we have been asked to support the acute trust diabetes service on a short term basis to cover their sickness absence.
• Joint working with Barnsley hospital via multi-disciplinary team (MDT) meetings; Intermediate Care at risk of re-admission pathway and In Reach Nurse.
• Ongoing work and development in line with cardiovascular disease and frailty core CCG work streams

Challenges
• Yorkshire smoke free Barnsley out for tender in April/ May 2019
• Yorkshire smoke free Calderdale – commissioning intention for 2020 not known
• Yorkshire smoke free Sheffield – service targets remain very challenging despite conversion rates being excellent.
• NHS England's draft management of chicken pox in initial accommodation (IA) centres has enormous consequences for Urban House and implementation will be very challenging.
• Interpreter costs are having a negative impact on children's service budgets
• Dietetics are experiencing patients being inappropriately referred into service for a one to one appointment due to waiting list for XPERT (Diabetic education package for self-management)
• Commissioner currently reviewing funding levels for Children's therapy services due to increasing waiting times.
• CQC preparation underway

Areas of Focus
• Stroke Integrated Pathway - work continues. A further executive level meeting took place in March. The proposals and financial profiles are now being considered. An independent review of the proposed early supported discharge (ESD) model will be undertaken.
• Work continues with partners on the emerging primary care network structures in Barnsley to be known as 'Integrated Care Networks'. The number of these locally is still to be determined. The 6 neighbourhoods will remain a key focus at delivery of service level. The senior operational team in the BDU are now part of the CCG workforce development group.
• Neuro rehabilitation unit open day planned for May 2019
• Staff survey – work underway to focus on the 4 priorities. Director of human resource, OD and estates attended our BDU Operational Management Governance meeting 18.3.19. Our initial feedback from focus groups (neighbourhood nursing service) was discussed. Posters re the key 4 areas were suggested for the open hot desk area (e.g. Fieldhead hospital) to capture staff ideas re issues and potential actions.

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 some staffing pressures leading to ongoing bank expenditure. This is being kept to a minimum by utilisation of resources across the wards and effective skill-mixing.
• 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.
• Demand and capacity remains a challenge in community services, particularly in the enhanced pathways, where the resource and practice adjustments required following the changes in the integrated service model are ongoing. Action plans and data improvement plans are in place and there is support with staff wellbeing. Partnership approaches and effective communication continues between the council and SWYPFT.
• Extensive work is underway to develop the new South Yorkshire wide model for liaison and diversion services following participation in a successful tendering process. The new service will be implemented on 1 April 2019.

Strengths

• Management of patient flow.
• Human resource workforce performance strong across all domains other than food safety where an action plan is in place.
• Service users in Barnsley acute wards are benefitting greatly from the new cardio wall installed as a result of successful capital bids. The wall is an innovative and self-lead approach to exercise and is supporting an intensive programme to improve the cardio-vascular health and general wellbeing of our service users, and is also according to service user and staff feedback hugely enjoyable.

Challenges

• Demand and capacity in community services.
• Action plan continues to improve data quality and in particular performance around care programme approach reviews and 14 day access as a key performance indicator, this continues to be impacted upon by the council staff being withdrawn from the integrated teams as above.
• Expected activity levels in the enhanced and core teams are being readjusted in partnership with the CCG following the disaggregation of social care resources.
• Barnsley BDU sickness rates are 5.2% overall in excess of trust target. For mental health, specialist services are 3.9% (within target), community 5.1% and acute 7%. General managers are working with HR business partners to review all cases and to ensure robust process and appropriate support is in place. This is monitored through team managers meetings and reported through to deputy director, for review at BDU level meetings.

Areas of Focus

• Admissions and discharges and patient flow in acute adults.
• Continue to improve performance and concordance in service area hotspots tracked team by team by general managers.
• Demand and capacity work in single point of access and the enhanced pathway.
• Reduction of agency and bank spend in acute services.
• Work continues with partners on integrated care networks , working with the neighbourhoods already in place. SWYPFT staff are represented at local and network level both developmentally and operationally.
• Local action planning in response to staff survey.
• Sickness management.

Calderdale & Kirklees BDU:

Key Issues

• Delayed transfers of care (DTOC) - Mental health MADE (multi agency discharge planning) CCG, local authority and trust meetings continuing and reductions in DTOC starting to take place.
• Continued pressure for admissions, particularly female, however a number of beds have been internally available especially for males. Occupancy and acuity remains high on all female adult wards and across the BDU.
• Staff survey results are being reviewed in each service line with action plans under development. Particular focus on results for rehab and administration staff.

Strengths

• Discharge co-ordinator capacity on all wards started in December to reinforce flow management. All 5 now in post. Evidence of benefits beginning to show with increased flow and emerging capacity.
• High levels of clinical supervision are being recorded across service lines.
• High performance on mandatory training.
• Appraisal completion over 99% across all bands.
• Sickness absence is well managed across BDU. Absence is higher in adult inpatients but all cases are being monitored.

Challenges

• Adult occupancy levels are high - inpatients and in intensive home based treatments.
• Caseload pressures have built up in some adult community teams, management actions are in place.

Areas of Focus

• Continue to focus on absence performance in service area hotspots such as adult inpatients. Other 3 service lines are green
• Ward 18 garden area reviewed for overall safety and new anti ligature, anti climbing and netting. Snagging work to complete before ward 18 garden can be reopened.
• Improvements to access and egress from The Dales to increase security work to be completed by April.
• Additional fencing work underway at The Dales garden due to recent incidences of absent without leave (AWOLs).

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

Forensic BDU:

Key Issues
• NHS England (NHSE) remain committed to de commissioning 8 learning disability beds. Further work has been undertaken within the Trust to identify an alternative use for those 8 beds.
• Service review/business case as lead provider continues to progress. Following the two successful workshops collaboration with partners continues. The partnership is hopeful that an opportunity to develop a forensic community service across West Yorkshire will be available by the end of March.
• Learning disability forensic outreach service recruitment to initial service has commenced. Team Leader and key clinicians appointed on a fixed term/secondment basis. Confirmation has now been received that £1.8m will be released by clinical commissioning groups (CCGs) to fund the original proposal. Work has been finalised on a revised specification and implementation plan. The aim is that the service will offer a consultancy and advisory service from 1.4.19.
• Following an Independent review commissioned by NHSE Leeds community health/SWYPFT are working collaboratively to finalise a recovery plan for the secure estate. A formal performance notice has been issued on the contract.
• Occupancy levels in medium secure above 95% but remain a concern in low secure being below target.

Strengths
• Strong performance on mandatory training.
• Developing innovative and collaborative work in the delivery of this years CQUINs.
• Progress being made on CQC action plans. Only action waiting to be addressed is the call system which is waiting a trust wide response.
• Service well-being group has identified key areas of development moving forward with a focus on sickness levels in particular short term sickness.

Challenges
• Low secure occupancy levels well below 90%
• Recruitment of band 5 nurses (23 vacancies across the business delivery unit).
• High turnover.
• Reducing sickness.
• Forensic child and adolescent mental health service performance notice. Extra resources deployed from elsewhere in forensic business delivery unit and support services.

Areas of Focus
• FCAMHs performance notice.
• The BDU will undertake a large piece of work supported by HR and will focus on the following areas:
*Leadership
*Sickness/absence
*Turnover
*Well-being
*Bullying and harassment

Specialist BDU:
Key Issues
• Optimising the pathway of care for child and adolescent mental health services (CAMHs) meetings had been held (19 December 2018 and 15 March 2019) - chaired by the NHSE North medical director – to consider the system difficulties in accessing specialist T4 hospital beds and the resulting risk to the care of children and young people. Whilst it was acknowledged that T4 beds would remain in scarce supply the meeting had allowed for improved communication and escalation processes between providers. It had also informed CCG 2019/20 investment plans – with a commitment to further build capacity in CAMHS crisis and home based treatment teams.
• Wakefield safeguarding boards are leading on a serious case review regarding a number of deaths since May 2017 of 16-21 year olds through apparent suicide. A child adolescent mental health services oversight and assurance forum has also been established to understand the learning for the local system and ensure this underpins improvement in service delivery.
• Sickness rates in the Wakefield CAMHS crisis team have increased significantly recently. A range of occupational health and managerial supports have been offered. Options are being explored to access more specialist 'supervisory' support to proactively build the resilience of staff.
• The recent staff survey identified significant challenges in CAMHS – most notably in the Barnsley team. Workload pressure, specifically related to on-call , is a key factor. The issue of on-call will be addressed with the move to an all-age liaison service model and a series of team-based workshops are being planned to proactively engage staff.
• Waiting times from referral to treatment in Wakefield and Barnsley CAMHS remain a concern. In Barnsley the wait for ADHD assessment and treatment is a particular concern
• Consultant recruitment cross CAMHS and learning disability remains a significant challenge – resulting in high agency use.

Strengths
• The transforming care partnership has recognised our learning disability service to be a stopping over medication of people (STOMP) good practice area nationally
• Friends and family tests return rates are much improved across all learning disability teams.
• Barnsley and Wakefield CCGs have committed to new investment in CAMHS waiting list initiatives. Additional investment will also be made available in 2019/20 from the new care models initiative.
• All CCG have prioritised investment in development of an all-age liaison model. Work is progressing on the detailed business cases in Wakefield and Calderdale/Kirklees.
• Kirklees application to be a CAMHs Trailblazer site was successful. Staff have now been recruited to the 2 school-hub based teams.

Areas for focus
• Proactively addressing vacancy levels in learning disability services and consultant posts in learning disabilities and CAMHs
• Development and implementation of the all-age service model and waiting list initiatives in CAMHs
• Continuing to disseminate early learning from review of the recent suicides of children/young people.
• Ongoing focus across specialist services on staff engagement and health and wellbeing.

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

Wakefield BDU:

Key Issues
• The acute service line continues to experience high demand and staffing pressures leading to ongoing bank expenditure.
• Out of area beds for Wakefield service users has been maintained as nil usage and intensive work takes place to adopt collaborative approaches to care planning, to build community resilience; and for presenting acute episodes, to explore all possible alternatives at the point of admission.
• 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 in community service lines leading to continued expenditure on agency medical staffing.

Strengths
• Management of patient flow and for Wakefield nil out of area bed usage.
• HR workforce performance strong across all domains other than food safety where an action plan is in place
• February's mental health safety thermometer for medication omissions showed a significant improvement for working aged adult inpatient services. Each ward have reviewed processes to ensure more robust monitoring and identification of omissions. Learning from the working age adult wards will be shared with colleagues from older peoples services.
• An infographic produced by SWYPFT explaining how Unity Centre coped with winter pressures has been featured on NHS Providers' website: https://nhsproviders.org/nhs-winter-watch-201819/week-12

Challenges
• Adult community consultant vacancies and gaps continue to be a pressure leading to financial and clinical continuity challenges.
• Adult acute occupancy and acuity levels remain high.
• Expenditure on bank and agency staffing in acute services and agency spending on medical staff in community.
• Wakefield BDU sickness rates are 4.9% in excess of trust target. Community services are 4.1% (within target), and acute 5.4%. General managers are working with HR business partners to review all cases and to ensure robust process and appropriate support is in place. This is monitored through team managers meetings and reported through to deputy director, for review at BDU level meetings.

Areas of Focus
• Admissions and discharge flow in acute adults with an emphasis on current approach to alternatives to admission and collaborative inter-agency planning.
• Local action planning in response to staff survey.
• Continue to improve performance in service area hotspots through focussed action planning.
• Medical recruitment to consultant psychiatry and specialty doctor posts.
• Reduction of agency spend.
• Sickness management.

Communications, Engagement and Involvement

- SystmOne for mental health – countdown to go live messages through targeted emails and social media, promotion of go live support (intranet resources, super users, support desk), regular updates to super users
- Staff survey results comms - including intranet section, briefing and infographic
- 2018/19 flu jab communications campaign announced as shortlisted in NHS Employers' Flu Fighter Awards in the 'Most innovative' category
- Promotion of West Yorkshire and Harrogate Health and Care Partnership "our neighbours" campaign, encouraging sign-up ahead of launch
- Internal comms survey analysis, completed by 560 staff (a 68% increase in responses compared to previous year)
- #Allofusimprove – developing case studies & promoting IHI training
- Continued collaboration with staff-side colleagues on the introduction of a staff app
- Co-development of a partnership communication campaign with Barnsley Hospital, the CCG and GP Federation to promote alliance working

This is the March 2019 priority programme update for the integrated performance report for progress on the 2018/2019 Trust priorities. A summary of key updates for activity conducted in February includes:

Out of Area:
• Bed pressures remain in the system and out of areas placements continue, though the levels fluctuate. Recent placements continue to be from the Calderdale/Kirklees locality.
• Criteria led discharge has now gone live across all inpatient units. Next steps will be to ensure that it is embedded and used as appropriate across the trust to ensure that it delivers the expected benefits.
• Following conclusion of activity with external consultants, SSG Health, where eight workstreams were identified, work has taken place to pull all activity into a priority plan for the Trust and align with other priorities that will support the reduction in bed use. Work is now ongoing on identifying priority strands and resources required to support the plan.
• A new partnership governance structure is being established to support the change programme as from April 2019.

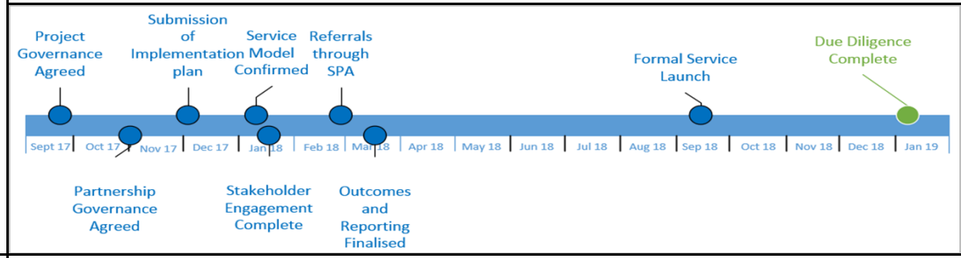
Clinical Record System:
• Go Live dates for inpatient (25th February) and mental health community (5th March) occurred to plan.
• Considerable background work was conducted on the run up to both Go Live dates, particularly in migration of data form RiO to SystmOne
• Go Live protocols were followed for both go lives to ensure all preparations were in place prior to go live
• Acceptable targets of staff training were reached to enable go live
• Work is still ongoing 'post both go lives

Stroke Services Review:
• New model developments are to be presented to the Members' Council in May
• Senior/executive level stocktake meeting took place on 21st January 2019 and a senior/executive level meeting re the stroke pathway costings meeting was held 27th February 2019.
• Work commenced with corporate communications (all organisations) to convey positive outcomes of integrated pathway
• Continued involvement from voluntary sector (Stroke Association) in steering group and other developments beyond the remit of this project e.g. Stroke Café
• Barnsley Metropolitan Borough Council social care department has been invited to future steering group meetings

Learning Disabilities Operational Delivery Network (ODN):
SWYPFT are the lead 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.
• The project progresses well and is on track against plan.
• Expressions of interest have been invited to increase membership of the community infrastructure work-streams and opportunities to co-lead the three groups to support existing leads.

Priority	Scope	Narrative Update	Area	RAG
IMPROVING HEALTH				
Joined Up Care				
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 As a result of the South Yorkshire integrated care System (ICS) work on the Hyper-Acute Stroke provision and the wider hospital services review SWYPFT and Barnsley Hospital NHS Foundation Trust (BHNFT) were asked to work together by CCG on an integrated pathway for stroke patients in Barnsley. The key themes within this are: MDT (Multi Disciplinary Team) working TIA (Trans Ischaemic Attacks) pathway ESD (Early Supported Discharge) pathway Project Objectives: • Develop integrated stroke services across Barnsley to establish improved patient flow and pathways • Reduce potential duplication across the borough, in particular TIA clinics and provide a one stop shop for patients. • Establish integrated MDT working across both organisations to reduce the impact of pathway handovers on patient care and improve system wide patient flow. • Develop a stroke specific ESD service which will support improved patients flow from the new hyper acute stroke unit (HASUs) and enable patients to reach their rehabilitation potential closer to home as/when appropriate in their recovery journey	• A communications was issued to staff in February, updating on progress in this project, following a steering group meeting held on 9th February 2019 • New model developments are to be presented to the Member's Council in May • Senior/Executive level stocktake meeting took place on 21st January 2019 and a senior/executive level meeting re the stroke pathway costings meeting was held 27th February 2019. • Work commenced with corporate communications (all organisations) to convey positive outcomes of integrated pathway • Continued involvement from voluntary sector (Stroke Association) in steering group and other developments beyond the remit of this project e.g. Stroke Café • Barnsley Metropolitan Borough Council social care department was invited to future steering group meetings <u>Single TIA pathway (TIA):</u> • Ongoing monitoring and review of new process via task and action group (TAG). • Follow up clinics have commenced at Cudworth, staffed by SWYPFT clinicians <u>Stroke early support discharge (ESD):</u> • Financial projection work was shared at the stroke pathway costings meeting on 27th February 2019. • Staffing model shared at the stroke pathway costings meeting on the 27th February 2019. • Outcome of financial discussions at senior/executive level meeting held 27.2.19 required further detailed break-down of proposed costs to enable a richer understanding of the financial modelling and to be presented back on the 15th March <u>Multidisciplinary teams (MDT):</u> • SWYPFT and BHNFT colleagues continue to meet to discuss patient flow. • Proposal for project support to develop integrated dashboard reporting system to share real time information to support MDT working and decision making • Continue to seek resolution for interoperability between clinical systems	Progress Against Plan	
		Initial areas of risk include: • Finances/contracting - in particular if there are issues with the cost of the remodelled ESD pathway - currently undertaking work on this. • Recruitment and retention - recruitment could be a challenge through 2019 if additional staffing is required to establish the new pathway. Also retaining current staff in the new model is a growing challenge. • Contracting arrangements • Hyper-acute stroke unit (HASU) timeline not on track • Demand for radiology/ availability of diagnostic testing within required timescale • Social care not yet fully included in scope of stroke developments • Requirement for shared IT systems • Viability of six acute beds	Management of Risk	
		High level milestones: ESD - financial projections in place (Dec / Jan) ESD - senior meeting to be organised for January 2019 ESD - service model agreement - February 2019 ESD costing meeting February 2019 ESD further modelling breakdown - 15 March 2019 ESD - implementation process - March onwards2019 New model presented to members council - May 2019		

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: • Neurological rehabilitation Barnsley CCG have reduced the number of beds they commission for neuro rehabilitation unit (NRU) from 12 to 8. NRU has always had some out of area bed usage but financially this is insufficient to offset the loss of commissioned income. We want to raise awareness of the unit across the Trust and the wider system.	This priority reports bi-monthly on the IPR. This is the last update competed in February 2019: • The project team continues working against a plan to promote and market capacity in NeuroRehabilitation unit (NRU) beds in Barnsley that are available due to de-commissioning. Progress is in line with this plan and is nearing completion. • The project team consists of representatives of the service, supported by members of the integrated change team, business development and our communications and marketing team. • A publicity leaflet about the unit, its service offer, facilities, outcomes and costs has been designed with 1000 copies printed and distributed to identified contacts within Clinical Commissioning Groups (CCGs)/General Practitioner (GPs) and hospitals across the region in early January. Positive feedback has been received with regard the booklets. • Pull-up banners to promote the service at conferences and clinical events are available • The Trust website has been updated to showcase the NRU unit in line with the new marketing booklet • An initial planning meeting has taken place with regards to the NRU open day which is planned for Tuesday 21st May; this event is to market the available beds and is targeted at commissioners and those who may potentially refer to the unit including the private sector. A further event will be held on Thursday 23rd May 2019 for patients, families and carers. Both events are scheduled to take place during 'Action for Brain Injury 'Week''. • NRU colleagues have drafted briefs of what it's like to work on the unit within their disciplines; these will be incorporated into the presentation material for the open day. • Current position is the NRU is operating with a sizeable deficit.	Progress Against Plan	
		Financial risk the service does not breakeven.	Management of Risk	
		Implementation Plan in place		
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: • Autism and ADHD	• Early discussions are taking place on developing a formal plan to take this priority forward. • This plan will include lessons learned from the current West Yorkshire and Harrogate Health and Care Partnership (WY&HHCP) priority for improving autism and attention deficit hyperactivity disorder (ADHD).	Progress Against Plan	
		No known risks at this time.	Management of Risk	
		Implementation Plan not yet available		
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: • Forensics: work with NHS and private sector partners in the region to develop and deliver a co-ordinated approach to forensic care.	New business activity within this priority is covered by the monthly bids and tenders report to SWYPFT extended management team (EMT) and is therefore not updated specifically in this priority section of the integrated performance report (IPR).	Progress Against Plan	
		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.	Management of Risk	

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: • Community Forensic CAMHS	Following implementation of this project and subsequent handover to business as usual (BAU) formally in December 2018 this priority now reports monthly. Activities completed for the reporting period of February 2019 include: • Paula Phillips will now oversee the Yorkshire and Humber (Y&H) regional forensic (FCAMHS) service following the move of the previous manager to the secure estatework. • Referrals continue into the service at a positive rate. Referrals declined over Christmas and new year, as anticipated, however are slowly increasing to normal levels. • Band 6 mental health practitioner is now in post, commencing 25 February 2019. • Y&H team representatives have met with East Midlands FCAMHS to discuss the Bassetlaw area and cases along the border of the two regions – East Midlands are really keen to work closely with us and we have agreed to meet regularly for peer support / shared training events etc. • The team attended a PREVENT event, put on by North West FCAMHS in January – this was a very informative day • NHS England have requested an annual review now that the service has been running for a year. This will take place end March/early April 2019. A full audit of the first year of the service will be compiled in preparation for this meeting. • The next national clinical network meeting will be held on 22 March 2019 in Reading and Yorkshire and Humber will be represented at this event.	Progress Against Plan	
		• There are currently no high level risks identified in this project. • Risk sharing agreements are developed for the partnership	Management of Risk	
				
West Yorkshire Projects: Forensic Community Mental Health	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&HHCP) to deliver shared objectives with our partners in the area of: • Forensic community mental health	In February 2018, NHSE approached SWYPFT regarding an opportunity to be one of three Wave 1 trial sites for a specialist community forensic team. A bid was duly prepared for this opportunity and submitted. We were informed that our bid was not successful and that SWYPFT was 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.	Progress Against Plan	N/A
		Not applicable	Management of Risk	N/A
		Not applicable		

West Yorkshire Projects: Forensic Community LD	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&HHCP) to deliver shared objectives with our partners in the area of: • Forensic community LD	• SWYPFT submitted a proposal to NHSE for provision of a community forensic learning disability service to support individuals with a learning disability (LD) 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. • SWYPFT were asked to provide a proposal for provision of a community forensic learning disability service to the West Yorkshire and Harrogate Health & Care Partnership (WY&HHCP) which was submitted to NHSE in September 2017. • 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&HHCP, building on our original bid of September 2017. • NHSE have invited bids for £50k initial implementation funding for this service, which SWYPFT have submitted in March 2018. • SWYPFT are awaiting confirmation of funding	Progress Against Plan	
		No known risks identified at this time.	Management of Risk	
		An implementation plan will be developed once a successful bid is approved		
West Yorkshire Projects: Improving Autism and ADHD	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&HHCP) to deliver shared objectives with our partners in the areas of: • Improving autism and attention-deficit hyperactivity disorder (ADHD)	There are separate workstreams under the WY&H HCP MH programme board for both adults and children's adults autistic spectrum condition (ASD)/attention-deficit/hyperactivity disorder (ADHD). • Sean Rayner is the senior responsible officer (SRO) for both projects under the WY&H HCP MH Programme Board. • The greater focus currently is on the Childrens ASC/ADHD project which has the key objective to reduce waiting times for ASC/ADHD assessment/diagnosis by focusing on sharing evidence based improvements and learning and where possible embedding consistency of approach/standardisation of practice. There will be an obvious link to the adult project which has the same key objectives as the childrens. <u>Childrens ASC ADHD:</u> • Waiting times for assessment and diagnosis for children and young people continue to be an issue across West Yorkshire and there is clearly enthusiasm and commitment from providers to work collectively to share the challenges faced in this priority and reduce waiting numbers in parallel to introducing new pathways for assessment and diagnosis. • Work has commenced to understand the evidence base around new initiatives for children's ASC ADHD and a report is being prepared on what would be needed to address the issues identified. Key actions going forward include: • Align ambition of project to the NHS Long Term Plan • Plan workshop for standardisation of pathway for assessment <u>Adults ASC ADHD:</u> • Pertinent work currently is that waiting list challenges in Bradford are being reviewed collectively by the three providers and support to the Bradford service is on offer from both SWYPFT and Leeds and York Partnership NHS Foundation Trust (LYPT). • Meeting between the three providers to look at regional response to waiting times in Bradford is ongoing	Progress Against Plan	
		<u>Childrens ASC ADHD high level risk:</u> • Current active risk exists around transition points (different services support assessment at different ages and interdependences with adults). Workstreams to be aligned and come together in an ASC/ADHD steering group to be established. <u>Adults ASC ADHD: high level risk:</u> • There is no nationally recommended pathway or specification for adult autism and ADHD - the remedy is to determine whether WY&H HCP set their own specification in light of this.	Management of Risk	
		Development of an implementation plan of key milestones is yet to be finalised		

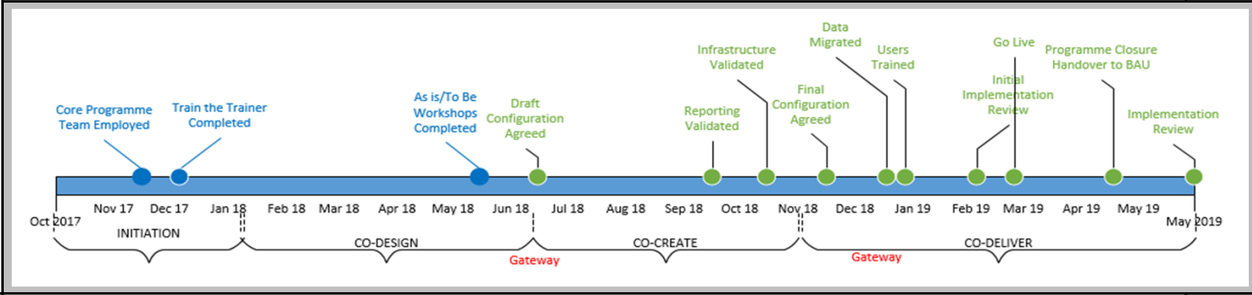
West Yorkshire Projects: Learning Disability ODN	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&HHCP) to deliver shared objectives with our partners in the area of: • Learning Disability Organisational Development Network (ODN)	SWYPFT are the lead through the Operational Delivery 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 period includes: • The project is on track against plan - hence is green RAG. • Expressions of interest have been invited to increase membership of the community infrastructure work-streams and opportunities to co-lead the three groups to support existing leads. • Task and finish groups have now been established and all leads, apart from the positive risk taking group that will be reallocated to a lead, appointed. • A workshop conducted on 25th January 2019 to launch the main work-stream (community infrastructure) with an objective to commence scoping of key areas of focus and prioritisation took place. A follow-up service user/carer engagement will be undertaken during February and March utilising questions that Matthews Hub are supporting the creation of that will be used to engage with service users and carers across the region. Feedback from this engagement will support the structure of the focus priorities of the work stream. • Quarterly North region ODN meetings are in place with North East and North West ODNs to facilitate information sharing and explore opportunities for efficiency (reduce duplication) and potential for completing some pieces of work at greater scale. A recent meeting has been undertaken to plan a joint forensic event and the purpose of the ODN involvement is around identifying best practice across a wider patch and articulating that as well as developing a model of how we support people with complex needs and how we build that local resilience. • The service user/carer engagement group has been renamed the co-production group and membership of this group has increased to cover the Yorkshire and Humber region more extensively. This group is now active and visible within the ODN and will lead on engagement work to support the community infrastructure work-streams. • Rehab Utilisation work is now drafted and a presentation of outcomes was delivered to the ODN steering group on 21st February. Following feedback from the steering group, the presentation has been completed and will be presented in March. • Timescale planning for activities in Year 2 has commenced by project team and proposals will be in place soon.	Progress Against Plan	
		No specific risks are identified at this point although a potential area to be mindful of is the level of engagement and commitment to ODN related work which is required of all members - ODN, wider network, work-stream leads and work-stream group members – for the ODN to be successful and productive. Whilst not having a clinical lead in post yet, the ODN have mitigated for this without affecting the programme progressing.	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	This priority reports bi-monthly on the IPR. This is the last update competed in February 2019: • 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 SWYPFT's contribution to the new care model continues.	Progress Against Plan	
		Risk management has yet to commence for this priority as part of the planning phase for this new model of care.	Management of Risk	
		Implementation planning will be an integral part of the planning phase of this priority		

West Yorkshire Projects: Eating Disorders	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&HHCP) to deliver shared objectives with our partners contributing to the following areas of work across WY&HHCP: • Eating Disorders	• 'New Care Models' for eating disorders (ED) are being established across the country as part of mental health five year forward view. • The West Yorkshire eating disorders community service is one of eleven national early-wave pilot sites to test new approaches. • A proposal to build upon the foundation of the established community services in Leeds (and including the service in Huddersfield) was accepted and funded by NHS England with the aim to replicate the community treatment and outreach approach that was working well in Leeds in each of the delivery areas making up the West Yorkshire & Harrogate STP. [Note: there was previously no community ED provision in Calderdale and Wakefield] • The project had central co-ordination, project management and leadership from Leeds and York Partnership NHS Foundation Trust with SWYPFT with supporting. • The financial case is based on minimising the requirement for out of area placements and avoiding extended lengths of stay with the aim of reducing the cost of out of area placements by £951k. • The existing community eating disorders services (Leeds and Kirklees) have been supplement by an additional investment of £810k to form the new community service. • The new service went live on the 1st April 2018.	Progress Against Plan	
		Any implementation risks are with Leeds and do not transfer to SWYPFT; there is a financial risk to the Trust which is being monitored. There are however a number of concerns raised about: • Potential gaps between the new service and the previous service commissioned for Huddersfield. It's too early to be certain, but this needs monitoring in conjunction with the CCG. • One GP practice has refused to monitor the physical health of a patient that they have argued would have been hospitalised prior to the introduction of the new model. Leeds and the Greater Huddersfield CCG are responding to this and SWYPFT medical staff have provided physical health monitoring in the interim. • Communications has been a weakness and may have contributed to some misunderstandings and dissatisfaction in both primary and secondary care.	Management of Risk	
		Implementation plan is with Leeds		
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.	Out of Area (OOA) • Bed pressures remain in the system and out of areas placements continue, though the levels fluctuate. Recent placements continue to be from the Calderdale/Kirklees locality. • Criteria led discharge has now gone live across all inpatient units. Next steps will be to ensure that it is embedded and used as appropriate across the trust to ensure that it delivers the expected benefits. • Following conclusion of activity with the external consultants, SSG Health, where eight workstreams were identified, work has taken place to pull all activity into a priority plan for the Trust and align with other priorities that will support the reduction in bed use. Work is now ongoing on identifying priority strands and resources required to support the plan. • A new partnership governance structure is being established to support the change programme and will be established from April 2019.	Progress Against Plan	
		Current high risk is that we continue send people out of area, which has an adverse impact on their care. This risk remains off project trajectory with ongoing pressures across the system.	Management of Risk	
				

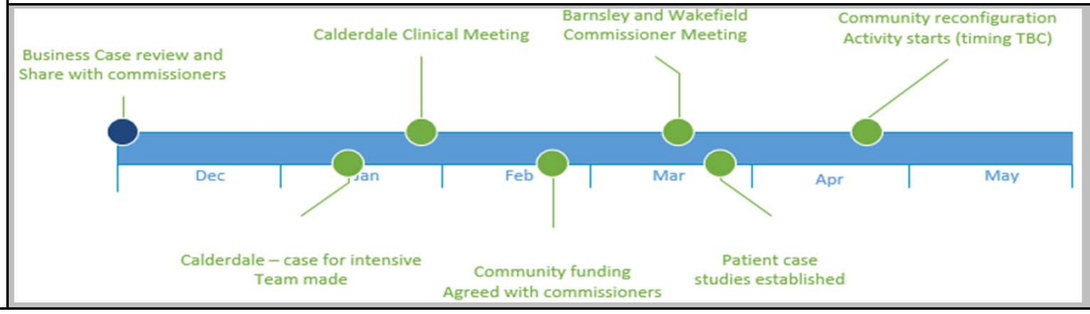
Workforce Productivity	Develop and deliver clinical support worker strategy. Develop new roles to improve rostering, reduce agency spend and enhance skill mix. Develop and deliver a retention strategy.	This priority reports bi-monthly on the IPR. This is the last update competed in February 2019: • Recruitment and Retention Steering Group in place – Last met on the 13th December. Professions and deputy director represented steering group with staff side representation. This group meets every month. An action plan is in place with key stakeholders identified and work is work ongoing on several themes which include: - Development of career pathways in professions following December meeting. Nursing, AHP and Psychology leads developing career structure pathways. Plan to develop more visual progress opportunity for staff both within intranet and at job application, job advert/NHS Jobs. - Review of recruitment process ongoing including LEAN processes of end to end recruitment. - Feedback sessions conducted in all identified areas of high turnover/hot spots (agreed areas within Strategy). Key themes paper completed. CAMHs will be running a summit in early 2019 to address some of the issues and concerns raised as part of the wellbeing and focus groups. - Increased internal marketing of available roles across SWYPFT. 21st edition published last week in Headlines (February 2019). - Trust now fully utilising NHS Yorkshire jobs Facebook feed. All new posts entered on NHS Jobs are now uploaded to Facebook feed. - Development started for bespoke webpage for apprenticeships which will include 'day in the life of…' information about roles available, benefits for working with the Trust. - Trust on boarding system plans being drawn up. Basis media have been approached to potentially deliver the Trusts own bespoke on boarding process microsite subject to procurement and tendering etc. Basis media reps attending next recruitment and retention steering group meeting. Basis Media already deliver on-boarding to several local trusts (Leeds Teaching, Leeds Community) - Staff ending employment procedure re-designed and in place with greater focus on feedback. Pro-active process now rather than re-active aimed at intervention where we are offering staff that are leaving alternative employment/opportunity to remain in the Trust etc. New process has already improved feedback levels by 600% since this time last year. Feedback response currently at 24% this year from 5% in previous years. Managers now getting feedback from forms which need attention. Next stage involves development of Trust wide report to capture ALL staff feedback in order to further improve response to concerns/development. This report currently being developed – circulation to service leads and senior management team/Board members. Implementation of internal transfer capture feedback to follow as this is currently not being done. - Capture of exit interview feedback from internal movement of staff being rolled out from next month. Currently only capturing feedback from staff who leave the Trust altogether. - New retirement interview procedure in place to focus on furthering employment within the Trust. Greater focus on opportunity to work flexibly in the Trust post retirement etc. - Barnsley allied health professionals (AHP) services have set up a number of career open days in the services for year nine students from all Barnsley academies. First one completed this week. - SWYPFT operational management group (OMG) has allocated £10k to develop our brand identity and corporate marketing initially. Part of this will be earmarked for communications to organise a refresh of our brand photography to reflect current staff in areas across the Trust and update our ability to add content to social media posts for vacancy recruitment etc. - Part of the £10k funding will go to organising SWYPFT representation at the mental health (MH) nursing recruitment fair in Edinburgh in May 2019. Business case currently being written by nursing professions. - Agreement in principal through OMG to support relocation costs incurred by nurses out of area who are successful in securing employment with the Trust. - Brexit retention. Work completed to identify staff in Trust liable for settlement status. Currently 24 have come forward. Human Resources (HR) working with those to ensure no impact on eligibility to work. Settlement status fees now being covered by Government although the Trust had already committed to covering this on employees behalf. No issues envisaged with retention of these staff. - Recruitment process has been evaluated. Main areas of blockage and delay currently being seen in operational areas. Currently averaging 134 days to recruit across all staff groups. Target set to achieve 100 day turnaround. This will be reviewed in 6 months. A number of interventions begun to improve timescales including: - Electronic vacancy recruitment form (VRF) - Automatic reminder emails weekly to operational managers and candidates to chase late information and speed up the process. - Automatic emails to operational managers to target problem areas.	Progress Against Plan	

		- We have evaluated the period of time it takes managers to submit recruitment documentation after a member of staff has given their notice to leave (This is the stage prior to 1st stage of recruitment in 9 stages). There is a significant variance so identifying an average is not a true reflection (different notice periods in bands, managers holding onto notifications). The average number of days from a sample taken is 32 days after notice is given to receiving paperwork in Recruitment. In reality all staff members have to give between 4 to 12 weeks' notice, therefore we would have an expectation to receive the recruitment paperwork within 5 working days of notice given. If managers adhere to this it will dramatically reduce the overall recruitment period (including initial notice). - '9 stages for recruitment' detailed analysis scoped and work to address blockages in recruitment process underway. • Development of trainee nursing associates (TNA) and nursing apprenticeships ongoing. Workforce planning workshops completed during January/February 2019. Workforce workshops focusing on identification of numbers for development roles in teams for TNA's nurse associates, advanced clinical practitioner (ACP) roles, physician associates and other potential developmental roles amongst other areas of workforce risk and training needs analysis, leadership development. Workforce plans by BDU to be signed off in readiness for April 2019. • Trusts clinical support workforce plan to be updated for 2019-2021. Initial 2016-18 plan now concluded. This is linked to the development of the roles above along with the continued delivery of the apprentice healthcare support worker (HCSW) apprenticeship cohorts. Current cohort delivery matched to projected turnover of HCSW roles. To be published by April 2019 following BDU Workforce Plans being signed off and complete. • Collaborative workforce planning being set up across both SY&B and WY&HHCP being led by SWYPFT workforce planning and learning and development (L&D) leads – large scale collaborative workforce planning in early stages aimed at improving our collective workforce needs into Universities and further education. Goal to be lead in production of West Yorkshire strategic workforce plans. Work ongoing. • Nursing professional leads and workforce/L&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 2, 3 to 4 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.		
		• Despite ongoing work around nursing strategy and recruitment/retention, we are still seeing sustained nurse vacancies across the whole Trust (currently 53wte within MH inpatient areas only). To achieve 100% nursing establishment approx. 180 additional whole-time equivalent (WTE) would be required over the next 12 months. Nurse vacancies are not reducing but not increasing either in general terms. Mitigating plans are being planned against which include greater emphasis on improving our nurse bank and increase/over recruitment into clinical support roles, alternative roles to recruitment to fill current workforce gaps in nursing including pharmacy technicians, AHP roles and AHP support roles. • Agency spend across Trust in excess of cap (projected £879k) above cap of £5.5m. Work within annual planning assumptions on workforce being conducted to identify ward establishment review requirements for skill mix of staff to identify reduction in agency spend.	Management of Risk	
		Milestones from the implementation plan for this priority: • Initial recruitment/retention steering group set up July • Analysis and focus groups in high turnover areas – July • Wellbeing survey deep dive done - August • West Yorkshire collaborative activity to commence - September • Professions workforce planning workshop underway – Jan/Feb 2019 • Workforce planning cycle starts - February 2019 following workforce workshops conclusion • Strategic workforce plan update and clinical workforce support strategy refresh – Two-year plan to be developed from April 2019.		

Clinical record system	Plan and deliver a new clinical record system which supports high quality care	Inpatient services • Inpatient 'Go Live' occurred on Monday 25th February 2019. Considerable work was completed in preparation for this go live date and by the start of the 25th all core data for inpatients (admission, discharge, referral, MHA, transfers, leave and (appointments (made by inpatients) up to 14 March 2019) were in SystmOne. • All go/no go protocols had been followed prior to go live • For inpatients the target for training of 85% was hit. This was a critical target for go live • Cutover plan for inpatients and community. • Option appraisal for training continues • SystmOne software client rolled out and staff emailed to test they can access the icon • Plan for onsite gateway in place per site. • Good progress on community start-up ahead of plan • Command centre structure/resources and role cards in place ready for go live • Cutover commenced on plan • Configuration signed off by CSDG, PSG and EMT, including the five key areas of documentation. • Super user 'Get Set' pre-go live sessions • Coordinator induction • Technical go live completed on 22 February 2019 • Business go live readiness confirmed and in place for 25 February 2019 for inpatient areas • Work continues on community training and business readiness for go live on 5 March 2019 Community (mental health) • Community (mental health) go live occurred on Tuesday 5th March 2019. • Again considerable and extensive preparations work was conducted on the run up to go live and the checklist assessment protocols were adhered to prior to go live. These included: training completeness; system configuration readiness; go live support readiness; community go live readiness assessment. The target of 85% of all staff trained was achieved • 100% of the referrals/discharges and transfers were transferred from RiO to SystmOne. A total of 18,000+ data items were transferred from RIO to SystmOne. • Inpatient data entry catch up continuing • Community start up activities completed as above • Training continues for community services • Go live support continues for inpatients areas • Lessons learned undertaken for first go live	Progress Against Plan	

		Management of risk is Amber due to the training risk. Risks identified are: 1285 DATA MIGRATION: All planned testing activities are completed. The first phase Delta Testing complete with no go live critical new issues raised. Second and final phase due w/c 14/1/19. However, there are still 50/575 raised issues outstanding. These are sat with TPP and are being monitored daily by the team. Of these three are identified as go live critical. 1223 PROGRAMME: Inadequate clinical engagement through all the key workstreams results in a risk that the system is configured in a clinically unsafe way 1224 TRAINING: Staff are not competent and unable to fulfil their job role at Go live. Inadequate number of staff attending the training and demonstrating competency will result in the organisation not getting the best use out of the clinical records system. 1277 REPORTING: Contract negotiations taking place on or near go live which may result in change requirement to reporting that cannot be met. 1344 RESOURCES: the team is made up from a range of temporary resources. Progress may be slower as staff leave and replacements are recruited. Costs may go up as more skilled and experienced staff is required nearer to go live. 1348 PROGRAMME RISK: ROLES AND RESPONSIBILITIES: Risk of role confusion after transfer to SystmOne with responsibilities being unclear between clinical and administrative staff.	Management of Risk	
				
	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.	This priority reports bi-monthly on the IPR. This is the last update competed in February 2019: • This project is now moving forward on the basis of seeking to make improvements to community services in advance of any proposed in patient changes. • Further conversations are now being planned in each locality to shape the local programme. Patient stories will be developed to show how the future community systems will lead to improvements and how those improvements would be delivered in each locality. • It is envisaged that local plans will be established before local community improvements are taken forward through 2019. These changes will take place as part of local partnership governance programmes as appropriate.	Progress Against Plan	

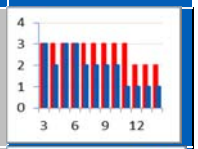
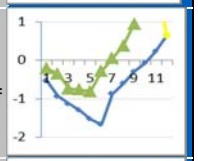
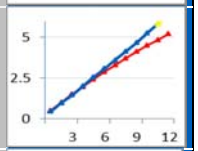
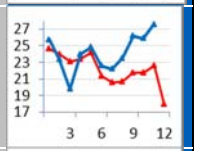
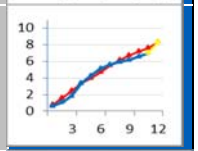
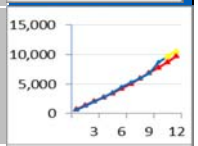
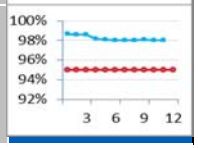
Older Peoples Services Transformation	• We will need to receive wide external support from partners to take the inpatient options being considered through an external consultation process. • The ongoing risk of slippage in the project timescale due to limited capacity across the project and across the BDUs remains, the project will need to ensure it is appropriately resourced.	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	1	2	The I & E margin metric remains at 1 in month. This is ahead of plan. All individual ratings are currently at level 1 except agency which is 2.	
2	Normalised Surplus (inc STF)	(£0.3m)	(£2m)	February 2019 finance performance excluding Provider Sustainability Fund (PSF) is behind plan at a deficit of £0.2m. Including PSF this is a surplus of £0.1m. The year end forecast is in line with plan with a surplus of £0.6m including PSF and a deficit of £2.0m excluding PSF.	
3	Agency Cap	£5.8m	£6.4m	Agency expenditure was £0.5m in February. Year-to-date costs of £5.8m are £1.0m (20%) above cap. Current year-end projection is to exceed our agency cap by £1.2m (23%).	
4	Cash	£27.6m	£22.6m	Cash remains ahead of plan primarily due to one off benefits such as asset sales, additional commissioner income and low levels of outstanding debtors.	
5	Capital	£7m	£8.3m	Expenditure is £0.6m (7%) behind plan year to date. The full capital programme is forecast to be spent by the year-end.	
6	Delivery of CIP	£9.7m	£10.6m	The upside cost reduction associated to the asset revaluation exercise was recognised in January 2019. This has helped to ensure that the Trust CIP target for 2018/19 has been exceeded to support the overall I & E position.	
7	Better Payment	98%		This performance is based upon a combined NHS / Non NHS value and remains ahead of plan.	

Red	Variance from plan greater than 15%
Amber	Variance from plan ranging from 5% to 15%
Green	In line, or greater than plan

Plan
Actual
Forecast

Contracting - Trust Board

Contracting Issues - General

The Trust is currently in the stage of finalising contract offers with main NHS commissioners.

CQUIN

The national CQUIN schemes for 19/20 contracts have been published and work continues with local commissioners to agree which schemes will be applied to SWYPFT contracts.

Contracting Issues - Barnsley

The Main and Alliance contracts for 2019/20 have been agreed with Barnsley CCG. The investment level for mental health in line with the mental health investment standard priorities has been approved by the CCG Governing Body. Further work will take place to finalise and agree the plan by the end of April across the range of priorities including all age liaison psychiatry, expansion of crisis resolution services for children and young people, diagnosis and treatment of ADHD in children and young people and further development of improving access to psychological therapies for long terms conditions in adults and young people. Further review will take place during 2019/20 in relation to neighbourhood nursing , musculoskeletal and dementia services. Additional investment has been provided to address pressures in tier 3 weight management services, children's therapies and continence services.

Contracting Issues - Calderdale

The contract offer is being finalised. The 2019/20 contract will see growth in mental health services in line with the Mental Health Investment Standard including investment for intensive home based treatment, early intervention in psychosis, mainstreaming of investment for perinatal mental health services and children's and young people's mental health services. Further work will take place in year in relation to the transformation of mental health services for older people to support provision of care closer to home through community based provision.

Contracting Issues - Kirklees

The contract offer is being finalised. The contract will continue to see significant growth in mental health services in line with the Mental Health Investment Standard including investment for improving access to psychological therapies for adults covering both core and long term conditions services, early intervention in psychosis and core mental health liaison. This also includes the mainstreaming of investment for perinatal mental health services. The CCGs are also investing in the transformation of mental health services for older people to support provision of care closer to home through community based provision.

Contracting Issues - Wakefield

The contract offer is being finalised. The contract, in line with the local Mental Health Alliance agreed priorities, will see growth in mental health services in line with the Mental Health Investment Standard including the mainstreaming of investment for perinatal mental health services, development of all age liaison psychiatry and the expansion of crisis services and support for addressing waiting lists for children and young people with a mental health need. Additional priority areas for investment identified are the expansion of adult crisis and intensive home based treatment services including a safe space to reduce the need for treatment out of area, the personality disorder and chaotic lifestyles pathway and suicide prevention. The Mental Health Alliance aims to review and agree the investment plans across these areas by the end of April 2019.

Contracting Issues - Forensics

The 2019/20 contract offer with NHS England for secure services is being finalised. The key priority work stream for 2019/20 remains the review and reconfiguration of the medium and low secure service beds as part of the work with NHS England in addressing future bed requirements as part of the wider regional and West Yorkshire integrated care system work.

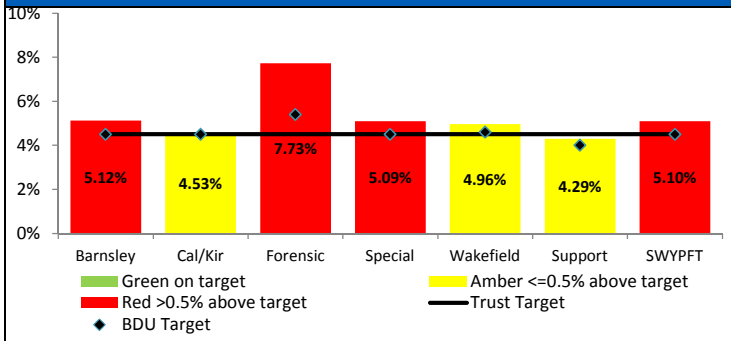
Contracting Issues - Other

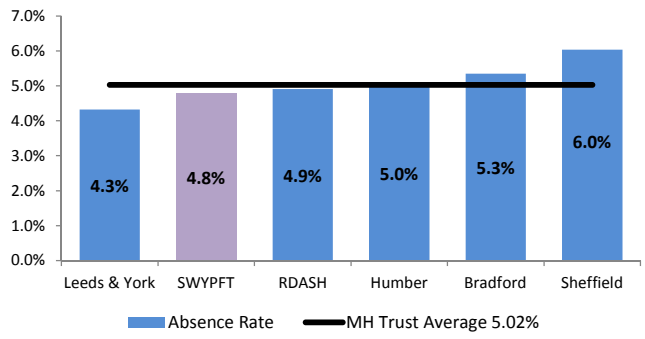
The key area of focus is the mobilisation of the provision of liaison and diversion services across South Yorkshire covering Barnsley, Rotherham, Doncaster and Sheffield for commencement from 1 April 2019. The NHS England contract for provision of childhood vaccinations and immunisations has been agreed.

Workforce

Human Resources Performance Dashboard - February 2019

Sickness Absence





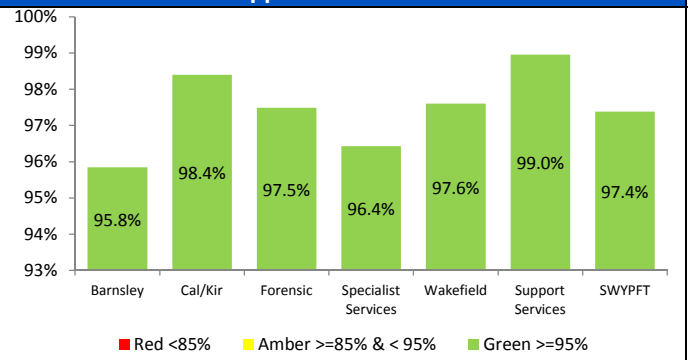
Current Absence Position and Change from Previous Month - Feb 2019

	Barn	Cal/Kir	Fore	Spec	Wake	Supp	SWYPFT
Rate	5.50%	4.90%	6.50%	4.70%	4.90%	4.60%	5.20%
Change	↓	↓	↓	↓	↓	↓	↓

The Trust YTD absence levels in February 2019 (chart above) were above the target at 5.1%.
The YTD cost of sickness absence is £5,542,680. If the Trust had met its target this would have been £4,890,600, saving £652,080.

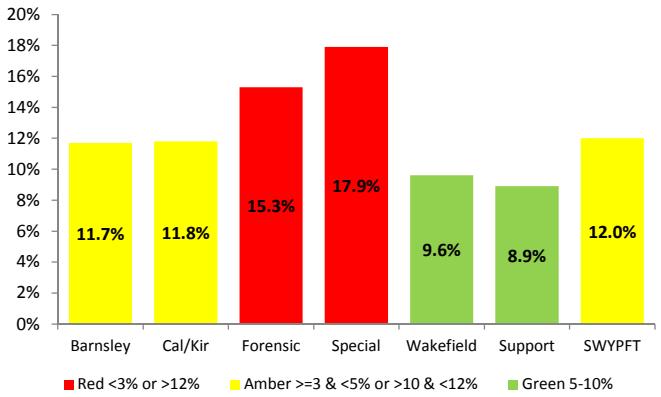
The above chart shows the YTD absence levels in MH/LD Trusts in our region for the period April 2018 to October 2018.
During this time the Trust's absence rate was 4.78% which is below the regional average of 5.02%.

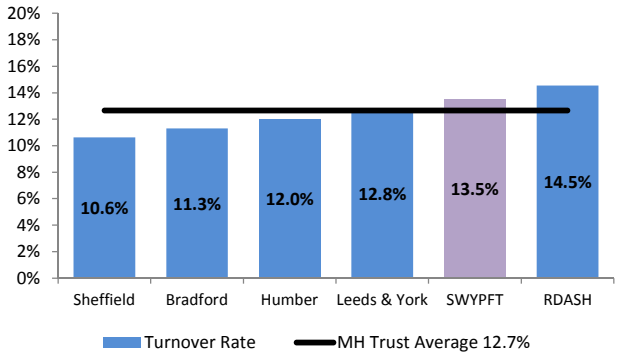
Appraisals - All Staff



The above chart shows the appraisal rates for the Trust to the end of February 2019.
From September 2018 all staff have been included in the figures.
All areas have improved, month on month, and are now well above the target of 95%.

Turnover and Stability Rate Benchmark

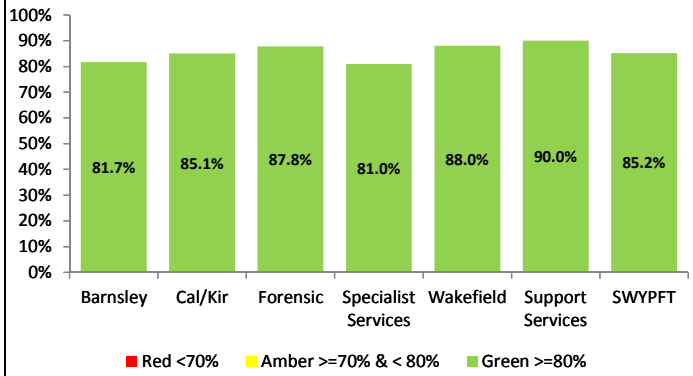




This chart shows the YTD turnover levels up to the end of February 2019.
*The turnover data excludes recently TUPE'd services

This chart shows turnover rates in MH Trusts in the region for the 12 months ending in November 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 Lecture Training



The chart shows the 12 month rolling year figure for fire lectures to the end of February 2019. The Trust continues to achieve the 80% target across all BDUs.

Workforce - Performance Wall

Trust Performance Wall

Month	Objective	CQC Domain	Owner	Threshold	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Sickness (YTD)	Improving Resources	Well Led	AD	<=4.5%	5.3%	4.4%	4.4%	4.4%	4.5%	4.5%	4.6%	4.8%	4.9%	5.0%	5.1%	5.1%
Sickness (Monthly)	Improving Resources	Well Led	AD	<=4.4%	4.9%	4.4%	4.4%	4.4%	4.7%	4.8%	5.1%	5.7%	5.8%	5.8%	6.0%	5.2%
Appraisals (Band 6 and above) 1	Improving Resources	Well Led	AD	>=95%	97.8%	7.3%	26.1%	72.2%	87.7%	92.8%	95.0%	95.8%	98.1%	98.2%	99.1%	99.1%
Appraisals (Band 5 and below)	Improving Resources	Well Led	AD	>=95%	96.0%	0.8%	2.8%	9.4%	21.6%	48.1%	78.6%	87.2%	94.3%	95.0%	96.5%	97.5%
Aggression Management	Improving Care	Well Led	AD	>=80%	79.3%	79.3%	81.7%	81.6%	82.9%	83.0%	82.2%	81.3%	81.4%	82.5%	83.1%	82.9%
Cardiopulmonary Resuscitation	Improving Care	Well Led	AD	>=80% by 31/3/17	81.4%	82.3%	84.0%	84.5%	84.8%	83.3%	81.6%	80.1%	80.2%	81.2%	82.1%	81.4%
Clinical Risk	Improving Care	Well Led	AD	>=80% by 31/3/17	85.1%	85.6%	85.5%	85.8%	85.9%	86.0%	85.8%	85.8%	86.1%	87.4%	87.8%	88.7%
Equality and Diversity	Improving Health	Well Led	AD	>=80%	88.5%	89.0%	89.8%	89.7%	89.8%	90.1%	89.8%	90.2%	90.7%	91.3%	90.9%	91.0%
Fire Safety	Improving Care	Well Led	AD	>=80%	85.4%	85.3%	86.8%	86.6%	86.6%	87.4%	86.3%	86.8%	86.7%	88.1%	85.2%	84.9%
Food Safety	Improving Care	Well Led	AD	>=80%	77.2%	76.2%	77.2%	77.5%	80.8%	81.9%	81.7%	81.9%	84.1%	82.2%	82.3%	83.7%
Infection Control and Hand Hygiene	Improving Care	Well Led	AD	>=80%	86.8%	87.0%	87.3%	87.3%	87.8%	88.5%	89.1%	89.3%	89.1%	89.7%	89.5%	90.4%
Information Governance	Improving Care	Well Led	AD	>=95%	96.5%	92.4%	92.7%	92.1%	91.9%	92.2%	92.1%	92.3%	90.2%	90.8%	96.1%	97.6%
Moving and Handling	Improving Resources	Well Led	AD	>=80%	85.5%	85.2%	85.9%	85.6%	85.7%	86.1%	87.2%	87.3%	88.6%	89.0%	87.8%	88.9%
Mental Capacity Act/DOLS	Improving Care	Well Led	AD	>=80% by 31/3/17	90.7%	91.1%	91.4%	91.3%	92.2%	91.7%	90.9%	91.4%	92.6%	92.3%	92.7%	92.5%
Mental Health Act	Improving Care	Well Led	AD	>=80% by 31/3/17	84.7%	85.7%	86.8%	86.5%	88.1%	87.3%	85.9%	85.8%	87.7%	86.7%	86.7%	86.4%
No of staff receiving supervision within policy guidance	Quality & Experience	Well Led		>=80%	87.6%	82.6%			83.6%			81.5%			Due April 19	
Safeguarding Adults	Improving Care	Well Led	AD	>=80%	89.9%	90.0%	91.0%	91.3%	91.7%	91.7%	91.5%	92.1%	93.0%	93.7%	93.2%	93.4%
Safeguarding Children	Improving Care	Well Led	AD	>=80%	87.8%	88.4%	88.6%	89.4%	90.1%	90.4%	90.0%	90.4%	89.4%	91.4%	91.3%	90.9%
Sainsbury's clinical risk assessment tool	Improving Care	Well Led	AD	>=80%	93.4%	94.4%	95.1%	94.9%	95.8%	95.2%	94.6%	94.6%	94.1%	94.5%	93.9%	94.5%
Bank Cost	Improving Resources	Well Led	AD	-	£907k	£557k	£603k	£768k	£646k	£730k	£845k	£615k	£674k	£678k	£752k	£1048k
Agency Cost	Improving Resources	Effective	AD	-	£555k	£444k	£538k	£484k	£526k	£566k	£522k	£537k	£536k	£530k	£596k	£545k
Overtime Costs	Improving Resources	Effective	AD	-	£6k	£8k	£13k	£5k	£11k	£5k	£8k	£4k	£5k	£7k	£7k	£8k
Additional Hours Costs	Improving Resources	Effective	AD	-	£23k	£29k	£15k	£23k	£31k	£32k	£29k	£30k	£31k	£24k	£26k	£276k
Sickness Cost (Monthly)	Improving Resources	Effective	AD	-	£483k	£430k	£449k	£420k	£461k	£471k	£507k	£586k	£580k	£580k	£612k	£476k
Business Miles	Improving Resources	Effective	AD	-	230k	274k	264k	259k	291k	269k	279k	267k	299k	279k	286k	270k

1 - this does not include data for medical staffing.

Workforce - Performance Wall cont…

Mandatory Training
• The Trust is above 80% compliance for each of the 14 mandatory training programmes with 7 being above 90%

Appraisals
• The appraisal rates continues to be above the 95% target and at the end of February was 97.5%, which is slightly above the rate for the same period last year (96.7%)

Sickness Absence:
• The Sickness Rate in February of 5.1% is below the January's rate of 6.0% and we are projecting a further reduction in March based on previous trends. There was a downward trend for every BDU in February compared to the previous month
• Forensic BDU continues to have the highest sickness rate and targeted support is being discussed with the BDU management team.
• The Trust compared to other MH/LD Trust in Yorkshire has a below average sickness rate and is the second lowest of the 6 organisations.
• The projection is that we will be below last annual sickness rate at the end of March 2019.

Turnover:
• Turnover continues to be an area of focus and the Recruitment and Retention task group have developed an action which is monitored through the Workforce and Remuneration Committee

Publication Summary

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

NHS England

NHS operational planning and contracting guidance 2019/20
This full planning guidance replaces the preparatory guidance published in December 2018 and covers system planning, the financial settlement, full operational plan requirements, and the process and timescales around the submission of plans. It is being published along with five-year indicative clinical commissioning group (CCG) allocations.

Click here for link to guidance

NHS Employers

Employer guide to nursing associates
Nursing associate is a new regulated role that bridges the gap between health and care assistants and registered nurses. With the first cohort of qualified nursing associates set to join the registered workforce, this interactive guide for employers has been produced to provide advice and support for those exploring the potential of this new role within their organisations.

Click here for link to guide

Ministry of Justice

Revising the Mental Capacity Act 2005 Code of Practice: call for evidence
The Mental Capacity Act is designed to protect and empower people who may currently lack the mental capacity to make their own decisions about their care and treatment. Since the Act came into force in 2007, the Code of Practice has provided practical guidance regarding its implementation. This Call for Evidence will seek to establish the extent to which the current Code of Practice reflects changes in case law and lessons learned through practical use of the Code of Practice over the last 11 years. The closing date for comments is 7 March 2019.

Click here for link to consultation

Publication Summary

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

NHS Improvement provider bulletin: 27 February 2019:

- Cyber security third party patching evaluation 2019/20
- EU Exit data guidance
- Planning for a 'no deal' EU Exit — medicines supply update
- Result of the consultation on proposals for the 2019/20 national tariff
- Guide to the NHS electronic staff record (ESR) — ensure your allied health professions are counted
- Resources to reduce catheter-associated urinary tract infections
- Talent management programme for aspiring deputy directors of nursing
- Guidance published to help trusts identify recurrent cost improvement plan (CIP) opportunities
- An NHS workforce for the future

NHS Improvement provider bulletin: 6 March 2019:

- Share your views on proposals for possible changes to legislation
- Changes to the leadership structure of NHS England and NHS Improvement
- New NHS Assembly leaders announced
- New Chief People Officer to help build the NHS workforce of the future
- Clostridium difficile infection (CDI) objectives 2019/20
- Join our Transformational Change through System Leadership (TCSL) programme
- New national medical examiner announced
- Model Hospital masterclass: equality, diversity and inclusion
- Same day emergency care workshop
- Elective care 2019: improving the patient experience
- Updates from our partners

Data on written complaints in the NHS:

NHS Staff Survey 2018 results briefing - the latest NHS staff survey shows a decline in overall levels of wellbeing and an increase in the numbers of staff reporting discrimination.

South West Yorkshire Partnership NHS Foundation Trust

Finance Report

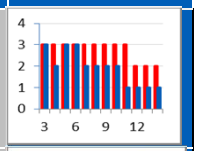
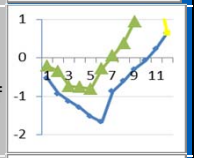
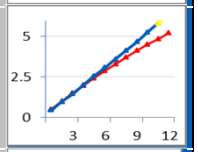
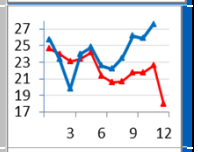
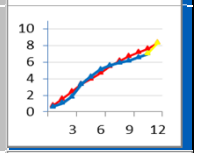
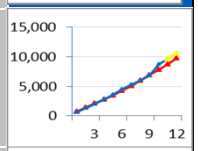
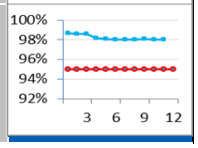
Appendix 1
Month 11
(2018 / 19)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

Contents

Executive Summary / Key Performance Indicators

	Performance Indicator	Year to date	Forecast	Narrative	Trend
1	NHS Improvement Finance Rating	1	2	The I & E margin metric remains at 1 in month. This is ahead of plan. All individual ratings are currently at level 1 except agency which is 2.	
2	Normalised Surplus (inc STF)	(£0.3m)	(£2m)	February 2019 finance performance excluding Provider Sustainability Fund (PSF) is behind plan at a deficit of £0.2m. Including PSF this is a surplus of £0.1m. The year end forecast is in line with plan with a surplus of £0.6m including PSF and a deficit of £2.0m excluding PSF.	
3	Agency Cap	£5.8m	£6.4m	Agency expenditure was £0.5m in February. Year-to-date costs of £5.8m are £1.0m (20%) above cap. Current year-end projection is to exceed our agency cap by £1.2m (23%).	
4	Cash	£27.6m	£22.6m	Cash remains ahead of plan primarily due to one off benefits such as asset sales, additional commissioner income and low levels of outstanding debtors.	
5	Capital	£7m	£8.3m	Expenditure is £0.6m (7%) behind plan year to date. The full capital programme is forecast to be spent by the year-end.	
6	Delivery of CIP	£9.7m	£10.6m	The upside cost reduction associated to the asset revaluation exercise was recognised in January 2019. This has helped to ensure that the Trust CIP target for 2018/19 has been exceeded to support the overall I & E position.	
7	Better Payment	98%		This performance is based upon a combined NHS / Non NHS value and remains ahead of plan.	

Red	Variance from plan greater than 15%
Amber	Variance from plan ranging from 5% to 15%
Green	In line, or greater than plan

Plan
Actual
Forecast

1.1 NHS Improvement Finance Rating

The Trust is regulated under the Single Oversight Framework and the financial metric is based on the Use of Resources calculation as outlined below. The Single Oversight Framework is designed to help NHS providers attain and maintain Care Quality Commission ratings of 'Good' or 'Outstanding'. The Framework doesn't give a performance assessment in its own right.

			Actual Performance		Plan - Month 11	
Area	Weight	Metric	Score	Risk Rating	Score	Risk Rating
Financial Sustainability	20%	Capital Service Capacity	3.0	1	2.4	2
	20%	Liquidity (Days)	23.9	1	20.1	1
Financial Efficiency	20%	I & E Margin	1.0%	1	0.1%	2
Financial Controls	20%	Distance from Financial Plan	0.9%	1	0.0%	1
	20%	Agency Spend	20.1%	2	0.0%	1
Weighted Average - Financial Sustainability Risk Rating				1		1

Impact

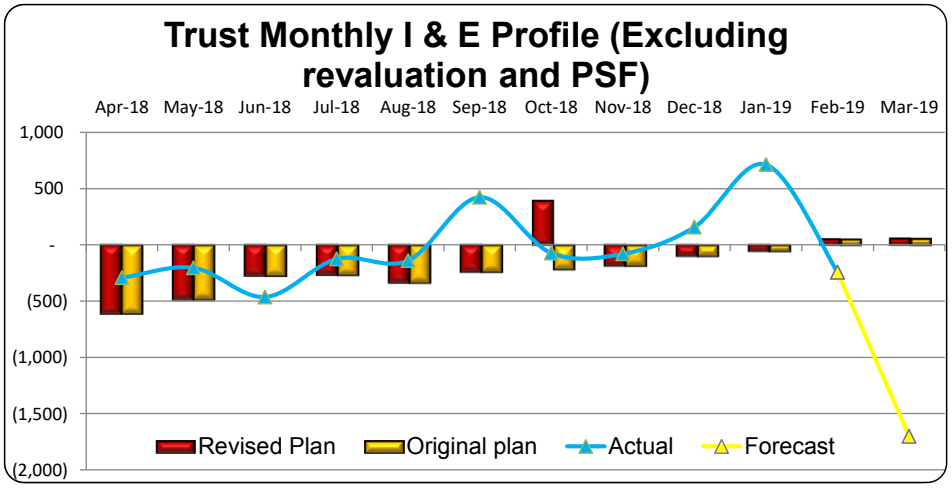
The Trust's I & E Margin (including PSF) has exceeded 1% and as such the risk rating has achieved a level 1, all other ratings are level 1 with the exception of agency which has achieved level 2. The overall finance risk rating which is based on a weighted average remains at 1, the highest rating available.

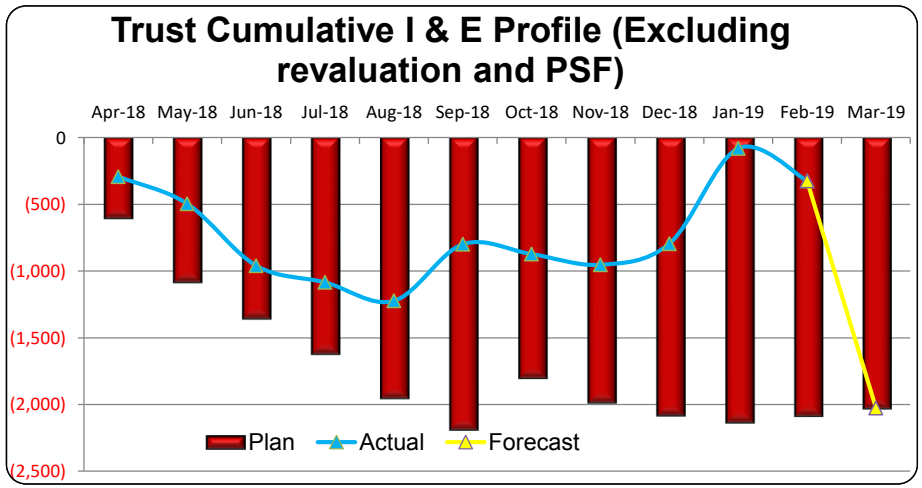
Definitions

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.

2.0 Income & Expenditure Position 2018 / 2019

Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Description	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Forecast Outturn	Forecast Variance
WTE	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**		**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
				17,053	17,303	250	Clinical Revenue	184,590	185,436	846	201,471	202,328	856
				17,053	**17,303**	**250**	**Total Clinical Revenue**	**184,590**	**185,436**	**846**	**201,471**	**202,328**	**856**
				1,309	1,070	(239)	Other Operating Revenue	12,453	13,038	585	13,596	14,285	689
				18,362	**18,373**	**11**	**Total Revenue**	**197,043**	**198,474**	**1,431**	**215,067**	**216,612**	**1,545**
4,104	4,077	(27)	0.7%	(14,149)	(13,959)	190	Pay Costs	(154,458)	(153,172)	1,286	(168,572)	(167,463)	1,108
				(3,629)	(3,458)	171	Non Pay Costs	(38,795)	(39,638)	(843)	(42,185)	(43,931)	(1,746)
				243	(364)	(607)	Provisions	2,103	578	(1,525)	2,415	40	(2,375)
				0	(129)	(129)	Gain / (loss) on disposal	600	526	(74)	600	526	(74)
4,104	**4,077**	**(27)**	**0.7%**	**(17,535)**	**(17,910)**	**(375)**	**Total Operating Expenses**	**(190,550)**	**(191,706)**	**(1,156)**	**(207,742)**	**(210,829)**	**(3,087)**
4,104	**4,077**	**(27)**	**0.7%**	**827**	**463**	**(364)**	**EBITDA**	**6,493**	**6,767**	**275**	**7,326**	**5,784**	**(1,542)**
				(470)	(456)	14	Depreciation	(5,201)	(4,285)	916	(5,671)	(4,742)	929
				(310)	(269)	42	PDC Paid	(3,415)	(2,952)	463	(3,726)	(3,220)	505
				4	17	13	Interest Received	41	145	104	45	152	107
4,104	**4,077**	**(27)**	**0.7%**	**50**	**(244)**	**(294)**	**Normalised Surplus / (Deficit) Excl PSF**	**(2,082)**	**(325)**	**1,757**	**(2,026)**	**(2,026)**	**0**
				312	312	0	PSF (Provider Sustainability Fund)	2,360	2,360	0	2,670	2,670	0
4,104	**4,077**	**(27)**	**0.7%**	**362**	**68**	**(294)**	**Normalised Surplus / (Deficit) Incl PSF**	**278**	**2,036**	**1,757**	**644**	**644**	**0**
				0	0	0	Revaluation of Assets	0	(11,081)	(11,081)	0	(11,081)	(11,081)
4,104	**4,077**	**(27)**	**0.7%**	**362**	**68**	**(294)**	**Surplus / (Deficit)**	**278**	**(9,045)**	**(9,323)**	**644**	**(10,437)**	**(11,081)**





Income & Expenditure Position 2018 / 2019

Despite further additional commissioner income new costs such as new VAT changes have resulted in deficit financial performance in February 2019.

Update to plan

The plan position was updated in October 2018 as agreed by Trust board to reflect the one-off £0.6m gain on the disposal of Trust properties. This is a challenging target but if achieved will enable access to an additional £1.2m Provider Sustainability Funding (PSF) monies through the 2:1 incentive scheme. The Trust has agreed a revised total of £2.0m deficit (pre PSF) for 2018/19 and a surplus of £644k including PSF.

Month 11

The February position is a pre PSF deficit of £244k and a post PSF surplus of £68k. The normalised year-to-date position is a pre PSF deficit of £325k, which whilst favourable to plan, has only been made possible by a number of non-recurrent measures. The underlying position remains concerning.

The key pressures remain as previous months and are outlined below; workforce pressures and out of area bed usage continue to be the most significant although these are partially mitigated through savings elsewhere within the Trust.

Income

At month 11 income is £250k higher than plan. A full breakdown of income is shown on page 7.

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.

Pay Expenditure

In February pay underspent by £190k. 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 cost pressure in the future. The Trust continues to work on its recruitment and retention action plan. Additional analysis is included within the pay information report to highlight the different expenditure levels across the services.

February agency costs are 56% higher than the NHSI agency cap, year to date expenditure of £5.8m exceeds the NHSI maximum agency cap of £5.2m by £0.6m. Bank costs continue to increase and to date £14.2m has been spent on temporary staffing. Additional information is provided on the pay and agency pages.

Inpatient wards across the Trust continue reporting significant pressures. Across all inpatient wards (excluding Forensic BDU) the average overspend each month year to date is £200k, in February the overspend was £300k due to high occupancy levels, high acuity levels, vacancies and sickness.

Non Pay Expenditure

Non pay is underspent by £171k in February. Out of area bed spend is £191k in-month and £3.6m cumulatively. More details are included within the out of area focus page. Drugs costs remains a pressure, overall spend has reduced from 2017/18 however this is primarily due to decommissioning of services, a year on year comparison of current services shows a marginal increase in costs.

Forecast

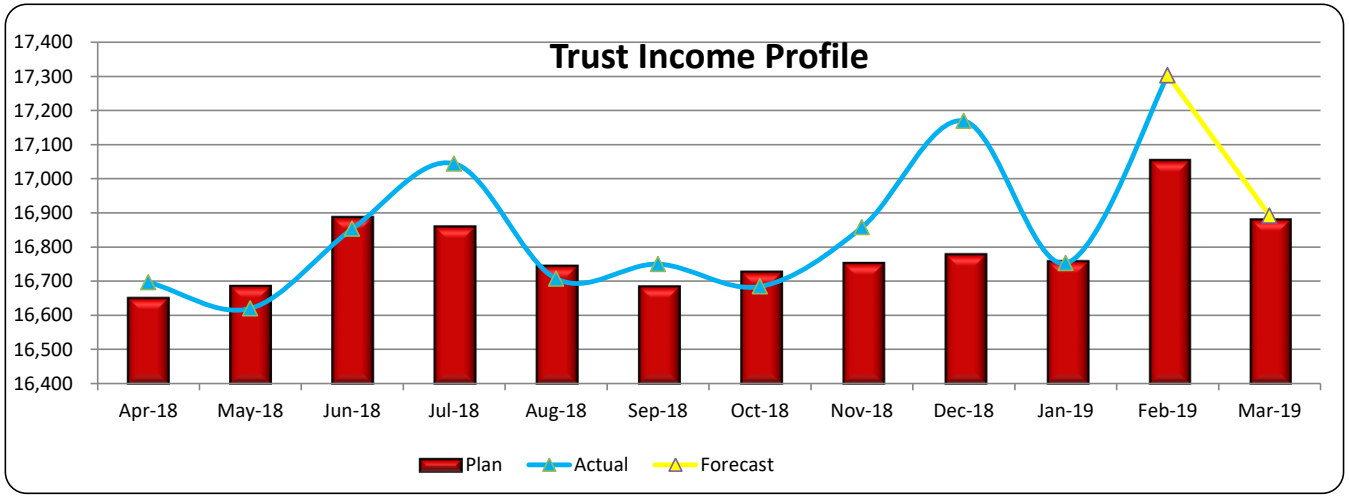
The Trust is currently forecasting to achieve a challenging revised year-end outturn of £2.0m deficit. Achievement of this position would enable access to a minimum of £2.7m PSF which will support the Trust's cash position and capital programme. If this can be exceeded additional PSF would be available; the value of this would not be confirmed till late April 2019.

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 return to a sustainable position. A financial sustainability plan is under development.

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. This is subject to regular discussions and triangulation with commissioners to ensure that we have no differences of expectation. This is periodically formally assessed by NHS Improvement.

	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	Total 17/18 £k
CCG	12,132	12,012	12,286	12,453	11,924	11,948	11,872	12,023	12,290	12,004	12,429	12,010	**145,383**	**151,142**
Specialist Commissioner	1,946	1,946	1,946	1,946	1,872	1,931	2,035	1,946	1,946	1,946	1,946	1,946	**23,356**	**23,661**
Alliance	1,053	1,105	1,079	1,079	1,270	1,270	1,257	1,298	1,282	1,290	1,288	1,330	**14,601**	**11,478**
Local Authority	430	413	422	438	426	426	416	437	437	437	375	437	**5,095**	**4,851**
Partnerships	577	577	577	585	655	595	561	612	611	559	605	613	**7,126**	**6,838**
Other	558	567	543	543	560	579	542	542	604	516	660	556	**6,768**	**6,981**
Total	**16,696**	**16,620**	**16,853**	**17,044**	**16,707**	**16,750**	**16,684**	**16,858**	**17,169**	**16,752**	**17,303**	**16,892**	**202,328**	**204,951**
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	**204,951**	



There has been a spike of income in February 2019; over and above income received from the main block contracts.

£400k relates to support of costs incurred by the Trust to deliver activity levels (inpatient staffing and out of area placements) from Kirklees CCG.

Additional non-recurrent income has also been confirmed during February 2019 which was not previously included in the figures. This relates to additional activity such as targeted waiting list schemes.

Contract discussions are ongoing for 2019/20 and are due to be finalised in March 2019.

2.1 Pay Information

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

The Trust workforce strategy was approved by Trust board during 2017 / 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. Additional analysis has been included to highlight the varying levels of overspend by service and is the focus of the key messages below.

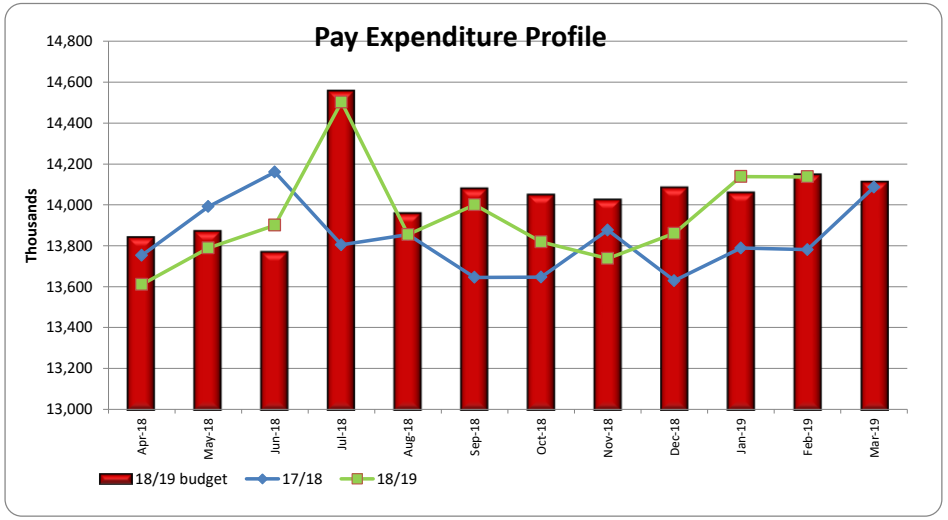
	Apr-18 £k	May-18 £k	Jun-18 £k	Jul-18 £k	Aug-18 £k	Sep-18 £k	Oct-18 £k	Nov-18 £k	Dec-18 £k	Jan-19 £k	Feb-19 £k	Mar-19 £k	Total £k
Substantive	12,595	12,598	12,578	13,290	12,529	12,600	12,647	12,498	12,605	12,755	12,478		**139,172**
Bank & Locum	571	652	839	687	749	878	635	704	726	787	1,114		**8,343**
Agency	444	538	484	526	575	522	537	536	530	596	545		**5,834**
Total	**13,610**	**13,789**	**13,901**	**14,503**	**13,854**	**14,000**	**13,819**	**13,738**	**13,861**	**14,138**	**14,137**	**0**	**153,350**
17/18	13,752	13,992	14,161	13,804	13,854	13,645	13,646	13,876	13,629	13,788	13,781	14,087	**166,257**
Bank as %	4.2%	4.7%	6.0%	4.7%	5.4%	6.3%	4.6%	5.1%	5.2%	5.6%	7.9%		5.4%
Agency as %	3.3%	3.9%	3.5%	3.6%	4.2%	3.7%	3.9%	3.9%	3.8%	4.2%	3.9%		3.8%

Year to Date Budget v Actuals - by staff group

	Budget £k	Substantive £k	Temp £k	Agency £k	Total £k	Variance £k
Medical	20,235	16,219	414	3,244	19,877	359
Nursing Registered	55,482	48,021	2,875	540	51,435	4,047
Nursing	16,459	15,597	3,974	1,278	20,849	(4,390)
Other	36,681	36,648	470	748	37,866	(1,184)
Corporate Admin	13,984	12,847	157	0	13,004	980
BDU Admin	11,616	9,841	454	25	10,320	1,297
Total	**154,458**	**139,172**	**8,343**	**5,834**	**153,350**	**1,108**

Year to date Budget v Actuals - by service

	Budget £k	Substantive £k	Bank £k	Agency £k	Total £k	Variance £k
MH Community	65,833	57,894	1,581	3,799	63,275	2,559
Inpatient	39,351	34,147	5,869	1,761	41,777	(2,426)
BDU Support	6,270	5,766	138	0	5,904	365
Community	18,779	18,298	330	197	18,825	(46)
Corporate	24,225	23,067	425	77	23,569	656
Total	**154,458**	**139,172**	**8,343**	**5,834**	**153,350**	**1,108**



Key Messages

In absolute terms pay expenditure has increased from £152.2m to £153.2m for the first 11 months of the year (0.7%). This is an increase from 81% to 83% as a proportion of Trust healthcare income partly due to the reduced levels of income in 2018/19.

The YTD overspend on inpatient services (excluding forensics) is £2.2m. In February this equates to an additional 142 members of staff. Of the 19 wards (excluding Forensics), 16 are reporting an overspend. The majority of wards are commissioned and staffed to operate at 85% occupancy level. Due to high demand many are operating at 100% and therefore require additional staff. Additional staffing requirements are often exacerbated by high observation levels, escorts, vacancies and sickness.

The overspend on inpatient areas is offset by underspends across all other service areas, more noticeably in mental health community (£2.7m) and corporate services (£0.7m).

Year to date bank expenditure is £8.3m , £1.8m (28%) higher than the same period in 2017/18 and agency expenditure is £561k (10%) higher than the same period in 2017/18. Where contracts have been agreed with agencies to supply agency workers under the NHS capped rates e.g. nursing, the comparative hourly rates between bank and agency do not differ substantially. Where rates have not been agreed or preferred suppliers are unable to meet demand, agency rates can exceed bank by up to 30%. These rates differences are more pronounced in specific medical staffing groups such as CAMHS.

Year to date medical staffing is underspent by £359k, and is running with circa 55 WTE vacancies, half of which are covered by temporary staffing and some by additional allowances to substantive staff.

2.1 Agency Expenditure Focus

The NHS Improvement agency cap is £5.2m

Year to date expenditure exceeds cap by £1.0m

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 have increased again this year to a value in excess of £0.5m 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 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. The current forecast position exceeds cap by £1.2m (23%), if this increases to 25% the NHSI agency metric will reduce from 2 to 3.

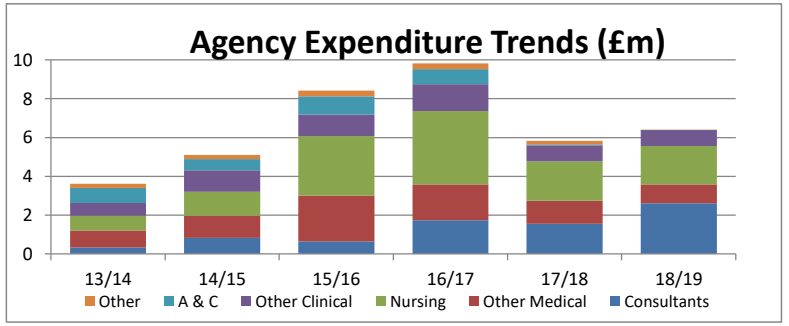
At month 11 agency spend is £545k, 56% above cap.

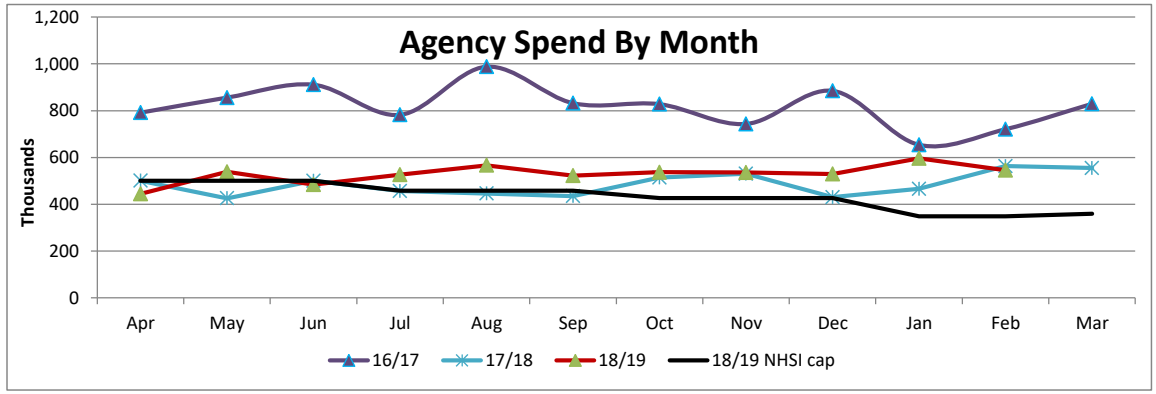
Year to date agency expenditure totals £5.8m, this is £0.6m higher than the same period in 2017/18. Agency medical staffing is £0.7m higher and unregistered nursing is £0.1m higher in 2018/19 offset by small reductions across other headings.

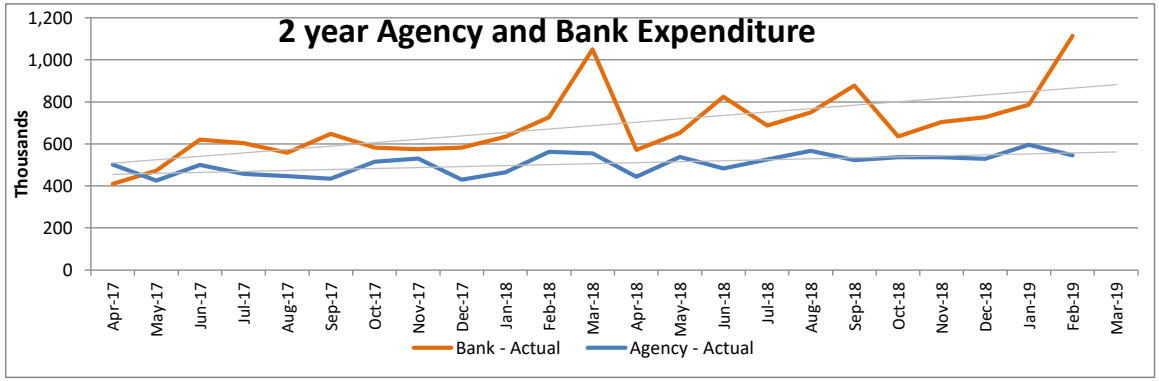
Year to date the agency cap has been breached by £975k, it is no longer possible for expenditure to remain within cap for 2018/19. Agency expenditure is subject to detailed scrutiny at all levels within the Trust. Plans continue to be progressed to reduce this level of expenditure. The Trust continues to report agency usage to NHS Improvement on a weekly basis.

Bank expenditure in February is £1,114k, the highest month this year and an increase of £327k compared to January. The increase is not restricted to one BDU and mainly results from high acuity, high sickness and on-call cover.

Year to date 82% of bank expenditure is on nursing staff of which 80% is across the Trust's 30 wards. Bank nursing expenditure on 4 wards, Johnson, Sandal, Nostell and Walton accounts for 25% of total year to date bank nursing expenditure.





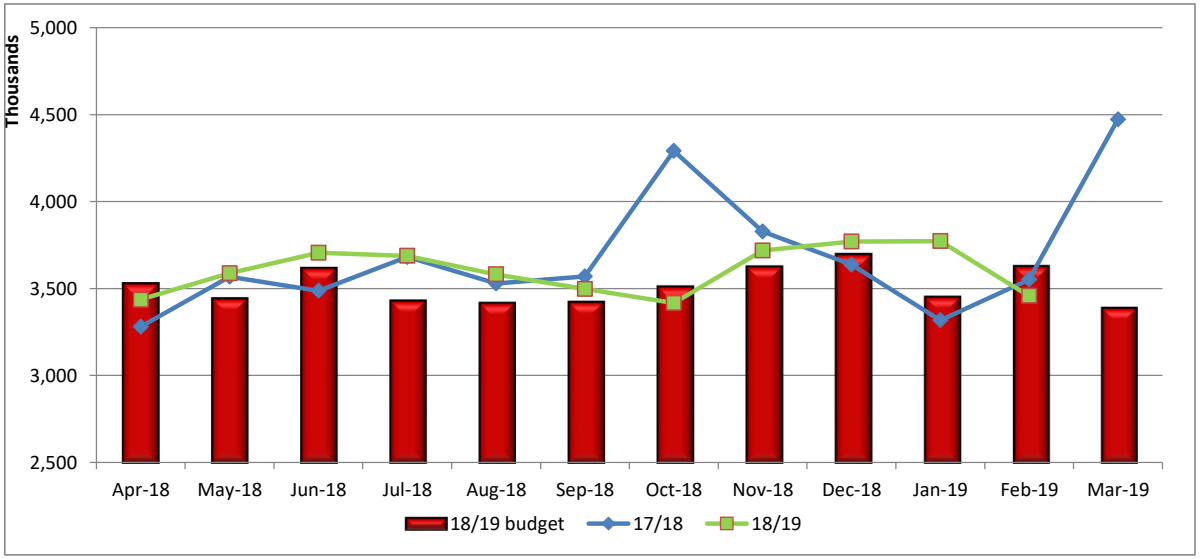


2.1 Non Pay Expenditure

Whilst pay expenditure represents over 75% of all Trust costs, 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 £k	May-18 £k	Jun-18 £k	Jul-18 £k	Aug-18 £k	Sep-18 £k	Oct-18 £k	Nov-18 £k	Dec-18 £k	Jan-19 £k	Feb-19 £k	Mar-19 £k	Total £k
2018 / 2019	3,437	3,588	3,706	3,689	3,582	3,498	3,417	3,719	3,771	3,773	3,458		**39,638**
2017 / 2018	3,281	3,568	3,488	3,681	3,529	3,570	4,292	3,829	3,637	3,318	3,552	4,474	**44,219**

	Budget YTD	Actual YTD	Variance
Non Pay Category	**£k**	**£k**	**£k**
Clinical Supplies	2,457	2,718	(261)
Drugs	2,694	3,096	(403)
Healthcare subcontracting	4,283	5,781	(1,498)
Hotel Services	1,700	1,712	(12)
Office Supplies	4,700	4,166	534
Other Costs	4,622	4,248	374
Property Costs	6,058	6,102	(43)
Service Level Agreements	5,654	5,540	114
Training & Education	787	705	81
Travel & Subsistence	3,443	3,038	405
Utilities	1,190	1,256	(66)
Vehicle Costs	1,207	1,274	(67)
Total	**38,795**	**39,638**	**(843)**
Total Excl OOA and Drugs	**31,818**	**30,760**	**1,058**



Key Messages

Healthcare subcontracting relates to the purchase of all non-Trust bed capacity and is overspending by £1.5m. As a constant and significant pressure the out of area focus provides further details on this.

Drugs expenditure is the second highest overspend category. As at February 2019 this is £403k overspent against budget. The Pharmacy team continue to review prescribing practices, standardise drugs and ensure that price changes are proactively managed.

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. Other costs includes a wide variety of expenditure associated with running such a diverse Trust. This includes advertising, recruitment, membership fees, interpretation and professional fees.

2.1 Out of Area Beds 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 (£)

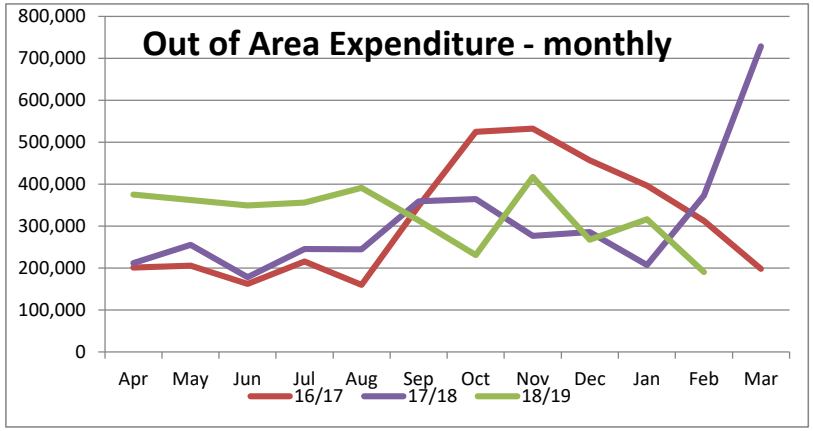
	Apr £000	May £000	Jun £000	Jul £000	Aug £000	Sep £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	Mar £000	Total £000
16/17	202	206	162	216	160	349	525	533	457	397	313	198	**3,718**
17/18	212	255	178	246	245	359	365	277	286	208	373	729	**3,733**
18/19	376	363	349	357	392	314	232	417	268	317	191		**3,574**

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	501	680	473	245	508	329	359	194		**4,682**

Bed Day Information 2018 / 2019 (by category)

PICU	316	207	142	91	76	30	48	41	31	31	28		**1,041**
Acute	278	157	258	348	542	401	127	396	278	289	126		**3,200**
Gender	13	10	12	62	62	42	70	71	20	39	40		**441**
Total	607	374	412	501	680	473	245	508	329	359	194		**4,682**

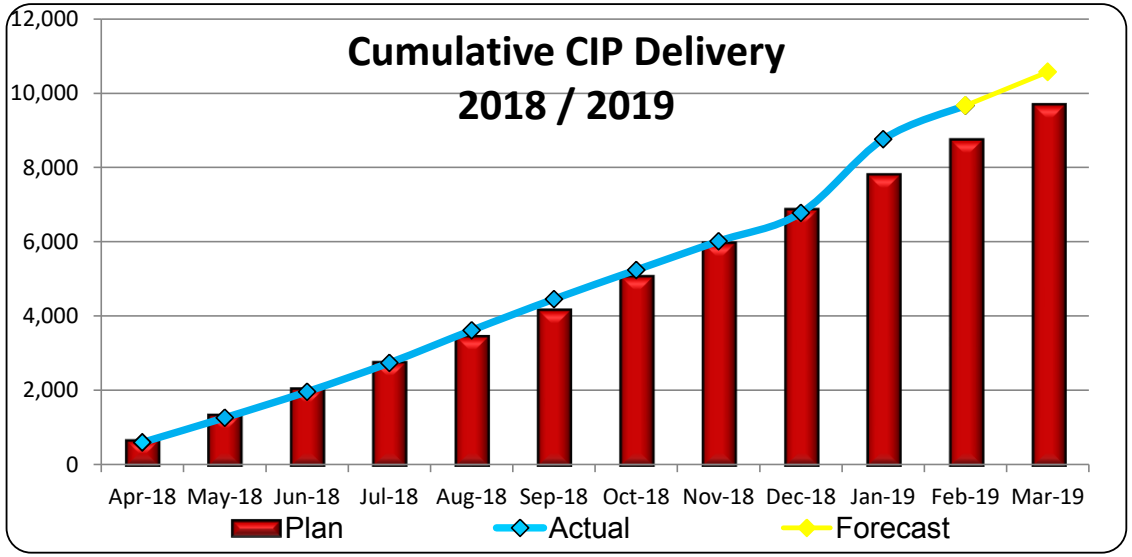


Due to the increasing levels of high demand from January to March 2018 the out of area budget has been weighted to account for higher spend at the start of the year reducing significantly across the year as actions from the project board are implemented.

In February acute activity reduced significantly to one patient placed out of area then increased to 5 patients placed out of area toward the end of the month. PICU activity remains low; of the two patients placed out of area one is waiting for an NHSE placement, the other requires a gender specific environment . The forecast assumes demand will remain at this level in March, action plans agreed continue and suggestions from external consultants are being trialled to establish their effectiveness.

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	8,762	9,701
Delivery as originally planned	555	1,136	1,699	2,259	2,827	3,394	3,975	4,560	5,139	5,739	6,342	6,945	6,342	6,945
Mitigations - Recurrent & Non-Recurrent	39	124	260	478	788	1,061	1,264	1,455	1,640	3,025	3,327	3,628	3,327	3,628
Mitigations - Upside schemes													0	0
Total Delivery	**595**	**1,260**	**1,959**	**2,737**	**3,615**	**4,455**	**5,240**	**6,015**	**6,779**	**8,764**	**9,669**	**10,574**	**9,669**	**10,574**
Variance	(96)	(122)	(132)	(61)	114	251	139	17	(116)	941	907	873	907	873



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.

This initial planning gap had a number of upside scenarios identified as a means for closing the gap. A number of these have now been finalised which has meant that the target for 2018/19 has been achieved in full.

Of the £10.6m identified £2.7m is non-recurrent (£1.9m as planned, £0.8m as additional mitigations). These continue to be reviewed as part of the 2019/20 annual planning process to confirm if this can be converted into recurrent schemes.

3.0 Balance Sheet 2018 / 2019

	2017 / 2018 £k	Plan (YTD) £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	123,810	124,853	99,189	1
Current Assets				
Inventories & Work in Progress	232	232	232	
NHS Trade Receivables (Debtors)	1,388	2,507	2,114	
Non NHS Trade Receivables (Debtors)	1,913	2,977	1,015	2
Other Receivables (Debtors)	1,219	1,000	1,367	3
Accrued Income	3,660	4,650	4,878	4
Cash and Cash Equivalents	26,559	22,599	27,581	5
Total Current Assets	**34,971**	**33,965**	**37,187**	
Current Liabilities				
Trade Payables (Creditors)	(4,158)	(6,090)	(3,640)	6
Capital Payables (Creditors)	(1,142)	(992)	(464)	6
Tax, NI, Pension Payables	(5,782)	(6,000)	(6,608)	
Accruals	(5,799)	(6,000)	(8,098)	7
Deferred Income	(670)	(670)	(1,059)	
Total Current Liabilities	**(17,552)**	**(19,752)**	**(19,869)**	
Net Current Assets/Liabilities	**17,419**	**14,213**	**17,318**	
Total Assets less Current Liabilities	**141,229**	**139,066**	**116,507**	
Provisions for Liabilities	(6,490)	(5,740)	(6,276)	
Total Net Assets/(Liabilities)	**134,739**	**133,326**	**110,231**	
Taxpayers' Equity				
Public Dividend Capital	44,015	44,015	44,034	
Revaluation Reserve	24,938	24,938	9,845	
Other Reserves	5,220	5,220	5,220	
Income & Expenditure Reserve	60,566	59,153	51,132	8
Total Taxpayers' Equity	**134,739**	**133,326**	**110,231**	

The Balance Sheet analysis compares the current month end position to that within the annual plan. The previous year end position is included for information.

1. Capital expenditure is detailed on page 14. Year to date spend remains below plan. In January 2019 the impact of the asset revaluation exercise has been actioned which has significantly reduced our asset value.

2. Non-NHS Debtors, and debtors generally continue to be lower than plan.

3. Other Receivables variance, including prepayments, is due to payment timing for licences and the lease car insurance.

4. Accrued income is slightly higher than plan, all valid invoices will be raised ahead of the year-end.

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 16.

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

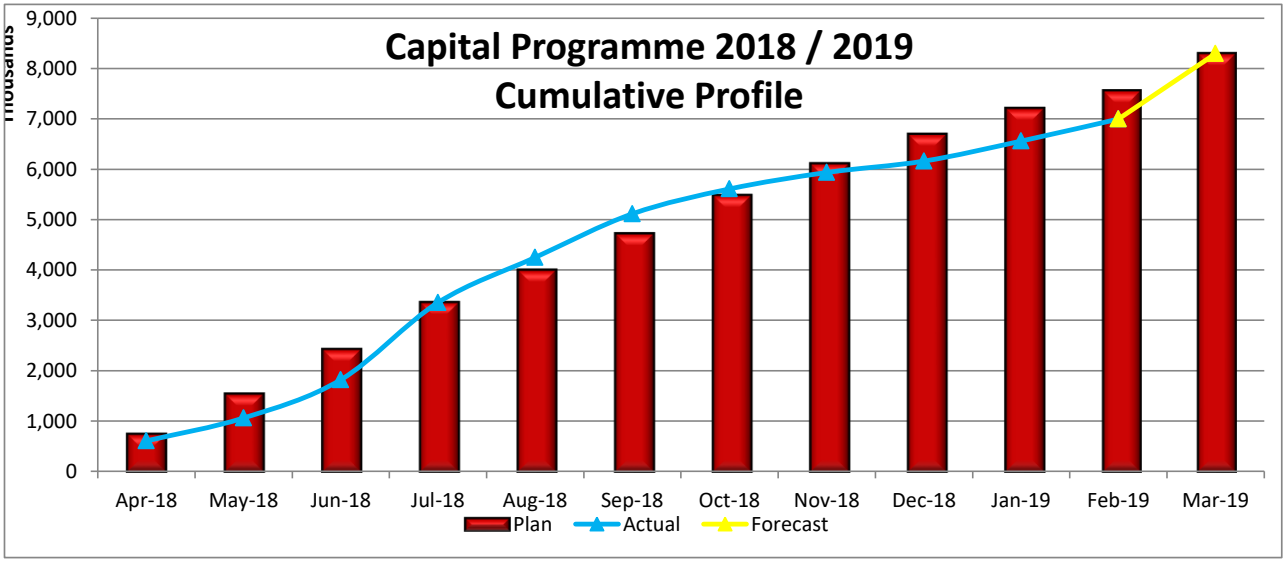
7. Accruals are higher than plan as some invoices have not yet been received.

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

3.1 Capital Programme 2018 / 2019

	Annual Budget £k	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Forecast Actual £k	Forecast Variance £k	Note
Maintenance (Minor) Capital							
Facilities & Small Schemes	1,628	1,291	1,076	(215)	1,851	223	
Equipment Replacement	0	0	36	36	68	68	
IM&T	1,610	1,405	1,033	(372)	1,382	(228)	
Major Capital Schemes							
Fieldhead Non Secure	4,229	4,035	4,156	121	4,249	20	
Clinical Record System	828	828	751	(77)	801	(27)	
VAT Refunds	0	0	(56)	(56)	(56)	(56)	3
TOTALS	**8,295**	**7,559**	**6,997**	**(562)**	**8,295**	**(0)**	1, 2

Remaining capital schemes are forecast to be delivered during 2018/19.



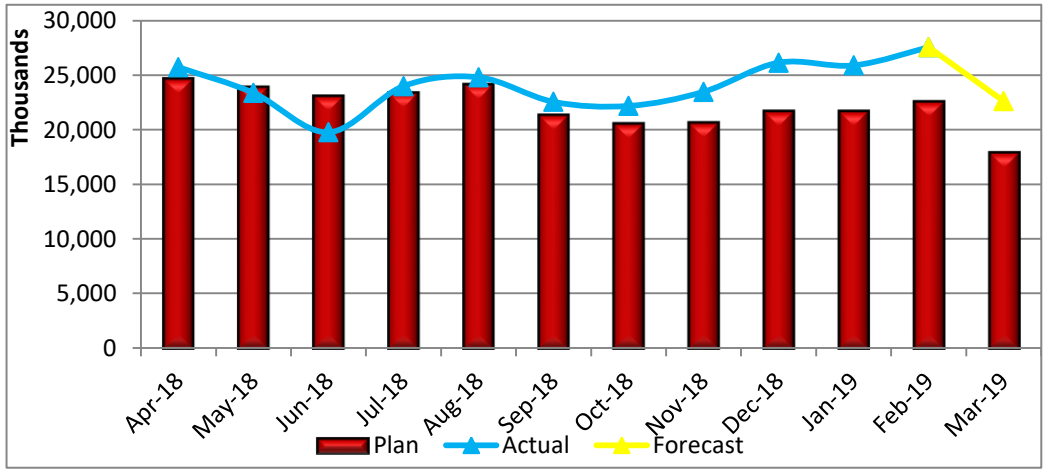
Capital Expenditure 2018 / 2019

1. 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 was previously added from national funding with a further £60k added in month for the commencement of IM & T / paper digitisation scheme.

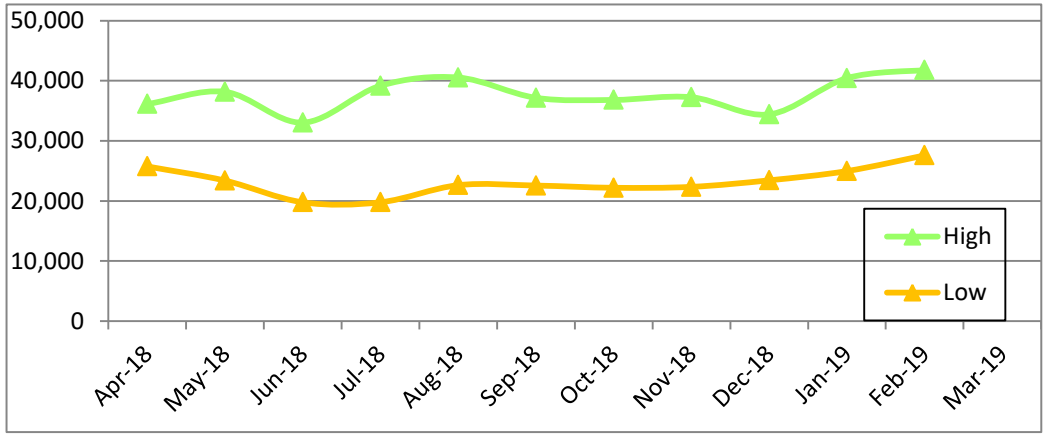
2. All schemes are planned to be completed by 31st March 2019 with the exception of the non-secure project and the clinical record system.

3. VAT claims for capital programmes are being chased. These will be added back into the capital programme as and when confirmed.

3.2 Cash Flow & Cash Flow Forecast 2018 / 2019



	Plan £k	Actual £k	Variance £k
Opening Balance	26,559	26,559	
Closing Balance	22,599	27,581	4,982



Effective cash management remains a key financial objective

Overall cash remains higher than planned due to one off benefits in previous months such as asset sales, additional commissioner income and continued low debtor levels.

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

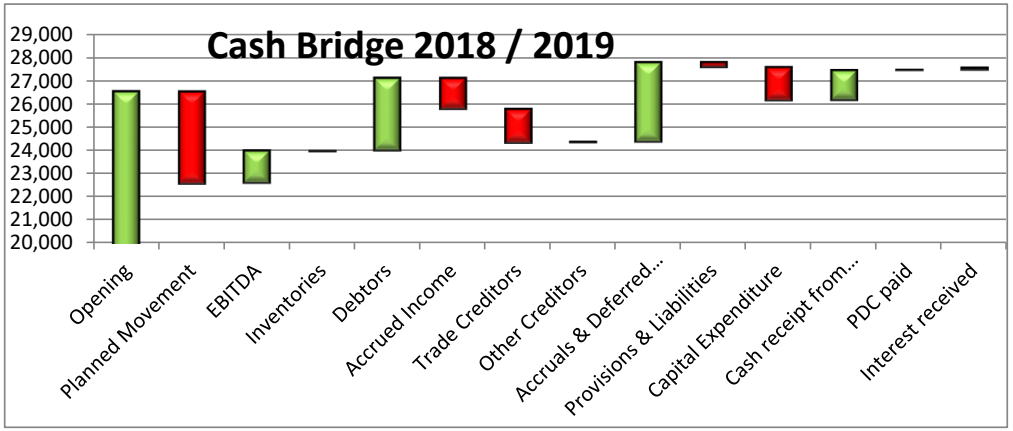
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £41.8m
The lowest balance is: £27.6m

This reflects cash balances built up from historical surpluses.

3.3 Reconciliation of Cashflow to Cashflow Plan

	Plan £k	Actual £k	Variance £k	Note
Opening Balances	**26,559**	**26,559**	0	
Surplus / Deficit (Exc. non-cash items & revaluation)	7,201	8,602	1,401	1
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	(3,000)	139	3,139	2
Accrued Income / Prepayments	0	(1,333)	(1,333)	5
Trade Payables (Creditors)	650	(797)	(1,447)	
Other Payables (Creditors)	0	20	20	
Accruals & Deferred income	(750)	2,687	3,437	3
Provisions & Liabilities	0	(215)	(215)	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(6,245)	(7,675)	(1,430)	6
Cash receipts from asset sales	0	1,295	1,295	4
PDC Dividends paid	(1,860)	(1,848)	12	
PDC Dividends received			0	
Interest (paid)/ received	44	145	101	
Closing Balances	**22,599**	**27,581**	**4,982**	



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

Factors which increase the cash positon against plan:

1. The overall I & E position is better than plan. This does not include the lower than plan depreciation costs which is a non cash item.

2. Debtors are lower than plan. This is exceptionally low and is forecast to increase in Month 12 but will continue to be managed as far as possible to maximise cash.

3. 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.

4. Cash receipts from the sale of Trust assets

Factors which decrease the cash position against plan:

5. 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.

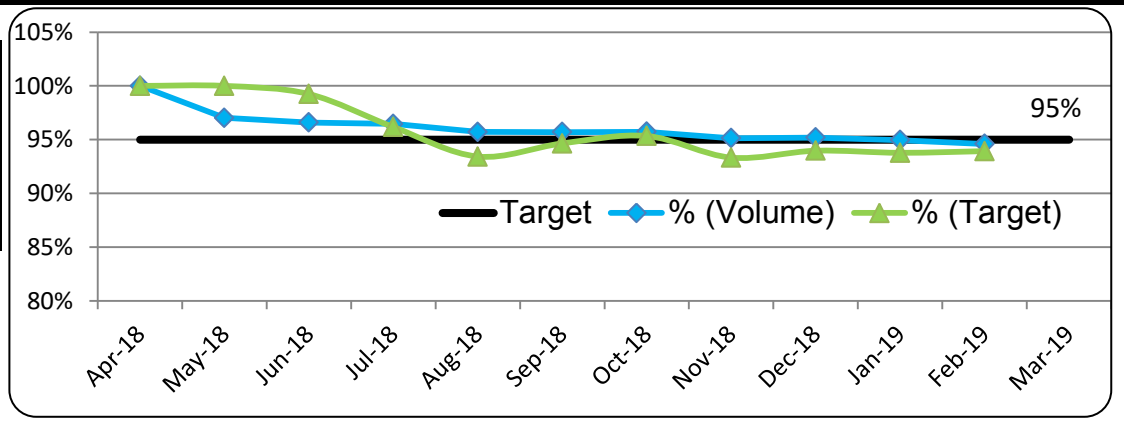
6. Creditors, and capital creditors, are higher than planned. Invoices are paid in line with the Trust Better Payment Practice Code and any aged creditors are reviewed and action plans for resolution agreed.

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

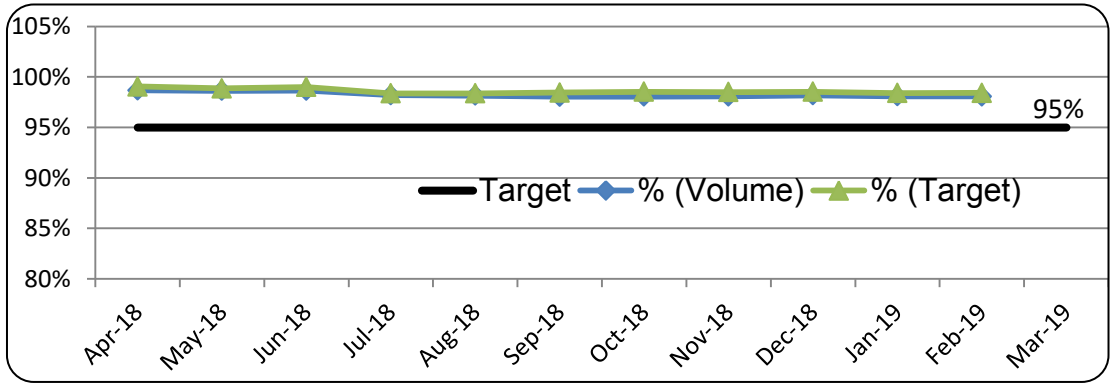
4.0 Better Payment Practice Code

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 January 2019	95%	94%
Year to February 2019	95%	94%



Non NHS	Number %	Value %
Year to January 2019	98%	98%
Year to February 2019	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.

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
08-Feb-19	Property Rental	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	3096942	226,501
28-Jan-19	Drugs	Trustwide	Bradford Teaching Hospitals NHS FT	3095706	132,280
07-Feb-19	Consultancy	Trustwide	SSG Partners Limited	3096713	120,000
05-Feb-19	IT Services	Trustwide	Daisy Corporate Services Trading Ltd	3096433	111,750
04-Feb-19	Staff recharge	Trustwide	Greater Manchester Mental Health NHS Foundation Trus	3096203	87,059
25-Jan-19	Drugs	Trustwide	NHSBSA Prescription Pricing Division	3095559	52,917
20-Feb-19	IT Services	Trustwide	Insight Direct (UK) Ltd	3098072	45,900
11-Feb-19	Drugs	Trustwide	Lloyds Pharmacy Ltd	3097084	40,851
04-Feb-19	Property Rental	Barnsley	Community Health Partnerships	3096469	31,178
04-Feb-19	Property Rental	Barnsley	Community Health Partnerships	3096471	31,178
20-Feb-19	IT Services	Trustwide	Insight Direct (UK) Ltd	3098070	29,400
04-Feb-19	Electricity	Trustwide	EDF Energy	3096175	28,192
14-Jan-19	Purchase of Healthcare	Trustwide	Humber NHS Foundation Trust	3094432	27,015
14-Jan-19	Purchase of Healthcare	Trustwide	Humber NHS Foundation Trust	3094430	27,015
19-Feb-19	Communications	Trustwide	Vodafone Corporate Ltd	3097954	25,686
04-Feb-19	Property Rental	Barnsley	Community Health Partnerships	3096471	25,051
04-Feb-19	Property Rental	Barnsley	Community Health Partnerships	3096469	25,051

4.2 Glossary

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

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

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

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

* Surplus - Trust income is greater than costs

* Deficit - Trust costs are greater than income

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

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

* Target Surplus / Deficit - This is the surplus or deficit the Board said it wanted to achieve for the year (including non-recurrent actions), and which was used to set the CIP targets. This is set in advance of the year, and before all variables are known. For 2018 / 2019 the Trust were set a control total deficit.

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

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

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

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

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

Appendix 2 - Workforce - Performance Wall

Barnsley District

Month	Objective	CQC Domain	Owner	Threshold	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.2%	4.5%	4.8%	5.0%	5.1%	5.2%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	5.1%	6.7%	6.8%	6.3%	6.2%	5.5%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	89.1%	90.2%	96.2%	96.7%	98.7%	98.7%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	69.3%	77.7%	90.9%	91.7%	94.1%	96.7%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	84.5%	83.5%	82.4%	81.1%	81.9%	83.6%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	79.6%	79.5%	80.4%	82.5%	82.8%	82.8%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	86.6%	87.3%	88.2%	88.9%	88.9%	86.5%
Equality and Diversity	Resources	Well Led	AD	>=80%	92.4%	92.5%	92.0%	92.6%	91.8%	90.9%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	87.3%	85.9%	86.6%	87.5%	81.7%	82.4%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	72.9%	74.1%	77.0%	75.0%	77.8%	77.2%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	88.9%	89.8%	90.0%	89.7%	88.8%	90.4%
Information Governance	Resources	Well Led	AD	>=95%	91.1%	90.9%	89.3%	88.6%	94.1%	96.2%
Moving and Handling	Resources	Well Led	AD	>=80%	83.5%	83.5%	85.2%	86.7%	85.4%	87.3%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	85.6%	87.5%	89.0%	89.1%	90.0%	88.8%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	81.4%	81.1%	85.0%	84.0%	83.2%	84.7%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	89.7%	89.1%	90.7%	90.9%	90.6%	90.0%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	90.6%	90.4%	89.4%	89.9%	89.1%	88.8%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	95.3%	95.2%	95.4%	95.8%	95.8%	95.8%
Agency Cost	Resources	Effective	AD		£71k	£90k	£73k	£68k	£46k	£30k
Overtime Costs	Resources	Effective	AD		£1k	£1k	£0k	£3k	£3k	£1k
Additional Hours Costs	Resources	Effective	AD		£15k	£15k	£17k	£10k	£9k	£13k
Sickness Cost (Monthly)	Resources	Effective	AD		£140k	£188k	£186k	£175k	£177k	£142k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		7876.0%	7774.0%	8442.0%	8579.0%	7340.0%	7385.0%
Business Miles	Resources	Effective	AD		105k	105k	107k	100k	104k	97k

Calderdale and Kirklees District

Month	Objective	CQC Domain	Owner	Threshold	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.4%	4.4%	4.4%	4.5%	4.5%	4.6%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	3.9%	4.4%	4.5%	4.9%	5.1%	4.9%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	99.2%	99.4%	99.7%	99.7%	100.0%	100.0%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	86.3%	92.8%	95.4%	97.1%	97.8%	98.5%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	81.2%	79.2%	80.6%	82.2%	82.4%	82.4%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	84.2%	80.2%	79.5%	78.4%	81.6%	79.1%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	87.2%	87.7%	87.7%	88.0%	88.0%	89.3%
Equality and Diversity	Resources	Well Led	AD	>=80%	89.8%	89.9%	90.4%	91.3%	90.5%	91.8%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	86.5%	88.7%	87.7%	88.8%	85.1%	83.6%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	83.3%	84.1%	88.1%	87.8%	84.6%	84.3%
Infection Control and Hand Hygiene	Quality & Experience	Well Led		>=80%	89.2%	88.1%	87.6%	89.9%	89.8%	90.2%
Information Governance	Resources	Well Led	AD	>=95%	94.8%	94.9%	92.7%	91.2%	97.5%	97.8%
Moving and Handling	Resources	Well Led	AD	>=80%	88.7%	88.5%	89.0%	88.8%	87.8%	88.9%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	92.4%	90.9%	91.4%	91.1%	91.9%	92.5%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	89.7%	89.6%	89.7%	89.1%	88.6%	87.5%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	90.9%	92.4%	93.6%	94.6%	93.9%	92.7%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	85.0%	87.4%	86.2%	89.9%	88.9%	88.0%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	95.7%	95.7%	95.2%	95.2%	94.9%	95.9%
Agency Cost	Resources	Effective	AD		£73k	£103k	£114k	£105k	£101k	£102k
Overtime Costs	Resources	Effective	AD		£6k	£1k	£4k	£2k	£2k	£1k
Additional Hours Costs	Resources	Effective	AD		£0k	£0k	£1k	£1k	£0k	£1k
Sickness Cost (Monthly)	Resources	Effective	AD		£98k	£107k	£103k	£119k	£126k	£111k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		76.65	78.65	79.51	74.99	68.26	70.03
Business Miles	Resources	Effective	AD		69k	54k	77k	57k	69k	64k

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

Forensic Services

Month	Objective	CQC Domain	Owner	Threshold	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Sickness (YTD)	Resources	Well Led	AD	<=5.4%	7.5%	7.5%	7.6%	7.6%	7.7%	7.6%
Sickness (Monthly)	Resources	Well Led	AD	<=5.4%	9.3%	8.1%	7.6%	8.3%	8.4%	6.5%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	94.8%	94.7%	93.3%	93.4%	94.6%	94.4%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	87.0%	89.7%	96.9%	97.2%	98.4%	98.3%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	84.6%	85.6%	86.8%	86.1%	85.1%	87.8%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	85.3%	85.0%	85.3%	84.7%	84.2%	86.2%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	83.8%	82.4%	82.2%	85.2%	86.4%	89.3%
Equality and Diversity	Resources	Well Led	AD	>=80%	93.6%	94.4%	95.0%	95.6%	95.3%	95.4%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	85.3%	85.6%	84.6%	87.7%	87.8%	88.5%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	87.1%	86.1%	88.1%	84.1%	84.3%	87.4%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	88.7%	90.2%	90.3%	90.4%	90.6%	90.6%
Information Governance	Resources	Well Led	AD	>=95%	90.4%	91.2%	89.8%	93.1%	95.4%	97.2%
Moving and Handling	Resources	Well Led	AD	>=80%	89.7%	91.4%	91.8%	91.4%	90.6%	92.7%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	89.5%	89.2%	91.3%	90.0%	89.6%	89.9%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	80.1%	80.6%	85.4%	83.6%	83.3%	83.2%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	93.1%	93.6%	93.5%	95.3%	96.0%	96.5%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	89.2%	89.5%	87.6%	91.4%	93.3%	94.2%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	92.6%	95.5%	82.8%	86.7%	93.3%	93.1%
Agency Cost	Resources	Effective	AD		£57k	£44k	£62k	£76k	£69k	£31k
Overtime Costs	Resources	Effective	AD			£0k		£0k	£2k	£0k
Additional Hours Costs	Resources	Effective	AD		£1k	£1k	£3k	£2k	£1k	£2k
Sickness Cost (Monthly)	Resources	Effective	AD		£77k	£75k	£69k	£79k	£86k	£55k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		73.91	63.16	63.48	57.24	48.97	62.2
Business Miles	Resources	Effective	AD		7k	5k	4k	9k	8k	7k

Specialist Services

Month	Objective	CQC Domain	Owner	Threshold	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.6%	4.8%	5.0%	5.1%	5.1%	5.1%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	5.0%	6.6%	6.3%	5.7%	5.3%	4.7%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	94.8%	95.8%	98.4%	98.4%	99.5%	99.5%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	67.4%	77.3%	90.5%	90.5%	91.8%	92.7%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	79.0%	76.6%	77.7%	83.7%	85.5%	81.8%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	78.9%	77.7%	79.0%	78.3%	78.2%	77.4%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	91.4%	91.9%	92.4%	93.2%	92.7%	94.0%
Equality and Diversity	Resources	Well Led	AD	>=80%	88.2%	88.3%	89.2%	90.2%	89.4%	88.8%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	85.2%	86.1%	82.0%	83.1%	81.0%	80.4%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	77.8%	70.0%	73.3%	73.3%	72.4%	72.4%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	87.9%	89.5%	89.4%	89.3%	89.1%	91.2%
Information Governance	Resources	Well Led	AD	>=95%	92.1%	92.1%	87.4%	87.7%	95.5%	98.2%
Moving and Handling	Resources	Well Led	AD	>=80%	88.4%	89.3%	89.2%	89.0%	87.7%	90.5%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	91.4%	92.7%	95.1%	94.4%	93.8%	93.9%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	86.9%	86.4%	88.7%	86.9%	87.8%	87.8%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	89.2%	92.4%	93.6%	93.9%	92.8%	93.2%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	90.4%	91.5%	92.1%	93.4%	92.8%	91.2%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	94.4%	94.0%	92.3%	92.8%	91.4%	91.9%
Agency Cost	Resources	Effective	AD		£197k	£221k	£202k	£202k	£264k	£276k
Overtime Costs	Resources	Effective	AD		£0k	£0k	£0k	£0k	£1k	£0k
Additional Hours Costs	Resources	Effective	AD		£1k	£1k	£0k	£2k	£1k	£1k
Sickness Cost (Monthly)	Resources	Effective	AD		£60k	£81k	£72k	£66k	£62k	£47k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		62.89	63.85	57.17	57.68	56.77	64.46
Business Miles	Resources	Effective	AD		35k	37k	44k	43k	38k	39k

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

Support Services

Month	Objective	CQC Domain	Owner	Threshold	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Sickness (YTD)	Resources	Well Led	AD	<=4.0%	3.9%	4.0%	4.1%	4.2%	4.3%	4.3%
Sickness (Monthly)	Resources	Well Led	AD	<=4.0%	3.9%	4.2%	5.0%	4.8%	5.4%	4.6%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	99.0%	99.5%	99.5%	99.5%	99.5%	99.5%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	83.6%	96.0%	98.3%	98.3%	99.2%	99.2%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	80.6%	79.6%	77.3%	74.0%	76.7%	73.2%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	87.5%	77.8%	75.0%	85.2%	84.0%	84.0%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	33.3%	25.0%	0.0%	100.0%	100.0%	100.0%
Equality and Diversity	Resources	Well Led	AD	>=80%	85.1%	86.0%	87.2%	87.5%	87.6%	88.1%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	87.3%	87.7%	89.1%	91.4%	90.0%	88.4%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	95.1%	94.4%	96.5%	95.9%	97.2%	97.2%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	88.5%	88.1%	87.2%	88.3%	88.7%	89.1%
Information Governance	Resources	Well Led	AD	>=95%	91.5%	91.8%	90.4%	94.4%	97.5%	98.7%
Moving and Handling	Resources	Well Led	AD	>=80%	90.5%	89.0%	91.6%	91.4%	89.3%	86.6%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	99.0%	99.0%	99.2%	99.2%	99.0%	99.3%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	85.7%	82.6%	85.7%	87.5%	95.2%	95.2%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	95.6%	95.3%	95.1%	96.2%	94.5%	97.5%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	96.2%	95.2%	94.2%	95.6%	96.1%	96.8%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%
Agency Cost	Resources	Effective	AD		£0k	£5k	£16k	£8k	£26k	£22k
Overtime Costs	Resources	Effective	AD		£1k	£1k	£1k	£1k	£0k	£4k
Additional Hours Costs	Resources	Effective	AD		£12k	£12k	£9k	£7k	£10k	£7k
Sickness Cost (Monthly)	Resources	Effective	AD		£63k	£70k	£79k	£73k	£82k	£65k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		36.87	42.92	41.1	46.27	50.42	52.74
Business Miles	Resources	Effective	AD		25k	32k	28k	32k	24k	23k

Wakefield District

Month	Objective	CQC Domain	Owner	Threshold	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Sickness (YTD)	Resources	Well Led	AD	<=4.6%	4.7%	4.7%	4.8%	4.8%	4.9%	4.9%
Sickness (Monthly)	Resources	Well Led	AD	<=4.6%	5.7%	4.9%	5.1%	4.9%	5.8%	4.9%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	95.8%	97.4%	98.9%	98.9%	99.5%	99.5%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	79.1%	89.9%	93.4%	93.9%	95.8%	95.8%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	83.6%	83.8%	83.1%	85.5%	86.2%	85.8%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	79.7%	79.2%	78.3%	83.0%	82.9%	81.6%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	79.2%	78.2%	78.4%	80.9%	82.6%	84.2%
Equality and Diversity	Resources	Well Led	AD	>=80%	89.0%	89.2%	90.8%	91.3%	92.2%	91.9%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	83.6%	85.9%	87.0%	88.3%	88.0%	89.1%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	67.9%	70.9%	69.7%	67.4%	68.7%	73.6%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	91.7%	91.1%	91.2%	91.3%	90.9%	92.1%
Information Governance	Resources	Well Led	AD	>=95%	91.9%	92.7%	90.0%	90.5%	97.6%	98.5%
Moving and Handling	Resources	Well Led	AD	>=80%	85.2%	87.1%	88.7%	89.2%	89.5%	92.3%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	90.0%	91.5%	92.5%	92.2%	93.1%	92.5%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	86.9%	86.7%	87.6%	87.2%	87.6%	86.9%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	91.7%	92.5%	93.5%	93.6%	94.3%	94.4%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	89.0%	89.0%	87.1%	89.8%	90.9%	89.4%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	91.9%	92.3%	93.3%	94.2%	91.9%	92.7%
Agency Cost	Resources	Effective	AD		£124k	£73k	£68k	£70k	£90k	£82k
Overtime Costs	Resources	Effective	AD			£0k		£1k		£1k
Additional Hours Costs	Resources	Effective	AD		£0k	£1k	£2k	£1k	£5k	£3k
Sickness Cost (Monthly)	Resources	Effective	AD		£70k	£61k	£60k	£59k	£69k	£55k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		48.13	42.47	45.36	45	45.52	41.04
Business Miles	Resources	Effective	AD		37k	34k	39k	38k	43k	40k

Glossary

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

KEY for dashboard Year End Forecast Position / RAG Ratings	
4	On-target to deliver actions within agreed timeframes.
3	Off trajectory but ability/confident can deliver actions within agreed time frames.
2	Off trajectory and concerns on ability/capacity to deliver actions within agreed time frame
1	Actions/targets will not be delivered
	Action Complete

NB: The Trusts RAG rating system was reviewed by EMT during October 16 and some amendments were made to the wording and colour scheme.

NHSI Key - 1 – Maximum Autonomy, 2 – Targeted Support, 3 – Support, 4 – Special Measures

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 March 2019
Agenda item 6.2

Title:	**NHS Staff Survey results 2018: Highlight report on final results**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates
Purpose:	The Trust's Workforce Strategy sets out three key strategic workstreams: ➢ Workforce Development ➢ Staff Wellbeing and Engagement ➢ Leadership and Management Development These are built on a foundation of Values Based Human Resource Management and Equality and Diversity. The Strategy also sets out an extensive range of key performance indicators (KPIs) which includes feedback from the NHS Staff Survey. The purpose of this paper is to provide the Trust Board with a summary of the final 2018 NHS Staff Survey results for the organisation.
Mission/values:	The NHS Staff Survey provides direct measures of staff views on whether the organisation lives its values and is meeting its mission.
Any background papers/ previously considered by:	The Trust Board approved the Workforce Strategy in 2017 and the NHS Staff Results are part of a comprehensive set of KPIs within it. The Workforce and Remuneration Committee receive regular updates on the Workforce Strategy annual action plan.
Executive summary:	The Trust recognised that an important part of the Workforce Strategy is continuous improvement and to support this on-going feedback from staff is vital. The NHS Staff Survey is one mechanism to get the views of staff and the Trust decided again this year to send it to every member of staff rather than a sample. The Trust uses Quality Health (one of the nationally approved contractors) to undertake the NHS Staff Survey on its behalf and over 1600 staff completed the survey. The official NHS staff survey results were released on the 26th February 2019 and the link to the full result is http://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2018-Results/ The format of the Survey has changed this year and has moved away from a series of 32 key findings to 10 key themes indicated below: ▪ Equality and Diversity ▪ Health and Wellbeing ▪ Immediate Managers ▪ Morale ▪ Quality of Care ▪ Quality of Appraisal ▪ Safe Environment- Bullying ▪ Safe Environment- Violence ▪ Safety Culture ▪ Staff Engagement

The Trust's NHS Survey report benchmarks the organisation against comparable NHS providers. It compares the Trust's results against the best, average and worst for similar NHS organisations. The results of the survey shows that broadly the Trust is average across all the 10 themes compared to its peer group. A more detailed analysis of the results is being undertaken to assess what actions are required across the Trust or what targeted interventions are needed for certain staff groups or areas of service, and this will be reviewed at the Workforce and Remuneration Committee on the 7 May 2019.

A summary of the key themes compared to comparable organisations is shown below:

Theme results	**Trust score 0-10**	**Average**	**Worst**	**Best**
Equality, diversity and inclusion	9.2	9.2	8.5	9.4
Health and Well-being	6.1	6.1	5.6	6.6
Immediate managers	7.1	7.2	6.9	7.4
Morale	6.2	6.2	6.0	6.7
Quality of Care	7.2	7.4	7.0	7.7
Quality of appraisals	5.5	5.5	4.8	6.0
Safe environment - Bullying	8.2	8.2	7.6	8.6
Safe environment - Violence	9.4	9.5	9.2	9.7
Safety Culture	6.7	6.8	6.4	7.4
Staff Engagement	6.8	7.0	6.4	7.4

The national report also provides a breakdown by BDUs and Support Services. This further breakdown shows a more mixed picture with staff in some areas reporting high levels of satisfaction and others where there is more concern. The attached report provides further detail of the scores by theme by BDU / Support Services.

The Executive Management Team and Operational Management Group have agreed to prioritise four key issues from the Workforce Strategy as a result of feedback from the NHS Staff Survey:

- Staff Engagement
- Quality of Appraisal
- Health and Wellbeing
- Preventing Bullying and Harassment

The emphasis for this year will be stronger local BDU / Directorate action plans supported by a Trust wide action plan. Key actions to date / planned are shown below:

1. A session with Extended EMT on the results of the NHS Survey has taken place with a focus on the leadership challenge in responding positively to the survey.
2. February's Staff Brief highlighted the importance of local action planning.
3. BDUs to produce a local action plan with a particular focus on the four priorities

	identified above by end of April 2019. 4. Appraisal form to be updated following feedback, new guidance for appraisees and appraisers to be issued and training to be offered on effective appraisal for both appraises and appraisers. 5. Action plan already agreed on preventing bullying and harassment. 6. Middleground to be re-launched with a stronger focus on behaviours, healthy teams and staff engagement. 7. OD Plan to include support on the four key priorities. 8. Targeted action plan to be agreed for Forensic Services and CAMHs. **Risk Appetite** The NHS Staff Survey is one source of feedback from staff on what we do well as an employer and where we can get better. The Remuneration and Terms of Service Committee will monitor overall workforce risks in line with the Trust's Risk Appetite statement.
Recommendation:	**Trust Board is asked to NOTE the report and the high level actions and next steps.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board: 26th March 2019

National Staff Survey 2018: Highlight Report on official results

1. Introduction

Between October and December 2018 the annual National NHS Survey was distributed to all staff in the Trust. The aim of the survey is to gather information to enable NHS organisations to improve the working lives of staff and consequently provide better care for service users and their carers.

The Trust issued the 2018 survey to all staff to enable the results to be meaningfully presented by BDU and service as well as at an organisational level. 1643 completed surveys were received, a response rate of 40% which is below the national response rate average of 45%. The Trust conducted its Well-being at Work Survey in July / August 2018 which may have influenced this year's response figure.

This paper summarises the official results supplied by NHS England which were published on 26 February 2019.

The format of the national reports has changed this year with responses grouped into key themes. There are no statistically significant changes in key theme results since 2017.

A summary of results is provided below compared to other community, mental health and learning disability Trusts. A higher score indicates a more positive result:

Theme results	Trust score 0-10	Average	Worst	Best
Equality, diversity and inclusion	9.2	9.2	8.5	9.4
Health and Well-being	6.1	6.1	5.6	6.6
Immediate managers	7.1	7.2	6.9	7.4
Morale	6.2	6.2	6.0	6.7
Quality of Care	7.2	7.4	7.0	7.7
Quality of appraisals	5.5	5.5	4.8	6.0
Safe environment - Bullying	8.2	8.2	7.6	8.6
Safe environment - Violence	9.4	9.5	9.2	9.7
Safety Culture	6.7	6.8	6.4	7.4
Staff Engagement	6.8	7.0	6.4	7.4

The themes 'Quality of Care' and Staff Engagement' are 0.2 below average. The themes 'Immediate Managers' and Safe Environment-Violence are 0.1 below average. Other themes are average.

Results by BDU are summarised below:

Theme results	Trust	Barnsley	Cald/Kirk	Forensic	Specialist	Support	W'field
Equality, diversity and inclusion	9.2	9.3	9.1	8.8	9.0	9.4	9.3
Health and Well-being	6.1	6.2	5.8	5.8	5.7	6.7	6.0
Immediate managers	7.1	7.1	7.2	7.3	6.8	7.2	7.2
Morale	6.2	6.4	6.1	6.2	5.7	6.3	6.5
Quality of Care	7.2	7.4	7.2	7.1	6.5	7.2	7.5
Quality of appraisals	5.5	5.4	5.5	5.2	5.0	5.6	5.9
Safe environment-Bullying	8.2	8.5	8.0	7.1	8.0	8.9	7.9
Safe environment-Violence	9.4	9.5	9.3	8.2	9.5	9.9	9.0
Safety Culture	6.7	6.9	6.7	6.8	6.3	6.8	6.7
Staff Engagement	6.8	6.9	6.8	7.0	6.5	6.9	7.0

Barnsley and the Support Services have higher staff satisfaction scores with Specialist Services and Forensics having lower than average results overall.

2. Action Planning

2.1 Trust wide action planning

The results inform the implementation of Key Trust strategies / objectives such as the Workforce Strategy and Patient Safety Strategy. Results will be reviewed in the Trust Well-being Partnership Groups, BDU well-being groups, and other Trust action groups.

Equality related data will be used by the Equality and Inclusion Forum to inform the EDS2, WRES and DES action plans.

Professional leads will also review their data to identify any actions required.

An action plan will be developed which is submitted to the CQC as part of their inspection process.

2.2 BDU/Service line data/Local Action Planning

NHS England provide results for each BDU as detailed above.

Individual question data by service line is also available and will be circulated to the BDU Leadership Teams.

Each BDU will be reviewing their data and developing local action plans by the end of April 2019. There is significant variation in results across the Trust and each BDU / Support Service will be engaging staff to support plans which are relevant to the service and informed by the survey results. Each BDU Partnership Forum should also review their results as part of the action planning process.

3. Further developments planned in 2019 to address survey feedback

Two key areas of focus during 2019 will be to preventing bullying and harassment in the workplace and improving levels of Staff Engagement.

A bullying and harassment action plan was agreed at the February 2019 Workforce and Remuneration Committee. At a Trust level results indicate lower than average levels of bullying from managers to colleagues and also colleague to colleague. There is variation in results across the service. Mental health services generally report lower than average levels of bullying from managers to colleagues. CAMHS staff report higher levels of bullying from managers. Forensics and CAMH services report higher levels of bullying between colleagues. Bullying, harassment and abuse from patients / service users, relatives or members of the public is above average. A clinical network has been established to look at how we reduce bullying and harassment from service users and carers led by the Deputy director Forensic Services.

Staff Engagement scores have remained stable over the last five years at either 6.9 or 6.8. However the 2018 score of 6.8 is 0.2 below average. The Staff Engagement theme in the NHS Staff Survey comprises of three elements:

- Motivation, i.e. looking forward to going to work, enthusiasm about the job and time passes quickly. Levels of reported motivation are around 5% below average.
- Ability to contribute to improvements at work. Trust scores are around 2% below the national average.
- Recommendation of the Trust as place to work or receive treatment. 75% of staff felt care of service users is the Trust's top priority which is 1% above average. 59% of staff would recommend the Trust as a place to work which is average although this has increased from 56% in 2014. 65% of staff would recommend the Trust to family and friends as a place to receive care and treatment, this is 1% below average although has increased by 2% since 2017.

The 'Middleground' leadership forum ran in 2018 and is being reviewed focussing on improving staff engagement, workplace well-being and preventing bullying and harassment. Survey data will also be used to inform our leadership and management development offer.

Patient Safety including the Freedom to speak up Guardian role remains a key priority for the Trust. The Safety culture theme scores vary from Barnsley at 6.9 to Specialist Services at 6.3. Data can be used to target patient safety activity.

Survey data will be used to inform the work of the Recruitment and Retention Strategy group.

4. Conclusion

The NHS Staff Survey provides extremely important feedback on colleague's experience of working for the Trust. The Trust scores average across the 10 themes highlighted in the survey, however, the organisational ambition is to see improvements in four key areas:

- Staff Engagement
- Quality of Appraisal
- Staff Wellbeing
- Preventing Bulling and Harassment

There will be greater emphasis on the development of local BDU / Directorate action plans through staff engagement.

More detailed analysis of the results and further drilling down into service lines is taking place. A more in depth report and action plan will go to the Workforce and Remuneration Committee in May 2019. Key high level actions to date / planned are:

1. A session with Extended EMT on the results of the NHS Survey has taken place.
2. February's Staff Brief detailed the leadership challenge and the importance of local action planning.
3. BDUs to produce a local action plan with a particular focus on the four priorities identified above by end of April 2019.
4. Appraisal form to be updated following feedback, new guidance for appraisees and appraisers to be issued and training to be offered on effective appraisal for both appraises and appraisers.
5. Action plan already agreed on preventing bullying and harassment.
6. Middleground to be re-launched with a stronger focus on behaviours, healthy teams and staff engagement.
7. OD Plan to include support on the four key priorities.
8. Targeted action plan to be agreed for Forensic Services and CAMHs.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 March 2019
Agenda item 6.3

Title:	**Clinical Record System for Mental Health programme – update**
Paper prepared by:	Director of Strategy
Purpose:	This paper provides Trust Board with; • Update and progress with Go Live. • Key milestones and related decision points for the programme from February 2019 onwards to the close down of the programme in May 2019 and move in to the optimisation phase.
Mission/values:	The Clinical Record System (CRS) for MH programme is a key priority programme for the Trust and is in line with our mission and values.
Any background papers/ previously considered by:	This is an update from the papers that were presented for discussion in December 2018 and to the extraordinary Board on the 11 February 2019. Updates with detailed discussions at EMT and the programme steering group have also informed this paper.
Executive summary:	The programme is being governed and managed in line with the Trusts Integrated Change Framework as a Trust wide programme. During the October EMT meeting a decision was made to defer the Go Live date for the CRS that was planned for January 2019. The Go Live plans were revised to Monday 25 February 2019 through to 5 March 2019. The Go Live approach included a phased business Go Live. This paper provides an update on the following; • Inpatient & Community Go Live • Continued support to services • key programme milestones **Risk Appetite** This update supports the risk appetite identified in the CRS Programme and Trust risk register.
Recommendation.	**Trust Board is asked to;** • **NOTE** the CRS Go Live progress update and on-going management of key risks • **NOTE** the key programme milestones
Private session:	Not applicable.

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Trust Board - 26 March 2019
Clinical Record System for Mental Health Programme Update

1. Purpose

The programme is being governed and managed in line with the Trusts Integrated Change Framework as a Trust wide programme. This paper provides an update on Go Live and Go Live assessment papers submitted to the Executive Management Team (EMT) on the 24 February 2019 and 4 March 2019, the paper sets out the following:

- Update and progress with Go Live.
- Key milestones and related decision points for the programme from February 2019 onwards to the close down of the programme in May 2019 and move to the optimisation phase.

2. Background to the programme

We have replaced our mental health clinical record system, RiO, with SystmOne. In October EMT agreed to defer the planned Go Live date from January 2018 on the basis of a number of factors, including acknowledging the significant impact and implications of the three week Cut Over approach and planning required to ensure a safe transition. The revised plan for Go Live was phased, **from Monday 25 February 2019 through to Tuesday 5 March 2019.**

The Trust **Executive Management Team** (EMT) acts as the programme board for all the priority programmes, of which this programme is one. EMT received an update on the development of the Cut Over and Go Live planning on 6 December 2018, and the Programme Steering Group (PSG) received a detailed presentation of the activities related to Cut Over planning on the 12 December 2018 these were further discussed at Trust Board in December. A detailed stage plan was developed to provide additional controls and weekly status reports put in place from 8 January 2019 to monitor progress against as well as increase confidence and assurance to Go Live in February 2019. An independent internal Audit was also carried out to support the Go Live readiness assessment and the results were used to inform the final Go / No Go Decision made by Executive members. There were further detailed updates to Trust Board in January and February.

3. Programme overview - progress

Since the last report to Trust Board the Trust has successfully gone live on SystmOne (inpatients 25/02/19 and community mental health plus LD inpatients 5/04/19).

The decision to Go Live was taken following status calls with relevant executives/Non executive representation over the two Go Live weekends with a detailed assessment against the Go Live criteria check-list provided by the programme lead 12-16 hours before each planned Go Live to ensure the information was as accurate as possible.

Over the start-up weekends 18,000 pieces of data where transferred by 200+ staff from RIO to SystmOne to ensure that all inpatients and new community patients were accounted for on Go

Live, this task was managed from a central command centre across three locality hubs that were supported by both core programme team staff and the support of operational colleagues.

At the time of writing this report the Trust is on day 16 of inpatient Go Live and day 8 of community Go Live. Therefore, it is still very early days but the current picture is positive. There are some "teething" issues which would be expected with such a significant change and the programme team has set up a 24/7 helpline/email address for staff and is working with operations to ensure a smooth transition between systems. As well as this the team have deployed floor walkers across the Trust and optimised the use of our 300+ super-users.

Common themes posts Go Live via the helpdesk include:

- System functionality queries (help with processes)
- Configuration of rotas migrated from RiO – (this was anticipated due to the different configurations)
- System access level queries – mostly people who hadn't logged on to RIO with a smartcard previously)

In addition further work has been required to support mental health act set-up and e-discharge for pharmacy.

On day one of community Go Live the Trust also successfully pulled down a standard reporting extract from SystmOne this was critical as it forms the basis for all of our reports. We are as previously indicated aware that there may be some data completeness / quality issues as staff get used to the new system but we are closely monitoring these.

The Delta cut is on track to repatriate some data for existing patients (progress notes, scanned documents and assessments) for the period 9 February to 4 March on the 13 March 2019, this should considerably reduce the amount of data entry for teams. The remaining data entry is required to be complete by 31 May 2019 ahead of RIO switch off on 30 June 2019. Plans for this are in progress and on track.

Training will re-commence week commencing 18 March 2019 to offer refresher training to staff and additional specialist training/support is being provided to super users by TPP early April 2019. This said the final training figures for Go Live were very positive as detailed below:

All Staff	Current	80%
Front Line Staff	Current	88%
Registered Staff	Current	89%

Further assurance was sought from services that they had sufficient SystmOne trained staff on duty for the first two weeks post Go Live.

4. Key post Go Live Issues and Risks

In addition to the programme risks identified there were two key issues that were outstanding at the time of inpatient Go Live.

Item	Description	Mitigation and update
1. The lack of suitable care plan functionality	The current care plan functionality does not satisfy the requirement of the clinical leads assuring it.	A workaround care plan was in place at Go Live, this has had further refinement since Go Live and although not ideal does allow recording on care plans in SystmOne, TPP are on track to deliver a mental health care plan by 31/05/19.
2. Training targets not met	85% of staff need to be trained by the end of February 2019 and be competent in using the system	The training figures at Go Live were – 80% all staff, 88% frontline and 89% registered staff with assurance from teams they had sufficient cover in place. Training/refresher training will continue from 18/03/19.

5. Recommendations

The board are asked to:

- **Note** the CRS Go Live progress update and on-going management of key risks
- **Note** the key issues and risks post Go Live
- **Note** the key programme milestones in Appendix 1

Appendix 1 - Revised Key Milestones and decision points

Change Phase	Key milestone	Decision point	Proposed Trust Board assurance/role
Co-Deliver	Feb 2019: **Users trained**	EMT 28/02/2019	IPR to include details of training including numbers across service lines
	Feb 2019: **Data Migrated**	EMT 28/02/2019	IPR and update to March Trust Board
	Feb 2019: **Go Live/ No Go Live decision**	EMT 21/02/2019	IPR and update to Trust Board in February (with NED involvement in decision)
	Feb 2019: **Data migration re-validated and 'signed-off'**	Work stream lead	IPR update
	Mar 2019: **Completion of reports validated**	Head of Performance and Information	IPR
	April 2019: **Initial Implementation Review**	EMT 04/04/2019	IPR and summary report to April Trust Board
End of Co-Deliver Phase	May 2019: **Programme Closure and move to Optimisation Phase**	EMT– date to be determined Programme Steering Group, 09/05/2019	IPR and end of Project report to Trust Board to support decision on closure of programme
	May 2019: **Implementation Review**	Programme Steering Group 21/05/2019 EMT – date to be determined	Audit report to Audit Committee, EMT and update to Trust Board
Post Go Live Optimisation Phase	To be confirmed	To be confirmed	To be confirmed

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Trust Board 26 March 2019
Agenda item 6.4

Title:	**Freedom To Speak Up Vision & Strategy and Freedom To Speak Up Guardian (FSUG) Update**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates
Purpose:	Creating a culture where staff feel safe to raise concerns at work, requires a strong and clear commitment from the Trust. A key recommendation following the Francis Report was the development of a Freedom to Speak Up Guardian (FSUG) role and this paper provides an update for the Board. The 18/19 Freedom to Speak Up action plan was developed using the National Guardian's Office self-assessment tool and included a Vision and Strategy signed off by the Board for Freedom to Speak up. A vision and strategy has been developed in partnership with the FSUG and has also been discussed with Staff Side.
Mission/values:	This paper supports directly and indirectly all of the Trust's values, particularly being Open, Honest and Transparent.
Any background papers/ previously considered by:	The Trust Board approved the development of the FSUG network on October 2017. The Clinical Governance and Clinical Safety Committee and EMT have received updates from on the FSUGs. The Clinical Governance and Clinical Safety Committee received the latest update in September 2018 which included a proposal to develop a business case for further dedicated FSUG time, which the Committee supported. The Executive Management Team (EMT) signed off a business case as part of the 2019/20 annual plan for a 0.5 whole time equivalent secondment to the FSUG role.
Executive summary:	The Trust has always recognised the importance of creating an organisational culture where staff feels able and safe to raise concerns at work including malpractice, service user and staff safety issues, harassment and bullying and fraud. To support this, the Trust established a network of Freedom to Speak Up Guardians. The role of the FSUGs is typically defined as helping to increase the profile of raising concerns, providing confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concerns have been handled. The biggest issue from the FSUG network was the need for more dedicated time to allow the proactive element of the role to be developed further. An investment of five hours a week of dedicated time was made available to one of the FSUG network from March 2018.

	This dedicated time has clearly had a significant impact and enabled the FSUG role and function to develop over the past 12 months. Whilst the dedicated five hours of FSUG time has been a real benefit the network believe that additional time is required to maximise the role and function. A business case was approved by the EMT for a half time secondment to a FSUG lead post. The network feels that there should be a maximum time for someone to be in such a role and therefore there is agreement it should be for a maximum of two years. The Trust recently updated a national self-assessment tool on the development of freedom to speak up within the organisation. The updated self-assessment is attached. A key action identified from the self-assessment was the development of a high level vision and strategy for the freedom to speak up. Attached is a vision and strategy which has been developed with FSUGs and discussed with Staff Side. The Vision and Strategy have been deliberately designed to be very simple, clear and complimentary to the Trust's overall Vision, Strategy and Values. The FSUG report that they have had a total of 14 cases raised with them in 18/19, seven of which concern allegations of bullying and harassment on staff. The Clinical Governance and Clinical Safety Committee will receive a more detailed update at its meeting in April 2019 from the FSUGs. **Risk Appetite** The FSU action plan and update along with the proposal for Vision and Strategy are consistent with the Trust's risk appetite for both workforce and patient safety
Recommendation:	**The Trust Board EMT is asked to NOTE the FSU update and approve the Vision and Strategy**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Freedom to Speak Up: Update

1. Introduction

The Trust recognised the importance, as part of a culture of safety and respect, of staff feeling able and safe to raise concerns at work. Guidance for staff on the different ways to raise concerns at work, including malpractice, service user and staff safety issues, harassment and bullying and fraud is provided to all staff, this is attached in appendix 1 for information. Included in this guidance is role and function of the Freedom to Speak Up Guardians (FSUG) and this paper provides an update on the development and activity of the guardians.

Initially a Freedom to Speak Up Guardian network was established and made up of Staff Governors. The BAME staff network was asked to nominate someone to join the FSUG network to widen the representation of members. The recently elected Staff Governors were given the option whether or not to become a FSUG and a number felt it was too much commitment and decided not to join the network. There are currently four active FSUG network members three staff governors and a representative from the BAME Staff Network.

In support of the FSUG network it was agreed that a day a week dedicated time would be provided to one of the guardians and this commenced in March 2018.

The role of the FSUGs is typically defined as helping to increase the profile of raising concerns, providing confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concerns has been handled. The dedicated time has seen the proactive role of the FSUG role really develop over the past 12 months.

This paper provides update on the FSU action plan and the self-assessment tool for NHS organisations which was completed in consultation with the FSUG and Staff Side. An action from the self-assessment tool is a vision and strategy for Freedom to Speak Up signed off by the Trust Board. A clear and simple FSU vision and strategy is attached for consideration and approval by the Trust Board.

2. Freedom to Speak Up Action Plan 18/19

An action plan was develop for 18/19 based on the self-assessment tool and agreed by the EMT and an update is provided below:

Action	Comments	Date
Trust Board to agree FTSU Vision and Strategy	Vision and strategy developed and agreed with the FSUGs, Staff Side and the EMT. Due to go to the Trust Board in March 2019	March 2019
Develop clear implementation plan for FTSU vision and strategy	To be part of the Trust Board paper at March's meeting	March 2019
Agree Speaking Up Policy including review and audit	Agreed and signed off by EMT	Complete
Development of Proposal for a post to undertake the lead role for the FTSU Guardian Network	Business case approved by EMT for a 0.5wte secondment to FSUG role as well as the network. Post going through agenda for change and to be advertised in Feb/March	Complete
Communications and engagement plan updated	Posters and engagement events organised	Complete
Non Staff Governor FTSU Guardian Network Members to meet with Chair	FTSU network originally made up of staff governors but has been extended to include Staff Equality Network representatives.	On-going
Annual report to included FTSU report	Future annual plans to include FTSU report	April 2019
Development of executive lead links with local Trusts	Director of HR, OD and Estates to establish links with local Trusts	On going
Strengthen direct links between NED lead and FTSU Guardians	FTSU Guardians meets NED through the Clinical Governance and Clinical Safety Committee. The links outside of the meeting to be strengthened with Deputy Chair to meet with FSUG network	On-going

A 19/20 action will be developed in partnership with the FSUGs and Staff Side and will go to the Clinical Governance and Clinical Safety Committee in April 2019.

3. National Guardian Office: Self-Assessment Tool

The National Guardian Office produced a helpful self-assessment tool for NHS organisations which was completed in partnership with the FSUGs. The updated self-assessment is attached.

The key actions from the self-assessment were captured in the 18/19 action plan detailed above.

The self-assessment tool will be used again to inform the 19/20 FSU action plan.

4. Freedom to Speak Up Vision and Strategy

A key action from the self-assessment tool was a FSU Vision and Strategy. In partnership with the FSUG a clear and simple Vision and high level Strategy was developed which the Staff Side were consulted upon and agreed too.

The Vision and Strategy is attached and the Trust Board is asked to approve it.

5. Recommendations

The Trust Board is asked to:

- Note the update on the FSU 18/19 Action Plan and Self-Assessment Tool
- Approve the FSU Vision and Strategy

Alan Davis
Director of Human Resources, Organisational Development and Estates

What if you still have concerns?

If you've tried the methods above and still have concerns, you have the right to contact any director of the Trust. You will be heard in confidence and your concerns will be listened to and taken seriously.

You may also want to think about speaking to a staff side organisation.

Developing and encouraging good practice

Appraisal interviews

These are where you agree annual objectives which identify your personal part in helping the Trust achieve its mission. Your achievement against these objectives, Trust values and behaviours is reviewed on a regular basis with your line manager.

Professional meetings

Professional meetings (both uni and multi professional) provide an opportunity to raise matters concerning good and bad practice, as well as sharing learning/experience and enabling issues on standards to be raised.

Managerial supervision

All managers of staff, particularly clinical staff, should have processes in place to appraise the clinical practice of the staff that they manage. There are a number of ways to do this, including feedback from peers, reviewing records, or using audit information.

Clinical supervision

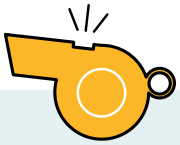
All clinical staff within the Trust are encouraged to seek out clinical supervision from whoever they feel can help them to reflect on clinical practice issues. This process is strongly encouraged, as it enables self-learning.

Staff counselling and therapy service

The Trust offers a range of staff support, including individual counselling designed to help staff to deal with and resolve work related problems. Contact occupational health for more.

Uni and multi disciplinary audit

A range of uni and multi disciplinary audits are undertaken within the Trust which helps identify clinical performance in individuals and teams that can be improved.



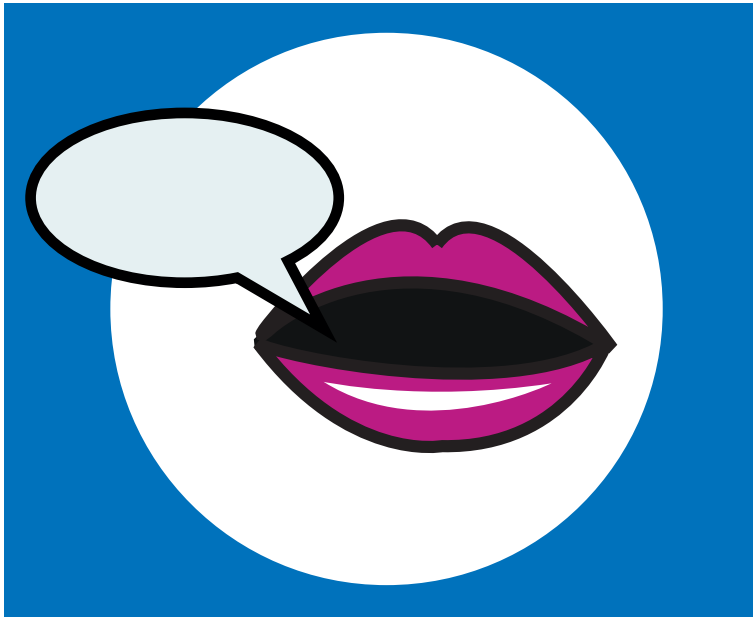
More information about whistleblowing, including our policy, is available on the intranet.

For more advice, contact human resources.

Job no. 0555 Apr 18

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Speak up



Raising concerns at work

With **all of us** in mind.

We want you to feel confident to speak up if you want to raise an issue or concern. These concerns may be about professional conduct, standards of care, or something you feel concerned about in the workplace. Issues can be raised whether you're an employee, an agency worker, a volunteer or a student working in the Trust.

How to raise a concern

Problems are best resolved when they are first identified. This not only leads to less distress for people using our services (where it involves patient care), but also leads to more effective results.

Direct discussion with the person

If you have doubts about a colleague's conduct or performance, you could raise this tactfully with them direct. This way, concerns may be resolved at an early stage.

Reporting to line management

We encourage staff to discuss concerns in an open and honest way with their line manager. If you have concerns about practices in agencies or contractors that the Trust works with, then you can also talk about this with your manager. When your manager isn't available (eg out of hours) then it may be appropriate to contact the 'on call' manager.

Incident reporting

You're encouraged to log incidents which happen at work on Datix. This helps us to identify problems, find trends and make improvements.

Safeguarding children and vulnerable adults policy

We have policies to protect children and vulnerable adults which must be used where there is concern about inappropriate care. Not acting appropriately could place professional staff in breach of their professional code.

Harassment and bullying policy

This policy enables you to address harassment and bullying in the workplace. Issues raised will be taken seriously even if the harasser works for another organisation.

Anti fraud, bribery and corruption policy

We all have a duty to report any suspicions. Any concerns of fraud should be reported to the Trust's director of finance (01924 316306) and not to a line manager.

Grievance procedure

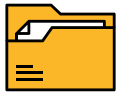
This procedure enables you to raise matters with your immediate supervisor. If issues are not resolved they can then progress through further stages.

GMC performance procedures

There is a process set out by the General Medical Council (GMC) for assisting doctors. Where a doctor's professional performance is seriously deficient the GMC's performance procedure should be followed. You can get details of this procedure from the GMC or from human resources.

Freedom to speak up guardians

We have a number of freedom to speak up guardians who can provide confidential advice and support on how to raise concerns.



Professional bodies

As a member of a professional body, you're expected to meet the standards set by that organisation. The standards of practice are set out in their code of conduct. You also have a duty to encourage good practice and raise concerns when professional practice or performance is below standard.

National Guardian
Freedom to Speak Up

NHS
Improvement

Freedom to Speak Up self-review tool for NHS trusts and foundation trusts

May 2018

How to use this tool

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust.

NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Our expectations			
Leaders are knowledgeable about FTSU			
Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office.	GREEN The Board through the Clinical Governance and Clinical Safety Committee (CG&CS) supports and has promotes the role of the FTSU network and has a good understanding of and recognises the importance of staff being confident and feeling safe to raise concerns	Trust Board to agree the FTSU Vision	6 monthly reports to the Board through the CG&CS Committee. 6 weekly meetings with the Director of HR, OD and Estates (Executive Lead) takes place with the FTSU Guardians Network Staff Governors who are members of the FTSU Guardian network meet with the Chair regularly FTSU guardians attend Executive Management Team meetings at least 3 times a year

Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up.	GREEN FTSU network has strong links to the executive team and the CG&CS Committee	Development of clear vision and action plan for FTSU Strengthen direct links with Non-Executive lead	FTSU Network meets every 6 weeks with the Director of HR, OD and Estates FTSU Guardians attend Executive Management Team meetings FTSU Guardian attend Extended EMT and present FTSU part of the Team Brief 6 monthly report to Clinical Governance and Clinical Safety Committee (Sub Committee of the Trust Board)
They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up.	GREEN Trust has a strong valued based approach to leadership and management development This includes a set of leadership values which has safety and openness at the core		Development of Values into Behaviours as part of the Trust value based leadership and management development approach Middleground programme involves 400/500 middle managers, clinicians and staff side has a meeting and discussion with Trust Board members Development of FTSU is part of the Trust's OD and Workforce Plans

	A culture which reflects a duty of candour has been a key development for the Trust		
Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.	AMBER The Trust is currently developing its formal FTSU Vision and Strategy	Development of FTSU Vision and Strategy following evaluation of the pilot	Regular meetings with Executive, Chief Executive and Chair 6 monthly meetings with Clinical CG&CS Committee FTSU guardians regularly update with the EMT
Leaders have a structured approach to FTSU			
There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement.	AMBER FTSU development part of the Workforce Strategy and OD action plans Need to develop a formally signed off FTSU vision and strategy	Development of FTSU Vision and Strategy following evaluation of the pilot	Trust Board paper on the development of the FTSU network. CG&CS Committee

There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement.	AMBER Policy developed in consultation with FTSU guardians and Staff Side. Awaiting final sign off with Staff Side before it goes to EMT and Board	To be signed off by staff side/Executive Management Team	Policy has been developed based on the NHS Improvement template and in consultation with operational managers, staff side representatives & FTSU guardians. The policy incorporates previous "whistleblowing" principles
The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian) and it aligns with existing guidance from the National Guardian.	AMBER The formal vision and strategy needs sign off by the Trust Board	Development of FTSU Vision and Strategy following evaluation of the pilot	Implementation plan/action plan agreed with FTSU Guardians as confirmed in annual report and update.
Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.	AMBER The formal vision and strategy needs sign off by the Trust Board	Development of FTSU Vision and Strategy following evaluation of the pilot	Regular reports submitted to a board sub committee (Clinical Governance and Safety Committee). 6 weekly meetings with Director of HR, OD & Estates. Meetings with EMT 3 times a year. Presentation to extended EMT

Leaders actively shape the speaking up culture			
All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.	GREEN A culture of safety, openness and learning is a key strategy for the Trust		FTSU guardian engagement with EMT, CGCS Committee, Executive leads and chair
They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.	GREEN A culture of safety, openness and learning is a key strategy for the Trust		Board, CGCS Committee, EMT and EEMT meetings
Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers.	GREEN Trust has a number of ways to get staff feedback		Chief Executive annual engagement workshops, Staff Partnership Forums, annual Wellbeing and Engagement, Team Brief
Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian.	GREEN Regular senior leader meets with FTSU	Strengthen direct link with Non-Executive lead	FTSU Network meets every 6 weeks with the Director of HR, OD and Estates. FTSU Guardians attend Executive Management Team

			FTSU Guardian attends Extended EMT and present FTSU part of the Team Brief 6 monthly report to Clinical Governance and Clinical Safety Committee (Sub Committee of the Trust Board)
Senior leaders model speaking up by acknowledging mistakes and making improvements.	GREEN A culture of safety, openness and learning is a key strategy for the Trust		Trust Board and CG&CS Committee discussions Patient Safety Arrangements Whistleblowing Policy Raising concerns leaflet
The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.	AMBER The Board recognises that further work following feedback from the Wellbeing and Engagement survey further embedding across the Trust	Continued communication and engagement plan part of the action plan	Board, CGCS Committee, EMT and EEMT meetings

Leaders are clear about their role and responsibilities			
The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility.	GREEN		Named Executive Director is Director of HR, OD and Estates. Deputy Chair/Chair of Clinical Governance/Senior Independent Director is the named non-executive director. Director of Nursing and Quality is the designated senior manager for raising concerns (whistleblowing)
They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.	GREEN FTSU guardian have confirmed access to Chief Executive	All FTSU network members to meet with Chair	Staff governors who form the FTSU network met with Trust Chair regularly. Network has been extended recently to include Staff Equality Network.
Other senior leaders support the FTSU Guardian as required.	GREEN		Guardians are aware they can contact any Trust director.

Leaders are confident that wider concerns are identified and managed			
Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns.	GREEN		Data provided on request to the FTSU guardians network.
The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.	GREEN		Open door approach to board/executive relevant to particular issues raised. 6 weekly meetings take place with the Director of human resources, organisational development and estates. Periodical reports and discussion at EMT and the clinical governance and safety committee
Leaders receive assurance in a variety of forms			
Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.	AMBER The Board recognises that further work following feedback from the Wellbeing and Engagement	Continued communication and engagement plan part of the action plan	Latest wellbeing survey results. On average 68% of respondents said they agreed/ strongly agreed that they were able to raise concerns with their local management team. On average 35% of respondents said that they agreed/strongly agreed that the Trust listens and acts when concerns are raised

	survey further embedding across the Trust		New section created on the Trust's intranet with a link on the front page providing ease of access to information on How to raise a concern; Whistleblowing; and FTSU guardians including who they are and contact details Dedicated (confidential) email address established with access only available to FTSU guardians Further engagement is planned with staff in all areas of the Trust
Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers	GREEN	Membership of FTSU Guardian network to be extended to all Staff Equality Networks as they develop	FTSU guardian recruited from BAME staff network. Has delivered presentations on the FTSU guardian role and FTSU processes to network members Other equality networks are being established and they will receive the same input from the FTSU guardian's network once they are fully established
Speak up issues that raise immediate patient safety concerns are quickly escalated	GREEN		FTSU guardians confirmed that they are confident that they can immediately escalate patient safety

			issues with the relevant Trust director.
Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority	GREEN		Example of a case that has been escalated to the Chief Executive and Director of HR, OD and Estates. A support plan was agreed in consultation with the individual and their staff side representative.
Lessons learnt are shared widely both within relevant service areas and across the trust	GREEN		Patient safety issues are reviewed by the patient safety group, staff partnership forums and HR/staff side meeting. Discussions will take place at staff networks to share learning
The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented	AMBER This will be built into the new policy review	Action following new policy implementation	Policy developed in consultation with FTSU guardians and Staff Side. Awaiting final sign off with Staff Side before it goes to EMT and Board
FTSU policies and procedures are reviewed and improved using feedback from workers	GREEN	Action following new policy implementation	All policies are subject to a review cycle and are consulted upon via the employment policy group which is made up of management

			and staff representatives. Input has already been received from the BAME staff network and will be requested from other equality networks once they are fully established
The board receives a report, at least every six months, from the FTSU Guardian.	GREEN		Board/Clinical Governance and Safety Committee receive updates
Leaders engage with all relevant stakeholders			
A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.	GREEN		Trust runs a wellbeing survey and this is used to develop local and trustwide action plans. Specific questions are included in the survey relating to raising concerns
Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.	GREEN		Data shared with CQC and NHSI and where appropriate with local commissioners
Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals).	GREEN		Discussed at board through reports from clinical governance and safety committee
The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture.	AMBER	To be included in annual report	

Reviews and audits are shared externally to support improvement elsewhere.	GREEN		As appropriate
Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture	GREEN		FTSU guardians attend national and local meetings which are supported by the Trust
Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians	GREEN		Encouraged to develop networks with other organisations and have access to CQC inspectors as appropriate and included in CQC reviews
Senior leaders request external improvement support when required.	GREEN		As appropriate
Leaders are focused on learning and continual improvement			
Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.	GREEN		Through engagement and quality improvement events
Senior leaders and the FTSU Guardian engage with other trusts to identify best practice.	AMBER FTSU Guardians have engaged with other Trusts through regional and national networks	Development of senior leaders with other local Executive lead	Through regional meetings to identify and discuss best practice

Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities.	GREEN		FTSU guardians review all guidance and case reviews. Summary reports to be included in clinical governance/clinical safety updates
Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.	GREEN		Part of Trust quality improvement strategy
The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.	AMBER Evaluation to be built into policy and regular reports to the CG&CS Committee		6 weekly meeting between FTSU guardians and Director of HR, OD and Estates
The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.	GREEN		Annual review in partnership with FTSU guardians.
A sample of cases is quality assured to ensure: • the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured	AMBER Cases discussed with Director of HR,OD and Estates as part of the 6 weekly review	Audit to take place annually	Where appropriate, cases are reviewed by Director of HR and Director of nursing and quality

• workers are thanked for speaking up, are kept up to date though out the investigation and are told of the outcome • Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored			
Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.	AMBER Built into the Communication plan		Part of ongoing communications and engagement programme
Individual responsibilities			
Chief executive and chair			
The chief executive is responsible for appointing the FTSU Guardian.	GREEN		Trust Board agreed the Staff Governors to form FTSU network. Proposal for further appointment to the network to be considered by EMT
The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust.	GREEN		Trust Board agreed the Staff Governors to form FTSU network.

			Proposal for further appointment to the network to be considered by the EMT
The chief executive and chair are responsible for ensuring the annual report contains information about FTSU.	GREEN	FTSU to be included in future annual reports	
The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's Office.	GREEN		FTSU guardians actively engaged with regional and national guardian network and office and report into CG&CS Committee
Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.	GREEN		See earlier responses
Executive lead for FTSU			

Ensuring they are aware of latest guidance from National Guardian's Office.	GREEN		Director of HR, OD and Estates regularly meets with FTSU Guardians
Overseeing the creation of the FTSU vision and strategy.	GREEN		Director of HR, OD and Estates regularly meets with FTSU Guardians
Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian.	GREEN		Director of HR, OD and Estates regularly meets with FTSU Guardians
Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence.	GREEN		Protected time allocated and reviewed regularly

Ensuring that a sample of speaking up cases have been quality assured.	AMBER	To be included in action plan	
Conducting an annual review of the strategy, policy and process.	AMBER	To be included in action plan	
Operationalising the learning derived from speaking up issues.	GREEN		Director of HR, OD and Estates regularly meets with FTSU Guardians and progresses action as appropriate
Ensuring allegations of detriment are promptly and fairly investigated and acted on.	GREEN		Director of HR, OD and Estates regularly meets with FTSU Guardians and progresses action as appropriate
Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.	AMBER To be included as part of ongoing evaluation and reporting		Regular reports go to the CG&CS Committee
Non-executive lead for FTSU			

Ensuring they are aware of latest guidance from National Guardian's Office.	GREEN		Non-Executive lead chairs CG&CS Committee and Senior Independent Director
Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy.	GREEN		Non-Executive lead chairs CG&CS Committee and Senior Independent Director
Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement.	GREEN		Non-Executive lead chairs CG&CS Committee and Senior Independent Director
Role-modelling high standards of conduct around FTSU.	GREEN		Non-Executive lead chairs CG&CS Committee and Senior Independent Director Appraisal
Acting as an alternative source of advice and support for the FTSU Guardian.	AMBER	Direct access to Non-Executive Lead to be strengthened	Non-Executive lead chairs CG&CS Committee and Senior Independent Director
Overseeing speaking up concerns regarding board members.	GREEN		Non-Executive lead chairs CG&CS Committee and Senior Independent Director

Human resource and organisational development directors			
Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up.	GREEN		Named HR Business partner acting as link to FTSU guardians to respond to queries re policies and requests for information
Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust.	AMBER	Further engagement to be part of new policy launch.	Forms part of staff induction/welcome event
Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.	GREEN		Included on trust welcome event. Annual values based appraisal. Management development programmes. Annual training needs analysis
Medical director and director of nursing			
Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues.	GREEN		FTSU Guardians have access to Medical and Nursing Director as appropriate
Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up.	GREEN		FTSU Guardians have access to Medical and Nursing Director as appropriate

Ensuring learning is operationalised within the teams and departments that they oversee.	GREEN		FTSU Guardians have access to Medical and Nursing Director as appropriate

South West Yorkshire Partnership NHS Foundation Trust

Draft Freedom to Speak Up Vision and Strategy: Embedding a Culture of Safety and Respect

Purpose

The purpose of this document is to set out clearly and simply South West Yorkshire Partnership NHS Foundation Trust's vision for safety and respect in the workplace including creating the right culture and environment for speaking up**.**

The Trust is fully committed to embedding a culture of safety and respect and recognises this requires staff to feel safe, able and confident to raise concerns. The freedom to speak up on issues that could impact directly or indirectly on the safety and quality of services has shown to be an essential element of a delivering compassionate care.

This document describes South West Yorkshire Partnership NHS Foundation Trust's Freedom to Speak Up vision and strategy and the high level actions which supports everyone feeling safe, able and confident to raise concerns at work. It takes full account of national guidance including the review by Sir Robert Francis in 2015 and the National Guardian reports.

Our mission, vision and values

Our mission is to help people reach their potential and live well in their community. Our vision is to provide outstanding physical, mental and social care in a modern health and care system.

Our mission and vision are underpinned by a strong set of values and these are directly linked to the ethos of Freedom to Speak Up:

- 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

We are committed to promoting an open and transparent culture across our organisation to ensure that all members of staff feel safe, able and confident to speak out.

Our Board and senior leadership team will support this agenda by:

- Modelling the behaviours to promote a positive culture in the organisation
- Providing the resources required to deliver an effective Freedom to Speak Up function
- Having oversight to ensure the policy and procedures are being effectively implemented
- Ensuring that staff who raise concerns in good faith are protected and do not suffer a detriment

Our FTSU Guardians have a key role in:

- Helping to raise the profile of raising concerns in our organisation.
- Providing confidential advice and support to staff in relation to concerns they have.
- Providing confidential advice and support to staff in relation to the way their concern has been handled.
- To advise the Chief Executive and where appropriate the Trust Board on issues of concern and barriers to staff feeling safe, able and confident to speak freely.

The Trust is fully engaged with the National Guardian's Office and the local network of Freedom to Speak Up Guardians in our region to learn and share best practice.

Our Strategy

The Trust will take the following actions to deliver this vision:

- Implement separate policies, which clearly differentiate between a grievance and raising a concern (whistleblowing).
- Increase awareness of staff so they are clear about their rights and responsibilities in raising concerns.
- Ensure that there are clear and easy ways to raise concerns.
- Ensure managers are clear about their roles and responsibilities when handling concerns and are supported to do so effectively.
- Provide regular communications to all staff to raise the profile and understanding of our raising concerns (whistleblowing) arrangements.
- Communicate key findings to staff about the level and type of concerns raised and any resultant actions taken, as is appropriate under the scope of confidentiality.
- Share good practice and learning from concerns raised, through a variety of fora, with the key aim of fostering openness and transparency.
- Actively seek the opinion of staff to assess that they are aware of and are confident in using local processes and use this feedback to ensure our arrangements are improved based on staff experiences and learning.
- Ensure that staff who raise concerns in good faith are protected and do not suffer a detriment.

- To establish a network of FSUGs including dedicated time for a lead Guardian role with strong links to the Members Council.
- Membership of the FSUG network will include the lead Guardian and be offered to all Staff Governors, representative of Staff Equality networks and additional members can be co-opted as appropriate.

Outcomes and Measures

1. Annual staff survey results
2. Numbers of staff attending awareness training
3. Regular review of referrals with other functions involved in the process
4. Quarterly FTSU updates for all staff via the Brief
5. Evidence that investigations are evidence based, undertaken by a suitably independent individual and focus on learning lessons and improving care
6. High level findings provided to the Board

Monitoring

A Freedom to Speak Up Annual Report will be presented to the Board each year by the Lead Freedom to Speak Up Guardian and the Executive Lead which will include:

- An assessment of the Raising Concerns (Whistleblowing) Policy
- An overview of the cases reported and the themes identified
- Benchmarking
- A development/action plan for the next 12 months

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 March 2019

Agenda item 7.1

Title:	**South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYBICS)**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates / Director of Strategy
Purpose:	The purpose of this paper is to update the Trust Board on the developments within the South Yorkshire and Bassetlaw Integrated Care System (ICS), and Barnsley integrated care developments.
Mission/values:	The Trust's mission to **enable people to reach their potential and live well in their communities** will require strong partnership working across the different health economies. It is therefore important that the Trust plays an active role in the South Yorkshire and Bassetlaw ICS.
Any background papers/ previously considered by:	The Trust Board have received regular updates on the progress and developments in the SYB ICS (formerly Sustainability and Transformation Partnership), including Barnsley Integrated Care Developments.
Executive summary:	**1. Integrated Care System (ICS) Collaborative Partnership Board** The Partnership Board last met on the 8 March 2019 and feedback from that meeting and a summary of the key points are detailed below: **1.1 Performance Scorecard** The attached scorecards shows the ICSs collective position at February 2019 (using December 2018 data) as compared with other areas in the North of England and also with the other nine advanced ICSs in the country. While the position on A&E performance continues to be one of the best in the North, it is still not on target and has dropped since last month (from 89.5% to 87.4%). There is good performance on diagnostics (2 weeks), 2 week waits and the three improving access to mental health standards but red for 32 day and 62 day cancer standards, referral to treatment (RTT) and two week breast waits. **1.2 Governance Approach** South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) has evolved from the establishment of a Sustainability and Transformation Partnership in January 2016, an Accountable Care System in April 2017, to then becoming one of the first and most advanced ICS systems in England and working arrangements have changed little over this time period. In September 2018 the ICS Partnership supported a review of governance and ways of working. Following the review and comments on

draft proposals, it has been agreed that interim governance will start from April 1, 2019 for a twelve month period covering the 2019/2020 financial year. Whilst some final details are still being resolved, this includes:

- Establishing interim governance arrangements for NHS collaboration which will work alongside much of our existing system collaborative forums. It includes:

  - **System Health Oversight Board (HOB)** - a quarterly joint forum between health providers, health commissioners, NHS England, NHS Improvement and other national arms' length bodies (ALBs), to respond to the national policy direction for health and implementation of the NHS Long Term Plan. It builds on the SYB ICS Partnership working on strategic health priorities requiring closer working across systems. It facilitates a maturing of relationships and system working, building on collaborative working locally in Places and across SYB collaborative health groups of Joint Committee of CCGs (JCCCG), Committees in Common (CsiC), Mental Health Alliance (MHA) and Primary Care Federations.

  - **System Health Executive Group** (HEG) - a monthly meeting of Chief Executives, Accountable Officers and other health partners, building on the work locally in each Place and collaborative health groups across the system, including JCCCG, CsiC MHA and Primary Care Federations.

- Continuing to work with our Local Authority partners to inform and shape how our system health and care partnership arrangements might be organised including a revised. Collaborative Partnership Board as set out in the NHS Long Term Plan. The next step for this will be a series of workshops led by Local Authority CEOs. System partnership working will of course be developed taking due account of existing partnership arrangements in Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield.

- Maintaining our current Collaborative Partnership Board meeting on a bi monthly basis which will be reviewed in due course in the light of the work above.

1.3 Hospital Services Update

The Hospital Services Review Programme has focused on two main areas. These are Hosted Networks and the development of clinical models on maternity, paediatrics and gastroenterology.

NHS Trusts have agreed to work together through a number of Hosted Networks, which will be the vehicle for collaboration around workforce,

clinical standardization and reconfiguration. Each NHS Trust will host one of the Networks. Barnsley Hospital NHS Foundation Trust will be the host for urgent and emergency care, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust will be the host for gastroenterology, The Rotherham NHS Foundation Trust for maternity, Sheffield Children's NHS Foundation Trust for paediatrics and Sheffield Teaching Hospitals NHS Foundation Trust for stroke. Each Host will bring together clinicians and workforce leads from all the NHS Trusts to support more consistent care for patients across South Yorkshire and Bassetlaw.

The Clinical Working Groups for maternity, paediatrics and gastroenterology have met monthly to develop clinical models to support greater sustainability of services in South Yorkshire and Bassetlaw. In particular, they have looked at ways to address interdependencies between maternity and paediatrics.

1.4 Hyper Acute Stroke Unit (HASU) Update

Work is progressing to enable the new model of hyper acute stroke care (HASU) in South Yorkshire and Bassetlaw, with 24 hours hubs in Doncaster, Sheffield and Wakefield. A phased approach to the implementation has been previously agreed by both NHS commissioners and NHS providers, with the proposal that Rotherham ceases to be a HASU first (from 1 July 2019), followed by Barnsley shortly thereafter (1 October 2019).

A HASU Implementation Group is coordinating all the necessary aspects, including communication and engagement, planned changes to estates, workforce planning and recruitment. Workforce planning is now a key area of focus and it is anticipated that SYB HASUs will soon be in a position

to recruit additional nursing and therapy staff. Briefings with existing staff are taking place and there is a commitment to supporting existing staff and maintaining expertise in SYB.

1.5 Commissioning Review

Following a review of the commissioning opportunities in SYB, a set of priority areas have been identified for collaborative commissioning where there is an opportunity for standardisation, financial efficiency and improved population outcomes. The SYB Clinical Commissioning Group (CCG) Governing Bodies are currently agreeing the priorities and will shortly be approving a work plan. The 2019/20 strategic commissioning priorities include services and contracting for 999/111, tariff and payment reform, the QUIT in hospital scheme, developing quality outcomes incentives based contracting, perinatal mental health, among others, They also include medicines optimisation in some primary care standard policies, commissioning policies and commonality of quality standards and outcomes and some service transformation. A Collaborative Commissioning Agreement (CCA) is also being developed to ensure clear and robust arrangements are in place for strategic commissioning which

will set out how the 5 CCGs will work together to commission once with clarity on roles, responsibilities, expectations and communication and engagement processes between CCGs, Governing Bodies, CCG memberships and the ICS and wider partners across the system.

2. SYB ICS Mental Health Learning Disability and Autism Programme Developments

The ICS Mental Health Learning Disability and Autism Executive steering group has a number of programmes of work that have been prioritised, below is an update on some of these programmes.

Adult Autistic Spectrum Condition/Attention Deficit Hyperactivity Disorder (ASC/ADHD) A workshop was held in February to focus on adult ASC/ADHD in February. Clinicians from the Trust attended the workshop. Links have been established with the West Yorkshire and Harrogate Health and Care Partnership.

Individual Placement and Support (IPS) Provision of IPS services is variable across the ICS and an expression of interest bid was submitted as part of the wave 2 funding. A total of £934,394 has been requested for transformation funding. Funding has been requested over two years; £497,781 in year one and £436,613 in year two. The model will be to provide a standardised service across the ICS for people with serious mental health and enduring mental health issues. The expression of interest has been accepted, and the bid has been submitted, with a probable lead provider model.

Currently there is an IPS service that operates across each place in the SYB ICS except Barnsley and Bassetlaw, the additional funding will support the expansion of existing services and see the development of new services in Bassetlaw and Barnsley. The Trust continues to work in partnership with all other providers on preparation and submission of a place based service model. Consideration is being given by commissioners to the requirements around any procurement process. The new model will commence on the 1st April 2019 with phased implementation and growth of service.

Out of Area Placements – there has been a significant reduction in the number of out of area bed days in SYB. The Mental Health and Learning Disability Executive Group were supportive of developing an SYB policy around the continuity of care principles. Areas of opportunities will be considered further.

Children and Young People - SYB has been successful in securing transformation money as part of the green paper Trailblazer funding for Sheffield and Barnsley. This is £61k non-recurrent and will be used to address improvements to waiting lists for ADHD.

	Forensic New Model of Care - Providers will be developing a partnership approach to develop new forensic pathways and new care models for secure care within the ICS footprint. A Memorandum of Understanding is under development. **3. Barnsley Integrated Care Update** The Barnsley Clinical Commissioning Group (CCG) continues to work 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, early help and support for people with Cardio Vascular Disease and developing an integrated model of care for stroke and frailty. The BCCG in response to the recently published Long Term Plan are also working with primary care to develop primary care networks that are supported by integrated care teams in neighbourhoods. **Risk Appetite** This update supports the risk appetite identified in the Trust's organisational risk register.
Recommendation:	**Trust Board is asked to NOTE the update from the SYBICS and Barnsley integrated care developments.**
Private session:	Not applicable.

How are we doing? An overview

Key performance report: February 2019 (December data)

	A&E (95%)	RTT (92%)	Diagnostics 6 weeks	2ww (93%)	2ww breast (93%)	31 day (96%)	62 day (85%)	EIP (50%)	IAPT Access 4.75% Q4)	IAPT Recovery (50%)
South Yorkshire and Bassetlaw	87.4	91.4	0.6	94.4	92.8	95.9	80.1	75.9	5.2	51.8
Greater Manchester										
Bucks, Oxfordshire and Berkshire West										
Frimley Health										
Dorset										
Nottinghamshire										
Blackpool & Fyde - Lancashire and S.Cumbria										
Milton Keynes, Bedfordshire & Luton										
Gloucestershire										
Suffolk and NE Essex										

The ICS financial position is reporting a year to date favourable variance against plan of £10.1m excluding PSF; but is forecasting a £2.3m adverse variance against outturn.

How are we doing? An overview

Key performance report: February 2019 (December data)

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South Yorkshire and Bassetlaw	87.4	91.4	0.6	94.4	92.8	95.9	80.1	75.9	5.2	51.8
Greater Manchester										
Cheshire and Merseyside										
Cumbria and North East										
Humber, Coast and Vale										
Lancashire and South Cumbria										
West Yorkshire										

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How are we doing? An overview

Key performance report: February 2019 (December data)

The ICS financial position is reporting a year to date favourable variance against plan of £10.1m excluding PSF; but is forecasting a £2.3m adverse variance against outturn.

*Data based on CCG and Acute Trust performance

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 March 2019
Agenda item 7.2

Title:	**West Yorkshire & Harrogate Health and Care Partnership and Local Integrated Care Partnerships update**
Paper prepared by:	Director of Strategy Director Provider Development
Purpose:	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 2. Local Integrated Care Partnership developments.
Mission/values:	The development of joined up care through place-based plans is central to the **Trust's strategy**. As such it is supportive of our mission, particularly to **help people to live well in their communities.** **The way in which the Trust approaches strategy and strategic developments must be in accordance with our values**. The approach is in line with our values - **being relevant today and ready for tomorrow**. This report aims to assist the Trust Board in shaping and agreeing the strategic direction and support for collaborative developments that support the Trusts strategic ambitions.
Any background papers/ previously considered by:	Strategic discussions and updates on place based plans have taken place regularly at Trust Board including an update to January Trust Board.
Executive summary:	The Trust Strategy refresh outlines the importance of the Trust's role in each place it provides services, including the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP). 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: • **West Yorkshire and Harrogate Health and Care Partnership** • **Kirklees**. • **Calderdale** • **Wakefield** **Risk Appetite** The development of strategic partnerships and the development and delivery of place-based plans is in line with the Trust's risk appetite supporting the development of integrated, joined up care and services that are sustainable. Risks to the Trust services in each place will need to be reviewed and managed as the partnerships develop to

	ensure that they do not have a negative impact upon services, clinical and financial flows.
Recommendation:	**Trust Board is asked to RECEIVE and NOTE the updates on the development of Integrated Care Partnerships and collaborations including:** ➢ **West Yorkshire and Harrogate Health and Care Partnership** ➢ **Wakefield** ➢ **Calderdale** ➢ **Kirklees**
Private session:	Not applicable.

West Yorkshire & Harrogate Health and Care Partnership and Local Integrated Care Partnerships - update

Trust Board 26 March 2019

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 Trust's strategic ambitions.

2. Background

Led by the Trust's 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 the 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 Partnership Board

The new Partnership Board will bring NHS, councils and communities closer together. Councillor Tim Swift, Leader of Calderdale Council and Chair of Calderdale Health and Wellbeing Board, will be Chair of the Partnership Board for the first two years. Angela Schofield, Chair of Harrogate District NHS Foundation Trust, will be the Vice Chair for the Partnership Board. The Partnership Board came together for the first time in March as part of their development as a group in readiness for meeting in public in June 2019. The purpose of the session was to spend some time thinking about the role of the Partnership Board, and how we can work together to improve health and care for the people of West Yorkshire and Harrogate. Sir Chris Ham and Nicola Walsh from The Kings Fund facilitated the session.

3.2 System Oversight and Assurance Group (SOAG)

The primary objectives of this group include oversight of progress for all the West Yorkshire and Harrogate priority programmes and system performance. SOAG will take full responsibility for system performance from the point at which the partnership moves to full integrated care system status, expected to be from April 2019. The group has met several times and key points from the February meeting include the following:

- Feedback was shared from the WY&H Joint Health Overview and Scrutiny Committee (JHOSC) which took place on 11 February. Discussions had been positive, on Urgent Emergency Care, mental health, changes to vascular services, and JHOSC plans for an inquiry into the workforce.
- The universal personalised care action plan was published by NHSE in late January. WY&H has been offered to be a demonstrator site again in 2019-20, and are working with NHSE to develop a proposition for this, building on the good progress made in 2018-19.

- **Key updates from the ICS programmes** was received at the meeting including:
  - ***Unpaid Carers***
    - The publication of the Long Term Plan (LTP) has enabled the programme to revise the WY&H Carers Strategy along with revised governance structures. Capacity within the programme has eased slightly with the appointment of the Unpaid Carers Programme Manager.
    - Details have been circulated for the Unpaid Carers event on 4 April 2019, this will offer an opportunity to review the outcomes of the programme, build on any updates following publication of the LTP and assist in identifying any existing gaps.
  - ***Primary and Community Care***
    - A letter has been circulated from Rob Webster and Carol McKenna regarding the new GP Contract, confirming that the network contract should not prevent the development of broader local networks, such as community partnerships. (*The Trust is working together with partners in each of the local places that it provides services to ensure that services are better integrated and joined up through the primary care networks that are developing)*

- **Review of System Performance and Delivery**
  - Members noted the current financial position in respect of WY&H NHS organisations including the significant risks for some providers.

- **Performance Dashboard**
  - The system dashboard has undergone significant development. It was agreed that it will be useful to focus on issues which show the greatest variation, and on a small number of 'obsessions' for both places and programmes. The partnership will need to consider how to resolve key obstacles to more effective use of data, the need for data sharing agreements, gaps in the availability of information, and Business Intelligence capacity.

- **Planning for 2019/20**
  - The latest iteration of operational plans have been reviewed and six place-based feedback sessions have been held with each system. A number of alignment and financial risks were acknowledged particularly for those organisations who had not accepted their control totals and the likely loss of PSF income. The Trust has contributed to the place based discussions; the Trust Director of Finance and Resources has been involved.
  - The ICS has submitted an aggregated plan on 19 February and a more detailed, final submission will be made on 11 April.

3.4 NHS Long Term Plan Editorial Group

An editorial group for the development of the Partnership's five year plan has met. There is an expectation that all Integrated Care Systems will produce a five year plan by autumn 2019. There is really strong alignment between the Long Term Plan and the Partnerships regional ambitions, as set out in the 'Next Steps to Better Health and Care for Everyone' document (Feb 2018). The draft plan will be shared with Partners, the Partnership Board and stakeholders, such as HWB chairs and governing boards for their views ahead of publication in the autumn 2019.

There was also a meeting with West Yorkshire and Harrogate communication and engagement leads with Healthwatch colleagues about the potential to do some high level engagement work.

3.5 Workforce development

West Yorkshire Local Workforce Action Board (LWAB) are focusing on new roles including physicians' associates, nurse associates and advanced clinical practitioners and how these can help improve the care offered to people. Career campaigns are being developed to increase the number of people applying to be a mental health and learning disability nurse and the LWAB are looking to commission a careers hub which will focus on promoting additional specialties where recruitment is an issue. The Trust Director of Human Resources is a member of this group.

3.6 Supporting people with learning disabilities

The National Transforming Care Programme (TCP), the Government and health and social care organisations are working on transforming care for people with learning disabilities and/or

autism, and in particularly those who also have a mental health illness. Transforming care is all about improving health and care services so that more people can live in the community, with the right support, and close to home.

There are three TCP partnerships in West Yorkshire including Barnsley. These TCPs, underpinned by the Winterbourne Review, have a common objective to improve the community response to prevent people going into hospital wherever possible. This includes reducing admissions to hospital unless needed and the length of time people stay there. It is also about making sure people don't spend time in hospital hundreds of miles from their home which can be distressing and difficult for family, carers and friends to visit.

A proposal has been agreed in principle to establish one TCP board for West Yorkshire and Harrogate from April 2019. This will be chaired by Helen Hirst, Chief Officer for Bradford District and Craven Clinical Commissioning Groups, who is also the WY&H HCP commissioning lead for mental health, learning disabilities and autism. The TCP Board will report into the Mental Health, Learning Disability and Autism Collaborative Programme Board.

Over the coming months work will be concluded on a business case to transform care provided across the three assessment and treatment units (ATUs), and how as a region we optimise service capacity to meet the service demand projection going forward.

Engagement activity for this work will be delivered over a 4 week period (started 18 February 2019). The engagement is an essential part of the process and is part of a planned approach to seek the views of people who access services, carers, families, staff and key stakeholders who have experiences of ATUs across West Yorkshire to further to inform the next stage of this work which will be how to reconfigure ATU provision in the region to ensure maximum benefit for both people who use these services and the system.

3.7 'Looking out for our Neighbours Campaign'

The first West Yorkshire and Harrogate Health and Care Partnership 'Looking out for our neighbours' campaign will launch on 15 March 2019. This campaign covers Bradford District and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield. The campaign aims to tackle the impact of loneliness. The campaign has received significant support from diverse organisations across West Yorkshire and currently has the support of around 300 plus organisations including the Trust.

3.8 WY&HMHSC Committees in Common

The committee continues to meet and 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.

3.9 Mental Health Learning Disabilities and Autism 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. Key developments to note include;

- Forensics New Models of Care: This project is using activity assumptions to plan for the future low and medium secure in-patient requirements across West Yorkshire ICS and the

model of Community Service support, all within the existing NHSE spend. Clinical workshops have been taking place over the last few months to focus on the longer term service vision and strategy, and have included discussions on: unified access and bed management arrangements; interface management, particularly focused on prisons, PICU and other non-Forensic mental health; community model and challenges to discharge; pathway development focusing on personality disorder and women's services; Forensic Outreach Liaison Service. A draft business case should be completed by March 2019 (subject to receipt of all relevant financial information from NHSE)–Before the final business case is submitted to NHS England, the governing bodies of the partner West Yorkshire forensic providers will need to have 'signed off' the business case (including the Trust Board). A governance proposal for the partnership going forward was presented to the Forensic Providers meeting on 6 March 2019, which covered the arrangements for 'sign off'. This will be approved, subject to any further comments, shortly.

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. Calderdale Cares is being progressed and Primary Care Networks are in the process of being established across the localities in Calderdale. North Halifax primary care at home and Central Halifax prototypes for Calderdale Cares continue to develop with three other localities now moving forward as primary care networks. The Sports England Bid secured to support physical activity and well-being in Calderdale continues to progress and Design Thinkers have completed the formal training and developing insights to better understand the challenges to increasing activity with a wide range of residents across Calderdale. Partners continue to work together to develop proposals to strengthen the role of arts and creativity in improving well-being as part of the Calderdale Cares development plans.

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 agreement. Priorities for 18/19 include mental health, Primary Care Home, frailty and older people, end of life care and cancer. There was a full day development session for the NMoC Board on 23 January 2019. The agenda for this session focused on the future integration arrangements for Wakefield, and the 2019/20 Priorities in that context.

Discussions at both the February and March meetings of the NMoC Board have included a focus on the arrangements for Provider Alliances within the context of views expressed that the overarching framework Alliance for the Integrated Care Partnership, and the associated 'business rules' (principles of ways of working together), require substantial updates. This update work is being led by Wakefield CCG on an urgent basis. The work on the Provider Alliance Agreement for the End of Life Care Alliance has been 'paused' in its current format to

allow these important overarching updates to be completed. This is also the position for the Mental Health Provider Alliance Agreement, as it was mirroring the End of Life Care Agreement in large parts. However, this will not prevent the work programme of both Alliances being progressed.

The Wakefield Mental Health Provider Alliance has continued to make progress on developing its governance framework (including the establishment of the Mental Health Stakeholder Group) and developing service pathways to improve service user outcomes and experience. The Alliance has been overseeing the review and development of service pathways for service users with personality disorder/chaotic lifestyle, support for those living with dementia and their families, and implementing the action plan from the young people's mental health summits. Recent focus for the Alliance has been discussion and review of proposals for 2019/20 priorities, including investment priorities. In February the Alliance had a development session. The outcome of this session shaped the next phase of how as providers we work together and the work programme priorities for 2019/20, including some potential early 'quick wins'.

The NHS Long Term Plan commitment to implement Primary Care Networks is taking the form of implementing the Primary Care Home (PCH) model (supported by the National Association of Primary Care). The Trust's Director of Provider Development is the SRO for this implementation (on behalf of the NMoC Board). There will be seven PCHs in Wakefield. The Trust's service offer in Wakefield is being aligned to these PCHs, and the lessons from this work (plus the equivalent work in Barnsley) will help shape the Trust's place based service configuration going forward.

4.3 Kirklees

System leaders have continued to meet and the Trust is a key partner in shaping the developments of integrated care across Kirklees. The Trust is leading the development of proposals to strengthen mental health and well-being through a partnership approach across Kirklees. The draft proposals include sharing the learning from the work that the Trust has led in developing an Alliance approach in Wakefield. The proposals were shared with the Kirklees Executive Partnership Group and have been supported. Further engagement is planned with key strategic leads across the system to clarify and develop the engagement plan, governance arrangements and scope that should include a focus on prevention and links to Primary Care Networks as they develop. As the proposals for an Alliance are developed and co-produced with partners in Kirklees due diligence will be carried out as part of moving the proposals forward.

5. Recommendations –

- **Trust Board is asked to receive and note the update on the development of Integrated Care Systems and collaborations:**
  - **West Yorkshire and Harrogate Health and Care Partnership**
  - **Calderdale**
  - **Wakefield**
  - **Kirklees**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 March 2019
Agenda item 8.1

Title:	**Learning from Healthcare Deaths policy**
Paper prepared by:	Director of Nursing and Quality
Purpose:	In line with the National Quality Board (NQB) guidance on Learning from Deaths, every Trust must have a policy in place that sets out how it identifies, reports, reviews, investigates and learns from a patient's death. The original policy came into effect in October 2017. The policy has recently been updated to reflect further national guidance and feedback from internal audit.
Mission/values:	This policy is in line with the Trust values: ➢ We put the person first and in the centre ➢ We know that families and carers matter ➢ We are respectful, honest, open and transparent ➢ We improve and aim to be outstanding ➢ We are relevant today and ready for tomorrow
Any background papers/ previously considered by:	The Board has been briefed on the need for the policy, advised on progress during its development and received updates on learning from deaths work. EMT have reviewed and approved the revised policy in detail.
Executive summary:	The Learning from Healthcare Deaths policy lays out the Trust's process for reporting deaths and which deaths will be in scope for review. It describes responsibilities, including those of the Trust Board who are accountable for ensuring compliance with the 2017 NQB guidance on Learning from Deaths. The Trust has been working towards achieving the highest standards in mortality governance; and an internal audit in Spring 2018 gave significant assurance of our policy and processes. ➢ This revised policy has been scrutinised by Executive Management Team (EMT). The original policy was also scrutinised by Clinical Governance & Clinical Safety Committee (CGCS). ➢ The original policy had a short review date, however the update was postponed due to delays in the anticipated national guidance. ➢ **The review of the policy has included:** • **Inclusion of support for bereaved families in line with July 2018 national guidance. Includes the principles we will use, guidance for staff with links to online resources** • **Changes in response to feedback from internal audit; includes use of term 'case record review' and recognition of our 48 hour managers review on Datix is a first stage case record review.** • **Minor improvements to refine processes, reflecting our learning since introduction in 1 October 2017.** • **Updated governance section to reflect the new Clinical Mortality Review Group.** • **Changes to the document structure to aid reading and improve understanding for staff, including updated flowcharts, terminology and additional definitions.**

	➢ The Trust has benefited from working with a northern alliance of mental health trusts to develop the principles and scope of reviews. The agreement was for the policy to be 80% across the group with a local 20% to meet the specific organisation process and requirements. This ratio continues and the scope has not changed. **Next steps** ➢ Work continues to develop support materials for bereaved families. A task and finish group has met to develop our plans for implementing the National Quality Board guidance on 'Learning from deaths: Guidance for NHS trusts on working with bereaved families and carers' to align with the principles set out in the policy. ➢ The policy acknowledges the importance of maintaining a focus on the desired outcomes rather than the process and this continues to be the case. ➢ Our first Clinical Mortality Review group will be held on 29 March 2019 with its purpose being to review and examine themes arising from reviews. This will support the key messages for sharing and implementation of learning across the Trust. ➢ Work continues in conjunction with the both the Northern Alliance of mental health trusts and the Improvement Academy Regional Mortality group to develop work on outcomes from the reviews/investigations and consider how to work together on themes and trends. ➢ The policy, reporting dashboard and themes are publically available on the Trust website. **Risk appetite** Risk identified – Trust must have a policy in place that sets out how it identifies, reports, reviews, investigates and learns from a patient's death. The development of this policy and processes to implement covers assurance for: ➢ **Compliance risk:** with CQC standards for reviewing healthcare deaths. This meets the risk appetite – low and the risk target 1-3. ➢ **Financial or commercial risks:** Reputational risks, negative impact on perceptions of service users, staff, commissioners. Cautious/moderate risk appetite and a risk target of 4-6 ➢ **Clinical risks:** risk to service user/public safety and risk to staff safety which is again low risk appetite and a risk target of 1-3. The reporting, reviewing, investigating and learning from healthcare deaths and implementing change supports the drive to reduce the number of healthcare related avoidable deaths.
Recommendation:	**Trust Board is asked to RECEIVE and APPROVE the Healthcare Deaths policy and the NEXT STEPS identified.**
Private Session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Document name:	Learning from Healthcare Deaths The right thing to do
Document type:	Policy
What does this policy replace?	Learning from Healthcare Deaths policy October 2017
Staff group to whom it applies:	Trust staff with a responsibility for patient care
Distribution:	The whole of the Trust
How to access:	Intranet
Issue date:	Version 2 January 2019
Next review:	January 2022
Approved by:	Trust Board 31 October 2017 Executive Management Team 10 January 2019 (update)
Developed by:	Assistant Director of Nursing, Quality and Professions and the Patient Safety Manager
Director leads:	Director of Nursing, Quality and Professions.
Contact for advice:	Deputy Director of Nursing, Quality and Professions Associate Director of Nursing, Quality and Professions. Assistant Director of Nursing, Quality and Professions Patient Safety Manager

Contents

1.0. Introduction

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, the experience is different and they experience poor quality provision for a number of reasons including system failure.

Learning from deaths is an essential part of quality improvement. It is the right thing to do to review and investigate deaths where care and service delivery problems occurred so that we can learn and prevent recurrence.

This policy is in line with the Trust values:

- ✓ We put the person first and in the centre
- ✓ We know that families and carers matter
- ✓ We are respectful, honest, open and transparent
- ✓ We improve and aim to be outstanding

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.

We will make it a priority to work more closely with families and carers of patients who have died and to ensure meaningful support and engagement with them at all stages, from the notification of the death of their family member through to actions taken following on from any investigation in line with the National Quality Board guidance on supporting bereaved families[1].

The Trust will also look at a selection of cases where we can learn from examples of good care and share this through our learning from healthcare deaths reporting.

A report by independent auditors Mazars, commissioned by NHS England was published in December 2015. It commented on services run by Southern Health NHS Foundation Trust.
The report found:-

- Failings in the way the Trust investigated serious incidents.
- Too few deaths were investigated and some should have been investigated further.
- The Trust could not demonstrate a comprehensive systematic approach to learning from deaths

[1] National Quality Board (July 2018) Learning from deaths - Guidance for NHS trusts on working with bereaved families and carers

These findings were reinforced in the *Care Quality Commission (CQC) report Learning, candour and accountability*[2]*.* It revealed that in some organisations learning from deaths was not being given sufficient priority and that valuable opportunities for improvements were being missed. Importantly the CQC also point out that there is much more we can do to engage families and carers, and recognising their insights and experiences is vital to our learning.

The National Quality Board (NQB) guidance on Learning from Deaths[3] was the starting point to initiate a standardised approach to the way NHS Trusts report, review, investigate and learn from patient deaths, which should lead to better quality investigations and more embedded learning. These reviews will provide the Trust with valuable information in deciding how Executive Teams and Boards can use these findings.

The Trust fully supports the approach it has developed with mental health providers in the North of England Alliance as part of our collaborative approach to learning from deaths. The Trusts participating are:

- Bradford District Care NHS Foundation Trust
- Cumbria Partnership NHS Foundation Trust
- Humber NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Northumberland, Tyne and Wear NHS Foundation Trust
- Rotherham, Doncaster and South Humber NHS Foundation Trust
- Sheffield Health & Social Care NHS Foundation Trust
- South West Yorkshire Partnership NHS Foundation Trust
- Tees, Esk and Wear Valley NHS Foundation Trust

Working collaboratively will enable shared learning and good practice, and information suitable for comparison across organisations.

This policy sets out the principles that guide our work and how we will implement them.

South West Yorkshire Partnership NHS Trust provides a range of services alongside its mental health portfolio –including learning Disability Services, Physical Health services and these have been considered when writing the policy. We have and will continue to liaise with physical health colleagues.

This policy should be read in conjunction with:-

- Being open policy
- Incident reporting and management (including serious incidents) policy
- Investigating and analysing incidents, complaints and claims to learn from experience policy

[2] Care Quality Commission (2016) Learning, candour and accountability[2]: A review of the way NHS trusts review and investigate the deaths of patients in England
[3] National Quality Board (2017) National Guidance on Learning from Deaths

2.0 Purpose and scope of the policy

Working with families/carers of patients who have died offers an invaluable source of insight to improve services. There is a need to ensure families are given the opportunity to comment on the care received, and ensure support is provided at all stages of the review process and an understanding that treating bereaved families/carers as equal partners in this process is vital.

In line with the National Quality Board guidance on Learning from Deaths[4], every Trust must have a policy in place that sets out how it identifies, reports, reviews, investigates and learns from a patient's death and reviewing the care they received prior to death to consider if this could have been improved.

The Trust already does significant work with working with families following deaths where care delivery may be an issue. We also involve service users and families in the development of services and provide opportunities to provide feedback on all aspects of care and services delivery.

We will continue to educate staff and encourage a more open culture of listening to the views and opinions of families and carers following all deaths. Staff will become more confident in identifying what can be done differently and improve systems and share systems and processes that are working well.

This policy sets out roles and responsibilities relating to learning from deaths and promotes a culture of learning lessons.

Learning from a review about the care provided to patients who die in our care is integral to the Trust's governance and quality improvement work.

2.1 Purpose

The Trust will implement the requirements outlined in the Learning from Deaths framework as part of the organisation's existing procedures to learn and continually improve the quality of care provided to all patients.

It will set out the Trust's expectation / principles on how it responds to deaths in our care and identifies the scope of review for each death and how the Trust will learn from them.

This policy sets out how staff can support the involvement of families and carers when a death has occurred and how to engage with them to ensure there are easy opportunities to discuss or ask questions about the care received by their loved one to their preferred timescale.

[4] National Quality Board (2017) National Guidance on Learning from Deaths

2.2. Objectives

While a focus on process is important, everything that is done should place emphasis on the outcomes of learning from deaths and supporting families and carers.

The core objectives of this policy are:

- To prioritise and enable consistently effective, meaningful engagement and compassionate support between families, carers and staff that is open and transparent to allow them to raise questions about the care provided to their loved one.
- To help to identify what can be improved to ultimately reduce the inequality in the life expectancy of people with a severe mental illness/learning disability.
- To standardise approaches to reviewing deaths across the northern cohort of mental health trusts in order to share information and key learning.
- To ensure there is a consistent and coordinated approach for undertaking mortality reviews for physical health care.
- To enhance learning at a personal, team and organisational level.
- To ensure the Trust engages with other stakeholders (Acute Trusts, Primary Care, Public Health, Safeguarding, Health and Wellbeing Boards etc.) to work collaboratively, sharing relevant information and expertise to maximise learning from deaths.
- To support the evaluation of the Trust's approach to learning from deaths in line with the northern alliance of mental health trusts agreed principles.

2.3. Scope of the policy

This policy applies to all Trust staff with a responsibility for patient care.

The National Quality Board Guidance on Learning from Patient Deaths applies to all acute, mental health/learning disability and community NHS Foundation Trusts.

2.0. Definitions

Term	Definition	Circumstances
Death certification	The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner.	When a death has been certified, no further review process is required[5]. In the event of there being concerns about the care provided from management, governance or family, then a case would move into case record review or investigation.

[5] In line with the National Quality Board - National Guidance on Learning from Deaths

Term	Definition	Circumstances
Case Record Review	A structured desktop review of a case record/note, carried out by clinicians, to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families or staff raise concerns about care.	The Trust has two types of case record review. The first stage case record review is the Manager's 48 hour Review, with the second stage being a Structured Judgement Review – see definitions.
Manager's 48 hour review	Following the manager's review of the clinical records against standards, the manager records their findings on the Manager's 48 hour review on the Datix incident record. The aim is to provide a summary of the care provided and identify good practice and any areas for further review.	Where a death has not been certified, the Manager's 48 hour review can be accepted as a first stage case record review. This is usually where the review is comprehensive, there are no concerns identified and care was provided as would have been expected.
Structured Judgement Review (SJR)	Reviewing case records to determine whether there were any problems in the care provided to the patient who died, in order to learn from what happened. The Trust uses the Royal College of Physicians Structured Judgement Review methodology[6] and Royal College of Psychiatrists Mortality Review Tool for Mental Health Trusts[7]	A Structured Judgement Review is undertaken when a more detailed, independent review of the care provided is required following review of the managers 48 hour review. This may be because there are questions remaining about the care provided.
Investigation	The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies and procedures, guidance, good practice and observation – in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first.	Investigations can include service level investigations, serious incident investigations, safeguarding reviews, learning disability reviews, etc

[6] Royal College of Physicians (2018) Mortality toolkit: Implementing structured judgement reviews for improvement

[7] Royal College of Psychiatrists (2018) Care Review Tool for Mortality

Term	Definition	Circumstances
Service Level Investigation	A service level investigation is commissioned by the Service and the investigator identified by the service. Principles as described under Investigation.	Some deaths which do not meet the criteria for a Serious Incident investigation may require a Service level investigation where there are questions that are unanswered by the manager's review or where learning could be significant.
Serious Incident Investigation	Principles as described under Investigation. Serious incidents (SIs) usual involve serious injury, harm or death, which meet specific criteria defined in NHS England's Serious Incident Framework. These incidents require additional external reporting to commissioning bodies on STEIS. Investigations are usually led by the Trust's Lead Serious Incident investigators and medical investigators.	Some deaths meet the criteria for a Serious Incident investigation. They are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.
Death due to a problem in care	A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as 'cause of death').	
STEIS	Strategic Executive Information System is the national system for reporting Serious Incidents (SI) that enables electronic logging, tracking and reporting of Serious Incidents with NHS Improvement	
LeDeR	The Learning Disabilities Mortality Review (LeDeR) programme has been commissioned by NHS England to support local areas in England to review the deaths of people with a learning disability to: • identify common themes and learning points and: • provide support to local areas in their development of action plans to take forward the lessons learned.	The LeDeR programme will be contacted regarding the death of a person with a learning disability. If the death has not been reported by another agency, the Trust will report the death. The Manager's 48 hour review will also be completed internally to enable any local learning to be identified. In some cases, a Structured Judgement Review may be completed.
Main provider of care	When the Trust is the main provider of care as described in section 6.	

Term	Definition	Circumstances
Deaths in scope	Deaths that the Northern Alliance of mental health trusts and the Trust for general community services have determined require further review under this policy.	
Severe Mental Illness	The term is generally restricted to psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder	
Patient safety incident	A patient safety incident is any unintended or unexpected incident which could have led or did lead to harm for one or more patients receiving NHS care.	

3.0. Duties

This policy applies to all Trust staff with a responsibility for patient care as set out below:

Mortality governance is a priority for all Trust Boards and the Learning from Deaths Framework places a greater emphasis on the importance of Board Leadership to ensure that learning from patient deaths becomes embedded in the organisation.

Role	Responsibility
Chief Executive, Executive Trust Board Directors and Non-Executive Directors	Trust Boards are accountable for ensuring compliance with the 2017 NQB guidance on Learning from Deaths and working towards achieving the highest standards in mortality governance. They must ensure quality improvement remains a priority by championing and supporting learning that leads to meaningful and effective actions that continually improve patient safety and experience and supports cultural change. They can do this by demonstrating their commitment to the work e.g. spending time developing Board thinking; ensuring a corporate understanding of the key issues around the deaths of service users and by ensuring that sufficient priority and resource is available for the work. The Director of Nursing and Quality has been identified as the Board level 'Patient Safety Director' with responsibility for learning from deaths. Additionally a named Non-Executive Director has taken lead responsibility for oversight of progress to act as a critical friend, holding the organisation to account for its approach in learning from deaths. The Board will ensure: • That robust systems are in place for reporting, reviewing and investigating deaths • That bereaved families are engaged and supported • That there is evident learning from deaths both internally and with our external partners and quality improvement is championed • That processes focus on learning, can withstand external scrutiny, by providing challenge and support and assurance of published information

Directors, Medical Staff, Consultant Nurses, Business Delivery Management, Ward and Team Managers and all Registered Nurses & Allied Healthcare Professionals	Staff should familiarise themselves with this policy and understand the process for learning from deaths. Identify the key changes required to implement this policy and ensure all appropriate action is taken. When a member of staff is made aware of a death, the family should be contacted by the most appropriate person to offer condolences, support and the opportunity to comment on the care provided in line with Being Open, and Duty of Candour, when this applies. Staff must record in a timely way information about deaths on clinical systems, including all details know about the cause and place of death. Managers should review the clinical records to ensure care was provided in line with clinical standards, policies and procedures. Staff must report any death on Datix if there are any concerns raised by family, clinical staff or through governance process or the Trust is a main provider of care (see flowchart in appendix D). To support staff to review and investigate deaths ensuring they have the time to carry out this process in a skilled way to a high standard, and as part of that to: • Ensure staff have the right level of skill through training and experience; • To promote learning from deaths; • That sufficient time is assigned in local governance forums to outline and plan for any lessons learned; • To ensure that learning is acted on. Patient safety support team will provide support. Manager's should ensure the Supporting staff involved in traumatic or stressful adverse events policy is followed and any staff affected by the death of a patient (or the death of a colleague) are offered support from Occupational Health in line with the above policy.
The Patient Support Team, Performance and Information, Customer Services and Legal team	These corporate Trust departments have a responsibility to ensure: • Data is collected and published to monitor trends in deaths with Board level oversight of this process • Ensuring the Datix incident reporting system is used to its full potential to record deaths (as agreed by what is in scope/where the Trust is the main provider of care) in accordance with Trust policy. • Processing information consistently and precisely and in a meaningful way to fulfill governance processes required to ensure high standards in mortality governance are maintained. Patient safety support team will provide support across the Trust

The Trust requires all staff to be open, honest and transparent about reporting deaths and for engaging with families and carers, actively enabling them to ask questions about care and identify if care can be improved.

5.0. Family engagement

In July 2018, the National Quality Board published guidance on supporting bereaved families[8]. The Trust will use the principles set out in the national guidance for how we will engage with and support bereaved families.

We will reinforce the importance of family engagement following deaths. Dealing respectfully, sensitively and compassionately with families and carers when someone has died is crucially important. At times, families may have questions, and/or concerns they would like answers to in relation to the care and treatment their loved one received but don't always want to make a complaint.

Families and Carers
If you are reading this as a family member of someone who has recently died who received care from our Trust and you have anything you would like to discuss, you can contact the clinical team involved to discuss or you can contact customer services directly on Freephone 0800 587 2108. Further details on customer services are available on our website.

First contacts
When a service user dies, there is an expectation that contact will be made with bereaved families /carers of service users to offer condolences, support and opportunities to comment on the care the Trust provided.

The Trust may be informed of a death through various routes. For example an admin member of staff may receive a call from a family member to inform us of the death or a clinician may be told of a death on a planned visit, or an update from the clinical records. All staff should be familiar with what is required in these circumstances, ensuring they follow the Being Open Policy which includes Duty of Candour when this is required.

During an initial contact with the family of a deceased service user, staff should ensure they:

- offer condolences
- obtain a name and contact details for the family member
- sensitively ask about the circumstances and cause of the death
- ask if they have any questions about the care their family member received from the Trust
- offer support and signpost to sources of support, e.g. GP, third sector organisations etc.

The initial contact should be followed up in writing by the manager or appropriate person (e.g. care coordinator). This could take the form of a letter, or in some areas, a card may be more appropriate. A copy of the communication, whatever format, should be retained in the team.

[8] National Quality Board (July 2018) Learning from deaths - Guidance for NHS trusts on working with bereaved families and carers

The written communication should include:

- condolences for the death;
- The below points should be covered in the communication, but will also be available in a separate first stage leaflet (leaflet 1) that should be enclosed with the communication.
    - an explanation of how families can comment, ask questions or raise concerns about their relative's care through the team manager or through the customer services team (further details will be included in a leaflet). The Trust needs to understand what families want to know, so these areas can be included in investigation terms of reference.
    - if they raise significant concerns, this would automatically prompt a review of the care received (further details will be included in a leaflet)
    - An overview of how we review the care of those who have died whilst under our care.
    - information about local and/or national bereavement support available to families (further details will be included in a leaflet)
- The content should be approved by a manager

The Trust has developed two leaflets to support families following bereavement. These are available on the Trust intranet under Learning from Deaths.

Leaflet 1 - Initial support and information following a bereavement	Provides details on how families can comment, ask questions or raise concerns about their relative's care. Includes a broad overview of our review processes. Gives information on sources of support for grief and bereavement. Contact details for customer services
Leaflet 2 - Details of review and investigation processes	Provides further information on our review processes. Explanation of different types of review or investigation. Aim of all reviews or investigations Explain why there is an investigation Where a case note review identifies potential problems with the care provided, how the trust will share the findings with the family How a review findings can trigger an investigation How families can get involved Frequently asked questions egg how to access records, speaking with a staff member who cared for their relative Contact details for customer services

This early discussion enables us to ensure that deaths where families raise concerns are reviewed or investigated. If there are any concerns raised at all, this must be reported on Datix irrespective of if the Trust is the main provider of care.

There are some circumstances where the Trust may find out about the death of a service user after some delay. In these circumstances a discussion should take place between the Patient Safety Support Team and the clinical team involved to determine the best approach.

Unable to contact
There may be occasions where the Trust is not able to make contact with family or carers. Attempts to make contact should be recorded in the clinical record. Where a service user does not have family or carers, or their details are not recorded on the clinical system. The reasons for no contact with family should be recorded in the clinical record.

Ongoing contact
It is understood that dealing with the death of a relative is a sensitive matter for families, carers and staff and that all situations are different. Staff may need to offer the opportunity for on-going involvement in-keeping with the family's needs and wishes.

Involvement in reviews and investigations
The Trust's approach should be to treat the family/carer as an equal in the review/investigation process from the beginning taking their views and opinions into account at each stage.

For deaths that meet the requirement for review or investigation, we need to provide information to families regarding the opportunity to be involved in the review of the care. The flowchart in Appendix E sets out the different review processes that may be used following a death.

We will write to the family to inform them that a review or investigation is being undertaken. We will provide further information in the form of a second leaflet (leaflet 2) that explains the review/investigation process. The leaflet will include:

- information that every month the trust review a number of records of patients who die in its care, and that their relative's case may be reviewed as part of this
- the review process we follow for all deaths of people who were under our care
- information about the different review/investigation processes including case note reviews and how they help the Trust take every opportunity to learn from the care it provides – both where care has been good and where there are opportunities to improve
- a statement that, where a case note review identifies potential problems with the care provided, the trust will share the findings with the family
- If a case note review identifies problems in care that the trust was previously unaware of, and which could have contributed to the death, an investigation will be triggered. Families should be told about the investigation and offered an opportunity to be involved
- How families can get involved in the review/investigation process
- Contact details for the customer services team will be included

Further information on our leaflets is available on the Trust intranet under Learning from Deaths.

Families can choose how they wish to be involved, this may include:

- providing evidence / contributions to the review or investigation e.g. providing a pen portrait of the person, time-line of events

- agreeing the level of the review / investigation;
- contributing to the terms of reference for serious incident reviews;
- Commenting on report content.

When this is an investigation, families/carers should also be given the option of seeing a final report to ensure they are comfortable with any findings. Ideally this should be undertaken in a face to face meeting with a staff member talking the family member/carer through the report.

Further information and support can be accessed from the Patient Safety Support Team as this is already practice in serious incident investigations.

Contact declined
If the family member/carer decides they do not want to be involved in the review/investigation process, staff should make it clear they can contact us at any time should their decision change and that any relevant information can still be shared. If the family does not want contact at all about the process or findings, this should be honoured and staff should record their wishes.

Unknown cause of death
In some cases the cause of death may not be known when a death is reported. Where it is not possible to obtain information on the cause of death and circumstances from family or carers, teams should attempt to obtain this through other routes. The service user's GP, care home or last care provider (e.g. acute hospital) may be able to provide information. When information is identified, the clinical record should be updated, and where reported on Datix, the Datix record updated.

In addition to this, the Patient Safety Support Team will liaise with the Legal Team to try to obtain cause of death/inquest conclusions from H M Coroner's office.

Family Bereavement Support
In line with the guidance in the National Quality Board's[9] guidance for NHS trusts on working with bereaved families and carers, the Trust is exploring the development of a support network. Information on this network will be available on the Trust's learning from healthcare deaths intranet pages when available.

6.0. Scope of reportable deaths

In order to support consistency in determining the scope of deaths for further review, the alliance of Northern Mental Health Trusts has agreed the core principles and the Trust has added to this to reflect the range of Trust services.

Where the Trust provides a wide range of clinical services across inpatient, community and other provider organisations this can lead to both a degree of

[9] National Quality Board (July 2018) Learning from deaths - Guidance for NHS trusts on working with bereaved families and carers

confusion as to who is responsible for the reporting and investigating of a patient's death and the risk of double reporting and investigation.

To support staff in their decision making, staff should refer to the flowchart in Appendix D which follows the principles below. They must consider any involvement of Trust teams outside of their own. However if there is any doubt staff should contact their line manager for advice.

Core reporting principles:

A) The Trust is deemed the main provider of care, if at the time of death the patient was subject to:

1. An episode of inpatient care within our service.
2. An episode of community treatment under CPA.
3. An episode of community treatment due to identified mental health, learning disability or substance misuse needs.
4. A Community Treatment Order.
5. A conditional discharge.
6. An inpatient episode or community treatment package within the 6 months prior to their death (Mental Health services only).
7. Guardianship
8. Deprivation of Liberties legislation (DOLS)
9. Patient discharged from SWYPFT inpatient bed in the 30 days prior to death.

B) Patients who meet the above criteria but are inpatients within another health care provider or custodial establishment at the time of their death.

In these circumstances the death will be reported by the organisation under whose direct care the patient was at the time of their death. That organisation will also offer condolences and exercise the responsibilities under being open and duty of candour if required.

However there will be a discussion to agree on if it is to be a joint or single agency review or investigation (this will be determined by the cause of death) and in the case of joint reviews/investigations who the lead organisation will be.

The Trust should still ensure the death is reported, to ensure we can review the care and treatment the Trust provided. In most cases, the certification and/or Manager's 48 hour review will be sufficient to identify any local learning. Where there has been a long standing relationship with family members, condolences and support should be offered by the relevant staff.

C) Services provided by the Trust where we are not classed as the main provider.

The Trust is not usually classed as the main provider of care for a small number of teams. These teams usually provide a small component of an overarching package

of care and the lead provider is usually the patients GP. For these teams, they should only report deaths where there are concerns regarding the care provided (see Appendix D). If, on review of the clinical records, it is identified that the deceased was on the caseload/waiting list of any of the listed teams but this was the incorrect pathway, the death should be reported so a review can take place.

List C

- Dietetics
- The drug and alcohol shared care services
- Care home liaison
- Acute hospital liaison
- Memory monitoring
- Recovery college deaths
- Support services, e.g. housing
- Rapid Access
- Tissue viability
- District Nursing
- Community physiotherapy
- Macmillan Nurses
- Podiatry
- Health and wellbeing
- Tele-health
- Long term conditions
- End of life team
- Primary care prevention services
- 0-19 service

D) Exception.

In addition to the above, if any act or omission on the part of a member of Trust staff where we are not classed as the main provider is felt to have in any way contributed to the death of a patient, an investigation will be undertaken by the Trust. These MUST be reported on Datix.

National guidance

The above core principles are underpinned by the National Quality Board guidance[10] which sets out certain types of death that must always be reported. These include:

- all in-patient, out-patient and community patient deaths of those with learning disabilities (this is through the LeDeR programme)
- deaths meeting the criteria within the Serious Incident Framework
- child (under 18) death reviews should be undertaken in accordance with national guidance, Working Together to Safeguard Children.
- maternity/perinatal deaths
- any death of a patient detained under the Mental Health Act is reported to the Care Quality Commission without delay
- all deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision;
- all deaths in a service specialty, particular diagnosis or treatment group where an ‘alarm’ has been raised with the provider through whatever means
- all deaths in areas where people are not expected to die, for example in relevant elective procedures;

[10] National Quality Board (2017) Learning from Deaths guidance

- deaths where learning will inform the provider's existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider. To maximise learning, such deaths could be reviewed thematically;

In addition, the Northern Mental Health alliance has identified a number of potential triggers in a mental health setting for a Review / Investigation. These include deaths:

1. Patient deaths of people with severe mental illness (SMI)*
2. Where medication with known risks such as Clozapine was a significant part of the treatment regime;
3. From causes or in clinical areas where concerns had already been flagged – (possibly at Trust Board level or via complaints or from data);
4. Where they had been subjected to a care intervention where death wouldn't have been an expected outcome e.g. ECT, rapid tranquilisation;
5. Where the service user had no active family or friends and so were particularly isolated e.g. with no one independent to raise concerns;
6. Where there had been known delays to treatment e.g. assessment had taken place or a GP referral made but care and treatment not provided, or where there was a gap in services;
7. Associated with known risk factors / correlations
8. Particular causes of death e.g. epilepsy;
9. Deaths in Distress which might include: drug and alcohol deaths, or deaths of people with an historic sex offence e.g. people who might not be in crisis but need support and from whose experience there may be learning from a thematic review;
10. Where a proactive initial assessment of a death has potentially identified that there was a deterioration in the physical health of a service user which wasn't responded to in a timely manner;
11. A further sample of other deaths that do not fit the identified categories, so that providers can take an overview of where learning and improvement is needed most overall; this does not have to be a random sample, and could use practical sampling strategies such as taking a selection of deaths from each weekday - When identifying the numbers for sampling the Trust needs to consider that services such as Community Specialist Palliative Care Service already review and record significant data that is subject to analysis. They also provide minimum data sets for palliative care for the national council for palliative care.

Severe Mental Illness*

In relation to this requirement, there is currently no single agreed definition of which conditions/criteria would constitute SMI. The term is generally restricted to the psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder.

It is acknowledged that there is substantive criticism of this definition; personality disorders can be just as severe and disabling, as can severe forms of eating disorders, obsessive compulsive disorder, anxiety disorders and substance misuse problems.

Further national guidance is expected to clarify expectations about mortality review in mental health and community services in the future however in the meantime, Trusts have been asked to use the above description of SMI.

These will be subject to a review of the case at the risk panel or Mortality review group and a decision made on an individual basis as to whether and what type of review is required.

Liaison with other organisations

Where problems are identified relating to other NHS Trusts or organisations, the Trust should make every effort to inform the relevant organisation so they can undertake any necessary investigation or improvement. A culture of compassionate curiosity should be adopted and the following questions should be asked:

- Which deaths can we review together?
- What could we have done better between us?
- Did we look at the care from a family and carers perspective?
- How can we demonstrate that we have learnt and improved care, systems and processes?

If the Trust receives requests from other organisations to review the care provided to people who are its current or past patients but who were not under its direct care at time of death, the Trust will review the care provided on the clinical records in the first instance to establish our involvement. Information will be shared with partners if the death is outside the Trust's scope. Where the death meets our reporting criteria the manager will ensure the death is reported on Datix and the normal process followed.

7.0. Identifying and Reporting Deaths

7.1 Identifying Deaths

The Trust has systems that identify and capture the known deaths of its service users on its electronic patient administration systems (PAS) and on its Datix system where the death requires reporting. This is to help ensure that the Trust Board has a comprehensive picture of the deaths of all its services users and the opportunities to learn from them.

The Trust's Performance and Information team has also developed ways to triangulate deaths across Trust systems and link in information from some local registration of deaths services.

Where deaths are identified through enquiries from the coroner, teams should report the death on Datix.

The Trust will be informed of a service user's death in a variety of ways. This could be by contacting to arrange an appointment or attending a planned visit, family

contacting staff to inform them of the death, coroner's requests, other care providers, through the clinical information system.

When the Trust becomes aware of a death, the **clinical team** should use the flowchart set out in Appendix D to ensure the process is followed when a death occurs. This initially includes contacting the family, and reviewing the clinical records. Appendix D helps teams identify which deaths should be reported on Datix.

7.2 Responding to Deaths

The first step that must happen in identifying a death is contacting the relevant family members to offer condolences. The team should agree who is the most appropriate person, ideally someone who has had previous contact. They should offer support to the family, and where possible, enquire about the circumstances and cause of death. They should be given the opportunity to raise any questions they may have about the care their family member received.

Attempts should be made to obtain further information from other providers, e.g. GP if information is limited.

The manager or deputy should be informed of the death as soon as possible.

The manager or deputy, should always review the care (minimum 6 months, and not limited to that team's care) on the clinical information system to understand if the care provided was in line with what would be expected against clinical standards, policies and procedures.

7.3 Reporting Deaths

For some teams providing care, a death of a service user will always be reportable as an incident on Datix. The flowchart in Appendix D helps staff to identify which incidents should be reported. If a team is not usually a main provider of care, they would not routinely report deaths on Datix (see section 6). However if there were concerns raised by the family, management or governance, the death would be reportable so that review can take place. Staff should follow the guidance in Appendix D.

If the death is reportable the death should be reported on Datix within 24 hours of being informed. If there any doubts about whether a death should be reported or not, it should be reported so it can be considered.

Staff should provide details of the circumstances and cause of death where known. Where there has been an inpatient death, the recording should include certified cause of death or state whether this has been referred to the Coroner and why.
Information on the communication with the family should be recorded, including a summary of the conversation, the offer of condolences, who was contacted, when, any information about cause of death. If contact cannot be made with family members, this should also be recorded.

All deaths where we are the main provider of care or there are concerns from family, clinical staff or through governance processes, that staff are made aware of must be reported through the Datix system to start the process of learning from patient deaths. The Manager's 48 hour review of care must be completed including any immediate action taken.

7.4 The decision to investigate or review

All deaths reported on Datix are reviewed by the Patient Safety Support Team on a regular basis. A flowchart has been developed to illustrate the mortality review process and categories of death which supports whether a review or investigation takes place. The flowchart is available on the intranet and the Trust website.

To ensure there is consistency in recording, a number of categories have been developed, used across the Northern Alliance. These have been added to Datix and the flowchart. The manager will record this when reviewing the death, being confirmed by patient safety support team from information given:

- Expected natural (EN1) – e.g. Terminal illness
- Expected natural (EN2) –e.g. cancer, expected but not in timescale
- Expected unnatural (EU) –e.g. death expected but not cause e.g. drug and alcohol
- Unexpected natural (UN1) –e.g. cardiac arrest, stroke, road traffic accident
- Unexpected natural (UN2) –e.g. alcohol dependency but care concerns
- Unexpected unnatural (UU) - e.g. suicide, homicide, abuse, neglect

The **patient safety support team** will prompt teams to ensure full and accurate information is recorded if this has not been already completed. The team will consider if the death meets the criteria for a serious incident. A death meeting the SI criteria will be reported as a serious incident and an investigation commissioned in line with the Trust's Incident reporting and management (including serious incidents) policy.

The Patient safety support team will determine if the case is in scope or out of scope for the Trust mortality review process and to indicate the proposed level of scrutiny.

If this requires further discussion it is taken to the weekly risk panel that involves medical and nursing directors to make a final decision or agree next steps. In some cases, deaths may be reviewed for decision making in the mortality review group.

8.0. Review methodology

Practice varies across Trusts in the northern alliance with regard to how deaths are reported and categorised.

Each Trust has core processes around:

- An initial screen of each death e.g. at a weekly Mortality review group, at a Huddle which will always necessitate the collection of core data around the service user and his or her death and sometimes the use of a structured tool;
- A way of making a judgement about which deaths are subject to further review which might be explicit and transparent against a set of criteria or sometimes more reliant on individual and clinical judgement;
- A way of deciding the level of further review; however this is described e.g. local review, clinical review, case record review, structured judgement review.

Levels of Review

The Trust has adopted the three levels of scrutiny suggested in the NQB guidance:

1	Death Certification	Details of the cause of death as certified by the attending doctor.
2	Case record review	Includes: (1) Managers 48 hour review (2) Structured Judgement Review
3	Investigation	Includes: Service Level Investigation Serious Incident Investigation (reported on STEIS) Other reviews e.g. LeDeR, safeguarding.

8.1 Certification

If the death has been certified by a doctor as a natural death and they have not reported the death to the coroner, no further review will usually be necessary unless the Trust is aware of any concerns expressed by family and clinical staff or through governance processes. The clinical team will normally review the case and make a note on Datix if they feel any further review may be required.

8.2 Case Record Review

Case record review is a method used to determine whether there were any problems in the care provided to a patient within a particular service. It is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help identify problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families/carers or staff raise concerns about care.

Some deaths will require further review to look at the care provided to the deceased as recorded in their case records in order to identify any learning.

The Trust has two types of case record review. The first stage case record review is the Manager's 48 hour Review, with the second stage a Structured Judgement Review, as described below.

8.2.1 Manager's 48 hour review

Where a reportable death has not been certified, the Manager's 48 hour review can be accepted as a first stage case record review.

The responsible manager records the findings of their case record review on the Manager's 48 hour review on the Datix incident record. This aims to provide a summary of the care provided, identify if the care was provided within clinical standards, policies and procedures, identify areas of good practice and any areas for further review.

The completed Managers 48 hour review is considered (usually at risk panel) and where the review is comprehensive, there are no concerns identified and care was provided as would have been expected, this will be accepted as a first stage case record review.

8.2.2 Structured Judgement Reviews

A Structured Judgement Review (SJR) blends a traditional clinical judgement based review with a standard format that enables reviewers to make safety and quality judgements over phases of care and which provides explicit written comments and a score for each phase. The Trust uses nationally agreed review toolkits. The first, issued by the Royal College of Physicians, has been in use in the Trust since April 2017. In November 2018, the Royal College of Psychiatrists published a toolkit focused on learning from patient deaths for NHS Mental Health Trusts. (see Structured Judgement Review in Definitions).

A SJR provides a relatively short but rich set of information about each case in a format that can be aggregated to provide knowledge about clinical services and systems of care. The Trust has trained a number of staff to be able to undertake these reviews.

Following a SJR being completed, it will be second reviewed, usually by a member of the mortality review panel to ensure consistency and completeness of the review. The second reviews and any recommendations are reported back into the Mortality Review Group.

8.3 Investigations

8.3.1 Service level investigation/serious incident investigation requiring STEIS reporting

Investigations are a review of care provided using recognised systems analysis tools. These are either undertaken at service level for a service level investigation or through a central dedicated team for serious incidents. The aim of the review is for the Trust to learn and prevent recurrence.

When the family/carers wish to be involved, their preference regarding how, when and where they want to engage will be paramount and built on the principles of

compassionate engagement. The findings will always be shared with the family subject to confidentiality requirements. We will always share the outcome and learning.

8.3.2 Joint investigations

There are some instances when a joint approach is required with another organisation to investigate. The Trust has developed links with neighbouring acute Trusts to enable this to take place when needed. Either organisation can request this to take place.

8.3.3 Other investigations

The Trust is an active member in Safeguarding Boards and should a death require investigation through the Safeguarding process the Trust will work through that process in line with serious incident framework. The manager's 48 hour review would be completed in these cases.

8.3.4 Learning Disability Deaths

All deaths of those with a Learning Disability diagnosis are reportable on Datix in the Trust. Each death will have the Manager's 48 hour review completed to enable any local learning to be identified. In some cases, a Structured Judgement Review may be completed. Alongside this internal review, the Trust's LeDeR lead managers will ensure the death is reported to the Learning Disability Mortality Review (LeDeR) programme.

9.0. Governance process / ensuring learning

The prime objective of the Learning from Healthcare Deaths Policy is that we can improve services and the experience of those services for the people that use them.

We have worked with eight other mental health trusts and will work locally with services to develop a consistent framework around learning. This will focus on whether the activity we do under the guidance of this policy (i.e. talking to the families of those who died, the investigations, thematic reviews, the analysis of data, the review of case records including SJR) makes a difference.

How we measure the impact of the work will develop over time as the information we access improves, as we evaluate the policy overall including feedback from families.

We will all assess learning against a common framework that:

1. Identifies potential improvements;
2. Develops a shared understanding of what these improvements might be across the Trust;
3. Leads to a series of actions locally, that should be able to be measured;

4. Provides knowledge of the difference made by those actions.

We will take the opportunity to share learning with our partner Trusts and other, local stakeholders. For example, there may be common issues where we could commission thematic reviews.

The actual practice in each Trust will differ for a variety of reasons: different cultures, priorities and policies. This co-existence of cohesion and diversity will be a strength as we will have the opportunity (through our continued regional work) to share and learn from each other's approaches and see which ones work best.

The Trust will ensure that lessons learnt result in change in organisational culture and practice by; identifying themes and trends in formal meetings and in the Quality Account; commissioning thematic reviews on a regular basis by the Mortality Review group and ensuring that associated action plans are implemented.

We will ensure learning is cascaded to frontline clinical staff on a regular basis by use of learning lessons events, learning reports and other methods being developed.

We will ensure transparency in decision making and accountability.

The Trust worked with the Northern Alliance of Trusts to develop the principles and policy. To ensure the Trust reviews the outputs from the reviews and investigations to inform quality improvements the Trust has developed a six monthly clinical mortality review group.

10.0. Data reporting

From 1 October 2017, Trusts have been required to publish information on deaths, reviews and investigations via a quarterly agenda item and paper to its public Board meetings. The Trust publishes its Learning from deaths reports on our website.

This report incorporates a dashboard of information. The Northern Mental Health Trusts alliance agreed the content of the dashboard to enable consistency of data presented across all the Trusts.

The dashboard will continue to develop over time, for example by looking into some areas in greater detail and by talking to families about what is important to them. We will also learn from developments nationally as these occur.

Understanding the data around the deaths of our service users is a vital part of our commitment to learning from all deaths.

When counting 'total number of deaths in scope' and 'total number of deaths reviewed (using the 3 levels of scrutiny on page x)' it should be possible to see what percentage of deaths has been reviewed in a particular period. In other words, the number of deaths reviewed can be reported as a percentage of the number of deaths.

For reporting purposes, there is a natural lag with obtaining this information, therefore reporting is offset a quarter. For example Q1 data would be reported at the end of Q2.

We have developed an internal Business Intelligence Dashboard that bring together information on all known deaths from our clinical information systems and Datix. This work also includes information obtained from some local registrars.

Some Trust services such as End of Life Team provide separate reports to fulfil their own contractual requirements. These deaths are usually not in scope so would not be included in the breakdown of mortality figures. However, the figure would be included in overarching figure for all deaths obtained through our Business Intelligence Dashboard.

The Northern Alliance of Trusts has decided not to report initially on what are described in general hospital services as **"avoidable deaths"** in inpatient services. This is because there is currently no research base for this in mental health services and no consistent accepted basis for calculating this data. We also consider that an approach that is restricted to inpatient services would give a misleading picture of a service that is predominately community focused. We will continue to support work to develop our data and general understanding of the issues.

11.0. Equality Impact Assessment

Equality Impact Assessment completed (see appendix A).

12.0. Dissemination and implementation arrangements (including training)

- This policy will be disseminated on the intranet.
- A presentation will be prepared for BDUs to share on key points from the policy.
- Patient safety support team has already spent much time and resources setting up the collection of the recording deaths on Datix, this will be refined through implementation of this policy.
- Performance and information team are aware and continue to develop reports on all deaths recorded on PAS and working with local registrars.
- Customer services are aware they may have contacts from families but they do not see this as additional to what is already available.
- Serious incident investigators are within the Trust and this needs to remain.
- A number of staff have been trained in structured judgement reviews; further training will be arranged as needed to meet our needs.
- Training of staff by patient safety support team to undertake service level investigations will need to continue.

- A clinical mortality review group to review and examine themes arising from reviews has been established. This will support the key messages for sharing and implementation of learning across the Trust.
- Continued review of the support requirements for the administration and coordination of learning from deaths agenda.

12.1 Process for monitoring compliance and effectiveness

• This policy will be ratified by the Trust Board and published on the Trust's intranet and external website.
• Line managers will disseminate this policy to all Trust employees through a line management briefing. This is mandated through The Brief.
• As and when further national guidance emerges, the Trust will review the policy and its implementation to ensure it continues to reflect best practice.
• The policy, procedures and processes will be audited on an annual basis by either the Quality Improvement and Assurance Team, Patient Safety Support Team or internal audit. The results of which will be considered at the Mortality Review group and/or Clinical Governance and Clinical Safety Committee. • The audit tool will be designed to capture both qualitative and quantitative data to demonstrate the lessons learned and how they have been shared and used to improve the quality of services.

12.2 Review and revision arrangements (including archiving)

The policy will be reviewed as required in response to national and/or internal changes as defined on the front cover. Earlier versions of this policy will be available in the Trust's document archive.

13.0. References

This Policy document is to be read in conjunction with the Trust's:

- Incident reporting and management (including serious incidents) policy
- Being open (incorporating Duty of Candour) policy
- Investigating and analysing incidents, complaints and claims to learn from experience policy
- Supporting staff involved in traumatic or stressful adverse events policy

Useful websites:

- NHS Improvement website: Learning from deaths in the NHS

And these national documents:

- Care Quality Commission (CQC) (2016) Learning, candour and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England
- National Quality Board (2017) National Guidance on Learning from Deaths
- NHSE Serious Incident Framework (2015): Supporting learning to prevent recurrence
- CQC Regulation 20: Duty of Candour (2014)
- Working Together to Safeguard Children. (2015)
- The Department for Education' forms for reporting child deaths
- National Quality Board (July 2018) Learning from deaths - Guidance for NHS trusts on working with bereaved families and carers
- Royal College of Psychiatrists (2018) Care Review Tool for Mortality
- Royal College of Physicians (2018) Mortality toolkit: Implementing structured judgement reviews for improvement

Appendices

All policies should include completed versions of the following:

- Equality Impact Assessment (see appendix A);
- Checklist for the Review and Approval of Procedural Document (see appendix B);
- Version control sheet (see appendix C).

Appendix A - Equality Impact Assessment

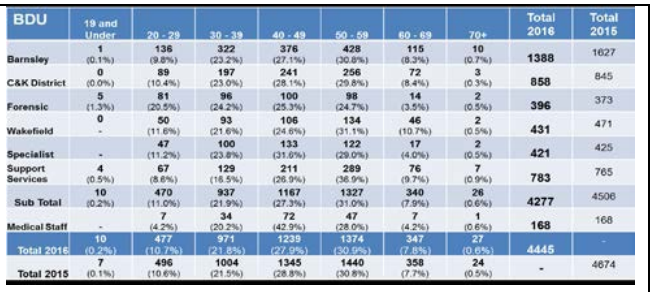
Date of assessment: 4/9/2017
Updated: 27/11/18

	Equality Impact Assessment Questions:	Evidence based answers & actions:
1	**Name of the document that you are Equality Impact Assessing**	Learning from Healthcare Deaths - The right thing to do
2	**Describe the overall aim of your document and context?** **Who will benefit from this policy/procedure/strategy?**	Working with families/carers of patients who have died offers an invaluable source of insight to improve services. Therefore there is a need to ensure appropriate support is provided at all stages of the review process and an understanding that treating bereaved families/carers as equal partners in this process is vital. In line with the National Quality Board guidance on Learning from Deaths, every Trust must have a policy in place that sets out how it identifies, reports, investigates and learns from a patient's death. This should include the care leading up to the patient's death and considering if this could have been improved.
3	**Who is the overall lead for this assessment?**	**Julie Warren-Sykes (Associate Director of Nursing Quality and Professions and Emma Cox (Assistant Director of Nursing, Quality and Professions)** **Previously developed by Julie Eskins (Assistant Director of Patient Safety)**
4	**Who else was involved in conducting this assessment?**	**Helen Roberts (Patient safety Manager)**
5	**Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy?** **What did you find out and how have you used this information?**	The Trust has worked with a northern alliance of other trusts to develop this policy. National guidance from the National Quality Board[11] was issued in July 2018 providing guidance for NHS Trusts on working with bereaved families and carers. An assistant director within the Nursing and Quality directorate was a member of a carers and relatives involvement group for the mortality review programme facilitated by Improvement Academy. Findings from their work has been incorporated into the national guidance. The Trust has reviewed the national guidance and is developing our support for bereaved families in line with the guidance. A recognised national figure ran a workshop with the northern alliance. A discussion has taken place at a carers group in Kirklees

[11] National Quality Board (July 2018) Learning from deaths - Guidance for NHS trusts on working with bereaved families and carers

		The Trust has also consulted with staff and families in developing policy and resources for undertaking investigations. We have linked with one neighbouring acute Trust. All of the key recommendations have been added in this policy.
6	**What equality data have you used to inform this equality impact assessment?**	CQC review in December 2016, 'Learning, candour and accountability: a review of the way trusts review and investigate the deaths of patients in England' found that some providers were not giving learning from deaths sufficient priority and so were missing valuable opportunities to identify and make improvements in quality of care. 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. Reports and case studies have consistently highlighted that in England people with learning disabilities die younger than people without learning disabilities. Data regarding the age of those who have died is collected on Datix and data is available to the Mortality Review Group. The JSNA, public health data and census data for each of our places including population statistics in respect of race equality, disability, gender, age and sexual orientation, religion and belief, marriage and civil partnership census have been used. Information on the nature of the population that the Trust cares for is provided within section 2 of the strategy. This background information covers population projections, ethnicity, deprivation and unemployment, health and the wider determinants of health and wellbeing. The makeup of our Trust membership and volunteers through individual self-declaration. Staffing profile: As per workforce annual report 2016 • staff in post by age: 

BDU	19 and Under	20 - 29	30 - 39	40 - 49	50 - 59	60 - 69	70+	Total 2016	Total 2015
Barnsley	1 (0.1%)	136 (9.8%)	322 (23.2%)	376 (27.1%)	428 (30.8%)	115 (8.3%)	10 (0.7%)	1388	1627
C&K District	0 (0.0%)	89 (10.4%)	197 (23.0%)	241 (28.1%)	256 (29.8%)	72 (8.4%)	3 (0.3%)	858	845
Forensic	5 (1.3%)	81 (20.5%)	96 (24.2%)	100 (25.3%)	98 (24.7%)	14 (3.5%)	2 (0.5%)	396	373
Wakefield	0 -	50 (11.6%)	93 (21.6%)	106 (24.6%)	134 (31.1%)	46 (10.7%)	2 (0.5%)	431	471
Specialist	-	47 (11.2%)	100 (23.8%)	133 (31.6%)	122 (29.0%)	17 (4.0%)	2 (0.5%)	421	425
Support Services	4 (0.5%)	67 (8.6%)	129 (16.5%)	211 (26.9%)	289 (36.9%)	76 (9.7%)	7 (0.9%)	783	765
Sub Total	10 (0.2%)	470 (11.0%)	937 (21.9%)	1167 (27.3%)	1327 (31.0%)	340 (7.9%)	26 (0.6%)	4277	4506
Medical Staff	-	7 (4.2%)	34 (20.2%)	72 (42.9%)	47 (28.0%)	7 (4.2%)	1 (0.6%)	168	168
Total 2016	10 (0.2%)	477 (10.7%)	971 (21.8%)	1239 (27.9%)	1374 (30.9%)	347 (7.8%)	27 (0.6%)	4445	-
Total 2015	7 (0.1%)	496 (10.6%)	1004 (21.5%)	1345 (28.8%)	1440 (30.8%)	358 (7.7%)	24 (0.5%)	-	4674

			 disability • The gender split is 76.8% female and 23.2%male • 46.6% of staff chose not to disclose their religion. • 73% of staff are heterosexual; sexual orientation not • 57% are married; 8.3% divorced or separated. Ethnicity: • 8 % of our staff are from a BAME background 
7	**What does this data say?**		As above
8	**Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavourably:**	**Yes/No**	The purpose of this policy is to ensure that SWYPFT is ready today and relevant for tomorrow, putting people first and in the centre of their own care. The Trust recognises the changing profiles of the populations we service, the increase in demand and the diversity of needs of staff, members and service users and families. The policy supports an equality competent organisation, with person centred care that is equally accessible and with equality of opportunity for our staff. Targeted action planning through service changes will need to address the needs of specific groups and we will work with communities, including people with protected characteristics, to ensure we meet their needs and preferences.
8.1	**Race**	**N**	Rationale as set out above.

			<table><tr><th></th><th>White</th><th>Asian</th><th>Black</th><th>Mixed</th><th>Chinese & Other</th></tr><tr><td>England % av.</td><td>85.5</td><td>5.1</td><td>3.4</td><td>2.2</td><td>1.7</td></tr><tr><td>Kirklees</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>% average</td><td>79.1</td><td>15.7</td><td>1.9</td><td>2.3</td><td>0.7</td></tr><tr><td>Barnsley</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>% average</td><td>97.9</td><td>0.7</td><td>0.5</td><td>0.7</td><td>0.2</td></tr><tr><td>Calderdale</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>% average</td><td>89.6</td><td>7</td><td>0.9</td><td>1.3</td><td>0.6</td></tr><tr><td>Wakefield</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>% average</td><td>95.4</td><td>2.6</td><td>0.77</td><td>0.9</td><td>0.29</td></tr></table> *Taken from Census 2011 for each area*
8.2	**Disability**	**N**	Rationale as set out above. **Disability groups** <table><tr><th></th><th colspan="3">Day to day activities limited by disability</th></tr><tr><th></th><th>Not at all</th><th>A little</th><th>A lot</th></tr><tr><td>England % av.</td><td>47.2</td><td>13.2</td><td>4.2</td></tr><tr><td>Kirklees</td><td></td><td></td><td></td></tr><tr><td>% average</td><td>45.5</td><td>12.5</td><td>13.7</td></tr><tr><td>Barnsley</td><td></td><td></td><td></td></tr><tr><td>% average</td><td>76.1</td><td>11.3</td><td>12.6</td></tr><tr><td>Calderdale</td><td></td><td></td><td></td></tr><tr><td>% average</td><td>56.5</td><td>12.2</td><td>13.8</td></tr><tr><td>Wakefield</td><td></td><td></td><td></td></tr><tr><td>% average</td><td>77.93</td><td>9.33</td><td>8.31</td></tr></table> *Taken from Census 2011 for each area*
8.3	**Gender**	**N**	Rationale as set out above. <table><tr><th></th><th>Male</th><th>Female</th></tr><tr><td>England % av.</td><td>49.2</td><td>50.8</td></tr><tr><td>Kirklees</td><td></td><td></td></tr><tr><td>% average</td><td>49.4</td><td>50.6</td></tr><tr><td>Barnsley</td><td></td><td></td></tr><tr><td>% average</td><td>49.1</td><td>50.9</td></tr><tr><td>Calderdale</td><td></td><td></td></tr><tr><td>% average</td><td>48.9</td><td>51.1</td></tr><tr><td>Wakefield</td><td></td><td></td></tr><tr><td>% average</td><td>49</td><td>51</td></tr></table> *Taken from Census 2011 data*
8.4	**Age**	**N**	Rationale as set out above

			<table><tr><th></th><th>0-15</th><th>16-29</th><th>30-44</th><th>45-64</th><th>65+</th></tr><tr><td>England % av.</td><td>18.9</td><td>18.6</td><td>20.3</td><td>22.4</td><td>16.9</td></tr><tr><td>Kirklees</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>% average</td><td>15.8</td><td>18.5</td><td>20.3</td><td>22.2</td><td>15.8</td></tr><tr><td>Barnsley (2011 data)</td><td></td><td>16-24</td><td>25-44</td><td>45-59</td><td>60+</td></tr><tr><td>% average</td><td>18.5</td><td>10.8</td><td>26</td><td>20.9</td><td>23.8</td></tr><tr><td>Calderdale</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>% average</td><td>19.6</td><td>16.4</td><td>20.1</td><td>24.2</td><td>16.6</td></tr><tr><td>Wakefield</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>% average</td><td>18.4</td><td>17.2</td><td>19.6</td><td>24.2</td><td>17.6</td></tr></table> *Taken from Census 2012 data unless specified*
8.5	**Sexual orientation**	**N**	Rationale as set out above. <table><tr><th></th><th>Living in a civil partnership</th></tr><tr><td>England % av.</td><td>0.01</td></tr><tr><td>Kirklees</td><td></td></tr><tr><td>% average</td><td>0.01</td></tr><tr><td>Barnsley (2011 data)</td><td></td></tr><tr><td>% average</td><td>0.2</td></tr><tr><td>Calderdale</td><td></td></tr><tr><td>% average (2011 data)</td><td>0.3</td></tr><tr><td>Wakefield</td><td></td></tr><tr><td>% average</td><td>0.01</td></tr></table> *Taken from 2012 census data unless specified*
8.6	**Religion or belief**	**N**	Staff will need to be mindful of service users who are undertaking religious practices such as fasting who may be impacted on for any restrictions on access to food. This may also impact on sleep patterns. Food should be pre-ordered or provided in accordance with health and safety regulations. There is a Spirit in Mind Group established across the trust where any issues may be taken via the Pastoral Care service.

			<table><tr><th></th><th>Christian</th><th>Buddhist</th><th>Hindu</th><th>Jewish</th><th>Sikh</th><th>Muslim</th><th>Other</th><th>No religion</th></tr><tr><td>England % av.</td><td>71.8</td><td>0.3</td><td>1</td><td>0.5</td><td>0.7</td><td>10.1</td><td>0.2</td><td>15.1</td></tr><tr><td>Kirklees</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>% average</td><td>67.2</td><td>0.2</td><td>0.3</td><td>0.1</td><td>0.7</td><td>10.1</td><td>0.2</td><td>14</td></tr><tr><td>Barnsley</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>% average</td><td>59.4</td><td>0.5</td><td>1.5</td><td>0.5</td><td>0.8</td><td>5</td><td>0.4</td><td>24.7</td></tr><tr><td>Calderdale</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>% average</td><td>60.6</td><td>0.3</td><td>0.3</td><td>0.1</td><td>0.2</td><td>7.8</td><td>0.4</td><td>30.2</td></tr><tr><td>Wakefield</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>% average</td><td>66.4</td><td>0.16</td><td>0.25</td><td>0.04</td><td>0.12</td><td>2.0</td><td>0.3</td><td>24.4</td></tr></table> *Taken from 2011 Census data*
8.7	**Transgender**	**N**	There should be no issues with transgender equality
8.8	**Maternity & Pregnancy**	**N**	There should be no issues with maternity or pregnancy.
8.9	**Marriage & civil partnerships**	**N**	There should be no issues with marriage /Civil partnerships equality <table><tr><td>av.</td><td></td><td></td><td>0.2</td><td>9.0</td><td>6.9</td><td>2.7</td></tr><tr><td>Kirklees</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>% average</td><td>48.4</td><td>32.4</td><td>0.2</td><td>9.3</td><td>6.8</td><td>2.8</td></tr><tr><td>Barnsley</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>% average</td><td>46.6</td><td>34.6</td><td>0.2</td><td>9</td><td>6.9</td><td>2.7</td></tr><tr><td>Calderdale</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>% average</td><td>46.7</td><td>32.1</td><td>0.3</td><td>10.5</td><td>7.3</td><td>3.0</td></tr><tr><td>Wakefield</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>% average</td><td>48.2</td><td>30.9</td><td>0.18</td><td>10.5</td><td>7.5</td><td>2.6</td></tr></table> Source unknown
8.10	**Carers (Our Trust requirement)**	**N**	
9	**What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-**		This policy covers healthcare deaths irrespective of characteristics. Some diagnostic or age groups are specifically highlighted. The mortality review meetings will pick up any reported areas of concern. Any difficulties later found that are related to an Impact Equality will be addressed
9a	**Promotes equality of opportunity for people who share the above protected characteristics;**		This policy covers healthcare deaths irrespective of characteristics.
9b	**Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;**		Recognised tools are available to support reviewing care in line with trust policies and procedures

9c	**Promotes good relations between different equality groups;**	All equality groups will be reviewed to the same standard.
9d	**Public Sector Equality Duty – "Due Regard"**	We are confident that the Trust healthcare deaths policy approach contributes to the effective Public Sector Equality Duty – "Due Regard"
10	**Have you developed an Action Plan arising from this assessment?**	**No**
11	**Assessment/Action Plan approved by (Director Lead)**	**Sign: Tim Breedon** **Date: 07/01/2019** **Title: Director of nursing and quality**
12	***Once approved, you must forward a copy of this Assessment/Action Plan to the partnerships team:*** **partnerships@swyt.nhs.uk** **Please note that the EIA is a public document and will be published on the web.** **Failing to complete an EIA could expose the Trust to future legal challenge.**	

Appendix B - Checklist for the Review and Approval of Procedural Document

To be completed and attached to any policy document when submitted to EMT for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
	Is it clear in the introduction whether this document replaces or supersedes a previous document?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is the method described in brief?	Yes	
	Are people involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	
	Are supporting documents referenced?	Yes	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
6.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/a	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	Yes	
8.	**Document Control**		
	Does the document identify where it will be held?	Yes	
	Have archiving arrangements for superseded documents been addressed?	Yes	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible implementation and review of the document?	Yes	

South West Yorkshire Partnership NHS Foundation Trust

Appendix C - Version Control Sheet

Version	Date	Author	Status	Comment / changes
Draft 1	Sept 2017	J.Eskins /H.Roberts	Draft	For consultation with CGCSC, EMT
Draft 2	Sept 2017	J.Eskins /H.Roberts	Draft	Updated minimally from consultation ready for Trust Board
Draft 3	Sept 2017	J.Eskins /H.Roberts	Draft	Updated following Trust Board review of papers
Version 1	Oct 2017	J.Eskins /H.Roberts	archived	Approved by Trust Board
Version 2	January 2019	H Roberts/E Cox	current	Changes throughout to reflect development of processes Updated flowcharts Updated references Additional definitions Terminology updated Links to new guidance

Appendix D - Death reporting requirements flowchart

To be read in conjunction with Learning from healthcare deaths policy, Being Open Policy, Investigating and the Analysing incidents, complaints and claims to learn from experience policy

The death of a service user is identified

Being Open and support for the bereaved

Contact the Next of Kin/ family to offer condolences.
Seek any further information regarding the circumstances of death as appropriate
Enquire if there are any questions regarding the care provided by SWYPFT
Offer support, signposting as appropriate
Offer contact details in case of further questions
Follow up in writing

Record the contact/s, conversation and information gathered from the conversation/s with the family/carers in the clinical record.

Initial review of care provided

Manager reviews clinical records to identify any concerns regarding care of the Trust (minimum 6 month period)
Ensure that the whole care experience is looked at, not just the individual team

Are there any concerns related to SWYPFT care raised by family, clinicians or governance?

This may include any act or omission on the part of a member of Trust staff where it is felt to have in any way contributed to the death of a patient

No

Yes

At the time of death, was the deceased person subject to any of the following:

- o A current inpatient in a SWYPFT ward/unit
- o An inpatient in a SWYPFT ward/unit within the last 30 days
- o Receiving care under Care Programme Approach (CPA)
- o Under a Community Treatment Order (CTO)
- o A Conditional Discharge
- o Guardianship Order
- o Receiving community treatment due to identified mental health, learning disability or substance misuse needs
- o *An inpatient episode or community treatment package within the 6 months prior to their death (Mental Health services only).*

A) If the answer to any of the above was yes, the Trust is deemed a main provider of care.
B) Where death occurred in another provider setting, report on Datix. Joint review may be beneficial.
C) Some teams are not usually a main provider, see list C in section 6
D) Exceptions that should be reported – eg all Learning disability deaths, child deaths - see full list from National guidance in Section 6 of the policy (page 16)

Yes

No

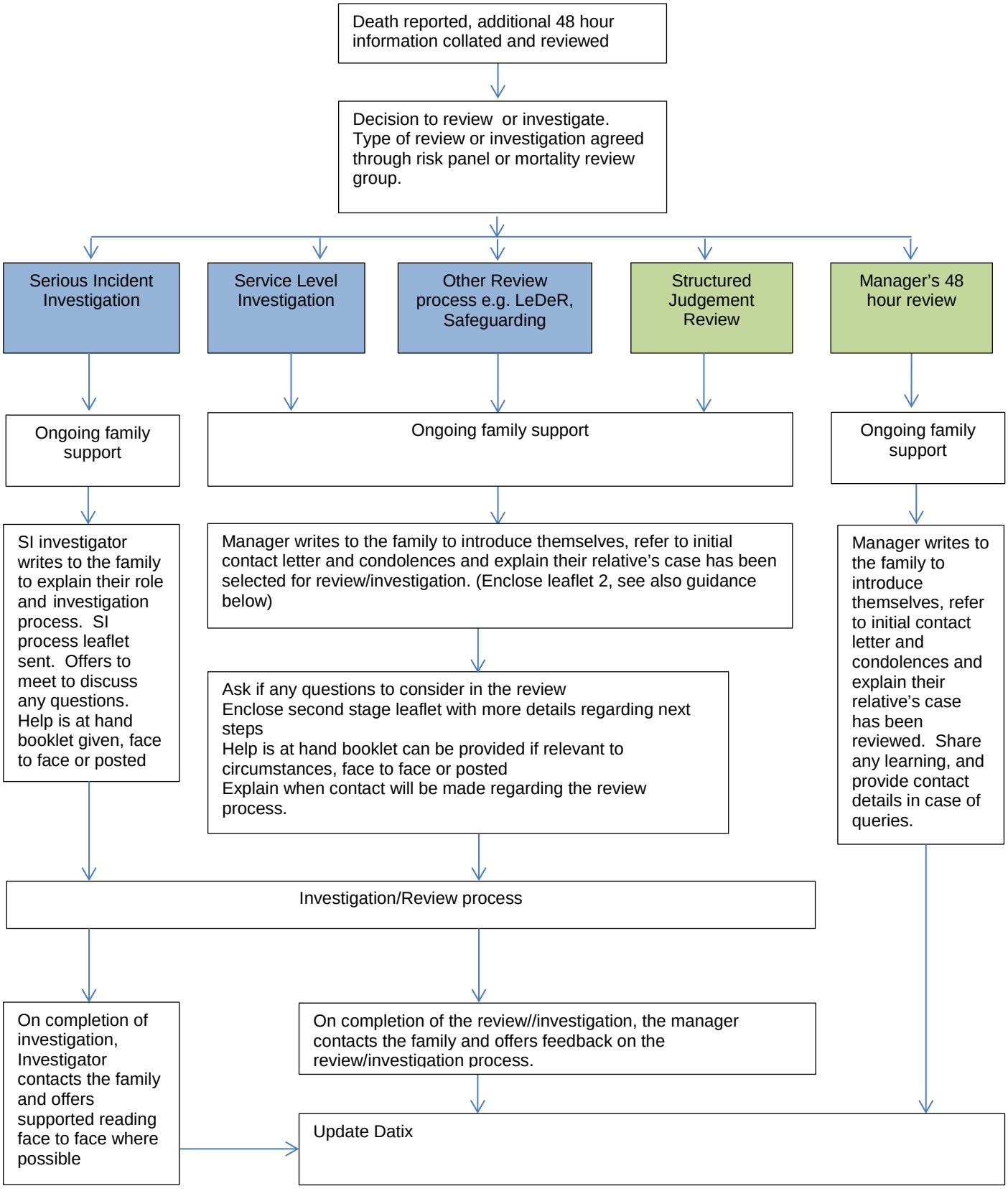
No further action
No requirement to report the death on Datix.

Report the death on Datixweb

Record the outcome as death, and complete the Death of a service user questions.
Manager records findings of review of clinical records on Manager's 48 hour review on Datix record.

Mortality review processes commences
Consideration of joint review where death occurred in another provider setting

Appendix E - Review and Investigation levels and family involvement flowchart



NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board 26 March 2019
Agenda item 9.1

Title:	**Eliminating mixed sex accommodation (EMSA) declaration of compliance**
Paper prepared by:	Director of Nursing and Quality
Purpose:	To appraise the Board of the Trust position in relation to eliminating mixed sex accommodation (EMSA) and approve the annual declaration. Clinical Governance and Clinical Safety Committee approved the paper at its meeting on 12 February 2019.
Mission/values:	We must support people to fulfil their potential and live well in their community. This includes safeguarding the privacy and dignity of service users when they are often at their most vulnerable.
Any background papers/ previously considered by:	Clinical governance and clinical safety committee reviews the compliance statement on an annual basis. Any exception reports regarding EMSA are reported to the Clinical Governance and Clinical Safety Committee by the Director of Nursing and Quality. **The committee approved the paper at its meeting on 12 February 2019.**
Executive summary:	**Background** This paper is intended to assure Trust Board of the organisation's level of compliance with the national standard in respect of eliminating mixed sex accommodation. The declaration of compliance, which will appear on the Trust's website, is shown below. The Trust is expected to make a declaration to commissioners by 31 March 2019 to confirm the Trust's position regarding compliance with the EMSA standard. The statement of compliance is then required to be posted on the Trust website. The guidance in relation to EMSA expects Trusts to provide the following accommodation. Single Sex accommodation can be provided in: ➢ single sex wards (the whole ward is occupied by men or women but not both); ➢ single rooms with adjacent single sex toilet and washing facilities; ➢ single sex accommodation within mixed wards (bays or rooms that accommodate either men or women, not both) with designated single sex toilet and washing facilities preferably within or adjacent to the bay or room. In addition, service users should not need to pass through accommodation or toilet / washing facilities used by the opposite sex to gain access to their own. During 2018 a review was undertaken on the review and governance of EMSA. The result was to simplify the governance while maintaining the

	scrutiny. ➢ The 2018 audit of incidents reported take place in line with the incident reporting policy. ➢ A quarterly report is submitted to the clinical governance group ➢ A more detailed audit was conducted on areas based on risk these included: o New buildings o Based on incidents o Feedback – e.g. Healthwatch, CQC The main conclusions are ➢ There were no recorded breaches of EMSA policy in 2018. ➢ As the Trust continues to increase its single sex accommodation, the number of EMSA related incidents decreases. ➢ The number of EMSA incidents recorded on Datix fell from 23 in 2016, 11 in 2017 to 9 in 2018. Preventative measure put in place to safeguard safety and dignity and no harm occurred; therefore no breaches. ➢ The results show high level of compliance with best practice st standards. The standards the teams are unable to declare full compliance is similar:- o Staff gender mix on wards can affect ability to provide same sex key worker, this is mainly shortage of males o Nurse call system being available in all toilets. ➢ CQC focussed inspection March 2018 *"All wards complied with the Department of Health's national guidance on eliminating same-sex accommodation. Over the 12 month period from 1 November 2016 to 31 October 2017 there were no mixed sex accommodation breaches within this core service. Two previous Mental Health Act review visits reported that the ward sometimes placed males on the female corridor and females on the male corridor. We discussed this with staff who reported that they increased observation levels to ensure patient safety if this occurred. Females in this corridor did not have to walk past male bedrooms to use a bathroom; therefore this still complied with guidance on same sex accommodation. "* Recommendations ➢ To continue to explore opportunities through the transformation agenda for wards to be designated single sex and to continue to improve the availability of en-suite accommodation in all units. ➢ To continue considering ways to avoid allocating bedrooms in areas designated for the opposite sex. **Risk Appetite** An EMSA breach could potentially be a clinical risk as well as a compliance risk. Through the flexibility within the Trust's accommodation the risk is mitigated in line with the Trust's risk appetite. However, it may be deemed safer to breach EMSA on an individual basis than not to admit in a clinical emergency and actions would be put in place to manage the individual risk.

Recommendation:	**Trust Board is asked to SUPPORT the compliance declaration that was approved by the Clinical Governance and Clinical Safety Committee on 12 February 2019.**
Private session:	Not applicable

Eliminating Mixed Sex Accommodation and Bed Management Incidents Annual Report

1. Executive Summary

South West Yorkshire Partnership NHS Foundation Trust provides a variety of services to a diverse population across the geographical localities and is committed to achieving the Trust's 'Mission and Values'.

Our mission

- We help people reach their potential and live well in their community

Our values

- We put the person first and in the centre
- We know that families and carers matter
- We are respectful, honest, open and transparent
- We improve and aim to be outstanding
- We are relevant today and ready for tomorrow

Trust inpatient services are provided in Calderdale, Kirklees, Wakefield and Barnsley. As part of clinical governance a priority area is ensuring the Trust meets the requirements for Eliminating Mixed Sex Accommodation (EMSA).

This report is based on information from 1 January 2018 to 31 December 2018.

The main conclusions are:

- The Trust can be assured it continues to meet the requirements of self-declaration.
- There were no recorded EMSA breaches in 2018.
- As the Trust continues to increase its single sex accommodation, the number of EMSA related incidents decreases.

Calendar year	2016	2017	2018
Number of reported incidents	23	11	9

- In 2018 EMSA incidents were reported on four wards. All of these patients were females placed on male corridors.

- Other bed management issues are reviewed.

- National guidance is scanned for implication for EMSA.

- The results show high level of compliance with best practice standards. The standards the teams are unable to declare full compliance is similar:-
  - Staff gender mix on wards can affect ability to provide same sex key worker, this is mainly shortage of males.
  - Nurse call system being available in all toilets.

2. Main Report

During 2018 a review was undertaken on the governance of EMSA. The current position of having a dedicated group was becoming obsolete due to the progress made. The result was to simplify the governance while maintaining the scrutiny.

- There was ongoing performance reporting and review of incidents reported taking place in line with the incident reporting policy.
- A quarterly report is submitted to the clinical governance group.
- The EMSA policy was updated and approved.
- The best practice standard audit would be conducted on areas based on risk, these included:
  - New buildings
  - Based on incidents
  - Feedback – e.g. Healthwatch, CQC

2.1 Incidents of potential breaches by team and month

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Beechdale Ward, The Dales Unit	0	1	0	0	0	0	0	0	0	0	0	0	1
Chantry Unit, Wakefield	1	0	0	0	0	0	0	0	0	0	0	0	1
Walton PICU (Trinity 1) - trustwide	0	0	0	0	0	1	0	0	0	1	0	1	3
Ward 18, Priestley Unit	2	2	0	0	0	0	0	0	0	0	0	0	4
Total	3	3	0	0	0	1	0	0	0	1	0	1	9

The table above shows the potential breaches reported by services. All 9 incidents were reviewed and none met the criteria for reporting as a breach. Every incident involved a patient being admitted as an emergency and the individual being on a corridor occupied by members of the opposite sex. All rooms were ensuite and the patient was supported to maintain privacy and

dignity. Two incidents (ward 18) relate to the same patient as she had to sleep on a male corridor for a prolonged time. Of note, all of these patients were females placed on male corridors.

Where such an incident occurs, mitigating action includes:

- Increased observation
- Updated risk assessment and monitoring
- Review of care plan

2.2 Best practice standard audit results

A best practice standard audit was undertaken on:

- The Unity Centre – Stanley, Nostell and Walton
- Ward 18
- Ward 19 – male and female side
- Horizon unit

These wards were chosen against the criteria identified during the review.

Comparisons with previous year are not possible as selection criteria for the audit is not replicated.

Standards and results

Standard	2018	Comments
Service users are accommodated in single rooms, single sex bed bays, separate corridors, pods or ensuite single rooms	**100%**	
Is a lounge available for sole use of female service users (new question for 2017)	**100%**	Available or not applicable as male only ward.
Bedroom doors are fitted with observation peephole or panel window and these can be operated by members of staff	**100%**	Horizon has some older type that have been identified as not appropriate.
Consultations take place in a private room	**100%**	
Toilets and bathroom doors are lockable from the inside and fitted with fail safe entry mechanisms which can only be opened by staff	**100%**	Ensuite toilets do not have locks but the main door locks
Separate male and female toilets and washing facilities (other than assisted facilities) are available within the ward or department	**100%**	
Bedroom doors are lockable from the inside with fail safe entry mechanisms to ensure service user safety	**100%**	
Clear information is provided for service users, relatives and carers on the arrangements made and the standards they should expect to ensure their privacy and dignity is maintained	**100%**	
Staff carrying out physical examinations are the same gender as the service user or if not are accompanied by a chaperone of that gender	**100%**	

Staff using planned restraint are the same gender as the service user or if not are accompanied by a chaperone of that gender	**83%**	Not always able to accommodate due to gender of staff on duty.
Toilets have nurse call systems to ensure safety	**67%**	Unity centre –in bariatric rooms and bathrooms only. Ward 18 –none. Ward 19 and Horizon in all bathrooms
Where toilets do not have nurse-call systems the service user is risk assessed	**100%**	
Service users are asked if they have a preference regarding same sex key worker	**Unable to rate**	All wards stated sometime or not an issue on female only wards as all staff are female. It is sometimes because it cannot always be accommodate as there is not enough male staff.
Bedroom doors have observation mechanisms to ensure service user safety	**100%**	
Male and Female toilets and washing facilities are clearly labelled male or female	**100%**	All toilets were labelled .Most teams answered by comments Located down male/female corridors so not necessary, single sex accommodation so not needed There are two toilets in the central communal area on ward 19 these can be used by either gender and have male and female symbols on.
In instances where a service user has been placed in a single sex bedroom within an area designated for the opposite sex this incident is reported in accordance with the Trusts reporting procedure (through Datix)	**100%**	
In instances where a service user has been placed in a single sex bedroom within an area designated for the opposite sex appropriate safeguarding measures such as enhanced observation are applied	**100%**	

The ward staff completed the survey on survey monkey and it was collated by the Quality, Improvement and Assurance Team (QIAT).

The above table shows the results and comments made. The results show a high level of compliance with the standards.

The standards the teams are unable to declare full compliance is similar:-

- Staff gender mix on wards can affect ability to provide same sex key worker, this is mainly shortage of males.
- Nurse call system being available in all toilets.

Both of these issues are part of wider plans within the Trust.

2.3 Summary of results - Trust Board

	Trust Board Self-Assessment		
	The Trust does not have any mixed sex accommodation so the standards are judged to be met as determined in previous audits. Commentary given is related to maintaining good practice in regard to Trust Board information		
	Mechanisms are in place to provide the Board of Directors with regular information on the views of patients and service users	**met**	The board receives regular reports providing service user feedback which capture any views expressed about mixed sex accommodation
	The Board receives regular reports on the Trust's progress in eliminating mixed sex accommodation	**met**	The board receives information in the quarterly quality reports where any EMSA breaches would be highlighted. There is also the annual EMSA statement from the lead Director
	The Board receives information from patient complaints and incidents, categorised on the basis of mixed sex accommodation issues. These should also include abuse and sexual safety issues	**met**	• The Board receives regular customer services reports including information on complaints broken down into themes which would capture mixed sex accommodation concerns. • The quarterly compliance report which goes to Executive Management Team specifies incidents which have occurred relating to people accommodated on other gender ward areas and associated safeguarding processes (increased observation levels etc.)
	The Board reviews and amends policies on mixed sex accommodation in light of experience, incidents and changes to the service	**met**	• There is an EMSA policy. • Trust uses national guidance to inform practice. Trust Board would respond and require practice change if breaches were to occur
	The Board sets annual measurable targets for improvement	**N/A**	N/A as declared that mixed sex accommodation has been eliminated in all SWYPFT hospitals
	The Trust considers the elimination of mixed sex accommodation in any refurbishment or new-build capital development schemes	**met**	This is an integral part of the planning procedure
	The Trust provides training to support the elimination of mixed sex accommodation & promote the protection of privacy & dignity	**met**	Not specifically - however safeguarding training links to protection of privacy and dignity

During 2018 there have been no reported EMSA breaches. The Trust is, therefore, in a position to declare EMSA compliance as follows.

"Every service user has the right to receive high quality care that is safe, effective and respects their privacy and dignity. The South West Yorkshire Partnership NHS Foundation Trust is committed to

providing every service user with same sex accommodation, because it helps to safeguard their privacy and dignity when they are often at their most vulnerable.

"We confirm that mixed sex accommodation has been eliminated in our organisation. Service Users that are admitted to any of our hospitals will only share the room where they sleep with members of the same sex, and same sex toilets and bathrooms will be close to their bed. Sharing of sleeping accommodation with the opposite sex will never occur. Occupancy by a service user within a single bedroom that is adjacent or near to bedrooms occupied by members of the opposite sex will only occur based on clinical need. If this occurs the service user will be moved to a bedroom block occupied by members of the same sex as soon as possible. On all mixed gender wards there are women only lounges or rooms which can be designated as such."

3. Other bed management incidents

During the year there have been 43 other bed management issues not linked to single sex accommodation but incidents that may have an impact on the quality of care. The table below breaks these down by BDU and sub category. Pressure on bed availability was an issue within quarters 1 and 2 when three patients slept on mattresses in interview rooms. One male had to sleep overnight in a lounge and a number had to sleep in inappropriate wards e.g. older peoples ward or PICU. Some patients were unable to be admitted from acute trusts. In quarter 3 there has been one incident of a patient being admitted directly to PICU. During quarter 4 there were 5 bed management issues reported. One incident was linked to transport for a person returning to the Trust in his area of residence which was outside the Trust geography, two people were admitted with no bed available; one had to sleep on a sofa and the other had a bed by night time. The remaining two incidents were individual being nursed in PICU for longer than required as no bed was available in local area.

3.1 Other bed management incidents by BDU and sub category

	Acute patient admitted into PICU bed	Admitted to ward - no bed available	Bed Management - Other	High risk leave bed used for admission	Lack of / delayed availability of beds (high dependency / intensive care)	Person detainable (MHA) - No bed available, not able to admit	Return From Leave - No Bed	Total
Barnsley Mental Health	0	1	0	0	0	0	0	1
Calderdale	0	2	1	0	0	1	0	4
Kirklees	0	2	6	0	0	0	1	9
Wakefield	5	4	14	1	1	0	2	27
Forensic Service	0	0	1	0	0	0	0	1
Specialist Services	0	1	0	0	0	0	0	1
Total	5	10	22	1	1	1	3	43

4. National and local feedback

4.1 CQC report and evidence appendix feedback

During 2018 the CQC undertook an inspection of the Trust below is taken from the appendix evidence of the report.

"All wards complied with the Department of Health's national guidance on eliminating same-sex accommodation. Over the 12 month period from 1 November 2016 to 31 October 2017 there were no mixed sex accommodation breaches within this core service. Two previous Mental Health Act review visits reported that the ward sometimes placed males on the female corridor and females on the male corridor. We discussed this with staff who reported that they increased observation levels to ensure patient safety if this occurred. Females in this corridor did not have to walk past male bedrooms to use a bathroom; therefore this still complied with guidance on same sex accommodation. Staff acknowledged this was not ideal and only occurred when necessary. Between 1 February 2017 and 1 February 2018, females had been placed on the male corridor on ten occasions and staff submitted an incident report each time. At the time of inspection on Walton ward, a patient was being nursed in an additional extra care area that restricted the use of the female only lounge to other patients. The trust reported this was the first instance of this in the last six months and was felt to be the least restrictive option for that individual patient."

Horizon Centre (evidence appendix)

"*At the time of the inspection, the ward had two female and three male patients admitted to the ward. We found that the ward complied with the Department of Health guidance on eliminating mixed sex accommodation. It provided en-suite accommodation in all bedrooms that meant no one had to pass through rooms occupied by the opposite sex to reach their toilet and washing facilities. The ward also provided a designated female only lounge in addition to communal areas. A female only environment is important to protect the privacy, dignity, and safety of women because of the increased risk of sexual and physical abuse and risk of trauma for women who have had prior experience of abuse. However, the room did not have any signage to inform patients it was a female only lounge and staff did not provided patients or their carers with written information about the mixed sex arrangements on the ward. We observed that the room was locked on two occasions and staff could not give a reason why. The manager was clear that the room should not be locked. We saw that staff discussed arrangements for the female only lounge in their staff meeting minutes and female patients could access the room during our inspection."*

Wards for people with a learning disability or autism

"*The trust should ensure that the female only lounge is clearly signed and that staff provide information for patients and carers about the arrangements for eliminating mixed sex accommodation."*

Progress

During a quality monitoring visit on the 16th October 2018 it was noted that the female lounge sign was now in place and that the new welcome information had information for patients and carers about arrangements for eliminating mixed sex accommodation.

Acute wards for adults of working age and psychiatric intensive care units
"The trust should ensure that the female only lounge on Walton ward is not restricted to other patients by using it as part of an extra care area."

Progress
No incident has been reported during the period of this report.

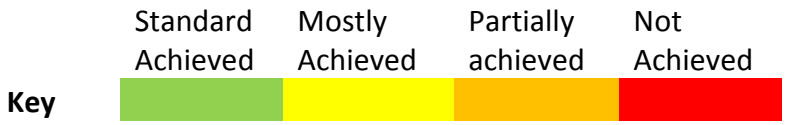
4.2 Estates updates

OPS Transformation Project – work is still ongoing and all estates option will consider EMSA requirements.

Unity Centre – Nostell Ward has opened and is EMSA compliant.

National association of psychiatric intensive care and low secure units

Design guidance was published in 2017. In 2018 an assessment of all of the Trust's PICU units against this guidance was completed. Assessments were undertaken by a member of the Estates and Facilities Team alongside a senior clinical lead from the unit, a Ward Manager, General Manager or Practice Governance Coach. Please note this is a guidance document only.



Yellow rating indicates that whilst there may be a small element of the criteria unmet, and some improvement could be offered, the solution in place is sufficient to ensure that service users are not disadvantaged.

Amber ratings clearly leave some areas of criteria unmet.

For both Red and Amber designations it is important to note that dependent upon the criteria and the physical environment on ward, there may not be an alternative that can be put in place, but regardless of this does mean that the criteria is unmet.

The full report is available from the estates department but exceptions linked to EMSA have been extracted and are below.

Single gender accommodation Melton Unit Oakwell Centre Barnsley.

3.5	Gender separate areas should be separated from communal areas by doors	due to the small size of the ward and the need for good corridor lines of site, there are no corridor doors in the bedroom areas	
3.6	Female only area is available which includes bedrooms, bathrooms and lounge.	There is a single gender lounge within the main day space. Should a single female be on the ward one bedroom is a suite of bedroom, lounge and shower room.	
3.7	Gender specific garden should be made available if possible	Only 1 courtyard area is available	
3.9	Access to gender specific areas should be controlled to ensure they are available only to appropriate individuals	There is control to individual bedroom doors and access is operationally managed but there are no doors/physical separation of male/female areas	
3.12	In a mixed sex unit 2 accessible bedrooms should be provided together with an assisted bathroom. If design allows an assisted bathroom to be accessed by both male and female patients without entering a corridor used by the opposite sex - a single accessible bathroom is permitted	Only the separate suite is an accessible room. There is a large bathroom available on the main bedroom corridor	
5.2	A range of outdoor spaces available to allow choice	Only one outdoor space available. No alternative area of single gender area available	

Due to the very small physical size of the unit, areas are not separated. The separation of the genders is managed operationally. The lack of a defined single gender area supports the ever changing requirements of the male/female service user split on ward at any one time and ensures that out of area placements are minimised. The current ward arrangements are hampered by lack of a second outdoor space which would facilitate a full single gender experience.

Recommendation

The unit could be improved by the addition of a second outdoor area to support women who choose to be entirely separated from male service users.

Progress
A minor capital bid has been submitted and approved; the work will be carried out during financial year 2019/20.

5. Compliance monitoring

The Clinical Governance and Clinical Safety Committee receive assurance through the Director of Nursing and Quality about the Trust's compliance with eliminating mixed sex accommodation. Any potential areas of risk are considered at clinical governance group meetings. During 2018, the clinical governance group has monitored all reported instances where service users have had to sleep in a single room on a corridor or pod designated for the opposite sex. From January to December 2017, there were 9 such instances reported on Datix compared with 11 for the same time period in 2018. The 2018 EMSA Best Practice Guidance Audit indicates that the Trust continues to perform well against best practice standards. The clinical governance group will implement action against any areas where improvements can be made. Provision of high quality facilities that meet the privacy and dignity of service users is a prime consideration when any changes to the Trust estate are made. The trust increased the numbers of single sex wards during 2018. Going forward, transformation projects will work with commissioners to look for opportunities to create new, and improve current single sex environments.

6. Actions planned for calendar year 2019

- Continue to monitor incidents and take action as required.
- To take quarterly reports to clinical governance group.
- EMSA is considered in quality monitoring visits.
- Estates and planning considered in any estates planning.

Appendix A

Best practice standard Questions

Standards
Service users are accommodated in single rooms, single sex bed bays, separate corridors, pods or ensuite single rooms
Is a lounge available for sole use of female service users (new question for 2017)
Bedroom doors are fitted with observation peephole or panel window and these can be operated by members of staff
Consultations take place in a private room
Toilets and bathroom doors are lockable from the inside and fitted with fail safe entry mechanisms which can only be opened by staff
Separate male and female toilets and washing facilities (other than assisted facilities) are available within the ward or department
Bedroom doors are lockable from the inside with fail safe entry mechanisms to ensure service user safety
Clear information is provided for service users, relatives and carers on the arrangements made and the standards they should expect to ensure their privacy and dignity is maintained
Staff carrying out physical examinations are the same gender as the service user or if not are accompanied by a chaperone of that gender
Staff using planned restraint are the same gender as the service user or if not are accompanied by a chaperone of that gender
Toilets have nurse call systems to ensure safety
Where toilets do not have nurse-call systems the service user is risk assessed
Service users are asked if they have a preference regarding same sex key worker
Bedroom doors have observation mechanisms to ensure service user safety
Male and Female toilets and washing facilities are clearly labelled male or female
In instances where a service user has been placed in a single sex bedroom within an area designated for the opposite sex this incident is reported in accordance with the Trusts reporting procedure (through Datix)
In instances where a service user has been placed in a single sex bedroom within an area designated for the opposite sex appropriate safeguarding measures such as enhanced observation are applied

South West Yorkshire Partnership NHS Foundation Trust

Trust Board – 26 March 2019
Agenda item 9.2

Title:	**Data Security & Protection Toolkit**
Paper prepared by:	Director of Finance & Resources
Purpose:	To provide approve the submission of the Data Security and Protection Toolkit.
Mission/values/objectives	All Trust objectives
Any background papers/ previously considered by:	➢ An annual report to the Trust Board. ➢ Internal audit will be an agenda item at the Audit committee.
Executive summary:	➢ The Data Security and Protection Toolkit (DSPT) was launched in April 2018, replacing the Information Governance Toolkit (IGT). ➢ The new DSPT requires organisations to achieve a status of 'standards met'. ➢ The data security standards are clustered under three leadership obligations, to enable peer support and cascade lessons learned. These are 1) People: Ensure staff are equipped to handle data respectfully and safely, according to the Caldicott Principles 2) Process: Ensure the organisation proactively prevents data security breaches and responds appropriately to incidents or near misses 3) Technology: Ensure technology is secure and up to date. ➢ Evidence for the submission has been collated by the Information Governance Manager and reviewed by the Senior Information Responsible Officer. ➢ The draft submission and evidence has been reviewed by internal audit. Some suggestions have been made including firming up the process for bank staff, providing further evidence relating to software supported and unsupported, evidence of action completion and an extra inclusion in procurement tender documentation. ➢ The evidence to date is such that the Trust can submit a return that meets the standards and will be strengthened by the additional observations highlighted. **Risk Appetite** This report needs to be considered in line with the Trust risk appetite statement which aims for compliance risk of 1-6. The contents of this report are in line with that level of risk appetite.
Recommendations	**It is RECOMMENDED that the Board:** ➢ **NOTES the work undertaken to date and that which is ongoing to ensure all mandatory standards are met by the deadline for submission by the 31st March 2019.** ➢ **That the Trust submits a DSPT that is compliant with the standards.**
Private session:	Not applicable

South West Yorkshire Partnership NHS Foundation Trust

Data Security & Protection Toolkit

1. Introduction

The Data Security and Protection Toolkit (DSPT) was launched in April 2018, replacing the Information Governance Toolkit (IGT).

The DSPT allows organisations to self-assess their performance against the data security standards recommended by Dame Fiona Caldicott, the National Data Guardian, as part of her review of Data Security in July 2017. It is an annual return all Trusts are required to make.

The IGT had four levels of compliance, with the minimum requirement being 'level 2 – satisfactory'; the new DSPT requires organisations to simply achieve a status of 'standards met'.

The data security standards are clustered under three leadership obligations, to enable peer support and cascade lessons learned:

- **Leadership obligation 1: People:** Ensure staff are equipped to handle data respectfully and safely, according to the Caldicott Principles.

  Data Security Standard 1: All staff ensure personal, confidential data is handled, stored and transmitted securely, whether in electronic or paper form. Personal confidential data is only shared for lawful and appropriate purposes (confidential PID).

  Data Security Standard 2: All staff understand their responsibilities under the National Data Guardian's Data Security Standards including their obligation to handle data responsibly and their personal accountability for deliberate or avoidable breaches (staff responsibilities)

  Data Security Standard 3: All staff complete appropriate annual data security and protection training and pass a mandatory test (training)

- **Leadership obligation 2: Process:** Ensure the organisation proactively prevents data security breaches and responds appropriately to incidents or near misses.

Data Security Standard 4: Personal, confidential data is only accessible to staff who need it for their current role and access is removed as soon as it is no longer required. All access to personal, confidential data on IT systems can be attributed to individuals (data access management).

Data Security Standard 5: Processes are reviewed at least annually to identify and improve processes that have caused breaches or near misses, or, which have forced staff to use workarounds that compromise data security (process reviews).

Data Security Standard 6: Cyber-attacks against services are identified and resisted and CareCERT security advice is responded to. Action is taken immediately following a data breach or near miss, with a report made to senior management within 12 hours of detection (incident responses).

Data Security Standard 7: A continuity plan is in place to respond to threats to data security, including significant data breaches or near misses, and it is tested once a year as a minimum with a report to senior management (continuity planning).

- **Leadership obligation 3:** Technology: Ensure technology is secure and up to date.

  Data Security Standard 8: No unsupported operating systems, software or internet browsers are used within the IT estate (unsupported systems).

  Data Security Standard 9: A strategy is in place for protecting IT systems from cyber threats, which is based on a proven cyber security framework such as Cyber Essentials. This is reviewed at least annually (IT security).

  Data Security Standard 10: IT suppliers are held accountable via contracts for protecting the personal confidential data they process and meeting the National Data Guardian's Data Security Standards (accountable suppliers).

For the purpose of the DSPT assessment, the data security standards are broken down into 41 assertions, which are further divided into 149 detailed evidence questions. For the current assessment period 100 of the questions are mandatory: every mandatory question must be answered before each assertion can be confirmed.

Internal audit have very recently completed a review of a sample of responses and evidence provided. Once the audit recommendations have been implemented and the Senior Information Risk Owner (SIRO) has confirmed the assertions, the final assessment can be submitted.

A baseline submission was made in October 2018 to assess the current position and the final submission must be made by 31 March 2019.

It should be noted that, whilst it has been approved for use by NHS Digital, the DSPT is currently a beta release and is subject to ongoing review and development. In addition, the guidance for meeting the data security standards is also in draft format. 360 Assurance, our internal auditors, have also advised that they are working with other organisations, such as Audit Yorkshire, to refine the approach and ensure consistency.

2. Action plan to meet the standards by 31st March 2019

Internal audit review

Terms of reference and a sample testing proposal were provided in late December and subsequently agreed.

Evidence has been uploaded to the DSPT and, for items where evidence is not required to be uploaded, e.g. where only a yes/ no response or date is completed; further information has been provided to validate how the response was determined.

The draft internal audit report was received on 18 March 2019 and the summary findings are as listed below. The final report will be reported to the Audit Committee.

Governance: the Trust's Information Governance (IG) arrangements are effective as there are clearly defined roles and responsibilities in place and groups with responsibility for IG meet regularly, are well attended and there is evidence of robust challenge, appropriate reporting and action being taken when required.

Validity of the DSPT submission: further evidence is required to support the mandatory data security and protection training assertion for Trust bank staff. If we focus on bank staff that have been active in the last twelve months then we do reach the required 95% target. However, further work will be carried out with Human Resources during 2019/20 to strengthen the mandatory IG training monitoring for bank staff. Some advisory comments have also been raised that will strengthen arrangements going forward.

Wider risk exposures: the auditors are generally in agreement with the Trust's assessment of the assertions but identified some areas where the response could be strengthened. There are no significant factors raised.

Current position

It is largely evidence items relating to the new standards that are clustered under leadership obligation 3 (technology) that are currently outstanding. Issues have been identified with a lack of clarity in the draft guidance that is available, which have been fed back to NHS Digital via the Strategic IG Network. Clarification has

been sought from internal audit. Further evidence will be provided to the internal auditor and included in the submission on the following items in order to strengthen the submission:

- Demonstrate the emergency contact list in held in hard copy:
- A list of unsupported software has been provided. This will be updated to provide a list of all software, detailing if it is supported or unsupported
- Evidence that to prove actions from previous pen test have been completed or are ongoing will be provided
- Trust due diligence doesn't include asking prospective suppliers if they have had any IG incidents. The head of procurement has advised this question can be incorporated if required

3. Summary & Monitoring

The Trust has prepared its DSPT self-assessment. Evidence has been collated and assessed by the Information Governance Manager and reviewed by the SIRO. This evidence is such that the Trust can be assured it meets the requirements of the DSPT. To supplement this review by internal trust staff, internal audit is used to review the draft submission. This review has been completed and subject to minor suggestions no issues have been identified. Any actions identified relating to the submissions will be taken immediately to implement any minor improvements prior to the submission deadline of March 31st.

Evidence required to ensure all mandatory items are completed is being finalised.

4. Conclusion and Recommendation

The Trust has made significant progress in its completion of the DSPT.

It is recommended that the Board notes the work undertaken to date and that which is ongoing to ensure all mandatory standards are met by the deadline for submission by the 31st March 2019.

It is recommended that the Trust submits a DSPT that is compliant with the standards.

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Trust Board 26 March 2019
Agenda item 9.3

Title:	**Update on financial & operational planning, integrated performance report and board assurance framework**
Paper prepared by:	Director of Finance and Resources
Purpose:	To provide Trust Board members with the current status of the financial & operational plan for 2019/20 and potential updates to the Integrated Performance Report (IPR) and Board Assurance Framework (BAF)
Mission/values:	All Trust values
Any background papers/ previously considered by:	Trust Board has received regular updates and contributed to the development of the financial and operational plan; the draft version of which was submitted in February 2019 Potential changes to the BAF were discussed at the Trust Board strategy session in February 2019 Potential changes to the IPR are agreed annually by the Trust Board and the IPR is reviewed and commented on regularly at Trust Board meetings
Executive summary:	➢ The draft operating plan for 2019/20 was submitted to NHS Improvement (NHSI) in February in line with the required timescales ➢ The Trust did not accept its control total in this original submission ➢ Feedback has been received from NHSI which will be incorporated in the final plan submission ➢ There has been scrutiny on the Trust's financial plan and the measures being taken to improve it both internally and by the regulator since the draft plan was submitted ➢ The final plan is due to be submitted on April 4th ➢ The Trust needs to consider any changes to the IPR including the summary dashboard which consists of the agreed metrics to monitor achievement against objectives, any additional national reporting requirements and any changes the Trust Board believe would be helpful Trust Board has discussed the format of the BAF and potential changes to risks at the February strategy session. Subject to board approval this may result in a fourth objective focusing specifically on workforce. Once agreed the BAF will be updated accordingly

Recommendation:	**Trust Board is asked to NOTE the following recommendations:** ➢ It is recommended that following agreement with regard to the financial plan for 2019/20 that delegated authority is provided to the Trust Chair, Chief Executive and Chair of Audit to agree the final plan submission for the April 4th deadline. ➢ It is recommended that a paper on potential updates to the integrated performance report for 2019/20 is brought to Trust Board in April 2019 ➢ It is recommended that depending on timescales for agreement and impact of year-end reporting on capacity an updated BAF is reported on at the April board meeting.
Private session:	Commercial in confidence

South West Yorkshire Partnership NHS Foundation Trust

Board update on

Financial and operational planning, integrated performance report and the board assurance framework

Introduction

The purpose of this paper is to provide an update on the status of the financial and operational plan for 2019/20, proposed updates to the integrated performance report (IPR) and the board assurance framework (BAF).

Financial and operational planning

The Trust submitted its draft operational plan for 2019/20 in February in line with the timescales required. At that stage the Trust Board did not feel able to agree to its financial control total for 2019/20 given the distance between the control total and what it felt confident it could deliver. Since that time the Trust has received feedback on its draft plan from the regulator, met with the regulators during place-based planning review meetings and met with senior finance staff in both NHS Improvement (NHSI) and the West Yorkshire & Harrogate Integrated Care System (ICS). There has been much focus on the Trust's financial plan submission and focus on how it can improve its position.

The final operating plan is due for submission on April 4th. Based on the feedback provided by NHSI updates to the plan will be incorporated which cover:

- Measures being taken to improve upon the planned deficit figure
- Measures being taken to improve the cash position, including reductions to capital expenditure plans
- Updates on contractual settlements
- Increased information on out of area bed risk and how it is being managed
- Cost Improvement Project (CIP) phasing
- Workforce and finance triangulation
- Plans to reduce agency staffing
- Quality risks
- Learning from the Gosport Independent Panel

This report has been written prior to a detailed discussion on options to improve the financial plan at Executive Management Team (EMT). The results of this will be factored into a separate Board report, being written and provided after the EMT meeting.

Integrated Performance Report

There are a number of considerations to take into account for the integrated performance report (IPR) in 2019/20. In particular these include any changes the Board requires to the summary dashboard which summarises those metrics that are focused on to help identify if the Trust is achieving its objectives. Based on the intent (subject to Trust Board approval) to introduce a fourth objective which focuses on workforce the summary dashboard will need to reflect this. Some metrics including sickness absence, staff turnover and training compliance will simply transfer from the use of resources objective to the new workforce objective. There may be other metrics the Trust Board wishes to add to monitor performance against this objective. Reporting against any revisions to the summary dashboard will not take place until after the completion of month 1 reporting in 2019/20. As such a recommendation will be provided to Trust Board in April with any proposed revisions to summary dashboard following discussion at EMT. The impact of the long term plan, requirements in the 19/20 operating plan need to be taken into consideration when assessing the most relevant metrics to be included in the summary dashboard for next year.

There are also likely to be additional metrics included relating to national reporting requirements. These include but not limited to:

- Clinically led review of NHS access standards – (linked to NHS Long Term plan):
    - Expert assessment for emergency referrals; and within 24 hours for urgent referrals in community mental health crisis services.
    - Access within one hour of referral to liaison psychiatry services and children and young people's equivalent in A&E departments.
    - Four-week waiting times for children and young people who need specialist mental health services.
    - Four-week waiting times for adult and older adult community mental health teams.
    - Perinatal MH - further work to be completed on defining metrics (working with commissioner)

Board Assurance Framework

The Trust Board discussed any updates required to the board assurance framework (BAF) for 2019/20 at its strategy session in February. The preferred approach at that meeting was to separate the workforce risks. This will be based on introducing a fourth Trust objective relating to workforce, subject to Board approval. Once this is complete the board assurance framework will be updated to reflect this. Some wording changes will also be considered to a number of the risks. Depending on timescales for agreement and impact of year-end reporting on capacity the intent is to provide this updated BAF at the April board meeting.

Conclusion and Recommendations

It is recommended that following agreement with regard to the financial plan for 2019/20 that delegated authority is provided to the Trust Chair, Chief Executive and Chair of Audit to agree the final plan submission for the April 4th deadline.

It is recommended that a paper on potential updates to the integrated performance report for 2019/20 is brought to Trust Board in April 2019.

It is recommended that depending on timescales for agreement and impact of year-end reporting on capacity an updated BAF is reported on at the April board meeting.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 March 2019
Agenda item 9.4

Title:	**Contingency Planning for Brexit**
Paper prepared by:	Director of HR, Organisational Development and Estates
Purpose:	This paper updates the Board on progress on the progress to date in respect of planning for the possibility that the UK leaves the EU with no deal in place.
Mission/values:	This work stream is in place to ensure that the Trust can operate safely in a period of uncertainty and looks at key areas which could be affected. The work is part of wider planning at national level.
Any background papers/ previously considered by:	Executive Management Team and Operational Management Group are receiving updates from the Brexit group Along with formal reports to Board.
Executive summary:	The Trust has a group considering the impact of a no deal Brexit from a contingency planning point of view. Members of this group report on progress in key areas of their responsibility as well as attending wider contingency planning groups operating at regional and national level. The Trust has a risk assessment and action plan which has been externally scrutinised and found to be in line with national guidance. The Brexit group has undertaken table top scrutiny exercises on pharmacy supply and continues to undertake tests on the key areas contained in the report. **Risk Appetite** This plan is in line with the Trust's risk appetite for both clinical services and emergency planning.
Recommendation:	**Trust Board is asked to NOTE and comment on the content of the report.**
Private session:	Not applicable

South West Yorkshire Partnership NHS Foundation Trust

Trust Board: 26 March 2019

Brexit - Contingency Planning

Introduction

This paper is intended to further update the Board on the preparations being made should there be a no deal when the UK is due to leave the European Union on the 29 March 2019. As previously stated the possibility of a no deal exit will have consequences in a number of key areas and the Trust, along with the NHS as a whole, needs to examine what it can do to mitigate any risks. The Department of Health and Social Care continues to update its advice on actions the NHS should take to prepare for a "no deal" Brexit scenario. The government advice remains broadly the same in all key areas. The Brexit group continues to meet fortnightly and the risk assessment and action plan contained in the appendices to this paper have been assessed by that group and have been prepared in line with that guidance.

Advice continues to be that supply chains will be maintained in key areas and that Trusts should not stockpile goods especially pharmaceuticals. The Trust lead on Brexit contingency planning (Director of HR, OD and Estates) has attended a local resilience forum where the Trust's plans were scrutinised in depth by the Department of Health and Social Care emergency planning leads and considered to be fit for purpose. The Brexit group is presently conducting further scenario planning exercises which were identified at the Department of Health and Social Care local resilience meeting as being exercises that all Trusts should consider.

Process

The key departments listed below continue to monitor developments in their specific areas of responsibility and update the EPRR (Emergency Planning & Resilience Response) lead who is managing the risk assessments and action plan for the group which has been revised during the process into the following people.

- Pharmacy – Kate Dewhirst
- General Procurement – Tony Cooper
- Workforce – Richard Butterfield
- Food supplies – Karen Whittam
- Information Technology – Paul Foster
- Estates and Facilities lead – Nick Phillips
- General EPRR issues arising from the centre – Martin Brandon
- Communications – Jude Tipper
- Medical devices and professions – Emma Cox

The group provides updates to the Operational Management Group (OMG) for noting and appropriate action as well as escalation to EMT.

The essences of the updates for each key area have not changed from the initial reports and for completeness are as follows:

Pharmacy

Advice remains that centrally purchased drugs should not be stockpiled. The few lines not from this supply chain have got assurances in place around continuing supply. The pharmacy plan has been tested by the Brexit group as a table top exercise where resilience against disruption of supplies for two key drugs not supplied by NHS supply chain was examined. The plan put forward by the pharmacy team was found to be workable and could operate under any of the scenarios tested in the exercise.

Procurement

The Trust again purchases most items through NHS supply chain and is working to their guidance. Where we do not purchase through NHS supply chain, key suppliers have given assurance around continuity of supply. This assurance includes continuity of supply of foodstuffs.

Workforce

The situation for workforce remains that EU nationals will still be able to work in the UK after 29 March 2019 and the registration process will be free of charge to the individual. Whilst outside of the immediate work of the No Deal Brexit Group, nationally there are concerns in the short to medium term of loss of the social care workforce due to Brexit. There are already plans in place for the NHS to meet the potential shortfall in EU workers through increased training places in Nursing and Medicine, development of new roles and international recruitment, however, such plans have not been developed for the social care workforce.

Food Supplies

The main concern here remains the supply of fresh foods, which means that menus may be revised, but the advice remains that food will generally be available with some unknown restrictions, especially around fruit. This will have to be managed at the time and alternatives will be available.

Energy

The Trust purchases most of its energy through a central contract and advice has been sought from them. They are not anticipating any supply issues but costs will rise post April as we transition to new contracts.

Estates Infrastructure

The main issue item which has come from national scenario planning is around fuel plans and this has been reviewed as part of the Brexit workstream.

Information Technology

At present no major issues are anticipated.

Recommendation

Board is recommended to

- Note the content of this report
- Note the Action plan and risk assessment at appendix 1 and 2

Nick Phillips
Head of Estates and Facilities

BREXIT No deal Risk Assessment - March 2019

What are the risks?	Potential impact?	What are you already doing?	Do you need to do anything else to control this risk?	Risk owner	Completion Date	Status	RAG rating (Low/Medium /High Risk)
Medicines	Patients – lack of suitable provision due to stock shortages, leaving patients potentially unwell	National instruction in place not to stockpile medicines or write longer scripts. DHSC NHSE are monitoring stock levels nationally and locally. Goods bought direct (unlicensed goods), such as from Germany can be stockpiled. All goods being reviewed and any items that can be stockpiled will be ordered accordingly – space for storage identified. Guidance on medicines due out before the end of January	Monitor stock levels. Maximise stocks of pharmaceuticals. Purchase unlicensed medicines. Complete weekly SITREP requirements.	Kate Dewhirst	January 2019		Risk rating L = 2 C = 2 RR = 4
Medical Devices and Clinical Consumables	Patients and Staff – risk of injury if incorrect devices in use Risk of inability to undertake clinical procedures if correct devices are not available	Standard levels of stock at BICES Asset register details location of all medical devices to enable transfer where necessary. 20 packs of defibrillator pads ordered to store to replace old stock. – complete. Audit of defib pads complete and stock levels identified. MD's and subsequent repairs to be monitored at Medical Devices Trust Action Group pre/post EU Exit.		Emma Cox	March 2019		Risk rating L = 1 C = 2 RR = 2
Non clinical Consumables, Goods and Services i.e. Food & Laundry	Patients Lack of suitable food provision and/or laundry service	Number of suppliers already contacted by Procurement as they are on the national supply chain (see Procurement) Local suppliers of fresh goods and suppliers of catering equipment identified and contacted Guidance re non-medical goods and consumables due out end of February.	07.03.19 – response not yet received from ISS	Karen Whittam	March 2019		L = 3 C = 3 RR = 9
Workforce	Patients due to loss of clinical staffing; Trust reputation due to loss of workforce	14 employees have come forward to date. 3 of these staff members are Irish and therefore no action is needed due to protected rights to work and live in the UK. No plans to look at international recruitment at the moment.	All staff communicated with via Payslips in January to identify any additional staff that need to apply for settled/ pre-settled status. Workshops/1-2-1 assistance to be put in place to help staff apply for settlement status when the application window opens in March.	Richard Butterfield/ Sandy Stones	March 2019		LOW Risk rating L = 1 C = 2 RR = 2

Reciprocal Healthcare	Impact on the provision of services due to an increase in demand due to the return of British Citizens from abroad.	Each BDU assessing potential impact ensuring Business Continuity plans would still be fit for purpose in the event of an increase in demand. Feedback noting that services will manage the demand increase via the implementation of OPEL levels – no noted concerns regarding impacts. System in place to liaise with Overseas Management Team in partner Trusts is transfer of care places patient in the care of SWYPFT.		EPRR Team	Ongoing		Risk rating L = 2 C = 2 RR = 4
Research and Clinical Trials	Access to devices/pharmaceuticals to undertake/finalise any trials the Trust are involved in.	One clinical trial underway in the Trust. Sponsor contacted and confirmed that no impact will be had as a result of a no deal Brexit	No action	Rachel Moser	January 2019		Risk rating L = 1 C = 2 RR - 2
Data Sharing, Processing and Access	Transfer and storage of clinical data	All suppliers of IM&T services are UK based. When tendering for any new services it is stipulated that hosting/processing of Trust data by carried out in the UK.	No further action required.	Paul Foster	January 2019		Risk Rating L = 1 C = 3 RR = 3
Procurement of Goods	Patients, Staff, Trust Inability to obtain suitable/sufficient stock to maintain patient care and back room functions	Undertaken self-assessment as instructed by Department of Health & Social Care. Response provided following cross reference of companies on assessment document.	Contact those companies not on the national framework to identify contingency arrangements. All companies contacted and contingencies confirmed.	Tony Cooper	31st January 2019		Risk Rating L = 1 C = 3 RR = 3
Diesel Access	Back Up Generators for clinical areas	In the event of power failure 25k litres of fuel will keep generators running (at full operation) for 4 days.	Fill all generators and order spare barrel of fuel for storage at the end of February. Plans to test generators and refill all generators and order spare goods by the end of March. Fuel tank ordered which will be situated in the gardeners compound at Fieldhead – holds 1200 litres of white diesel (equate to 20 tanks of fuel) which will be utilized to run Trust vehicles to deliver food and linen in the event of a fuel crisis.	Tony Tipton	March 2019		Risk Rating L = 1 C = 2 RR = 2
Fuel Crisis	Staff access to fuel limited in the event of a national fuel crisis. Patients – staff unable to attend appointments in the community or get to work on inpatient wards	Fuel plan drafted for implementation. Liaison with Community lead in Barnsley BDU to update BCPs to encompass loss of fuel	Finalise and implement Fuel Crisis BCP Cascade to all teams Request teams to update BCP's in line with Trust plan and processes. Plan in draft format and out for comment 07.03.19	Emma Hilton	March 2019		Risk Rating L = 1 C = 3 RR = 3

Registration Process for Smart Card Issue	There may be instances where staff cannot provide the required documentation for accessing NHS systems (such as NI numbers for access to smartcards)	Contingency is to provide a temporary username and password access to SystmOne. This temporary username/password SystmOne access is time-limited and will be only be invoked in such instances where appropriate to do so. Any such requests will need approval by Senior IM&T Management and confirmation from HR.	Continue to monitor	Paul Foster	March 2019		Risk Rating L = 1 C = 2 RR = 2

No Deal BREXIT Action Plan
January 2019
Please read in conjunction with the Operational Readiness Guidance, in particular actions for Providers of Healthcare Pages 16 - 24

No.	Action	Lead	RAG Rating/ Progress	Target Date for Completion	Comments
	Risk Assessment and Business Continuity Planning - Undertake an assessment of risks associated with EU Exit by the end of January 2019, covering, but not limited to:				
1	Undertake an assessment of risks associated with EU Exit by the end of January 2019, covering but not limited to: • Medicines • Medical Devices and Clinical Consumables • Non Clinical Consumables, Goods and Services • Workforce • Reciprocal Healthcare • Research and Clinical Trials • Data Sharing, Processing and Access	EH/NP/MB		31 January 2019	Ensure covers the potential increases in demand associated with wider impacts of a 'no deal' exit and also locally specific risks resulting from EU Exit. Risk assessment in draft format; comments due Monday 21 January; to finalise Tuesday 22 January and take to OMG Wednesday 23 January 2019.
2	Continue business continuity planning, taking into account this guidance and working with wider system partners to ensure plans across the health and care system are robust.	EH/MB		31 January 2019	Ongoing liaison with Mental Health partners; confirmed all progressing in the same direction. All local BCP's to be reviewed based on the 7 key areas noted – initial feedback is that BCP's are fit for purpose and no local issues anticipated. Catering and Laundry BCP's to be reviewed due to anticipated possible impacts. SITREP document updated and prepared for submission 24.01.19, forms part of business continuity planning. 29.01.19 SITREP collection not yet commenced.

3	Test existing business continuity and incident management plans against EU Exit risk assessment scenarios to ensure these are fit for purpose.	MB		28 February 2019	To attend the West Yorkshire LHRP meeting on 15th February where a Health specific exercise will take place for all West Yorkshire Health partners to test their BCP's. Test on unlicensed pharmaceuticals undertaken 21/02/19 – report to be written and provided to Working Group.
4	Communicate with local BCP authors and as to review plans in light of no deal Exit.	EH		31 January 2019	All BDU's emailed to review their BCP's and provide assurances by 30.01.19 All to be completed and submitted by this date.
5	Ensure board is sighted on EU Exit preparation and take steps to raise awareness amongst staff.	NP		Ongoing	OMG apprised of preparations which will be presented to Board at each Trust Board meeting. Comms article circulated 04 February 2019 and Intranet page for staff detailing EU Exit preparations and requests for help/advice available at http://nww.swyt.nhs.uk/brexit/Pages/default.aspx
6	Ensure Local Health Resilience Partnerships, Local Resilience Forums and Local A&E Delivery Boards are sighted on EU Exit preparation in your local health economy.	MB		Ongoing	To be undertaken at LHRP meeting on 15 February and via SITREP reporting when initiated.
7	Review capacity and activity plans, as well as annual leave, on call and command and control arrangements around the 29 March 2019.	EH		28 February 2019	No request to reduce capacity or activity around this time. (02/01/19). Review to be undertaken early February. Tim Breedon identified as Director on Call during EU Exit week. 07.03.19 – all Managers on call identified during EU Exit weekend.
8	Confirm escalation routes for different types of issues potentially arising from or affected by EU Exit into the regional NHS EU Exit teams listed in this document.	EH		28 February 2019	england.yheuexit@nhs.net confirmed as the discussion conduit and escalation route for all Yorkshire and Humber Trusts.
9	Note your nominated regional NHS lead for EU Exit and their contact details.	EH			Sarah Tomlinson
10	Escalate any issues you have identified as having a potentially widespread impact immediately to your regional EU Exit team.	ALL via EH/MB		Ongoing	22.02.19 – escalated medicines supply concerns and also delays in receipt of medicines due to FMD.

11	Confirm your organisation's Senior Responsible Officer for EU Exit preparation and identify them to your regional EU Exit team	MB			This role should be held by a board level member and will entail providing information returns to NHS England and Improvement, reporting emerging EU Exit-related problems, and ensuring your organisation has updated its business continuity plan to factor in all potential 'no deal' exit impacts. Confirmed to be Alan Davis.
12	Organisations should also identify named staff to work in a team with the Senior Responsible Officer to support EU Exit preparation, implementation and incident response.	NP			Procurement – Tony Cooper Comms – Jude Tipper Estates & Facilities – Nick Phillips/ Tony Tipton/ Karen Whittam/ Derrick Kelly Emergency Planning – Martin Brandon/ Emma Hilton Pharmacy – Kate Dewhirst HR – Richard Butterfield IM&T – Paul Foster Incident Response would activate via Command and Control arrangements as per policy.
13	Ensure the Trust follows the Secretary of State's message not to stockpile additional medicines beyond their business as usual stock levels. No clinician should write longer prescriptions for patients.	KD		January 2019	Note that Chief and Responsible Pharmacists are responsible for ensuring their organisation does not stockpile medicines unnecessarily. Any incidences involving the over-ordering of medicines will be investigated and followed up with the relevant Chief or Responsible Pharmacist directly.

14	Direct staff to promote messages of continuity and reassurance to people who use health and care services, including that they should not store additional medicines at home.	Comms		Ongoing	JT suggested a slide in the Brief (31.01.19) on BREXIT – include who BREXIT representatives are, cover BCP reviews, settlement status, qualifications and registration and a side box on staff communicating that patients do not stockpile medication. Page also to be added to the Intranet for BREXIT. Headlines article circulated 04/02/19 and intranet page launched. Pharmacy – National Guidance being released. 21.02.19 – Next Brief to include a slide on EU Exit re-communicating previous information. Medicines information to be circulated in the Headlines Monday 11/03/19 – also to be sent direct to wards for information.
15	Regional Pharmacy and Emergency planning staff to meet at a local level to discuss and agree local contingency and collaboration arrangements	Pharmacy			The Chief Pharmaceutical Officer will hold a meeting with the chairs of regional hospital and CCG Chief Pharmacist networks (and representatives of private hospital Chief Pharmacists) in January 2019 to help inform local plans.
16	Procurement to submit the results of their self-assessment on non-clinical consumables, goods and services to contractreview@dhsc.gov.uk , if not done so already.	Procurement			The Trusts self-assessment review was sent to the DHSC on 30th November 2018, and a response was received from Steve Oldfield on 8th January 2019
17	Write to CHFT and Mid Yorks regarding entering same arrangements that cover off Priestley and The Dales. (Food, Portering, laundry etc.)	NP			NP to write to both Trusts.
18	Services provided by Pathology to be reviewed to ensure service provision will be maintained.	Procurement/ KD			TC to check Service Level Agreements. TC sending out draft letter. KD also to write and send out contact details. Contacted – update to come in via Tony.

19	Assess whether the Trust has incurred a reduction in the number of EU nationals in your workforce before the UK leaves the EU.	HR			Ongoing exercise; so far numbers are small enough – do not see this as an operational issue. Work ongoing. 27.02.19 – confirmation from Andrew Prince that given the number of EU Nationals in our workforce (14) this is not high risk. No reduction noted to date.
20	Publicise the EU Settlement Scheme to staff who are EU citizens. The scheme will open fully by March 2019 and remain open until 31 December 2020.	Comms/HR			Communicated in the Headlines 21/01/19 and also payslips on 23/01/19.
21	Monitor the impact of EU Exit on your workforce regularly and develop contingency plans to mitigate a shortfall of EU nationals in your organisation, in addition to existing plans to mitigate workforce shortages.	HR			These plans should be developed with your Local Health Resilience Partnership, feed into your Local Resilience Forum(s) and be shared with your local commissioner(s). Staffing BCP is within BDU business plans and will continue to review once staffing locations identified. 27.02.19 – Andrew Prince confirmed that EU Nationals represent 0.2% of workforce; given the low numbers and low risk as BCP is not required.
22	Undertake local risk assessments to identify any staff groups or services that may be vulnerable or unsustainable if there is a shortfall of EU nationals.	EH		Ongoing	Undertaken locally by BCP authors as part of local reviews. No confirmations of expected impact as of 24.01.19.
23	Ensure board has approved business continuity plans that include EU Exit workforce planning, including the supply of staff needed to deliver services.				Board have approved the formation of the BREXIT contingency planning group who continues to update Board on progress.

24	Notify local commissioner and regional NHS EU Exit Team at the earliest opportunity if there is a risk to the delivery of your contracted services.	NP		31 January 2019	Updating all local commissioners within the timescales identified. Following organisations requested sight of risk assessment and action plans and provided as such: North Kirklees and Wakefield CCG (Caroline Andrews) Barnsley CCG (Amanda Capper) Calderdale CCG (Robert Gibson) Barnsley Public Health (Kaye Mann) Wakefield Council (Chris Wathen) Calderdale Council (Ben Leaman) Doncaster Council – request being processed Wakefield Public Health – request being processed
25	Inform staff that health and care professionals (including UK citizens), whose qualification has been recognised and who are registered in the UK before 23:00 on 29 March 2019, will continue to be registered after this point.	HR			This is being covered in the work to identify numbers of EU Nationals working for the Trust. Information cascaded on Intranet page and also Headlines article.
26	Inform staff that health and care professionals (including UK citizens), who apply to have their qualification recognised in the UK before 23:00 on 29 March 2019, will have their application concluded under current arrangements.	HR			Completed as part of a communications exercise.
27	Continue to support individuals who apply for NHS authorised treatment or maternity care in another member state (the S2 and cross-border healthcare processes).	Contracting (Annette Taylor)			Contract Team continuing to support individuals.
28	Maintain a strong focus on correctly charging those who should be charged directly for NHS care.	Contracting Team			Focus continues to be maintained.
29	Ensure there is capacity available for any further training that may be required if there are changes to the reciprocal healthcare arrangements.	Contracting Team			Capacity confirmed to be available to support this requirement.

30	Provide information about your Horizon 2020 grant here. This should be actioned as soon as possible. Further guidance can be found here and all queries should be sent to EUGrantsFunding@ukri.org.				Not applicable
31	Contact officials at EU-Health-Programme@dhsc.gov.uk with information regarding your Third Health Programme grant, and any queries that you have, as soon as possible.				Not applicable
32	Consider your supply chains for those IMPs, medical devices, in vitro diagnostic devices, advanced therapy medicinal products, radioisotopes and other clinical consumables, used in clinical trials and investigations, which originate from, or travel through, the EU and EEA as soon as possible if you sponsor or lead clinical trials or investigations in the UK.				Supply chain of goods for the one medical trial in the Trust has been reviewed and no impacts are expected.
33	Liaise with trial and study Sponsors to understand their arrangements to ensure that clinical trials and investigations using IMPs, medical devices, IVDs, advanced therapy medicinal products, radioisotopes and other clinical consumables which come from, or via, the EU or EEA, are guaranteed in the event of any possible border delays. If multiple sites are involved within the UK, then co-ordinate with the lead site or Chief Investigator in the UK, or organisation managing the clinical trial/investigation, e.g. Clinical Research Organisation, to ensure a single approach to the Sponsor.				As above

34	Investigate your organisation's reliance on transfers of personal data from the EU/EEA to the UK, especially those that are critical to patient care and/or would have a serious impact upon the system if they were disrupted.	IM&T			No data leaves the UK – all sits in UK services.
35	Follow the advice from The Department for Digital, Culture, Media and Sport and the ICO on data protection in a 'no deal' scenario, which can be viewed on gov.uk and on the ICO website, in particular to determine where to use and how to implement standard contractual clauses.	IM&T			See link to ICO Website pages: https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/accountability-and-governance/contracts/?q=Standard+contract+clauses
36	Record costs (both revenue and capital) incurred in complying with this guidance. Costs with a direct financial impact should be recorded separately to opportunity costs. Providers should discuss these costs with their regional NHS EU Exit support team. Feedback from providers will inform decisions on whether further guidance on cost collection is required.	ALL			Impact of this action to be assessed. 25 staff identified – checking impact in terms of roles and finance. Medicines highlighted to the Board already. Check with Karen to see if food is going up –emailed 26.02.19 – confirmation 27.02.19 no increase noted. Check with Richard for bank staff to cover – emailed Sandy Stones 26.02.19 – confirmation 27.02.19 no costs noted as a direct result of EU Exit.
37	SRO/Board level member to attend Regional EU Exit Workshop	Alan Davis			Alan Davis confirmed to be attending the workshop in Manchester on 13 February.
38	Data Collections to commence post 01 February 2019. Submissions to be co-ordinated.	EH		Ongoing	To identify what is needed for each submission and train staff to cover in the event of absence. 21/02/19 – no submissions requested to date. 07/03/19 – no correspondence on required SITREPS from centre to date.
39	Discuss and put in place table top exercise for medicines	EH/KD			EH to meet with KD. Exercise undertaken 21/02/19 at EU Exit Meeting

40	Pack of information to be developed and supplied in advance of EU Exit and placed in the Directors and Managers on Call packs in the event of activation of command rooms.	EH		15 March 2019	07.03.19 – information in draft – to be circulated week commencing 11 March 2019.
41	Respond to Keith Willetts letter re out of hours deliveries	NP		1 March 2019	NP to confirm that all deliveries are to be made to Eaglepoint, providing contact details for Porters at Fieldhead. A request will be made to provide 30 minutes notice prior to delivery so that porters can attend Eaglepoint to take delivery. This was also confirmed at the SRO dial in meeting on 06.03.19

Key

	Complete
	On Target
	In progress, some risks
	Not on target
	Not yet started

Please send all updates to Emma Hilton for maintenance of central files.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 March 2019

Agenda item 10 – Receipt of public minutes of partnership boards

Barnsley Health and Wellbeing Board

Date	5 February 2019
Member	Chief Executive / Director of Strategy
Items discussed	➢ To be confirmed.
Minutes	Papers and draft minutes (when available): http://barnsleymbc.moderngov.co.uk/mgCommitteeDetails.aspx?ID=143

Calderdale Health and Wellbeing Board

Date	21 February 2019
Non-Voting Member	Medical Director / Director of Nursing & Quality
Items discussed	➢ NHS Long Term Plan from a West Yorkshire and Harrogate Health and Care Partnership perspective. ➢ Calderdale Cares update ➢ Domestic abuse pledge. ➢ Hospital and community services reconfiguration – West Yorkshire Joint Health Overview and Scrutiny Committee briefing. ➢ Health and Wellbeing Board forward plan.
Minutes	Papers and draft minutes (when available): https://www.calderdale.gov.uk/council/councillors/councilmeetings/agendas-detail.jsp?meeting=25859

Kirklees Health and Wellbeing Board

Date	31 January 2019
Invited Observer	Chief Executive / Director of Nursing & Quality
Items discussed	➢ The NHS Long Term Plan. ➢ Tackling lung cancer – West Yorkshire & Harrogate Cancer Alliance. ➢ Prevention Concordat and Better Mental Health. ➢ Healthy Weight Declaration.
Minutes	Papers and draft minutes (when available): https://democracy.kirklees.gov.uk/mgCommitteeDetails.aspx?ID=159

Wakefield Health and Wellbeing Board

Date	Next meeting scheduled for 21 March 2019
Member	Chief Executive /

	Director of Provider Development
Items discussed	➢ To be confirmed
Minutes	Papers and draft minutes are available at: http://www.wakefield.gov.uk/health-care-and-advice/public-health/what-is-public-health/health-wellbeing-board

South Yorkshire & Bassetlaw Integrated Care System Collaborative Partnership Board

Date	8 March 2019
Member	Chief Executive
Items discussed	➢ CEO ICS Report ➢ ICS Highlight Report ➢ Development of Integrated Care in Places ➢ Long Term Plan ➢ Population Health Management ➢ Prevention and Social Prescribing ➢ Hospital Services Programme Update ➢ Finance Update
Minutes	Approved Minutes of previous meetings are available at: https://www.healthandcaretogethersyb.co.uk/about-us/minutes-and-meetings

West Yorkshire & Harrogate Health & Care Partnership System Oversight and Assurance Group

Date	28 February 2019 (next meeting scheduled for 19 March 2019)
Member	Chief Executive
Items discussed	➢ Programme updates. ➢ Review of system performance and delivery. ➢ Wider system risks and issues.
Further information:	Further information about the work of the System Oversight and Assurance Group is available at: https://www.wyhpartnership.co.uk/blog

West Yorkshire & Harrogate Health & Care Partnership System Leadership Executive

Date	8 January 2019 and 5 February 2019
Member	Chief Executive
Items discussed	8 January ➢ West Yorkshire and Harrogate approach to planning. ➢ Apprenticeship Levy. ➢ The Trust Project “I will be heard” campaign. 5 February ➢ The Wigan Deal – Transforming Health and Social Care Through the Power of People. ➢ Response to the NHS Long Term Plan and developing our 5-year strategy. ➢ Operational planning for 2019/20 update and next steps. ➢ Developing the West Yorkshire and Harrogate clinical strategy. ➢ Update on West Yorkshire and Harrogate campaigns:

	‘looking out for our neighbours’ and ‘breathe 2025’.
Further information:	Further information about the work of the System Leadership Executive is available at: https://www.wyhpartnership.co.uk/blog

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 March 2019

Agenda item 11 – Assurance from Trust Board Committees

Clinical Governance & Clinical Safety Committee

Date	12 February 2019
Presented by	Charlotte Dyson, Deputy Chair / Senior Independent Director (Chair of Committee)
Key items to raise at Trust Board	➢ CQC action plan. ➢ Waiting lists. ➢ Patient experience internal audit. ➢ Forensic CAMHS. ➢ MAV.
Approved Minutes of previous meeting/s for receiving	➢ Approved Minutes of the Committee meeting held on 20 November 2018.

Equality & Inclusion Forum

Date	5 March 2019
Presented by	Angela Monaghan, Chair (Chair of Committee)
Key items to raise at Trust Board	➢ Recommendation to change the Forum to a Committee. ➢ Update on the dashboard development. ➢ Further work required regarding completion of EIAs. ➢ Update on EDS2 panels – all panels will have taken place by the time the Board meets on 26 March. ➢ Update on the staff network progress.
Approved Minutes of previous meeting/s for receiving	➢ Approved Minutes of the Committee meeting held on 2 October 2018.

Mental Health Act Committee

Date	12 March 2019
Presented by	Kate Quail, Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	➢ **Monitoring & Management Information** • Considered MHA in IPR & including items on organisational risk register. • Report of BDU performance to provide improved narrative and context. • New one page tracker for CQC recommendations. ➢ **Committee Annual Report 2018 /2019 and & self-assessment** (review of effectiveness). Terms of Reference and Annual Work Programme 2019/20. ➢ **The Trust is fully prepared for upcoming legislation**. ➢ **Current performance (compliance with Act):** Ongoing challenges re documentation (Section 17 leave). Action taken: new MHA Office process - return forms to ward if not completed. SystmOne should also resolve this. ➢ **Partnership working:** • Positive feedback from CHFT - strong, effective partnership working with SWYPFT services.

	• Variable attendance from Local Authorities. Action: new template for views/ experiences of partners to be fed into Committee. ➢ **Staff Training**: MCA/DOLs 92.71%; MHA 86.70%. Increase in both figures. ➢ **Positive feedback** from Chair Hospital Managers' Forum - excellent care at Poplars.
Approved Minutes of previous meeting/s for receiving	➢ Approved Minutes of the Committee meetings held on 13 November 2018

Workforce & Remuneration Committee

Date	12 February 2019
Presented by	Rachel Court, Non-Executive Director (Chair of the Committee)
Key items to raise at Trust Board	➢ Organisational Development: Committee reviewed links between the OD Plan and oversight by Sub-Committees and Executive Groups. The Committee noted that the OD Strategy are due for renewal in 2019/20 and suggested this might be a focus of a strategic board session. ➢ Workforce Strategy Update: The Committee received an update on the Trust's approach to coaching and mentoring including the potential development of reciprocal mentoring. ➢ 2017/18 Pay Audits based on Gender, Ethnicity and Disability and Action Plan. ➢ Preventing Bullying and Harassment: Call to Action: The Committee received proposals for an engagement process to develop and organisational wide approach to prevent bullying and harassment in the workplace. ➢ HR Exception Report: The Committee received a focus report on sickness / absence including a deep dive into Forensic Services. The Committee also received an update on the recruitment and retention action plan. ➢ Annual review of Annual Report 2018/19 including self-assessment, Terms of Reference and Annual Work Programme 2019/20.
Approved Minutes of previous meeting/s for receiving	➢ Approved Minutes of the Committee meetings held on 23 October 2018 and 18 December 2018.

West Yorkshire Mental Health Services Collaborative Committees in Common

Date	4 March 2019
Presented by	Angela Monaghan, Chair (member of the Committee)
Key items to raise at Trust Board	➢ Relationships and communication – organisational check in (local issues, key risks, successes) ➢ Business and strategy - ICU update - Programme update delivery report ➢ Programme governance and infrastructure
Approved Minutes of previous meeting/s for receiving	➢ To be confirmed.

Minutes of Clinical Governance and Clinical Safety Committee held on 20 November 2018
Meeting room 1, Block 7, Fieldhead, Wakefield

Present:	Angela Monaghan (AM)	Chair of the Trust
	Charlotte Dyson (CD)	Deputy Chair (Chair of the Committee)
	Tim Breedon (TB)	Director of Nursing and Quality (Lead Director)
	Dr Subha Thiyagesh (SThi)	Medical Director
	Alan Davis (AGD)	Director of Human Resources, Organisational Development and Estates
	Kate Quail (KQ)	Non- Executive Director
Apologies:	Committee	
	None	
	Others	
	Richard Norman (RN)	Change Governance Manager
In attendance:	Mike Doyle (MD)	Deputy Director of Nursing & Quality
	Sarah Harrison (SH)	PA to Director of Nursing and Quality (author)
	Dave Ramsay (DR)	Deputy Director of Operations
	Sam Young (SY)	Non-Executive Director (for induction)
	Carol Harris (CH)	Director of Operations
	Yvonne French (YF)	Assistant Director Legal Services
	Usman Niazi (UN)	360 Assurance (in attendance for audit)

CG/18/121 Welcome, introductions and apologies (agenda item 1)

The Chair Charlotte Dyson (CD) welcomed everyone to the meeting. The apologies, as above, were noted. Usman Niazi (UN) from 360 Assurance was also at the meeting, Sam Young, NED observer and Yvonne French (YF) observer.

CG/18/122 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/18/123 Minutes of previous meeting held on 18 September 2018 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the meeting held on 18 September 2018

CG/18/124 Matters Arising (agenda item 4)

Actions from the meeting held on 18 September 2018 were noted and the action log was updated as appropriate.

- CG/18/96 Trust Achievements - CD to discuss with Jude Tipper the distribution of Trust achievements being circulated further afield.

ACTION: Charlotte Dyson

CG/18/125 Consideration of items from the organisational risk register relevant to the remit of the Clinical Governance & Clinical Safety Committee (agenda item 5)

Tim Breedon (TB) updated the Committee with the required clarification in respect of the paper submitted to the previous Clinical Governance & Clinical Safety Committee. He advised that the June and September reports have been reviewed and there was only a duplication of Risk ID 1119, the rest of the paper was correct.

The Committee reviewed the risk report as follows:-

CD noted that Risk ID 1368 was appropriately aligned to the Committee and reflected in the Committee agenda.

The Committee reviewed the risks and risk level relevant to the Committee in some detail.

Risk ID 1078 and Risk ID 1032 are subject to regular reports scheduled within the Committee workplan and the controls and mitigation are appropriate. Angela Monaghan (AM) noted that the long CAMHS waits are indeed happening and queried 3 as the likelihood score and feels that this is too low and would like some justification. Carol Harris (CH) advised that this was discussed in Executive Management Team (EMT) and has been reviewed.

The Committee agreed that this is taken back to EMT for discussion.

AM requested that the risk metrics scoring details are included in the paper where the levels are shown including the explanation of the levels. AM noted that if this was changed to a 4 this would change our response.

AM highlighted to the Committee that this was an active review of the Risks.

The Committee noted that some risks required an update in terms of completion dates and asked that this be updated before the next meeting.

ACTION: Carol Harris

Risk ID 1362 – Medicines falsified. Drug & Therapeutics Subcommittee (D&T) are on track from a Trust perspective. There are regional meetings regarding this and there is more legislation due from February 2019. It was noted that the issue is more legislative rather than patient safety related.

Risk ID 1370 - Alan Davis (AD) informed the Committee that everything is now place with a new provider which is being subcontracted from Leeds Teaching Hospitals. The situation is being monitored and contingency plans are in place. The Committee agreed that they are comfortable with the score of this risk.

Risk ID 2275 – AD informed the Committee that this has been delayed and is going to EMT this week for an extension as staff side would like more time. This was agreed at the last Partnership Forum.

Risk ID 1159 – Smoking policy is being updated and is going to EMT on the 6 December. Vaping has now been included as an option within the policy to support the smoke free position. The Trust is approving the use of E-burn equipment and is working with vending machine providers and this will be rolled out in December 2018. AD informed the Committee that the Trust is retro fitting sprinklers in all areas across the Trust.

Risk ID 1319 – AM raised again the point of completion dates in relation to out of area PICU placements. CH informed the Committee that this has been superseded.

TB advised that EMT had considered two items for inclusion on the ORR, Learning from Deaths, and Inpatient Safety / Ligatures. The learning from deaths risk will be considered at the Clinical Reference Group in December. The Inpatient Safety/ Ligatures risk is being considered at local BDU level, once complete the registers will be reviewed collectively to assess the need for escalation to the ORR. Outcome of discussions to come back to CGCS.

Action: Tim Breedon

It was RESOLVED to NOTE the changes in the current Trust-wide Corporate risk register and confirm that the current risks levels are appropriate, subject to the comments above.

CG/18/126 Quality Accounts, Including Quality Priorities (agenda item 6)

TB provided a brief update to the Committee. TB reminded the Committee that the Quality Priorities for 18/19 are regularly reported in the Integrated Performance Report on a monthly basis.

TB advised that the key points to note in respect of this years Quality Account are as follows:

- A timetable of activity is in development (as per previous years)
- Members Council Quality group has proposed a local indicator – physical health monitoring of people with mental illness
- Consultation on quality priorities has commenced for 19/20, with further consultations planned for Jan/ Feb 2019

TB informed the Committee that an early draft of the Quality Account Report may be provided to the Committee in February 2019 and that we await the national guidelines for the production of the quality account for 2018/19

CD asked about the impact of a change in our Clinical recording System upon quality account reporting. TB advised that the Clinical Records Programme Board has been assured that routine reports will be maintained during and post transition

It was RESOLVED to NOTE the progress on the production of the Quality Account.

CG/18/127 NHS Resolutions Paper – Learning from suicide related claims (agenda item 7)

Mike Doyle (MD) updated the Committee regarding the thematic review analyses the data held by NHS Resolution on compensation claims that relate to suicide between 2015 and 2017. The claims that are reviewed are those where member organisations received funding to provide legal representation at inquest via NHS Resolution's inquest scheme. In addition, there is a review of non-fatal suicide attempts following which a claim was pursued. The purpose of this review is to identify the clinical and non-clinical issues in care that arose in those claims, share this learning with the wider system to act as a driver for improvement, and make recommendations to reduce further harm.

While compensation claims relating to suicide are a small, highly specific group of incidents which may involve potentially avoidable harm, this may not reflect the entirety of care across the NHS. This review looks at cases both where liability has been admitted which by definition means that there were errors that should have been prevented and where liability was denied. In both instances claims will contain learning that should be shared. It should be noted that not all incidents analysed here received a suicide or open verdict.

There were four main areas of concern, where:

- There was a lack of family involvement and staff support through the investigation and inquest process.
- The quality of root cause analysis undertaken as part of the Serious Incident (SI) investigation was generally poor and did not focus on systemic issues.
- Due to the poor SI report quality, the recommendations arising from SI investigations were unlikely to reduce the incidence of future harm.
- Reports to prevent future deaths (PFDs) were issued to trusts by the coroner with little consistency and there were poor mechanisms to ensure that changes in response to the PFDs had been made or addressed the issues highlighted.

MD highlighted the recommendations made and noted that risk assessment mandatory training is a priority and that the Trust induction is targeted for this. It was also noted that advances in training are becoming apparent.

MD noted that since 2015, SWYPFT have had four claims following apparent suicide and one following attempted suicide. These are all at various stages of the legal process and may be incidents from prior to 2015

MD informed the Committee that the report will be shared with OMG and Clinical Governance Group to identify where further action is required in response to the report and that the Mortality Review Group will develop an action plan and evaluate.

AM thanked MD for the update and queried if staff haven't received the training can they do observations. MD informed the Committee that it is covered as part of the induction. AD also noted the same and asked who signs off competency. Subha Thiyagesh (SThi) would also like the same clarification on both Medical and Nursing staff also.

The Committee agreed that this needs to be clearer and MD will take it to the Clinical Governance group on the 26 November 2018 to discuss the breadth of the matter.

ACTION: Mike Doyle

It was RESOLVED to RECEIVE the report and NOTE the next steps.

CG/18/128 Transformation & Priority Programmes Update (agenda item 8)

TB highlighted some items from the Transformation & Priority Programme report.

- Older Peoples Mental Health
  Date of the next gateway is still yet to be confirmed and won't be until consultation with commissioners is complete

- Clinical Record System
  TB alerted the Committee to the fact that the Cutover and Data Migration planning had become more complicated that originally anticipated and as a result further planning was required. The impact of this will be that the original go live date will be delayed by some week. A detailed plan is being developed to understand and mitigate the impact by the end of November 2018. TB reiterated that the system would not go live until a safe transition could be assured

The Committee requested a more detailed update for the February meeting.

- Perinatal Mental Health
  QIA will be conducted at post implementation review in March 2019.

ACTION: Richard Norman

It was RESOLVED to RECEIVE the update and NOTE the progress.

CG/18/129 Care Quality Commission Action Plan (agenda item 9)

MD gave the Committee an update on the CQC Action Plan and also noted a slight error in the paper which will be corrected (the paper refers to some actions as amber/red whereas they should be showing as amber/green).

We have a number of mechanisms in place to assure the quality of our care. These include high level strategies, (with implementation plans), systems and processes to monitor quality improvement and assurance and structures that facilitate ward to board connectivity and meaningful activity to improve the safety, effectiveness and experience of care.

The CQC action plan is a live document that will be constantly updated to reflect the action undertaken and the further action to be carried out prior to the inspection.

The quality monitoring visit programme for 2018 commenced in October. The programme has been planned based on intelligence we hold regarding the CQC risk based process. In total we will visit 39 teams across our core services. The focus of these visits is predominantly to assess teams against progress from the CQC action plans. Where teams were not inspected by the CQC in 2018 we are assessing against the key lines of enquiry and monitoring progress against 2016 and /or 2017 actions.
To date visits have been made to the Learning Disability (LD) inpatient unit; Intensive Home based Treatment teams (Trustwide) and the Acute wards & PICU visits are in progress.

Regular conversations with the CQC at the Engagement meetings keep the CQC updated on our processes.

CD raised a concern regarding the importance of ensuring that actions were embedded in the organisation and that services that required support received it. MD notified the Committee that spot checks are performed across the Trust on a regular basis to monitor

services. TB also informed the committee that progress reports are regular and any concerns escalated. Services are also asking how they can improve. The Committee agreed that it was very positive that the services are proactive in asking how they can improve

It was RESOLVED to RECEIVE and COMMENT on the CQC action plan and NOTE the areas of risk.

CG/18/130 Care Quality Commission Mental Health Act (agenda item 10)

TB advised the Committee that in future the CQC MHA Action Plans will be performance managed through OMG and progress reports will be taken into the Mental Health Act Committee. The MHAC will then highlight any areas that they feel require consideration by this Committee.

Kate Quail (KQ) gave a brief overview of some items from the Mental Health Act Committee for information. At this time there are no items requiring CGCS review.

1. **Poor ethnicity recording**
   This is being held by the Equality & Inclusion forum.

2. **Increased Section 49 activity**
   CH confirmed that this is being monitored through operational management teams.

3. **Increased internal transfers between two inpatient units in Calderdale and Kirklees** (the Priestly Unit and the Dales)
   50% of all Trust internal transfer activity is from Priestly & 24% from the Dales. Transfers may be due to mixed sex wards, ECT (Dewsbury does not have ECT suite) & acting in best interests of patients.

4. **Under 18's** -
   Dr Ovi Sandica reported system issues and asked on behalf of all clinicians for help with this.
   August 28th MHAC - AMPH reported that AMPHs are doing far more assessments on under 18's - because alternatives are no longer available. Could previously use the Children Act as means of detention but alternative secure accommodation is not available now due to cuts in Local Authority funding, so have to use MHA

5. **Decreasing number of applications from service users for appeals to the Tribunal or Hospital Managers' reviews.**
   Does it link to people not being given their rights? This would tally with data from 2 previous MHAC audits - (Access to Advocacy and Patients' Rights) showing not reiterating rights.
   CH reported that OMG think it's because of shorter inpatient stays. But how does this tally with other data showing increase in stay? Is it linked to more internal transfers?

The Committee had nothing escalated into MHAC.

It was RESOLVED to NOTE the update.

CG/18/131 Trust achievements (agenda item 11)

The Committee noted the Trust achievements throughout the organisation and also the Trust Excellence awards which took place on the 13 November. The Committee received the booklet of the winners and nominees and congratulated everyone involved with the awards.

CG/18/132 Patient Safety Strategy update (agenda item 12)

MD provided a summary of the Patient Safety Strategy to the Committee.
This year, the implementation plan has focused on a small number of work-streams including:

- Each Business Delivery Unit identified their top 5 patient safety priorities for 2018 which they are progressing locally
- Patient safety communications through #allofusimprove and kitchen table events
- Improved patient safety information
- Continued development of the use of Human Factors methodology
- Implementation of safety huddles which has shown some results in reducing harm and improving safety
- Sign up to safety work has continued and 2017 data showed some positive improvements with a number of targets being achieved.
- Work has continued to promote sharing of learning across the Trust through Bluelight and Greenlight alerts, and developing a 'learning library' using SBAR methodology.

KQ queried if the Strategy will be driven at BDU level in the future and MD informed that this is the case. Engagement with some services and some areas has not been as positive as with others and this will be discussed at the Patient Safety Strategy meeting on the 21 November 2018.

CD raised the question of restraints and prone restraints and how these are reported in line with other Trusts. MD informed the Committee that we reported all our prone restraints regardless of time on to Datix and that we are looking at techniques that have been developed around sitting positions etc.

The Committee would like to understand the issue of prone restraints with greater clarity and TB agreed that we can add more details to this report or the MAV subcommittee report. MD suggested a quarterly report similar to the annual report which highlights this.

AM would like to know which Trust is leading in the country on this and what have they done? Can we compare? And what our ambitions are and when?

CH suggested that it would be helpful to the Committee to have a description / definition of what we mean by restraint and prone restraint.

It was suggested that Emma Cox attend to provide a presentation responding to the above queries / additional assurance required.

ACTION: Mike Doyle

Committee also noted that there was some very positive work around this agenda and commended progress to date.

It was RESOLVED to RECEIVE the report and ACCEPT that it provides assurance of work undertaken.

CG/18/133 Patient Experience report (agenda item 13)

TB highlighted the Patient Experience report and noted that in the second quarter, BDU lessons there was an error / duplication from previous paper. MD to circulate correct paper.

ACTION: Mike Doyle

TB informed the Committee that the backlog of complaints has significantly reduced and is now in single figures. Work is continuing to improve our customer services process to make sure that the Trust always responds in ways that ensure learning and becomes more responsive where service issues arise. This will mean services will see the issues first, with a robust process in place to support a resolution.
This Q2 18/19 report has an amended format which will evolve over time to ensure we are capturing the correct assurance information for CGCSC. We will expand on the range of feedback we include, e.g. student nurse feedback, staff (Friends & Family Test) FFT and themes from feedback and lessons learnt as work progresses with #allofusimprove.

Key points to note:

- As in Q1 responding to complaints within a 40 day timeframe remains a challenge to the Trust. The ongoing review of customer services process has identified:
- A high number of complaints are complex in nature and require thorough investigation to resolve the issues.
- The amount of time the Customer Services team have to dedicate to complaints is decreasing due to the rise in general enquiries and freedom of information requests the team are responding to.
- Resources allocated to habitual complainants.
- These factors put the opportunity to achieve the 40 target at risk.
- A number of complainants are seeking financial address from the Trust and could cause a potential financial risk.

It was RESOLVED to REVIEW and NOTE the feedback.

CG/18/134 E-cigarettes Policy update (agenda item 14)

No further update required as covered at agenda item 5

CG/18/135 Issues arising from Performance report (agenda item 15)

TB provided an update on the following:-

- **Acuity measure 19/20** – "How acuity changes in a ward environment. TB advised that we are trialing the Safe Care System which includes acuity information.

CG/18/136 Update on topical, legal and regulatory risks (agenda item 16)

TB briefed the Committee on the following:-

MH Legislation

Review of the Mental Health Act

- Reviewing reasons for:
- Rising rates of detention under the Act
- Disproportionate number of BAME people detained under the Act
- Processes that are "out of step" with the current system

Mental Health Units (Use of Force) Bill

- Looking at the use of force in relation to people in mental health units
- Hospitals will be required to publish data on how and when physical restraint is used
- Any non-natural death within mental health units will automatically trigger an independent enquiry

Brexit

In response, the Government has stepped up contingency planning for a "no deal" Brexit

- Secretary of State wrote in August to NHS staff providing assurances around national stockpiling of medicines and highlighting the Emergency Preparedness, Resilience and Response process as the means through which local contingency planning should take place.
- DHSC issues guidance for pharmaceutical companies and medical device suppliers on stockpiling six weeks' worth of supplies

CQC

Care Quality Commission – a New CEO

- Ian Trenholm took over from Sir David Behan back in July
- Strong focus on improving systems and processes and more public facing
- More "regular digital dialogue" less primary focus on big inspections

CQC State of Health and Adult Social Care 2017/2018

- Overall, the quality of health and social care has been maintained or improved
- Some providers coping better than others with pressures, and safety still at risk
- Hospital and mental health pressures caused by struggling local system / social care. Quality is now an "integration lottery"
- Five factors
  1. Access
  2. Quality
  3. Workforce
  4. Capacity
  5. Funding & Commissioning
- NHS Long term plan funding will be wasted without long-term social care funding
- Ratings: more good or outstanding than 16/17, moving from RI to Good getting more difficult

CQC continues to focus on systems

- CQC's "Beyond Barriers" report in July summarised findings from the 20 local system reviews, looking at how health and care services are working together to meet older people's needs
- CQC have been commissioned to carry out 3 further local system reviews by the end of 2018
- CQC are also returning to 3 or 4 of the systems already reviewed to follow up on progress
- CQC are calling for the powers to look at the quality of care across a system, as well as in individual organisations, and the powers to regulate commissioners
- The local system reviews are informing broader CQC work
  1. Adapting the CQC operating model for "complex providers"
  2. Developing relationships with STP's and ICSs
  3. How to encourage improvement at system level
  4. Working with Frimley health and Care and Greater Manchester to develop and test new regulatory model

The Committee raised a query around reporting of delayed transfers of care, and whether this is an issue within the Trust, TB advised that this is not an issue for SWYPFT at present.

It was RESOLVED to RECEIVE and COMMENT on the CQC publications briefing and NOTE the impact on the organisation.

CG/18/137 Child and adolescent mental health services - update (agenda item 17)

DR provided an overview of the key points from the CAMHS Update report.

NHS Benchmarking 2017/18

The 2017/18 national benchmarking project incorporated 107 submissions from NHS and independent services. The report noted CAMHS teams show more diversity than parallel services for adult mental health and recommended any interpretation of results required reference to the portfolio of services offered by the provider. Results for SWYPFT were at an organisational level – not by individual team/area.

In SWYPFT the waiting time from referral to treatment and from referral to ASC 1st appointment have been highlighted as the primary concerns. Both are the highest within the sample. Whilst investment and staffing levels are below the national mean this may be accounted for by disparities in service configuration. The referral and caseload numbers do not in themselves evidence higher than average levels of activity pressure.

CD asked whether we are still checking the data regarding ASC and DR assured the Committee that this is correct. Caseload sizes are smaller than the national average.

SThi queried if this sample could be broken down and DR informed that this is SWYPFT wide and is an average.

The Committee noted that there is a significant issue and is adequately reflected on the risk register.

AM queried who provides Tier 2 services and DR informed the Committee that:

- Calderdale – North Point, who provide SPA (Tier 2)
- Kirklees – Northorpe Hall who provides SPA (Tier 2)
- Barnsley - SWYPFT contribute to this service
- Wakefield, SWYPFT provide this service
- ASC - Barnsley is Barnsley General Hospital
- ASC – Wakefield is Pinderfields General Hospital (Partnership)

Committee noted that it is quite complicated to navigate the pathway and queried whether this could contribute to the current issues.
AM noted that the data was interesting but feels it is a struggle to apply it due to the disjointed pathways.

The Committee would like this to be discussed with our Commissioners. CH informed the Committee that benchmarking reports are not normally shared with Commissioners.

SThi informed the Committee that she was discussing CAMHS with Dr Andy Cotgrove as part of the MHSIP programme with a view to working with SWYPFT on this issue.

AD asked if it was possible to benchmark each of the areas and the Committee acknowledged that this would be helpful to try and break this down to areas/caseloads etc.

DR made the Committee aware regarding the ongoing on call issue and that CQC had noted gaps during their recent visits. DR informed the Committee that this issue is improving however it does remain a concern.

DR also made the Committee aware of a young person in Wakefield that had been admitted through A&E to an adult assessment ward and is still awaiting a Tier 4 bed. It was noted that there seems to be an issue at present with young people being admitted to adult beds whilst awaiting Tier 4 beds. TB indicated that the escalation has increased over last few weeks and that issues have been more apparent.

TB advised that NHSE are aware of the situation and a discussion will be taking place in the near future. It is both a local health and social care issue. A possible summit with local authority & partners etc to try and address issues may take place. However in the meantime we need to ensure our offer is understood by partners.

It was RESOLVED to NOTE the update paper.

CG/18/138 Quality Impact Assessment review (agenda item 18)

TB provided a brief overview of the Quality Impact Assessment paper.
This is the interim report for October 2018 and provides details and the results of 113 Quality Impact Assessments (QIA) and the 2 assessment still to take place.

The Committee discussed the need for staff to understand that this is about improvement and not cost reduction and should add value to what we are trying to achieve.

The Committee felt that this was a robust process and understood the current position.

It was RESOLVED to RECEIVE and NOTE the update.

CG/18/139 Safer Staffing report (agenda item 19)

MD updated the Committee on the key issues:

- The inpatient wards in SWYPT required a 17% uplift on establishment and planned staffing.
- A further 12 hour shift review was commissioned and recommendations made to ensure the quality and safety of care and the health and wellbeing of staff are improved
- As part of a new NHS Improvement initiative, SWYPT has developed a staff recruitment and retention strategy
- Introducing the safer staffing agenda into the community has proven challenging for a variety of reasons but the plan is to commence community safer staffing groups from December 2018
- Care Hours Per Patient Day will be published on NHS Choices from January 2019

- Plans going forward for 2019/20 include:
- SWYPT involvement in the development of a national acuity and staffing resource for community teams, to ensure the trust is at the forefront of any developments
- Support establishment of cohorts of staff with annualised hours within BDUs
- Review the Medical Bank capability

- Publish the new staff bank procedure
- Continue expanding the bank to support other areas including AHPs and community teams
- Interpret and act upon NHSi Care Hours Per Patient Day (CHPPD) statistics as they are reported monthly from January 2019
- Support the introduction of the acuity staffing management tool, *Safe Care*
- Work with OMG to review how we capitalise on opportunities arising from new national workforce initiatives (e.g. nursing associates, advanced clinical practitioners)
- Contribute to implementation of SWYPT Recruitment & Retention Strategy

AM queried as to whether SWYPFT is making maximum use of the e-rostering system and AD informed that NHSI guidance will address most of the issues that AM has raised.
The Committee agreed that this was a very comprehensive report.

AM queried if the care hours for patient day data is available and TB informed that it is and will be in the establishment review. MD informed the Committee that nationally SWYPFT are on average performing well.

AM stated that the Committee would like more information around volunteers within SWYPFT.

ACTION: Mike Doyle

In summary the Committee noted that:-

- The report provides a comprehensive review of activity relating to the Safer Staffing agenda.
- The positive work around staff retention through the workforce strategy has contributed to the current position.
- The regular system of exception reporting of planned vs actual fill rates remains an important part of the routine assurance, through the IPR.
- The establishment review is an important part of maintaining assurance and will be addressed during workforce planning this year.
- The report provided assurance that the Safer Staffing agenda is being addressed appropriately throughout the organisation.

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

CG/18/140 Serious Incidents Quarterly Report Q2 (agenda item 20)

MD highlighted the Serious Incidents Quarter 2 & Learning from Healthcare Deaths Quarter 1 Report to the Committee.

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.

- Overall figures for incident reporting. Q2 had 3017 incidents; lower than the previous quarter (3200).
- 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).

- "Violence and Aggression" continues to be the highest reported incident type. Staff have reported that this can be linked to individual service users but also say some incidents are linked to the trusts current smoking policy.
- There have been no 'Never Events' reported in the Trust during Q2; the last Never Event reported was in 2010/11.
- The total number of serious incidents reported through Strategic Executive Information System (STEIS) in Quarter 2 was 9; a slight increase on Quarter 1 (8). The range of serious incidents reported this quarter has included deaths, pressure ulcers and violence and aggression.

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.

AM queried the headings on page 9 of the report as to whether these were our headlines or national ones. MD informed that they are core headlines however we had added parts over time.

CD noted that the examples given of the changes made are comprehensive and puts things into perspective and reinforces the assurance that the Committee required.

The Committee noted the following:-

- Robust systems and processes remain in place for the reporting and investigation of incidents.
- The rolling total of apparent suicides over the previous 4 quarters is slightly above the National Confidential Enquiry (NCI) estimates and remain a focus of attention and action.
- Violence & aggression continues to be the highest reported incident type. The work associated with this is positive and is contained in the Patient Safety Strategy received by the Committee.

TB provided the Committee with an update on current SI's.

It was RESOLVED to NOTE the report on incident management and the assurance provided.

CG/18/141 CQC Briefing (agenda item 21)

TB highlighted to the Committee the CQC Briefing paper

- State of Care – 2017/18 (October 2018):
- Sexual safety on MH wards - September 2018
- Equality & Inclusion
- Equally Outstanding Report

CQC update: sharing good practice & innovation in MH services

It was RESOLVED to RECEIVE the paper and NOTE the impact.

CG/18/142 Ligature report (agenda item 22)

MD informed the Committee that the policy has been updated.

The annual environmental suicide and ligature risk assessment and management process is a fundamental element of patient safety. A systematic approach to risk assessment and risk management is followed. During the 2017 round of audits, 28 wards were assessed.

The environmental risk assessment for suicide and self-harm is a component part of comprehensive clinical risk assessment, which includes individualised service user risk assessment, formulation and care planning. The appropriate use of observation and engagement, including positive risk-taking and environmental risk assessment, support the management of identified risks.

EMT confirmed that there are no restrictions on capital funding as safety is the priority. However, there may be delays when agreeing the most appropriate technical solution and sometimes there may not be a solution available. Also a need to do remedial work in a measured way to ensure minimal disruption to clinical practice. At these times clinical, relational and procedural safety measures in place to mitigate risk.

The Committee agreed how difficult it is to make any areas totally ligature free and AM noted the concern when there is no obvious solution. Committee agreed that the report is of good quality and acknowledge the hard work that had gone into this.

It was RESOLVED to RECEIVE the report and NOTE the progress in completing remedial action.

CG/18/143 Emergency Preparedness, Resilience & Response (EPRR) Compliance (agenda item 23)

AD highlighted the report to the Committee and explained that the Trust participates fully in the EPRR network for the region and as such measures itself against a list of 54 standards for compliance. On first check of the standards the Trust is overall partially compliant and has declared at this level. There is an action plan to move us to substantial compliance which we can then declare at Public Trust Board in January 2019 at the latest. The Trust will not achieve full compliance as some of the requirements require system working amongst the local Trusts which needs to be led by the larger Acute Hospitals and they have not achieved the standards as yet. The Trust declared compliance in 45 of the 54 standards at the end of October 2018 and therefore was partially compliant overall. To achieve substantial compliance, the Trust needs to declare compliance in 48 of the 54 standards. The action plan will see three of the partial compliance standards move to full compliance by the end of December 2018 after which the Trust will be able to declare substantial compliance overall against the standards. This will mean the Trust Board will be able to declare at its meeting in January 2019 substantial compliance

It was RESOLVED to RECEIVE the report and NOTE the plan to move to substantial compliance in January 2019.

CG/18/144 Sub-groups – exception reporting (agenda item 24)

Drug & Therapeutic (agenda item 24.1)
Committee noted the improvement of these reports and SThi noted the general improvement of the attendance at the meetings. Subcommittee to note over medication – STOMP in the next update.
It was RESOLVED to NOTE the report.

Safety & Resilience (agenda item 24.2)
The TAG is working well and has the correct attendance
It was RESOLVED to NOTE the report.

Infection Prevention and Control (agenda item 24.3)
The TAG is requiring more work around getting the right people in attendance and this is underway. However all work is complete
It was RESOLVED to NOTE the report.

Safeguarding adults & children (agenda item 24.4)
It was RESOLVED to NOTE the report.

Managing Aggression and Violence (agenda item 24.5)
More detail was added to the update. Please refer to agenda item 20. The TAG was working well and now MAV has been rebranded to RRPI, Reducing Restrictive Practice Initiative.

It was RESOLVED to NOTE the report.

Any feedback from other TAGs/groups (agenda item 24.6)
None.

CG/18/145 Issues and items to bring to the attention of Trust Board and other Committees (agenda item 25)

Issues were identified as:

- Patient Safety Strategy
- Ligature
- Safer Staffing
- CQC Action Plan
- Serious Incidents
- Restraints
- CAMHS

CG/18/146 Consideration of any changes from the organisational risk register relevant to the remit of the Clinical Governance & Clinical Safety Committee (agenda item 26)

The Committee considered items discussed on the agenda and did not consider any changes other than the matters discussed at CG/18/123 were necessary.

CG/18/147 Work Programme (agenda item 27)

No changes were made to the work plan.

CG/18/148 Any other business (agenda item 28)

None.

CG/18/149 Date of next meeting (agenda item 29)

The next meeting will be held at 14.00 on 12 February 2019 in Meeting room 1, Fieldhead Hospital, Ouchthorpe Lane, Wakefield WF1 3SP.

South West Yorkshire Partnership NHS Foundation Trust

Equality and Inclusion Forum held on 2 October 2018

Present:	Angela Monaghan (AM)	Chair of the Trust (Chair)
	Sam Young (SYo)	Non-Executive Director
	Tim Breedon (TB)	Director of Nursing and Quality (lead Director)
	Alan Davis (AGD)	Director of Human Resources, Organisational Development & Estates
	Nasim Hasnie (NH)	Public Governor, Members' Council
Apologies:	Members	
	Erfana Mahmood (EM)	Non-Executive Director
	Sean Rayner (SR)	Director of Provider Development
	Rob Webster (RW)	Chief Executive
	Attendees	
	Dr Subha Thiyagesh (SThi)	Medical Director
In attendance:	Aboo Bhana (AB)	Equality & Engagement Development Manager
	Claire Hartland (CHa)	Human Resources Business Manager
	Emma Jones (EJ)	Company Secretary (author)
	Zahida Mallard (ZM)	Equality & Engagement Development Manager

EIF/18/33 Welcome, introduction and apologies (agenda item 1)

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

EIF/18/34 Declaration of interests (agenda item 2)

There were no further declarations over and above those made in the annual return to Trust Board in March 2018 and Members' Council in April 2018 or subsequently.

EIF/18/35 Minutes from the meeting held on 12 June 2018 (agenda item 3)

The minutes of the previous meeting held on 12 June 2018 were approved.

EIF/18/36 Matters arising (agenda item 4)

Action log from the meeting held on 12 June 2018

The following matters arising were discussed:

- EIF/18/17 Welcome, introduction and apologies (meeting timetable) - Dates for 2019/20 finalised and circulated to the Forum.
- EIF/18/23 Equality and diversity annual report for Trust Board (protected characteristic data) - Tim Breedon (TB) commented that it would be included in next year's report.
- EIF/18/23 Equality and diversity annual report for Trust Board (engagement and involvement agenda) - Update under agenda item 13.
- EIF/18/23 Equality and diversity annual report for Trust Board (update against strategy) - TB commented that an update would come to the Forum in March 2019.

- EIF/18/25 Equality Impact Assessments (EIA) update (EMT policy proforma) - EJ commented that an updated policy proforma would be implemented to include confirmation that an EIA had been completed / reviewed. TB commented that a column could also be added to the Policy Register which is reviewed by the Executive Management Team (EMT) monthly.

Action: Emma Jones

- EIF/18/25 Equality Impact Assessments (EIA) update (promotion through comms) - TB commented that he has spoken to the Comms team and there was also potential to add it to a further Extended EMT meeting as part of the #allofusimprove campaign.

Action: Tim Breedon

- EIF/18/31 Items to bring to the attention of Trust Board and other committees (update to Members' Council) - TB commented that this could be included as part of the performance report update.

Action: Tim Breedon

- EIF/17/16 Feedback from BAME staff network (reporting of incidents on Datix) - AM commented that this is an area that the RACE clinical network could look at.

Action: Tim Breedon

Nasim Hasnie (NH) commented that the equality update could also be included as part of the Annual Members' Meeting.

Action: Tim Breedon

Actions from Trust Board 24 April 2018:

- ethnicity of complaints
- Improving Access to Psychological Therapies (IAPT) outcomes by ethnicity

TB advised that the detail would be reviewed by the Clinical Governance & Clinical Safety Committee. A new high level dashboard would be developed including complaints, IAPT, Mental Health Act, and Workforce Race Equality Standards (WRES).

The Forum discussed whether protected characteristics data was currently available for these areas, that they should be linked to the duties of the Forum and to the Equality strategy. The Forum requested a proposal to come to the next meeting on the data available and areas that may be included in the Integrated Performance Report to the Trust Board.

Action: Tim Breedon

EIF/18/37 Feedback from staff equality networks (agenda item 5)

Black, Asian and minority ethnic (BAME) staff network

Alan Davis (AGD) advised that the BAME staff network steering group elections had taken place and there had been a positive response. The network was now well established with lots of areas of work taking place including actions in response to the staff survey results. The annual celebration event would take place on 24 October 2018.

AM asked if there were any areas that the BAME staff network had asked to be brought to the attention of the Forum. AGD advised that any areas are raised at EMT and he would ask in future if there were areas to be raised at the Forum.

Action: Alan Davis

Disability staff network

AGD advised that the disability staff network elections had also taken place and the group had their first formal meeting on 1 October 2018. The network had been established using the learnings from the BAME staff network.

Lesbian, gay, bisexual and transgender (LGBT) Plus staff network

AGD advised that the LGBT Plus staff network was starting to take shape with a small working group reviewing some terms of reference. As with the other staff networks it was important that it was owned and run by staff as their network.

EIF/18/38 Learning from the NHS Staff Survey and Well-being at Work Survey (agenda item 6)

AGD highlighted the following in relation to the Well-being at Work Survey:

- The Well-being at Work survey allowed results to be broken down further to team level to allow for more detailed review.
- A discussion has taken place with the BAME staff network chair about the information that could be shared with the network and the development of actions.
- A high number of responses selected 'I don't wish to discuss my ethnic origin' and further work was needed to promote that the survey is confidential.
- The survey showed some positive areas as highlighted in the report although it was difficult to make comparisons due to the unidentified ethnic origin responses.

AGD highlighted the following in relation to the NHS Staff Survey:

- A number of areas show BAME staff are positive, although again there were a number of responses within an unidentified group
- Bullying and harassment was identified as an area that needs focus, which is also a national issue in the NHS. For this Trust it was particularly from service users and relatives and showed a worse position than the last survey. It was noted that the last survey was a sample only and the response levels were higher this time.
- Career progression is another area where there has been a decrease from BAME staff and focus needs to be on whether opportunities are being made available. There are several programmes in place including RACE and Moving Forward to support and encourage staff.
- The results from disabled staff were felt to be the most negative, which is one of the reasons why having the disability staff network was really important.
- The paper provided examples of the Trust's results in comparison to the national survey.

ZM commented that sometimes staff members may identify across more than one protected characteristic.

SYo commented that the colleague and manager bullying element stood out as an area for focus. AGD commented that it was one of the most difficult areas for an organisation to tackle as the issues can be complex and involve relationship breakdowns. The largest numbers of actual cases are white staff and it is important to note that it was not just about a policy and that a cultural shift was needed across the organisation, with a framework for resolving matters quickly and supporting healthy teams in place. Where there are areas related to protected characteristics, focused work would also be needed.

AB commented that case studies in relation to mandatory training had generated a lot of discussion and specific bullying and harassment training could be considered as an area for development.

The Forum noted the report.

EIF/18/39 Workforce Race Equality Standard (WRES) and Disability Equality Standard (DES) (agenda item 8)

AGD reported that the action plan had been updated from the 2017 version. CH added that the EDS2 and WRES were now integrated and when the DES comes into place it would also be integrated.

SYo asked whether the actions and progress to date would continue to make the step change in the future if the same actions had been in place for a period of time. ZM commented in relation to 3.1 there had been positive changes around training and other opportunities, such as the Moving Forward programme and out of those there have been staff who have moved to other roles and it helped them progress. This has encouraged others within the BAME staff network to take part the next time it is run. AM commented that the Shadow Board and Insight Programme were also examples of development opportunities.

AM commented that greater clarity was needed around the indicators, actions, progress and outcomes. ZM commented that there was potential to include some aspirational targets as an organisation. AGD commented that some would require working alongside other organisations such as universities to enable a diverse workforce for recruitment and there are some programmes already in place to support that. TB commented that a lot of the actions identified are part of the annual report on equality which may be a way of bringing the information together.

Action: Alan Davis

AM asked about a BAME pay gap analysis. AGD commented that this year the pay gap analysis was in relation to gender and next year it would look at BAME and disability.

The Forum supported the WRES action plan and requested a further review takes place by the Chair prior to it being submitted to the Trust Board.

Action: Alan Davis / Angela Monaghan

EIF/18/40 Consideration of items from the corporate / organisational risk register aligned to the Forum (agenda item 7)

The Forum reviewed the risk on the corporate / organisational risk register aligned to the Forum. TB commented that the action reflected the actions being taking in relation to the Equality Strategy and the WRES.

EIF/18/41 Equality standard updates (by exception) (agenda item 9)

No matters were raised under this item.

EIF/18/42 Equality Impact Assessments (EIA) update (agenda item 10)

ZM reported that a lot of progress had been made by the BDUs. The future area of focus would be on EIAs that had been in place for a number of years to ensure actions had been completed.

AB commented that it was important that when data is migrated to the new clinical records system that the quality of data is not diminished.

The Forum thanked staff for the work they have done to improve the position.

EIF/18/43 Equality Delivery System (EDS2) update (agenda item 11)

ZM reported that the paper highlighted the ongoing work in relation to the Trust's current assessment against NHS England EDS2 and plans for the 2019/20 process in respect of public facing goals. There was potential that EDS2 would move to EDS3 next year and there may be a reduction in the number of outcomes. At the moment Barnsley would continue to be reviewed separately.

The Forum noted the update provided.

EIF/18/44 Inclusive leadership and development programme updates (agenda item 12)

AGD advised that in relation to building leadership for inclusion, a workshop had been held, however it was not progressing as quickly as anticipated.

EIF/18/45 Equality, inclusion and engagement review (agenda item 13)

TB highlighted the following:

- A scoping report was requested by EMT in June 2018 to look at the current activities, resources available and provide any recommendations for action.
- These areas were mapped including resources, key stakeholders and actions required. There was a short turnaround with the attached report provided to EMT in August 2018.
- The outcome was to ensure there is the right level of leadership to take this work forward. Staff need to be involved in developing a coherent action plan and detailed metrics to report back into EMT.
- A workshop will take place on 9 October 2018 to develop the plan.

AB asked if the aim was to still have one lead Director for all areas. TB commented that yes the aim was to have one lead Director. However there are some areas such as engagement that require matrix working.

AM asked if the proposed changes would support membership engagement. EJ commented that the Membership Strategy is separate but also feeds into the Communication, Engagement and Involvement Strategy. An area that would assist is better links with the Membership Office so members and governors can be advised of engagement opportunities taking place across the Trust's footprint.

AB gave an example of work commencing under the Calderdale and Kirklees BDUs in relation to engagement with service users and carers and patient experience with action plans in place.

EIF/18/46 National issues and impact locally (agenda item 14)

The following areas were noted:

- BAME pay gap as discussed previously.
- EDS3 as discussed previously.
- NHS England have raised an interest in relation to monitoring of sexual orientation which may be added to the NHS contract.

EIF/18/47 Any other business (agenda item 15)

No matters were raised under this item.

EIF/18/48 Consideration of any changes to the corporate / organisational risk register relevant to the remit of the Forum (agenda item 16)

No matters were raised under this item.

EIF/18/49 Items to bring to the attention of Trust Board and other committees (agenda item 17)

This was agreed as:

- Dashboard to be developed
- Staff equality networks - positive update on developments
- Workforce Race Equality Standard (WRES) action plan
- Equality Impact Assessment - showing good improvements

AM advised that the Member's Council had requested an update on equality and diversity which could be given as part of the update on the integrated performance report.

Action: Tim Breedon

EIF/18/50 Work programme (agenda item 18)

The Forum requested an update against the Equality Strategy to be added to the work programme every six months with the next update due in March 2019.

Action: Emma Jones

AB asked if an update was needed in relation to the needs of LGBT in Calderdale. AM asked AB to provide the details outside of the meeting to be considered at the next agenda setting meeting.

Action: Aboo Bhana

EIF/18/51 Date of next meeting (agenda item 19)

The next meeting will be held at 10.30am on Tuesday 5 March 2019 in Meeting room 1, Block 7, Fieldhead, Wakefield.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Minutes of the Mental Health Act Committee Meeting held on 13 November 2018

Present:	Dr Subha Thiyagesh	Medical Director (lead Director)
	Kate Quail	Non-Executive Director (Chair)
	Tim Breedon	Director of Nursing and Quality
	Erfana Mahmood	Non-Executive Director
	Salma Yasmeen	Director of Strategy
Apologies:	Members	
	Laurence Campbell	Non-Executive Director
	Attendees	
	Andy Brammer	Mental Health Act Professional Lead (Wakefield) – local authority representative
	Carol Harris	Director of Operations
	Terry Hevicon-Nixon	Operations Manager - Working Age Mental Health (Calderdale) – local authority representative representative
	Anne Howgate	AMHP Team Leader (Kirklees) – local authority
	Gillian Pepper	Adult Safeguarding Lead (Barnsley) – acute trust
	Victoria Thersby	Head of Safeguarding (Calderdale and Kirklees) – acute trust representative
In attendance:	Shirley Atkinson	Professional Development Support Manager (Barnsley) – local authority representative
	Julie Carr	Clinical Legislation Manager
	Yvonne French	Assistant Director, Legal Services
	David Longstaff	Independent Associate Hospital Manager
	Dr Ovidiu Sandica	Medical Clinical Lead, CAMHS Barnsley and Wakefield
	Sarah Millar	PA to Medical Director (author)
	Stephen Thomas	MCA/MHA Team Manager (Wakefield) – local authority representative
	James Waplington	General Manager (for Carol Harris)
	Sam Young	Non-Executive Director (induction)

MHAC/18/43 Welcome, Introductions and Apologies (agenda item 1)

The Chair, Kate Quail (KQ) 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/18/44 The Act in Practice (agenda item 2)

MHAC/18/44a Use of Legislative Frameworks in CAMHS (agenda item 2.1)

Presentation from Dr Ovidiu Sandica, Medical Clinical Lead for CAMHS Barnsley and Wakefield. The Committee discussed the challenges around partnership working, available facilities and resources and increased pressure on AMHPs. Tim Breedon (TB) reported that SWYPFT had made contact with NHS England to raise concerns around the lack of access

to Tier 4 beds which presented challenges when individuals were assessed as requiring an inpatient bed. It was acknowledged that additional funding was being made available and a Tier 4 unit in Leeds would be built although this was not a solution to the immediate difficulties.

The Committee thanked Dr Sandica for his presentation.

MHAC/18/45 Legal updates (agenda item 3)

MHAC/18/45a NICE guidance assessment of capacity and consent (agenda item 3.1)

Julie Carr (JC) reported that the NICE Guidelines for Decision making and Capacity had been published on 3 October 2018. These had been uploaded to the Mental Capacity Act intranet page. The guidance focused on four key areas:

- Supporting decision making
- Advance care planning
- Assessment of mental capacity
- Best interest decision making

It was noted that there was an emphasis being placed on care planning at the moment in all aspects of healthcare.

JC advised that the Trust Mental Capacity Act Policy and associated documents had been reviewed and amended as required. Implementation of the guidance would be monitored by the Quality Impact Assessment Team and there was a six month period to enable development and delivery of the implementation programme.

The Committee queried the impact on training for clinical staff and it was noted that updated information was available on the intranet and that any updates to the training would be done as part of the implementation programme.

It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.

MHAC/18/45b Briefing – Capacity and the Mental Health Review Tribunal (agenda item 3.2)

JC reported on a recent case where a patient's capacity to bring proceedings before the Tribunal was considered. It was clarified that the patient must understand that they are being detained against their wishes and that the Tribunal is a body that would be able to decide whether they should be released. The Committee noted that this equalised the threshold with the Mental Health Act.

The briefing would be circulated to all Responsible Clinicians and would be incorporated into the February 2019 MHA/MCA mandatory medical staff refresher training. David Longstaff (DL) agreed to provide an update to the next Hospital Managers' meeting.

Action: David Longstaff

It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.

MHAC/18/45c Briefing – Compulsory Medication and CTO's (agenda item 3.3)

JC reported that usually when individuals are under a Community Treatment Orders (CTO), treatment cannot be compelled unless a patient is recalled to hospital. It was noted, however that Section 64(B) (3)(b)(ii) MHA 1983 provided that in rare circumstances treatment may be compelled provided this is authorised by the Court of Protection. JC referred to a case where an application was made to the Court of Protection on the basis that whilst the request was unusual, this was the least restrictive option available and in the best interests of the individuals concerned. The application was supported in this case.

The Committee noted that the briefing would be circulated to all Responsible Clinicians and community teams, to Hospital Managers, Drugs and Therapeutics Committee and the MAV team to review against current Trust policies. The update would also be incorporated into the February 2019 MHA/MCA mandatory medical staff refresher training.

Erfana Mahmood (EM) queried the efficacy of circulating small pieces of information by way of update and whether there would be an expectation on clinicians to have the relevant knowledge that may affect their practice. Yvonne French (YF) advised that whilst the updates are circulated for information, the mandatory training would cover all aspects of MHA/MCA.

It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.

MHAC/18/46 Local Authority and partner agencies (agenda item 4)

Shirley Atkinson (SA) advised that Social Workers in Barnsley had been moved from SWYPFT mental health teams to their own team in the Local Authority. The majority of AMHP resource was now in one place. SA reported experiencing delays with the police and with conveyance by the Yorkshire Ambulance Service. After a meeting with the CCG the Local Authority were considering arranging their own private ambulances. SA also raised an issue around data sharing and that AMHPs need to be able to access and share information. Stephen Thomas (STho) added that there were similar problems in Wakefield.

YF advised that the Trust do have an inter-agency data sharing protocol and agreed to liaise with SA.

Action: Yvonne French

STho referred to capacity and consent and gave two local examples from Wakefield. STho added that the local authority had delivered training in the past and offered to do so again for SPA and IHBT services. It was agreed that James Waplington (JW) would raise the wider issue about patients being capacitous in crisis with the management of IHBT.

Action: James Waplington

It was acknowledged that the collaborative care plans for multiple assessments were useful but that AMHPs were not always aware that they existed.

MHAC/18/47 Minutes of previous meeting held on the 28 August 2018 (agenda item 5)

It was RESOLVED to APPROVE the notes of the meeting held on 28 August 2018 as a true and accurate record of the meeting.

MHAC/18/48 Matters arising (agenda item 6)

MHAC/18/48a Action points (agenda item 6.1)
The action points were noted and one item raised:

- MHAC/18/29 – Terms of Reference would be reviewed as part of the Committee annual review in February 2019.

MHAC/18/48b Consideration of items from the organisational risk register relevant to MHA Committee (agenda item 6.2)
Subha Thiyagesh (ST) advised the Committee that although risks associated with Brexit were a priority for Trust Board, nothing in particular had been assigned to MHAC.

The Committee would be aware of issues that it was anticipated would be resolved by the implementation of SystmOne and be clear on what could be managed. It was noted that YF was engaged with responsible groups and Salma Yasmeen (SY) added that the priority would be for a safe changeover of systems primarily.

MHAC/18/49 Statistical information use of the Mental Health Act (MHA) 1983 and Mental Capacity Act (MCA) 2005 (agenda item 7)

MHAC/18/49a Performance report – Monitoring information Trust wide July-September 2018 (agenda item 7.1)
KQ advised that the review of the performance report was ongoing but this version was shorter and some of the graphs had been removed. There would be more changes made prior to the next meeting.

The report was considered and the following noted:

- Section 49 MCA activity was now being directed solely at consultant psychiatrists rather than the wider MDT. The courts were also asking for much more detail and the estimated time commitment was 10-12 hours. The risk implications would be added to BDU Risk Registers given the potential clinical impact on workload capacity.
- There were three exception reports in relation to use of Part 2 and 3 of the MHA. It was noted that refresher Receipt and Scrutiny training had been delivered by the MHA Office Manager at the request of a Ward Manager.
- Of four detentions that were found to be unsafe, three were as a consequence of the medical recommendations not passing medical scrutiny. The Committee discussed the levels of scrutiny involved in medical recommendations and ST added that there is usually a difference of opinion. It was agreed that JC would draft a checklist to ensure consistency which would be agreed at Committee.

Action: Julie Carr

- Hospital Managers' Compliments and Concerns had been included in the performance report for the first time.
- All SOAD requests were up to date, with the one month standard agreed with the CQC being met.
- There had been a notable decrease in DoLS applications given the changes to the physical health services in Barnsley.
- There had been two deaths of detained patients in Quarter 2 and both were subject to Serious Incident investigations.
- There had been one formal complaint raised by an MP in relation to a patient subject to a Section 3 detention which had been resolved.

Recommendations:

- Request the opinion of the BDUs of reasons for the diminishing rates of applications for appeals to both Hospital Managers and the Tribunal. The Committee agreed that JC would put together a proposal paper to consider potential factors for the reduction in applications.

Action: Julie Carr

- Request an opinion from the BDUs for the increase in length of stay and the impact on the use of the MHA 1983.
- Request that the Calderdale and Kirklees BDU keep under review the level of internal transfer activity between the two inpatient units for the BDU and the impact that this may have on patients' rights. It was agreed that the Committee would take a risk based approach to this.
- To accept the assurances provided to the exception reports.

It was RESOLVED to RECEIVE the findings of the monitoring report and APPROVE the recommendations within the paper.

MHAC/18/49b Local Authority Information (agenda item 7.2)
Figures were received from the Local Authority in Kirklees and noted by the Committee.

There was nothing of note from Barnsley or Wakefield.

MHAC/18/50 CQC compliance actions (agenda item 8)

MHAC/18/50a MHA Code of Practice action plan (agenda item 8.1)
YF provided an update on the development of policies to ensure compliance with the Code of Practice:

- Transporting patients under the Act – this had been approved at Operational Management Group on 12 September 2018.
- The outstanding policies have taken longer because they are multi-agency. Their development was being lead by other organisations. The policies were:
  - 136 MHA policy – South Yorkshire and West Yorkshire had developed working documents with proposed changes and these were out for consultation.
  - Joint local policies for admission to hospital.
  - Local Partnership arrangements to deal with people experiencing mental health crisis.

It was RESOLVED to RECEIVE the update.

MHAC/18/50b MHA/MCA/DoLS mandatory training update (agenda item 8.2)
YF reported the current position as:

- Mental Capacity Act/DoLS training – 91% compliant
- Mental Health Act training – 88% compliant

against an 80% target.

It was noted that there had been a minor administrative issue around recording which would be resolved shortly.

YF reported that the training plan in relation to the Deprivation of Liberty draft bill was in the final stages of being developed.

It was RESOLVED to RECEIVE the report and to NOTE the level of compliance with mandatory training target and plans for future training.

MHAC/18/51 Audit and Compliance Reports (agenda item 9)

MHAC/18/51a Community Treatment Audit (agenda item 9.1)

JC reported that the response rate of 87% for the CTO patients' rights audit for 2018 was a significant improvement on the previous year's rate of 26%. JC had met with the Audit Team to consider the level of assurance sought by the CQC.

The Committee noted the audit findings that 93% of patients were subject to Section 3 of the Mental Health Act and the inconsistency in terms of practice in different BDUs. It was acknowledged that this most likely related to the judgement of Responsible Clinicians and it was suggested that this should be explored further in order for the Committee to understand the discrepancy and identify the reasons for the inconsistency of practice. It was noted, however that this was a national issue and there was no evidence that outcomes differed based on individual patients and teams. JC added that this is a matter under the remit of the Mental Health Act Review, the outcome of which was awaited.

Next steps:

- The audit would be circulated to the BDUs for review and development of action plans. The Committee queried how the action plans would be monitored in the year between audits and Tim Breedon (TB) gave assurance that these would be performance managed.
- For CTO patient's rights to remain on the MHA Committee annual work plan for 2018 to be assured of the continued level of compliance.
- For a future audit to develop a more detailed understanding of the reiteration of rights.

It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.

MHAC/18/51b Annual Review Hospital Managers (agenda item 9.2)

JC reported on the findings from the Annual Independent Hospital Managers Review. It was noted that a number of Hospital Managers had stepped down in the last year and DL advised that there were a sufficient number of staff to manage the activity and that this was kept under regular review.

Next steps:

- To keep under review over the coming year the potential for further recruitments.
- To develop an annual training programme to support the Forum, based on legislative changes and areas of practice identified through the Hospital Managers annual reviews.
- To collate the findings from the annual reviews to inform a 'You said we did' report to be presented at the Forum.

The Committee RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.

MHAC/18/51c Escalation process CQC visits (agenda item 9.3)
YF reported that the escalation process had been implemented at the request of the MHA Committee to provide assurance between MHAC and the Clinical Governance Committee in relation to CQC action plans and visits. The process had been reviewed by Carol Harris, Director of Operations and no changes had been made.

KQ queried the reason for implementation of the process and TB advised that there had been a process in place previously but we did not have appropriate sight of the data. This process had successfully tightened the links between the two committees.

The Committee RESOLVED to NOTE the update.

MHAC/18/52 Care Quality Commission visits (agenda item 10)

MHAC/18/52a Visits and summary reports received in Quarter 2 (agenda item 10.1)
YF reported that there were 10 CQC Mental Health Act visits in Quarter 2.

Within the quarter, 8 MHA monitoring summary reports were received relating to ward visits made to; Willow, Ashdale, Ward 19 (male), Johnson, Newhaven, Priestley, Thornhill and Walton.

4 responses were submitted to the CQC; Willow, Ward 19 (male), Johnson and Newhaven.

The Committee received detailed information about the outstanding issues.

EM raised that there appeared to be a number of recurring themes and queried the detail behind these. YF advised that this was a very high level summary of a massive action plan that used to come to Committee but was deemed to be too detailed for this meeting. EM suggested that it might be useful for Committee to be sighted on the top issues including information on who was dealing with them and how they were being resolved. YF and EM agreed to meet to discuss this further.

Action: Yvonne French/Erfana Mahmood

It was RESOLVED to RECEIVE the report and to NOTE the update.

MHAC/18/52b Outstanding Actions/Progress Report Quarter 2 – Clinical report (agenda item 10.2)
YF reported that the following 3 actions had been outstanding for above 12 months:

- WIFI access
  Four wards did not have access to WIFI – Lyndhurst, Enfield Down and Wards 18 and 19 in Dewsbury. YF reported that there were plans for a new WIFI server at the end of the financial year and EM asked to meet with YF to discuss how the Committee could be assured that this issue was being satisfactorily resolved.

  Action: Yvonne French/Erfana Mahmood

  It was noted that there were no plans to install WIFI at Lyndhurst and consideration was being given to installing a couple of desktop computers as an alternative.

- Newton Lodge
  Observation panels (bedrooms) had been chosen. Funding agreed by EMT and schedule of work in place – expected time of completion 2019.
- Poplars
  Environmental review – this was part of the transformation work for Older Peoples Services. Committee noted that there were two important elements to this work; one had been completed and the other had been submitted as a minor capital bid.

It was RESOLVED to RECEIVE the update and to NOTE the completed actions and progress of outstanding actions.

MHAC/18/53 Monitoring Information (agenda item 11)

MHAC/18/53a Hospital Managers' Forum Notes 4 September 2018 (agenda item 11.1)

The Committee received the notes of the last Forum. DL raised an issue with the new Tribunal Room located in the Unity Centre being very noisy. YF had asked Estates if the room could be sound proofed.

It was RESOLVED to NOTE the update.

MHAC/18/54 Key Messages to Trust Board (agenda item 12)

The key issues to report to Trust Board were agreed as:

- Committee being briefed on the use of the legislative framework in CAMHS
- Positive message around the good compliance with CTOs
- CQC visits – improve performance management of those
- Ethnicity recording
- Section 49 requests
- Sharing of information with AMHPs (Local Authority)

KQ suggested, after discussion with non-executive colleagues, that it would be useful to contribute some MHA related sections to the Integrated Performance Report so that Board is sighted on key messages from the Committee.

Action: Kate Quail

MHAC/18/55 Date of next meeting (agenda item 13)

The next Committee meeting will be held on 12 March 2019 in Meeting Room 1, Block 7, Fieldhead Hospital, Wakefield from 2.00-4.30 pm.

Notes from the

West Yorkshire Mental Health Services Collaborative Committees in Common (WYMHSC C-In-C)

held Thursday 4 October 2018, 10.30-11.30, MR 7, Block 7, SWYPFT, Fieldhead Hospital, Wakefield, WF1 3SP

Present: Sue Proctor (Chair), Sara Munro, Brent Kilmurray, Emma Fraser, Angela Monaghan, Rob Webster, Neil Franklin, Cath Hill.
In attendance: Lucy Quirk (notes)
Apologies: Mike Smith, Thea Stein

Glossary of acronyms in this document can be found on page 4.

Item	Discussion / Actions	By whom
1	**Introductions:** S Proctor welcomed the group and noted apologies as above. S Proctor reminded people that this is a shortened meeting.	
2	**Declaration of Interests Matrix / Conflict of Interest:** C Hill presented the paper. With the exception of a duplicated entry, the matrix was accepted as an accurate record. The updated matrix will be presented to members at the next meeting.	
3a	**Review of Previous Minutes:** The notes from the previous meeting held 30 July were accepted as an accurate record.	
3b	**Actions from previous meeting:** The log had been updated with progress to date and brief updates provided for the open actions: Action 1/9 – Strategic mapping of services: Proposal is to keep members advised of progress as this will feature as part of a bigger piece of work across the system looking at clinical services and pathways and the relationship between WY&H and local place. Action 2/7 – Draft communications plan is not at the stage to present to the group as planned. Trust communications leads met in September but further work is required on the plan. Currently drawing on available resources including extra support offered from the ICS central team. Action 7/7 – Members agreed the NEDs engagement day originally scheduled for January 2019 should take place late March/early April to ensure we can incorporate detail of the long term plan. **ACTION 1/10**: Agenda for NED's engagement event to be added to workplan for January.	**LQ**
3c	**Dementia improvement work:** Following the presentation to the group in July from Public Health England, work underway on dementia service improvement has been collated on a local and West Yorkshire level and presented as a pack to the group. The group held a brief discussion concluding that dementia will not become part of the programme workstreams as it is a local place based development but there are advantages in pooling intelligence and sharing activities underway in each trust. Members concluded that any remaining data will be added to the pack to provide a baseline should the need for collective work arise and can also contribute to the older peoples part of the WY&H clinical strategy. **ACTION 2/10**: BDCFT and Leeds dementia updates to be added to the dementia pack. **ACTION 3/10**: A dementia update on the expectations and progress to be fed back to the group as it develops. As well as how we are linking with the WY&H older people aspect of the clinical strategy.	**LQ/ LCH** **EF**
4	**Relationships & Communication: Local issues and context** **LYPFT- Sara Munro:** Experiencing continued pressure with out of area placements (OAP). A big engagement exercise was has been undertaken and the redesign of community mental health services signed off. A business case is being developed as part of influencing commissioning intentions for next year. The Board have agreed, subject to certain caveats, that an improved control total will be submitted.	

Item	Discussion / Actions	By whom
	A meeting set up to establish the detail of the upcoming health and safety executive inspection. Also part of the Leeds system CQC inspection who are tracking cases of people over 65 and those with dementia. The Leeds Love Arts Festival launching today through to 13 October. **LCH – Neil Franklin:** A large multi-agency working group are looking at the new IAPT contract for the city with a focus on co-production of the delivery of the contract. Arrangements in place to build the new CAMHs T4 unit which will total 22 beds. Discussions underway as to how it is going to be delivered, including potential s136 provision. The first meeting of the Leeds providers Committees in Common was held and also the new Committees in Common was launched; between LCH and the GP confederation (looking to develop a wider involvement including mental health going forward). **BDCFT – Brent Kilmurray**: Signed up to a stretch in terms of the control total of £100k. A new organisational structure has been signed off; the director of nursing and operations role will be split and a new chief operating officer role created. The current business units will be reorganised into 2 care groups. Looking at an investment in a trust system wide QI approach and methodology with external support to train a number of senior leaders. Crowd sourcing company Clever Together have been utilised to help with the development of a new organisational strategy. Responding to the procurement of the 0-19 children's services is going to be testing in terms of its impact. **SWYPFT – Rob Webster:** Phase 2 of the trust's estates plan completed with the new inpatient acute facilities now open at Fieldhead. Phase 3 about to commence at the same time as the ATU upgrade. SWPFTs estate strategy is to develop community hubs and 2 main hospital sites. Finances on track with the exception of out of area beds which is a significant problem. Control total at risk therefore not appropriate to get an extra stretch target. 60% of people admitted to acute beds in Calderdale have not been known to services before. CAMHS high on the national agenda, recognising that there is a significant problem in terms of pressure. Huge piece of work completed with partners around children's services and the role of CAMHS. Continued escalation to NHSE regarding children admitted to adult beds. The trust is continuing to play a significant role in the two integrated care systems. Agreed with partners in Wakefield to create a provider alliance; SWYPFT to be the lead provider. Series of workshops underway in Barnsley to look at all services; debate whether mental health is embedded into community services or specialist that community services buy into. A portfolio review completed and restructuring to a single director of operation and may be subsequent restructuring of the delivery units too.	
5 **5a**	**Business and Strategy:** **Integrated Care System (ICS) update:** R Webster provided a progress update including: • As an ICS now get invited to national groups with NHSE, NHSI, and CQC etc. • Positive feedback received that we are in a good place and ahead of other programmes; NHSE want to work alongside us to put a case study/toolkit together for others to use. • Nationally exploring how financial flaws and risks will work in the ICS • Inputting into the MH and LD programmes for the 10 year plan • First peer review of a placed based system taking place in Wakefield using local government framework • MoU been through vast majority of boards some minor textual changes then each of the boards will receive a final copy. • Partnership Board being finalised and seeking a council chair • Membership for the System Oversight and Assurance group agreed; there will be a chair, vice chair and S Munro will be the lead mental health Chief Executive. Members acknowledged the amount of work underway and the stretch in capacity of all the teams;	

Item	Discussion / Actions	By whom
	and gave credit to this work and the commitment to the principles and values of the programme. Members also noted the excellent communications from the central team, which we need to build on and incorporate into this programme.	
5b	**<u>Programme Delivery report:</u>** E Fraser presented the report which provided high level progress to date and highlighted key areas to the group: • The Executive Group have agreed to get external support for the acute pathway/OOA work to further test the collective opportunities to support the work already taking place locally • Seen good early performance around the NCM's for both ED and CAMHS; additional investment into local CAMHS team been agreed. The eating disorder service (CONNECT) have been nominated for a national award next week. • LD assessment treatment work progressing well; a focussed discussion will be brought back to this group in January. • Secured additional resource from the ICS transformation money for 2018/19; the allocation will be prioritised by the Programme Board taking into consideration the ongoing challenge of capacity for the programme. • Agreed the four trusts will underwrite the costs in terms of ensuring the right capacity into the programme with a view that there will be future in year transformation funding. • Work underway to recruit to a small core transformation/programme team as well as exploring how we utilise existing capacity and expertise within the trusts. The group discussed further with the following points and actions captured: • Performance framework work underway • Confirmed that the RAG rating status is based on delivery and progress, rather than actual change and outcome at this stage. • Some disconnect with staff; the joint Exec team workshop on 18th October will help translate strategic aspects into what is happening on an operational level. It was noted that the programme doesn't touch all service areas. **ACTION 4/10**: The differing levels of staff/service involvement in the programme to be reflected in the communication's plan. **ACTION 5/10**: Current progress against set delivery targets to be brought back to this group. **ACTION 6/10**: The SRO to be added into the delivery report. **ACTION 7/10**: Specific item on risk to be included on January's agenda/add to workplan. Members noted the programme report and the planned refinement in future reports.	**EF/ Comms lead** **EF** **EF / LQ** **EF / LQ**
7	**Any other business:** A Monaghan raised a question around the NHS 10 year plan and how it will feed into the programme. A progress update was provided in that individual trusts responded directly and a collaborative response was also submitted. The WY&H strategy will have to encompass all of the long term plans and then distil into what it means in terms of MH and LD. The key principles will remain the same i.e. doing once at WY level/ local place. R Webster attending a meeting 17 October in London to share what the current compiled plan looks like.	
8	**Summary (including actions) and items for escalation:** No items for escalation were noted. Actions were summarised throughout the meeting. S Proctor acknowledged that although this meeting was condensed it provided assurance that the programme is moving in the right direction.	
	<u>Date and Time of Next Meeting</u>: The next meeting date is Tuesday 8 January, 2.00-4.00, MR 1&2, LYPFT, Trust HQ, Thorpe Park, Leeds, LS15 8ZB.	

Item	Discussion / Actions	By whom

Glossary

ATU	Assessment and Treatment Unit
BDCFT	Bradford District Care NHS Foundation Trust
CQC	Care Quality Commission
CAMHS	Child and Adolescent Mental Health Services
ED	Eating Disorder
IAPT	Improving Access to Psychological Therapies
ICS	Integrated Care System
LD	Learning Disabilities
LCH	Leeds Community Healthcare NHS Trust
LYPFT	Leeds and York Partnership NHS Foundation Trust
MH	Mental Health
MoU	Memorandum of Understanding
NCM	New Care Model
NED	Non-Executive Director
NHSE	NHS England
NHSI	NHS Improvement
OOAP	Out of Area Placements
QI	Quality Improvement
RAG	Red, Amber, Green (rating)
SWYPFT	South West Yorkshire Partnership NHS Foundation Trust
WYHHCP	West Yorkshire & Harrogate Health and Care Partnership
WY&H STP	West Yorkshire & Harrogate Sustainability and Transformation Partnerships (internal reference to WYHHCP)
WYMHSC	West Yorkshire Mental Health Services Collaborative

South West Yorkshire Partnership NHS Foundation Trust

Minutes of the Workforce and Remuneration Committee held on 23 October 2018

Present:	Rachel Court	Non-Executive Director (Chair)
	Angela Monaghan	Chair of the Trust
	Charlotte Dyson	Non-Executive Director
	Rob Webster	Chief Executive
In attendance:	Erfana Mahmood	Non-Executive Director
	Sam Young	Non-Executive Director
	Alan Davis	Director of HR, OD and Estates
	Janice White	PA to Director of HR, OD and Estates (author)

WRC/18/49 Welcome, Introductions and Apologies (agenda item 1)

The Chair, Rachel Court (RC) welcomed everyone to the meeting and it was noted that there were no apologies.

WRC/18/50 Declaration of Interests (agenda item 2)

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

WRC/18/51 Minutes of the meeting held on 3 July 2018(agenda item 3)

It was RESOLVED to APPROVE the minutes of the meeting held on 3rd July 2018 subject to the following amendment: WRC/18/46 Annual Work Programme *(agenda item 17), wording should read Gender Pay Gap instead of Agenda Pay Gap.*

WRC/18/52 Matters arising (agenda item 4)

The Committee discussed the schedule of matters arising and the following point was made:

a. WRC/18/36 Minutes of the Meeting held on 8th May 2018
It was noted that the minutes were re-circulated by email and approved.

b. WRC/17/51 Recruitment of NEDs to sit on Appeals and Consultant Recruitment Panels
It was agreed that AGD would bring a proposal to the WRC meeting in February 2019.
Action: Alan Davis

c. WRC/17/58 Workforce Strategy 2017/18 – NHS Staff Survey and Action Plan
It was noted that an updated action plan will come to the WRC in March/April, then go to the Trust Board.
Action: Alan Davis

AM asked if any action had been taken at Wetherby YOI following the Middleground session, where an individual had raised some concerns about the culture there. AGD informed the Committee that he had spoken to both Andrew Cribbis and Carol Harris about undertaking some development work with the team along the lines of that undertaken with the Kirklees IAPT team. AGD reported that Carol has had a subsequent conversation with Sue Threadgold and whilst this work was supported, the issue was timing.

CD mentioned that it is important that we learn from the issues, particularly what we need to consider when bidding for remote services.

RC mentioned that there was a lot of workforce related issues coming out of Middleground and asked if there was a process at the end of the programme of bringing together all the common themes. AGD said Andrew Cribbis is collating information at the end of each workshop and where appropriate feeding it back after the session to the relevant manager/director. He said that recruitment and retention has had a lot of coverage and that this is being fed back into the recruitment and retention task group. RC mentioned that it would be useful if there was a process of pulling together themes in general. AGD agreed to look at this with Andrew.

AM mentioned that when the evaluation is complete it would be helpful if it came back to this Committee.

Action: Alan Davis

AM asked in terms of addressing the gender pay gap in the Clinical Excellence Awards what was being done to encourage female consultants to apply for an award. AGD said that there had been discussions with the local BMA committee about them encouraging female consultants to apply and the importance of clinical leads supporting doing the same. It was agreed to await the outcome of this round of awards and monitor the process to see the number of awards to female consultants.

WRC/18/53 Workforce Strategy: 2018/2019 Action Plan (agenda item 5)

AGD presented the paper and informed the Committee that good progress had been made with most areas being rated as either achieved or on target. He commented that the annual BDU workforce planning workshops to support the continuous development of the Trust's strategic workforce plan have been rescheduled to January pending the operational management structure. AGD said that he had been really encouraged by the importance that the BDUs were placing on these workshops. RC mentioned that it would be helpful to have feedback from the workshops. AGD agreed to provide a further update at the next meeting.

Action: Alan Davis

AGD mentioned that results of the Robertson-Cooper Asset Survey had been published and a high level action plan agreed and also that BDUs were working on local actions in response to staff feedback. He informed the Committee that the follow up solution groups organised for September had to be cancelled due to poor attendance and that they are being rearranged for later in the year. The Committee felt that we might need to relook at the time of the solution groups and suggested possibly using team meetings or other forums.

RW mentioned with the implementation of system one, the focus on mandatory training and not being allowed to carry over annual leave this could have all had an impact on staff release.

AGD mentioned that local wellbeing groups have already been established in Forensic, Estates and Facilities, Calderdale and Kirklees and that Barnsley, Wakefield and Specialist Services will come on stream later in the year.

AGD informed the Committee that Estelle Myers has been working one day a week in the freedom to speak up role since March and this has been key in taking this important agenda forward. Whilst the day a week dedicated time has allowed Estelle to progress matters, the

FSUGs believe more dedicated time is still required. AGD mentioned that a FSUG action plan has been developed with the Guardians, which has gone to the Executive Management Team (EMT) and also a business case is being finalised for a 0.5wte freedom to speak up guardian post as a secondment opportunity. It was noted that Estelle has recently held some drop in sessions and there are some further sessions planned.

AGD mentioned that a clinical network on reducing harassment and bullying from service users and carers has been launched with police input. AGD stated there have been some very constructive and positive discussions with staff side and the extended EMT about adopting a new and different approach to preventing bullying and harassment. In these discussions it was recognised that a policy in itself will not solve these issues and that a framework to focus on prevention of bullying and harassment is being finalised, which engages everyone in the solution. An update will come to the next Workforce and Remuneration Committee (WRC) meeting.

Action: Alan Davis

AGD mentioned to the Committee that we are slightly behind where we planned to be on talent management, coaching and mentoring. It was noted in respect of talent management the appraisal scheme is being revised for next year to facilitate better talent conversations. In terms of coaching and mentoring a number of actions have taken place but these need to be brought together in a framework to ensure a broader organisational focus.

RW stated that we have achieved a lot of what we said we would do but we needed to understand the impact and ensure there are good links with the Equality and Inclusion Forum. AGD said that we would be updating the Workforce Strategy Dashboard, which is based on some of the outcome measures developed by Dr Michael West, in April.

Action: Alan Davis

The Committee discussed the importance of ensuring that the equality and diversity agenda has a clear action plan which includes the Workforce Race Equality Scheme. The Committee felt the equality and diversity agenda was a mixed picture for example BAME staff are the most positive within the staff survey but also have the highest reported rate for bullying and harassment. It was agreed that it is vital that the Trust keeps this as an organisational priority.

EM and SY commented that given they had not been involved previously it was difficult to understand the actions and how they were RAG rated. They felt it would be helpful at a future meeting to have a bit more detail on the actions and an understanding of their impact. AGD said the monitoring of the impact was through the Workforce Strategy Dashboard which the Trust is prototyping and will come back to a future meeting.

It was RESOLVED to NOTE and COMMENT on the Workforce Strategy 2018–2019 Action Plan.

WRC/18/54 Organisational Development Strategy 2018/2019 Action Plan (agenda item 6)

AGD presented the update of the OD action plan and informed the Committee that the Executive Management Team (EMT) had spent some time going through this action plan. He felt that this year's plan placed a greater emphasis on the system and structural transformation and the 19/20 strategy and plan is likely to focus more on organisational culture.

RW felt the update showed the substantial amount of work that has gone on this year. In terms of structure RW highlighted that the Deputy Chief Executive role is now in place, there is a single Director of Operations supporting BDUs to work together as a one team and a Director of Provider Development supporting key developments in West Yorkshire. He said that Carol, Subha and Tim are now working as the executive trio with an oversight on the CQC action plan.

AGD confirmed that Carol is finalising the details of the job descriptions and consulting with Staff Side within the next few weeks on the changes to the inpatient structure.

RW said that the financial recovery plan was an important part of the OD plan and we are on track with this in accordance with the Trust Board agreed timetable.

AM asked how the new appraisal system is being evaluated. AGD said that the general feedback was staff like it better than the previous one as it is easier to use and has a clearer link to the Trust's values. It was noted that the Staff Survey results will be used as a key part of the evaluation.

RC said that the OD plan touches a number of different workstreams which cut across a number of different forums/committee and it would be helpful to understand this.

AGD is asked to find out which forum is doing oversight work for each area in the OD plan.

Action: Alan Davis

It was RESOLVED to NOTE and COMMENT on the Organisational Development Strategy 2018–2019 Action Plan.

WRC/18/55 Strategic Workforce Plan (agenda item 7)

AGD presented the paper and informed the Committee that there continues to be significant supply issues within the NHS which is causing all Trusts major difficulties in staffing clinical services. He said that there has been a lot of work on the recruitment of newly qualified nurses from the Universities which has proved to be successful but we still have a number of vacancies. It was noted that there has been a slow-down in retirements and an increase in people retiring and returning. The Committee recognised that there were some good early signs and it is clear some of the actions are already starting to work, however, turnover was still a major concern and work needs to continue to reduce this.

It was RESOLVED to CONSIDER and SUPPORT the recommendations.

WRC/18/56 Interim 2017/2018 Pay Audits based on Gender, Ethnicity and Disability (agenda item 8)

AGD presented this paper and informed the Committee that this was designed to give them a very early sight of the results on the pay audits undertaken by the Trust and that a more detailed paper will come to the February's WRC. AGD said that although the Trust is only required to undertake a gender pay audit, it had decided as part of the EDS2 and the WRES joint action plan to extend the audits to cover ethnicity and disability.

The Committee discussed the initial results and noted a more detailed paper with suggested actions will come to February's meeting.

AGD confirmed that the Trust is required to only publish the results of the gender pay audit by the 31st March 2019.

Action: Alan Davis

It was RESOLVED to NOTE the interim report and that an action in response to the Findings will be presented in February 2019.

WRC/18/57 Human Resources Exception Report (agenda item 9)

AGD presented the report.

Recruitment and Retention

AGD informed the Committee that there are positive trends and a lot of action is underway including: a series of workshops run with staff in areas of high turnover; and a review of the recruitment process to ensure it is streamlined and lean.

The Committee recognised all the work that is going on and that recruitment and retention must continue to be a priority area for the workforce and annual plan.

Sickness Absence
AGD informed the Committee that absence is better than the same time last year and we continue to perform well when compared to other similar Trusts in Yorkshire and Humber The Extended EMT workshop had been very helpful in both engaging staff in the areas for further work and identifying what else we can due on staff health and wellbeing.

The Committee recognised that there were positive signs in Calderdale, Barnsley and Wakefield but felt Forensics was still an area of concern. It was agreed in the next exception report to look at the issues in Forensic in a bit more depth including the impact of managing violence and aggression.

Action: Alan Davis

Agency Expenditure
AGD informed the Committee that agency expenditure is still increasing and we are projecting to breech the cap. AGD said that the biggest issue remains medical locums particularly in specialist services. It was noted that reducing agency spend is part of the financial recovery plan and that a number of actions are planned including potential for oversea recruitment and the development of new advance practitioner roles to replace some hard to fill medical posts.

It was RESOLVED to NOTE the HR Exception Report.

WRC/18/59 Directors Objectives Update (agenda item 11)

Rob Webster reminded the Committee that these are summaries of the Directors Objectives which are placed on the Trust's website and mentioned that as line manager he keeps more detailed objectives for each Director. He also said that we are getting to the period for mid-year reviews for Directors.

The Committee commented on the paper as follows:

Subha Thiyagesh, Medical Director – RW mentioned that exec lead on medical education is Professor Steve Curran.

Salma Yasmeen, Director of Strategy - It was commented that there is no mention of Charitable Funds.

Action: Alan Davis

It was RESOLVED to NOTE and COMMENT on the Directors Objectives Summaries Report.

WRC/18/60 Clinical Excellence Award Scheme Update (agenda item 12)

AGD informed the Committee that all the papers have now gone out in respect of the Clinical Excellence Award Scheme and will be scored in the next two weeks to decide on the awards. The Medical Director from Rotherham, Doncaster and South Humber NHS Foundation Trust (RDASH) is the external assessor. He said that Subha Thiyagesh is applying for an award and Adrian Berry is stepping in as Medical Director on the panel. RW confirmed the fact that because we have points to give this doesn't necessarily mean we give them. AGD informed the Committee that there have been 14 applicants for the 2016 awards and 21 applicants for the 2017 awards.

It was RESOLVED to NOTE the update.

WRC/18/61 Freedom to Speak Up Guardian Update (agenda item 13)

The Committee had previously touched on this earlier in the meeting.

It was RESOLVED to NOTE the update.

WRC/18/63 Workforce Risk Register (agenda item 15)

The Committee reviewed the risk register and noted a number of areas had already been discussed earlier in the meeting.

The Committee said that the risk on sickness absence should be reviewed at the next meeting to see if the Forensic situation needs strengthening.

Action: Alan Davis

It was RESOLVED to AGREE the Workforce Risk Register subject to the actions discussed being added.

WRC/18/64 Annual Work Programme (agenda item 16)

The Committee commented that the OD Strategy runs out in 2019 and is on the Annual Work Programme to be discussed at the meeting in April 2019.

Action: Alan Davis

It was RESOLVED to AGREED the Annual Work Programme subject to *Agenda Pay Gap* be amended to read *Gender Pay Gap* and add *Including PRP* be added to *Directors Remuneration.*

WRC/18/65 Matters to report to the Trust Board and other Committees (agenda item 17)

These were agreed as:

- Workforce Strategy 2018/2019 Action Plan Update
- Organisational Development Action Plan 2018/2019 Update
- Strategic Workforce Plan Update
- Extension of Pay Audit to cover ethnicity, disability as well as gender
- Update received on recruitment and retention, sickness absence and agency spend
- Directors Objectives Progress Update
- Risk Register updated with additional actions and timescales

WRC/18/66 Any Other Business (agenda item 18)

The Committee asked for a meeting to be organised to discuss induction requirements for Non-Executive Directors to include Rachel Court, Sam Young and Alan Davis.

Action: Janice White

WRC/18/67 Date and Time of next meeting

The next meeting will be held at 10.30am on 12th February 2019 in the Chair's office, Block 7, Fieldhead Hospital.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of the Workforce and Remuneration Committee held on 18 December 2018

Present:	Rachel Court	Non-Executive Director (Chair)
	Angela Monaghan	Chair of the Trust
	Charlotte Dyson	Non-Executive Director
	Rob Webster	Chief Executive
In attendance:	Sam Young	Non-Executive Director
	Alan Davis	Director of HR, OD and Estates
	Janice White	PA to Director of HR, OD and Estates (author)

WRC/18/68 Welcome, Introductions and Apologies (agenda item 1)

The Chair, Rachel Court (RC) welcomed everyone to the meeting.

WRC/18/69 Declaration of Interests (agenda item 2)

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

WRC/18/71 Clinical Excellence Awards (agenda item 4)

AGD introduced a paper detailing the breakdown of candidates for clinical excellence awards by service, ethnicity and gender. He said the process was very robust and there had been constructive discussions which included an external assessor from Rotherham, Doncaster and South Humber Hospitals NHS Foundation Trust (RDASH). He said that each of the panel members received the application forms individually and scored them independently. The Awards Panel then met together on the 28th November 2018 and discussed the results of the individual scores in a lot of detail. He informed the Committee that after careful consideration the panel agreed to recommend 5 awards for 2016 and 7 awards for 2017. In terms of the gender pay gap there was a higher number of awards for female consultants than in previous years for 2016 and for 2017 this was about the same as previous years.

CD said she is happy that there is a robust process in place but mentioned there was a low number of Consultant applicants for the awards and asked if we have the right process in place. AGD said there is a new scheme for future awards and that the Trust with the BMA will be reviewing the whole process to ensure it promotes excellence.

AM said it is worth noting that we don't allocate the minimum number of awards in each year.

AGD informed the Committee that individuals who have received an award will be advised that they might want to take advice in view of the pension changes and that their applications will be published on the intranet.

RW said that the external assessor offered to come back to do a workshop for consultants on what a successful application would look like.

Action: Alan Davis

It was RESOLVED to RATIFY the recommendations of the Clinical Excellence Awards Panel for the 2016 and 2017 clinical excellence awards as detailed in the paper.

WRC/18/48 Date and Time of next meeting

The next meeting will be held at 10.30am on 12th February 2019 in the Chair's office, Block 7, Fieldhead Hospital.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 March 2019
Agenda item 12

Title:	**Use of Trust Seal**
Paper prepared by:	Company Secretary on behalf of the Chief Executive
Purpose:	The Trust's Standing Orders, which are part of the Trust's Constitution, require a report to be made to Trust Board on the use of the Trust's seal every quarter. The Trust's Constitution and its Standing Orders are pivotal for the governance of the Trust, providing the framework within which the Trust and its officers conduct its business. Effective and relevant Standing Orders provide a framework that assists the identification and management of risk. This report also enables the Trust to comply with its own Standing Orders.
Mission/values:	The paper ensures that the Trust meets its governance and regulatory requirements.
Any background papers/ previously considered by:	Quarterly reports to Trust Board.
Executive summary:	The Trust's Standing Orders require that the Seal of the Trust is not fixed to any documents unless the sealing has been authorised by a resolution of Trust Board, or a committee thereof, or where Trust Board had delegated its powers. The Trust's Scheme of Delegation implied by Standing Orders delegates such powers to the Chair, Chief Executive and Director of Finance of the Trust. The Chief Executive is required to report all sealing to Trust Board, taken from the Register of Sealing maintained by the Chief Executive. The seal has been used three times since the report to Trust Board in December 2018 in respect of the following: ➢ Contract extension – second supplement agreement between the Borough Council of Calderdale and the Trust for the provision of public health services – Calderdale Stop Smoking Service. ➢ Sale contract and transfer: Mount Vernon Hospital, Barnsley – between the Trust and Orion Homes Ltd (condition on planning permission). ➢ Lease for dental service at New Street Health Centre, Barnsley between the Trust and Rotherham FT.
Recommendation:	**Trust Board is asked to NOTE use of the Trust's seal since the last report in December 2018.**
Private session:	Not applicable.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board annual work programme 2018-19

Agenda item/issue	Apr	June	July	Sept	Oct	Dec	Jan	Mar
Standing items								
Declaration of interest	✘	✘	✘	✘	✘	✘	✘	✘
Minutes of previous meeting	✘	✘	✘	✘	✘	✘	✘	✘
Chair and Chief Executive's report	✘	✘	✘	✘	✘	✘	✘	✘
Business developments	✘	✘	✘	✘	✘	✘	✘	✘
STP / ICS developments	✘	✘	✘	✘	✘	✘	✘	✘
Integrated performance report (IPR)	✘	✘	✘	✘	✘	✘	✘	✘
Assurance from Trust Board committees	✘	✘	✘	✘	✘	✘	✘	✘
Receipt of minutes of partnership boards	✘	✘	✘	✘	✘	✘	✘	✘
Question from the public	✘	✘	✘	✘	✘	✘	✘	✘
Quarterly items								
Corporate/organisational risk register	✘		✘		✘		✘	
Board assurance framework	✘		✘		✘		✘	
Customer Services quarterly report (now patient experience report included in IPR from quarter 1)	✘		✘		✘		✘	
Guardian of safe work hours (now included in IPR)	✘		✘		✘		✘	
Serious incidents quarterly report		✘		✘		✘		✘
Use of Trust Seal		✘		✘		✘		✘
Corporate Trustees for Charitable Funds# (annual accounts presented in July)	✘		✘		✘		✘	
Half yearly items								
Strategic overview of business and associated risks	✘				✘			
Investment appraisal framework (private session)	✘				✘			
Safer staffing report	✘				✘			
Digital strategy (including IMT) update	✘				✘			
Estates strategy update			✘				✘	
Annual items								
Draft Annual Governance Statement	✘							

Agenda item/issue	Apr	June	July	Sept	Oct	Dec	Jan	Mar
Audit Committee annual report including committee annual reports	✘							
Compliance with NHS provider licence conditions and code of governance - self-certifications *(date to be confirmed by NHS Improvement)*	✘							
Risk assessment of performance targets, CQUINs and Single Oversight Framework and agreement of KPIs	✘							
Review of Risk Appetite Statement	✘							
Annual report, accounts and quality accounts - update on submission		✘						
Health and safety annual report		✘						
Customer Service annual report		✘						
Serious incidents annual report		✘						
Equality and diversity annual report			✘					
Medical appraisal/revalidation annual report			✘					
Sustainability annual report				✘				
Workforce Race Equality Standard (WRES)					✘			
Assessment against NHS Constitution						✘		
Eliminating mixed sex accommodation (EMSA) declaration								✘
Information Governance toolkit								✘
Strategic objectives								✘
Trust Board annual work programme								✘
Operational plan (two year) *(next due in December 2018 - date to be confirmed by NHS Improvement)*						✘		
Policies and strategies								
Constitution (including Standing Orders) and Scheme of Delegation							✘	
Risk Management Strategy *(deferred to April 2019)*								
Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies)							✘	

Policies/strategies for future review:

- Trust Strategy *(reviewed as required)*
- Standing Financial Instructions *(reviewed as required)*
- Membership Strategy *(next due for review in April 2019)*
- Communication, Engagement and Involvement strategy *(next due for review in December 2019)*
- Organisational Development Strategy *(next due for review in December 2019)*
- Treasury Management Policy *(next due for review in January 2020)*
- Workforce Strategy *(next due for review in March 2020)*
- Customer Services Policy *(next due for review in June 2020)*
- Equality Strategy *(next due for review in July 2020)*

Agenda item/issue	Apr	June	July	Sept	Oct	Dec	Jan	Mar
• Standards of Conduct in Public Service Policy (conflicts of interest) *(next due for review in October 2020)* • Learning from Healthcare Deaths Policy *(next due for review in October 2020)* • Digital Strategy *(next due for review in January 2021)* • Quality Strategy *(next due for review in March 2021)* • Trust Board declaration and register of fit and proper persons, interests and independence policy *(next due for review in March 2021)* • Estates Strategy *(next due for review in July 2022)*								

	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.	

NHS
South West Yorkshire Partnership
NHS Foundation Trust

DRAFT Trust Board annual work programme 2019-20

Agenda item/issue	Apr	June	July	Sept	Oct	Dec	Jan	Mar
Standing items								
Declaration of interest	✘	✘	✘	✘	✘	✘	✘	✘
Minutes of previous meeting	✘	✘	✘	✘	✘	✘	✘	✘
Chair and Chief Executive's report	✘	✘	✘	✘	✘	✘	✘	✘
Business developments	✘	✘	✘	✘	✘	✘	✘	✘
STP / ICS developments	✘	✘	✘	✘	✘	✘	✘	✘
Integrated performance report (IPR)	✘	✘	✘	✘	✘	✘	✘	✘
Assurance from Trust Board committees	✘	✘	✘	✘	✘	✘	✘	✘
Receipt of minutes of partnership boards	✘	✘	✘	✘	✘	✘	✘	✘
Question from the public	✘	✘	✘	✘	✘	✘	✘	✘
Quarterly items								
Corporate/organisational risk register	✘		✘		✘		✘	
Board assurance framework	✘		✘		✘		✘	
Serious incidents quarterly report		✘		✘		✘		✘
Use of Trust Seal		✘		✘		✘		✘
Corporate Trustees for Charitable Funds# (annual accounts presented in July)	✘		✘		✘		✘	
Half yearly items								
Strategic overview of business and associated risks	✘				✘			
Investment appraisal framework (private session)	✘				✘			
Safer staffing report	✘				✘			
Digital strategy (including IMT) update	✘				✘			
Estates strategy update			✘				✘	
Annual items								
Draft Annual Governance Statement	✘							
Audit Committee annual report including committee annual reports	✘							

Agenda item/issue	Apr	June	July	Sept	Oct	Dec	Jan	Mar
Compliance with NHS provider licence conditions and code of governance - self-certifications *(date to be confirmed by NHS Improvement)*	✘							
Guardian of safe work hours	✘							
Risk assessment of performance targets, CQUINs and Single Oversight Framework and agreement of KPIs	✘							
Review of Risk Appetite Statement	✘							
Annual report, accounts and quality accounts - update on submission		✘						
Health and safety annual report		✘						
Patient experience annual report		✘						
Serious incidents annual report		✘						
Equality and diversity annual report			✘					
Medical appraisal/revalidation annual report			✘					
Sustainability annual report				✘				
Workforce Equality Standards				✘				
Assessment against NHS Constitution						✘		
Eliminating mixed sex accommodation (EMSA) declaration								✘
Data Security and Protection toolkit								✘
Strategic objectives								✘
Trust Board annual work programme								✘
Operational plan	✘					✘ (draft / private)	✘ (draft / private)	✘ (draft / private)
Five year plan				✘				
Policies and strategies								
Constitution (including Standing Orders) and Scheme of Delegation					✘			
Communication, Engagement and Involvement strategy		✘ (update)				✘		
Organisational Development Strategy						✘		
Risk Management Strategy	✘							
Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies)							✘	
Treasury Management Policy							✘	
Workforce Strategy								✘

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- Estates Strategy *(next due for review in July 2022)*

	Business and risk
	Performance and monitoring
Strategic sessions (including Board development work) are held in February, May, September and November which are not meetings held in public.	
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# Corporate Trustee for the Charitable Funds which are not meetings held in public.	