

**Trust Board (performance and monitoring)  
Tuesday 25 June 2019 at 9.30am  
Rooms 5 & 6, 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	2	To receive
2.	9.32	Declarations of interest	Chair	Verbal	3	To receive
3.	9.35	Minutes and matters arising from previous Trust Board meeting held 30 April 2019	Chair	Paper (to follow)	5	To approve
4.	9.40	Service User Story	Director of Operations	Verbal	10	To receive
5.	9.50	Chair and Chief Executive's remarks	Chair Chief Executive	Verbal Paper	15	To receive
6.	10.05	Performance reports				
	10.05	6.1 Integrated performance report M2 2019/20	Director of Finance & Resource and Director of Nursing & Quality	Paper	60	To receive
	11.05	Break				
	11.15	6.1i Update on Learning Disability Services and National Context	Director of Nursing & Quality	Paper	10	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	11.25	6.2 Incident Management Annual Report 2018/19	Director of Nursing & Quality and Director of Operations	<b>Paper</b>	5	To receive
<b>7.</b>	<b>11.30</b>	<b>Business developments</b>				
	11.30	7.1 South Yorkshire update including South Yorkshire & Bassetlaw Integrated Care System (SYBICS)	Director of HR, OD & Estates and Director of Strategy	<b>Paper</b>	10	To receive
	11.40	7.2 West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP)	Director of Strategy	<b>Paper</b>	10	To receive
	11.50	7.2i Calderdale Cares - One year on	Director of Strategy	<b>Paper</b>	10	To receive
	12.00	7.2ii Wakefield's Integrated Care Partnership	Director of Provider Development	<b>Paper</b>	10	To approve
<b>8.</b>	<b>12.10</b>	<b>Strategies and policies</b>				
	12.10	8.1 Communications, Engagement and Involvement Strategy - progress update	Director of Nursing & Quality	<b>Paper</b>	10	To receive
<b>9.</b>	<b>12.20</b>	<b>Governance matters</b>				
	12.20	9.1 Update on Annual Report and accounts including Quality Account 2018/19	Director of Finance & Resources	<b>Paper</b>	5	To receive
	12.25	9.2 Trust Board self-certification (FT4) - Corporate Governance Statement 2018/19	Director of Finance & Resources	<b>Paper</b>	5	To approve

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	12.30	9.3 Annual Safety Services Report 2018/2019 and 2019/2020 Action Plans	Director of HR, OD & Estates	<b>Paper</b>	10	To approve
	12.40	9.4 Finance and performance governance - Terms of Reference	Chair	<b>Paper</b>	5	To approve
<b>10.</b>	<b>12.45</b>	<b>Receipt of public minutes of partnership boards</b>	Chair	<b>Paper</b>	5	To receive
<b>11.</b>	<b>12.50</b>	<b>Assurance and receipt of minutes from Trust Board Committees</b>	Chairs of committees	<b>Paper</b>	5	To receive
		- Audit Committee 21 May 2019				
		- Clinical Governance & Clinical Safety Committee 14 May 2019 and 11 June 2019				
		- Equality & Inclusion Committee 4 June 2019				
		- Mental Health Act Committee 14 May 2019				
		- Workforce & Remuneration Committee 7 May 2019				
<b>12.</b>	<b>12.55</b>	<b>Use of Trust Seal</b>	Chair	<b>Paper</b>	5	To receive
<b>13.</b>	<b>13.00</b>	<b>Trust Board work programme</b>	Chair	<b>Paper</b>	3	To receive
<b>14.</b>	<b>13.03</b>	<b>Date of next meeting</b>	Chair	<b>Verbal</b>	2	To note
		The next Trust Board meeting held in public will be held on Tuesday 30 July 2019, Conference centre Boardroom, Kendray, Barnsley				

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
15.	13.05	Questions from the public	Chair	Verbal	10	To receive
	13.15	<i>Close</i>				

## Trust Board 25 June 2019 Agenda item 5

<b>Title:</b>	Chief Executive's report
<b>Paper prepared by:</b>	Chief Executive
<b>Purpose:</b>	To provide the strategic context for the Trust Board conversation.
<b>Mission/values/Objectives:</b>	The paper defines a context that will require us to focus on our mission and lead with due regard to our values.
<b>Any background papers/ previously considered by:</b>	This cover paper provides context to several of the papers in the public and private parts of the meeting and also external papers and links.
<b>Executive summary:</b>	<p>The Brief, provided monthly to all staff and cascaded through the Extended Executive Management Team (EEMT), delivers a summary of the Trust's context, performance and finances. The May version of this is attached <b>[Annex A]</b>. Board members may want to note that the structure of The Brief now follows the strategic objectives and priority programmes of the Trust. This allows us to continually reinforce key messages to staff on areas of focus or priority.</p> <p>I wanted to emphasise the following points from The Brief or where there have been developments subsequent:</p> <ul style="list-style-type: none"> <li>➤ The Brief highlights issues in relation to learning disability services following three major reports in a single week. These covered a third LeDeR report (<a href="https://www.england.nhs.uk/wp-content/uploads/2019/05/action-from-learning.pdf">https://www.england.nhs.uk/wp-content/uploads/2019/05/action-from-learning.pdf</a>), the Care Quality Commission (CQC) review of segregation and seclusion (<a href="https://www.cqc.org.uk/sites/default/files/20190521b_rssinterimreport_full.pdf">https://www.cqc.org.uk/sites/default/files/20190521b_rssinterimreport_full.pdf</a>) and the Panaroma documentary on Whorlton Hall (<a href="https://www.bbc.co.uk/news/health-48367071">https://www.bbc.co.uk/news/health-48367071</a>). Each of these demonstrated significant failings in supporting people with a learning disability. The Clinical Governance and Clinical Safety Committee has been considering lessons for the Trust and the Integrated Performance Report (IPR) includes a focus on learning disability services. As a Trust we need to ensure that we are delivering safe and effective care. I would also suggest that we should be demonstrating leadership on this agenda through our role on the ODN and in our integrated care system (ICS).</li> <li>➤ The interim People Plan for the NHS was published. A briefing from NHS Providers is attached at <b>[Annex B]</b> that describes the main points of the plan. The Board should note that the plan is interim pending the spending review which will confirm a range of workforce budgets. The Board should also note that I have been asked to lead one of the workstreams on creating a</li> </ul>

	<p>new infrastructure for delivery.</p> <ul style="list-style-type: none"> <li>➤ NHS England and NHS Improvement have been seeking phased reduction on capital expenditure this year. This has been coordinated through integrated care systems. As we are in active discussions regarding any contribution we can safely make.</li> <li>➤ We continue to work with our colleagues in West Yorkshire and Harrogate and South Yorkshire &amp; Bassetlaw on a range of mental health and learning disability developments. In particular we are seeing additional resources for crisis services in mental health and a move to transfer the responsibility for specialised commissioning budgets from NHS England to providers. This is covered more fully in the private part of the meeting due to commercial considerations.</li> <li>➤ The number of place-based developments continues to grow. The board papers show that significant developments are continuing in Wakefield, Calderdale, Barnsley and Kirklees; in particular we are seeing the developments of the primary care networks, which will form a significant part of the future.</li> <li>➤ The CQC have visited the Trust to undertake a well-led review. This follows four service visits. We expect a process of report writing and factual accuracy checking to conclude with a report by the end of July. We are working through initial feedback and final requests for information from the CQC.</li> </ul>
<b>Recommendation:</b>	<b>Trust Board is asked to NOTE the Chief Executive's report.</b>
<b>Private session:</b>	Not applicable.

A large decorative graphic in the center of the slide. It features a white circular area in the middle, surrounded by a pattern of blue rectangular segments arranged in concentric, slightly irregular rings, creating a textured, circular effect.

# The Brief

## 30 May 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



Creative Minds, Live Well Wakefield and our befriending service help launch phase 2 of the West Yorkshire and Harrogate 'Look out for your neighbours' campaign in our museum

With **all of us** in mind.

# NEWS

[Home](#) | [UK](#) | [World](#) | [Business](#) | [Politics](#) | [Tech](#) | [Science](#) | [Health](#) | [Family & Education](#)

## Health

### Whorlton Hall: Hospital 'abused' vulnerable adults

By Nick Trigg  
Health correspondent

22 May 2019

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With **all of us** in mind.

Our **priorities** for **2019/20**  
so that we can be **OUTSTANDING**

**OUR AIM**

**WHAT WE'LL DO**

**THE OUTCOME**

**IMPROVE  
HEALTH**



- Work with our partners to join up care in our communities
- Improve our mental health offer for older people
- Advance our wellbeing and recovery approach

We deliver our role  
in integrated care in  
every place

**IMPROVE  
CARE**



- Provide safe care every time and in every service
- Provide all care as close to home as possible
- Make care quickly and easily available, to reduce waiting times
- Embed #allofusimprove to enhance quality

Our CQC ratings and  
reports improve in  
every service

**IMPROVE  
RESOURCES**



- Spend money wisely and reduce waste
- Make the most of our clinical information
- Make better use of digital technology

We achieve our  
financial plan and  
targets

**MAKE THIS  
A GREAT  
PLACE TO  
WORK**



- Support the wellbeing of #allofus
- Have better conversations with all of our people
- We will not tolerate bullying and harassment

All our staff have a high  
quality appraisal and  
give us great feedback

With all of us in mind.

# Improving Health: Joining up care in every place

## West Yorkshire:

- CAMHS whole system exemplar
- Forensic Services, including Adults, Children, LD
- Eating Disorders
- Learning Disabilities – Transforming Care Partnerships
- Suicide Prevention
- Employment

## South Yorkshire:

- Liaison and Diversion across SY
- QUIT smoking cessation approach

Every place identifying primary care networks, operational by June 2019

Services being joined up through:

- Wakefield New Models of Care Board
- Wakefield Mental Health Alliance
- Calderdale Cares
- Kirklees Strategy
- Barnsley Integrated Care Partnership

Joining up our own services, to tackle Out of Area placements and fragmented care. E.g. IAPT for physical conditions, investments in IHBTT

With **all of us** in mind.

# Improving Care: Safety and quality

In April we had:

- 1130 incidents - 1017 rated **green** (no/low harm)
- 105 rated **yellow or amber**
- 8 rated as **red**
- 3 **serious incidents** – 1 apparent suicide, one cause of death unknown/awaiting confirmation and one allegation of violence and aggression

The % of **people dying in a place of their choosing** is improving thanks to better care and recording of data.

We have seen a slight **decrease in falls** for the month. Number of falls over past quarter remains higher than desired. Increased observation and staffing in place to mitigate risks

To make our systems more **cyber secure** you will need to change your login password. See the intranet to find out how.



There were **3 confidentiality breaches in April**, a significant reduction. Please remember to always double check details and always stay focussed.



With **all of us** in mind.

## Improving care: Our performance in April

- **98%** of people recommend our community services
- **95%** of people recommend our mental health services
- **194** out of area bed days
- **93%** inpatients with a Cardiometabolic Assessment (CMA)
- **54.1%** moving to recovery on IAPT
- **26.3%** referral to treatment in CAMHS timescales
- **84%** of people dying in a place of their choosing
- **76%** of prone restraint lasted less than 3 minutes
- **24.5%** medicines omissions
- **65%** would recommend the Trust as a place to work (March)
- **84.9%** of staff receiving supervision within policy guidance

The number of restraint incidents during April has increased compared to previous months. % of prone restraints lasting more than 3 minutes has increased.

Thank you to staff for helping us achieve our 2018-19 **CQUINs**. To do the same in 2019-20 your support is needed.

Medicines omissions performance has deteriorated in April compared to previous months and stands at 24.5%. Pharmacy is working with our inpatient units on the causes and possible solutions.



With all of us in mind.

# Improving care: #Allofusimprove

We've listened to your feedback and made improvements to i-hub. It looks and feels a bit different but the purpose is the same – to help...



i-hub is your chance to make changes, big and small. Staff have the best insights and solutions, so we are making an online space to embrace this. **Get your ideas directly in front of the chief executive and directors.**



Thanks to everyone who contributed to conversations on making SWYPFT a great place to work and improving quality

Our next conversation in June is about 'Going Green'. **Go to the intranet to find out more and get involved in the conversation.**

**Only 30 places left on the Institute of Healthcare Improvement Certificate in Quality and Safety.**

It takes around **20 hours** and you'll become an **improvement facilitator.**



With **all of us** in mind.

# Care Quality Commission (CQC)

Don't count the days until our visit... make the days count

## Our core services inspection

Visits began on 8 May in four of our core services:

- All acute mental health wards for working all adults
- All acute wards for older people
- Barnsley and Wakefield CAMHS teams
- Barnsley, Kirklees and Wakefield community mental health services for working age adults.



The CQC also held skype calls with the management teams from CAMHS and the acute mental health wards for working age adults.

Thanks to everyone who came along to our staff briefings and has taken part in the inspection so far.

Remember we have a toolkit full of useful resource, available on the intranet.



## Next steps

Teams are responding to early feedback on services



CQC will be meeting with our senior management team and holding further focus groups as part of our **well led review** on 11 and 12 June.

We will then receive our draft CQC report within 12 weeks of completion of the review.

Before the report is made public we will be given a two week period to make comments on any factual inaccuracies within the report.

With **all of us** in mind.

# Improving resources: Our finances in 2019/20

Performance Indicator		Year to date	Forecast
1	NHS Improvement Finance Rating	3	1
2	Normalised Deficit (excl PSF)	(£0.7m)	(£0.2m)
3	Agency Cap	£0.6m	£7.1m
4	Cash	£26.4m	£26.9m
5	Capital	£0.7m	£7m
6	Delivery of CIP	£0.7m	£10.6m

The overall risk rating is a 3 (out of 4 with 1 being the highest).

April 2019 finance performance is ahead of our plan at a deficit of £0.7m.

Agency expenditure was £0.6m in April, £0.2m above the agency cap set by NHS Improvement.

The Trust cash position remains healthy at £26.4m.

Expenditure is £0.4m ahead of plan year to date. Nationally there is a need to reduce capital spend and there is an expectation that we will need to reduce further.

Initial CIP delivery is in line with our plan. Further work is required to ensure that central schemes such as drugs savings, non pay reductions etc. are achieved.

# Improving Resources: Our finances explained

This year our target is to break even, spending no more than we receive.

Last month we spent **£728k** more than we received. This was due to an expected one off payment related to the NHS pay settlement for staff on Agenda for Change and will have affected all NHS Trusts.

Our cost improvements are in line with plan. We still have a gap in the plan though, and need to identify an additional **£1.4million** in cost reductions or improvements. **Everyone has a part to play. By making small changes you can help us save money.**

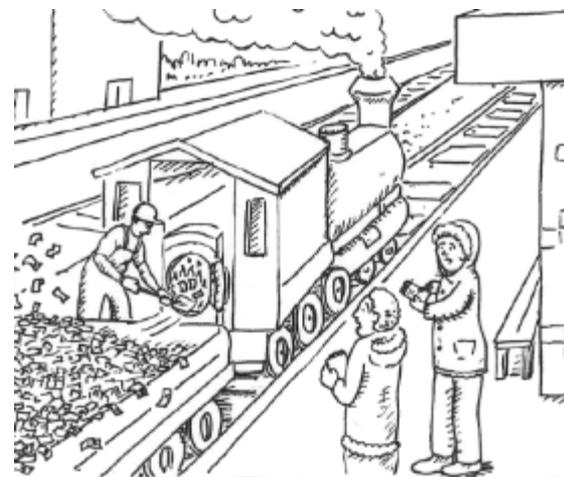
Please spend time discussing with your teams:

- Are we spending our money the best way we can?
- How can we improve?
- What can my service do differently to reduce inefficiency and waste?

Out of area placements cost us £3.9m in 18/19. We're aiming for **zero** placements. This is already being achieved in Barnsley and Wakefield.



Have you seen our new campaign?



*"Apparently it's run entirely on taxpayers' money."*

This month we're reminding you how you can save us money by spending less on rail fare.

With all of us in mind.

## Improving Resources: SystmOne for mental health – Optimisation

Over the next year, we'll be co-producing improvements to SystmOne that will enable better practice. This is **optimisation**.

### Questionnaire based care plans

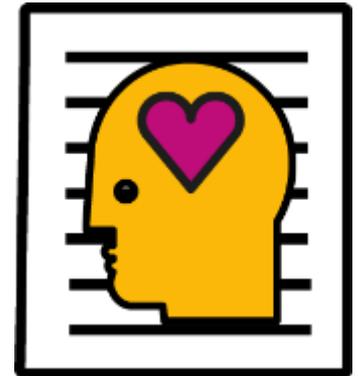
The programme team have worked with clinicians and the SystmOne supplier to **co-design a new mental health care plan** that will be used nationally across providers of mental health services. More importantly we can tailor the care plan(s) to meet our patients' needs.

**Now:** The supplier is building the new care plan

**June:** Testing functionality with staff

**July/August:** Co-design and build of care plan questionnaires with staff

**September:** Launch across mental health services



### RiO switch off – four weeks to go

RiO is switched off on 30 June. So far you have caught up over **99%** of missing data – thank you for all your hard work!

With all of us in mind.

## Making this a great place to work



Sickness absence was 4.7% in April, above our target. Turnover fell to 8.8%. There's support for [#allofus](#)

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Find out who your [freedom to speak up guardians](#) are?

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Make sure you schedule in your values-led appraisal. It's your chance to have a two-way conversation.

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Our BAME, LGBTQ+ and disability [staff networks](#) have all met recently. Find out more on the intranet.

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We celebrated the Trust's first cohort of [newly registered nursing associates](#). Congratulations.

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We want the Trust to be a great place to work for [#allofus](#). Get involved with HR conversations and complete the staff Friends and Family Test to give your feedback.

Our comms team won a **HSJ Value award** for most innovative communications campaign for [#allofus](#)



With **all of us** in mind.

# Making this a great place to work

## Four big priorities this year:

- Tackling bullying and harassment
- Staff engagement
- Quality of appraisal
- Workplace health and wellbeing

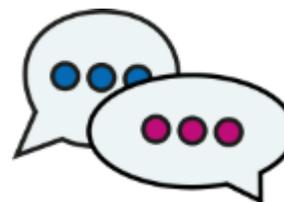
## Staff Friends and Family Test results:

Recommend as a place to work: **65%**

Recommend as a place to receive care and treatment: **75%**

## Join the conversation at our director listening events.

Taking place across the Trust the events are your chance to find out about what's happening and have your say on how we can improve.



## MySWYFT

Download our staff app.



Find out how on the intranet.

With **all of us** in mind.

# Take home messages

We are proud to deliver high quality learning disability services – we need to show everyone what great care looks like

Don't forget - safety first and quality counts, remain professionally curious and see the person in front of you

Get involved in #allofusimprove and take a look at the new i-hub

Help us reduce waste and manage our finances

Get involved in HR conversations and complete the Friends and Family staff test

Invest in your appraisal and make it of high quality

Book your place at one of our director listening events

## 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 the comms team.

### Learning disability services in the news

In the past month we have seen an example of what can happen when organisations don't live by their values.

The third [LeDeR learning disability mortality report](#) has been published looking into deaths for people with learning disabilities, and indicates ongoing concerns about the premature deaths of people with learning disabilities. The CQC also gave their [interim findings](#) from a review of the use of restrictive interventions in places that provide care for people with mental health problems, a learning disability and/or autism.

This was followed by an expose by the [BBC's Panorama programme](#), where they went undercover in Whorlton Hall in County Durham, a privately run, NHS funded unit for people with a learning disability. This programme showed how badly some learning disability service users are treated, and demonstrates what happens when values are not followed.

We need to ensure people recognise that services are not all like this. Our LD services have seen improvements and we need to be proud of what we provide and the way we put service users and carers first. We recruit, induct and appraise based on values. We need to maintain our focus on service users and carers and make sure that our staff are supported too.

We want you to stay professionally curious. It is your right and responsibility to report things wherever you see it. Feel confident in saying if something isn't right. Our Freedom to Speak Up Guardians can help if you want to raise an issue or talk about something you have seen.

## #allofusimprove - our priorities for the year ahead

Our aim is to be outstanding. We have set our priorities for the year ahead. Every team should discuss these and have a conversation about what they mean for you and how your priorities will link to these.

Printed versions have been sent to all teams- it was better value to have them printed in bulk than for each team to print them individually.

## Improving health: Joined up care in every place

We are working to join up care through our partnerships in West Yorkshire and in South Yorkshire. We are also working on a local level in each of our places, such as the Wakefield New Models of Care Board, Wakefield Mental Health Alliance, Calderdale Cares, Kirklees Strategy and the Barnsley Integrated Care Partnership. We deliver care throughout this footprint.

We are also joining up our own services. We are committed to tackling out of area placements and fragmented care. This is demonstrated in our IAPT for physical conditions and investment in IHBT.

Calderdale vocational team are getting an additional **Individual Placement Support** post, thanks to a funding bid by West Yorkshire & Harrogate Health and Care Partnership. This will help more people with serious mental illness find and retain employment.

## Improving care: Safety and quality

We put safety first, always.

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

- 1130 incidents – 1017 rated green (no/low harm)
- 105 rated yellow or amber
- 8 rated as red
- 3 serious incidents – 1 apparent suicide, one cause of death unknown/awaiting confirmation and one allegation of violence and aggression

There were 3 confidentiality breaches in April, a significant reduction. Please remember to always double check details and always stay focused.

The % of **people dying in a place of their choosing** is showing an improving trend. This is due to better care and recording of data. We have seen a slight **decrease in falls** for the month. The number of falls over the past quarter remains higher than desired. Increased observation and staffing are in place to mitigate risks.

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

### Computer password change – what you need to do

To increase our cyber security we need to change the passwords on our computers. At some point during the week commencing Monday 3 June, you will be asked to change your password when you log into your computer.

Your new password must:

- Be a minimum of 12 characters
- Contain an upper and lower case character
- Contain one or more numbers
- Contain one or more special characters. These are ~!@#\$%^&\* \_-+=`|\(){}[];:"'<>,.?/ and a space.

Even if your current password meets these criteria you will still need to set a new one. If you don't log into your computer during this week you will just be prompted to change your password the next time you log in. For more information, read our FAQs on the intranet.

### Improving care: Performance (April)

- **98%** of people recommend our community services
- **95%** of people recommend our mental health services
- **194** out of area bed days
- **93%** inpatient with a Cardiometabolic Assessment (CMA)
- **54.1%** moving to recovery on IAPT
- **26.3%** referral to treatment in CAMHS
- **84%** of people dying in a place of their choosing
- **76%** of prone restraint lasted less than 3 minutes
- **24.5%** medicines omissions
- **65%** would recommend the Trust as a place to work in March
- **84.9%** of staff receiving supervision within policy guidance in Q4

**Medicines omissions** performance has deteriorated in April compared to previous months and stands at 24.5%. This relates to inpatient areas in Calderdale, Kirklees and Wakefield.

We have 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.

The number of **restraint incidents** during April has increased compared to previous months. Prone restraints lasting 3 minutes or more has increased and now stands below target at 76%.

Thank you to all staff for helping us achieve our **CQUINs** for 2018-19. CQUIN stands for Commissioning for Quality and Innovation. This is a system to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care. This means that a proportion of

our income depends on achieving quality improvement and innovation goals, agreed between the Trust and our commissioners.

Staff support can make a big difference to whether we achieve our CQUINs. To make sure we achieve them in 2019-20 we will need your help.

## Improving care: #allofusimprove

### **New and improved i-hub**

i-hub is an online network for staff to share improvement ideas and good practice, and help them to work with other colleagues to solve challenges.

We've listened to feedback and made improvements so that i-hub is easy to use and fit for purpose. It looks and feels a bit different but the purpose is the same – to help. #allofusimprove.

### **Why get involved?**

It's a real chance to make change happen, both on a small and large-scale. We know that people working within and accessing services have the best insights and solutions, so we are making space to embrace this. I-hub is an opportunity to get ideas and opinions out there and have your voice heard.

### **Try this...**

Your mission, should you choose to accept it, is to post at least one idea this month in any of the challenges on i-hub. Our next conversation in June is about the Trust and environmental sustainability so tell us your ideas for 'going green'.

Go to the intranet to find out more and get involved in the conversation.

### **Institute for Healthcare Improvement – Certificate in Quality & Safety**

Are you passionate about improving services? Is identifying, planning and delivering improvement part of your job? Why not complete the Institute of Healthcare Improvement certificate in Quality and Safety? We have 30 licences remaining.

There are 13 online modules in areas such as improvement capability, patient safety, leadership and person and family centred care. Each module takes approximately 1.5 hours to complete and at the end you'll receive an IHI Certificate of Quality and Safety. What's more you'll become a Trust Improvement Facilitator helping to ensure we continuously improve and continue to deliver the very best services and care to our service users.

## CQC update

### CQC debriefing sessions

The Quality Improvement and Assurance Team facilitated CQC briefing sessions across the Trust prior to our anticipated core service visits. These briefings were held in various venues in Barnsley, Calderdale, Kirklees and Wakefield. The briefings captured staff from 60 different teams and were attended by 158 people in total. Staff spoke positively about their learning from the briefings and how it had improved their understanding of the inspection process and the type of things CQC may ask or look at.

Feedback from the events have been shared with the engagement team for incorporating into the directors listening events

### Core service inspections

CQC began visits on 8 May 2019. These visits took place over three days. They inspected four of our core services:

- All acute mental health wards for working all adults
- All acute wards for older people
- Barnsley and Wakefield CAMHS teams
- Barnsley, Kirklees and Wakefield community mental health services for working age adults.

Following the visits to the teams, CQC also held skype calls with the management teams from CAMHS and the acute mental health wards for working age adults. The purpose of these calls was made because CQC had not had chance to speak with all of the management team at the time of their initial visit. It also gave our management team the opportunity to provide clarity and context around some of the issues raised.

### Data information requests

As part of this CQC visit we received 23 information data requests. This was significantly less than had been requested when CQC last visited in 2018.

### The next phase of the process

Teams are responding to early feedback on services. CQC will be meeting with our Trust senior management team and holding further focus groups as part of our well led review. This will be taking place on the 11 and 12 June.

We will then receive our draft CQC report within 12 weeks of the completion of the review. Before the report is made public we will be given a two week period to make comments on any factual inaccuracies within the report.

## Improving resources: Our finances 2019-20

The overall risk rating is a 3 (out of 4 with 1 being the highest). It is limited to a maximum of a 3 due to individual metrics being rated at 4. This is the impact of the year to date deficit position and is in line with our plan.

April 2019 finance performance is ahead of our plan at a deficit of £0.7m. This was due to an expected one off payment related to the NHS pay settlement for staff on Agenda for Change and will have affected all NHS Trusts.

Agency expenditure was £0.6m in April, £0.2m above the agency cap set by NHS Improvement. At this rate we will exceed our agency cap by £1.7m (34%). Actions within the agency workstream are being progressed to reduce this.

The Trust cash position remains healthy at £26.4m.

Expenditure is £0.4m ahead of plan year to date. Nationally there is a need to reduce capital spend and there is an expectation that we will need to reduce further.

Initial CIP delivery is in line with our plan. Further work is required to ensure that central schemes such as drugs savings, non pay reductions etc. are achieved.

## Improving our resources: Our finances explained

### Our performance in 2019/20

Our financial target for the new financial year (2019/20) is essentially to breakeven; spending no more than the income we receive. As in previous years this will be a challenging plan to deliver but we have a good track record of achieving together.

April 2019 is the first month of this plan. Performance is a deficit of £728k. This is due to the one off payment staff who was at the top of their pay band received in April and was planned for. The NHS pay settlement was for staff on Agenda for Change and will have affected all NHS Trusts.

However this does mean that we need to make savings throughout the year to compensate for this. Part of this will be delivering the Trust cost reduction (CIP) plan of £10.6m. This includes a target of £1.4m which is still to be identified.

Additionally we need to continue work to reduce spending on a number of key financial pressures. Out of area placements cost the Trust £3.9m in 2018/19. This was nearly 5,000 days where service users were placed outside of the Trust, away from family and friends. We have an aspiration for **zero** placements and this is already being achieved in Barnsley and Wakefield.

Agency spend also continues to be a key financial pressure. Spend in April was £613k which is an increase for last year. This links into the wider Trust workforce strategy. If we are unable to reduce this then we will need to make additional cost reductions elsewhere.

## Improving resources: SystmOne for mental health

### Optimisation

The safe transition from RiO to SystmOne was the implementation phase of this change. Following implementation, we had stabilisation, where support was offered to staff to help them get to grips with the new system. The next phase is optimisation, where the programme team will work with staff across the Trust to co-produce improvements to the system that will enable better practice.

### Questionnaire based care plans

The programme team have worked with clinicians to co-design a new mental health care plan that will be used nationally across mental health Trusts. More importantly, we'll be able to tailor it to suit patients' needs.

- **Now:** The supplier is building the new care plan
- **June:** Testing functionality with staff
- **July/August:** Co-design and build of questionnaires with staff
- **September:** Launch across mental health services

If you want to help co-produce your new service specific care plan, email Julie.Williams2@swyt.nhs.uk.

### RiO switch off... only four weeks to go

RiO will be switched off on 30 June so all missing data must be manually updated by then. So far, staff have caught up 99% off missing data. This is a huge achievement – thank you for all your hard work.

## Making this a great place to work

- The marketing and communications team have won a [HSJ Value award](#) for the #allofus staff wellbeing campaign. The campaign can be seen all over the Trust and on the intranet. It highlights the support that is available for staff to support their health and wellbeing.
- [Sickness absence](#) was **4.7%** in April, above our target of **4.5%**. Turnover has fallen to **8.8%**. Remember there is wellbeing support available to #allofus.
- Make sure you know who your freedom to speak up guardian is and what they can do to help you.
- [Your values led appraisal](#) is an opportunity for a supportive two way conversation about: your achievements, your personal development and training needs, your health and wellbeing, your job related objectives, and our Trust

behaviours. If you're band 6 and above, please organise your appraisal with your manager by the end of June. If you're band 5 or below, please do this from July to September.

- Our [staff networks](#) are there to support you. The BAME, LGBTQ+ and disability networks have all met up recently. You can find more information on the networks, including how you can get involved, on the intranet.
- We celebrated the Trust's first cohort of [newly registered nursing associates](#).

### **#allofus - making our Trust a great place to work**

Following the results of the staff survey we want to make sure that our Trust is a great place to work for everyone. The HR team have been visiting teams across the Trust, the feedback has been invaluable and will help us improve staff experience. We are focussing on four key themes:

- Staff engagement
- Workplace health and wellbeing
- Bullying and harassment
- Quality of appraisals

We are meeting with groups of staff to find out what we do well in these areas, where we can improve and, most importantly, what more we need to do to be a great employer that delivers great services. Colleagues can also complete the Quarter 1 Staff Family and Friends Test Staff FFT/Great Place to Work. Any information will be treated in confidence.

### **Making this a great place to work**

#### **Join the conversation at our director listening events**

Each year we hold a round of events across Barnsley, Calderdale, Kirklees and Wakefield to discuss progress we've made, check what's working well and what needs to change.

The annual staff listening events will start in June. Attending these events gives you a chance to tell directors what works, what we need to get better, as well as learn about developments happening across the Trust.

Look out also for our director walkabouts coming soon.

#### **Four big priorities this year**

To help us make this a great place to work we will be focused on four priorities:

- Tackling bullying and harassment
- Staff engagement and empowerment
- Quality of appraisal
- Workplace health and wellbeing

Take part in our conversations wherever you can and will help us to improve our staff  
Friends and Family Test (FFT) results:

**Staff Friends and Family Test results:**

Recommend as a place to work: **65%**

Recommend as a place to receive care and treatment: **75%**

**MySWYFT – staff app now available**

My SWYFT is the app for our staff. Designed for staff on the go, it provides important Trust information and news at your fingertips.

The app is not available publicly on the App or Play Store as it's only for Trust staff. Downloading and installing it is completely safe to do. It has been developed with zero cost to the Trust and will be maintained and updated weekly.

Find out how to download our new staff app on the intranet.

### Take home messages

1. *We are proud to deliver high quality learning disability services – we need to show everyone what great care looks like*
2. *Don't forget – safety first and quality counts, remain professionally curious and see the person in front of you*
3. *Get involved in #allofusimprove and take a look at the new i-hub*
4. *Help us to reduce waste and manager our finances*
5. *Get involved in HR conversations and complete the Friends and Family staff test*
6. *Invest in your appraisal to make it of high quality*
7. *Book your place at one of our director listening events*

## Interim NHS People Plan – national workforce strategy

NHS Improvement, NHS England and HEE have published the interim NHS People Plan (the plan) which sets the national strategic framework for the workforce over the next five years. The plan has been drawn up under the direction of Baroness Dido Harding, NHS Improvement Chair and senior responsible officer Julian Hartley, Chief Executive of Leeds Teaching Hospital NHS Trust. During the first quarter of 2019, a national steering group was set up to support engagement with key stakeholders and ensure wide input into the interim plan from across the sector. NHS Providers contributed significantly to the work of the steering group and its sub-groups. A final people plan will be published in the months following the 2019 spending review.

This briefing provides an overview of the key proposals within the document and a summary of each section within the plan.

### Overview of key proposals

- A “new offer” to NHS staff will be developed through consultation this summer to ensure the NHS rapidly becomes a better place to work.
- A consultation on changes to pensions policy has been announced, which includes the proposed introduction of some added flexibility for senior clinicians through a “50:50” option enabling them to halve their pension growth beyond a certain point in exchange for halving their contribution.
- The NHS will engage on a “new leadership compact”, establishing the cultural values and behaviours expected from leaders at all levels across the service.
- The compact will include a review of regulatory oversight frameworks and implementation of 360 degree feedback from providers, commissioners and Sustainability and Transformation Partnerships (STPs)/Integrated Care Systems (ICSs) on support received from regional and national leaders.
- A “new operating model” for increase workforce devolution to regions, ICSs and local organisations will be developed, utilising an ICS maturity matrix to benchmark workforce planning capabilities.
- A series of initiatives will aim to recruit an additional 40,000 nurses to the NHS in the next five years, including a rapid expansion and review of clinical placement capacity; increasing the acceptance rate; and consolidating national recruitment campaigns with a particular focus on learning disability and mental health nurses.
- Funding for CPD should be restored to its previous levels over the next five years, depending on the spending review.
- An independent review of HR/OD best practice in the NHS will be carried out later in 2019.
- NHSE will develop a new procurement framework for approved international recruitment agencies, while STPs and ICSs will implement ‘lead recruiter’ arrangements for staff coming from overseas.
- The NHSI national retention programme will be expanded to all trusts and into primary care.
- The NHS will review its levels of undergraduate medical school places and launch a national conversation on what patients and the public require from 21<sup>st</sup> century medical graduates.

## NHS – the best place to work

### A new offer to staff

A key pillar of the plan is its aim to ensure the NHS rapidly becomes “a much better place to work”. This is to be achieved through the development of a “new offer” to staff, the details of which will emerge in full following a period of consultation this summer.

The idea of a new offer comes following an acknowledgement from NHS leaders that the service needs to make significant progress to ensure healthcare careers remain an attractive option. The plan argues that jobs in the sector have become “increasingly demanding”, noting that staff are overstretched and struggling from the impact of poor recruitment and retention. The document also states that the NHS is operating “in a highly competitive employment market with changing generational expectations about careers”.

This reflects widespread concern around the lack of flexibility that NHS organisations – including trusts – are able to provide particularly to younger members of staff in the current environment. [HEE’s draft workforce strategy in 2018](#) first acknowledged the need to consider a different approach for “millennial” staff seeking career breaks and non-linear careers, and this requirement is reflected in the people plan’s goal for the NHS to be a “modern” and “flexible” employer.

The offer will ultimately be made up from a series of new or revised commitments in the NHS Constitution and form the basis of a “balanced scorecard” under the NHS Oversight Framework which will inform future CQC well-lead assessments. It will make explicit commitments around the broad themes of:

- Creating a healthy, inclusive and compassionate culture, with a focus on equality and inclusion, bullying and harassment.
- Enabling development and fulfilling careers, with a focus on CPD, credentialing of expertise and line management.
- Ensuring voice, control and influence for NHS staff, by improving health and wellbeing, work-life balance and conditions for whistleblowers.

The document also calls for an independent review of HR/OD best practice in the NHS, to be carried out later in 2019. The plan’s authors are seeking a greater focus on people issues at board level which it feels is lacking following “a quick survey of board papers” during the development of the plan.

### Leadership compact and culture

The plan has placed a heavy emphasis on improving leadership and organisational culture throughout all levels of the NHS. This work comes on the back of the [Developing People Improving Care Framework](#) in 2016 which, according to document, has “not led to the widespread culture change it set out to deliver”. The plan has also noted the impact of greater systems collaboration, which it says introduces new and different leadership challenges.

The plan frequently refers to the need for inclusivity, diversity, compassion and positivity in leadership and culture, stressing that these ideals apply to the NHS arms length bodies as they do to frontline leaders across the country. Its central ambition in this area is to undertake system-wide engagement on a “new NHS leadership compact” establishing the cultural values and behaviours expected from leaders. The compact will be a “gives and gets” agreement, also setting out the type of development and support local leaders can expect from the centre.

Within the leadership compact, the people plan also calls for:

- The development of competency, values and behaviour frameworks for all senior leadership roles (an extension of the [Kark Review's](#) recommendation for board members to meet specified measures of competence).
- A review of regulatory and oversight frameworks to ensure “a greater focus on leadership, culture, improvement and people management”.
- Implementation of 360 degree feedback from providers, commissioners and STPs/ICSs on support received from regional and national teams.
- The roll-out of talent boards to every region and an expansion of the NHS Graduate Management Training Scheme.
- Development of a central database for directors and engagement over the remaining recommendations from the Kark report.

## Pensions

The NHS workforce has been hit hard by the impact of the annual and lifetime pension allowances, causing large and unpredictable tax bills for senior doctors and managers in particular over the past year. Increasingly, NHS trusts have been struggling to stem the tide of senior medical staff leaving the NHS pensions scheme, reducing their working hours and – sometimes – leaving the NHS altogether to avoid effective 100% marginal tax rates brought about by a poorly designed taxation system.

Following extensive discussions between all key parties, including DHSC, it's arms-length bodies, the Treasury and the British Medical Association (BMA), the government has announced a policy change increasing pensions contributions flexibility for scheme members. The people plan says briefly describes a proposal to allow senior clinicians the option of halving their pension growth beyond a certain point in exchange for halving their contribution. This has been described as the “50:50” option in the sector and is similar to the offer given in local government pensions.

Alongside the release of the interim people plan, the Department of Health and Social Care (DHSC) said it was consulting on new plans enabling senior clinicians to “freely take on additional shifts to reduce waiting lists, fill rota gaps or take on further supervisory responsibilities”. However, it is not clear whether this goes beyond the “50:50” option, which the doctors’ union opposes. Additional funding will come from DHSC, instead of the Treasury.

## Tackling nursing shortages

NHSI, NHSE and HEE have identified the nursing workforce as the key group in need of support, with a fear that the current level of vacancies – 40,000 across NHS trusts – is set to rise exponentially without concerted action to address the gap. The plan says shortages in nursing are “the single biggest and most urgent we need to address”, predicting that the policy initiatives outlined in the document can grow the size of the workforce by 40,000 over the next five years “to keep pace with rising demand”. It states that further action will be needed within the final people plan to hit a 5% vacancy rate target by 2028 (currently 11%).

## Increasing supply through undergraduate training

Given the time it takes to train a nurse through an undergraduate degree, the plan highlights the need to immediately increase the supply of newly trained nurses through this route. It sets out the ambition to provide capacity for all suitable applicants to secure a place. The NHS will work with higher education institutions (HEIs) to expand their intakes and identify the correct number of corresponding clinical placements by improving coordination between HEIs and trusts.

Alongside this, a more comprehensive review of current clinical placement activity will take place to identify outliers and support the removal of barriers to expanding capacity, including the potential to expand placements in primary and social care.

Further initiatives to increase undergraduate supply include:

- A rapid expansion programme to increase clinical placement capacity by 5,000 for September 2019, with NHSE working alongside trust directors of nursing to assess organisational readiness and provide targeted infrastructure support.
- Increasing the acceptance rate from its 2018 level of 55% to 70%, with a programme of work to understand what is behind the decline, ensuring that intake levels are increased without compromising rigorous standards for entry or patient safety.
- A consolidation of current recruitment campaigns run by different national bodies, including the recent 'we are the NHS' campaign, to develop a single campaign that reflects the realities of a career in modern nursing.
- ALBs working with the Office for Students to agree a standard definition for attrition for all healthcare programmes.
- Further work with DHSC to improve awareness and effectiveness of financial support programmes for trainee nurses through the Learning Support Fund (LSF).

The full people plan will identify concentrated action in areas of nursing with the greatest shortages, including mental health, learning disability, and primary and community nursing. NHSE will work with HEIs to identify and address these shortages by promoting nursing roles in these areas and highlighting the rewarding nature of these career options.

## International recruitment

The plan acknowledges the need to increase international recruitment significantly in the short and medium term to rapidly increase supply. This will involve ensuring the system for overseas recruitment is effective and achieves economy of scale. Specifically, the plan promises that:

- HEE will continue to build global partnerships and exchanges and NHSE/I regional teams will become responsible for the coordination of local health systems' recruitment efforts.
- STPs and ICSs will implement 'lead recruiter' arrangements as part of delivering their five year workforce plans.
- NHSE will develop a new procurement framework of approved international recruitment agencies for these lead recruiters to draw on to ensure consistent operational and ethical standards.
- A best-practice toolkit will be developed with NHS Employers to highlight good practice and improve the experience and retention of international nurses through improved pastoral support. NHSE will work with DHSC and professional regulators to streamline regulatory processes.

## Retention and return to practice

NHSI's retention programme launched in 2017 has contributed to minor progress in nursing turnover, with rates reducing from 12.5% to 11.9% in participating trusts. The plan outlines further actions to improve retention, including:

- An expansion of the national programme to all trusts and into primary care, focusing on early years retention and providing hands-on support where the need is greatest.
- Boosting the numbers of nurses with lapsed registration to return to practice, working with Mumsnet to launch a new marketing campaign to inspire nurses to enrol in return to practice courses and make them aware of opportunities and support available.
- Further work in the full people plan to convert participation in return to practice courses into employment for mature staff and filled vacancies in shortage areas.

## Continuing professional development and flexible entry

The plan admits that funding pressures on the CPD budget has led the NHS to invest less in developing current staff in order to invest in training new staff. The budget for CPD and workforce development has dropped by almost half since 2013/14. The plan's authors argue that CPD should remain a mixed model with investment from local employers supplementing the national investment from HEE.

In terms of CPD funding, action will be taken to inform the full people plan, reviewing how to increase national and local investment with the aim of achieving phased restoration over the next five years of previous funding levels for CPD. Alongside increased development opportunities for current staff, the plan has identified new entry routes as a priority, proposing:

- That the final people plan explores the potential for a blended learning nursing degree programme with an online theoretical component.
- The development of a clear model that sets out the different routes into nursing and their benefits, and an expanded pilot programme for nursing associates wishing to continue their studies to registered nurse level.
- Consideration of job guarantee approaches at system level to maximise opportunities for nurses using the blended model to qualify.

## Workforce devolution

A significant policy shift is offered in the plan through its call for increased workforce devolution from the centre. The document proposes a "new operating model", arguing that a complex architecture at ALB level and a lack of alignment between workforce, service and financial planning at national and local levels has hampered efforts to put forward clear and coherent plans to tackle rising vacancies.

The plan emphasises the need for "honest conversations ... about who needs to do what at which level to increase our chances of success" in workforce planning. Contrary to some reports, it does not simply demand a shift to full control for ICSs, but instead proposes differentiated responsibilities under the following principles:

**National** workforce activity where:

- it is necessary to meet statutory responsibilities;
- to benefit from economies of scale;

- Planning is needed over a longer timeframe, eg over 15 years;
- There are clear benefits from a national role in standardisation or coordination/implementation; and/or
- National teams have specific and scarce skills/knowledge that it is not possible or desirable to duplicate sub-nationally.

**Regional** workforce activity where:

- There is a need for an assurance role in delivering national priorities such as international recruitment.
- Planning is needed over a medium-term time frame, e.g. over five years.
- There is demand for improvement support on a large scale.
- There is a need to help foster capacity and capability in local health systems.
- Decisions need to be made across a regional labour market.

**ICS** workforce activity where:

- Regional footprints are too large to affect change.
- Strong local partnerships are required.
- Planning is needed over a short- to medium-term time-frame, eg in-year or over three years.
- Decisions need to be made across a local labour market.

**Local** workforce activity to:

- Develop and sustain a clear vision for the organisations aligned to the overall ambition of the ICS.
- Develop and embedding local values, derived from the NHS Constitution.
- Build an inclusive, compassionate and improvement-focused culture.
- Ensure all people are able to do their best work.
- Recruiting and retain people for a local organisation.
- Account for the wellbeing of employees and advance equality of opportunity.
- Develop and implement organisational people plans and contribute to ICS people plans.

Shifting responsibility for planning and other workforce activity will not happen immediately, particularly in respect to ICSs, with the document announcing plans for a co-produced ICS maturity framework to benchmark workforce activities at system level. This will both inform the support that systems can expect from HEE and NHSI and their regional teams, and influence decisions on the pace and scale at which systems can take on additional responsibility.

The plan underlines consistent and timely data as a key to enhanced workforce planning while – at a national level – a new People Board, chaired by the new NHS Chief People Officer Prerana Issar, and its advisory group, will oversee the development of the full people plan later in 2019/20.

## Transformation and skills mix

While the headline announcements for healthcare professionals relate mostly to the nursing workforce, the document sets out its expectations for the development of other professions towards the goal of “delivering 21<sup>st</sup> century care”.

The people plan calls for a “transformed workforce with a more varied and rich skills mix” to support the move towards new care models and better multidisciplinary working. This ambition reflects a drive to ‘do things differently’ in workforce planning: not simply relying on linear and inflexible staffing models of the past.

A vision for the future of various medical and clinical professionals outside of nursing is provided, with an acknowledgment of the need to “refine our estimates of the number and mix of new posts needed over the next five years”. Further work will need to take place in this space to ensure these estimates reflect priorities set out in the Long Term Plan, and within local and national implementation plans due to be published this financial year. An “open debate” will take place on the level of growth needed in different staff groups, closely coinciding with discussions on education and training funding through the spending review.

Specific proposals around workforce transformation include:

- Recruitment of an additional 7,500 nurse associate trainees by December 2019.
- The establishment of a national programme board to address geographic and specialty shortages in doctors.
- A review of undergraduate medical school places, with potential to expand beyond the recent addition of 1,500 places.
- Work with the GMC and medical colleges to roll out credentialing.
- Expansion of the NHSI national retention programme to include allied health professional (AHP) support.
- Support for every STP/ICS to put in place a collaborative approach to apprenticeships and maximise levy use.
- Developing infrastructure for a new pharmacy foundation training programme.
- More flexible career entry routes for healthcare scientists;
- Training to ensure a core level of digital ability for all non-technical NHS staff.
- A new internal medicine training model for junior doctors, with the aim of increasing generalist expertise.
- The launch of a national consultation on what the NHS, patient and the public require from 21<sup>st</sup> century medical graduates.

## NHS Providers View

Trust leaders tell us that the range of workforce challenges they face, centred on recruiting and retaining the right number of staff, and building a positive culture, are their number one concern. The interim people plan is the first, clear, public recognition from our national system leaders of the severity of this issue.

As such, it is a welcome statement, containing an important acknowledgement that solving our workforce challenge isn’t just about future workforce planning and more money, important though these are. We welcome the focus on making the NHS a great place to work, changing its leadership culture and training a workforce equipped for the future. Trust leaders have a key role to play on each of these issues.

The plan also seeks to pull all of the NHS together behind this single, clear, approach: a unity of purpose that's been sadly lacking for far too long. Government, arms length bodies and front line leaders all have a vital part to play here, with more responsibility and resource rightly being devolved towards local systems. We particularly welcome the much more inclusive way this plan has been developed and the speed of the work, which have genuinely felt different.

However the publication of the interim plan also makes clear how far the NHS has to go to stabilise the workforce challenges we face. We are conscious that the development of some of the solutions helpfully flagged in the interim plan will take time and that we remain dependent, to some extent, on the publication of the final document later this year, after the 2019 spending review, and on a sustainable approach to recruitment and retention of the social care workforce.

The interim plan promises several consultations and significant further work to inform the final strategy. It is important the positive and inclusive approach of the national steering group continues under new structures in the coming months to ensure new proposals and solutions deliver maximum benefit as they are implemented at the frontline. Consultations on leadership behaviours, HR/OD practice, and systems maturity are particularly important areas for which NHSI and NHSE must receive wide input and where there will be learning for leaders across the system, nationally, regionally at system and individual organisational levels.

Colleagues in the national bodies must also continue to work closely with national stakeholders to come to a sector-wide consensus on future workforce design and the levels of funding necessary for education and training. We cannot ignore the significance of the upcoming spending review. Priorities include a clear increase in funding for CPD; clarity over financial support and targets for international recruitment; and a revision to the currently unworkable apprenticeship levy.

NHS Providers will continue to engage closely with the work of the new National People Board, ensuring that the provider voice is heard and the momentum we have helped to create is maintained in addressing both the short, and longer term, challenges facing workforce planning for health and care

## Trust Board 25 June 2019

### Agenda item 6.1

<b>Title:</b>	<b>Integrated Performance Report</b>
<b>Paper prepared by:</b>	Director of Finance & Resources and Director of Quality & Nursing
<b>Purpose:</b>	To provide the Board with the Integrated Performance Report (IPR) for May 2019.
<b>Mission/values/objectives</b>	All Trust objectives
<b>Any background papers/ previously considered by:</b>	<ul style="list-style-type: none"> <li>➤ IPR is reviewed at Trust Board each month</li> <li>➤ IPR is reviewed at Executive Management Team (EMT) meeting on a monthly basis</li> </ul>
<b>Executive summary:</b>	<p><b>Quality</b></p> <ul style="list-style-type: none"> <li>➤ The percentage of prone restraints lasting more than three minutes has reduced and met target</li> <li>➤ The number of falls has reduced this month</li> <li>➤ Medication omissions increased this month and targeted work underway to address this increase</li> <li>➤ Information Governance breaches increased after two months of good progress. Work continues to manage effectively</li> </ul> <p><b>NHSI Indicators</b></p> <ul style="list-style-type: none"> <li>➤ Not all national metric data is available yet for May.</li> <li>➤ Most significant issue is that of 5 children and young people being placed in an adult ward in May including a 15 year old</li> <li>➤ Inappropriate out of area bed placement days of 303 at the highest level since November 2018</li> </ul> <p><b>Locality</b></p> <ul style="list-style-type: none"> <li>➤ Neuro rehab open day held to market 4 available beds.</li> <li>➤ Yorkshire smoke free tender for Barnsley due for submission in June</li> <li>➤ Bed pressures remain across all geographies</li> <li>➤ Barnsley early intervention in psychosis team have been invited to be part of an international research project into outcomes associated with open dialogue</li> <li>➤ Process in place to convert use of Appleton ward from forensic learning disability to medium male secure following agreement with the specialist commissioner</li> <li>➤ Learning disability forensic outreach service currently offering a consultancy and advisory service until further recruitment is completed. Recruitment process continues</li> <li>➤ Consultant recruitment across CAMHS and learning disability services remains a challenge</li> </ul>

	<ul style="list-style-type: none"> <li>➤ Out of area beds for adult acute service users in Wakefield remains at nil</li> </ul> <p><b>Priority Programmes</b></p> <ul style="list-style-type: none"> <li>➤ Good focus on system working across the places we work in including an agreement of 19/20 priorities for the Wakefield mental health alliance and re-design of the stroke pathway in Barnsley</li> <li>➤ Mapping workshops have been held for all work streams involved in the care closer to home priority aimed at reducing the need for out of area bed placements</li> <li>➤ The data catch up in respect of the SystemOne implementation is virtually complete</li> </ul> <p><b>Finance</b></p> <ul style="list-style-type: none"> <li>➤ Pre Provider Sustainability Funding (PSF) deficit in month 2 of £457k, which is a little better than plan. Cumulative deficit is £1.2m which is £0.1m favourable to plan and includes £0.7m of pay increases paid fully in April.</li> <li>➤ Income was £0.1m lower than plan largely due to the fact not all neuro rehab beds were occupied</li> <li>➤ Out of area bed costs were £0.3m in the month and £0.6m cumulatively with one service user accounting for £0.1m of this cost in April. Costs are currently higher than plan by £0.2m</li> <li>➤ Agency staffing costs were £0.6m, 45% higher than plan</li> <li>➤ Net savings on pay amounted to £124k in-month and £471k year-to-date</li> <li>➤ CIP delivery of £1,353k is slightly below plan.</li> <li>➤ Cash reduced to £24.6m in May with 2018/19 PSF monies expected in quarter 2.</li> </ul> <p><b>Workforce</b></p> <ul style="list-style-type: none"> <li>➤ Sickness absence reduced to 4.6% in May which is a 0.1% improvement compared to April but higher than the same month last year</li> <li>➤ The Trust is above 80% compliance for all mandatory training programmes</li> <li>➤ Staff turnover reduced to 10.4% in month</li> <li>➤ Actual level of vacancies (pre use of temporary staffing) is currently 10.3%</li> </ul>
<b>Recommendation:</b>	<b>Trust Board is asked to NOTE the Integrated Performance Report and COMMENT accordingly.</b>
<b>Private session:</b>	Not applicable

# Integrated Performance Report Strategic Overview



**May 2019**

With **all of us** in mind.



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## Introduction

Please find the Trust's Integrated Performance Report (IPR) for May 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 provide a report that showcases the breadth of the organisation and its achievements, meet the requirements of our regulators and provides 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 April 19, the Trust undertook work to review and refresh the summary dashboard for 2019/20 to ensure it remains fit for purpose and aligns to the Trust's updated objectives for 2019/20. These updates are planned to take effect as soon as possible with some taking effect this month. A number of other developments identified by Trust board are being worked on and will be incorporated in the IPR in the coming months. This includes further information related to mental health act assessments; additional workforce metrics to include leavers feedback; health and safety metrics; NHS access standards which we intend to flow from the end of quarter 1.

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 four strategic objectives are:

- Improving health
- Improving care
- Improving resources
- Making SWYPFT a great place to work

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.

The Trust successfully went live with SystemOne for mental health during February and March 2019. This has resulted in delays to some information being available and there is increased requirement for data quality checking. As such a number of metrics are not included in this report. It is currently expected that the majority of information will be available early July, although reporting against some access targets may take longer than this.

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 2019/20. Some metrics require development and it is anticipated that these will be ready by end of quarter 1, reported from July 19 onwards.

KPI	Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-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	
<b>Improve people's health and reduce inequalities</b>	<b>Target</b>	<b>Jun-18</b>	<b>Jul-18</b>	<b>Aug-18</b>	<b>Sep-18</b>	<b>Oct-18</b>	<b>Nov-18</b>	<b>Dec-18</b>	<b>Jan-19</b>	<b>Feb-19</b>	<b>Mar-19</b>	<b>Apr-19</b>	<b>May-19</b>	<b>Year End Forecast</b>	
% service users followed up within 7 days of discharge	95%	100%	97.7%	94.9%	98.4%	96.9%	99.0%	95.4%	100%	99.2%	98.2%	96.2%	Due July 19	4	
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks <sup>1</sup>	90%	86.7%	84.6%			84.2%			82.8%			Due July 19		95%	
Out of area beds <sup>2</sup>	Q1 940, Q2 846, Q3 752, Q4 658	375	448	620	394	200	430	269	299	163	154	207	303	1	
Physical Health - Cardiometabolic Assessment (CMA) - Proportion of clients with a CMA Community Inpatient <sup>9</sup>	Community 75%	81.1%	82.0%	82.8%	84.1%	84.5%	84.5%	83.8%	83.3%	83.2%	88.1%	88.0%	87.6%	4	
	Inpatient 90%	90.6%	93.3%	91.2%	90.1%	91.0%	92.5%	95.3%	97.4%	96.6%	90.2%	92.6%	91.5%	4	
IAPT - proportion of people completing treatment who move to recovery <sup>5</sup>	50%	53.2%	54.0%	52.1%	47.1%	50.8%	50.1%	57.8%	55.1%	55.0%	57.0%	53.3%	60.3%	4	
Number of suicides (per 100,000) population	tbc	Reporting to commence for 19/20													
Delayed Transfers of Care	3.50%	2.6%	2.4%	2.4%	1.5%	1.6%	1.9%	1.7%	1.8%	1.6%	1.6%	1.4%	0.4%	4	
<b>Improve the quality and experience of care</b>	<b>Target</b>	<b>Jun-18</b>	<b>Jul-18</b>	<b>Aug-18</b>	<b>Sep-18</b>	<b>Oct-18</b>	<b>Nov-18</b>	<b>Dec-18</b>	<b>Jan-19</b>	<b>Feb-19</b>	<b>Mar-19</b>	<b>Apr-19</b>	<b>May-19</b>	<b>Year End Forecast</b>	
Friends and Family Test - Mental Health	85%	82%	88%	91%	88%	89%	86%	90%	87%	84%	95%	95%	86%	85%	
Friends and Family Test - Community	98%	98%	99%	97%	98%	100%	97%	99%	97%	98%	99%	98%	99%	98%	
Patient safety incidents involving moderate or severe harm or death (Degree of harm subject to change as more information becomes available) <sup>4</sup>	trend monitor	20	29	23	16	30	35	20	34	29	29	23	41		
IG confidentiality breaches	<=8 Green, 9-10 Amber, 11+ Red	14	16	14	15	14	20	11	10	13	9	3	11		
Proportion of people detained under the MHA who are Black, Asian & Minority Ethnic <sup>7</sup>	trend monitor	15.1%	14.1%			13.0%			16.6%			Due July 19		N/A	
CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks <sup>3</sup>	trend monitor	34.9%	35.6%	37.9%	37.0%	39.1%	34.4%	33.4%	31.5%	26.7%	24.3%	26.3%	Due July 19		
Psychology waiting times	tbc	Reporting to commence in 19/20													
Access within one hour of referral to liaison psychiatry services and children and young peoples' equivalent in A&E departments	tbc	Reporting to commence in 19/20													
<b>Improve the use of resources</b>	<b>Target</b>	<b>Jun-18</b>	<b>Jul-18</b>	<b>Aug-18</b>	<b>Sep-18</b>	<b>Oct-18</b>	<b>Nov-18</b>	<b>Dec-18</b>	<b>Jan-19</b>	<b>Feb-19</b>	<b>Mar-19</b>	<b>Apr-19</b>	<b>May-19</b>	<b>Year End Position</b>	
Surplus/(Deficit)	In line with Plan	(£464k)	(£125k)	(£139k)	£424k	(£73k)	(£80k)	£158k	£714k	(£244k)	(£1240k)	(£728k)	(£457k)	(£240k)	
Agency spend	In line with Plan	£484k	£526k	£575k	£522k	£537k	£536k	£530k	£596k	£545k	£634k	£613k	£641k	£7.1m	
CIP delivery		£1074k	£1981k	£2737k	£3615k	£4452k	£6015k	£6779k	£8764k	£9669k	£10574k	£670k	£1353k	£10.7m	
Staffing costs compared to plan <sup>10</sup>	tbc	Reporting to commence in 19/20											(£367k)	(£124k)	tbc
Completion of milestones assumed in the optimisation of SystmOne for mental health	tbc	Reporting to commence in 19/20													
Financial risk in forecast	0	Reporting to commence in 19/20											£1.5m	£1.5m	-
<b>Making SWYPFT a great place to work</b>	<b>Target</b>	<b>Jun-18</b>	<b>Jul-18</b>	<b>Aug-18</b>	<b>Sep-18</b>	<b>Oct-18</b>	<b>Nov-18</b>	<b>Dec-18</b>	<b>Jan-19</b>	<b>Feb-19</b>	<b>Mar-19</b>	<b>Apr-19</b>	<b>May-19</b>	<b>Year End Position</b>	
Sickness absence	4.5%	4.4%	4.5%	4.5%	4.6%	4.8%	4.9%	5.0%	5.1%	5.1%	5.0%	4.7%	4.6%	5.0%	
Staff Turnover <sup>6</sup>	10%	11.6%	12.4%	13.0%	12.8%	12.5%	12.3%	12.0%	12.0%	12.0%	11.9%	11.9%	10.4%		
Staff FFT survey - % staff recommending the Trust as a place to receive care and treatment	80%	75%	N/A	N/A	N/A	71%	N/A	N/A	N/A	N/A	75%	N/A	N/A		
Staff FFT survey - % staff recommending the Trust as a place to work	N/A	70%	N/A	N/A	58%	N/A	N/A	N/A	N/A	N/A	65%	N/A	N/A	N/A	
Actual level of vacancies	tbc	Reporting to commence in 19/20											10.4%	10.3%	
% leavers providing feedback	tbc	Reporting to commence in 19/20													

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.

Summary

Quality

National Metrics

Locality

Priority Programmes

Finance/Contracts

Workforce

**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 - 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. The reported figure is a Trust wide position.

6 - Introduced into the summary for reporting from 18/19.

7 - Introduced into the summary for reporting from 18/19. Black, Asian & Minority Ethnic (BAME) includes mixed, Asian/Asian British, black, black British, other

8 - Work has taken place to identify a suitable metric across all Trust smoking cessation services. The metric will identify the 4 week quit rate for all Trust smoking cessation services. National benchmark for 17/18 was 51%. Q1 data will be available in September 18.

9 - The figure shown is the proportion of eligible clients with a cardiometabolic assessment. This may not necessarily align to the CQUIN which focuses on the quality of the assessment.

10 - Staffing costs compared to plan is reported per month not cumulative.

#### Lead Director:

- This section has been developed to demonstrate progress being made against Trust objectives using a range of key metrics.
- A number of targets and metrics are currently being developed and some reported quarterly.
- Opportunities for benchmarking are being assessed and will be reported back in due course.
- More detail on areas of underperformance are included in the relevant section of the Integrated Performance Report.

The performance information above shows the performance rating metrics for the 2017 Single Oversight Framework which captures Trust performance against quality, finance, operational metrics, strategy and leadership under one single overall rating. The most significant reasons for the Trust to be rated as 2 relates to our 16/17 agency expenditure performance and our financial risk.

#### Quality

- The percentage of prone restraints lasting more than 3 minutes has reduced and target met
- The number of falls has reduced this month
- Medication omissions increased since last month and targeted work underway to address this increase
- IG breaches increased after two months of significant progress but work ongoing to manage effectively

#### NHSI Indicators

- Not all national metric data is available yet for May.
- Most significant issue is that of 5 children and young people being placed in an adult ward (total of 29 days) in May including a 15 year old
- Inappropriate out of area bed placement days of 303 at the highest level since November 2018

#### Locality

- Neuro rehab open day held to market 4 available beds.
- Yorkshire smoke free tender for Barnsley due for submission in June
- Bed pressures remain across all geographies
- Barnsley early intervention in psychosis team have been invited to be part of an international research project into outcomes associated with open dialogue
- Process in place to convert use of Appleton ward from forensic learning disability to medium male secure following agreement with the specialist commissioner
- Learning disability forensic outreach service currently offering a consultancy and advisory service until further recruitment is completed. Recruitment process continues
- Consultant recruitment across CAMHS and learning disability services remains a challenge
- Out of area beds for adult acute service users in Wakefield remains at nil

#### Priority Programmes

- Good focus on system working across the places we work in including an agreement of 19/20 priorities for the Wakefield mental health alliance and re-design of the stroke pathway in Barnsley
- Mapping workshops have been held for all work streams involved in the care closer to home priority aimed at reducing the need for out of area bed placements
- The data catch up in respect of the SystemOne implementation is virtually complete

#### Finance

- Pre Provider Sustainability Funding (PSF) deficit in month 2 of £457k, which is a little better than plan. Cumulative deficit is £1.2m which is £0.1m favourable to plan and includes £0.7m of pay increases paid fully in April.
- Income was £0.1m lower than plan largely due to the fact not all neuro rehab beds were occupied
- Out of are bed costs were £0.3m in the month and £0.6m cumulatively with one service user accounting for £0.1m of this cost in April. Costs are currently higher than plan by £0.2m
- Agency staffing costs were £0.6m, 45% higher than plan
- Net savings on pay amounted to £124k in-month and £471k year-to-date
- CIP delivery of £1.353k is slightly below plan.
- Cash reduced to £24.6m in May with 2018/19 PSF monies expected in quarter 2.

#### Workforce

- Sickness absence reduced to 4.6% in May which is a 0.1% improvement compared to April but higher than the same month last year
- The Trust is above 80% compliance for all mandatory training programmes
- Staff turnover reduced to 10.4% in month

Summary

Quality

National Metrics

Locality

Priority Programmes

Finance/Contracts

Workforce

Quality Headlines

Section	KPI	Objective	CQC Domain	Owner	Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Year End Forecast		
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks <sup>5</sup>	Improving Health	Responsive	CH	TBC	39.8%	34.9%	35.6%	37.9%	37.0%	39.1%	34.4%	33.4%	31.5%	26.7%	24.3%	26.3%	Due July 19	N/A		
Complaints	Complaints closed within 40 days	Improving Health	Responsive	TB	80%	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	50% 1/2	31% 4/13	44% 5/18	1		
	% of feedback with staff attitude as an issue	Improving Health	Caring	AD	< 20%	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	11%	36% 4/11	28% 5/18	4		
Service User Experience	Friends and Family Test - Mental Health	Improving Health	Caring	TB	85%	75%	82%	88%	91%	88%	89%	86%	90%	87%	84%	95%	95%	86%	4		
	Friends and Family Test - Community	Improving Health	Caring	TB	98%	100%	98%	99%	97%	98%	100%	97%	99%	97%	98%	99%	98%	99%	4		
Quality	Staff FFT survey - % staff recommending the Trust as a place to receive care and treatment	Improving Health	Caring	AD	80%	N/A	75%	N/A	N/A	71%	N/A	N/A	N/A	N/A	N/A	75%	N/A	N/A	N/A		
	Staff FFT survey - % staff recommending the Trust as a place to work	Improving Health	Caring	AD	N/A	N/A	70%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		
	Number of compliments received	Improving Health	Caring	TB	N/A	109	44	27	45	48	63	26	60	49	10	15	64	N/A			
	Number of Duty of Candour applicable incidents <sup>4</sup>	Improving Health	Caring	TB	N/A	308													21	N/A	
	Duty of Candour - Number of Stage One exceptions <sup>4</sup>	Improving Health	Caring	TB	N/A	11													0	Due July 19	
	Duty of Candour - Number of Stage One breaches <sup>4</sup>	Improving Health	Caring	TB	0	1	0	0	0	0	0	0	0	0	0	0	0	1			
	% Service users on CPA given or offered a copy of their care plan	Improving Care	Caring	CH	80%	85.8%	86.2%	88.7%	86.3%	86.4%	86.6%	86.5%	87.5%	87.5%	Due July 19					4	
	Number of Information Governance breaches <sup>3</sup>	Improving Health	Effective	MB	<=9	11	14	16	14	15	14	20	11	10	13	9	3	11			
	Delayed Transfers of Care <sup>10</sup>	Improving Care	Effective	CH	3.5%	2.1%	2.6%	2.4%	2.4%	1.5%	1.6%	1.9%	1.7%	1.8%	1.6%	1.6%	1.4%	0.4%	4		
	Number of records with up to date risk assessment - Inpatient <sup>11</sup>	Improving Care	Effective	CH	tbc	85.0%	87.5%	78.5%	84.9%	91.0%	86.5%	84.3%	83.2%	89.3%	84.6% **	Due July 19					N/A
	Number of records with up to date risk assessment - Community <sup>11</sup>					78.4%	78.3%	74.6%	77.5%	78.4%	81.7%	86.2%	93.8%	92.9%	76.4% **	Due July 19					N/A
	Total number of reported incidents	Improving Care	Safety Domain	TB	trend monitor	1090	1039	1168	1004	863	1085	1109	985	1098	1048	1094	1153	1233	N/A		
	Total number of patient safety incidents resulting in Moderate harm. (Degree of harm subject to change as more information becomes available) <sup>9</sup>	Improving Care	Safety Domain	TB	trend monitor	13	15	21	21	12	21	25	17	23	21	19	19	31	N/A		
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) <sup>9</sup>	Improving Care	Safety Domain	TB	trend monitor	1	1	4	0	3	4	5	1	1	1	3	1	6	N/A		
	Total number of patient safety incidents resulting in death harm. (Degree of harm subject to change as more information becomes available) <sup>9</sup>	Improving Care	Safety Domain	TB	trend monitor	5	4	4	2	1	5	5	2	10	7	7	3	4	N/A		
	MH Safety thermometer - Medicine Omissions	Improving Care	Safety Domain	TB	17.7%	20.6%	18.4%	23.2%	22.4%	22.1%	17.8%	22.0%	29.8%	23.5%	13.9%	17.7%	24.5%	27.0%	3		
	Safer staff fill rates	Improving Care	Safety Domain	TB	90%	120%	118%	118%	117%	116%	116%	119%	118%	119%	119%	118%	118%	Due July 19	4		
	Safer Staffing % Fill Rate Registered Nurses	Improving Care	Safety Domain	TB	80%	100%	99.5%	96.4%	92.5%	93.7%	98.3%	99.1%	96.6%	98.7%	97.5%	96.5%	96.6%	N/A			
	Number of pressure ulcers (attributable) <sup>1</sup>	Improving Care	Safety Domain	TB	N/A	29	29	26	21	30	34	29	30	30	30	44	41	46	N/A		
	Number of pressure ulcers (avoidable) <sup>2</sup>	Improving Care	Safety Domain	TB	0	0	1	0	1	0	0	0	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	4			
% of prone restraint with duration of 3 minutes or less <sup>4</sup>	Improving Care	Safety Domain	CH	80%	61.3%	75.0%	76.3%	72.7%	72.7%	88.6%	81.3%	90.9%	82.4%	80.6%	88.0%	75.8%	87.5%	4			
Number of Falls (inpatients)	Improving Care	Safety Domain	TB	TBC	40	44	43	37	52	40	41	49	39	48	59	52	40	N/A			
Number of restraint incidents	Improving Care	Safety Domain	TB	N/A	211	143	192	151	134	190	201	136	165	207	287	303	N/A				
No of staff receiving supervision within policy guidance <sup>7</sup>	Improving Care	Well Led	CH	80%	82.8%			83.7%			82.5%			84.9%			Due July 19	4			
% people dying in a place of their choosing	Improving Care	Caring	CH	80%	ing commenced J			92.9%	85.7%	90.0%	89.2%	90.9%	83.3%	87.9%	80.0%	92.0%	82.6%	82.6%	85.7%		
Smoking Cessation - 4 week quit rate <sup>12</sup>	Improving Care	Effective	CH	tbc	63.0%			65%			63%			Due July 19			Due Oct 19				
Infection Prevention	Infection Prevention (MRSa & C.Diff) All Cases	Improving Care	Safety Domain	TB	6	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	4		

\* See key included in glossary

Figures in italics are not finalised

\*\* - figures not finalised, outstanding work related to 'catch up' activities in relation to the SystemOne implementation impacting on reported performance.

## Quality Headlines

- 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.
12. This metric has been identified as suitable metric across all Trust smoking cessation services. The metric identifies 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.

## Quality Headlines

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

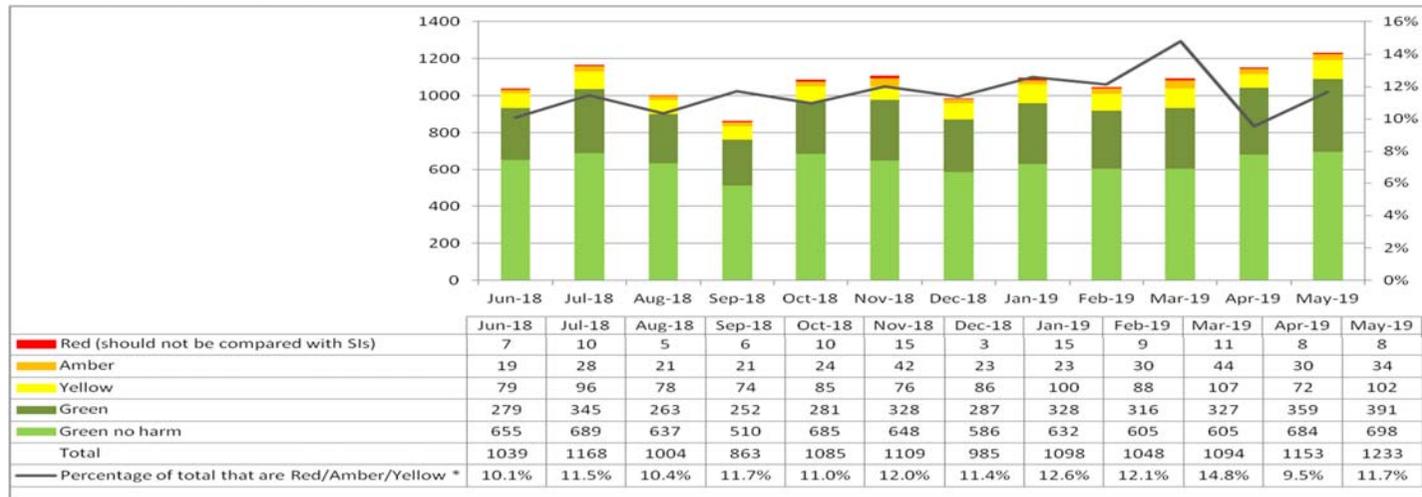
- Number of restraint incidents - the number of restraint incidents during May has increased (303) compared to previous months, please see below headline related to reducing restrictive physical intervention, which gives more detail.
- NHS Safety Thermometer - medicines omissions – performance has continued to deteriorate in May 19 compared to previous months and stands at 27%. Some issues with data collection have been identified which are impacting on the reported position. The pharmacy team have undertaken some ward audits and it has been identified that if a patient is absent from the ward then this is being counted as an omission, this should be excluded. Further work to continue and action plans being drawn. A data collection brief has been circulated to assist with recording issues. Shared learning from both within the Trust and peer organisations is also being undertaken. Figures for medicines omissions have increased overall.

- Number of falls (inpatients) - May 19 has seen a further decrease in fall incidents during the month compared to the previous months and now sits within previous months levels. May 19 falls related to Calderdale and Wakefield remained predominantly due to an increase in service users with high acuity high and as such increased levels of observations being put into place to mitigate the risk. Staffing has been increased as a result of the acuity and falls risks which is reflective of the current service user group awaiting longer term placements.

## Safety First

### Summary of Incidents since June 2018

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



\* A high level of incident reporting, particularly of less severe incidents is an indication of a strong safety culture (National Patient Safety Agency, 2004: Seven Steps to Patient Safety). The distribution of these incidents shows 86% are low or no harm incidents.

Safety First cont...

Summary of Serious Incidents (SI) by category 2018/19 and 2019/20

	Q1 19/20 (Apr & May Only)	Q2 18/19	Q3 18/19	Q4 18/19	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Total
Death - cause of death unknown/ unexplained/ awaiting confirmation	3	0	0	1	0	0	0	0	0	0	0	0	1	0	1	2	4
Informal patient absent without leave	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Information disclosed in error	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Lost or stolen hardware	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Lost or stolen paperwork	0	1	1	0	0	0	1	0	1	0	0	0	0	0	0	0	2
Self harm (actual harm) with suicidal intent	1	0	1	0	0	0	0	0	1	0	0	0	0	0	0	1	2
Suicide (incl apparent) - community team care - current episode	2	3	4	11	0	2	1	0	2	1	1	5	3	3	1	1	20
Suicide (incl apparent) - community team care - discharged	0	1	0	2	2	0	1	0	0	0	0	2	0	0	0	0	5
Suicide (incl apparent) - inpatient care - current episode	0	0	1	1	0	0	0	0	1	0	0	0	0	1	0	0	2
Unwell/illness	0	1	1	0	0	0	1	0	0	0	1	0	0	0	0	0	2
Allegation of violence or aggression	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Physical violence (contact made) against staff by patient	0	0	1	0	1	0	0	0	1	0	0	0	0	0	0	0	2
Pressure Ulcer - Category 3	1	1	0	2	1	1	0	0	0	0	0	0	0	2	0	1	5
<b>Total</b>	<b>8</b>	<b>9</b>	<b>10</b>	<b>17</b>	<b>4</b>	<b>5</b>	<b>4</b>	<b>0</b>	<b>6</b>	<b>2</b>	<b>2</b>	<b>7</b>	<b>4</b>	<b>6</b>	<b>3</b>	<b>5</b>	<b>48</b>

- Incident reporting levels have been checked and remain within the expected range.
- Degree of harm and severity are both subject to change as incidents are reviewed and outcomes are established.
- Reporting of deaths as red incidents in line with the Learning from Healthcare Deaths has increased the number of red incidents. Deaths are re-graded upon receipt of cause of death/clarification of circumstances.
- All serious incidents are investigated using Systems Analysis techniques. Further analysis of trends and themes are available in the quarterly and annual incident reports, available on the patient safety support team intranet pages.  
See <http://www.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 May 2019
- Patient safety alerts not completed by deadline of May 2019 - None

Mortality

A new Clinical Mortality review group was held on 29/3/19 which focussed on learning and action from outcomes from learning from deaths reviews, including serious incidents, structured judgement reviews and other investigations. A further group will be held in June to continue this work.

Regional work: A meeting took place 5 April 2019 with the Northern Alliance. Looked at themes, and deaths from choking were discussed. Further work to be carried out internally and regionally. Next meeting July.

Training: Further Structured Judgement Reviewer training is being arranged for July and December.

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. These include learning to date. See <http://www.southwestyorkshire.nhs.uk/about-us/performance/learning-from-deaths/>

Learning: Mortality is being reviewed and learning identified through different processes:

-Serious incidents and service level investigations – learning is shared in Our Learning Journey report for 2017/18

-Structured Judgement Reviews – learning from 2017/18 and Q1-2 cases is included in the latest report.

56% of reviews completed to date rated overall care as good or excellent

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.

## Safer Staffing

Overall Fill Rates: 117%

Registered fill rate: (day + night) 94.9%

Non Registered fill rate: (day + night) 137.9%

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

BDU Fill rates - February 19 - May 19

Overall Fill Rate Unit	Month-Year		
	Mar-19	Apr-19	May-19
Specialist Services	103%	119%	118%
Barnsley	122%	117%	107%
C & K	108%	110%	114%
Forensic	115%	112%	108%
Wakefield	140%	143%	147%
<b>Overall Shift Fill Rate</b>	<b>118%</b>	<b>118%</b>	<b>117%</b>

The figures (%) for May 2019:

Registered Staff: Days 87.5 (a decrease of 0.8 on the previous month); Nights 102.3 (a decrease of 2.7 on the previous month)

Registered average fill rate: Days and nights 94.9 (a decrease of 1.7 on the previous month)

Non Registered Staff: Days 134.4 (a decrease of 2.7 on the previous month); Nights 141.4 (an increase of 1.4 on the previous month)

Non Registered average fill rate: Days and nights 137.9 (a decrease of 0.6 on the previous month)

Overall average fill rate all staff: 116.4 (a decrease of 1.1 on the previous month)

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

### Summary

No ward has fallen below the 90% overall fill rate. Of the 31 inpatient areas 22, a decrease of three on the previous month, (70.4%) achieved greater than 100%. Indeed of those 22 areas, 12 again achieved greater than 120% fill rate. This was consistent with the previous month.

Registered On Days (Trust Total 88.3%)

The number of wards that have failed to achieve 80% increased by one to seven (22.4%) on the previous month. Five wards were within the Forensic BDU (Bronte, Appleton, Johnson, Hepworth and Waterton). The others were Enfield Down in Calderdale and Kirklees BDU as well as Willow Ward within the Barnsley BDU. There were various factors cited including vacancies, sickness and supporting acuity across the BDU.

Registered On Nights (Trust Total 105%)

One ward (Bronte within the Forensic BDU with 72.6%) has fallen below the 80% threshold. The number of wards who are achieving 100% and above fill rate on nights fell decreased to 17 wards (54.4%) this month.

Average Fill Rates for most areas showed a marked fluctuation. Barnsley BDU decreased by 10% to 107%. Calderdale and Kirklees BDU increased by 4% to 114%. Forensic BDU were 108% a decrease of 4%. Wakefield BDU increased by 4% to 147%. Specialist services were 118% a decrease of 1%. Overall fill rate for the trust decreased by 1% to 118%.

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

During May 19, there has been an increase in the number of confidentiality IG breaches reported compared to the reduced number reported over the last two months. These included 3 incidents of lost or stolen paperwork, 4 patient healthcare record issues and 4 information disclosed in error.

Work continues in the Trust to support services to reduce the number of IG incidents occurring.

None of these incidents required reporting to the information commissioners office.

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## Commissioning for Quality and Innovation (CQUIN)

All quarter 4 submissions were undertaken to timescale. Feedback from some commissioners is still awaited and final results from the national audit by Royal College of Psychiatry awaited for the physical health CQUIN.

The Trust is currently working on the 19/20 CQUIN requirements. Applicable indicators were agreed with each commissioner as part of the contract negotiation process. Overall value of the scheme has reduced to 1.25% of contract value. The indicators have been identified as follows:

- Staff flu vaccinations (Barnsley)
- Alcohol and tobacco (Barnsley, Calderdale, Kirklees, Wakefield)
- 72hr follow up post discharge (Barnsley, Calderdale, Kirklees, Wakefield)
- Mental health data - Mental Health Data: Data Quality Maturity Index; Mental Health Data: Interventions (Barnsley, Calderdale, Kirklees, Wakefield)
- Use of anxiety disorder specific measures in IAPT (Barnsley)
- Three high impact actions to prevent hospital falls (Barnsley)
- Improving awareness and uptake of screening and immunisation services in targeted groups (Barnsley Child Health service)
- Improving physical health for people with severe mental illness (Calderdale, Kirklees, Wakefield)
- Develop and submit a quality improvement plan in Q1 and report on progress and achievement in Q4 via an annual quality report (Wakefield TB)
- Healthy weight in adult secure MH services (Forensic)

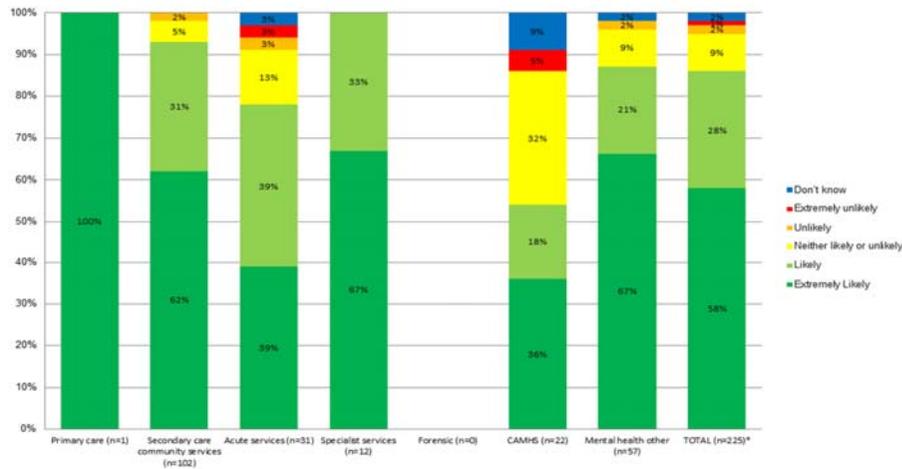
Work is underway to develop action plans to ensure maximum achievement for the year.

Patient Experience

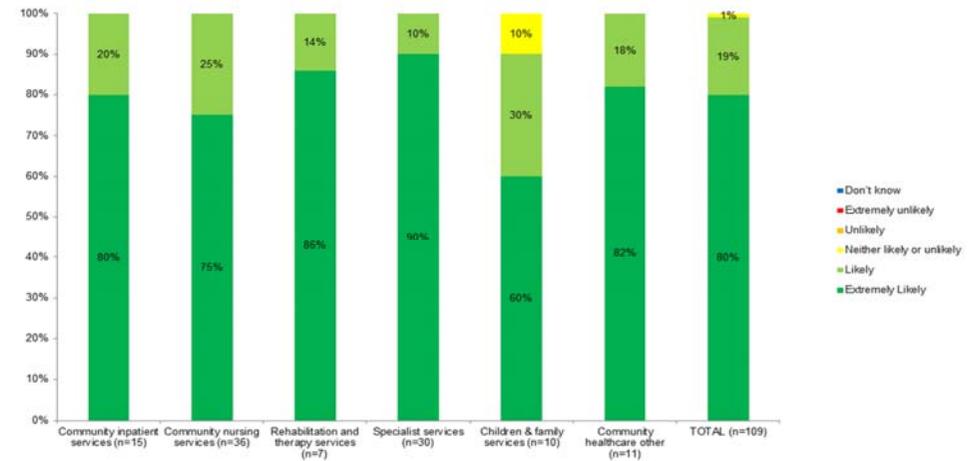
Friends and family test shows

- Community Services – 99% would recommend community services.
- Mental Health Services – 86% would recommend mental health services.
- Significant variance across the services in the numbers extremely likely to recommend the Trust – between 36% in child and adolescent mental health services and 100% in primary care mental health services
- Small numbers stating they were extremely unlikely to recommend.

Mental Health Services



Community Services



Returns remain low due to the Appointment Reminder / firmeds and family text messaging service being offline as part of the transition from RiO to SystmOne and ongoing issues with the patient experience electronic tablets. The text messaging system is due to recommence in June and a resolution should be reached by mid-July regarding the electronic tablets.

## Reducing Restrictive Physical Intervention

There were 303 restraints reported in May this being a 5% increase on the April figures that stood at 288. The new data capture set on Datix is now fully in use, this means that we can now examine all levels of holds and positions of restraint Service user are held in. This does mean however that the number of levels of holds and restraint positions will appear to increase this however is not the case, in the past staff were only able to record on Datix one level of hold and one position of restraint used in any one incident where restrictive physical interventions were used, however due to the complex nature of incidents various holds and positions are often used. The new data set will ensure that we can be confident that we can see what restrictive physical interventions are being to maintain the safety of Service users and others in our care and have confidence in the transparency of our recording of such events to the optimum degree. The highest proportion of all restraints again was in the standing position 254 which equates to 29% of all positions used. Seated restraints stood at 185 that equates to 21% of all positions used. In relation to incidents of that would be deemed prone restraint, there was a 13% increase of prone restraint use in May (54) as opposed to April (46).

Please Note. The New Data set was incorporated into Datix mid-April, the changes to Daix also included the ability for staff to report/record multiple positions that are used in a single incident of restraint. Although this means that the number of restraints by position will be a higher number than the number of all restraints for any given time period it does mean that we have complete transparency of what physical interventions are being used by staff in any given incident of Restrictive Physical Intervention use, which will be needed with the Restraint Reduction Standards published in May 2019 for compliance 2020.

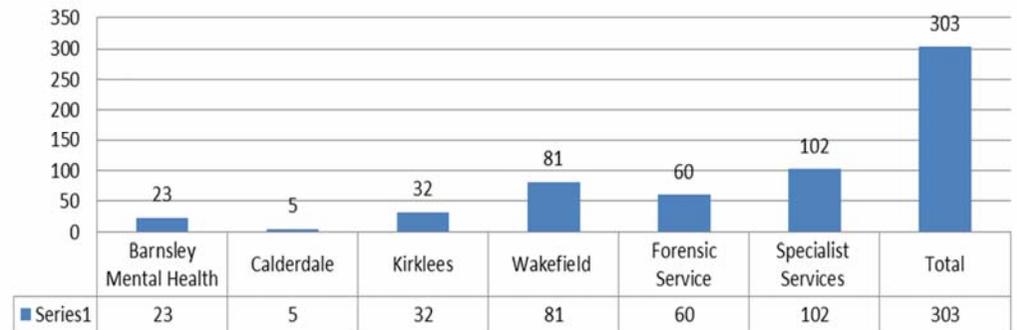
The 48 incidents of prone restraint involved 28 individual service users. Of these 48 incidents of not rolling a service user when going into prone reasons given for this were 11 to facilitate a safe seclusion exit, 22 to facilitate the administration of I.M medication, 15 due to the level of aggression displayed. 1 Incident was recorded but outside of trained techniques due to incident, for further investigation.

The RRPI team as always continue during training to place all the emphasis on non-physical interventions 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 90% of prone restraints being under 3 minutes is discussed at length and the importance of striving to maintain this is strongly emphasised. In May 87.5% of prone restraints under 3 minutes.

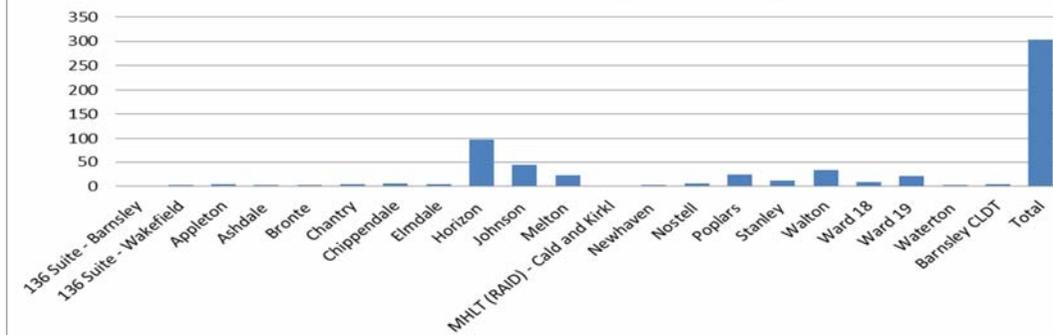
### Of 303 Incidents of Restraint in May 2019 Restraint Positions Utilised



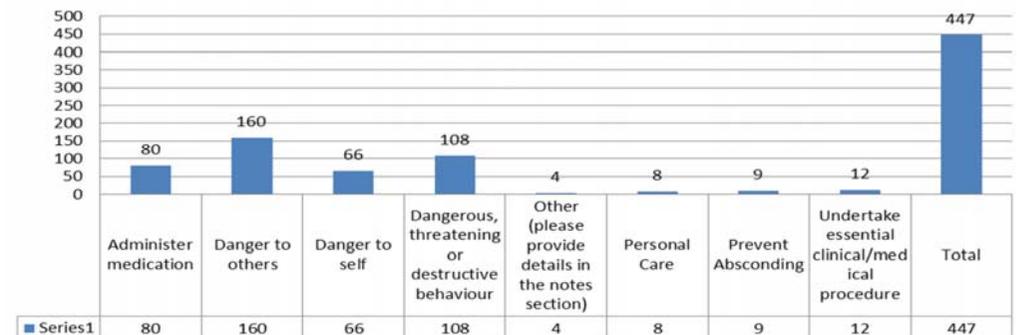
### All Incidents of Restraint by BDU May 2019



### All Incidents of Restraint by Team May 2019



### All Restraints by Reason for Restraint May 2019



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## Care Quality Commission (CQC)

### Well-led inspection

CQC carried out our well-led review on the 11th and 12th June. As part of this review CQC interviewed several members of our senior executive management team and non-executive directors and held a number of focus groups.

### Feedback from the well-led inspection

CQC reported that there was a strong sense of vision and values amongst leaders and commented they had experienced open and honest communication during our well led interviews. They acknowledged where progress had been made since their previous visit e.g. diversity and equality work. CQC also told us our governance structures were strong and clear although some of these needed more time to become fully embedded.

### Data information requests

We continued to receive a steady flow of information data requests during and following the well-led inspection. . This was significantly less than had been requested when CQC last visited in 2018. We are not expecting any further data requests at the current time.

### The next phase of the process

CQC have told us they are intending on getting our core service and well-led reports back to us by the end of July. This is earlier than expected and we will have 10 working days to then make any factual accuracy comments before the report is then made public. We must remember that CQC could undertake further visits to our core services at any time.

## Safeguarding

- Conducted a quality monitoring visit to the older peoples service in Barnsley, resulting in consideration of protocols, link practitioner involvement and reporting of incidents
- Co-developed a briefing with the Barnsley Hospital safeguarding lead to support staff in care homes around where to source information to support decision making around safeguarding and pressure ulcers as part of the Barnsley safeguarding adult board subgroup work.
- Delivered domestic abuse training to the neurological rehabilitation unit as part of the actions from a domestic homicide review, contextual safeguarding training to the children's speech and language therapy team and the children's society "seen and heard" training session to the Wakefield and district safeguarding children's board (WDSCB) learning and development sub group.
- The named nurse safeguarding children hosted and chaired the regional safeguarding professionals forum.

## Infection Prevention Control (IPC)

- Mandatory training for infection prevention and control and hand hygiene continues to be maintained above 80% trust training threshold.
- There have been not MRSA, C difficile MSSA for any BDU. There has been 1 ecoli bacteraemia at SRU (Barnsley), this cases will be peer reviewed at post infection review group , no internal target for these cases.
- There has been an outbreak of gastroenteritis on Chanrty ward in May affecting – 5 service users and 3 staff, ward closed for 7 days.



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.

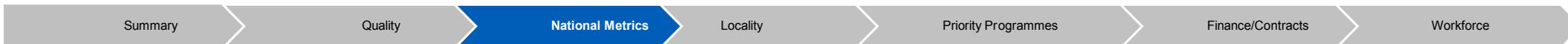
- Due to the requirements of staff to support the SystemOne go live, not all performance data is available this month at the time of report submission.

**NHS Improvement - Single Oversight Metrics - Operational Performance**

KPI	Objective	CQC Domain	Owner	Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Apr-19	May-19	Year End Forecast	Trend
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Improving Care	Responsive	CH	92%	96.2%	97.2%	98.0%	99.0%	99.3%	99.8%	98.2%	97.2%	97.2%	97.2%	99.3%	97.2%	99.2%	98.7%	4	
Maximum 6-week wait for diagnostic procedures	Improving Care	Responsive	CH	99%	100%	100%	100%	100%	97.9%	31% 41.3	44% 4.0	100%	100%	100%	97.9%	100%	98.7%	100%	4	
% Admissions Gate kept by CRS Teams	Improving Care	Responsive	CH	95%	97.5%	97.0%	99.0%	98.8%	97.6%	95.5%	97.4%	97.4%	97.6%	97.9%	98.9%	96.8%	99.2%		4	
% SU on CPA Followed up Within 7 Days of Discharge	Improving Care	Safe	CH	95%	94.9%	98.4%	96.9%	99.0%	95.4%	100.0%	99.2%	98.2%	97.7%	97.1%	97.1%	99.2%	96.2%	Due July 19	4	
Data Quality Maturity Index 4	Improving Health	Responsive	CH	95%	98.2%	98.2%	98.3%	98.2%	98.1%	98.1%	98.1%	98.0%	98.2%	96.8%	98.1%	98.0%	98.0%		4	
Out of area bed days 5	Improving Care	Responsive	CH	Q1 547, Q2 494, Q3 411, Q4 329	620	394	200	430	269	299	163	154	1181	1450	899	616	207	303	1	
IAPT - proportion of people completing treatment who move to recovery 1	Improving Health	Responsive	CH	50%	52.1%	47.1%	50.8%	50.1%	57.8%	55.1%	55.0%	57.0%	54.4%	51.1%	52.4%	55.4%	53.3%	60.3%	3	
IAPT - Treatment within 6 Weeks of referral 1	Improving Health	Responsive	CH	75%	94.8%	94.0%	94.6%	96.9%	91.1%	92.4%	87.1%	86.0%	91.3%	94.3%	94.4%	88.7%	82.9%	85.7%	4	
IAPT - Treatment within 18 weeks of referral 1	Improving Health	Responsive	CH	95%	99.5%	99.6%	99.7%	99.7%	99.4%	99.3%	99.0%	99.4%	99.4%	99.6%	99.6%	99.2%	98.6%	99.1%	4	
Early intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Improving Care	Responsive	CH	56%	91.4%	90.3%	94.2%	94.7%	88.6%	85.1%	85.3%	69.2%	81.7%	90.3%	92.6%	80.5%	92.0%	72.7%	4	
% clients in settled accommodation	Improving Health	Responsive	CH	60%	78.8%	79.0%	78.5%	78.2%	78.5%	78.0%	78.2%	78.2%	79.1%	78.8%	78.2%	78.2%	87.5%		4	
% clients in employment 6	Improving Health	Responsive	CH	10%	9.5%	8.9%	8.6%	9.0%	9.3%	9.2%	9.2%	9.2%	8.6%	8.8%	9.3%	9.2%	11.2%	Due July 19	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												Due June 20		2	

Mental Health Five Year Forward View	Objective	CQC Domain	Owner	Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Apr-19	May-19	Year End Forecast	Trend	
Total bed days of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	TBC	1	22	8	29	2	4	15	4	16	45	39	23	5	29	2		
Total number of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	TBC	1	2	2	3	1	1	1	1	4	6	6	3	1	5	2		
Number of detentions under the Mental Health Act	Improving Care	Safe	CH	Trend Monitor	192			184			199			212	192	184	199	Due July 19		N/A	
Proportion of people detained under the MHA who are BAME 2	Improving Care	Safe	CH	Trend Monitor	14.1%			13.0%			16.6%			15.1%	14.1%	13.0%	16.6%	Due July 19		N/A	

NHS Standard Contract	Objective	CQC Domain	Owner	Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Apr-19	May-19	Year End Forecast	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%	98.5%	99.1%	98.9%	97.0%	98.7%	98.8%	85.7%	98.6%	97.8%	98.8%	98.1%	98.9%	98.7%	99.7%	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%	100.0%	99.9%	100.0%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.7%		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%	95.5%	95.1%	91.0%	90.9%	90.8%	90.4%	90.7%	89.6%	90.8%	91.1%	90.9%	89.6%	84.1%	Due July 19	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 originally introduced from November 2017 as part of the revised NHSI Single Oversight Framework operational metrics. It measures 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

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:

- A number of metrics have not been finalised at the time of the report. This is largely related to the impact of transition to a new mental health clinical record system. Progress has been good on data catch up, but at this point in time additional data quality checking is required and not all information is fully available yet.
- The Trust continues to perform well against the majority of NHS Improvement metrics
- During May 2019, the number of service users aged under 18 years placed in an adult inpatient ward was 5. 1 15year old was placed in a bed in Barnsley, 4 admissions related to 17 year olds - 3 in Kirklees, 1 in Barnsley. The admissions continue to relate to factors 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.
- Inappropriate out of area bed placements amounted to 303 days in May which has increased compared to last month.
  - % 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**

**General community services**

**Key Issues**

- Provision of DEXA scanning ceases in June given lack of resource.
- Continence specification reviewed and re-written and submitted to CCG for approval

**Strengths**

- Neuro rehab unit held an open day on 21st May, to market 4 available beds. Initial interest in their use has been expressed.
- Tissue viability nurse - attended Westminster and presented at a national conference

**Challenges**

- Yorkshire smoke free (YSF) Barnsley tender submission is due in June.
- Child health information system (CHIS) – issues with regard to data sharing – discussions continue with partners.
- Cardiac/pulmonary rehab – remedial action plan submitted. Ongoing review of capacity and service delivery model to accommodate additional activity

**Areas of Focus**

- Stroke services – work continues in partnership with CCG and BHNFT in line with hyper-acute stroke unit and pathway remodelling. Proposed model to be independently assessed.
  - Children's services - commissioners have indicated that all services will be reviewed in 19/20
  - Development and mobilisation of 6 primary care networks in Barnsley and neighbourhood wellbeing teams
  - End of life (EOL) – ANP pilot going well. Electronic palliative care co-ordination systems (EPaCCs) being rolled out, majority now completed. Palliative care beds in care homes – initial meeting with CCG, draft paper prepared, further meeting June 26th. Macmillan spec being reviewed.
- EOL Strategy for re-write to be led by CCG
- Neighbourhood nursing demand and capacity paper – almost completed
  - Musculo skeletal service – intense work continues in the service to understand the elements of the pathways e.g., the top half of the pathway is where the capacity is an issue and does require additional admin resource, the case mix has been found to be different to what we were expecting, waiting times are under close review. The service assessment of what was deliverable in terms of timings of clinic slots, triage times appears to have been underestimated in eagerness to meet the financial envelope of the initial bid.

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

**Barnsley BDU:**

**Barnsley 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. Action plans and data improvement plans are in place and there is support with staff wellbeing.
- Work continues to implement the South Yorkshire wide model for liaison and diversion services with successful recruitment to posts in each team.

**Strengths**

- Management of patient flow.
- Recruitment to medical posts minimising agency spending
- Early intervention in psychosis team have been invited to be part of an international research project into outcomes associated with open dialogue.
- We are taking the lead as community services with professions directorate in developing safer staffing for community services.
- We are developing Lundwood Health Centre into a community focussed hub and have recently moved senior managers into the building to co-locate with front-line services, improving our communication, visibility and support for colleagues and service users and carers.

**Challenges**

- Demand and capacity in community services.
- Barnsley BDU monthly sickness rates are in excess of Trust target with a hotspot in acute services. General managers continue to work with human resource 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 community services.
- Reduction of agency and bank spend in acute services.
- Work continues with partners on integrated care networks, working with the neighbourhoods already in place.
- Sickness management.

**Calderdale & Kirklees BDU:**

**Key Issues**

- Continued pressure for adult admissions within May and June.
- Older adult wards under pressure, especially females from Trust wide admissions and pressures and very high acuity and need levels. Additional workforce costs are being seen as a consequence. Management oversight is in place to look at mitigations.
- Adult bed pressure and out of area work is progressing positively in each of the workstreams.
- A bid to the integrated care system (ICS) for additional crisis home treatment team resources has been completed and will be submitted in June. Additional monies identified to contribute to a West Yorks wide ICS crisis helpline.

**Strengths**

- High performance on mandatory training with one training area for improvement.
- Improving access to psychological therapies has met its revised access trajectory and exceeded the 50% recovery target.
- Sickness absence is well managed across BDU another positive months performance.
- Delayed transfers of care are below the target with Kirklees being one person and Calderdale zero.
- Early intervention in psychosis sustained performance well above target for people accessing services within 14 days with all teams achieving 100%

**Challenges**

- Adult occupancy levels are high in inpatients and intensive home based treatment teams.
- Caseload pressures have built up in some adult community teams. Recruitment is being reviewed in order to look at workforce options to replace leavers.
- Improving access to psychological therapies target for treatment started within 6 weeks has improved on back of recruitment and agency use in spite of national psychological wellbeing practitioner recruitment difficulties.

**Areas of Focus**

- Work streams are progressing rapidly to focus on reduction of out of area bed usage.
- Intensive support team NHSE team to meet Trust and clinical commissioning group colleagues to discuss joint action/recovery plan and lower performance outturn on last quarter returns for 2018/19. Overall 2018/19 performance was achieved.

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

- 8 learning disability beds de-commissioned by NHS England. Plan in place to assess and admit out of area medium secure service users to Appleton in place once Ministry of Justice approval is granted.
- Invitation to bid for a forensic community service has been received from NHSE. The bid will be on behalf of the West Yorkshire provider collaborative and is a 2 year pilot. The service will be evaluated nationally. The aim is to provide a community model which provides an alternative option to a secure bed.
- Learning disability forensic outreach service is offering a consultancy and advisory service across the core week. Recruitment continues and a number of appointments have been made and interviews planned across several weeks.
- Work on the recovery plan for forensic child and adolescent mental health services (FCAMHS) secure estate continues with good progress being made. Results of the health needs analysis have been shared and are likely to require some service re-design.
- Regional forensic CAMHS service review has been completed as part of the national pilot. Feedback generally very positive, action plan to address suggestions in the feedback is currently being completed.
- Successful recruitment to psychology posts at Newton Lodge which has been a significant gap for several months partially covered by agency

##### Strengths

- Strong performance on mandatory training.
- Good track record delivering commissioning for quality and innovation (CQUIN).
- Progress being made on CQC action plans.

##### Challenges

- Delivering the recovery plan for the secure estate.
- Recruitment of registered staff in all disciplines. A significant resource is being utilised to optimise recruitment activity.
- High turnover.
- Reducing sickness.
- Delivery of service improvement with a view to removing the performance notice.

##### 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

- Ensuring the culture remains positive and reflect the values of the organisation.

#### Specialist BDU:

##### Key Issues

- Consultant recruitment across CAMHS and learning disability remains a significant challenge – resulting in high agency use. Plans are in pace with respect to recruitment to two substantive posts in CAMHS.
- Waiting times from referral to treatment in Wakefield and Barnsley CAMHS remain a concern. New investment has been secured in Wakefield to target a waiting list initiative and an ADHD-related business case is under consideration in Barnsley.
- Learning disability staff vacancies remain relatively high and this creates some challenges re waiting times for specialist interventions – most notably psychology (Barnsley/Wakefield). In the vast majority of cases those waiting are receiving support from another member of the multi-disciplinary team.

##### Strengths

- Learning disability (LD) teams have completed catch up activity and quality checking following the transition to SystemOne. The first reference group meeting has now been held with a focus on tailoring the system improving the LD pathway on the system so that it is tailored to the needs of clinicians and systematically records as the pathway requires
- Calderdale and Kirklees CCGs have committed to further Autism Spectrum Condition (ASC) waiting list initiative investment in 2019/20.
- All CCGs have prioritised 2019/20 investment in development of an all-age liaison model. New care models investment is also available to facilitate early implementation

##### 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
- Ongoing focus across specialist services on staff engagement, appraisal, prevention of bullying/harassment and health and wellbeing.
- CAMHS waiting list reduction. Plans focused on strengthening early help offers and robust job planning. Oversight and Assurance arrangements operational in Wakefield. Demand and capacity modelling being progressed in Barnsley CAMHS.

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, however the acuity on the wards and maintaining safer staffing remains a significant challenge.
- 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 has made good progress and the use of agency is now significantly reduced.

##### Strengths

- Management of patient flow and for Wakefield nil out of area bed usage.
- The introduction of safety crosses for medication omissions on Stanley ward has continued to be a success and has led to no missed doses of medication in April.
- Our nurse consultant for dual diagnosis has attended a national veterans event and is leading across the BDUs and Trustwide on our accreditation under the 'getting it right first time' (GIRFT) - veterans covenant hospital alliance.

##### Challenges

- Adult acute occupancy and acuity levels remain high.
- Adult community medical vacancies and gaps continue to be a pressure leading to financial challenges.
- Expenditure on bank and agency staffing in acute services and agency spending on medical staff in community.

##### 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.
- Continue to improve performance in service area hotspots through focussed action planning.
- Preparation for re-accreditation of memory service through 'memory services national accreditation programme in July 2019

## Communications, Engagement and Involvement

### Communications and Marketing

#### Comms and marketing

- The #alofus staff wellbeing campaign won a national HSJ Value award for 'best communications initiative'.
- 'Our year' report being finalised. Trust prospectus in development.
- Comms plan developed for integrated care in Barnsley. Film has been produced focused on partnership working in the Dearne and is currently being shared. Website resource has been developed.
- Project plan being developed for the official opening of the Unity Centre in October, linked to mental health awareness day. Films of the build being developed with deadline digital. Development of a roadmap of estates investment across all our BDUs.
- Promotion and hosting of the phase 2 launch of the WY and Harrogate Health and Care Partnership 'Our neighbours' campaign
- Promotion of i-hub and the environmental sustainability challenge
- Support to EyUp! Charity, including developing a communications plan for activity for the rest of the year. Preparations being made for a launch of the next team challenge.
- SystemOne for mental health – CQC support, comms shared linked to the RIO turnoff and optimisation stage.
- Support to the nursing directorate for the CQC inspections
- Financial sustainability cartoon released, focused on reducing travel costs.
- Staff app – MySWYFT – has been launched and downloaded by 200 people so far. Publicity campaign planned to promote the app to staff who don't have routine access to IT.
- Comms and design support for the Calderdale arts and health report "Living a larger life".
- Taking a leading role in the development of a Kirklees wide partnership communication and engagement network.
- Working on a suite of improvements to support Barnsley improving access to psychological therapies (IAPT) increase their presence in Barnsley and make people more aware of their services.
- Support to the early stages of the flu campaign.

#### Engagement

- Stakeholder engagement analysis being carried out, which will then be developed into a stakeholder strategy and action plan.
- A volunteer celebration event held was held in Wakefield to coincide with volunteer week. 55 volunteers attended the celebration, each receiving a Trust thank you card. The annual volunteer awards were presented. The service is involved in the development of Wakefield Volunteer, launched on 31 May.
- Leading development of the black and minority ethnic (BAME) staff network - Supporting the building leadership for inclusion action research with the Tavistock institute, raising the profile through development of lunch and chat sessions and case studies. Support being given to the LGBTQ+ and disability networks as they establish themselves and set their scope.
- Supporting MP meetings
- Senior leader listening events preparation for June and July
- Mental health first aider training preparation for MP researchers to take place on 15 and 22 July
- Compassion Hub held in Kirklees in May, an informal special interest group which brings together people with an interest in the field of compassion. It is led by Spirit in Mind.



This is the June 2019 priority programme progress update for the integrated performance report (IPR). It is a summary of the activity conducted in the period for May 2019. The priority programme areas of work providing an update in this report are:

- Wakefield projects
- Barnsley projects
- West Yorkshire projects
- South Yorkshire projects
- Clinical record system
- Provide all care as close to home as possible (Out of Area)
- Embed #allofusimprove to enhance quality
- Make better use of digital technology.

The framework for this update is based on the Trust priorities for 2019/20 (as agreed in April 2019), and provides details of the scope, improvement aims, delivery and governance arrangements, and progress to date including risk management. Some areas of focus are for the Trust where the position is strategic and emergent; others are priority change programmes which will be delivered over 19/20. The reporting arrangements for each programme of work are identified; some are hidden as they either report elsewhere on the IPR, do not report on the IPR, or do not report this month on the IPR. The proposed delivery is in line with the agreed integrated change framework.

Priority	Scope	SRO	Change Manager	Governance Route	Improvement Aim(s)	Reporting Frequency	Narrative Update	Progress RAG rating	
<b>IMPROVE HEALTH</b>									
Work with our partners to join up care in Wakefield	<p>1. To develop and deliver partnership structures and relationships that underpin integrated working</p> <p>2. To deliver integrated networks in the neighbourhoods of Wakefield which meet the requirements of primary care home objectives whilst fully engaging the communities</p> <p>3. To develop population health management so that decisions are underpinned by a sound understanding of what the information tells us</p> <p>4. To deliver improvement programmes in key areas as identified by the partnership groups. These include:</p> <ul style="list-style-type: none"> <li>• Elderly and frailty</li> <li>• Mental health (via the MH Alliance)</li> <li>• Dementia (via the MH Alliance)</li> </ul> <p>5. SWYPFT to take a lead partnership role in the development and delivery a MH Alliance for Wakefield that oversees</p> <ul style="list-style-type: none"> <li>• the delivery of new work streams: <ul style="list-style-type: none"> <li>- Crisis pathway</li> <li>- Personality Disorder</li> <li>- Suicide prevention</li> </ul> </li> <li>• the delivery of the 8 projects that make up the dementia programme</li> <li>• the delivery of legacy commitments for the following: <ul style="list-style-type: none"> <li>- Peri-natal mental health investment</li> <li>- Psychiatric liaison core 24</li> <li>- Children and young people (CYP) eating disorders</li> <li>- Improving access to psychological therapies long term conditions (in partnership with Turning Point).</li> </ul> </li> </ul>	Sean Rayner	Sharon Carter	Transformation Board	<p>By 31/03/20</p> <ul style="list-style-type: none"> <li>• All primary care home neighbourhoods will have: <ul style="list-style-type: none"> <li>- an established integrated leadership team</li> <li>- co-produced priority areas of focus</li> <li>- population health data pack available to underpin decisions</li> <li>- produced stories that demonstrate impact for the people in their area</li> </ul> </li> <li>• Each programme area will have delivered on key improvement aims as set out at the beginning of the year.</li> </ul>	Monthly on IPR	<p>An update on progress in May is as follows:</p> <ul style="list-style-type: none"> <li>• The provider alliance agreed the priorities for 19/20 which have been approved by the Wakefield integrated care partnership (WICP, formerly the new models of care board (NMOCB)) in May.</li> <li>• Funding has been approved by WICP for a programme manager post to support the work of the mental health (MH) alliance. SWYPFT to host the programme manager on behalf of the Alliance.</li> <li>• Work is underway to produce one overarching costed proposal for the 3 areas: Adult crisis, personality disorder and chaotic lifestyle, and suicide prevention to the WICP Board on 3rd July. SWYPFT leading the production of the proposal on behalf of the provider alliance.</li> <li>• Work is progressing to produce 2 proposals bids for all age liaison and CYP 7 day crisis support.</li> <li>• In addition, a dementia work programme consisting of 8 separate projects is underway. The aim of the programme is to make Wakefield a good place to live with dementia. Each project will be informed by a project team of key stakeholders including people living with dementia and their carers.</li> </ul>	Progress Against Plan	Green
							<p>Risks are managed by each programme of work. Areas of risk to report include:</p> <p>Failure to deliver timely response to bids and proposals due to lack of resource, other work priorities and skills.</p> <p>There is a risk that the timescales are too ambitious and do not allow for sufficient time to engage with all partners and stakeholders.</p>	Management of Risk	Yellow
							<p>By 31/03/20 each programme area will have delivered on key improvement aims as set out at the beginning of the year.</p>		Grey
Work with our partners to join up care in Barnsley	<p>1. To develop and deliver partnership structures and relationships that underpin integrated working</p> <p>2. To deliver integrated care networks in the six neighbourhoods of Barnsley which meet the requirements for primary care networks whilst fully engaging the communities</p> <p>3. To develop population health management so that decisions are underpinned by a sound understanding of what the information tells us</p> <p>4. To deliver improvement programmes in key areas as identified by the partnership groups. These include:</p> <ol style="list-style-type: none"> <li>Frailty</li> <li>Cardio vascular disease (CVD)</li> <li>Stroke</li> </ol> <p>5. To develop and deliver a communication and engagement plan that promotes integrated working, inspires staff to work in different ways and helps create an empowered public that takes more responsibility for their health and wellbeing.</p> <p>To underpin this work with a clear plan for SWYPFT in via the Barnsley and South Yorkshire internal integration group.</p>	Salma Yasmeen	Sue Barton	Transformation Board	<p>By 31/03/20 All six neighbourhoods will have</p> <ul style="list-style-type: none"> <li>• an established integrated leadership team</li> <li>• co-produced priority areas of focus</li> <li>• population health data pack available to underpin decisions</li> <li>• produced stories that demonstrate impact for the people in their area</li> <li>• The integrated care outcomes framework will be used by partners to begin to demonstrate impact of the different pieces of work</li> <li>• Each programme area will have delivered on key improvement aims as set out at the beginning of the year</li> </ul>	Monthly on IPR	<p>An update on work undertaken in April and May is as follows:</p> <ul style="list-style-type: none"> <li>• Stroke: Following further exchange of information between SWYPFT/Barnsley hospitals NHS foundation Trust (BNHFT) and clinical commissioning group (CCG) discussing remodelled assumptions and proposals, an additional meeting is in place for June.</li> <li>• The neighbourhood nursing service specification has been reviewed and additional key performance indicators (KPIs) have been developed and approved by the alliance management team (AMT).</li> <li>• There was a deep dive on musculoskeletal (MSK) service in May. A new MSK steering group with a wider membership will meet on the 26 June to ensure actions from this are delivered.</li> <li>• RightCare Barnsley: IT proposal submitted from SWYPFT to support the service. Additional staffing requirement identified to support the service moving forward. Decisions required from AMT to support proposals made.</li> <li>• There was a diabetes deep dive at May's AMT where a number of issues relating to waiting lists for training and joint clinics were identified.</li> <li>• A falls, bone health and osteoporosis workshop was held on 5th April. The current baseline was discussed and gaps identified. A further workshop facilitated by the Royal Osteoporosis Society will take place on the 20th June 2019. An action plan will be developed at the workshop.</li> <li>• All general practices in Barnsley have now agreed and signed up to work as part of a Supra primary care network (PCN), and the necessary paperwork forwarded to NHS England for a go-live date of 1 July 2019. There will be 6 primary care network (PCNs) (Penistone, Central, North, North East, Dearne and South); each with a population of 30,000-50,000 patients, and each would have a clinical director to provide local autonomy and direction.</li> </ul>	Progress Against Plan	Green

Summary      Quality      NHS Improvement      Locality      **Priority Programmes**      Finance/Contracts      Workforce

						<p>Risks are managed by each programme of work. Areas of risk to report include: Stroke:</p> <ul style="list-style-type: none"> <li>• Finances/contracting - potential increasing risk.</li> <li>• 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.</li> <li>• Contracting arrangements</li> <li>• Hyper-acute stroke unit (HASU) timeline - our ability to implement in line with HASU go live could be at risk depending on when the new model is agreed.</li> <li>• Demand for radiology/ availability of diagnostic testing within required timescale</li> <li>• Social care not yet fully included in scope of stroke developments</li> </ul> <p>Implementation plan/key milestones:            By 31/07/19 Programme areas have identified key improvement aims for 19/20            By 30/09/19 6 neighbourhoods have established leadership teams            By 31/12/19 6 neighbourhoods have identified priority areas            By 31/03/20 Stories have been shared from the networks, intelligent commissioning federation (ICOF) populated and shared, Programme areas have delivered on key improvement aims.</p>	Management of Risk		
Work with our partners to join up care in South Yorkshire	Work with our South Yorkshire (SY) partners to deliver shared objectives as described through the integrated care systems plans. As the programmes of work develop, we aim to underpin this work with a clear plan for SWYPFT via the Barnsley and SY internal integration group.	Alan Davis & Salma Yasmeen	Sue Barton	Transformation Board	By 31/03/20 Each programme area will have delivered on key improvement aims as set out at the beginning of the year.	Bi-monthly on IPR	<p>Alan Davis will be the SWYPFT representative on the new Executive group at the integrated care system (ICS).</p> <p>An internal mapping exercise has been undertaken within the internal integration group to identify the key workstreams and meetings. Attendees/influencers from SWYPFT have previously been allocated to the Mental Health and Learning Disability meetings and mechanisms for reporting back are being strengthened. Work has commenced on understanding the other streams of work at an ICS level and clarifying the key areas of connection for the Trust.</p>	Progress Against Plan	
							no work programme yet identified	Management of Risk	
Working with our partners to join up care in West Yorkshire	<p>Work across the West Yorkshire and Harrogate Health &amp; Care Partnership (WY&amp;HHCP) Integrated Care System (ICS), including active membership of the West Yorkshire Mental Health Service Collaborative, to deliver shared objectives with our partners in the areas of:</p> <ul style="list-style-type: none"> <li>• Forensic services including adult, children and learning disability (LD) projects</li> <li>• LD transforming care partnerships including SWYPFT lead role in Learning disability organisational development network (ODN)</li> <li>• Children and Adolescent Mental Health services whole system pathway development</li> <li>• Suicide Prevention</li> <li>• Eating Disorders</li> <li>• Autism and Attention deficit and hyperactivity disorder (ADHD)</li> </ul> <p>We aim to underpin this work with a clear plan for SWYPFT via the WY internal integration group.</p>	Sean Rayner	Sharon Carter & Sarah Foreman	Transformation Board	By 31/03/20 Each programme area will have delivered on key improvement aims as set out at the beginning of the year. Each programme area will have delivered on key improvement aims as set out at the beginning of the year	Monthly on IPR	<p>An update on progress in May is as follows:</p> <ul style="list-style-type: none"> <li>• The final WY ICS strategy aims to be in situ by September.</li> <li>• The WY&amp;H ICS is one of three pilot sites for the National Dementia Programme. The programme has 3 key elements - improving advance care planning, delirium awareness, and managing psychological aspects of dementia.</li> <li>• Health Education England (HEE) has made £700k plus funding available (non recurrent) to help progress workforce transformation across WYH.</li> <li>• Suicide Prevention: A deep dive on suicide prevention will be undertaken at the next SOAG meeting in June.</li> <li>• Adult acute mental health programme: Away day for providers and stakeholders is planned for 21/6.</li> <li>• The Trust has commenced on the numerous WY&amp;H ICS bids for funding:               <ul style="list-style-type: none"> <li>- Forensic trial site bid</li> <li>- Forensic lead provider submission</li> <li>- West Yorkshire ICS- MH Crisis funding. While an ICS bid, it was suggested that this should be 'built up' from 'place' proposals.</li> <li>- West Yorkshire ICS- mental health transformation funding. While an ICS bid, it was suggested that this should be 'built up' from 'place' proposals.</li> </ul> </li> <li>• The Trust has established a WY ICS co-ordination group, providing assurance to Transformation Board. The Group will co-ordinate feedback from, and our tactical contribution to, the multiple ICS work programmes.</li> </ul>	Progress Against Plan	
							<p>Risks are managed by each programme of work. Areas of risk to report include:</p> <p>Failure to deliver timely response to bids and proposals due to lack of resource, other work priorities and skills.</p> <p>There is a risk that the timescales are too ambitious and do not allow for sufficient time to engage with all partners.</p> <p>Stakeholder engagement remains a challenge to progression for the majority of the programmes.</p> <p>Suicide Prevention programme manager role - No further funding allocated at present, request to ICS for short term funding for this role to ensure continuity.</p> <p>West Yorkshire Forensic Lead Provider business case: whether a new models of care (NMOC) for forensics is achievable owing to financial challenges.</p>	Management of Risk	
							By 31/03/20 Each programme area will have delivered on key improvement aims as set out at the beginning of the year.		

Summary      Quality      NHS Improvement      Locality      **Priority Programmes**      Finance/Contracts      Workforce

IMPROVE CARE									
Provide all care as close to home as possible	To reduce the use of inpatient beds (both out of area and within the Trust) in a way which contributes to increased quality and safety across the whole pathway and improves staff wellbeing.	Carol Harris	Ryan Hunter	OMG (with monthly report to EMT)	To deliver the programme of work described in the driver diagram and associated plans. The programme of work is a mixture of significant change & important improvement projects.	Monthly on IPR	Mapping workshops were held in early May for each strand of activity in the plan. The workshops span the range of activity, including: <ul style="list-style-type: none"> <li>• SPA</li> <li>• Community (core discharge)</li> <li>• Intensive Home Based Treatment</li> <li>• Inpatient (criteria led discharge)</li> <li>• Trauma Informed Personality Disorder (TIPD)</li> </ul> The purpose of each workshop was to ensure that we reach agreement on the detail of the expected future model and the key actions to achieve it. Plans are now being finalised for each strand from these workshops and task and finish groups set up with delivery leads and clinical leads to drive forward the work. Meetings have been organised (and now held) for early June to support the programme as follows: <ul style="list-style-type: none"> <li>• Tuesday 4 Jun – out of area stocktake meeting with the executive trio, to review the programme and planned activities at a high level and test whether we think we've got the right plan and resource in place to deliver changes required.</li> <li>• Wednesday 5 Jun – Project challenge panels with Rob Stafford from SSG – to test in more detail the plans, ownership and resources on each strand of work.</li> </ul> These were well attended with feedback that there is now strong buy in from key people to take forward key activity.	Progress Against Plan	
							The following risks have been identified and agreed with the care closer to home (CC2H) steering group. Risk managers and owners have been identified and mitigating actions are planned to reduce the likelihood of the risk occurring. Failure to deliver timely improvement due to lack of resource, other work priorities and skills Lack of relevant information and poor data quality could lead to poor decision making and / or poor assessment of changes, leading to: <ul style="list-style-type: none"> <li>- being unable to quantify impact of some changes</li> <li>- changes having a negative impact</li> <li>- changes leading to other unintended consequences</li> </ul> Activity required to reduce admissions to beds may not be sustainable in the long term, either due to resources or external pressures. Differing cultures across the trust and varying levels of engagement could lead to failure to deliver the proposed changes.	Management of Risk	
Embed #alofusimprove to enhance quality	To build improvement capability and capacity in the Trust. To use improvement tools in key projects and capture the impact.	Tim Breedon & Salma Yasmeen	Vicki Whyte	EMT	Capability across the Trust will be increased A network of #alofusimprove champions and facilitators will be in place across the Trust to support continuous improvement. The #alofusimprove toolkit and helpdesk will be refreshed to support people to 'do and share' their improvements ideas. I Hub will be re-launched and used to strengthen the sharing, development and embedding of improvement and innovation across the Trust	at key milestones	Update on activity made towards achieving key milestones: <ul style="list-style-type: none"> <li>• Re-launched i hub with rolling programme of Trust priority conversations</li> <li>• 227 staff across the Trust currently completing the institute for healthcare improvement (IHI) certificate of quality &amp; safety.</li> <li>• 23 staff completed IHI certificate and are now Trust improvement facilitators</li> <li>• 4 members of staff are 80% through quality service improvement re-design practitioner training with ACT academy.</li> <li>• Case studies published on intranet demonstrating impact.</li> <li>• Learning library established to share learning from experience.</li> <li>• Knowledge café on benefits, welfare reform and poverty completed.</li> </ul> no key risks identified	Progress Against Plan	
							By 1/05/19 I Hub Relaunching. By 31/08/19 #alofusimprove toolkit updated and in place. By 31/03/20: 250 people to complete quality improvement training 24 improvement case studies developed and shared 4 x QI Silver Training sessions held 20 x Improvement Coaching & Mentoring sessions held.	Management of Risk	

IMPROVE RESOURCES									
Make the most of our clinical information	Delivering SystmOne optimisation plan	Salma Yasmeen	Jules Williams & Sharon Carter	Transformation Board	Completion of phase 1: implementation of clinical record system, SystmOne for MH, project closure report. Completion of phase 1: SystmOne for MH post implementation review. Build on from lessons learnt into phase 2: optimisation Co create and co deliver all priority areas of Optimisation plan (areas tbc)	Monthly on IPR	<p>Update on May activities are as follows:</p> <ul style="list-style-type: none"> <li>- 95.5% of all Trust staff have now completed their SystmOne Training. Further training videos and guidance is in development</li> <li>- Work continues to refine post go live configuration based on staff feedback.</li> <li>- Weekly meeting continues to review and progress calls logged via service desk</li> <li>- A dedicated helpdesk and floor walking support was re-launched from 29/4/19 for 4 weeks to support operational staff during CQC inspection. This was well received from operational staff.</li> <li>- The majority of all reports now built, validation making good progress. The MHSDS and CDS have been generated and submitted.</li> <li>- Concerns re contacts not getting into SystmOne, have been resolved with further configuration of system. The total number of reportable contacts for May is expected to be approx. 35,000, which is in line with activity levels previously reported from RiO. From June onwards we anticipate that reportable contacts will be higher than activity levels from RiO – this is due to the fact that we are now able to report on non-diarised activity which was not reportable from RiO (e.g. ad hoc telephone calls).</li> <li>- Weekly communications on progress and training/guides continue to be supported by the Trust communications team</li> <li>- We expect data catch up activities to be complete by the 6/6/19. Audit has commenced and on track for completion by 17/6/19 to provide a level of assurance about the data that has been manually moved over.</li> <li>- There is a forecast underspend for phase one: implementation of the clinical record system programme of approx £30k.</li> <li>- Project closure report for phase one: implementation has commenced with a report to be submitted to the June Programme Steering Group.</li> <li>- Phase 2: Optimisation programme high level plan to be submitted to EMT 6/6/19. Change reference groups continue to meet and once the plan is approved, full activities will commence.</li> </ul>	Progress Against Plan	
							<p>2 risks remain:</p> <ul style="list-style-type: none"> <li>- risk that TPP failed to deliver the revised care planning documentation by the 31/5/19, which would reduce user confidence. This was scored as a 6, but given the fact that TPP have met the deadline and testing has proved successful with minor tweaks requested this is likely to be closed at the June programme steering group.</li> <li>- risk that sub-optimal transition from RiO to SystmOne will result in significant loss or ineffective use of data resulting in the inability to capture and share information and produce reports - this will be reviewed following successful auditing of catch up activities at the June programme steering group</li> </ul>	Management of Risk	
							<p>Optimisation plan in place by end of May 2019 Project closure report completed June 2019 Post implementation Review of phase 1: implementation of SystmOne completed by October 2019.</p>		
Make better use of digital technology	Make better use of digital technology across the Trust to improve our use of resources.	Salma Yasmeen	Vicki Whyte	Transformation Board	The use of a Digital Health App Library and associated prescribing is embedded across 5 Trust services. Digital Dictation business case developed and pilot study completed and evaluated to support a decision for adoption and implementation across the Trust. Virtual Clinic business case developed and pilot study completed and evaluated to support a decision for adoption and implementation across the Trust.	Bi-monthly on IPR	<p>An update on work undertaken in April and May is as follows:</p> <ul style="list-style-type: none"> <li>• Paper Digitisation: workshops have been finalised and the team have commenced work with the Neighbourhood nursing and Crisis Response Team in Barnsley; workshops have also been booked in with other services around the Trust - initial meetings with services are still being conducted. The team have also been working on the development of the intranet pages, accreditation documentation and have confirmed that 3 fax machines are able to be removed from the Trust, thus far.</li> <li>• Digital Health apps: Specification and EMT report for digital health app service with Orcha developed.</li> </ul>	Progress Against Plan	
							<p>Risks are managed by each project.</p> <p>Paper Digitalisation:</p> <ul style="list-style-type: none"> <li>- Prioritisation of services from BDUs</li> <li>- Co-operation from services to accommodate Paper Digitisation team</li> </ul>	Management of Risk	
							<p>By 30/09/19 Implementation of Digital App prescribing in place across 5 Trust Services. By 31/10/19 Business Case for Digital Dictation and Virtual Clinics submitted to Digital Strategy Group. By 31/03/20 Pilot Studies completed, evaluated and reported to Digital Strategy Group.</p>		



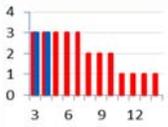
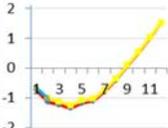
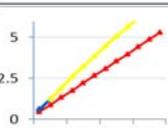
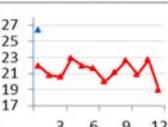
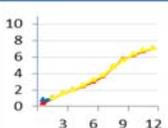
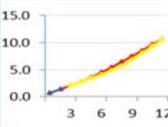
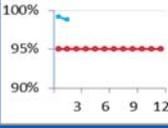
**MAKE THIS A GREAT PLACE TO WORK**

These programmes of work report at key milestones directly to EMT and thus no update is required via the IPR

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 2019/20

Executive Summary / Key Performance Indicators

Performance Indicator		Year to date	Forecast	Narrative	Trend
1	NHS Improvement Finance Rating	3	1	The overall risk rating is a 3 (out of 4 with 1 being the highest). It is limited to a maximum of a 3 due to the impact of the year to date deficit position. This is in line with plan.	
2	Normalised Deficit (excl PSF)	(£1.2m)	(£0.2m)	May 2019 finance performance excluding Provider Sustainability Fund (PSF) is ahead of plan at a deficit of £0.5m. Year to date there is a deficit of £1.2m. Performance is forecast to improve over the course of the year and as such the planned £0.2m year end deficit is still considered as achievable. Continued financial control will be required to deliver this.	
3	Agency Cap	£1.3m	£7.3m	Agency expenditure was £0.6m in May, £0.2m above the agency cap set by NHS Improvement. Current year-end projection is to exceed our agency cap by £2m. Detailed plans with key milestones are being developed.	
4	Cash	£24.6m	£25.9m	The Trust cash position remains healthy at £24.6m although a focus remains on effective cash management. Cash is forecast to increase in Qtr 2 as the outstanding 2018/19 PSF (£3.8m) is received.	
5	Capital	£1m	£7m	Expenditure for the year to date, and forecast, are in line with plan.	
6	Delivery of CIP	£1.4m	£10.6m	Delivery is in line with plan for the year to date. Unidentified CIPs which require mitigation have increased to £1.6m.	
7	Better Payment	99%		This performance is based upon a combined NHS / Non NHS value and is ahead of plan.	

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

## Contracting - Trust Board

### Contracting Issues - General

Priorities for the Barnsley £1.2m mental health investment plan have been agreed as improving access to psychological therapies (IAPT) expansion, extension to development of all age and crisis liaison services and support for children and young people with a diagnosis of attention deficit hyperactivity disorder (ADHD) waiting for treatment. Work continues through the Wakefield mental health alliance to agree the additional investment plans for expansion of crisis and intensive home based treatment services, personality disorder and chaotic lifestyle pathways in Wakefield.

### CQUIN

The national CQUIN schemes for 19/20 contracts applicable to contracts has been agreed.

### Contracting Issues - Barnsley

The detail of the £1.2m mental health investment plan for 2019/20 has been agreed as improving access to psychological therapies (IAPT) expansion, extension to development of all age and crisis liaison services and support for children and young people with a diagnosis of attention deficit hyperactivity disorder (ADHD) waiting for treatment. Review is ongoing in relation to neighbourhood nursing.

### Contracting Issues - Calderdale

Key ongoing work priorities include early intervention in psychosis (EIP), reduction in out of area (OOA) in adult mental health, continued development of perinatal services and further development of children and young people's services in line with implementation of the THRIVE model. 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

Key ongoing work priorities include continued development of psychological therapies for adults covering both core and long term conditions services, expansion of early intervention in psychosis services, continued development of perinatal services transformation of mental health services for older people to support provision of care closer to home through community based provision. Commissioners are making additional investment to support the further development of pathways for people with personality disorder.

### Contracting Issues - Wakefield

Key ongoing work priorities include continued development of 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. Work continues through the mental health alliance to agree the additional investment plans for 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.

### Contracting Issues - Forensics

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.

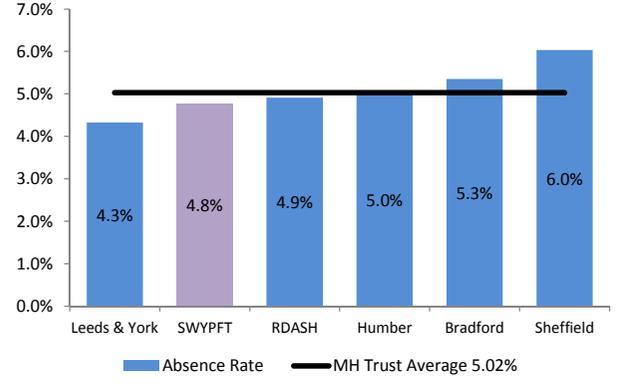
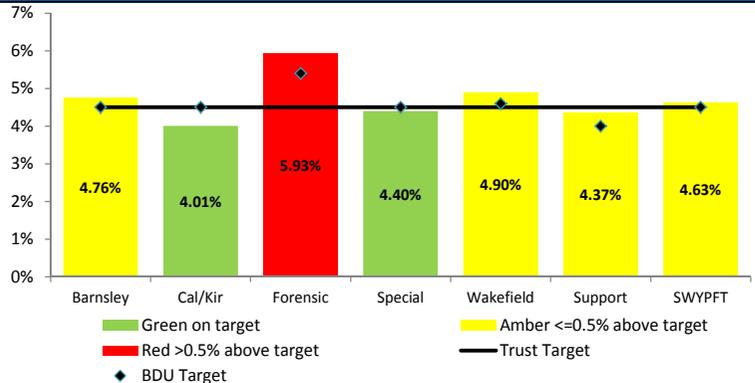
### Contracting Issues - Other

The new contract for the provision of liaison and diversion services across South Yorkshire covering Barnsley, Rotherham, Doncaster and Sheffield has been mobilised following commencement on 1 April 2019.

Workforce

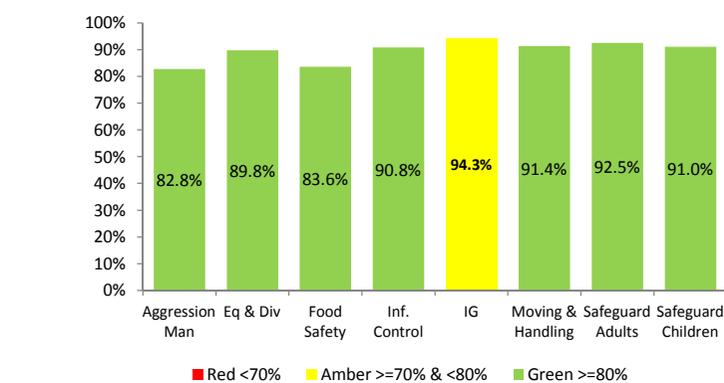
Human Resources Performance Dashboard - May 2019

Sickness Absence



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



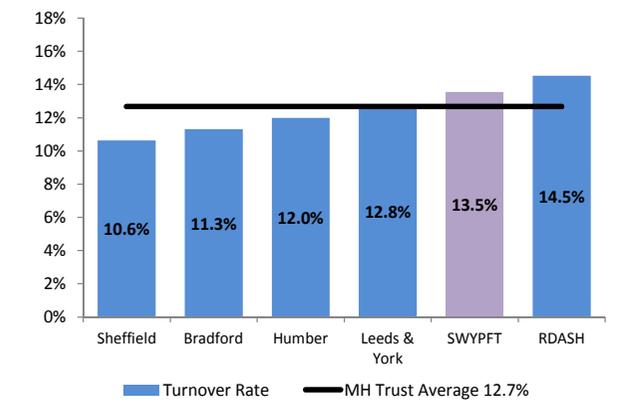
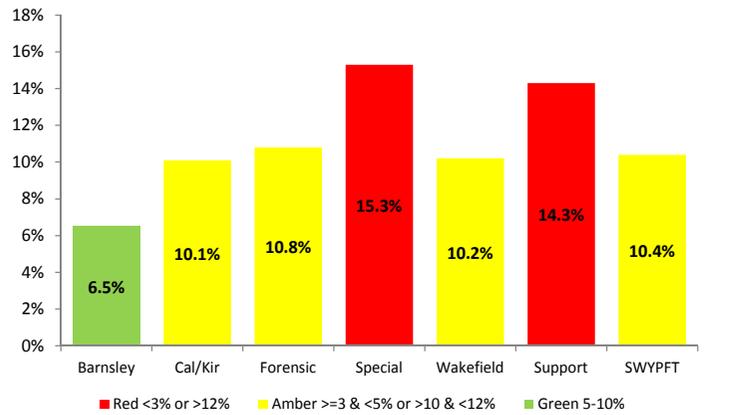
The above chart shows the mandatory training rates for the Trust to the end of May 2019. The Trust target for all mandatory training is 80% apart from Information Governance (IG) which has a target of 95%. All are based on a rolling year.

**Current Absence Position and Change from Previous Month - May 2019**

	Barn	Cal/Kir	Fore	Spec	Wake	Supp	SWYPFT
Rate	4.8%	3.9%	6.3%	4.4%	4.4%	4.3%	4.6%
Change	↑	↓	↑	↑	↓	↓	↓

The Trust YTD absence levels in May 2019 (chart above) were above the target at 4.63%.  
The YTD cost of sickness absence is £952,203. If the Trust had met its target this would have been £925,467, saving £26,736.

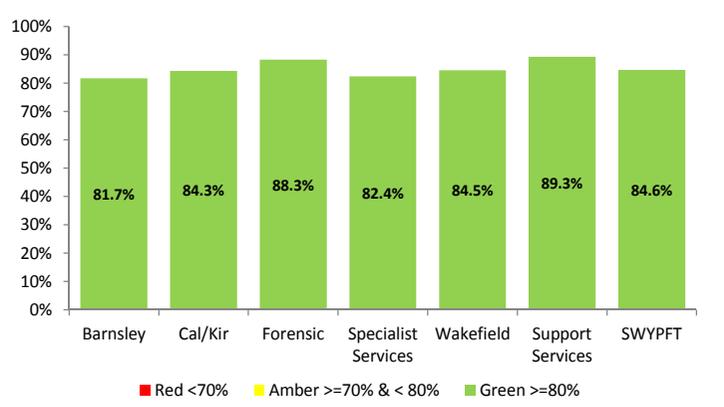
Turnover and Stability Rate Benchmark



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.

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

Fire Training Attendance



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

Summary

Quality

National Metrics

Locality

Priority  
Programmes

Finance/Contracts

Workforce

## Workforce - Performance Wall cont...

### **Mandatory Training**

- The Trust is above 80% compliance for all 14 mandatory training programmes with 6 being above 90%. Information Governance training has a target of 95% and is currently slightly below this.

### **Appraisals**

- Given the fact it is the start of a new year and the appraisals process is commencing the appraisal completion rate across the Trust is low. There is focus on ensuring that all band 6 and above appraisals are scheduled in before the end of June 19.

### **Sickness Absence:**

- The sickness rate in May has decreased slightly to 4.6%.
- Calderdale & Kirklees, Support and Wakefield services all saw an in month reduction in sickness. Forensic and Barnsley BDUs both saw an in month increase in absence.

### **Turnover:**

- Turnover continues to be an area of focus and the recruitment and retention task group have developed an action plan which is monitored through the workforce and remuneration committee.
- May staff turnover was 10.4% which is a reduction compared to previous month (11.9%)

Summary

Quality

National Metrics

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Workforce

## Workforce - Performance Wall

Trust Performance Wall																	
Month	Objective	CQC Domain	Owner	Threshold	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Sickness (YTD)	Improving Resources	Well Led	AD	<=4.5%	4.4%	4.4%	4.5%	4.5%	4.6%	4.8%	4.9%	5.0%	5.1%	5.1%	5.0%	4.7%	4.6%
Sickness (Monthly)	Improving Resources	Well Led	AD	<=4.4%	4.4%	4.4%	4.7%	4.8%	5.1%	5.7%	5.8%	5.7%	5.8%	5.1%	4.6%	4.7%	4.6%
Appraisals (Band 6 and above) <sup>1</sup>	Improving Resources	Well Led	AD	>=95%	26.1%	72.2%	87.7%	92.8%	95.0%	95.8%	98.1%	98.2%	99.1%	99.1%	99.1%	6.3%	19.8%
Appraisals (Band 5 and below)	Improving Resources	Well Led	AD	>=95%	2.8%	9.4%	21.6%	48.1%	78.6%	87.2%	94.3%	95.0%	96.5%	97.5%	97.5%	0.2%	1.5%
Aggression Management	Improving Care	Well Led	AD	>=80%	81.7%	81.6%	82.9%	83.0%	82.2%	81.3%	81.4%	82.5%	83.1%	82.9%	81.7%	81.6%	82.8%
Cardiopulmonary Resuscitation	Improving Care	Well Led	AD	>=80% by 31/3/17	84.0%	84.5%	84.8%	83.3%	81.6%	80.1%	80.2%	81.2%	82.1%	81.4%	80.7%	80.2%	80.1%
Clinical Risk	Improving Care	Well Led	AD	>=80% by 31/3/17	85.5%	85.8%	85.9%	86.0%	85.8%	85.8%	86.1%	87.4%	87.8%	88.7%	88.4%	87.9%	88.7%
Equality and Diversity	Improving Health	Well Led	AD	>=80%	89.8%	89.7%	89.8%	90.1%	89.8%	90.2%	90.7%	91.3%	90.9%	91.0%	90.3%	89.6%	89.8%
Fire Safety	Improving Care	Well Led	AD	>=80%	86.8%	86.6%	86.6%	87.4%	86.3%	86.8%	86.7%	88.1%	85.2%	84.9%	84.6%	84.6%	84.6%
Food Safety	Improving Care	Well Led	AD	>=80%	77.2%	77.5%	80.8%	81.9%	81.7%	81.9%	84.1%	82.2%	82.3%	83.7%	83.4%	83.6%	83.6%
Infection Control and Hand Hygiene	Improving Care	Well Led	AD	>=80%	87.3%	87.3%	87.8%	88.5%	89.1%	89.3%	89.1%	89.7%	89.5%	90.4%	89.9%	90.5%	90.8%
Information Governance	Improving Care	Well Led	AD	>=95%	92.7%	92.1%	91.9%	92.2%	92.1%	92.3%	90.2%	90.8%	96.1%	97.6%	98.5%	97.2%	94.3%
Moving and Handling	Improving Resources	Well Led	AD	>=80%	85.9%	85.6%	85.7%	86.1%	87.2%	87.3%	88.6%	89.0%	87.8%	88.9%	90.5%	90.4%	91.4%
Mental Capacity Act/DOLS	Improving Care	Well Led	AD	>=80% by 31/3/17	91.4%	91.3%	92.2%	91.7%	90.9%	91.4%	92.6%	92.3%	92.7%	92.5%	91.7%	91.2%	91.7%
Mental Health Act	Improving Care	Well Led	AD	>=80% by 31/3/17	86.8%	86.5%	88.1%	87.3%	85.9%	85.8%	87.7%	86.7%	86.7%	86.4%	84.5%	84.2%	85.2%
No of staff receiving supervision within policy guidance	Quality & Experience	Well Led		>=80%	82.8%			83.7%			82.5%			84.9%			Due July 19
Safeguarding Adults	Improving Care	Well Led	AD	>=80%	91.0%	91.3%	91.7%	91.7%	91.5%	92.1%	93.0%	93.7%	93.2%	93.4%	92.9%	92.4%	92.5%
Safeguarding Children	Improving Care	Well Led	AD	>=80%	88.6%	89.4%	90.1%	90.4%	90.0%	90.4%	89.4%	91.4%	91.3%	90.9%	91.1%	89.6%	91.0%
Sainsbury's clinical risk assessment tool	Improving Care	Well Led	AD	>=80%	95.1%	94.9%	95.8%	95.2%	94.6%	94.6%	94.1%	94.5%	93.9%	94.5%	94.9%	94.0%	94.8%
Bank Cost	Improving Resources	Well Led	AD	-	£603k	£768k	£646k	£730k	£845k	£615k	£674k	£678k	£752k	£1048k	£772k	£625k	£844k
Agency Cost	Improving Resources	Effective	AD	-	£538k	£484k	£526k	£566k	£522k	£537k	£536k	£530k	£596k	£545k	£634k	£613k	£641k
Overtime Costs	Improving Resources	Effective	AD	-	£13k	£5k	£11k	£5k	£8k	£4k	£5k	£7k	£7k	£8k	£48k	£12k	£28k
Additional Hours Costs	Improving Resources	Effective	AD	-	£15k	£23k	£31k	£32k	£29k	£30k	£31k	£24k	£26k	£27k	£40k	£46k	£38k
Sickness Cost (Monthly)	Improving Resources	Effective	AD	-	£449k	£420k	£461k	£471k	£507k	£586k	£571k	£572k	£602k	£476k	£482k	£476k	£476k
Business Miles	Improving Resources	Effective	AD	-	264k	259k	291k	269k	279k	267k	299k	279k	286k	270k	289k	274k	240k

<sup>1</sup> - this does not include data for medical staffing.

## Publication Summary

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

### **Department of Health and Social Care**

NHS property: guidance for NHS trusts and foundation trusts on requesting transfers of estate in the ownership of NHS property companies

This guidance allows NHS trusts and foundation trusts to apply for the transfer of ownership of properties on their estate. This is where property on a trust's estate belongs to NHS Property Services and community health partnerships. The change recognises that, in many cases, NHS trusts are best placed to judge how to use their estate to benefit the local community.

[Click here for link to guidance](#)

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

### NHS Improvement provider bulletin: 22 May 2019:

Submit your board assessment framework for seven day hospital services

- Productivity benchmarking metrics for community mental health services
- Community services operating model guidance
- CQUIN: Implementing three high-impact actions to prevent hospital falls
- CQUIN: 2019/20 indicator specification
- Learning from deaths webinar
- NHS national commercial directors meeting
- Updates from our partners

### NHS Improvement provider bulletin: 29 May 2019:

Never Events list: exclusion of wrong site infiltration of dental blocks

- Health and Care Innovation Expo 2019
- Leeds NHS commercial network

### NHS Improvement provider bulletin: 12 June 2019:

- What is a biosimilar medicine? - an updated guide
- Optimising the nursing workforce to support retention
- Frailty toolkit: providing the best care for people living with frailty
- Aspire Together Talent Pools — nominations and applications
- Health and Care Innovation Expo 2019
- Aspire Together Talent Pool — webinars to support applications and nominations

### NHS Improvement costing newsletter: 15 May 2019

### Female genital mutilation: January – March 2019

### NHS sickness absence rates: January 2019, provisional statistics

### NHS workforce statistics: February 2019

### Diagnostic imaging data set: April 2018 – January 2019

### NHS vacancy statistics England: February 2015 - March 2019, provisional experimental statistics

### Seasonal influenza vaccine uptake in healthcare workers in England: winter season 2018 to 2019

### NHS Improvement costing newsletter: 5 June 2019

### Monthly hospital activity data: April 2019



South West  
Yorkshire Partnership  
NHS Foundation Trust



# Finance Report



Month 2  
(2019 / 20)  
5 ddYbXjI %



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

With **all of us** in mind.

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Executive Summary / Key Performance Indicators

Performance Indicator		Year to date	Forecast	Narrative	Trend
1	NHS Improvement Finance Rating	3	1	The overall risk rating is a 3 (out of 4 with 1 being the highest). It is limited to a maximum of a 3 due to the impact of the year to date deficit position. This is in line with plan.	
2	Normalised Deficit (excl PSF)	(£1.2m)	(£0.2m)	May 2019 finance performance excluding Provider Sustainability Fund (PSF) is ahead of plan at a deficit of £0.5m. Year to date there is a deficit of £1.2m. Performance is forecast to improve over the course of the year and as such the planned £0.2m year end deficit is still considered as achievable. Continued financial control will be required to deliver this.	
3	Agency Cap	£1.3m	£7.3m	Agency expenditure was £0.6m in May, £0.2m above the agency cap set by NHS Improvement. Current year-end projection is to exceed our agency cap by £2m. Detailed plans with key milestones are being developed.	
4	Cash	£24.6m	£25.9m	The Trust cash position remains healthy at £24.6m although a focus remains on effective cash management. Cash is forecast to increase in Qtr 2 as the outstanding 2018/19 PSF (£3.8m) is received.	
5	Capital	£1m	£7m	Expenditure for the year to date, and forecast, are in line with plan.	
6	Delivery of CIP	£1.4m	£10.6m	Delivery is in line with plan for the year to date. Unidentified CIPs which require mitigation have increased to £1.6m.	
7	Better Payment	99%		This performance is based upon a combined NHS / Non NHS value and is ahead of plan.	

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

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

Area	Weight	Metric	Actual Performance		Plan - Month 2	
			Score	Risk Rating	Score	Risk Rating
Financial Sustainability	20%	Capital Service Capacity	0.8	4	0.5	4
	20%	Liquidity (Days)	21.8	1	17.5	1
Financial Efficiency	20%	I & E Margin	-2.7%	4	-3.0%	4
Financial Controls	20%	Distance from Financial Plan	0.3%	1	0.0%	1
	20%	Agency Spend	42%	3	21%	2
<b>Weighted Average - Financial Sustainability Risk Rating</b>				<b>3</b>	<b>3</b>	

### Impact

The Trust weighted financial risk rating is currently 3. This is the capped maximum rating as we have individual metrics rated as 4. These ratings are as a direct result of the year to date deficit position and are forecast to improve over the course of the year. The forecast is to improve to 2 in Qtr 4 2019/20.

The agency rating is the only metric which is lower than planned.

### 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.

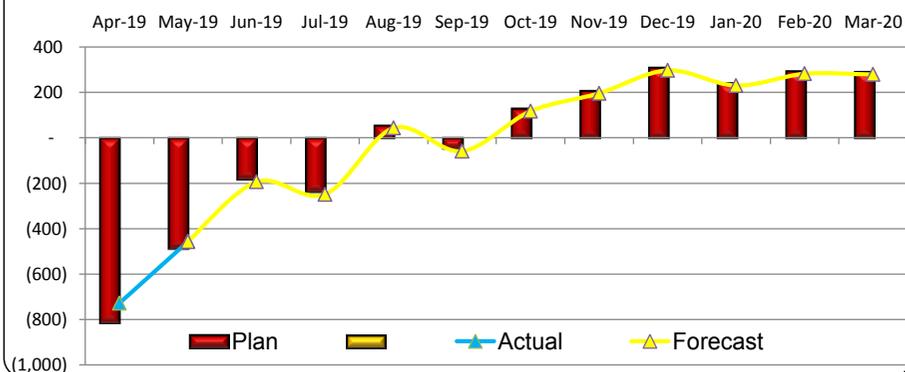
**I & E Margin** - the degree to which the organisation is operating at a surplus/deficit

**Distance from plan** - variance between a foundation Trust's planned I & E margin and actual I & E margin within the year.

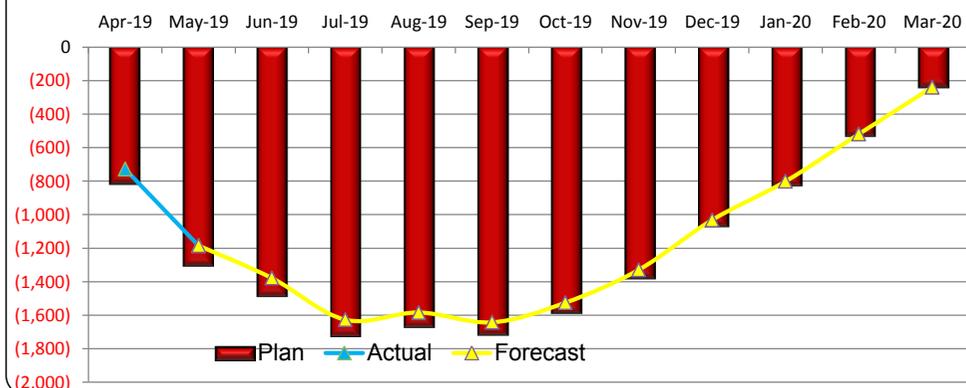
**Agency Cap** - A cap of £5.3m has been set for the Trust in 2019 / 2020. This metric compares performance against this cap.

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
				17,653	17,502	(151)	Clinical Revenue	35,257	35,010	(247)	211,797	211,480	(317)
				<b>17,653</b>	<b>17,502</b>	<b>(151)</b>	<b>Total Clinical Revenue</b>	<b>35,257</b>	<b>35,010</b>	<b>(247)</b>	<b>211,797</b>	<b>211,480</b>	<b>(317)</b>
				1,192	1,280	88	Other Operating Revenue	2,261	2,423	162	12,993	13,285	292
				<b>18,845</b>	<b>18,782</b>	<b>(63)</b>	<b>Total Revenue</b>	<b>37,518</b>	<b>37,433</b>	<b>(85)</b>	<b>224,790</b>	<b>224,765</b>	<b>(25)</b>
4,123	4,013	(110)	2.7%	(14,576)	(14,452)	124	Pay Costs	(29,846)	(29,375)	471	(176,517)	(175,692)	825
				(3,606)	(3,391)	215	Non Pay Costs	(7,034)	(6,724)	310	(42,599)	(42,438)	161
				(491)	(721)	(230)	Provisions	(619)	(1,172)	(553)	2,015	1,302	(712)
				0	0	0	Gain / (loss) on disposal	0	0	0	0	0	0
4,123	4,013	(110)	2.7%	<b>(18,673)</b>	<b>(18,564)</b>	<b>108</b>	<b>Total Operating Expenses</b>	<b>(37,499)</b>	<b>(37,271)</b>	<b>228</b>	<b>(217,102)</b>	<b>(216,828)</b>	<b>274</b>
4,123	4,013	(110)	2.7%	173	218	45	EBITDA	19	162	143	7,688	7,937	249
				(442)	(463)	(21)	Depreciation	(884)	(926)	(42)	(5,302)	(5,565)	(263)
				(227)	(227)	0	PDC Paid	(454)	(454)	0	(2,726)	(2,726)	0
				8	16	7	Interest Received	17	33	17	100	113	13
4,123	4,013	(110)	2.7%	<b>(488)</b>	<b>(457)</b>	<b>31</b>	<b>Normalised Surplus / (Deficit) Excl PSF</b>	<b>(1,302)</b>	<b>(1,185)</b>	<b>117</b>	<b>(240)</b>	<b>(240)</b>	<b>(0)</b>
				88	88	0	PSF (Provider Sustainability Fund)	176	176	0	1,765	1,765	0
4,123	4,013	(110)	2.7%	<b>(400)</b>	<b>(369)</b>	<b>31</b>	<b>Normalised Surplus / (Deficit) Incl PSF</b>	<b>(1,126)</b>	<b>(1,009)</b>	<b>117</b>	<b>1,525</b>	<b>1,525</b>	<b>(0)</b>
				0	0	0	Revaluation of Assets	0	0	0	0	0	0
4,123	4,013	(110)	2.7%	<b>(400)</b>	<b>(369)</b>	<b>31</b>	<b>Surplus / (Deficit)</b>	<b>(1,126)</b>	<b>(1,009)</b>	<b>117</b>	<b>1,525</b>	<b>1,525</b>	<b>(0)</b>

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



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



## Income & Expenditure Position 2019 / 20

**The deficit run rate continued into May. The deficit is lower than the previous month due to the one off staff payment made in April 2019. Actions are focussed on returning the run rate to surplus.**

### Month 2

The May position is a pre PSF deficit of £457k and a post PSF deficit of £369k, this is £31k ahead of plan. The key headlines are below. Whilst favourable to plan the reporting of a deficit is a concern and the run rate must improve in order to achieve the surplus planned for the full year.

In May there is a continued underspend in both on pay and non pay categories partly offset by income being below plan.

### Income

Clinical income in month 2 is £151k lower than plan. A full breakdown of income is shown on page 7.

CQUIN income risk is currently being assessed. The current position (actual and forecast) assumes 100% achievement of all schemes. It is confirmed this is a lower value than previous years as CQUIN income has reduced from 2.5% to 1.25% of applicable contract values.

### Pay Expenditure

In May pay underspent by £124k. The Trust continues to run with a number of vacancies and utilises temporary staff (both internal bank and external agency) to meet clinical and service requirement. Recruitment is actively being undertaken and 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.

The NHSI maximum agency cap for 2019/20 has been set at £5.3m. In May agency costs are £641k. This is £198k (45%) higher than cap.

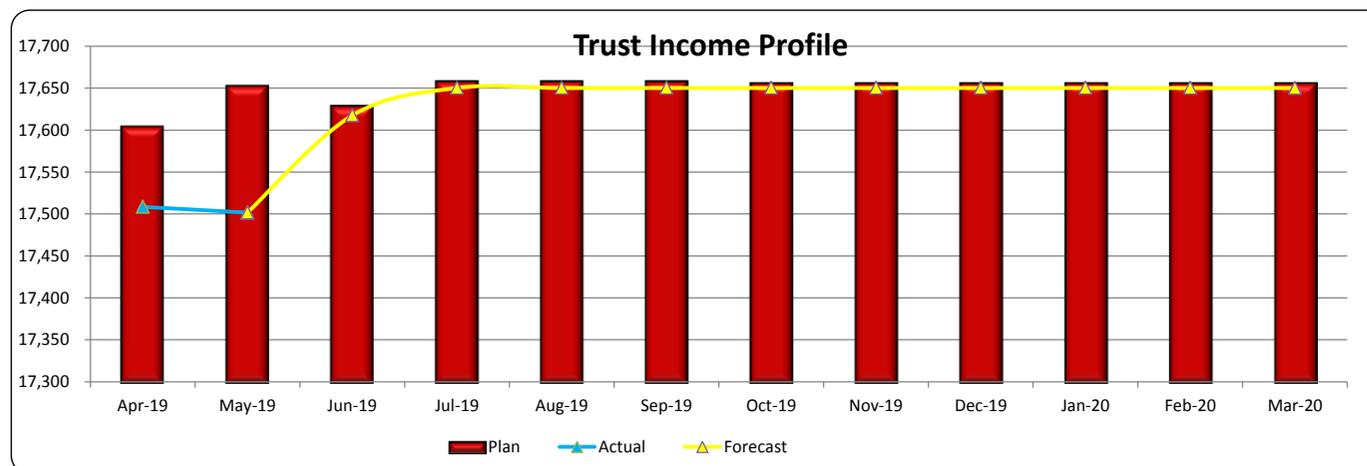
### Non Pay Expenditure

Non pay is underspent by £215k in May and is at a lower level overall than in previous years. This will continue to be monitored due to the volatility in key areas such as out of area placement expenditure. More details are included within the out of area focus page.

## 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-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total	Total 18/19
	£k	£k												
<b>CCG</b>	12,398	12,398	12,398	12,398	12,398	12,398	12,398	12,398	12,398	12,398	12,398	12,398	<b>148,772</b>	<b>146,036</b>
<b>Specialist Commissioner</b>	2,025	2,025	2,025	2,025	2,025	2,025	2,025	2,025	2,025	2,025	2,025	2,025	<b>24,297</b>	<b>23,356</b>
<b>Alliance</b>	1,295	1,295	1,295	1,295	1,295	1,295	1,295	1,295	1,295	1,295	1,295	1,295	<b>15,540</b>	<b>14,596</b>
<b>Local Authority</b>	441	441	444	442	442	442	442	442	442	442	442	442	<b>5,303</b>	<b>5,074</b>
<b>Partnerships</b>	614	614	643	643	643	643	643	643	643	643	643	643	<b>7,654</b>	<b>7,172</b>
<b>Other</b>	737	730	813	848	848	848	848	848	848	848	848	848	<b>9,914</b>	<b>6,708</b>
<b>Total</b>	<b>17,509</b>	<b>17,502</b>	<b>17,618</b>	<b>17,650</b>	<b>211,480</b>	<b>202,942</b>								
18/19	16,696	16,620	16,853	17,044	16,707	16,750	16,684	16,858	17,169	16,752	17,303	17,506	<b>202,942</b>	



As in previous years the majority of Trust clinical income is in the form of block contracts. These were agreed as part of the 2019/20 annual planning process with commissioners and therefore there is currently little variance forecast from this baseline position.

Income budgets have increased in May 2019 due to additional income secured as expansion of the service already provided into Youth Offenders Institutes. This service is delivered in partnership with Leeds Community Healthcare NHS Trust.

The year to date underspend of £247k relates to:  
No additional income assumed from the sale of Neuro Rehabilitation beds in Barnsley. Activity levels, and future plans, are under review.

Income lower than plan for services which are charged on actual staff in post (South Yorkshire Liaison & Diversion for Qtr 1 and Youth Offender expansion noted above)

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 80% of total Trust expenditure.

The Trust workforce strategy was approved by Trust board during 2017 / 18 and annual plans are agreed by the Workforce and Remuneration Committee. The Trust's strategic workforce plan was approved in March 2018 and is updated annually.

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-19 £k	May-19 £k	Jun-19 £k	Jul-19 £k	Aug-19 £k	Sep-19 £k	Oct-19 £k	Nov-19 £k	Dec-19 £k	Jan-20 £k	Feb-20 £k	Mar-20 £k	Total £k
<b>Substantive</b>	13,647	12,904											<b>26,552</b>
<b>Bank &amp; Locum</b>	663	906											<b>1,569</b>
<b>Agency</b>	613	641											<b>1,254</b>
<b>Total</b>	<b>14,923</b>	<b>14,452</b>	<b>0</b>	<b>29,375</b>									
18/19	13,610	13,789	13,901	14,503	13,854	14,000	13,819	13,738	13,861	14,138	14,137	15,126	<b>168,476</b>
Bank as %	4.4%	6.3%											5.3%
Agency as %	4.1%	4.4%											4.3%

Year to Date Budget v Actuals - by staff group						
	Budget £k	Substantive £k	Bank £k	Agency £k	Total £k	Variance £k
Medical	3,917	2,943	100	696	3,739	178
Nursing Registered	10,610	9,031	529	93	9,653	957
Nursing	3,216	3,034	744	255	4,033	(817)
Other	7,336	7,215	75	203	7,493	(157)
Corporate Admin	2,103	1,738	38	7	1,783	320
BDU Admin	2,665	2,591	84	0	2,674	(10)
<b>Total</b>	<b>29,846</b>	<b>26,552</b>	<b>1,569</b>	<b>1,254</b>	<b>29,375</b>	<b>471</b>

Year to date Budget v Actuals - by service						
	Budget £k	Substantive £k	Bank £k	Agency £k	Total £k	Variance £k
MH Community	13,011	11,157	286	826	12,268	744
Inpatient	7,242	6,311	1,106	387	7,804	(562)
BDU Support	1,246	1,212	35	0	1,247	(3)
Community	3,652	3,527	55	14	3,596	56
Corporate	4,695	4,345	87	28	4,460	236
<b>Total</b>	<b>29,846</b>	<b>26,552</b>	<b>1,569</b>	<b>1,254</b>	<b>29,375</b>	<b>471</b>

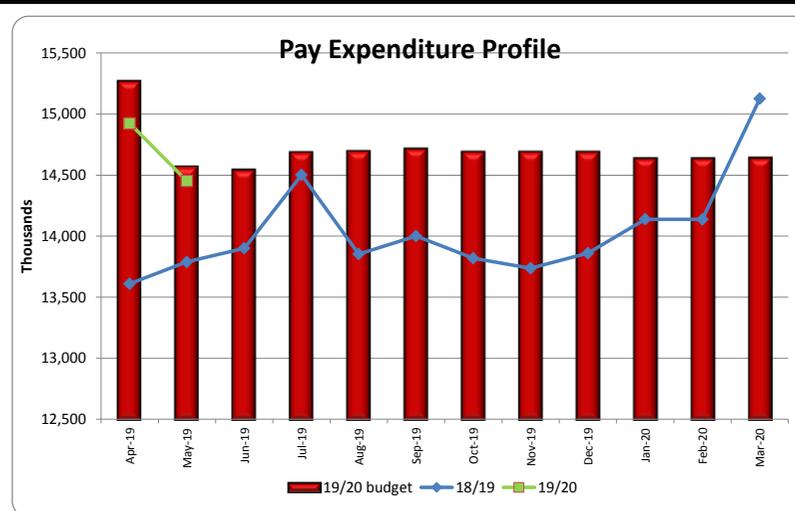
#### Key Messages

Overall pay expenditure is higher in 2019/20 than previous years. This is to be expected as a result of the national pay awards and pay increments under Agenda For Change. The Trust has also been successful in securing new services such as Liaison and Diversion from April 2019.

In May pay underspent by £124k. Year to date the underspend is £471k. Temporary staffing provided by both agency and bank staff totals £2.8m to date (9.6% of total pay expenditure) and this level of expenditure is being offset by vacancies. However additional staffing requirements and vacancies are often within different services or BDUs within the Trust. The service, quality and financial impact of this is considered as part of the monthly internal review.

Key variances above highlight that the largest area of underspend is within registered nursing due to known recruitment and retention difficulties. The current workforce strategy includes the utilisation of additional unregistered nurses to provide support. Recurrent workforce strategies have been developed and a focus on inpatient, particularly adult acute, is being undertaken.

To date the all inpatient areas, excluding Forensics, is overspent by £562k. However there is funding currently held within provisions to provide for an agreed recurrent workforce model in line with spend in 2018/19. As and when the model is finalised funding will be allocated. Taking this into account these inpatient areas would still be overspent by £190k to date.



**The NHS Improvement agency cap is £5.3m**

**May 2019 agency spend exceeds the cap by 47%**

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.

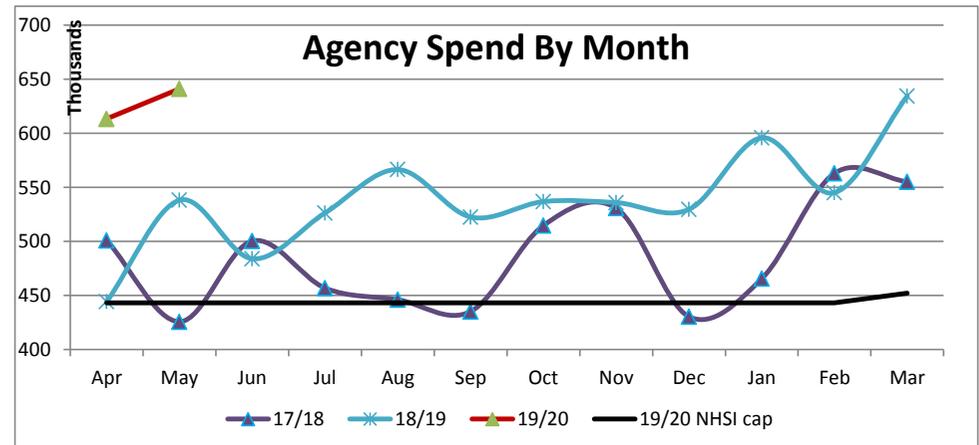
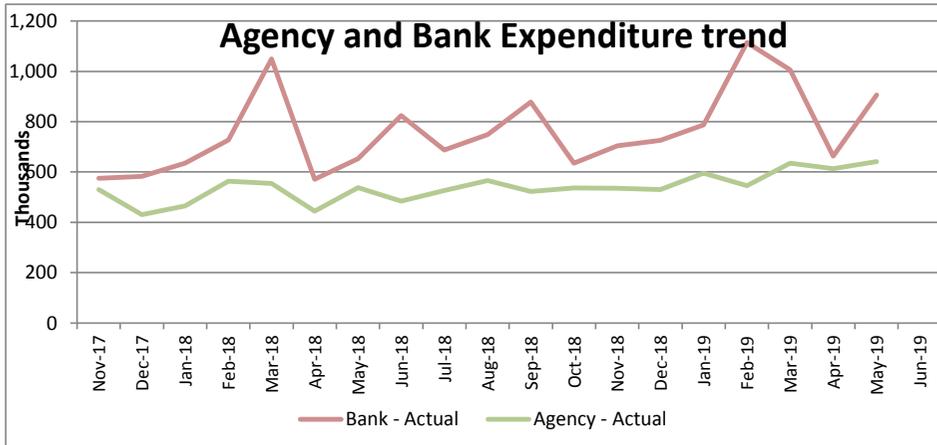
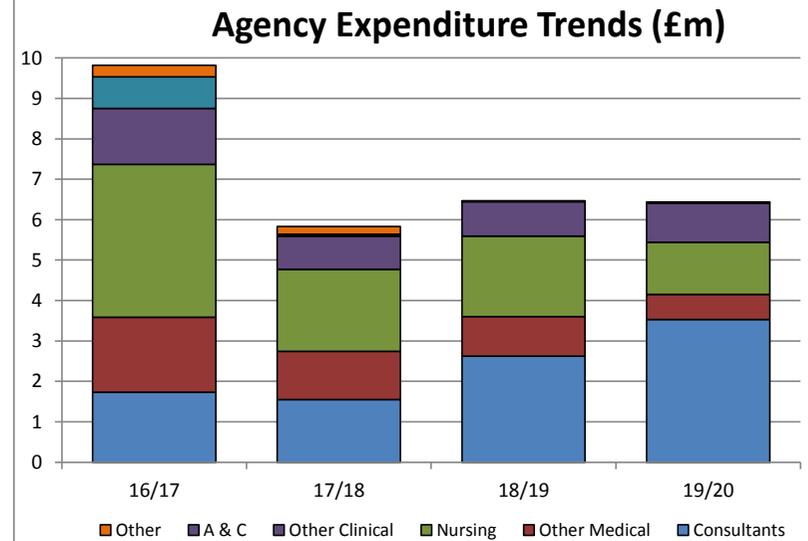
The maximum agency cap established by NHSI for 2019/20 is £5.3m which is £0.1m higher than the 2018/19 cap. In 2018/19 spend was £6.5m which breached the cap by £1.3m (24%). The NHSI agency cap has been profiled equally across the year with a maximum spend of £443k a month. The Trust plan assumed spend in excess of the cap at £5.9m.

Actual agency usage continues to be reported to NHS Improvement on a weekly basis.

Month 2 agency spend is £641k, 45% above cap. This continues to be a higher rate than incurred in 2018/19. The Trust agency action group continues to progress actions to reduce this level of spend. Cumulatively agency spend is £1.25m which is 42% above cap and 28% higher than the same period last year.

The current forecast, based upon plans in place, is £7.3m. All medical post action plans have been updated with key milestones dates identified.

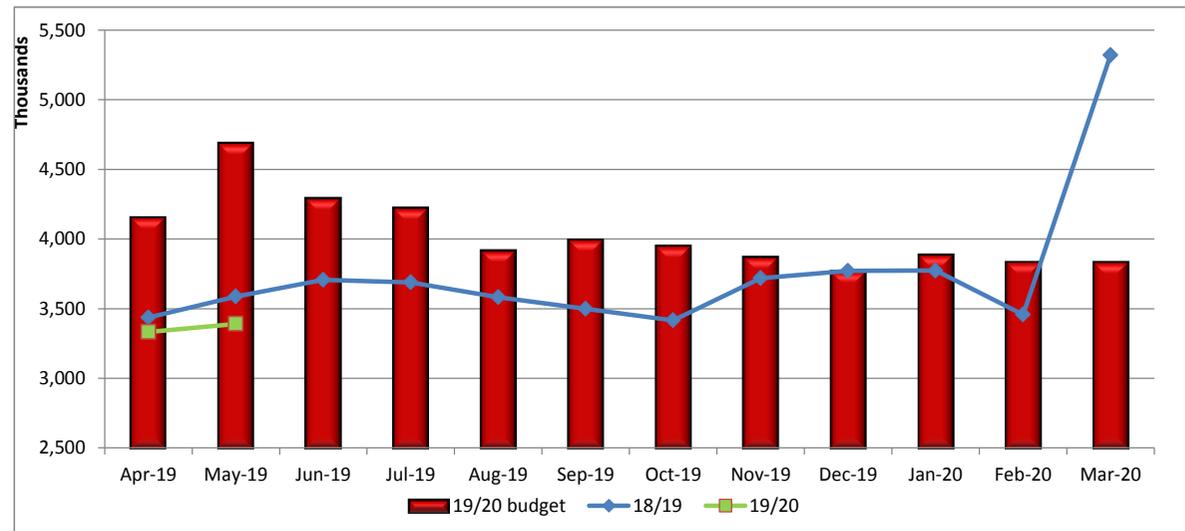
Bank expenditure at £906k, whilst higher than April 2019, is in line with Qtr 4 2018/19 run rates. Bank usage is not restricted to one BDU and mainly results from high acuity, high sickness and on-call cover across the wards.



Whilst pay expenditure represents over 80% of all Trust expenditure, 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-19 £k	May-19 £k	Jun-19 £k	Jul-19 £k	Aug-19 £k	Sep-19 £k	Oct-19 £k	Nov-19 £k	Dec-19 £k	Jan-20 £k	Feb-20 £k	Mar-20 £k	Total £k
2019 / 2020	3,333	3,391											6,724
2018 / 2019	3,437	3,588	3,706	3,689	3,582	3,498	3,417	3,719	3,771	3,773	3,458	5,321	44,959

Non Pay Category	Budget	Actual	Variance
	Year to date £k	Year to date £k	£k
Clinical Supplies	488	434	54
Drugs	605	559	46
Healthcare subcontracting	889	904	(15)
Hotel Services	305	248	57
Office Supplies	747	758	(11)
Other Costs	744	714	29
Property Costs	1,088	1,133	(45)
Service Level Agreements	1,032	1,024	8
Training & Education	67	83	(16)
Travel & Subsistence	639	428	211
Utilities	196	222	(26)
Vehicle Costs	237	217	20
<b>Total</b>	<b>7,034</b>	<b>6,724</b>	<b>310</b>
<b>Total Excl OOA and Drugs</b>	<b>5,540</b>	<b>5,260</b>	<b>280</b>



### Key Messages

Budgets and plans were reset during the 2019/20 annual planning round and, to date, there is little variation from plan. The plan included resetting those categories which have historically overspent such as healthcare subcontracting (use of out of area placements) and drugs. Whilst these variances are small the focus remains on ensuring that all spend is appropriate and provides value for money.

To date overall non pay expenditure is lower than in the previous year.

Travel and subsistence costs are currently £211k under plan for the year to date. This is being validated within the Trust non pay review group with an expectation that any savings will be taken and allocated against the currently unidentified CIP.

Other workstreams within the non pay review group includes phones, energy, rates as we continue to focus on waste reduction and value for money.

## 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 is for the out of area placements relating to adult acute beds including PICU in all areas. This 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
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	355	3,929
19/20	289	289											578

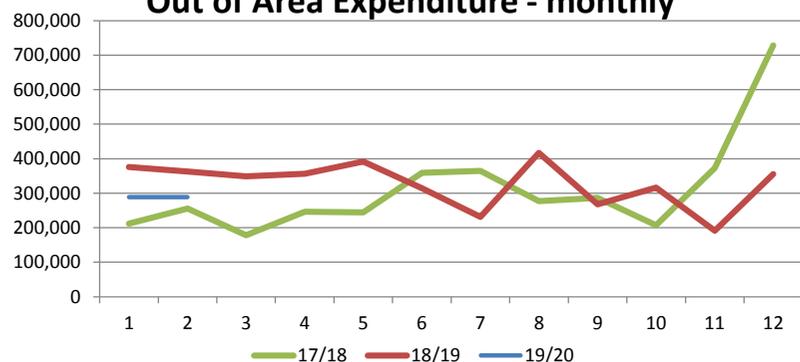
### Bed Day Trend Information

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
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	358	197	220	4,904
19/20	282	356											638

### Bed Day Information 2019 / 2020 (by category)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
PICU	32	26											58
Acute	160	278											438
Appropriate	90	52											142
Total	282	356	0	0	0	0	0	0	0	0	0	0	638

### Out of Area Expenditure - monthly



In 2019/20 the PICU out of area budget has been set to fund 2 appropriate out of area placements at any time. The acute out of area budget is phased to fund 9 out of area placements in April reducing to 5 placements by March 2020.

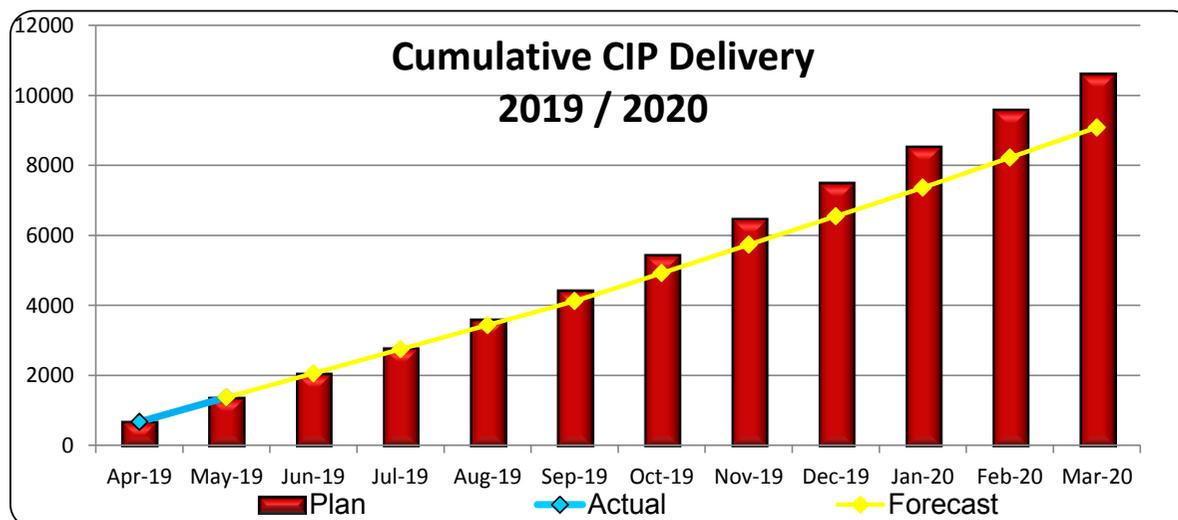
Demand for placements increased in May meaning that the year to date position is 28 more days than planned (638 used compared to 610 planned).

This activity is within a wider care closer to home programme. The objective is to reduce the use of inpatient beds (both out of areas and within the Trust), enabling more care closer to home, in a way which contributes to increased quality and safety across the whole pathway and improves staff wellbeing. Elements of this programme includes reviewing appropriate inpatient stays and ensuring the right community and primary care support.

## 2.1

## Cost Improvement Programme 2019 / 2020

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
<b>TOTAL - CUMULATIVE</b>	£	£	£	£	£	£	£	£	£	£	£	£	£
Target	688	1,376	2,066	2,790	3,615	4,439	5,455	6,481	7,507	8,542	9,596	10,624	1,376
Achieved - plan	667	1,353	2,030	2,710	3,390	4,070	4,855	5,658	6,461	7,268	8,118	8,970	1,353
Achieved - mitigation	4	19	28	38	47	57	66	75	85	94	104	113	19
Mitigations - Upside schemes									386	771	1,156	1,541	0
Shortfall / Unidentified	16	5	8	43	178	313	533	747	575	409	218	(0)	5



The Trust has set a challenging CIP target for 2019/20 of £10.6m which included £1.4m of unidentified savings at the beginning of the year.

Delivery is in line with plan for the first 2 months of 2019/20 although there has been more non-recurrent than planned.

Additional schemes need to be in place to deliver at least £1.5m cost reductions over the course of the year. Identification, and delivery, of these remains a focus for the Trust Operational Management Group.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
<b>RECURRENT - CUMULATIVE</b>	£	£	£	£	£	£	£	£	£	£	£	£	£
Target	405	811	1,217	1,666	2,214	2,763	3,503	4,243	4,984	5,734	6,482	7,206	811
Achieved - plan	376	771	1,157	1,561	1,964	2,368	2,880	3,399	3,917	4,446	4,998	5,551	771
Achieved - mitigation	3	17	25	33	41	50	58	66	74	83	91	99	17
Shortfall / Unidentified	26	24	35	72	208	345	565	779	992	1,205	1,394	1,555	24

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
<b>NON RECURRENT - CUMULATIVE</b>	£	£	£	£	£	£	£	£	£	£	£	£	£
Target	283	566	848	1,124	1,400	1,676	1,952	2,237	2,523	2,808	3,113	3,419	566
Achieved - plan	291	582	873	1,149	1,425	1,702	1,976	2,259	2,543	2,822	3,120	3,419	582
Achieved - mitigation	1	2	3	5	6	7	8	9	10	12	13	14	2
Shortfall / Unidentified	(9)	(19)	(28)	(29)	(31)	(32)	(32)	(32)	(31)	(25)	(20)	(14)	(19)

	2018 / 2019 Plan (YTD)		Actual (YTD)	Note
	£k	£k	£k	
Non-Current (Fixed) Assets	100,005	100,115	100,034	1
<b>Current Assets</b>				
Inventories & Work in Progress	259	232	259	
NHS Trade Receivables (Debtors)	3,019	1,003	1,686	2
Non NHS Trade Receivables (Debtors)	1,007	2,646	797	
Prepayments, Bad Debt, VAT	1,559	2,246	3,177	
Accrued Income	5,138	5,616	7,947	3
Cash and Cash Equivalents	27,823	20,750	24,643	4
<b>Total Current Assets</b>	<b>38,806</b>	<b>32,493</b>	<b>38,509</b>	
<b>Current Liabilities</b>				
Trade Payables (Creditors)	(4,663)	(2,826)	(3,911)	5
Capital Payables (Creditors)	(1,070)	(468)	(404)	5
Tax, NI, Pension Payables, PDC	(6,002)	(6,455)	(6,284)	
Accruals	(8,020)	(8,072)	(9,774)	6
Deferred Income	(276)	(617)	(448)	
<b>Total Current Liabilities</b>	<b>(20,031)</b>	<b>(18,438)</b>	<b>(20,821)</b>	
<b>Net Current Assets/Liabilities</b>	<b>18,775</b>	<b>14,055</b>	<b>17,688</b>	
<b>Total Assets less Current Liabilities</b>	<b>118,780</b>	<b>114,170</b>	<b>117,722</b>	
Provisions for Liabilities	(7,221)	(6,270)	(7,171)	
<b>Total Net Assets/(Liabilities)</b>	<b>111,560</b>	<b>107,900</b>	<b>110,551</b>	
<b>Taxpayers' Equity</b>				
Public Dividend Capital	44,221	44,221	44,221	
Revaluation Reserve	9,453	9,845	9,453	
Other Reserves	5,220	5,220	5,220	
Income & Expenditure Reserve	52,666	48,614	51,657	7
<b>Total Taxpayers' Equity</b>	<b>111,560</b>	<b>107,900</b>	<b>110,551</b>	

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

1. Capital expenditure is detailed on page 14. The original agreed plan for 2019/20 is £7.0m although this has subsequently reduced to £6.8m following a national request.

2. NHS trade debtors are higher than plan, a number of old invoices continue to be pursued to achieve resolution. We work to ensure that block invoices are paid in month.

3. Accrued Income is above plan as this includes the additional PSF received at 31st March 2019 which is expected to be paid in Q1 2019 (£3.8m).

4. The reconciliation of actual cash flow to plan compares the current month end position to the annual plan position for the same period. This is shown on page 16.

5. Creditors are higher than plan although we continue to ensure invoices are paid in line with the Better Payment Practice Code (page 17).

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

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

## 3.1 Capital Programme 2019 / 2020

	Annual Budget £k	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Forecast Actual £k	Forecast Variance £k	Note
<b>Maintenance (Minor) Capital</b>							
Facilities & Small Schemes	3,007	69	42	(27)	2,860	(147)	2
Equipment Replacement	50	0	(3)	(3)	90	40	
IM&T	2,245	253	29	(224)	2,242	(3)	3
<b>Major Capital Schemes</b>							
Fieldhead Non Secure	635	424	801	377	806	171	4
Nurse Call system	600	75	0	(75)	600	0	
Clinical Record System	220	146	85	(61)	159	(61)	
VAT Refunds	0	0	0	0	0	0	
<b>TOTALS</b>	<b>6,757</b>	<b>967</b>	<b>955</b>	<b>(12)</b>	<b>6,757</b>	<b>(0)</b>	

National 2019 / 20 NHS capital programmes are subject to further review

### Capital Expenditure 2019 / 2020

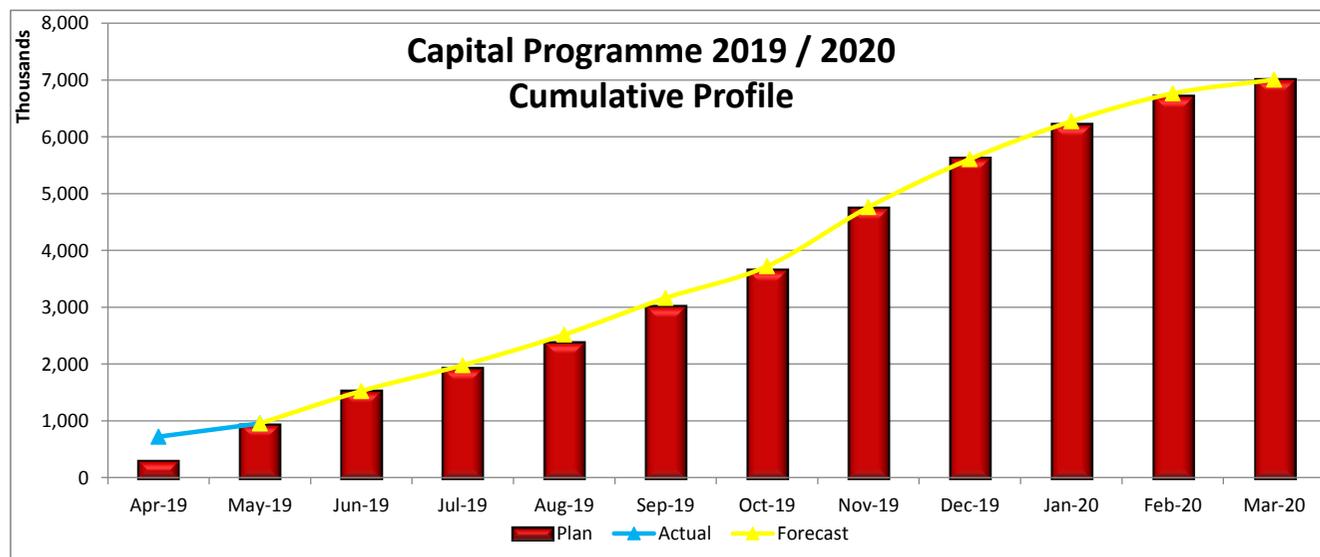
1. The originally agreed capital plan for 2019 / 20 was £7.0m and schemes are guided by the current estates and digital strategies.

NHS Improvement asked all Trusts to conduct a further review and prioritisation of their capital programmes; this led to the Trust submitting a revised capital plan of £6.8m in May 2019.

2. Expenditure is low as many schemes are in the planning stage. This is in line with the plan which is weighted towards expenditure from quarter 2.

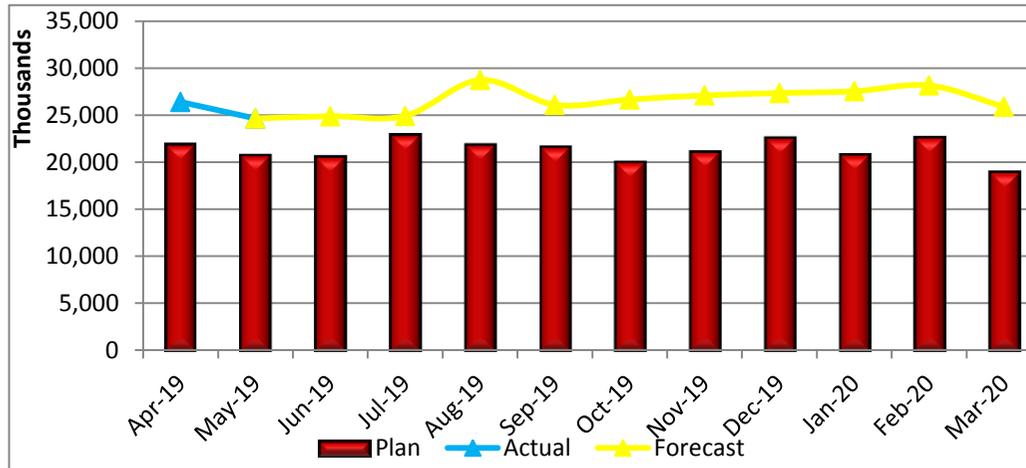
3. IM & T spend is behind the original plan. Tendering has been delayed, in conjunction with suppliers, for some of the high value hardware as the Trust works to ensure the best value for money solutions.

4. Final values for the non secure scheme are being validated. It is currently forecast to exceed the 2019/20 plan value but will be in line with the overall project budget.

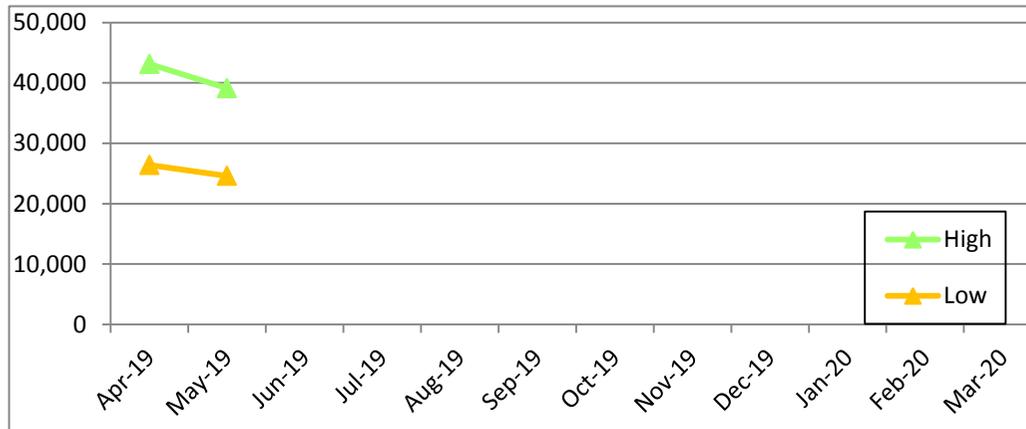


### 3.2

## Cash Flow & Cash Flow Forecast 2019 / 2020



	Plan £k	Actual £k	Variance £k
Opening Balance	22,617	27,823	
Closing Balance	20,750	24,643	3,893



**Effective cash management remains a key financial objective for 2019/20**

Cash started the year higher than plan (as the plan was submitted prior to the year end position being finalised).

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: £39.1m  
The lowest balance is: £24.6m

This reflects cash balances built up from historical surpluses.

### 3.3 Reconciliation of Cashflow to Cashflow Plan

	Plan £k	Actual £k	Variance £k	Note
<b>Opening Balances</b>	<b>22,617</b>	<b>27,823</b>	<b>5,206</b>	<b>1</b>
Surplus / Deficit (Exc. non-cash items & revaluation)	194	338	144	2
<i>Movement in working capital:</i>				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	(1,137)	(2,884)	(1,747)	
Accrued Income / Prepayments	0	0	0	
Trade Payables (Creditors)	(26)	(924)	(898)	4
Other Payables (Creditors)	0	0	0	
Accruals & Deferred income	58	1,926	1,868	3
Provisions & Liabilities	(5)	(50)	(45)	
<i>Movement in LT Receivables:</i>				
Capital expenditure & capital creditors	(967)	(1,621)	(654)	4
Cash receipts from asset sales	0	0	0	
PDC Dividends paid	0	0	0	
PDC Dividends received			0	
Interest (paid)/ received	16	33	17	
<b>Closing Balances</b>	<b>20,750</b>	<b>24,643</b>	<b>3,893</b>	

The plan value reflects the April 2019 submission to NHS Improvement.

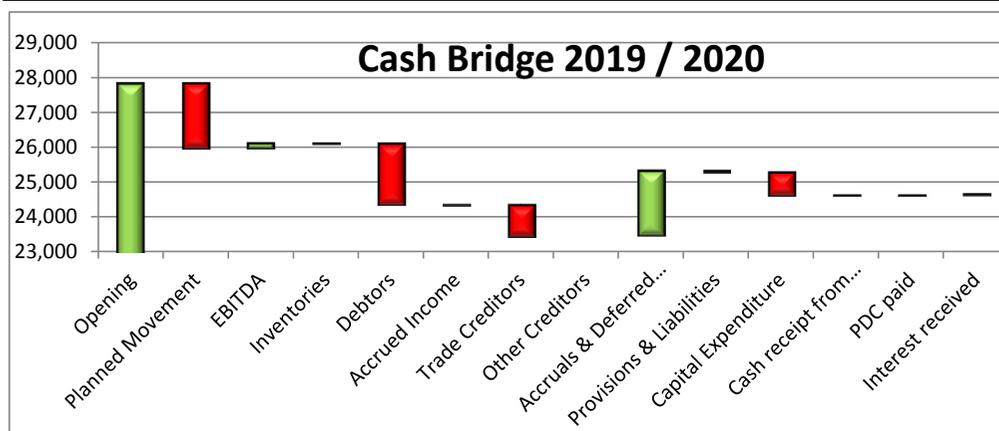
Factors which increase the cash position against plan:

1. The opening cash balance was higher than included in the annual plan submission.
2. The in year I & E position is better than plan.
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.

Factors which decrease the cash position against plan:

4. 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.



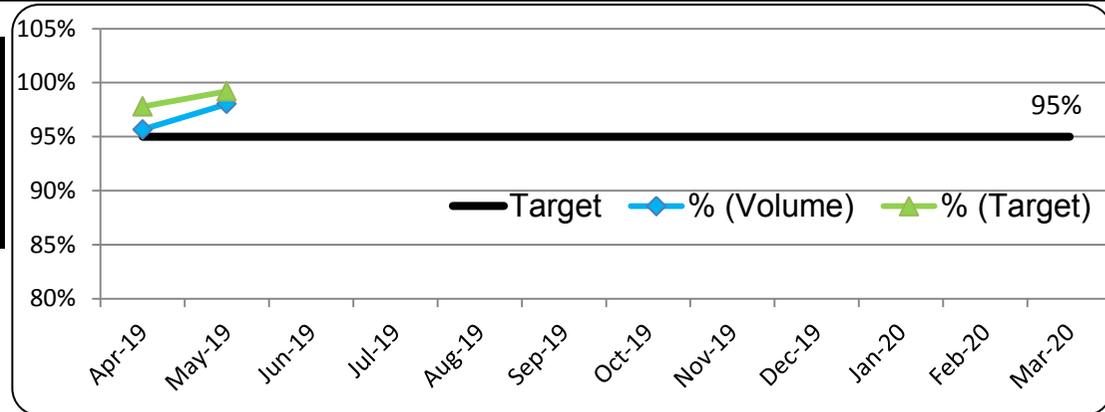
# 4.0

# Better Payment Practice Code

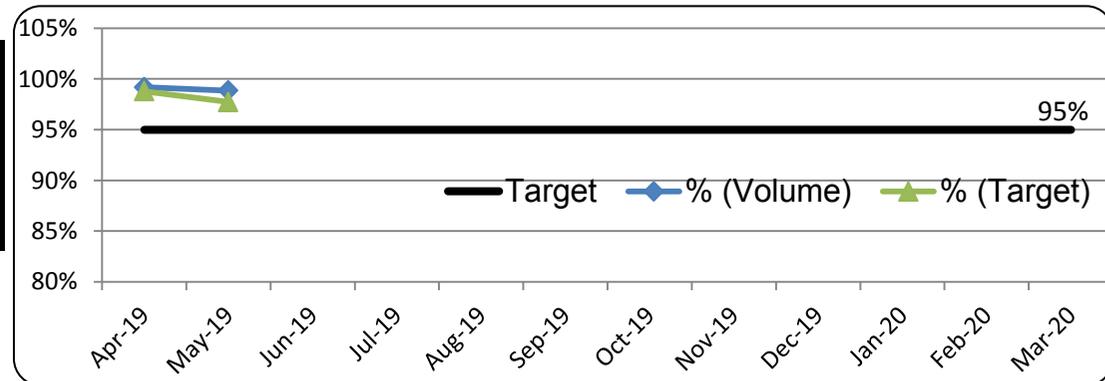
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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 April 2019	96%	98%
Year to May 2019	98%	99%



Non NHS		
	Number	Value
	%	%
Year to April 2019	99%	99%
Year to May 2019	99%	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 (£)
29-May-19	Insurance Costs	Trustwide	Zurich Insurance Company	3107662	786,290
03-May-19	Property Rental	Trustwide	Calderdale and Huddersfield NHS Foundation Trust	3105511	226,501
24-Apr-19	Membership Fees	Trustwide	Care Quality Commission	3104469	159,780
12-Mar-19	Staff Recharge	Trustwide	Leeds and York Partnership NHS FT	3100250	153,889
29-Apr-19	Drugs	Trustwide	Bradford Teaching Hospitals NHS FT	3104802	133,467
08-May-19	IT services	Trustwide	Daisy Corporate Services Trading Ltd	3105732	111,750
25-Mar-19	Project Support	Trustwide	Fischer Associates	3101558	109,500
30-May-19	Property Rental	Wakefield	Assura HC Ltd	3107794	90,000
10-Apr-19	Property Rental	Barnsley	Barnsley Metropolitan Borough Council	3103461	80,771
01-May-19	Purchase of Healthcare	Calderdale	Elysium Healthcare Ltd	3105655	66,583
01-Apr-19	Photocopying Rental & Charges	Trustwide	Xerox (UK) Ltd	3102294	54,389
09-May-19	Project Support	Trustwide	SSG Partners Limited	3105980	52,860
30-Apr-19	Staff Recharge	Wakefield	Wakefield MDC	3104913	47,934
03-May-19	Drugs	Trustwide	NHSBSA Prescription Pricing Division	3105348	42,034
26-Apr-19	Medical & Surgical Equipment Maintenance contract	Trustwide	Mid Yorkshire Hospitals NHS Trust	3106737	39,500
09-May-19	Insurance Costs	Trustwide	Willis Limited	3105933	38,387
09-May-19	Staff Recharge	Trustwide	Leeds and York Partnership NHS FT	3105994	33,874
21-May-19	Hearing Aids	Barnsley	Sonova UK Ltd	3107061	32,587
24-May-19	Property Rental	Barnsley	Community Health Partnerships	3107390	31,925
02-May-19	Communications	Trustwide	British Telecommunications Plc	3105234	27,676
08-May-19	Utilities	Trustwide	EDF Energy	3105700	26,740
28-May-19	Communications	Trustwide	Virgin Media Payments Ltd	3107495	25,852
24-May-19	Property Rental	Barnsley	Community Health Partnerships	3107390	25,624
28-May-19	IT services	Trustwide	Bionical Solutions Limited	3107543	25,215

- \* Recurrent - an action or decision that has a continuing financial effect
- \* Non-Recurrent - an action or decision that has a one off or time limited effect
- \* Full Year Effect (FYE) - quantification of the effect of an action, decision, or event for a full financial year
- \* Part Year Effect (PYE) - quantification of the effect of an action, decision, or event for the financial year concerned. So if a CIP were to be implemented half way through a financial year, the Trust would only see six months benefit from that action in that financial year
- \* Surplus - Trust income is greater than costs
- \* Deficit - Trust costs are greater than income
- \* Recurrent Underlying Surplus - We would not expect to actually report this position in our accounts, but it is an important measure of our fundamental financial health. It shows what our surplus would be if we stripped out all of the non-recurrent income, costs and savings.
- \* Forecast Surplus / Deficit - This is the surplus or deficit we expect to make for the financial year
- \* Target Surplus / Deficit - This is the surplus or deficit the Board said it wanted to achieve for the year (including non-recurrent actions), and which was used to set the CIP targets. This is set in advance of the year, and before all variables are known. For 2018 / 2019 the Trust were set a control total deficit.
- \* In Year Cost Savings - These are non-recurrent actions which will yield non-recurrent savings in year. So are part of the Forecast Surplus, but not part of the Recurrent Underlying Surplus.
- \* Cost Improvement Programme (CIP) - is the identification of schemes to increase efficiency or reduce expenditure.
- \* Non-Recurrent CIP - A CIP which is identified in advance, but which only has a one off financial benefit. These differ from In Year Cost Savings in that the action is identified in advance of the financial year, whereas In Year Cost Savings are a target which budget holders are expected to deliver, but where they may not have identified the actions yielding the savings in advance.
- \* EBITDA - earnings before Interest, Tax, Depreciation and amortisation. This strips out the expenditure items relating to the provision of assets from the Trust's financial position to indicate the financial performance of it's services.
- \* Provider Sustainability Fund (PSF) - is an income stream distributed by NHS Improvement to all providers who meet certain criteria (this was formally called STF - Sustainability and Transformation Fund)

## Appendix 2 - Workforce - Performance Wall

Barnsley District										
Month	Objective	CQC Domain	Owner	Threshold	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Sickness (YTD)	Resources	Well Led	AD	<= 4.5%	5.0%	5.1%	5.1%	5.2%	4.7%	4.8%
Sickness (Monthly)	Resources	Well Led	AD	<= 4.5%	6.2%	6.1%	5.7%	5.4%	4.7%	4.8%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>= 95%	96.7%	98.7%	98.7%	98.7%	8.1%	22.1%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>= 95%	91.7%	94.1%	96.7%	96.7%	0.4%	2.7%
Aggression Management	Quality & Experience	Well Led	AD	>= 80%	81.1%	81.9%	83.6%	82.2%	77.8%	77.9%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>= 80%	82.5%	82.8%	82.8%	82.7%	83.5%	82.4%
Clinical Risk	Quality & Experience	Well Led	AD	>= 80%	88.9%	88.9%	86.5%	84.6%	78.0%	81.9%
Equality and Diversity	Resources	Well Led	AD	>= 80%	92.6%	91.8%	90.9%	89.8%	88.9%	89.7%
Fire Safety	Health & Wellbeing	Well Led	AD	>= 80%	87.5%	81.7%	82.4%	80.9%	81.6%	81.7%
Food Safety	Health & Wellbeing	Well Led	AD	>= 80%	75.0%	77.8%	77.2%	81.7%	82.4%	83.3%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>= 80%	89.7%	88.8%	90.4%	90.0%	89.9%	90.9%
Information Governance	Resources	Well Led	AD	>= 95%	88.6%	94.1%	96.2%	97.6%	96.8%	92.6%
Moving and Handling	Resources	Well Led	AD	>= 80%	86.7%	85.4%	87.3%	87.6%	87.0%	87.5%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>= 80%	89.1%	90.0%	88.8%	87.4%	86.5%	88.3%
Mental Health Act	Health & Wellbeing	Well Led	AD	>= 80%	84.0%	83.2%	84.7%	78.8%	75.6%	78.6%
Safeguarding Adults	Quality & Experience	Well Led	AD	>= 80%	90.9%	90.6%	90.0%	89.2%	87.5%	88.3%
Safeguarding Children	Quality & Experience	Well Led	AD	>= 80%	89.9%	89.1%	88.8%	89.1%	85.6%	87.2%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>= 80%	95.8%	95.8%	95.8%	96.2%	90.5%	93.7%
Agency Cost	Resources	Effective	AD		£68k	£46k	£30k	£37k	£28k	£57k
Overtime Costs	Resources	Effective	AD		£3k	£3k	£1k	£2k	£3k	£1k
Additional Hours Costs	Resources	Effective	AD		£10k	£9k	£13k	£10k	£17k	£14k
Sickness Cost (Monthly)	Resources	Effective	AD		£172k	£177k	£146k	£165k	£140k	£148k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		85.79	73.4	73.85	79.37	84.36	80.88
Business Miles	Resources	Effective	AD		100k	104k	97k	97k	97k	99k

Calderdale and Kirklees District										
Month	Objective	CQC Domain	Owner	Threshold	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Sickness (YTD)	Resources	Well Led	AD	<= 4.5%	4.5%	4.5%	4.5%	4.5%	4.2%	4.0%
Sickness (Monthly)	Resources	Well Led	AD	<= 4.5%	4.9%	5.1%	4.7%	4.2%	4.2%	3.9%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>= 95%	99.7%	100.0%	100.0%	100.0%	9.7%	25.1%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>= 95%	97.1%	97.8%	98.5%	98.5%	0.2%	1.7%
Aggression Management	Quality & Experience	Well Led	AD	>= 80%	82.2%	82.4%	82.4%	81.4%	81.9%	82.3%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>= 80%	78.4%	81.6%	79.1%	77.3%	76.3%	75.1%
Clinical Risk	Quality & Experience	Well Led	AD	>= 80%	88.0%	88.0%	89.3%	89.8%	91.2%	91.2%
Equality and Diversity	Resources	Well Led	AD	>= 80%	91.3%	90.5%	91.8%	90.9%	90.2%	90.2%
Fire Safety	Health & Wellbeing	Well Led	AD	>= 80%	88.8%	85.1%	83.6%	84.5%	84.2%	84.3%
Food Safety	Health & Wellbeing	Well Led	AD	>= 80%	87.8%	84.6%	84.3%	83.4%	82.5%	81.5%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>= 80%	89.9%	89.8%	90.2%	88.4%	90.1%	90.0%
Information Governance	Resources	Well Led	AD	>= 95%	91.2%	97.5%	97.8%	98.8%	97.8%	95.1%
Moving and Handling	Resources	Well Led	AD	>= 80%	88.8%	87.8%	88.9%	89.6%	90.5%	91.3%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>= 80%	91.1%	91.9%	92.5%	91.6%	91.3%	91.6%
Mental Health Act	Health & Wellbeing	Well Led	AD	>= 80%	89.1%	88.6%	87.5%	86.4%	86.9%	87.3%
Safeguarding Adults	Quality & Experience	Well Led	AD	>= 80%	94.6%	93.9%	92.7%	91.4%	91.7%	92.3%
Safeguarding Children	Quality & Experience	Well Led	AD	>= 80%	89.9%	88.9%	88.0%	88.6%	89.5%	90.8%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>= 80%	95.2%	94.9%	95.9%	95.9%	96.6%	96.4%
Agency Cost	Resources	Effective	AD		£105k	£101k	£102k	£135k	£146k	£157k
Overtime Costs	Resources	Effective	AD		£2k	£2k	£1k	£1k	£2k	£7k
Additional Hours Costs	Resources	Effective	AD		£1k	£0k	£1k	£4k	£5k	£4k
Sickness Cost (Monthly)	Resources	Effective	AD		£121k	£127k	£109k	£109k	£102k	£95k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		74.99	68.26	70.03	68.72	75.61	80.5
Business Miles	Resources	Effective	AD		57k	69k	64k	82k	66k	45k

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

Forensic Services										
Month	Objective	CQC Domain	Owner	Threshold	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Sickness (YTD)	Resources	Well Led	AD	<=5.4%	7.6%	7.7%	7.6%	7.5%	5.6%	5.9%
Sickness (Monthly)	Resources	Well Led	AD	<=5.4%	8.3%	8.4%	6.5%	5.6%	5.6%	6.3%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	93.4%	94.6%	94.4%	94.4%	3.5%	15.5%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	97.2%	98.4%	98.3%	98.3%	0.7%	0.7%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	86.1%	85.1%	87.8%	87.5%	85.1%	85.9%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	84.7%	84.2%	86.2%	85.8%	83.1%	86.1%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	85.2%	86.4%	89.3%	89.9%	90.3%	90.2%
Equality and Diversity	Resources	Well Led	AD	>=80%	95.6%	95.3%	95.4%	94.4%	91.1%	91.4%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	87.7%	87.8%	88.5%	87.7%	86.8%	88.3%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	84.1%	84.3%	87.4%	83.6%	84.3%	82.1%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	90.4%	90.6%	90.6%	90.4%	90.1%	90.4%
Information Governance	Resources	Well Led	AD	>=95%	93.1%	95.4%	97.2%	98.5%	97.0%	95.3%
Moving and Handling	Resources	Well Led	AD	>=80%	91.4%	90.6%	92.7%	94.6%	95.3%	95.3%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	90.0%	89.6%	89.9%	89.0%	89.2%	91.9%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	83.6%	83.3%	83.2%	81.8%	83.9%	89.7%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	95.3%	96.0%	96.5%	96.1%	95.1%	94.6%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	91.4%	93.3%	94.2%	93.6%	88.4%	89.6%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	86.7%	93.3%	93.1%	92.9%	90.3%	90.3%
Agency Cost	Resources	Effective	AD		£76k	£69k	£31k	£69k	£50k	£59k
Overtime Costs	Resources	Effective	AD		£0k	£2k	£0k	£0k	£1k	£0k
Additional Hours Costs	Resources	Effective	AD		£2k	£1k	£2k	£1k	£1k	£2k
Sickness Cost (Monthly)	Resources	Effective	AD		£80k	£88k	£56k	£55k	£52k	£59k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		57.24	48.97	62.2	64.52	78.25	84.96
Business Miles	Resources	Effective	AD		9k	8k	7k	9k	5k	6k

Specialist Services										
Month	Objective	CQC Domain	Owner	Threshold	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	5.1%	5.1%	5.0%	4.9%	4.4%	4.4%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	5.6%	5.0%	4.6%	3.0%	4.4%	4.4%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	98.4%	99.5%	99.5%	99.5%	2.8%	10.9%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	90.5%	91.8%	92.7%	92.7%	0.0%	2.4%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	83.7%	85.5%	81.8%	80.9%	82.9%	81.8%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	78.3%	78.2%	77.4%	76.7%	78.6%	79.0%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	93.2%	92.7%	94.0%	93.6%	94.4%	95.6%
Equality and Diversity	Resources	Well Led	AD	>=80%	90.2%	89.4%	88.8%	88.3%	87.5%	86.3%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	83.1%	81.0%	80.4%	80.7%	81.6%	82.4%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	73.3%	72.4%	72.4%	71.0%	73.3%	70.0%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	89.3%	89.1%	91.2%	90.7%	90.9%	89.4%
Information Governance	Resources	Well Led	AD	>=95%	87.7%	95.5%	98.2%	98.7%	98.2%	95.2%
Moving and Handling	Resources	Well Led	AD	>=80%	89.0%	87.7%	90.5%	90.2%	89.7%	91.3%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	94.4%	93.8%	93.9%	93.4%	93.4%	91.1%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	86.9%	87.8%	87.8%	86.9%	87.3%	84.9%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	93.9%	92.8%	93.2%	93.2%	93.1%	91.3%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	93.4%	92.8%	91.2%	91.2%	90.7%	90.8%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	92.8%	91.4%	91.9%	92.3%	92.8%	94.4%
Agency Cost	Resources	Effective	AD		£202k	£264k	£276k	£275k	£283k	£268k
Overtime Costs	Resources	Effective	AD		£0k	£1k	£0k	£0k	£1k	£2k
Additional Hours Costs	Resources	Effective	AD		£2k	£1k	£1k	£3k	£10k	£5k
Sickness Cost (Monthly)	Resources	Effective	AD		£66k	£59k	£46k	£32k	£48k	£53k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		57.68	56.77	64.46	61.42	55.85	63.99
Business Miles	Resources	Effective	AD		43k	38k	39k	35k	34k	34k

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

Support Services										
Month	Objective	CQC Domain	Owner	Threshold	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Sickness (YTD)	Resources	Well Led	AD	<=4.0%	4.2%	4.3%	4.3%	4.3%	4.5%	4.4%
Sickness (Monthly)	Resources	Well Led	AD	<=4.0%	4.8%	5.4%	4.6%	4.3%	4.5%	4.3%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	99.5%	99.5%	99.5%	99.5%	3.3%	12.9%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	98.3%	99.2%	99.2%	99.2%	0.0%	0.2%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	74.0%	76.7%	73.2%	68.0%	72.1%	80.1%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	85.2%	84.0%	84.0%	84.6%	76.9%	88.0%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Equality and Diversity	Resources	Well Led	AD	>=80%	87.5%	87.6%	88.1%	88.5%	90.0%	89.7%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	91.4%	90.0%	88.4%	90.0%	89.1%	89.3%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	95.9%	97.2%	97.2%	97.9%	98.6%	97.1%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	88.3%	88.7%	89.1%	90.3%	92.0%	92.1%
Information Governance	Resources	Well Led	AD	>=95%	94.4%	97.5%	98.7%	99.2%	95.7%	94.2%
Moving and Handling	Resources	Well Led	AD	>=80%	91.4%	89.3%	86.6%	92.9%	92.4%	94.6%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	99.2%	99.0%	99.3%	99.3%	98.9%	99.0%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	87.5%	95.2%	95.2%	95.2%	90.5%	90.0%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	96.2%	94.5%	97.5%	97.5%	97.6%	97.8%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	95.6%	96.1%	96.8%	96.8%	96.5%	97.6%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Agency Cost	Resources	Effective	AD		£8k	£26k	£22k	£12k	£14k	£15k
Overtime Costs	Resources	Effective	AD		£1k	£0k	£4k	£45k	£5k	£16k
Additional Hours Costs	Resources	Effective	AD		£7k	£10k	£7k	£17k	£10k	£8k
Sickness Cost (Monthly)	Resources	Effective	AD		£74k	£83k	£66k	£63k	£62k	£62k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		46.27	50.42	52.74	49.57	45.38	37.6
Business Miles	Resources	Effective	AD		32k	24k	23k	29k	35k	22k

Wakefield District										
Month	Objective	CQC Domain	Owner	Threshold	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Sickness (YTD)	Resources	Well Led	AD	<=4.6%	4.8%	4.9%	4.8%	4.8%	5.4%	4.9%
Sickness (Monthly)	Resources	Well Led	AD	<=4.6%	4.9%	5.6%	4.7%	4.7%	5.4%	4.4%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	98.9%	99.5%	99.5%	99.5%	4.3%	23.8%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	93.9%	95.8%	95.8%	95.8%	0.0%	0.8%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	85.5%	86.2%	85.8%	86.2%	86.8%	87.6%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	83.0%	82.9%	81.6%	80.8%	79.0%	79.6%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	80.9%	82.6%	84.2%	83.6%	83.4%	82.8%
Equality and Diversity	Resources	Well Led	AD	>=80%	91.3%	92.2%	91.9%	91.3%	89.8%	90.7%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	88.3%	88.0%	89.1%	86.9%	87.0%	84.5%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	67.4%	68.7%	73.6%	74.0%	72.7%	79.3%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	91.3%	90.9%	92.1%	90.5%	90.2%	91.6%
Information Governance	Resources	Well Led	AD	>=95%	90.5%	97.6%	98.5%	98.9%	98.3%	95.5%
Moving and Handling	Resources	Well Led	AD	>=80%	89.2%	89.5%	92.3%	92.6%	92.2%	93.0%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	92.2%	93.1%	92.5%	91.8%	90.8%	89.7%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	87.2%	87.6%	86.9%	85.6%	84.5%	83.5%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	93.6%	94.3%	94.4%	95.3%	94.9%	95.1%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	89.8%	90.9%	89.4%	90.1%	89.6%	92.4%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	94.2%	91.9%	92.7%	94.1%	93.8%	93.4%
Agency Cost	Resources	Effective	AD		£70k	£90k	£82k	£107k	£92k	£84k
Overtime Costs	Resources	Effective	AD		£1k		£1k	£0k	£1k	£2k
Additional Hours Costs	Resources	Effective	AD		£1k	£5k	£3k	£3k	£4k	£5k
Sickness Cost (Monthly)	Resources	Effective	AD		£59k	£68k	£53k	£58k	£71k	£59k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		45	45.52	41.04	39.69	39.49	37.44
Business Miles	Resources	Effective	AD		38k	43k	40k	37k	38k	34k

## Glossary

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

## Trust Board 25 June 2019 Agenda item 6.1i

<b>Title:</b>	<b>Update on Learning Disability (LD) Services and national context</b>
<b>Paper prepared by:</b>	Director of Nursing and Quality Director of Operations
<b>Purpose:</b>	To provide an update on recent developments in Learning Disability service provision and our response.
<b>Mission/values:</b>	Honest, Open and Transparent.
<b>Any background papers/ previously considered by:</b>	Annual Reducing Restrictive Physical Interventions report to Clinical Governance & Clinical Safety Committee (CGCS) 11 June 2019. Regular Mortality Review / LeDer reports to CGCS with Board Integrated Performance report.
<b>Executive summary:</b>	<p>Three recent reports/broadcasts relating to learning disability services have raised the profile of LD services in the media.</p> <p><b>BBC Panorama exposes abuse of people with learning disabilities in NHS funded care in a hospital operated by Cygnet Health Care in County Durham (May 2019).</b></p> <ul style="list-style-type: none"> <li>➤ Outside of our secure services, South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) do not ourselves provide any long-term hospital placements for people with learning disabilities.</li> <li>➤ Our Community Learning Disability Teams and Intensive Support Teams have a supportive role in this process however; providing assessment and advice regarding appropriate future placements and supporting any transition and resettlement between other providers.</li> <li>➤ There are currently 36 people placed from our footprint in out of area hospital placements.</li> <li>➤ As an explicitly short-term inpatient service, whilst our ATU at Horizon Centre may be considered as a temporary option for re-accommodating people in an emergency, it is unlikely to be a suitable place for repatriation of long-stay patients.</li> </ul> <p><b>Latest Mortality Review relating to people with learning disabilities published in May 2019 identifies large health inequalities compared with the general population and significant issues amongst NHS staff with regards to implicit bias/prejudice in relation to disabled people.</b></p> <ul style="list-style-type: none"> <li>➤ Most of the development work relates to improving access, experience and outcomes for disabled people using universal health services. As a specialist provider SWYPFT have a key role in providing support and education to primary and acute general care colleagues.</li> <li>➤ SWYPFT is well placed to support improvement in the areas identified in the LeDeR review as we have recently appointed a specialist practitioner in</li> </ul>

	<p>respiratory care and have established posts working across primary and general acute care settings within the region.</p> <ul style="list-style-type: none"> <li>➤ An implementation plan for the Long-Term-Plan for People with Learning Disabilities &amp;/or Autism is due soon and we are anticipating further guidance with regard to the commitment to mandatory training of NHS staff in learning disability &amp; autism.</li> <li>➤ NHS Improvement have approached SWYPFT to support them in establishing a pilot service-improvement programme within West Yorkshire to develop approaches for improving access, experience, outcomes and control/choice within the local health care system.</li> <li>➤ SWYPFT need to work with local authority colleagues and other health providers to improve information sharing and care-coordination arrangements, particularly for people with long-term conditions.</li> </ul> <p><b>The Care Quality Commission (CQC) published an interim report following review of restraint, prolonged seclusion and segregation of people with a mental health problem, learning disability and/or autism (May 2019)</b></p> <ul style="list-style-type: none"> <li>➤ The report focusses specifically on the segregation of people with learning disabilities admitted to specialist LD wards or wards for children and young people between 2017 &amp; 2018.</li> <li>➤ The report identifies that segregation is being used with 62 people across 89 wards. Over 25% of these have been in segregation for more than a year. Most have autism and display aggressive, destructive and self-injurious behaviours</li> <li>➤ The CQC report acknowledges that busy, open wards are sometimes not suitable for people with autism or other sensory needs and that good quality care can be provided to people in segregation, but considers that overall the need to use segregation is indicative of a failure in the longitudinal model of care.</li> <li>➤ SWYPFT have 3 people in long term segregation (LTS) currently. All are subject to close MDT scrutiny and both internal and external review. We believe all cases of LTS are necessary, justified and helpful/compassionate/therapeutic for the people concerned.</li> </ul> <p><b>Risk appetite</b></p> <p>This report provides assurance in respect of a potential clinical risk to service users which is within a risk target level of 1-6.</p>
<b>Recommendation:</b>	<b>Trust Board is asked to NOTE the report and the actions identified.</b>

## **Update on Learning Disability Services and National Context**

### **Background Context:**

In general terms, UK government policy in relation to people with learning disabilities has for over 70 years repeatedly directed that:

- 1. Long-term care and support should - in all but the most exceptional circumstances - be provided in community settings, outside of hospitals and institutions.**
- 2. Disabled people should have the same human rights as everyone else and should have equal access to public services.**
- 3. Services should work to continually reduce the level of restriction and restraint applied in the provision of any required care and support, and ensure that the least restrictive practices are used.**

There is a broad consensus amongst people with lived experience of disability (disabled people and their families) and professionals, that despite repeated efforts and policy directives – over many decades – insufficient progress has been made in all three of these areas.

### **Response to BBC Panorama Programme broadcast May 2019:**

In November 2011 a BBC Panorama programme highlighted the physical and emotional abuse of people with learning disabilities living in NHS funded care in an independent hospital operated by Castlebeck (Winterbourne View), which led to a national programme of hospital bed closures and greater scrutiny of care arrangements for people with learning disabilities and/or autism in hospital placements or at risk of admission.

The 'Transforming Care Programme' formally ran from April 2014 to April 2019 with an ambition to reduce the number of people with learning disabilities in hospital placements by 50%. Nationally the programme realised a reduction in hospital placements of 30% and is currently extended until March 2020 with the 50% ambition reiterated in the Long Term Plan for the NHS.

A second BBC Panorama programme broadcast in May 2019 evidenced further psychological, emotional and physical abuse of people with learning disabilities in NHS funded care in another independent hospital –operated by Cygnet Health Care (Whorlton Hall).

The latest scandal has led many to question both the effectiveness of the 'Transforming Care Programme' and the broader quality, safety and regulation of current care provision for disabled people who have complex care and support needs - particularly those admitted to long-stay hospitals and particularly where these are in out-of-area placements a long-way from the scrutiny of family, their originating community care providers and placement commissioners (NHSE, CCGs).

NHS England & NHS Improvement are working with NHS Provider Trusts and Clinical Commissioning Groups to identify those people placed in long-stay hospitals (particularly in out-of-area placements) and to arrange urgent reviews of their care arrangements. Where there are concerns about the quality, safety or suitability of existing placements,

commissioners have been requested to work with local NHS providers to identify alternate provision closer to home.

Outside of its secure services, SWYPFT does not currently provide any long-stay hospital based care to people with learning disabilities. Our role in this is therefore a supportive one; with our Community Learning Disability Teams (CLDTs) and Intensive Support Teams (ISTs) clinically assessing patients and advising commissioners on appropriate future care arrangements for people being re-accommodated or repatriated into one of our local areas.

For most cases of people who are placed out-of-area - where SWYPFT are not directly providing clinical services (assessment or treatment) - we are not commissioned to provide on-going care-coordination/CPA. Subsequently most of the cases involved in this process will have been discharged from our community learning disability teams once the person has been supported to transition to a different area and we have handed over responsibility to a new clinical team. Within CKWB, care-coordination and review of people placed in out-of-area placements is mostly the responsibility of the respective CCG funding the placement. In some cases where an out-of-area placement is considered temporary, our community services will remain involved in order to support return to the local area. **\*\*Note that this contractual arrangement is different to some other equivalent NHS providers who retain long-term care-coordination responsibility for people placed out of area by the CCG.**

Our inpatient Assessment & Treatment Unit at the Horizon Centre has recently received referrals regarding people seeking transfer from long-stay, out-of-area hospitals as part of this work. However, as a unit with the explicit purpose of providing short-term assessment and treatment of mental and/or behavioural disorder, we have been mindful that we are not an optimal service or environment for the provision of long-term rehabilitative or therapeutic programmes for people whose placements are deemed inappropriate. Subsequently we have advised seeking alternative longer-term placement solutions for these cases, whilst acknowledging that we may be required to provide a temporary emergency service if an urgent need for re-accommodation arises.

### **Response to 2018 National Mortality Review (LeDeR) – Published May 2019:**

In 2015, following a confidential enquiry into the premature deaths of people with learning disabilities (CIPOLD, 2013) a national Learning Disabilities Mortality Review (LeDeR) programme was established to provide local scrutiny and review of the deaths of people (4+ years old) with learning disabilities in England. LeDeR's latest (3<sup>rd</sup>) annual report was published in May 2019 and highlighted – as in previous years and before then in CIPOLD (2013), 'Death by Indifference' (Mencap, 2007) and 'Six Lives' (Parliamentary & Health Service Ombudsman, 2009) – that people with learning disabilities living in England experience **significant health inequalities; poor access to universal health services; poor experience of NHS services generally** (primary/universal and specialist), **poorer health outcomes than the general population**, and **significantly increased mortality** - with premature deaths (median age of death between 23 and 29yrs earlier than the general population) and **high proportions of preventable/avoidable deaths** (19%).

Key learning points from the latest LeDeR review relate to:

1. The main causes of death in people with learning disabilities: Respiratory-Related, Sepsis, Constipation & Epilepsy.
2. Implicit bias by health professionals regarding the quality and value of the lives of people with learning disabilities (e.g. Professionals placing barriers to disabled people accessing specialist health services, 'Learning Disability' and 'Down's Syndrome' given as reasons not to attempt resuscitation).
3. Lack of education and awareness among NHS staff regarding the common signs and symptoms of illness, pain and distress in people with learning disabilities, and lack of understanding of basic communication/reasonable adjustments which can be helpful to disabled people.
4. Lack of coordination and information sharing between health and social care agencies supporting people with learning disabilities.

The LeDeR (2018) review makes 12 recommendations. Many of these relate to the structural arrangements deemed necessary for the national LeDeR programme to work effectively in future (e.g. future leadership & commissioning arrangements of the programme, increasing capacity of LeDeR reviewers within each locality). However, some of the recommendations do link to the key areas identified within the review as contributory factors to health inequality and increased mortality - though these are quite broad in their scope and will require some development to make specific and actionable locally:

- Work to better recognise deteriorating health and early signs of illness in people with learning disabilities.
- Work to minimise the risks of pneumonia and aspiration pneumonia
- Develop guidance on care co-ordination and information sharing arrangements in respect to agencies supporting people with LD at individual, organisational and strategic levels.
- Work to address poor transition arrangements for people moving from children's to adults' services
- Work to improve care-coordination and information sharing between agencies
- Urgently address issues of unconscious bias within clinicians particularly with respect to DNACPR orders.

In addition, NHS England has commenced some service-development work through its 'Action from Learning' team and proposed plans for:

- Working out a way to take the learning from reviews which is the same for everyone.
- Making sure that LeDeR reviews, and other investigations that are required by the law, are linked together when they need to be.
- Working with people with a learning disability and families through programmes like "Ask, Listen, Do" to find out whether people are seeing changes in services linked to the themes and recommendations from LeDeR reviews (for example, sepsis, constipation or aspiration pneumonia).
- Collecting evidence for health and care services so that they can understand that caring for people with a learning disability and their families is everyone's business.
- Making sure that we know what is changing and where so that we can tell if the LeDeR programme is helping people to live longer, healthier, happier lives

Much of the focus of this improvement work sits within universal health service providers (primary care and acute general hospitals) rather than with specialist providers of learning disability services such as SWYPFT. It is acknowledged though that we (and our specialist

workforce) have a key role in supporting and driving change; working in partnership with universal health care services to provide education, support and advice regarding reasonable adjustments and specific clinical knowledge and skills. In addition we have a direct action to work with local authority and other health and care colleagues to improve our processes of information sharing and resolve issues with care-coordination (particularly for people transitioning between children's and adults' services).

Local data for West and South Yorkshire (reviews of 70 deaths since 2017) are consistent with the findings described in the national review; 33% of deaths are of people between 55 and 64 yrs, around half of the deaths (34/70) were considered respiratory-related.

SWYPFT have recently employed a specialist practitioner in respiratory care to support improvements in respiratory care within the local health system. In addition SWYPFT learning disability services employ a 'Strategic Health Facilitator' working within primary care services in Wakefield and an 'Acute Liaison Nurse' who works across Mid Yorkshire Hospitals Trust. Our community teams also have regular links with GP surgeries in each of our localities as well as each of the acute general hospital providers.

Last year NHS Improvement published 'The learning disability improvement standards for NHS trusts' which focus on improving NHS care in four key areas:

- Respecting and protecting rights
- Inclusion and engagement
- Workforce
- Learning disability services standard (aimed solely at specialist mental health trusts providing care to people with learning disabilities, autism or both)

Locally, the WYHHCP (ICS) has been approached by NHS Improvement with a view to developing and piloting a system-wide service-development programme. We are working with colleagues in the WYHHCP (ICS) to establish links with acute general hospital trusts to try and progress this. (There may be some funding support for this from NHSE regional team).

The Long-Term-Plan for People with Learning Disabilities and/or Autism attends to much of the learning from the latest LeDeR review. We are expecting publication of the implementation plan for the LTP very soon which should include some guidance and recommendations for how some of the actions can be addressed. This will include details around the commitment made to mandatory training of all NHS staff around learning disabilities and autism for which there has been significant national consultation.

**Response to CQC's interim report into reviews of restraint, long-term segregation and seclusion of people with a mental health problem, learning disability and/or autism – Published May 2019**

This interim report (May, 2019) focusses particularly on the use of long-term segregation of people with learning disabilities and/or autism on 'specialist learning disability wards or a mental health wards for children and young people'. The findings are based on detailed review of 39 cases between 2018 and 2019.

(The full report is due Spring 2020)

Following information requests sent to 89 registered providers, it was identified that:

- 62 people were managed in conditions of segregation

- Of these, 16 people had been in segregation for more than a year.
- On average people in segregation were placed 87km away from their home addresses.
- Approximately 50% of the people in segregation were in wards managed by the independent sector.
- 24 of the hospital places were CCG commissioned and 30 NHSE Specialised Commissioned. 3 were local authority commissioned, 2 by Welsh Commissioning and 3 did not specify.
- All cases of segregation were reported to be due to the person having behaviours services found challenging – aggressive, destructive and self-injurious behaviours.
- 31 of the 39 cases reviewed in detail had autism (79.5%)
- Some of the wards were not deemed able to meet the sensory needs of a person with autism.
- Many staff lacked the necessary training and skills to work with people with autism who have complex needs/challenging behaviour.
- Most staff working with people in segregation were unqualified.
- Several people in segregation were not deemed to have received adequate assessment or support.
- For 26 of the 39 people reviewed (67%), staff were not attempting to reintegrate the person back onto the general ward.
- For 25 people (64%) staff reported believing that the person's quality of life was better in segregation than in the less predictable open ward environment.
- 13 of the 39 people reviewed (33%) were delayed discharges due to there being no suitable placement available outside of a hospital.

The CQC conclude that the current national system of care for this cohort of people is not fit for purpose and has failed those individuals who are being managed in segregation. Often failures in care were identified as occurring during early childhood with inadequate early-years support. The report identifies that open wards can be unpredictable with many sensory stimuli, and are not always appropriate for people.

Some high-quality care of people in segregation was identified and acknowledged.

Recommendations:

1. Within 12-months there should be an independent, in-depth review of every person placed in segregation to confirm that they are receiving 'good care' and that no opportunities are missed to end segregation or hasten discharge.
2. An expert group of clinicians, people with lived experience and academics (including from other countries/cultures) should consider what would make a better system of care for this group of people.
3. Strengthen safeguards to protect against punitive culture – units should be open to external and independent scrutiny, with a potentially increased role for independent advocates and commissioners.
4. Focus on human rights and prevention of admission – particularly for children and young people. If a hospital placement is required it should be provided close to home and for as brief a period as possible.
5. CQC should review and revise its approach to regulating and monitoring hospitals that use segregation

'Segregation' describes the condition of being supported in a dedicated area away from other patients on the ward but with the continual presence and support of staff and visitors (family, visiting professionals etc.). People in segregation have their own bedrooms, bathrooms and lounge areas (and sometimes individual kitchen/dining areas). By contrast, 'seclusion' describes the condition of being entirely alone in a room or suite of rooms – usually because someone is acutely distressed and their behaviour poses a significant risk to themselves or other people. Whilst segregation can occur long-term, seclusion is only ever temporary and takes place in a safe environment (usually a specialist bedroom with ensuite facilities).

Both segregation and seclusion are highly governed with regular reviews by multi-disciplinary professionals and independent clinicians from other teams and outside agencies.

We currently have a number of people (3) in Long-Term-Segregation (LTS) on our ATU at the Horizon Centre. We believe this is appropriate, necessary, compassionate/therapeutic and proportionate in each case, but are mindful that this number and proportion (3/5 patients [60%]) is high. None of our patients have been in LTS for more than 12-months.

All of the patients managed in LTS leave the ward and access the community multiple times each day.

With regard to the findings of the interim report, we are probably typical in the rationale we have for using segregation: in response to aggression or self-injury and with the aim of reducing over-stimulation which can occur on the open ward. 2 of the 3 people currently in LTS have autism and are particularly sensitive to unpredicted stimuli. We believe in each case that the person's own quality of life is enhanced by being having a dedicated area to themselves rather than sharing with other patients on the open ward.

The main ward environment on Horizon is autism friendly to a degree but there are some improvements we would like to make in this regard (e.g. altered lighting and additional sensory resources).

The main staff supporting the patients in LTS are Health Care Support Workers. Whilst formally unqualified, they are mostly well-skilled in meeting the needs of the patients they support and have regular guidance and support from the nursing team and wider MDT.

All patients admitted to the ATU (including those in LTS) have a comprehensive multi-disciplinary assessment and care-plan.

There is significant governance around each incident of segregation, involving 24hourly nursing reviews, daily medical reviews, weekly consultant psychiatrist reviews and fortnightly independent consultant psychologist/psychiatrist reviews by consultant clinicians not directly part of the ATU's clinical team.

**\*\*NOTE: In addition to the above, there is a requirement every 3-months for an independent medical review of LTS by a consultant psychiatrist from another Trust. Previously we have been supported in this by colleagues from Bradford District Care Trust and LYPFT, but recently they have been unable to assist. Due to being unable to identify someone from a neighbouring Trust to do these reviews, we recently breached with this governance requirement: DATIX submitted. Although intended to be a reciprocal arrangement with LYPFT, we**

**have never been asked to reciprocate with this. In order to be compliant with LTS policy, it may be necessary to consider offering payment specifically for this purpose.**

There is some change in language to note in the report compared to previous guidance. Namely that the appropriateness of seclusion and segregation should be judged against being: '**Lawful, Legitimate and Necessary**'. This is a change from previous guidance which advised LTS should be established as being 'necessary', 'proportionate' and 'least restrictive'. Yvonne French is reviewing the Trust's governance and monitoring/recording processes for LTS to ensure they remain appropriate.

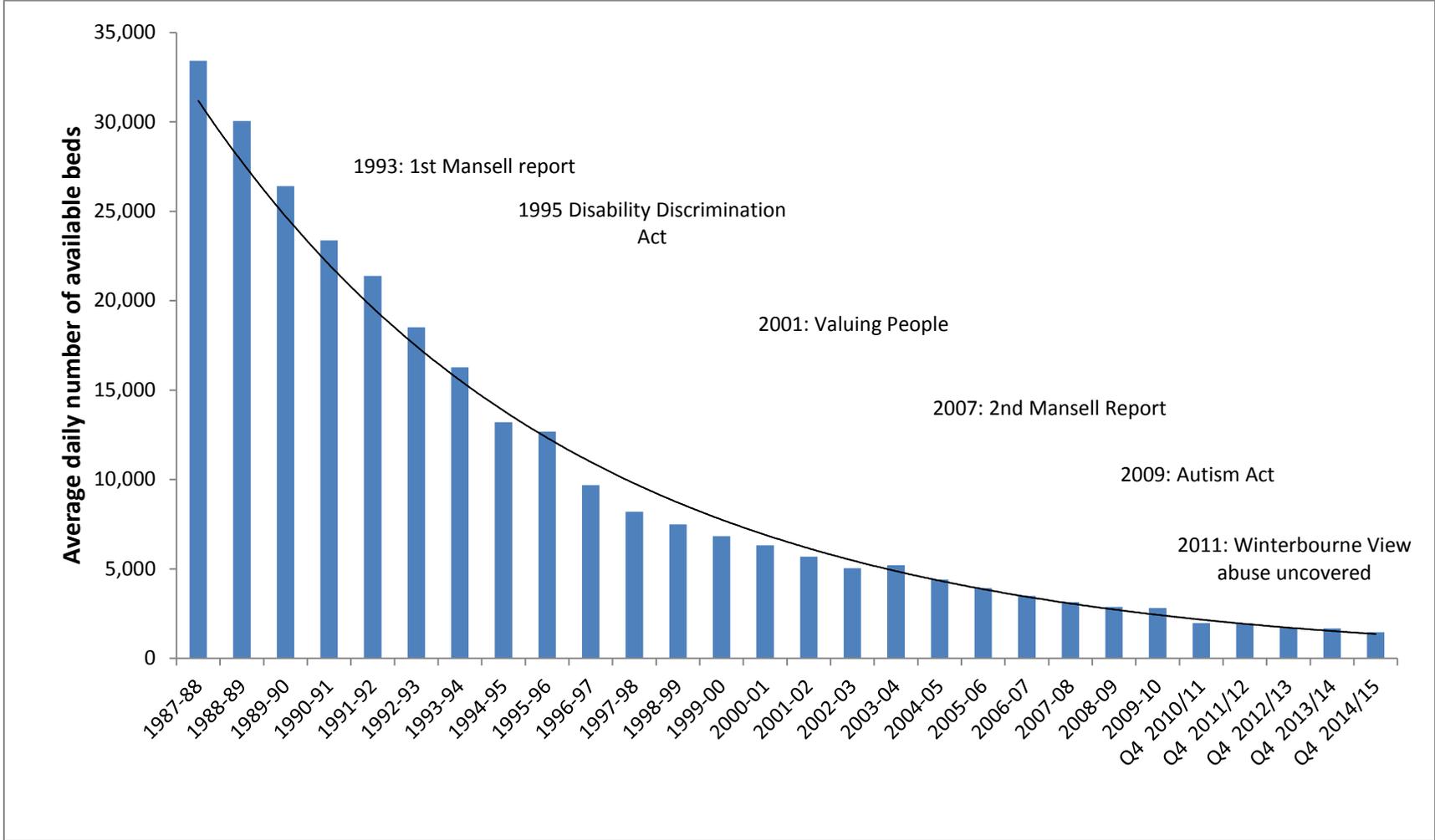
**Summary of UK Policy in Relation to People with Learning Disabilities (1950's to Present Day):**

Decade	1950's	1960's	1970's	1980's	1990's	2000's	2010's
<b>Political Direction</b>	Promotion of community care rather than institutional care	Hospital Closure Programme  Equal access to Education	<i>'Normalisation'</i> comes to the fore as a concept for disabled people, alongside ideas of <i>'Care in the Community'</i>	Ideals of equality, citizenship and 'social role valorisation' come to prominence	Development of a 'Mixed Care Economy' (system) and introduction of equality legislation	Focus on disabled peoples 'rights'	Focus on:  Quality & Safety of care and overcoming Health Inequalities
<b>Key Drivers</b>	'50,000' Outside the Law: Detention of people with learning disabilities is <i>'an affront to civil liberties'</i>	Minister for Health (Enoch Powell) says "Mental hospitals" to close within 15years.	National programme of developing community 'hostels' to support people with learning disabilities to live in their local communities.	Government promotes access to mainstream public services for people with learning disabilities.	Disability Discrimination Act provides protection in Law for disabled people's right to make choices and have control and self-determination over their own lives.	Valuing People  & subsequently  Valuing People NOW (2009)	BBC Panorama (exposure of abuse at Winterbourne View) (2011) triggers subsequent 'Transforming Care' programme (2015)
		Education for all: <i>'no child is ineducable'</i> (Stanley Segal)		People with learning disabilities are granted voting rights.			



				'People First' & 'An Ordinary Life'	purchasers (NHS commissioners) and providers (NHS Trusts) and increased reference to public and privately funded health services.		Equality Act (2010)
				The Community Care Act (1990)			The Care Act (2014)

**Changes in hospital provision for People with Learning Disabilities:**



## Trust Board 25 June 2019 Agenda item 6.2

<b>Title:</b>	<b>Incident Management Annual Report 2018/19</b>
<b>Paper prepared by:</b>	Director of Nursing and Quality
<b>Purpose:</b>	This report provides an overview of all the incidents reported in the Trust during 2018/19. It also includes further analysis of Serious Incidents, and brief analysis of recommendations arising from completed Serious Incident investigations submitted to commissioners for the period of 1 April 2018 to 31 March 2019. The report provides an overview of the national developments related to patient safety that have occurred throughout the year and summary of the work undertaken by the Patient Safety Support Team.
<b>Mission/values:</b>	<ul style="list-style-type: none"> <li>➤ We are respectful, honest, open and transparent</li> <li>➤ We put the person first and in the centre</li> <li>➤ We are always improving</li> </ul>
<b>Any background papers/ previously considered by:</b>	Previous annual reports which have been submitted to Trust Board.
<b>Executive summary:</b>	<p>The Trust reported <b>12640</b> incidents during the year; a slight increase (<b>2.7%</b>) on the previous year. A high level of incident reporting, particularly of less severe incidents is an indication of a strong safety culture (NPSA: Seven Steps to Patient Safety). The distribution of these incidents is in line with an established reporting process showing a triangle with <b>88%</b> of incidents resulting in no/low harm.</p> <p>There were <b>45</b> serious incidents reported during the year accounting for <b>0.36%</b> of all incidents, a small decrease in both number and percentage of all incidents reported than in 2017/18. The highest overall category of serious incident is apparent suicide of service users in current contact with community teams (23) compared to (34) in 2017/18.</p> <p>Separate analysis of serious incidents is included in this report. Analysis of apparent suicides reported as serious incidents has been prepared separately, but included as Appendix A to this report.</p> <p><b>No 'Never Event'</b> incidents were reported by SWYPFT in 2018/19. The last Never Event reported by the Trust was in 2010/11. Never Events is a list (DOH) of serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.</p> <p><b>This report was scrutinised by the Clinical Governance and Clinical Safety Committee meeting held on the 11 June 2019.</b></p> <p>The Committee reviewed the annual report alongside the 18/19 Apparent Suicides report which informed the discussion and scrutiny</p> <p>The Committee commented as follows:-</p> <ul style="list-style-type: none"> <li>➤ The report is of high quality and well structured</li> <li>➤ The Committee was assured that robust systems and processes for the reporting and investigation of incidents remain in place.</li> </ul>

	<ul style="list-style-type: none"> <li>➤ The Committee also noted the importance of the weekly risk panel where all amber and red incidents are reviewed.</li> <li>➤ The Committee took assurance from the internal audit reports relating to serious incident reporting &amp; learning from deaths, both of which have a significant assurance rating.</li> <li>➤ The Committee noted the positive trend in respect of incident reporting.</li> <li>➤ Feedback from the CQC report on serious incidents and mortality reviews provides an additional external positive opinion.</li> <li>➤ The Committee requested assurance that the Annual Incident report and Apparent Suicides report outcomes and actions are contained within the Patient Safety Strategy action plan with particular reference to the work to address the increase in apparent suicide levels. It was recognised that the Trust Suicide Prevention Plan describes the planned action and that the Committee will monitor progress through regular reporting.</li> </ul> <p><b>Risk appetite</b></p> <p>Risk identified – the trust continues to have a good governance system of reporting and investigating incidents including serious incidents and of reporting, analysing and investigating healthcare deaths.</p> <p>This report provides assurance for compliance risk relating to health and safety legislation and compliance with CQC standards for incident reporting. This meets the risk appetite</p>
<p><b>Recommendation:</b></p>	<p><b>The Trust Board is asked to RECEIVE the Incident Management Annual Report for 2018/19 and the assurance from the Clinical Governance and Clinical Safety Committee.</b></p>

# Incident Management Annual Report

**April 2018 to March 2019**

**Patient Safety Support Team**

**1 June 2019 (Draft Version)**

## Executive Summary

This report provides an overview of **all** the incidents reported in the Trust during 2018/19. It also includes further analysis of Serious Incidents, and brief analysis of recommendations arising from completed Serious Incident investigations submitted to commissioners for the period of 1 April 2018 to 31 March 2019 (data as at 04/04/2019). The report provides an overview of the national developments related to patient safety that have occurred throughout the year and summary of the work undertaken by the Patient Safety Support Team.

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



- **12640** incidents reported
- **2.7%** increase in reporting on 2018/19
- **88%** of incidents resulted in no/low harm
- **45** Serious incidents reported
- No Never Events
- Serious Incidents account for **0.36%** of reported incidents
- High reporting rate with high proportion of no/low harm is indicative of a positive safety culture<sup>1</sup>



The Trust reported **12640** incidents during the year; a slight increase on the previous year. A high level of incident reporting, particularly of less severe incidents is an indication of a strong safety culture (NPSA: Seven Steps to Patient Safety<sup>1</sup>). The distribution of these incidents is in line with an established reporting process showing a triangle with **88%** of incidents resulting in no/low harm.

There were **45** serious incidents reported during the year accounting for 0.36% of all incidents, a small decrease in both number and percentage of all incidents reported than in 2017/18. The highest overall category of serious incident is apparent suicide of service users in current contact with community teams (23) compared to (34) in 2017/18.

Separate analysis of serious incidents is included in this report. Analysis of apparent suicides reported as serious incidents has been prepared separately, but included as Appendix A to this report.

**No 'Never Event'** incidents were reported by SWYPFT in 2018/19. The last Never Event reported by the Trust was in 2010/11. Never Events is a list (DOH) of serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

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<sup>1</sup> [NPSA. \(2004\). Seven Steps to Patient Safety](#)

During 2018/19, many positive outcomes have been achieved in relation to patient safety.



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



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

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

The 2019/20 plan will continue to support the implementation of the Patient Safety Strategy, Suicide Prevention Strategy and Mortality work along with ensuring we continue to develop learning from incidents to reduce harm.

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## Introduction

The purpose of this incident management annual report for 2018/19 is to present key headline data for incidents reported within the Trust on the incident management system (Datix). This includes brief analysis of all incidents and more detailed analysis of serious incidents. A summary of work undertaken during the year will be given and some of the key next steps planned for 2019/20.

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

Further information can be provided on request. In addition to this report, 'Our Learning Journey' report, presenting the work of the BDUs in terms of implementing learning and learning from serious incident investigations will be available June 2019.

The report is structured into the following sections:

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

**Section 2** includes a summary of all reported incidents occurring from 1 April 2018 to 31 March 2019. It should be noted that this report provides only an overview; detailed reports are produced on a quarterly basis for Business Delivery Units and many specialist advisors run/analyse incident reports.

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

**Section 4** focuses on incidents reported as Serious Incidents during 2018/19. The first part looks at what these incidents were, and secondly provides more details on the different types of serious incidents that were reported. It includes detailed analysis of apparent suicides reported as serious incidents.

**Section 5** sets out an analysis of the serious incident investigations that have been completed and sent to commissioners during 2018/19. It includes an analysis of the themes arising from serious incident recommendations.

**Section 6** gives a summary of the development plans of the Patient Safety Support Team for 2018/19.

## Section 1: Background and 2018/19 developments

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



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



### Governance structure

Reporting, analysis and learning from incidents is managed through a clear governance structure. The Director of Nursing, Quality and Professions works closely with the Medical Director to ensure there are robust processes in place. This is supported by an Associate Director of Nursing, Quality and Professions (with Patient Safety within their portfolio), an Assistant Director of Nursing, Quality and Professions (with Patient Safety within their portfolio) and an Associate Medical Director (AMD) for Patient Safety. The Patient Safety Support Team provides support to all Business Development Units (BDU's) and Quality Academy teams. Investigation of serious incidents is undertaken by full-time lead investigators, a band 7 investigator secondment, specialist advisors, external investigators and individuals working on the bank, supported by dedicated sessions from medical investigators. A list of co-opted experts within the Trust has been developed from a variety of specialties and disciplines to provide specialist support to serious Incident investigators where necessary.

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

The patient safety clinical reference group meetings, chaired by the AMD for patient safety, is a forum for collecting and disseminating ideas and information between a core group of individuals directly involved in developing, implementing and monitoring systems to improve patient safety. During 2018/19 one session focused on formulation of risk to aid understanding for investigators.

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

A monthly mortality review group meets to consider all in scope deaths, progress with reviews and considers outcomes. The group focuses on the process and technical development to support learning from healthcare deaths. A Clinical Mortality Review Group has been established to focus on outcomes and action. In 2018/19 the group reviewed themes that had emerged from serious incidents, service level investigations and structured judgement reviews. Individual actions and areas for improvement, along with good practice from structured judgement reviews.

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

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

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

## Learning from Healthcare Deaths developments

In line with the **Learning, Candour and Accountability**<sup>2</sup> report from the CQC and the National Quality Board (NQB) guidance on **learning from deaths**<sup>3</sup>, 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 and included:

- Inclusion of support for bereaved families in line with July 2018 national guidance<sup>4</sup>. Includes the principles we will use, guidance for staff with links to online resources. Work continues to develop support materials for bereaved families.
- 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

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.

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<sup>2</sup> [Care Quality Commission. 2016. Learning, Candour and Accountability.](#)

<sup>3</sup> [National Quality Board. 2017. National guidance on learning from deaths.](#)

<sup>4</sup> National Quality Board 2018. 'Learning from deaths: Guidance for NHS trusts on working with bereaved families and carers'.

Our learning from deaths information has been published [on our website](#) from October 2017.

The policy acknowledges the importance of maintaining a focus on outcomes rather than the process. A Clinical Mortality Review Group has been established to support the examination of themes arising from reviews.

The Patient Safety Support Team has continued to provide substantial resources to support and develop the Trust's learning from healthcare deaths systems, processes and policy developments.

## External scrutiny and feedback

### Care Quality Commission

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

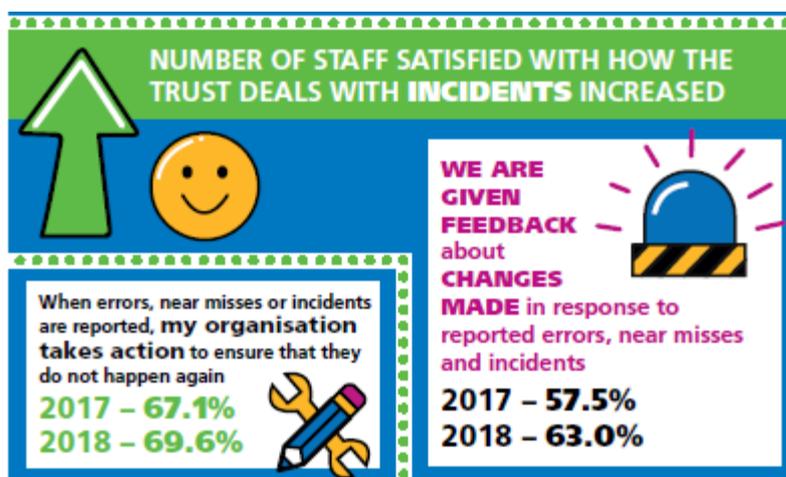
During 2018/19 we have worked closely with our CQC Inspector to develop process to enable us to provide the CQC with regular flows of information relating to deaths, serious incidents and severe harm incidents.

The CQC Interim report 2019 can be found here:

<https://www.cqc.org.uk/publications/themed-work/interim-report-review-restraint-prolonged-seclusion-segregation-people>

### National Staff Survey 2018

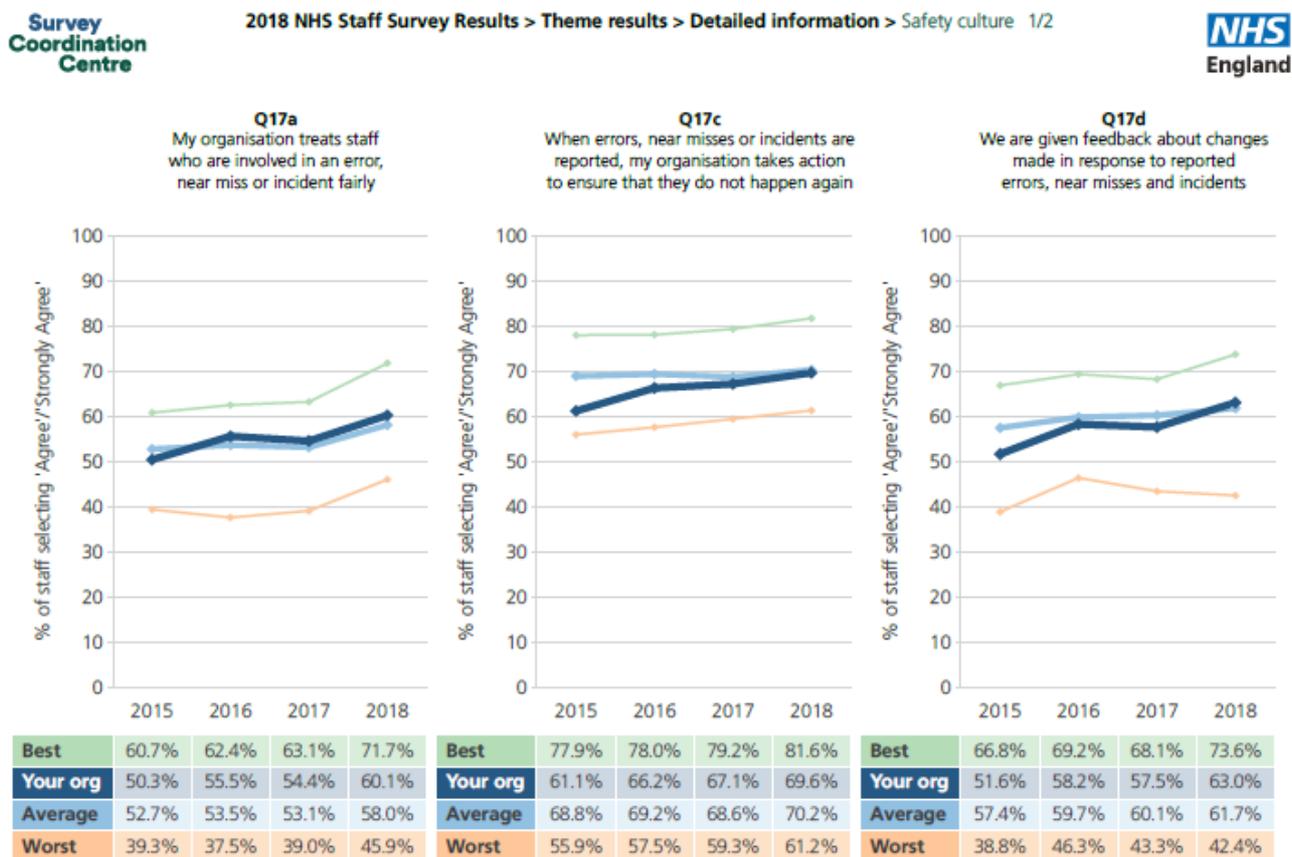
A number of questions were asked in the National Staff Survey 2018<sup>5</sup> which provided direct feedback on staff views with regards to the incident reporting system and our safety culture.



These responses showed positive results, with improvements being made on previous years. The 2018 staff survey was published in 2019. For the full report, [click here](#).

<sup>5</sup> [SWYPFT Staff Survey results 2018](#)

Figure 1 Extract from Staff Survey 2018 relating to safety culture



## Homicide Independent Reviews

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

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

## Patient Safety Strategy developments

The patient safety support team has supported the development and coordination of the Patient Safety Strategy implementation plan. During 2018, the Patient Safety Strategy Implementation Group has focused on:

### Patient safety communication

- Trust wide initiative [#allofusimprove](#) has been developed and includes **patient safety** as a strand to promote improvement and shared learning
- [Key messages](#) for patient safety developed.
- Several safety case studies developed and shared across the Trust including:

- Case study 8: Reducing medication missed on inpatient wards
- Case study 5: Occupational health support for serious incidents
- Case study 1: Safety huddles
- Supported [Sign up to Safety](#) Kitchen Table event initiative in September. BDUs were asked to host conversations about how we work safely and improve safety and to identify priorities for patient safety. Themes from this year's events have been used in the development of the patient safety strategy from 2019 onwards.
- Worked with the Trust volunteers to review and update the new Patient Safety Strategy.

## Safety Huddles

During 2018/19 interest in Safety huddles has continued. Involvement with safety huddles is entirely voluntary, and to be successful, the concept and harms must not be imposed.

- We now have 14 wards/ team actively involved in, or working towards having a huddle. Although this is only a slight increase on last year, the teams involved have changed. Some teams have withdrawn their interest, (e.g. because of timing, capacity), whilst other teams have got involved. Some teams have been holding safety huddles without support, which has been addressed when identified.
- Change language to 'how will we keep safe', rather than focus on harm.
- Discussions have taken place about developing safety trigger list e.g. self-harm, suicide prevention within huddles format.
- Shared our learning at regional Improvement Academy network meetings.
- Hosted and co-facilitated a regional mental health safety huddles network group in September 2019 to promote and support those using safety huddles.
- We are exploring other options, including expanding our group of coaches to support teams with the huddles process, and we have established support network for coaches to learn from each other.
- Significant achievements have been made in reducing harm during 2018/19 (not award goals differ for each team based on their historic data):

Team	Focus	Baseline	Days between achieved	Award
Chantry (OPS)	Falls	0.8 falls/week	33 days without a fall	Bronze
Willow (OPS)	Falls	1 fall in 8 days	>100 days without a fall	Platinum
Willow (OPS)	Violence & Aggression	Average 31 days between	70 days without V&A incident	Silver
Stroke unit	Falls	1 fall/6 days	64 days without a fall	Platinum
Neuro Rehab unit	Falls	18 days	43 days within a fall	Silver
Beechdale (OPS)	Violence & aggression	2.65/week	39 days without V&A incident	Gold

## Human factors

We have continued to develop our use of Human Factors methodology:

- Human Factors [intranet page](#) has been developed.
- E-learning is available for all staff as Bronze on-line training through the Improvement Academy
- Several staff have attended silver level Human Factors training.
- Human Factors continue to be examined as part of investigations
- The Patient Safety Support Team have developed a Significant Event Analysis template as a tool that can be used to analyse an adverse event, which helps teams to focus on Human Factors

- Human Factors is now included in the Systems Analysis training delivered by the Patient safety support team.
- Our Significant Event Analysis tool has continued to be implemented; this enables teams to analyse incidents using human factor principles.

### **Significant Event Analysis (SEA)**

During 2017/18 we developed and piloted our Significant Event Analysis tool. We have continued to use this tool to review specific incidents that require more detailed analysis or would benefit from team discussion. The tool helps teams to focus on human factors involved in an incident to help identify areas for improvement and good practice.

### **Learning**

Developments to strengthen methods of learning and sharing have continued:

Work has continued to promote sharing of learning across the Trust:

- [Bluelight alerts](#) have embedded across the Trust, with 9 alerts being issued to all staff. These have included potential risks associated with ligatures, ligature points, methods of self-harm, fire risks from emollients, use of modified texture diets, and guidance for service users purchasing medication online.
- After a review of the process, these are now sent to managers via Datix Safety alerts module to enable managers to record their actions in response to each Bluelight alert. This strengthens this process and provides assurance that action has been taken where required.
- [Greenlight alerts](#) are being used to share information and learning on a range of medication topics including availability of medication, PRN medicines, liquid medication, flu vaccines.
- Incident Reports routinely include examples of learning
- Learning from other BDUs recommended as standard agenda item for BDU learning events.

### **Learning Library #allofusimprove**

A small group of staff explored ideas for how we can improve how we share learning from our experiences, whatever its source, e.g. incident, serious incident, complaint, compliment, audit, patient experience, case note review. As a result, we have:

- Agreed the name 'learning library' which is linked to #allofusimprove
- Developed a standard template that can be completed by any member of staff using the Situation, Background, Assessment/Analysis, Recommendation (SBAR) headings that were already in use for Bluelight alerts. These help to share information in a concise way.
- Created [Learning library intranet pages](#) where staff will find the template and guidance.
- Shared network drive [K:\#allofusimprove](#) and central inbox [learninglibrary@swyt.nhs.uk](mailto:learninglibrary@swyt.nhs.uk) created to manage content.

### **BDU patient safety priorities**

In addition, each Business Delivery Unit identified their top 5 patient safety priorities for 2018 which they are progressing with. The work includes:

- Safer staffing
- Harm reduction
- Learning from incidents to promote patient safety and improve culture
- Clinical environment safety
- Medication safety
- Record keeping
- Safeguarding
- Staff recruitment and retention
- Patient safety supervision

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

## Sign up to Safety

Sign up to Safety data for 2018 showed positive outcomes, with a number of our 3 year targets being achieved as shown in Figure 2.

The target for reducing the duration of prone restraint continues during 2019, and will be monitored through the Patient Safety Strategy group in addition to the Reducing Restrictive Physical Interventions Group.

For medicine omissions, this is measured through the Safety Thermometer which is conducted as an audit on one day of a month. The figures are disappointing but do show a reduction. There were issues with the accuracy of data collection and very high numbers for several wards in December 2018 when data collection was on Boxing Day with many service users on leave having affected 2018 data. Many wards have shown significant improvements with figures for some wards down to as few as 6% of service users having omitted doses. This work will continue and forms part of the CQC action plan and is a potential subject for safety huddle work on wards where figures are high. The implementation of the new clinical record system has delayed the introduction of electronic prescribing and administration system which formed part of the plan.

Work towards the remaining targets continues. It should be noted that not all our targets had the same 3 year timeframe due to improvements in data collection.

Figure 2 Sign up to Safety measures for 2018

Area	Target	Baseline period	Baseline figure	Current data	% reduction from baseline	End period
Medicine omissions	To reduce unintended missed doses by 25% by 31/12/2018	2015	23.46%*	2018 21.4%	8.8% reduction  Monitoring to continue	31/12/2018
Pressure ulcers	To reduce the frequency of new pressure ulcers that are attributable to SWYPFT care and avoidable by 50% by 31/12/2018	2015	23	2018 6	74% reduction in three years ACHEIVED	31/12/2018
Falls	To reduce the frequency of falls by inpatients by 15% by 31/12/2017	2014	825	2017 524	36.4% reduction in 3 years ACHEIVED	31/12/2017
Falls	To reduce the frequency of inpatient falls resulting in moderate/severe harm or death by 10% by 31/12/2017	2014	19	2018 15	21% reduction in four years ACHEIVED	31/12/2017
Restraint	To reduce moderate harm and above to patients in incidents that resulted in restraint by 30% target by 31/12/2017	2014	7	2017 2	71.4% reduction ACHEIVED	31/12/2017
Prone Restraint	To reduce the frequency (use of) of prone restraint by 30% by 31/12/2018	2015 part year average	438 prone from 1695 restraints	364 prone from 2056 restraints	30.7% decrease in prone as % of all restraints in 3 years ACHEIVED	31/12/2018
Prone restraint duration	To have 90% of prone restraints with a duration of 3 minutes or less by 31/12/2019	July - Dec 2016	78%	Dec 2018 92%	Continued monitored through IPR ONGOING	31/12/2019

Care should be taken not to compare this data with performance information as criteria and date ranges are not the same.

## **Suicide Prevention Strategy**

Much work has been completed over the last 18 months, and this update aims to provide a summary of some of the work (Please see **Apparent Suicide** annual report for more detail). There will be work undertaken to improve the alignment of our local suicide prevention work with the West Yorkshire and Harrogate Health Care Partnership plan.

Summary of some of the work:

### **Training**

- Applied Suicide Intervention Skills Training (ASIST) has continued and this model is now being adopted across West Yorkshire. Additional trainers are being trained – this is for anyone who wants to feel more comfortable, confident and competent in helping to prevent the immediate risk of suicide.
- SafeTALK training continues, which is for anyone to help identify those with thoughts of suicide and connect them to suicide first aid resources.
- A course on developing safety plans has been run by a Recovery College. This is being evaluated and it is hoped this can be spread across the Trust.

### **Bereavement support**

- Work is underway to scope suicide bereavement services across WYHCP. Some local work has been done to collate resources.
- Postvention development is being explored through WYHCP and training is taking place shortly. Training will be part of this plan.
- This also links with Learning from Healthcare deaths guidance (July 2018) on supporting bereaved families.

### **Analysis and Review**

- Work is progressing to improve our understanding of apparent suicide data
- We have been developing our mortality review systems in line with national guidance. Some apparent suicides are now reviewed using Structured Judgement Review.
- Datixweb is now configured to collect additional data for all apparent suicide. Annual reports are produced. Dashboards for each BDU apparent suicides are available.
- Deep dive analysis on hotspot areas and targeting clinical teams and service user groups where there is concern continues when required.
- Analysis has taken place in Kirklees and no area was identified for focussed action.
- A workshop has been held in the Child and Adolescent services which the Trust initiated in response to a cluster of apparent suicides. This was supported by [PAPYRUS](#) a charity to **prevent young suicide**.
- An in-depth review of the patients under 35 who died by apparent suicide is underway.

### **Support for staff**

- A new procedure for providing proactive in-reach support to staff after an apparent suicide has been implemented. This includes a critical incident stress information sheet. Occupational health staff are now alerted to potential serious incidents directly from Datix.
- Our Supporting staff after traumatic events policy is being reviewed.

### **In-patient services**

- Ligature risk assessment group has ensured all areas have a plan with data being collected by tablet.
- A recent audit found that 63% of discharged inpatients were followed up within 72 hours of discharge as advised by NCI

- Work will be undertaken with inpatient wards to renew emphasis on suicide prevention in line with the NCI guidance. Work may include: removal of ligature points, ensuring care plans are in place during agreed leave, measures to reduce leaving the ward without agreement, e.g. improvements to ward milieu, better monitoring of ward access and exit points, and observation protocols.

### **Risk**

- A significant piece of work is underway to design the way risk will be recorded in the new clinical information system (SystemOne). This will have a risk formulation based approach. Training on risk formulation will be delivered through train the trainer. This will include safety plans, positive risk taking, service user and carer involvement in managing risk.
- Risk formulation sessions have been held in some teams with increased numbers of apparent suicides. These will continue in other teams.
- Within the clinical system development, we will be exploring ways to identify factors which may pose individuals with an increased risk of suicide, such as people's circumstances (as per NCISH recommendations, such as living alone)
- The Trust's Bluelight alert system has been used several times to alert all staff to a range of ligature risks identified through incidents. It has also been used to share information about pre-leave risk assessments from wards.

### **Depression**

- We have been holding 'excellence in depression' events across BDUs, and promoted depression themed learning events, as depressive illness was the highest primary diagnosis of those dying by apparent suicide in 2017/18.

### **Dual Diagnosis**

- Further analysis of our cases which involved drug and/or alcohol problems will be completed to help improve the service this group of service users receives.
- Our substance misuse policy is being updated, and we exploring the development of videos to support learning and development.

### **Self-harm**

- An audit tool has been developed for psychiatric liaison teams to review the level of need and current provision of services for people presenting with repeated self-injury. This will inform further development of a consistent approach to supporting them within the Trust. This information will also be fed into proposals to establish a clear personality disorder pathway within the Trust.
- Further work will be undertaken to explore the medication involved in self-poisoning apparent suicides to understand types of medication, whether they were prescribed on our advice and quantities dispensed. If they were opiates, we will consider Greenlight alert highlighting the risks. The method of recording medication in the apparent suicide data collection tool on Datix will be reviewed.

### **Other**

- Exploring how we identify patients with chronic physical health conditions and improving the support offered.
- Development of national peer review group for serious incidents
- Assessing SWYPFT compliance against the National clinical guidelines which have been developed with reference to NCISH findings (e.g. NICE guideline on transition between in-patient and community care settings).
- Work is progressing to introduce supportive text messages for patients on waiting lists, with the potential to expand this to making contact with discharged patients.
- A West Yorkshire wide working group has been established to develop guidance for staff on removing access to means of suicide.

## Learning from incidents

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

Learning from incidents occurs at many different levels in the organisation, examples of these levels are [available here](#).

### *Incident analysis*

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

The lead investigators continue to work closely with the practice governance coaches to produce reports on the learning from incidents in each BDU. The [‘Our Learning Journey’](#) report will be available [separately](#).

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

Incident data (including SIs) is often requested under the Freedom of Information Act (FOIA) 2000. During 2018/19, the number of requests has fallen, 14 requests were made and responded to by the patient safety support team. Many of these requests are complex in nature, and continue to include requests for information relating to deaths, AWOL, restraints, assaults, self-harm and numbers of SIs.

The Trust has continued to contribute to national learning via the National Reporting and Learning System<sup>6</sup> (NRLS - key functions moved to NHS Improvement in April 2016) by ensuring the Trust’s patient safety incidents are regularly transferred to the national system (NRLS).

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

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

### *Datix developments*

The Trust has continued to use and develop the Datix incident management database to record, analyses and aggregate incident information. Datix is a dynamic system and the team, in

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<sup>6</sup> [NHS Improvement. National Reporting and Learning System](#)

collaboration with services and specialist advisors, continue to examine ways to exploit the system. One area this year has been the development of Datix modules such as feedback module, risk modules and streamline them to make them more user friendly,

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

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

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

The Datix system supports the collection of data that is used for many CQUIN targets, KPIs, contract information, quality accounts and benchmarking both local and national. The Patient Safety Support Team provides regular compliance information to support fulfilment of these

The Patient safety manager also carried out system wide improvements for the customer service team in enhancing the feedback module.

The Datix system supports the distribution and monitoring of Patient Safety Alerts.

#### IN 18/19 WE SAID WE WOULD:

- Develop processes for managing CQC request for severe harm and death incidents
- Develop new format for Quarter reports
- Maintain the Datix dashboard configuration and monitor additional requests
- Continue with Datix system audits to ensure IG requirements are met
- Ensure Datix configuration reflects the current management structures
- Work with business intelligence to triangulate data
- Improve incident reporting content
- Ensure the Datix system is reviewed and refined to meet user needs
- Continue to network with other Trusts across West Yorkshire to share good practice and learn from each other

## Policy Developments

During 2018/19 the Learning from Healthcare Deaths Policy has been reviewed and updated. The original policy had a short review date, however the update was postponed due delays in the anticipated national guidance.

## Training

Datix training has continued to be delivered during 2018/19 following the success of the bespoke face to face approach first introduced in 2016/17. Staff can book a session with a member of the team who will tailor the content to individual or group needs. The team also offers a wide range of support materials on their intranet pages.

As a team we have provided root cause/systems analysis training as part of the formal Trust training program to managers. This provides training on how to conduct an investigation into all types of investigation but there has been an emphasis on using this training for the completion of the service level investigations.

This training also provides some input on the completion of manager's 48 HR reports.

This training was also provided to both ward and team managers in Barnsley. This was in response to a recommendation from a SI investigation and as an attempt to offer this across all Business Delivery Units.

This training has shown an improvement in the quality of SLI reports and 48 hour reports.

Within Kirklees and Calderdale the team has provided some training on ward 18 on the completion of 48 hour reports. The team also provided input on the role of the PSST, roles of the Investigators and investigations.

The team is currently planning to provide some training at the Poplars though this year financial year 2019/20.

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

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

## Audit and Service Evaluations

### Apparent suicide analysis

The apparent suicide audit is now incorporated into Datix. The Investigator or team manager completes the data while undertaking investigation/review of the incident. This enables more scope for analysis.

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

### Internal audit

In 2018/19 the Patient Safety Support Team conducted an audit of Datix incidents reviewed by managers.



Datix Audit Results  
infographic.docx

### **External audits**

In 2018 the Patient Safety Team has been involved in the Royal College of Psychiatrists SII peer review. This involved reviewing 10 SII reports against the proposed standards and produced a report for the Deputy Director of Nursing, Quality and Professions to present the findings and contribute to the development of the final standards.

### **External partnerships**

The Patient Safety Support Team works closely with a range of external agencies in relation to incidents. This includes the Care Quality Commission and Clinical Commissioning Groups (CCG) in terms of reporting and performance monitoring of serious incidents. The team has also been involved more in joint investigations with the acute Trusts. The Trust is a key partner in the Northern alliance, the suicide strategy federation of Trust's group. The team has partnered with the Improvement Academy in relation to safety huddles, quality improvement work and learning from deaths.

## Section 2 - Incident Reporting Analysis

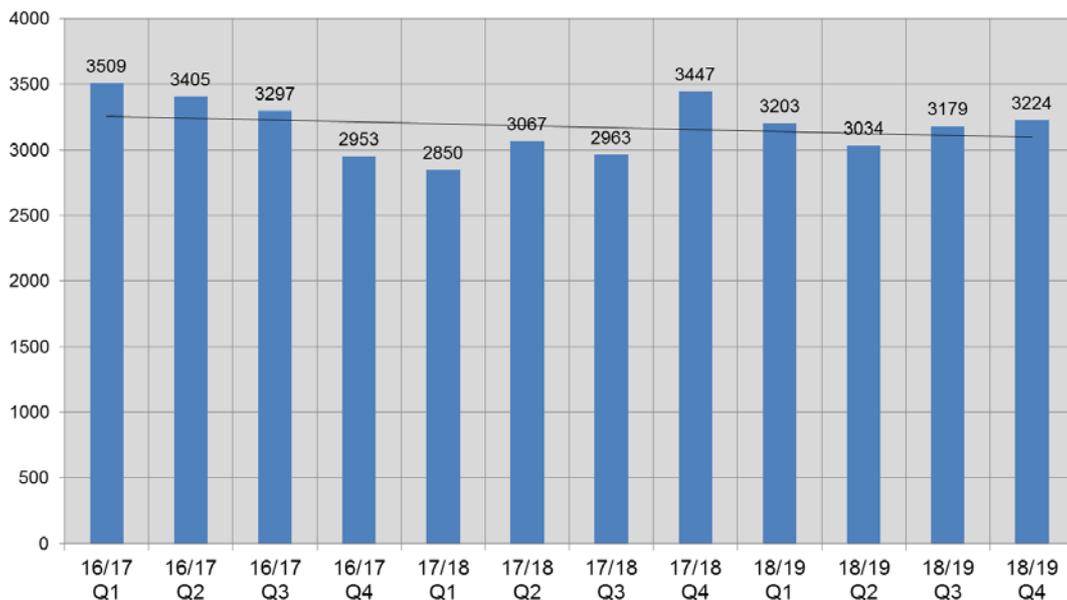
### Headlines

The Trust reported **12640** incidents of all severity during the year, a 2.7% increase on 2017/18 (12303). The average number of incidents reported per financial year over a 3 year period is 12710 incidents.

- **12640** incidents reported
- **2.7%** increase in reported incidents on 2017/18
- **88%** of incidents resulted in **no/low harm**
- **45** Serious incidents reported (0.36% of all incidents)
- Reduction in serious incidents on 2017/18 (71)
- High reporting rate with high proportion of no/low harm is indicative of a positive safety culture

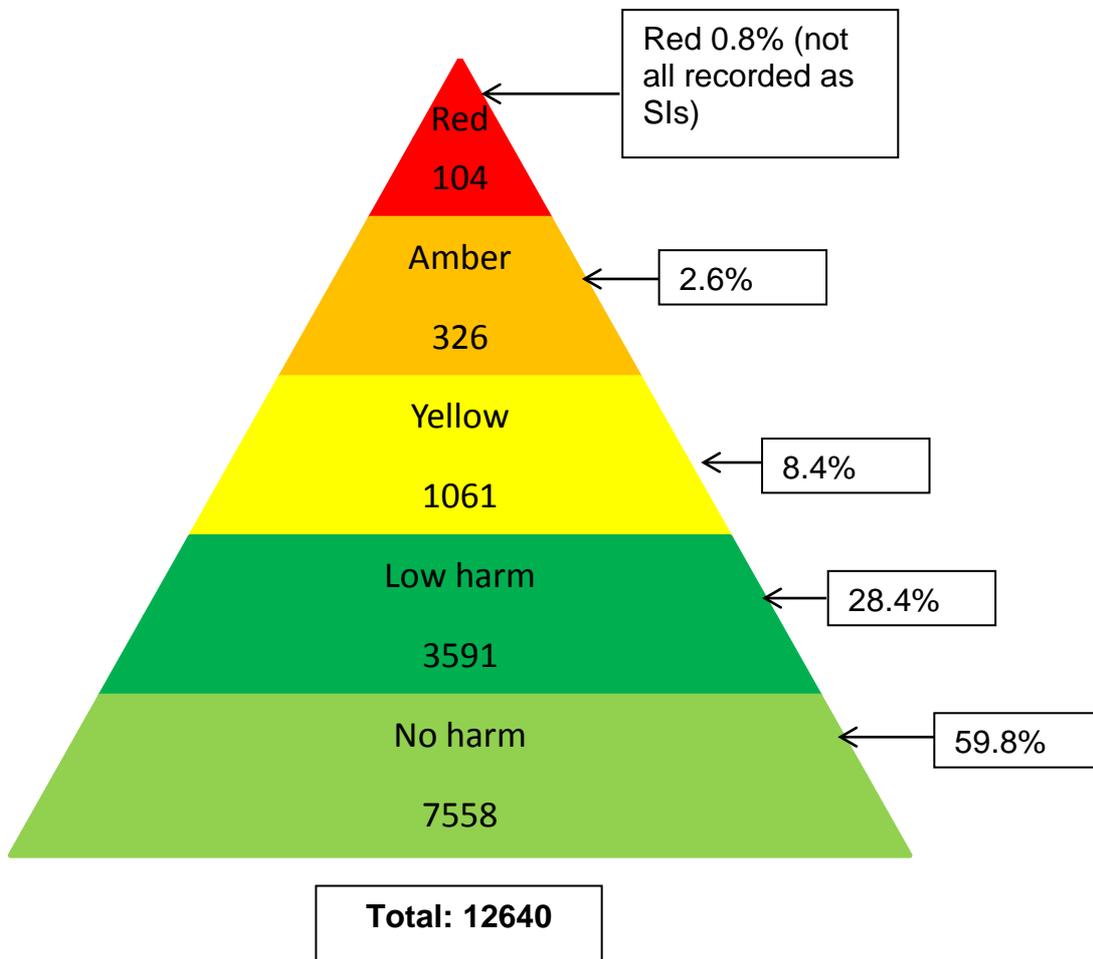
Figure 3 below shows the pattern and number of incidents reported by quarter in the Trust over the last 3 financial years, and indicates the average is stable, with natural fluctuations each quarter. It should be noted that direct comparisons should be viewed with caution due to the Trust changing profile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

Figure 3 Comparative number of incidents reported by financial quarter 2016/17 to 2018/19



The distribution of these incidents in terms of severity is pyramid-shaped, with serious incidents being fewest in number; and most incidents (88%) resulting in no/low harm, as illustrated in Figure 4. The proportion of no/low harm incidents has remained consistent with 2017/18. The number of serious incidents reported slightly decreased during 2018/19, which will be reported on later in the report. An organisation with high reporting rate, particularly with a high proportion of no/low harm is indicative of a positive safety culture where staff are encouraged to report incidents and near misses.

Figure 4 Incidents reported by severity 2018/19



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

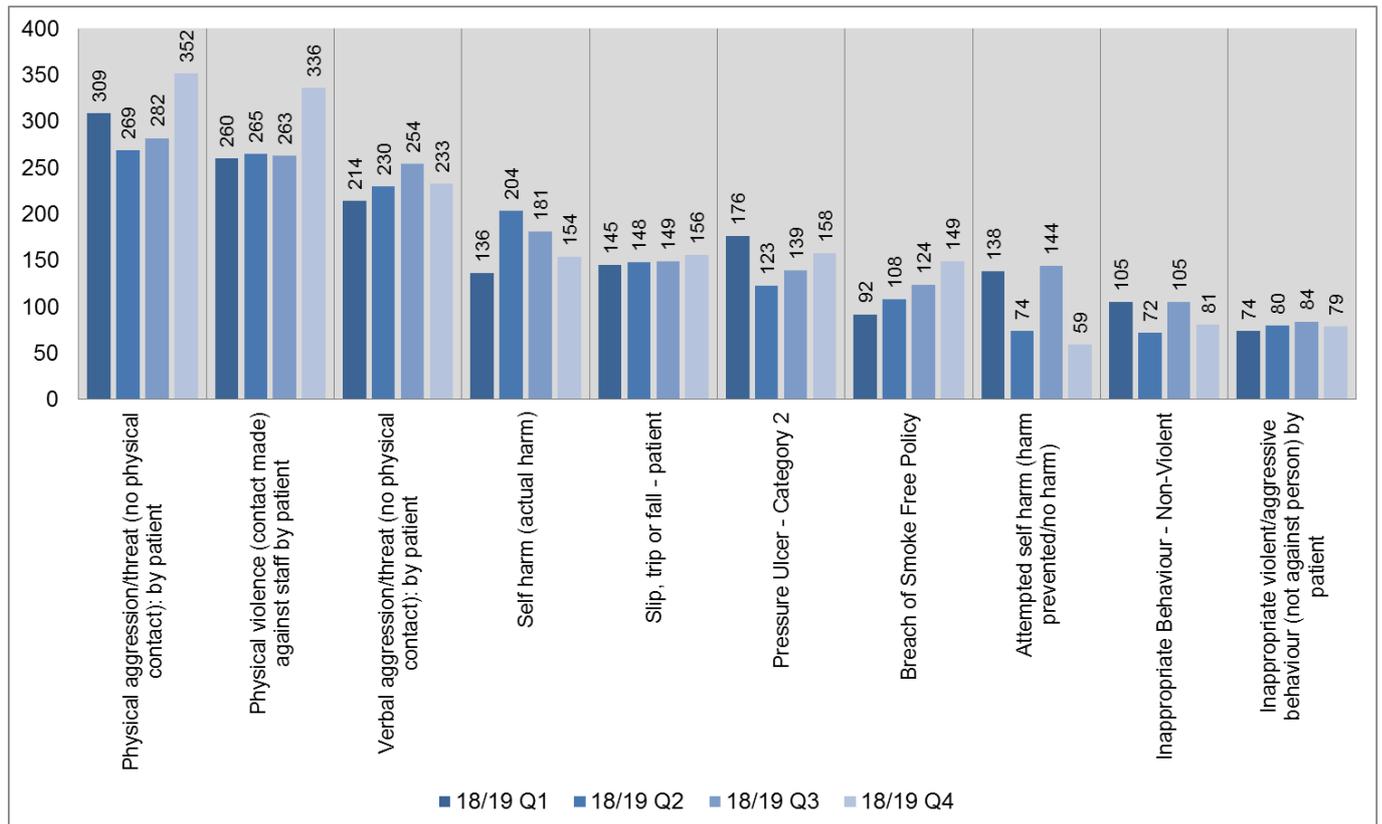
- Slightly less red than 17/18 but percentage similar– deaths until knows circumstances possible
- Increase in amber although percentage is similar – escapes from inpatient wards now reported as Amber
- Increase in yellow although percentage is similar
- Increase in green, similar percentage
- Increase in no harm, similar percentage

## Type and Category of incidents

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

Figure 5 shows the top 10 highest reported categories of incidents across the Trust during 2018/19. During 2018/19 incidents were reported against 145 different categories of incident. The top 10 categories account for 53% of all incidents reported.

Figure 5 Trust-wide Top 10 most frequently reported incident categories in year 2018/19



Physical aggression/threat (no physical contact): by patient was the highest reported incident category with a total of 1212 incidents in the year accounting for 9.6% of all incidents reported.

Physical aggression/threat (no physical contact): by patient was the highest reported incident category with a total of 1212 incidents in the year accounting for 9.6% of all incidents reported.

There are three other categories of violence and aggression related incidents appearing in the top 10; 'Physical violence against staff by patient (where contact was made)' (previously the highest category in 17/18); 'Verbal aggression/threat (no physical contact): by patient', and 'Inappropriate violent/aggressive behavior (not against person) by patient'. All four categories are the same as those appearing in the top 10 in 2017/18.

In relation to incidents of Physical violence (contact made) and Physical aggression (No contact made) against staff by patient, 2018/19 has seen an increase in acuity across certain areas. Some of these incidents also feed into the other sections of the report as contributing factors, e.g. Breach of smoke free policy and self-harm. This is due to a large increase in actual and attempted self-harm within areas and the need for staff's intervention. The Reducing Restrictive Intervention Team continued to push the need for consistent and precise reporting of all incident of both physical and verbal aggression. The consistently improving reporting of verbal aggression is to be commended as this can be used by staff to identify changes or increasing levels of aggression with service users presentation, and also show that there are many incidents (near misses) where staff have been confronted by an angry aggressive individual and through the de-escalation skills employed, have limited the incident to verbal aggression. Additionally in 2019/20 the RRPI team will work with the Datix team to further improve recording of incidents in-line with the National Data set.

Breach of Smoke Free policy incidents have continued to reduce during 2018/19 compared with 2017/18.

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

Self-harm incidents have risen; both actual harm and incidents where self-harm was attempted and prevented through the year, with particular increases in quarter 2. Again this is indicative of staff reporting near misses or where patients have been prevented from self-harming. Figures are affected by individual service user presentation.

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

## External comparison

Patient Safety Incidents are uploaded to the National Reporting and Learning System (NRLS) when they have been through the internal management review and governance processes. This ensures accuracy of data. Incidents are exported to NRLS when these reviews have been completed, which results in a natural delay in uploading patient safety incidents to the NRLS. This data has been prepared on 9 April 2019, and it should be noted that the reporting rate to NRLS will increase after this date.

It is worth mentioning that in August 2018, the National Reporting and Learning System (NHS Improvement), released and introduced a new look organisation level summary report. The new report replaced the former report, where direct comparisons could be made with other similar Trusts in our cluster.

NHS Improvement believe that the new format of the organisation level summary report has been revised to better assist NHS trust boards to understand and improve their organisation's patient safety culture and reporting of patient safety incidents to the NRLS. The updated report encourages

organisations to compare against themselves over periods of time, rather than with other organisations which may not be comparable for a number of reasons.

In 2018/19, the Trust uploaded a total of 5487 patient safety incidents to the NRLS, compared with 5764 reported in 2017/18 Quality Accounts. 95% of the 5487 incidents resulted in no harm or low harm.

The Trust reported a total of 58 severe harm and patient safety related death incidents in 2018/19, compared to 65 incidents in 2017/18 (as at 09/4/19).

The Trust's data is available on NHS Improvement [accessible here](#) which shows the Trust in the middle of the mid-range in terms of reporting compared to all mental health trusts. A key finding: that the Trust (47 days) was above our statistical partner's average of 25 days for the median number of days between incidents occurring and being reported on NRLS. An in-depth review of this was undertaken which found that there was a back log of incidents awaiting a final review. A quality improvement plan was implemented in January 2019 to reduce the 2050 incidents awaiting final approval to an average of 15 awaiting final approval. This has seen a decrease in the mean number to 37 for the reportable months until the end of March 2019 and this should improve again in 2019/20 data.

Not all incidents are reportable to the national database, which has strict criteria, based on patients being directly affected by an incident; as such, violence against staff incidents are not shared with NRLS. Other external reporting processes are used for staff incidents.

## Duty of Candour

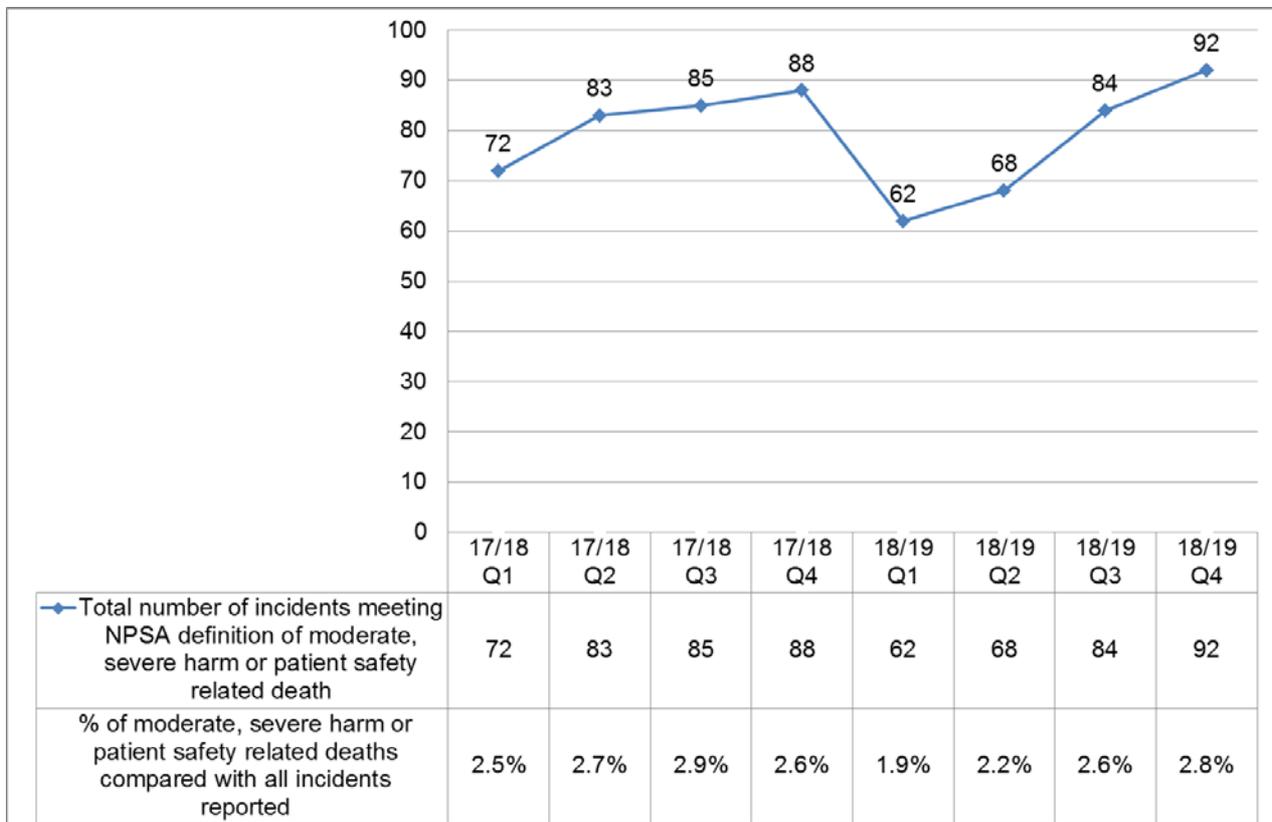
Duty of Candour applies to all patient safety incidents that result in moderate harm or above. The Trust has been following the principles of Being Open since 2008 and had a policy in place since that time. The NHS contract includes Duty of Candour for patient safety incidents with moderate harm and above and the Trust has been reporting on this since April 2014. In November 2014 this was strengthened when this became a statutory CQC regulation<sup>7</sup> to fulfill the Duty of Candour requirement.

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

The data contained in this section of the report was correct at the time of reporting (30/4/19). The data is extracted from a live system, and is subject to change. The degree of harm (moderate, severe or death) is initially recorded by the Patient Safety Support Team based upon the potential harm, and is subject to change as further information becomes available e.g. when actual injuries or cause of death are confirmed.

During 2018/19, there were 306 potentially applicable patient safety incidents (2.6% of all incidents reported). The number of patient safety incidents meeting the NRLS definition of moderate or severe harm or death has steadily risen over the past two years, as shown in Figure 6. The percentage of Duty of Candour applicable incidents against the total number of incidents reported each quarter has remained fairly similar. Some data is still subject to change.

**Figure 6 Total number of patient safety incidents with moderate or severe harm or death between 2017/18 and 2018/19**



<sup>7</sup> [Care Quality Commission. Duty of Candour guidance](#)

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

Figure 7 Duty of Candour applicable incidents by degree of harm and month 1/4/2017 – 31/3/19

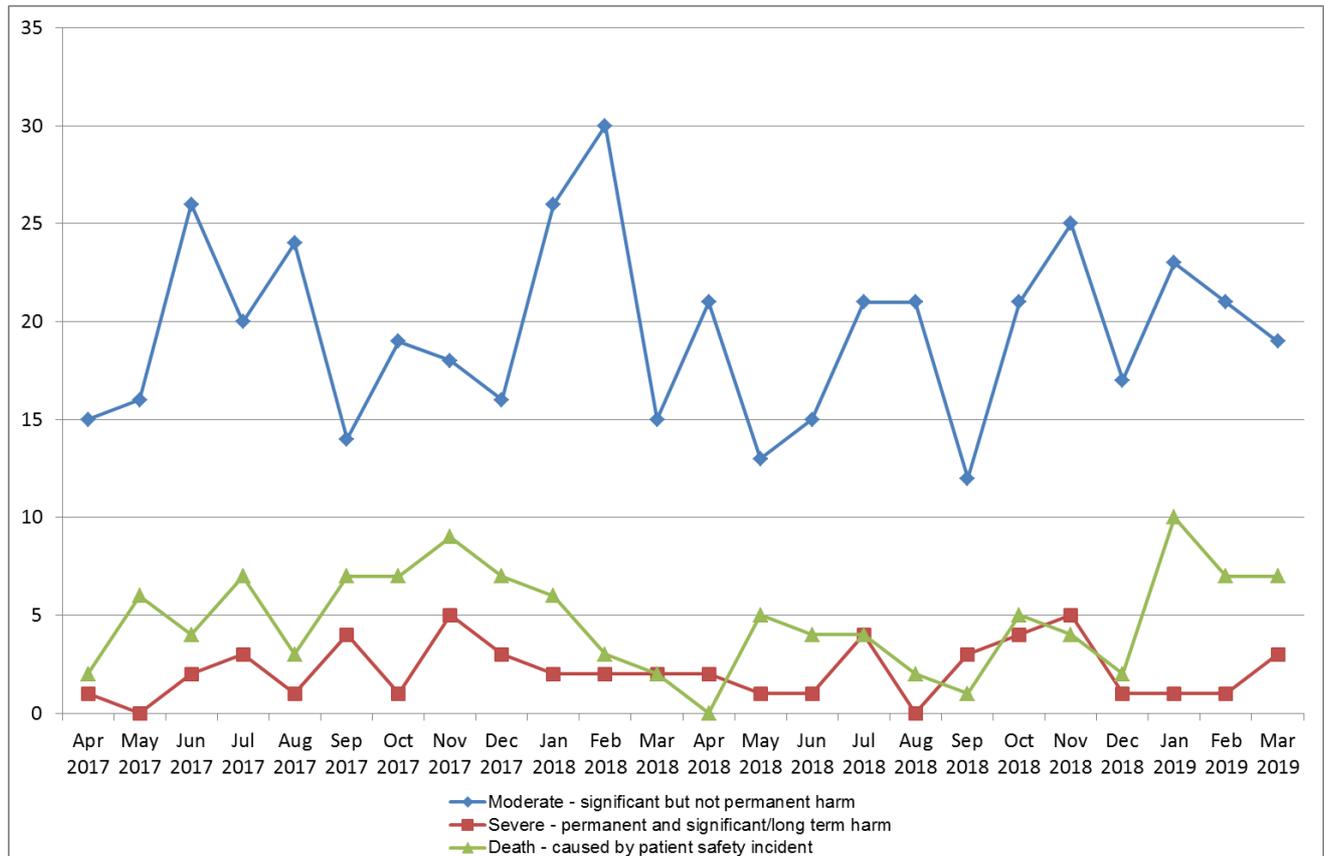


Figure 8 shows the highest number of applicable incidents is in Barnsley General Community Services with 150 incidents. This is an increase of 138 in comparison to 2017/18. A high proportion of these were pressure ulcers, grade 3 (moderate harm), and grade 4 (severe harm).

Figure 8 Duty of Candour incidents in 2018/19 by BDU and financial quarter

	Barnsley Mental Health	Barnsley General Community Services	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Total
17/18 Q1	8	33	7	4	9	1	0	62
17/18 Q2	5	32	6	12	13	0	0	68
17/18 Q3	8	48	1	13	12	1	1	84
17/18 Q4	8	37	10	19	15	2	1	92
<b>Total</b>	<b>29</b>	<b>150</b>	<b>24</b>	<b>48</b>	<b>49</b>	<b>4</b>	<b>2</b>	<b>306</b>

### Compliance with Duty of Candour

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

- In 90% of cases (275), a verbal conversation has happened with the patient and/or family within 10 days of the incident occurring or being identified (as per the contract).
- There were 19 cases where Duty of Candour was not completed but exception reasons were given (6%). The number of exceptions has decreased on 2017/18 (8%).
- There was 1 breach of duty of candour recorded during 2018/19. In all cases, an apology was given, but after the 10 day timeframe.

Figure 9 Duty of Candour compliance 2018/19

	Barnsley Mental Health	Barnsley General Community Services	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Total
Stage 1 Duty of Candour - verbal apology completed within 10 days	23	149	17	37	43	4	2	<b>275</b>
Stage 1 Duty of Candour - verbal apology completed after 10 days (breach)	0	1	0	0	0	0	0	<b>1</b>
Stage 1 Duty of Candour verbal apology not given following MDT decision (exception)	3	0	4	3	1	0	0	<b>11</b>
Stage 1 Duty of Candour - not completed (exception)	3	0	3	8	5	0	0	<b>19</b>
<b>Total</b>	<b>29</b>	<b>150</b>	<b>24</b>	<b>48</b>	<b>49</b>	<b>4</b>	<b>2</b>	<b>306</b>

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

\* Reference that this data will not match incidents reported to NRLS as some incidents where duty of candour applies, are not reportable to National Reporting and Learning System (NRLS) – e.g. apparent suicide of a discharged community patient.

## Section 3 Learning from healthcare deaths

### Introduction

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

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

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

When a death has been reported on the Trust incident reporting system, Datix, it will be reviewed by the patient safety support team in line with this [flowchart](#).

Deaths that were reported in the Trust between 1 April 2018 – 30 June 2018 have been reported to our Trust Board. The information is available in our latest [learning from healthcare deaths report](#). This will be updated on a quarterly basis. Our 2017/18 learning from healthcare deaths report is available [here](#)

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

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

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

The Trust reviews deaths which have been agreed which are in scope through the policy. We aim to work with families/carers of patients who have died as they offer an invaluable source of insight to learn lessons and improve services.

### Scope

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

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

The Trust started reviewing all deaths reported on Datix, using an incremental approach and to date has subjected the following to further review:

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

The LeDeR report 2019 can be found here: <http://www.bristol.ac.uk/news/2019/may/leder-report.html>

These are some of the report's key findings:

- By 31 December 2018, 25% (1,081) of deaths notified had been reviewed by local areas in England.
- Adults with learning disabilities from Black, Asian and Minority Ethnic (BAME) groups appear to be under-represented in notifications of deaths.
- Just under half of the reviews completed in 2018 reported that the person had received care which met, or exceeded, good practice.
- One in ten (11%) of reviews completed in 2018 reported that concerns had been raised about the circumstances leading to a person's death.
- 71 adults (8%) were reported to have received care that fell so far below expected good practice that it either significantly impacted on their well-being, or directly contributed to their death.
- Women with learning disabilities died 27 years earlier; men 23 years, when compared to the general population.
- Pneumonia, or aspiration pneumonia, were identified as causes of death in 41% of reviews - conditions which are potentially treatable, if caught in time.
- There was evidence of bias in the care of people with learning disabilities, resulting in unequal treatment.

### **From 1 October 2017**

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

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

1. Death Certification
2. Case record review, including Structured Judgment Record Review (SJRR)
3. Investigation – including service level, serious incident or other review e.g. LeDeR, safeguarding.

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

### Learning from Healthcare Deaths reporting

During 2018/19, 307 number of deaths were reported on Datix. (see figure 10). This figure relates to deaths of people who had any form of contact with the Trust within 180 days (approx. 6 months) prior to death, identified from our clinical systems through Business Intelligence software. This includes services such as end of life, district nursing and care home liaison services. Of note is that for a large number, the Trust was not the main provider of care at the time of death.

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

Figure 10 Summary of 2018/19 Annual Death reporting by financial quarter to 31/3/2019

	Quarter 1 2018/19	Quarter 2 2018/19	Quarter 3 2018/19	Quarter 4 2018/19	2018/19 total
1) Total number of deaths reported on Datix by staff (by reported date, not date of death)	56	71	83	97	307
2) Total number of deaths reviewed	56	71	83	97	307
3) Total number of deaths which were in scope	48	58	76	88	270
4) Total number of deaths reported on Datix that were not in the Trust's scope	8	11	6	9	34
5) Total number of reported deaths which were rejected following review, as not reportable or duplicated.	0	2	0	1	3

Figure 11 Reported deaths by category and BDU reported during 2018/19

	Barnsley Mental Health	Barnsley General Community Services	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Safeguarding external review (for safeguarding team use only)
Death - cause of death unknown/unexplained/ awaiting confirmation	12	2	10	16	11	1	7	2
Death - confirmed as accidental	0	0	2	2	1	0	0	0
Death - confirmed from infection	1	0	1	0	0	0	4	0
Death - confirmed from physical/natural causes	34	4	24	43	35	0	33	0
Death - confirmed related to substance misuse (drug and/or alcohol)	0	0	0	2	0	0	0	0
Safeguarding Adults - Neglect concerns	0	3	0	0	1	0	0	0

Safeguarding Adults - Physical abuse	0	0	0	0	1	0	0	0
Suicide (including apparent) - community team care - current episode	6	0	8	8	6	0	0	0
Suicide (including apparent) - community team care - discharged	2	0	2	6	1	0	2	0
Suicide (including apparent) - inpatient care - current episode	0	0	0	2	0	0	0	0
Unwell/Illness	0	0	0	2	0	0	0	0
Apparent suicide - not SWYPFT incident (for use by Patient Safety only) see notes	0	0	1	1	1	0	2	0
Pressure Ulcer - Category 4	0	1	0	0	0	0	0	0
Safeguarding external review (for safeguarding team use only)	0	0	0	0	0	0	0	1
<b>Total</b>	<b>55</b>	<b>10</b>	<b>48</b>	<b>82</b>	<b>57</b>	<b>1</b>	<b>48</b>	<b>3</b>

Figure 11 shows the deaths reported by the category and BDU. There are 3 deaths Safeguarding external review (for safeguarding team use only) This table excludes the death that were rejected which were 3 in total because of duplication.

Of the 307 deaths, 270 met the Learning from Healthcare Deaths review criteria and were classed as being 'in scope' for mortality review processes. Figure 12 shows the review process and the financial quarter they were reported in. .

**Figure 12 Learning from Healthcare Deaths during 2018/19 by financial quarter and mortality review process**

Financial Quarter	Certification	Managers 48hour Review (1st Stage case review)	Structured Judgement Review(SJR)	Service level investigation	Serious Investigation	Learning Disability Death process	Safeguarding Review	Total
18/19 Q1	11	8	13	6	4	6	0	48
18/19 Q2	17	13	12	0	5	10	1	58
18/19 Q3	32	16	10	8	7	11	2	76
18/19 Q4	33	12	10	2	14	17	0	88
<b>Total</b>	<b>93</b>	<b>39</b>	<b>45</b>	<b>16</b>	<b>30</b>	<b>44</b>	<b>3</b>	<b>270</b>

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

### Deaths reported as SIs

Of the 270 deaths reported on Datix between 1 April 2018 and 31 March 2019, 32 were reported as serious incidents, this figure will not match those reported in the Serious Incident section of this report due to the use of different dates for different processes (SI uses date reported on STEIS; mortality uses date reported on Datix).

## Suicides not reported as SIs

Within the 270 deaths, there are 16 apparent suicides that were not reported (or are no longer classed) as serious incidents. Figure 13 shows this breakdown by method of apparent suicide and BDU.

Figure 13 Apparent Suicides not reported as Serious Incidents by method and BDU

	Barnsley Mental Health	Calderdale	Kirklees	Specialist Services	Wakefield	Total
<b>Suicide (including apparent) - community team care - discharged</b>	<b>2</b>	<b>2</b>	<b>3</b>	<b>1</b>	<b>1</b>	<b>9</b>
Burning - self injury	1	0	0	0	0	1
Hanging - self injury	0	2	1	1	1	5
Contact with moving vehicle (car, train) - self injury	0	0	1	0	0	1
Suffocation - self injury	1	0	0	0	0	1
Prescription medication - self poisoning	0	0	1	0	0	1
<b>Suicide (including apparent) - community team care - current episode</b>	<b>2</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>3</b>	<b>7</b>
Hanging - self injury	1	0	0	0	2	3
Prescription medication - self poisoning	1	2	0	0	0	3
Other - self poisoning	0	0	0	0	1	1
<b>Totals:</b>	<b>4</b>	<b>4</b>	<b>3</b>	<b>1</b>	<b>4</b>	<b>16</b>

The Serious Incident Framework<sup>8</sup> defines that serious incidents are;

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

All 16 deaths have been reviewed by managers and been discussed at the clinical risk panel and/or mortality review group and the cases did not or no longer met this criteria. All cases have been reviewed through other processes, as set out in figure 14. Some examples are given below:

- Some cases were identified for review through a sample of cases identified through the wider Business intelligence dataset, resulting in Structured Judgement Record Review.
- Structured Judgement Record Reviews have been undertaken where there has been limited contact with services, for example:

<sup>8</sup> [NHS England. Serious Incident Framework. March 2015](#)

- Seen once by services and they requested no further follow up. They were discharged 2-3 months prior to their death.
- Referred to the Trust, they were screened but not seen before their death. The response to the referral was as expected and reasonable.
- Last contact with the service was three months prior to their death, and they were not on a caseload. They had previous contact with the Trust approximately 12 months prior to death.

**Figure 14 Apparent suicides not reported as serious incidents by category and review process**

	Structure Judgement Review (SJR)	Service Level Investigation	Total
Suicide (including apparent) - community team care - current episode	2	5	7
Suicide (including apparent) - community team care - discharged	6	3	9
<b>Total</b>	<b>8</b>	<b>8</b>	<b>16</b>

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

#### **Actions Taken From Findings:**

Active work has been undertaken to reduce the backlog of incidents awaiting final approval. This will be reflected in the next National Reporting and Learning System (NRLS) Report.

Red and Amber incidents are reviewed and submitted within 5 working days.

The Patient Safety Support Team has strengthened relationships with our CQC relationship officer, providing timely and regular information which diminishes the need to request additional information, during and prior to CQC inspection.

#### **Next Steps**

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

This will include:

- To agree the function, accountability and purpose of the mortality review group, including a review of mortality groups terms of reference
- Continue to embed and improve upon the work to date on systems and processes for learning from healthcare deaths.
- Work closely with other Trusts in the northern Alliance to share experiences and learning to meet the national policy requirements.
- Host a forum (June 2019) to share learning from deaths and incidents
- Develop an annual work plan to support work stream priorities
- We will further develop processes and consistency in sharing learning

- Strengthen our approach to identification and recording of main providers other than SWYPFT and processes to support sharing of information is strengthened.
- We will continue to be on part of the group work with Improvement academy with service users and carers about communication and approach following mortality.
- The Trust is providing training to increase the number of Structured Judgment Record Reviewers.

## Section 4 - Serious Incidents reported during 2018/19

### Background context

Serious incidents are defined by NHS England as;

“...events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation’s ability to deliver ongoing healthcare.”<sup>9</sup>

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

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

- the unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- serious harm to one or more patients, staff, visitors or members of the public or where outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm (this includes incidents graded under the NPSA definition of severe harm)
- a scenario that prevents, or threatens to prevent, a provider organisation’s ability to continue to deliver health care services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment. IT failure or incidents in population programmes like screening and immunisation where harm potentially may extend to a larger population
- allegations of abuse
- adverse media coverage or public concern for the organisation or the wider NHS one of the core set of *Never Events*<sup>10</sup>.

### Investigations

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

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<sup>9</sup> [NHS England. Serious Incident Framework. March 2015](#)

<sup>10</sup> [NHS Improvement. Never Event policy and framework 2018](#)

## Headlines

During 2018/19, 45 Serious Incidents were reported to the relevant Clinical Commissioning Group (CCG) via the NHS England Strategic Executive Information System (StEIS). This is a 37% reduction on 2017/18 (71).

Never Events<sup>11</sup> are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There were **no 'never event'** incidents reported by SWYPFT in 2018/19. The last Never Event reported by the Trust was in 2010/11. A revised list of Never Events came into effect on 1 February 2018. This is available on the Trust intranet.

There were no **homicides** reported in 2018/19.



- 45 Serious incidents reported
- Serious incidents account for 0.36% of all incidents
- Reduction on total from 2017/18 (71)
- No homicides reported
- No Never Events



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<sup>11</sup> [NHS Improvement. Never Event policy and framework 2018](#)

## Serious Incident Analysis

Figure 15 below shows all serious incidents reported on StEIS between 1 April 2014 and 31 March 2019. During this time, the definitions of serious incidents has changed, and also the reporting criteria for pressure ulcers has changed over time, a) with the introduction of recording as SIs from 2013/14 onwards, and in February 2015, to report only those that are avoidable.

Figure 15 Total number of Serious Incidents reported by financial year 2014/15 to 2018/19

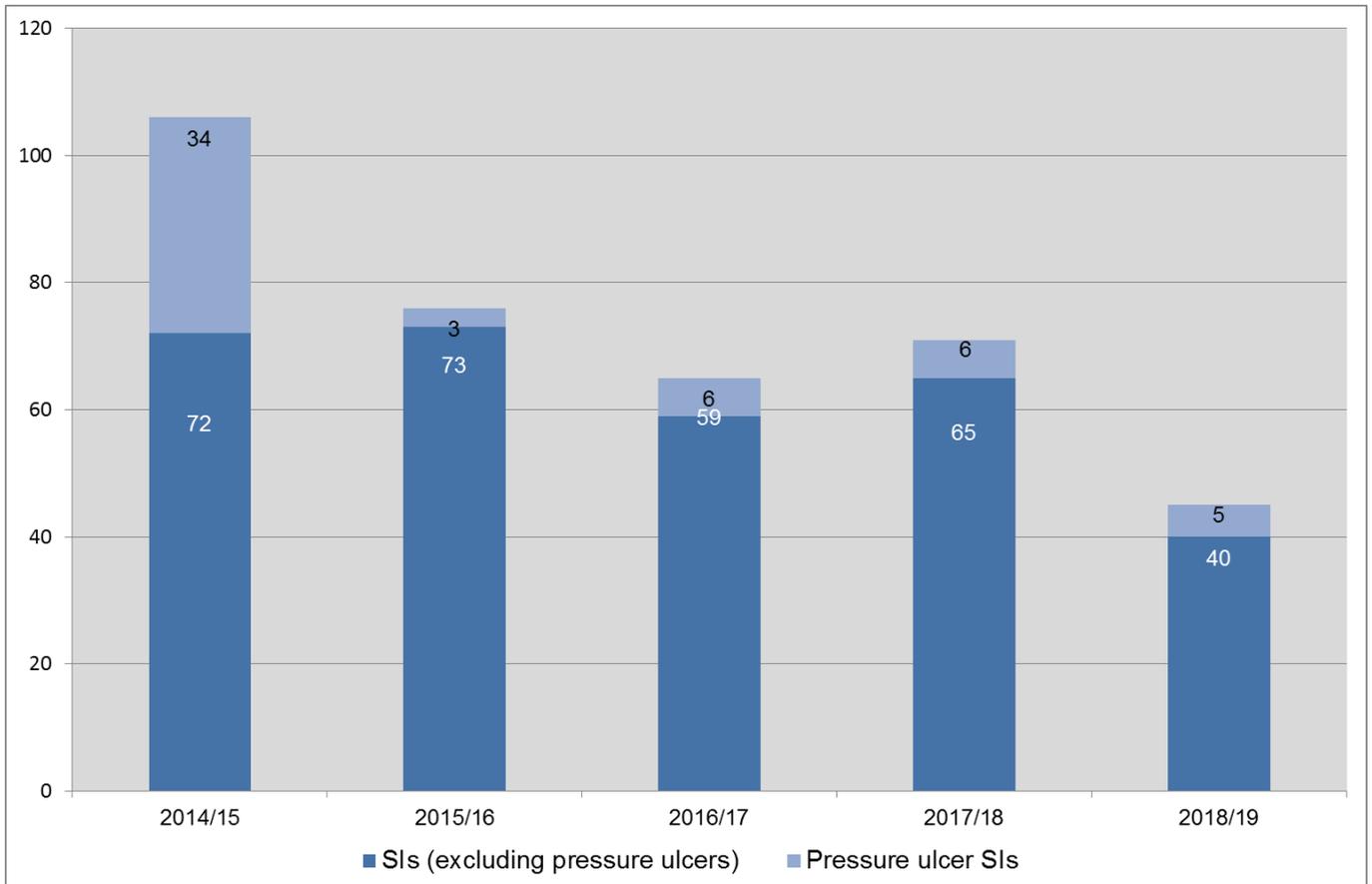
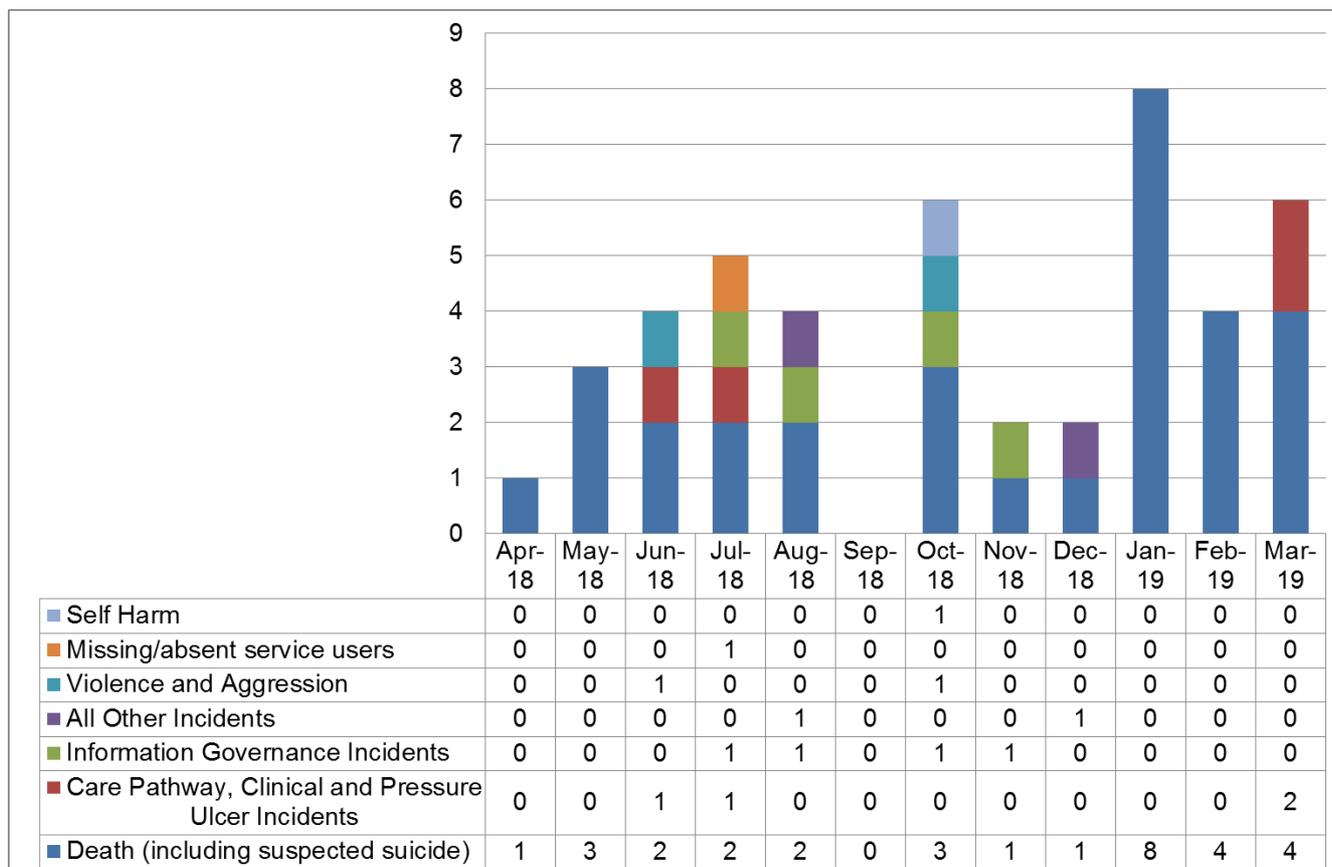


Figure 16 shows a breakdown of the 45 serious incidents by the type of incident by the month reported. The patient safety support team has undertaken analysis of all serious incidents that have been reported by category, team, month and year. The number of SIs reported in any given period of time can vary, and given the relatively small numbers involved and the wide definition of an SI, it can be difficult to identify and understand the reasons for this. However it is important that any underlying trends or concerns are identified through analysis. There are no obvious trends by teams or category from previous years.

Figure 16 Types of All Serious Incidents reported in 2018/19 by date reported on StEIS



As in previous years, the highest type of serious incident (as described in section 2) is death of a service user (Figure 16). Further analysis of deaths shows that the highest proportion of these being by apparent suicide (40) and a further 5 deaths which were unexpected (this includes 2 which remained recorded as the originating incident i.e. a self-harm incident where the patient died from their injuries, and a death of a patient after they were on leave from a ward). Further breakdown is available later in this section.

Figure 17 Serious Incidents reported during 2018/19 by reported category

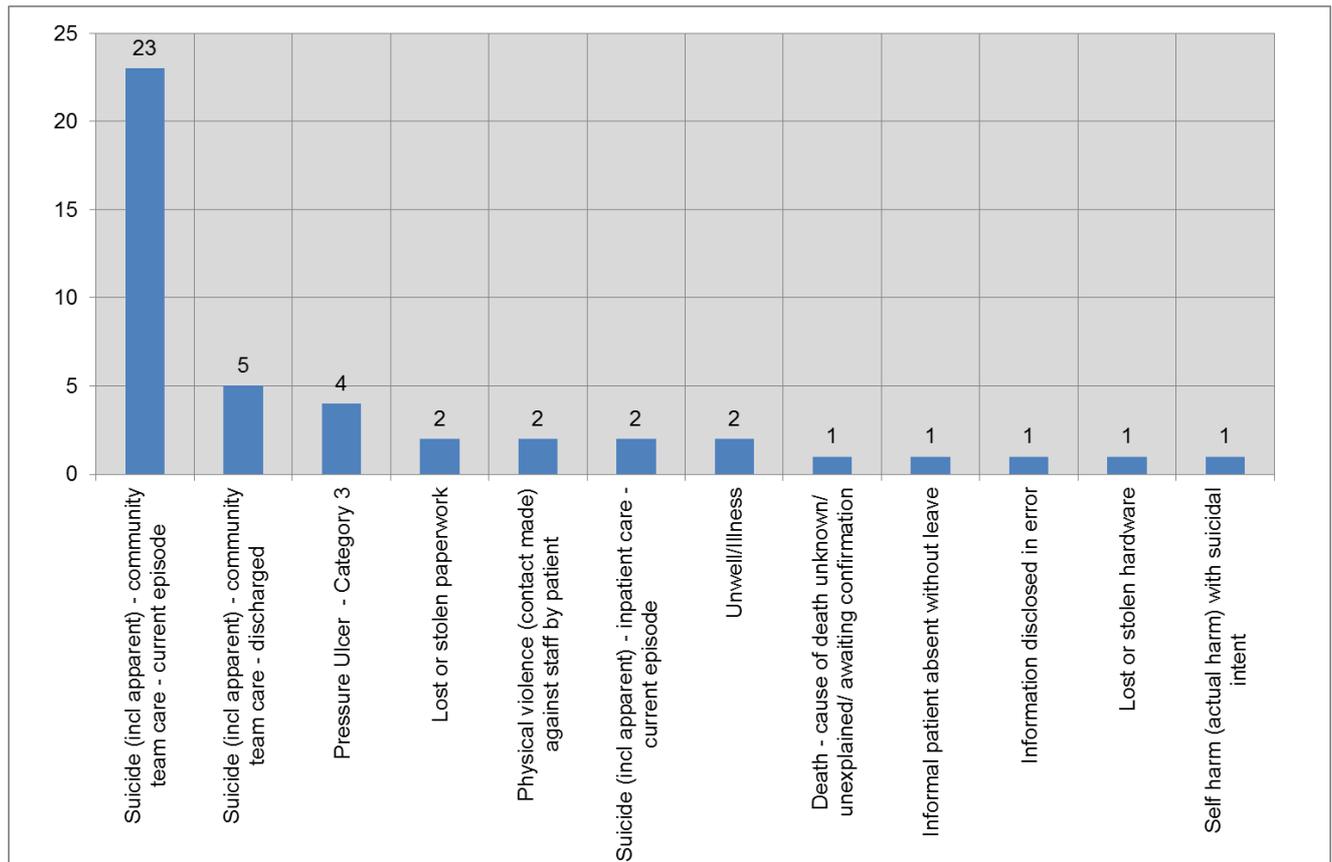


Figure 17 shows a breakdown of the reported serious incidents by category. The category of incident (a subset of ‘type’, as shown in Figure 16) provides more detail of what occurred. It shows that apparent suicide of service users in current contact with community teams is the highest reported category with 23 (2017/18 [34]; 2016/17 [17]). There are a further 7 incidents relating to apparent suicide. These include 2 deaths where the patient was under the care of inpatient services at the time of death; 5 deaths where the service user was discharged from mental health services at the time of their death.

As Figure 18 shows, during 2018/19, the area with the highest number of SIs reported was Kirklees (15), this is a decrease on 2017/18 (30). This is followed by Calderdale (9), Wakefield (8) and Barnsley Mental Health Services (7) SIs that were reported this financial year 2018/19. In 2017/18 Calderdale had 10 SIs reported, Wakefield had the same figure (8) as 2018/19 and Barnsley Mental Health reported 10 SIs. This is a reduction of 3 SIs compared to 2018/19. Barnsley General Community has reported 4 SIs in 2018.19. Forensic services have reported no SIs this financial year (2018.19) compared with 2 in 2017/18. Specialist services have had a reported 1 SIs, compared with 3 in 2017/18.

Figure 18 2018/19 Reported Serious incidents by BDU and category

	Barnsley General Community	Barnsley Mental Health	Calderdale	Kirklees	Specialist Services	Trust wide (Corporate support services)	Wakefield	Total
Suicide (incl. apparent) - community team care - current episode	0	5	6	8	0	0	4	23
Suicide (incl. apparent) - community team care - discharged	0	0	0	3	1	0	1	5
Pressure Ulcer - Category 3	3	0	0	0	0	0	1	4
Lost or stolen paperwork	0	0	1	0	0	0	1	2
Physical violence (contact made) against staff by patient	0	0	1	0	0	0	1	2
Suicide (incl. apparent) - inpatient care - current episode	0	0	0	2	0	0	0	2
Unwell/Illness	0	0	0	2	0	0	0	2
Death - cause of death unknown/unexplained/ awaiting confirmation	0	1	0	0	0	0	0	1
Informal patient absent without leave	0	0	1	0	0	0	0	1
Information disclosed in error	0	0	0	0	0	1	0	1
Lost or stolen hardware	1	0	0	0	0	0	0	1
Self-harm (actual harm) with suicidal intent	0	1	0	0	0	0	0	1
<b>Total</b>	<b>4</b>	<b>7</b>	<b>9</b>	<b>15</b>	<b>1</b>	<b>1</b>	<b>8</b>	<b>45</b>

## Demographic comparison of Serious Incidents reported

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

### Population-

When serious incidents are viewed against population size (Figure 19) it shows Barnsley with an increase. Calderdale had a very slight decrease to 4.29 compared to 4.76 in 17/18. Kirklees had the biggest changes with a decrease down to 3.43% compared to 7.09% last year, Wakefield also saw a slight decrease.

The Trust total for SIs reported used in Figure 19 was 44 (excludes one Serious incident not geographic specific). Three Serious incidents in CAMHS services in Wakefield have been included under Wakefield

**Figure 19 BDU population estimates and serious incident figures (STEIS reported) per 100,000 population and 10000 mental health contacts**

Geographical district	<a href="#">Population estimates Mid 2017 ONS[1]</a>	Serious Incident figures per 100,000 population for 2017/18	Mental health service users who have had one or more contacts 2017/18	Serious Incidents 2017/18 per 10,000 mental health contacts (only mental health SIs)	Serious Incident figures per 100,000 population for 2018/19*	Mental health service users who have had one or more contacts 2018**	Serious Incidents 2018/19 per 10,000 mental health contacts (only mental health SIs)***
Barnsley	241,341	7.46	13544	7.38	4.55	12759	5.48
Calderdale	209,454	4.76	5561	17.98	4.29	6967	12.91
Kirklees	437,145	7.09	15884	18.88	3.43	14872	10.08
Wakefield	340,790	3.26	9273	8.62	2.64	10893	8.26
Total	1,230,730	5.71	42641	13.6	3.57	45491	8.79

\* 2018/19 Serious incident total includes Barnsley General Community Services SIs, and CAMHS Wakefield SI). One SI is excluded as it was not geographic specific (Trustwide Corporate Services)

\*\* Please note this is calendar year 2018

\*\* includes Wakefield CAMHS SI, excludes Trustwide Corporate Services SI and Barnsley General Community Services SIs

### Mental Health contacts

When comparing serious incident reported on STEIS against mental health service users who have had one or more contacts recorded per 10,000 contacts, the range is between 5.48 for Barnsley and 10.08 for Kirklees.

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

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

Of the 45 serious incidents reported, 33 related to the death of a service user as mentioned earlier. Of the 33 deaths, 34 patients were male (64%) and 12 female (36%) (Figure 20).

Figure 20 Deaths reported as Serious Incidents 2018/19 by gender and age band

Increase females aged 45-54

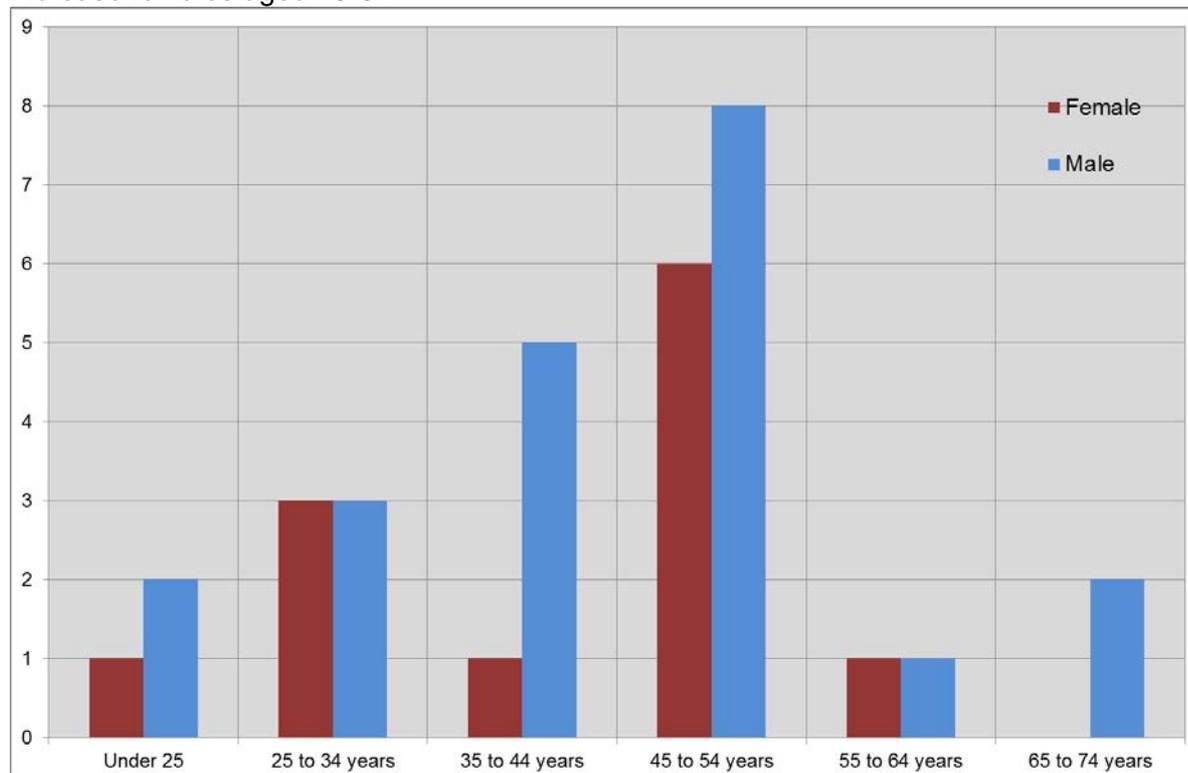


Figure 21 shows the apparent category of death at the time of writing.

Figure 21 Breakdown of all deaths reported as SIs 2018/19 by category of death and BDU

	Barnsley Mental Health	Calderdale	Kirklees	Specialist - CAMHS	Wakefield	Total
Suicide (incl. apparent) - community team care - current episode	5	6	8	0	4	23
Suicide (incl. apparent) - community team care - discharged	0	0	3	1	1	5
Suicide (incl. apparent) - inpatient care - current episode	0	0	2	0	0	2
Death - patient choked on food	0	0	2	0	0	2
Death - cause of death unknown/ unexplained/ awaiting confirmation	1	0	0	0	0	1
<b>Total</b>	<b>6</b>	<b>6</b>	<b>15</b>	<b>1</b>	<b>5</b>	<b>33</b>

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

## Apparent and actual suicide

### Apparent and actual suicide

There were a total of 43 apparent suicides reported during 2018/19. This is a significant decrease on the number of apparent suicides reported in 2017/18 (60).

Work has taken place during to strengthen links with HM Coroner (through Legal services) which has resulted in improved and timelier information about causes of death/inquest conclusions. This information has been updated on Datix which has resulted in more accurate information being collected.

Further detailed analysis of apparent suicides is available separately in the 2018/19 apparent suicide report; however a summary of the findings is included below.

The purpose of the report is to provide assurance to Clinical Governance and Clinical Safety Committee that the apparent suicides that have been reported within the Trust during 2018/19 have been further analysed and that the findings have been reviewed to identify areas for action.

This report includes analysis of data for the 43 apparent suicides reported within the Trust during the year 2018/19. Its purpose is to present key headline data for apparent suicide incidents to inform our understanding of what the circumstances can be for someone who tragically takes their own life. It is through better understanding and analysis that we can refine and improve the services we offer to our service users and carers.

The report also provides a summary of the findings of the 2018 National Confidential Inquiry (NCI) into Suicide and Homicide report covering the period January 2006 to December 2016.

The main findings of the 2018/19 apparent suicide report are:

\*43 apparent suicides reported during 2018/19, compared with 2017/18 (60) and 2016/17 (34).

\*Four year average rate of 45.75/year is higher than national figures would predict.

\*During 2018/19 the demographics of the service users dying by suicide have changed. For age comparison:

\*The largest number of deaths in 2018/19 occurred within the 45-54 years age range, with 17 deaths (40%), 11 of which were male. This is a significant increase on 2017/18 and 2016/17 where there were 16 (27%) and 6 (18%) respectively.

\*Deaths of those under 25 have continued to reduce to 5 (12%) compared with 7 in 2017/18.

\*Compared with recent years, there has been a reduction in deaths of those 55 and over in 2018/19 (5), compared with 13 in 2017/18.

\*There has been a significant decrease in the number of apparent suicide of males under 35 years with 12 deaths compared to 20 in 2017/18.

\*40% of deaths were by females (17), an increase on 2017/18 (15). The largest number of deaths of females occurred within the 45-54 age group with 6.

\*72% of deaths by suicide were from those in the white - British ethnic group.

\*The number of service users recorded as unemployed remains high with 21% recorded as being unemployed, however this number could be much higher as there were 18 cases where the employment status was not recorded on the incident record.

\*30% were on Care Programme Approach.

\*The number of service users recorded as living alone continues to be high. 33% of service users were recorded as living alone in 2018/19.

\*The most common method of suicide continues to be hanging with 65% of deaths recorded as hanging. This is higher than the national percentage (47%).

\*The most common location of apparent suicide is at the patient's own home with 58%.

\*For those dying by suicide, the primary diagnosis is analysed. 21% of people had a primary diagnosis of depressive illness (9).

\*Of the 43 people who died by suicide, 44% of service users had a documented history of self-harm.

\*26% of service users (11) had a history of alcohol misuse. 30% (13) had a history of drug misuse. 7 of these service users had a history of both alcohol and drug misuse (16%).

\*During 2018/19 there were 2 deaths associated with inpatient care. One death occurred whilst the individual was on leave from the ward environment; one death involved a service user who absconded from the garden area of the ward. 1 of the patients was detained under the Mental Health Act.

\*Of the 43 deaths, 11 were where the individuals' last contact was with Enhanced Pathway. This is followed by Core Pathway (9) and Crisis/IHBTT (8).

\*37% (16) of all apparent suicides occurred in Kirklees BDU however, population sizes, service configuration and number of mental health contacts must be taken into consideration.

\*In 14 cases (33%) it was recorded that the patient was known to have experienced a significant life event however, the nature of this event was not recorded.

\*The last contact with services was routine or non-urgent in 44% of cases.

\*In 47% of cases the last contact with services was within 7 days.

## **Death – other causes**

There were 3 serious incidents reported relating to the unexpected death of service users. This is comparable with last year (2 in 2017/18, 8 in 2016/17).

There were 2 unexpected deaths related to service users who died as a result of apparent choking incidents and a further incident where a service user died from a suspected heart attack in A&E. Clinical concerns were raised which are being investigated.

It can take a significant amount of time for the cause of death to be identified through the coroner's office. However, irrespective of the outcome, this does not prevent the investigation being completed.

## **Information Governance**

During 2018/19 four Information Governance incidents were reported as Serious Incidents. This is the same figure as reported in 2017/18, when all four serious incidents related to information being disclosed in error as correspondence was sent to the wrong address. There was one incident of this type in 2018/19 which involved an email containing sensitive payroll data was sent to the wrong email account. The other three serious incidents related to lost or stolen confidential information. These included a laptop bag stolen from a car, lost list of patient details from a ward, and a patient obtaining a list of patient details from a ward. The incidents were spread across four different teams in different BDUs. For further information please contact the Information Governance Team.

## **Pressure ulcers**

During 2018/19, a total of four category 3 pressure ulcers were reported as Serious Incidents on StEIS. This figure is lower than 2017/18 (6). Three of the pressure ulcers were reported by District Nursing/Neighbourhood teams in Barnsley General Community Services and one by Poplars unit in Wakefield. Three of the four patients affected were male.

## **Violence and Aggression**

During 2018/19 there were 2 violence and aggression incidents, which is a reduction on 2017/18 (6). Both violence and aggression serious incidents occurred in inpatient ward or 136 suite (different areas). Both incidents involved patient assault of staff members.

### **Self-harm/attempted suicide**

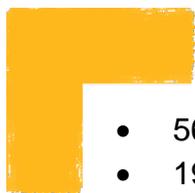
During 2018/19 there was one serious self-harm incident; a reduction on 2017/18 (3). The service user made a deep laceration to his throat at home. He was under the care of Enhanced team, Barnsley.

### **Absent without Leave**

During 2018/19 there was one incident where a community patient under the care of the Mental Health Liaison Team, Calderdale and Kirklees in the Acute Trust, did not return to the acute hospital when agreed (not detained under the MHA).

## Section 5 - Findings from Serious Incident Investigations completed during 2018/19

This section of the report focuses on the **56** serious incident investigation reports were completed and submitted to the relevant commissioner during the period 1 April 2018 to 31 March 2019. Please note this is not the same data as those reported in this period (see Section 3) as investigations take a number of months to complete. The term 'completed' is used in this section to describe this.



- 56 serious incident investigations completed
- 198 associated actions
- All investigations include a recommendation to share learning
- Top 3 action themes:
  - 1) Record keeping
  - 2) Staff education, training and supervision
  - 3) Risk Assessment/Policy and procedure - in place but not adhered to (joint 3<sup>rd</sup>)



### Performance

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

Serious Incident investigation progress is monitored through the weekly patient safety support team investigators meeting, and reported through the weekly clinical risk panel. There can be delays in completing investigations within the 60 working days. Reasons for delays varying, but generally relate to issues such as complexity, staff availability to conduct interviews and investigation allocation delays due to capacity. Some of the investigations in 2018/19 have involved other organisations and this can increase complexity. Bank investigators and external investigators have been used to manage some of the pressure.

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

## Headline data

Of the 56 serious incidents investigation reports completed and submitted to the relevant commissioner between 1 April 2018 and 31 March 2019, there were 198 actions made (figure 22). A standard recommendation to share learning and the outcome of the investigation with staff involved and wider is now in place. This has increased the number of actions. Fifty-four of the 198 actions were related to sharing learning.

**Figure 22 Breakdown of the number of Serious Incidents completed, compared with the number of recommendations and associated actions**

<b>BDU</b>	<b>SIs completed</b>	<b>Number of SI actions</b>
Barnsley General Community Services	4	15
Barnsley Mental Health	7	34
Calderdale	9	29
Kirklees	25	73
Specialist Services	3	25
Trust wide (Corporate support services)	1	5
Wakefield	7	17
<b>Grand Total</b>	<b>56</b>	<b>198</b>

It should be noted that one recommendation can result in a number of associated actions. For the purposes of analysis, actions are used in this report. In addition, one incident investigation can generate a high number of actions as shown in figure 23 when considered by service type across the Trust.

**Figure 23 Number of SIs and associated actions by Trust wide service areas (SIs completed in 2018/19)**

<b>Row Labels</b>	<b>Number of SIs completed</b>	<b>Number of SI actions</b>
Core pathway	12	28
Crisis/IHBTT (Adult)	9	36
Enhanced Pathway	7	26
Acute Inpatients (Adult)	6	25
Single Point of Access (SPA)	5	12
Child and Adolescent Mental Health Services	3	25
District Nursing	3	13
CMHT's (OPS)	2	6
Inpatient Service (OPS)	2	6
Liaison Services	2	5
Early Intervention Services	1	1
General Community Therapy Services	1	2
Human Resources and Workforce	1	5
Improving Access to Psychological Therapy (IAPT) Team	1	4
Psychological Therapy Services (Adult)	1	4
<b>Grand Total</b>	<b>56</b>	<b>198</b>

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

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

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

## Categorisation of actions

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

Figure 24 Ordinal list of action themes from 2018/19 compared with 2017/18

Top 6 action themes	2018/19	2017/18
Record keeping	Joint 1 <sup>st</sup>	1
Staff education, training and supervision	Joint 1 <sup>st</sup>	2
Risk assessment	Joint 3 <sup>rd</sup>	Joint 5 <sup>th</sup>
Policy and procedure - in place but not adhered to	Joint 3 <sup>rd</sup>	Joint 5 <sup>th</sup>
Communication	5	Not in top 6
Carers/family	6	Not in top 6

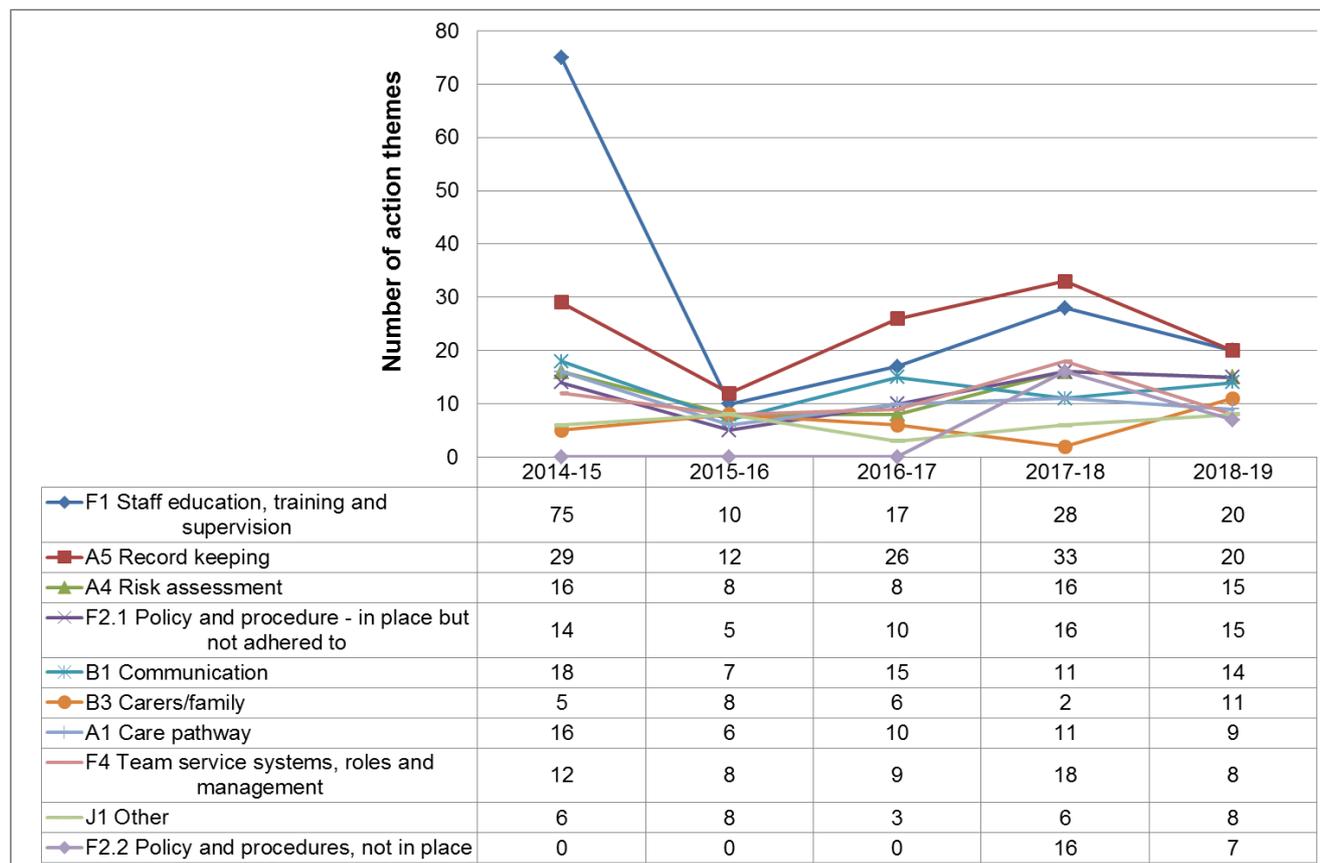
The types of SIs completed in the year affects the action themes, for example, an Information governance serious incident, is more likely to have actions related to Organisational systems, increasing that figure.

Figure 24 illustrates the ranking of the most common themes this year in comparison to last year. 'Record keeping' remains the highest, with 'Staff education, training and supervision' remaining the second most common theme. Risk assessment has risen to 3<sup>rd</sup> on the ordinal list.

'Team/service systems, roles and management' which was 3<sup>rd</sup> in 2017/18 has fallen outside the top 6 this year.

The top 10 action themes have also been reviewed over the last five financial years for comparison. As shown in Figure 25, there was a peak of staff education/training/supervision in 2014/15 which was related to a high volume of pressure ulcer SIs during that year. Many of the themes have reduced over time. Record keeping has remained one of the highest themes, along with staff education and training.

Figure 25 Top 10 action themes in the 5 years between 1/4/2014 and 31/3/19



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

In 2018/19 the most frequent three action themes were 'Record keeping', 'Staff education, training and supervision', and 'Risk assessment'. Below is a summary of some of the issues identified within these themes. As can be seen, there is some overlap between themes.

## 1) Record keeping (joint #1):

Record keeping has remained within the top 3 action themes in the last six years. There were 20 actions relating to record keeping. Where possible these have been grouped by sub-theme:

Sub theme	Barnsley MH	Calderdale	Kirklees	Specialist Services	Wakefield	Total
Clinical decision recording	0	0	3	1	0	4
MDT discussion	1	1	2	0	0	4
Risk assessment	2	0	0	0	1	3
Crisis/contingency plan	1	0	0	2	0	3
Mental Health Act	2	0	0	0	0	2
Access to records	1	0	0	1	0	2
Care planning	0	1	0	0	0	1
Family/carers contact details	0	0	1	0	0	1
<b>Total</b>	<b>7</b>	<b>2</b>	<b>6</b>	<b>4</b>	<b>1</b>	<b>20</b>

Some examples of areas for action are given below:

### Clinical decision recording

- Reviewing the process for documenting out of hours consultation
- Where an individual's care needs cannot be reasonably met, there should be a process to record the reasons
- Ensuring that the rationale for the clinical view and the family view in relation to risk assessment is clearly recorded.
- All communications to the duty worker will be documented in the progress notes

### MDT discussion

- Not recording risk information in case management reviews
- Checking of ward round entries
- MDT actions and minutes were being recorded on paper notes separate to the electronic record and were not easily accessible.
- Ward review notes had been produced in triplicate due to a lack of clarity about the process and for two of the reports it is difficult to confirm what the process for this was.

### Risk assessment

- Risk assessment was not reviewed and updated, and there was no written care plan.
- The Sainsbury risk assessment level 1 was not completed on initial presentation to mental health services and took several weeks for this to be identified. It was missed at intervening contacts.
- Incorrect monitoring of Waterlow scores and underestimation of the risk (in Mental Health setting)

### Crisis/contingency plan

- Ensure that all young people who are at risk of suicide have safety plans
- Consider the role of the wider MDT in formulation based assessment and care planning as there was a Safety Plan which was verbal rather than written, so could not reasonably be called a care plan which was accessible to others including family members.
- Care plans and crisis and contingency plans should be updated following referral to the community team.

## Mental Health Act

- The rationale for taking the service user of her section was not documented.
- The details for the service user being taken off her section were not detailed in the clinical notes

## Access to records

- Ensuring paper records are scanned and archived so clinicians can access
- Ensuring all clinical correspondence is saved in the clinical record and not in local drives to ensure all colleagues can assess the information.

## Care planning

- Significant reportable incidents in an individual's care should be recorded in detail and cross referenced to the DATIX report

## Family/carers

- Recording Next of kin details in the clinical record

## 2) Staff education, training and supervision (joint #1):

Staff education, training and supervision have remained within the top 3 action themes in the last six years. There were 20 actions relating to staff education, training and supervision. Where possible these have been grouped by sub-theme:

Sub theme	Barnsley General Community	Barnsley MH	Kirklees	Specialist Services	Wakefield	Corporate support	Total
Information governance	0	0	0	1	2	2	5
Risk assessment	3	0	0	0	0	0	3
Safeguarding	0	1	1	0	0	0	2
Physical health	0	0	0	0	2	0	2
Inadequate supervision of caseload	0	0	2	0	0	0	2
Mental Health Act	0	0	1	0	0	0	1
Documentation	0	0	0	1	0	0	1
Guidance	0	1	0	0	0	0	1
Training	0	0	0	1	0	0	1
Consent	0	0	0	1	0	0	1
Information management and technology	0	0	0	0	0	1	1
<b>Total</b>	<b>3</b>	<b>2</b>	<b>4</b>	<b>4</b>	<b>4</b>	<b>3</b>	<b>20</b>

Some examples of areas for action are given below:

### Information governance

- A reminder should be sent out to all medical staff within the Wakefield BDU that they should not print electronic patient records including the bed status sheet.
- As part of the junior medical's staff induction it should be made clear that printing of electronic clinical records should not take place for routine use on the wards
- IG team to deliver bespoke training on transferring confidential information
- Reminder to all staff that personal data must only be shared by email using NHS.net accounts
- That CAMHS BDU can provide assurances that staff can demonstrate an understanding of the Trusts Caldicott guardian's role and when to refer to the guardian

### **Risk assessment**

- Knowledge, skills and Training reviewed and further training identified relating to Risk Assessing, Identification of a deteriorating patient, Care Planning / Communication, Record Keeping and Assessment Process
- Review the knowledge and skill relating to Risk Assessing and identification of a deteriorating patient and wound. This will include factors which affect the Waterlow Scores such as Long term conditions and how effective assessment should influence decisions in care planning and provision of pressure relieving equipment.
- Review the knowledge and skills of the NNS relating to factors which affect the Waterlow score

### **Safeguarding**

- A team training session and briefing paper is produced to raise awareness on self-neglect and hoarding
- The Trust Safeguarding Policy has been updated to reflect what actions are expected from practitioners when disclosures are made to thoughts, intentions and any planning or preparation that has been made to harm people they reside with or are in a relationship with.

### **Physical health**

- Management of constipation
- Staff to undertake training in order to recognise pressure damage

### **Inadequate supervision of caseload**

- Ensuring caseload reviews are provided to practitioners in line with the Trust supervision policy.
- Staffing responsibilities that are impeded due to changes in capacity or capability should be reviewed as part of the management supervision process and action taken to mitigate against the risk of service user care being compromised, this should be in line with trust policy and procedure.

### **Mental Health Act**

- MHA assessors (including AMHP) to take into consideration views of the Consultant Psychiatrist &/Care Coordinator prior to MHA assessment

### **Documentation**

- That the Child and Adolescent Mental Health Services RANE non-engagement form is reviewed

### **Guidance**

- When presented with a noose, staff did not take steps to request removing access to it. Guidance to be developed for staff on how to deal with situations when presented with access to means of suicide

### **Training**

- All CAMHS staff to complete the Sainsbury's risk assessment training

### **Consent**

- The Child and Adolescent Mental Health Services BDU need to provide assurances that staff can demonstrate an understanding and show competency in the use of the mental capacity act specifically regards consent to share for 16 to 18 year olds.

### **Information management and technology**

- Reporting of IT issues that impact on data sharing and privacy, such as the loss of a shared drive, to the ServiceDesk

### 3) Risk Assessment issues (joint #3):

Risk assessment issues have been in the top 6 in the last two years. There were 15 actions relating to risk assessment. These have been grouped by sub-theme:

Sub theme	Barnsley MH	Calderdale	Kirklees	Specialist Services	Wakefield	Total
Inadequate exploration of risk	0	2	1	3	0	6
Risk assessment tools not used	2	2	0	0	0	4
Risk assessment timescales	0	0	3	0	0	3
Documentation	0	0	0	0	1	1
Waiting lists	0	0	0	1	0	1
<b>Total</b>	<b>2</b>	<b>4</b>	<b>4</b>	<b>4</b>	<b>1</b>	<b>15</b>

Some examples of areas for action are given below:

#### **Inadequate exploration of risk**

- Full consideration of the service user's mental health (including detention under the mental health act to treat his mental disorder and mitigate the risk to self) did not take place.
- Prompt practitioners to screen for problems at school or college as part of the comprehensive risk assessment
- Where service users with long term history of mental health problems discontinue medications, a review of risk and care plan with the individual should be undertaken
- Historic information relating to risk had not been brought forward adequately on RiO and the last two care coordinators had not familiarised themselves with the historic risk assessment so when the service user began to make comment to these it was not picked up or identified. Therefore at the point of transfer of a service user, their risk history should be fully understood
- It was unclear what the standard is for reviewing completed clinical questionnaires, the action was to identify a process for reviewing clinical rating scales

#### **Risk assessment tools not used**

- Completion of level 2 risk assessments to be reinforced by Team Managers
- No level 2 risk assessment was completed when the service user took her own discharge from the ward.
- The process for completing level 2 Sainsbury's risk assessment should be agreed across community and in-patient settings.
- To review the level 1 risk assessment and where indicated to update and refresh the clinical records post visit

#### **Risk assessment timescales**

- Although risk was clearly documented within the progress notes a formal risk assessment document had not been completed on annual basis in line with policy.
- Although there was evidence of a review of the level of risk in the progress notes prior to discharge, the formal risk assessment tool was not updated at the point of transfer between teams.
- Implementation of Sainsbury level 2 assessments to be agreed across the in-patient and community settings to ensure it is completed in the agreed timescales

## Documentation

- The assessment of risk linked to the disclosure of taking an overdose was not documented

## Waiting lists

- Undertake an audit to review the children and young people on the waiting list to ensure appropriate support, advice and action is considered.

## 4) Policy and Procedures – in place but not adhered to (joint #3):

Policy and procedure in place but not adhered to has been in the top 6 in the last two years. There were 15 actions relating to risk assessment. These have been grouped by sub-theme:

Subtheme	Barnsley General Community	Barnsley MH	Calderdale	Kirklees	Specialist Services	Corporate support	Total
CPA policy	0	1	0	3	0	0	4
Clinical Risk Assessment Policy	0	0	1	0	1	0	2
Being Open (Duty of Candour) policy	0	1	0	0	0	0	1
Business Continuity plans for RiO.	0	0	0	0	1	0	1
Local induction	0	0	0	1	0	0	1
Local procedures for information sharing	0	0	0	0	0	1	1
Searching of Patients and their Property Policy	0	0	1	0	0	0	1
Standard Operating Procedure for 136	0	0	1	0	0	0	1
Do Not Attend (DNA) policy	0	0	0	1	0	0	1
Identification of patients	1	0	0	0	0	0	1
Leave	0	0	0	1	0	0	1
<b>Total</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>6</b>	<b>2</b>	<b>1</b>	<b>15</b>

Some examples of areas for action are given below:

### CPA policy

- A Crisis/Contingency Plan was not developed during the period of contact with the teams, and it was confirmed that this is usual practice where a referral is not made from a secondary care team.
- All staff to be reminded that the transfer of care for services users should be completed in line with the CPA operational policy
- IHBTT's should ensure that a copy of the care plan is given to the service user
- Team managers should remind staff of the importance of completing actions required of them in line with operational policy and procedure and clinical record keeping standards

### Clinical Risk Assessment Policy

- Clinical risk management policy, requirements for medics acting as lead professional for those on standard care - update of level 1 risk assessment yearly.
- Compliance with the Clinical Risk Assessment, Management and Training Policy and Procedure

### Being Open (Duty of Candour) policy

- Following initial duty of candour contact by the service this was not followed up in writing in line with expected practice.

#### **Business Continuity plans for RiO.**

- To ensure that all staff are familiar with the Business Continuity plans for RiO.

#### **Local induction**

- The current local induction for locum psychiatrists is reviewed and updated to ensure that the locums are aware of the procedure for arranging follow up outpatient appointments

#### **Local procedures for information sharing**

- Documentation and implementation of local procedures for routine sharing of data.

#### **Searching of Patients and their Property Policy**

- When service users return from home leave they should be reminded about what items are not allowed on the ward.

#### **Standard Operating Procedure for 136**

- The operational procedure relating to section 136 was not adhered to, communicating the feedback of a section 136 assessment is the responsibility of the lead health care professional in the 136 suite. The outcome was not sent to the general practitioner

#### **Do Not Attend (DNA) policy**

- The DNA process in the OP clinic did not comply with the Trust DNA policy as letters were not being sent to the GP or service user.

#### **Identification of patients**

- Review policy and procedure re identification of patients

#### **Leave**

- The Trust policy on leave and the Mental Health Act Code of Practise 1983 guidance were not followed in this case.

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

## **Implementation of recommendations and actions**

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

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

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

The outcome of an incident does not reflect the care given. The number of reports with no recommendations has reduced because of the standard recommendation to share learning.

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

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

## Section 6 - Key Actions and Areas for Development in 2019/20

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

Plans for 2019-20 include:

- Patient Safety Strategy: continued implementation including:-
  - Work will continue to reduce avoidable harm.
  - Continued implementation of Safety Huddles
  - Using quality improvement methodologies to improve safety
  - Suicide prevention plans
  - Continued implementation of the Significant Event Analysis tool
  - Continue to embed our learning library to capture and share learning and evidence of positive change, including further promotion, strengthening governance structures and sharing content further.
  - Improving incident report content
  - Monitor progress of the BDU action plans
  - Respond to anticipated national guidance:
    - National patient safety strategy
    - Serious Incident Framework
    - Patient Safety Incident Reporting System (PSIRS) which will replace STEIS and NRLS systems
- Learning from healthcare deaths
  - Continue to embed and improve upon the work to date on systems and processes for learning from healthcare deaths.
  - Work closely with other Trusts in the northern Alliance to share experiences and learning to meet the national policy requirements.
  - Host a forum (June 2019) to share learning from deaths and incidents.
- Continued development of Datix risk management system to improve recording and analysis to meet user needs.
- Work closely with the RRPI team to introduce the National Recording Data into Datix
- To continue networking with other Trusts across West Yorkshire

## Trust Board 25 June 2019

### Agenda item 7.1

<b>Title:</b>	<b>South Yorkshire update including the South Yorkshire &amp; Bassetlaw Integrated Care System (SYB ICS)</b>
<b>Paper prepared by:</b>	Director of Human Resources, organisational development and estates Director of strategy
<b>Purpose:</b>	The purpose of this paper is to update the Trust Board on the developments within the South Yorkshire and Bassetlaw Integrated Care System (ICS), and Barnsley integrated care developments.
<b>Mission/values:</b>	The Trust's mission to <b>enable people to reach their potential and live well in their communities</b> will require strong partnership working across the different health economies. It is therefore important that the Trust plays an active role in the South Yorkshire and Bassetlaw ICS.
<b>Any background papers/ previously considered by:</b>	The Trust Board have received regular updates on the progress and developments in the SYB ICS (formerly Sustainability and Transformation Partnership), including Barnsley Integrated Care Developments.
<b>Executive summary:</b>	<p><b>1. SYB response to the NHS Long Term Plan</b></p> <p>The ICS is refreshing the vision and ambition for South Yorkshire and Bassetlaw in setting out a five year strategic plan in response to the Long Term Plan (LTP) which will include:</p> <ul style="list-style-type: none"> <li>➤ Population health and population health management</li> <li>➤ Preventing disease and reducing health inequalities</li> <li>➤ How far we want to integrate, 'boost out of hospital care' and make the most of new models of care</li> <li>➤ Maximising the opportunities of digital innovation</li> <li>➤ All of our workforces in delivering the ambition in the LTP</li> <li>➤ Making the best use of every pound we have</li> </ul> <p>To enable coordination and development of the plan over the next six months the ICS will:</p> <ul style="list-style-type: none"> <li>➤ Establish a cross-system task and finish group to help partners coordinate the development of the plan – the first meeting of this group was held on 23 May 2019</li> <li>➤ Establish a number of guiding coalition events to support wider engagement on developing the plan priorities, the Trust has been invited to take part in a workshop in July 2019.</li> <li>➤ Through the System Health Executive Group ensure the development of the plan progresses as agreed</li> <li>➤ Will build on the work and plans of our 5 places and the work across SYB</li> <li>➤ Use the 2019/20 plans to form year one of the system strategic plan</li> </ul> <p><b>2. Priorities of joint working for Local Authorities</b></p> <p>The Collaborative Group discussed and agreed the importance of the whole</p>

system working together on three key priorities:

- 1) Complex Lives: Supporting people experiencing multiple disadvantage
- 2) Connectness: Dealing with the loneliness and the impact
- 3) Physical Activity/Active Travel: Getting the population more physically active

### **3. Collaborative Partnership Board Arrangements (CPB)**

The Collaborative Board discussed the new interim ICS Governance arrangements and agreed:

- The terms of reference and arrangements for the CPB need to be updated in light of the new interim governance arrangements.
- That the Board needed to discuss the emerging themes, priorities and topics which would benefit from health and care collaboration at a system level including any that are missing over the next few meetings.
- Further exploring how the CPB membership might be constituted to best support its agenda.
- The Board agreed to receive revised proposals at the next meeting.

### **4. SYB ICS Population Health Management (PHM) update**

The NHS Long Term Plan sets out clear intentions that ICS's will focus on population health, population health management together with more health action on prevention and health inequalities to support the integration of care and delivery of the *quadruple aim; improving the health of populations, enhancing the experience of care for patients, reducing the per capita cost of healthcare and improving the staff experience of providing care.*

Some elements of PHM have been established in each place for a number of years predominantly around risk stratification to support proactive case management and care coordination for older people and people with LTCs to avoid unnecessary admission to hospital. Places are working collaboratively with their partners to better understand their population's health and care needs using data and intelligence to target specific groups of the population. This includes implementing data sharing arrangements across health and care providers to improve communication and to better understand population need.

The ICS PHM Delivery Group progress to date:

- Established a SYB ICS PHM Delivery Group to agree a consensus of approach and developed a SYB PHM work plan with clinical priorities agreed
- Clinical leadership in place for the delivery group
- Proposed a number of PHM priorities for system (where it adds value and supports places) and for place
- Secured £380K NHSE non recurrent funding to support the programme 2018/19
- Established Programme director support
- Supported and developed PHM understanding and skills development across SYB (including master classes on PHM through a SYB community of practice network, consistent BI / analytical approaches eg population segmentation, predictive modelling, economic benefits
- SYB is one of 14 PHM wave 1 ICSs nationally
- SYB is a member of the national PHM Reference Group working with

- the national teams to shape PHM support to ICS's across the country
- The PHM Delivery Group is working with the national PHM dashboard team, influencing the development of the dashboard for release to all systems in the summer.

### **5. SYB QUIT Programme**

The South Yorkshire and Bassetlaw QUIT programme is an innovative systematic intervention for people who are tobacco dependent, based on current best practice and research. It builds on learning from Canada and London, where similar hospital-based programmes had a significant impact on not only health outcomes, but also on short and medium term hospital re-admissions.

Hospitals in SY&B see a large proportion of its population as patients each year, many of whom are admitted for at least several days. It is estimated that 25% of hospital patients are current smokers. Their admission period is a unique opportunity during which they could be supported to make one of the single most effective changes possible to improve their long-term health.

We recognise that working together at system level we will have a consistent approach and a clarity of message that can add real value. All our hospitals have appointed senior executive sponsors and are signed up to delivering the programme.

The programme was launched in Sheffield In November 2018 and is already making an impact. The programme is being rolled out to include mental health and community providers and the Trust will be a partner in this programme moving forward. This is in addition to the services and support provided through the Yorkshire Smoke free Service.

### **6. ICS place review - Barnsley**

The ICS CEO Lead and members of the ICS Core team together with representatives from NHSI will conduct quarterly place reviews. The first place review for Barnsley was held in May 2019. The review focused on performance, integration and joined up care and service developments including Primary Care at scale. The team also visited the Acorn Unit at BHNFT and met with staff from the Right Care Barnsley team.

### **7. 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 Primary Care Networks, neighbourhood model, early help and support for people with Cardio Vascular Disease and developing an integrated model of care for stroke and frailty.

	<p><b>Risk Appetite</b></p> <p>This update supports the risk appetite identified in the Trust's organisational risk register.</p>
<b>Recommendation:</b>	<b>Trust Board is asked to NOTE the update from the SYBICS and Barnsley integrated care developments.</b>
<b>Private session:</b>	Not applicable.

## Trust Board 25 June 2019 Agenda item 7.2

<b>Title:</b>	<b>West Yorkshire &amp; Harrogate Health and Care Partnership and Local Integrated Care Partnerships update</b>
<b>Paper prepared by:</b>	Director of strategy Director provider development
<b>Purpose:</b>	The purpose of this paper is to provide the Trust Board 1. With an update on the development of the West Yorkshire and Harrogate Health and Care Partnership and 2. Local Integrated Care Partnership developments.
<b>Mission/values:</b>	The development of joined up care through place-based plans is central to the <b>Trust's strategy</b> . As such it is supportive of our mission, particularly to <b>help people to live well in their communities</b> . <b>The way in which the Trust approaches strategy and strategic developments must be in accordance with our values</b> . The approach is in line with our values - <b>being relevant today and ready for tomorrow</b> . This report aims to assist the Trust Board in shaping and agreeing the strategic direction and support for collaborative developments that support the Trusts strategic ambitions.
<b>Any background papers/ previously considered by:</b>	Strategic discussions and updates on place based plans have taken place regularly at Trust Board including an update to April Trust Board.
<b>Executive summary:</b>	The Trust Strategy refresh outlines the importance of the Trust's role in each place it provides services, including the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP). The place-based plans are being mobilised through strengthening existing partnerships and developing collaborative arrangements to commission, deliver and transform services. Progress and key developments that are summarised in the paper include: <ul style="list-style-type: none"> <li>• <b>West Yorkshire and Harrogate Health and Care Partnership</b></li> <li>• <b>Kirklees</b>.</li> <li>• <b>Calderdale</b></li> <li>• <b>Wakefield</b></li> </ul> <b>Risk Appetite</b> 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.
<b>Recommendation:</b>	<p><b>Trust Board is asked to RECEIVE and NOTE the updates on the development of Integrated Care Partnerships and collaborations including:</b></p> <ul style="list-style-type: none"> <li>➤ <b>West Yorkshire and Harrogate Health and Care Partnership</b></li> <li>➤ <b>Wakefield</b></li> <li>➤ <b>Calderdale</b></li> <li>➤ <b>Kirklees</b></li> </ul>
<b>Private session:</b>	Not applicable.

# **West Yorkshire & Harrogate Health and Care Partnership and Local Integrated Care Partnerships - update**

**Trust Board 25 June 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) focusing on developments that are of importance or relevance to the Trust. 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. The Partnerships priorities, ambitions and progress are set out in the 'Our Next Steps to Better Health and Care for Everyone' document.

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 West Yorkshire and Harrogate Health and Care Partnership**

### **3.1 Partnership Board**

The Partnership Board met for the first time in public in June 2019 at Leeds Civic Hall. The Partnership Board further strengthens joint working arrangements between all organisations involved, including the NHS, councils, care providers, Healthwatch, community and voluntary groups. The Board is an important group for the Partnership, bringing elected members, non-executives and public lay members into the decision making process. Over 70 representatives make up the Board.

The Partnership Board is chaired by Councillor Tim Swift, MBE, Leader of Calderdale Council and Chair of Calderdale Health and Wellbeing Board, the first meeting discussed the Board's

terms of reference; priorities for transformation funding and the development of the Partnership's five year plan which will be published in winter. It also included an overview of the Partnership approach, as well as an update from Board members from the six places which make up West Yorkshire and Harrogate (Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield). Propositions for future programmes of work around children, young people and families and health inequalities were outlined and further work will be carried out to scope these programmes of work. A paper was also presented by Healthwatch on the partnerships approach to public questions at future meetings in public.

### **3.1.2 Transformation Funding 19/20**

The **designated transformation funding** expected to be received by the ICS in 2019/20 is between £15m and £20m (based on a population share of the national designated funding available for ICS's) To date, the ICS has been notified of funding for cancer (£6.6m), GP forward view (£2.1m), maternity (£1.7m) and personalisation of care (£0.3m). The designated funding will be overseen through relevant programme Boards and spent in place.

The Partnership was notified in May 2019 that it was likely to receive **£8.75m of flexible transformation funding in 2019/20**. Decision making authority for where flexible transformation funding should be prioritised sits with the Partnership Board. Views from the six places as to which programmes should be considered as priorities for accessing the flexible transformation funding was sought during May 2019. The following high-level priority programmes on how the £8.75m flexible transformation funding could be deployed were supported at the Partnership Board. These reflect the priorities recommended by places with some minor adjustments to ensure that priority areas like Children and Young People and population health management are supported.

- Urgent and emergency care 3.80
- Mental health, learning disabilities and autism 1.40
- Improving population health 1.40
- Specific priority areas in place (VCS) 0.90
- Children and Young People 0.40
- Programme capacity/system issues 0.85

The proposals are high-level and further discussions in each of the six places is expected in terms of how the proposals are further developed for a final discussion and decision at the System Leadership Executive Board in July that will be ratified by the Chair and Vice Chair of the Partnership Board. **The Trust as a key partner in Kirklees, Calderdale and Wakefield as well as the West Yorkshire Mental Health, Learning Disability and Autism collaborative will continue to contribute to the development of these proposals.**

### **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. Key points from the May meeting include the following:

- The Quarter 4 ICS assurance meeting with NHS England/NHS Improvement regional director and team took place on 29 April and members in attendance offered a summary of the conversation. The meeting was positive, and recognition was received

from the regional director on the progressive work the partnership had undertaken. Key areas raised as requiring attention included ED performance across the partnership and the need to add pace to our approach to the Learning Disabilities agenda.

- The ICS Financial Framework for 2019/20 has been agreed with a PSF link to system performance.

### **3.2.1 Key updates from the ICS Programmes - received at the May SOAG meeting, updates particularly of note for the Trust Board include:**

- **Local Maternity System (LMS)**
  - The Perinatal Mental Health Event hosted in May had been well attended and the links with the Mental Health LD and Autism Programme had allowed for any gaps between programmes to be considered. Continuity of care remained a significant challenge across the partnership as it did on a national level, whilst the partnership has seen significant improvement compared to the previous year, work was ongoing to support trusts on a local basis. ***(The Trust provides Perinatal Mental Health Services across the Trust footprint and the links between the two programmes will strengthen the delivery of seamless services in each place)***
  - The intended governance and sign off process for the £1.7m transformational funding was outlined and how each place could input into this process.
- **Carers**
  - Business case approved to adopt a working carers passport with mental health providers and acute hospitals across the partnership. The 'Employers for Carers' digital resources are also being used across the six local areas. ***(The Trust is a partner in this programme.)***

### **3.2.2 Review of System Performance and Delivery at the May SOAG meeting**

- There is no national requirement to report the financial position at Month 1. The latest reporting year to date has seen all providers performing to plan except one Trust. All WY&H organisations continued to forecast delivery of their planned control totals and conversations as a partnership will continue to offer support to those challenged systems through agreed governance processes. Due to changes in financial performance for 2019/20 there is no longer a risk to accessing PSF and RSF funding, the changes mean that access to these funds will be linked to delivery against control totals and not A&E delivery.

### **3.3 WY&H HCP Priority Programmes Refresh and 'Check and Confirm' sessions**

W&H system leaders and programme leads took part in the check and confirm sessions that were held during May 2019. This gave colleagues the opportunity to discuss the ambitions of their programmes, and ensure that the right capacity, support and working arrangements are in place to deliver. The panel included CEO Partnership Lead Rob Webster, peers from other programmes and members of the core team.

### **3.4 Engagement - Healthwatch report**

The Partnership's 5-year strategy will build on the extensive engagement that has been undertaken at place and WY&H level over recent years. As part of the process, NHS England has commissioned each local Healthwatch to undertake a piece of specific engagement work

on the NHS Long Term plan, particularly focusing on “hearing the voices of the seldom heard”. This will feed into the development of the Partnership’s five-year strategy. Healthwatch will provide a report to the partnership this month that will include the findings from two surveys and fifteen focus groups that have been carried out. The findings from this report will feed in to the development of the partnership’s five year plan that is in development. The report will also be shared with communications and engagement leads across the partnership.

### **3.5 Voluntary and Community Sector event (VCS)**

More than 80 VCS representatives from West Yorkshire and Harrogate attended a Partnership event in Bradford on Tuesday 21 May. The Partnership event raised awareness of the NHS Long Term Plan, its implementation (in particular the role of Primary Care Networks) and how the voluntary community sector could get involved as equal partners across the area. VCS partners updated those at the event on the work they have done in communities with their contribution of the £1million loneliness fund.

### **3.6 WY&H MHLDA Committee in Common**

The committee continues to meet and drive forward the agreed transformation areas across the system in line with the national improvements set out in the Mental Health Five Year Forward View and the new Long Term Plan.

#### **3.6.1 Mental Health Learning Disabilities and Autism Collaborative 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:

- ***Supporting people with learning disabilities***

The Partnership Leadership group took part in a workshop in April that focused on supporting good health services for people with learning disabilities. **Following this workshop, organisations from across the partnership including the Trust and programme areas, including cancer, improving planned care and mental health, have come together to develop a health champions network of people with learning disabilities from across the area.** A local organisation BTM will lead on the development of this work over the next 12 months.

- ***Suicide Prevention***

The Partnership has set a target of reducing suicides across the partnership footprint by 75% in targeted areas and 10% reduction in overall suicides by 2020. **The programme is led by Mike Doyle Deputy Director of Nursing and Quality at South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) on behalf of the Partnership.** There has been a significant amount of work that is underway in each of the places that make up the partnership including the following key updates:

- **Suicide prevention training for Fire and Rescue Services**

The Partnership has invested £22,000 in a basic ‘train the trainers’ fire service pilot. Five trainers from West Yorkshire Fire and Rescue Service will become trainers in ‘safeTALK’ a suicide prevention training course that helps people know what to do if someone’s suicidal by following the easy to remember TALK steps - Tell, Ask, Listen and Keep-safe. These practical steps offer immediate

help to someone having thoughts of suicide and help them move forward to connect with more specialised support. A further four fire service places have been allocated to training trainers in ASIST - Applied Suicide Intervention Skills Training (ASIST). ASIST teaches participants to recognise when someone may have thoughts of suicide and works with them to create a plan that will support their immediate safety. The training builds on other suicide prevention work across the area such as the 'Adopt a Block' scheme in Leeds, which has seen firefighters building suicide prevention work into their existing safety and prevention work in high rise buildings. It also acknowledges that firefighters are often among the first people on the scene when there are suicide attempts

- **Suicide Prevention Trailblazer funding to support men**  
The partnership has been awarded £114,000 funding to support suicide prevention targeting men at risk across the region. The funding was awarded by NHS England and NHS Improvement.
- **Funding to support postvention**  
The Partnership has been awarded £173k for postvention work, the funding will be used to roll out the Leeds model.
- ***Transformation funding for community mental health*** has been announced with the deadline for submissions by 21 June 2019. The WY&H ICS bid will be built from place proposals to ensure that the bid reflects the priorities in each area to reduce acute and complex care out of area placements.
- ***Transformation funding for community crisis care*** has been announced with the deadline for submissions by 24 June 2019. As for the community mental health bid (above), the WY&H ICS bid will be built from place to ensure that it reflects the scope of the funding intention - to increase provision of 24/7 Crisis Resolution and Home Treatment (CRHT) and crisis/acute alternative provision in all areas of the country
- **NHS England specialised commissioning** - have invited 'Applications' from the ICS by 5 July 2019 to move to steady state commissioning for CAMHS tier 4, adult eating disorder and forensics. The intention is that by 2022/23, there will be 100% Provider Collaborative coverage nationally across all specialised mental health, learning disabilities and autism services. If successful this would result in four year contracts being awarded to the provider collaborative to lead on the delivery of these services for the Partnership. This builds on the new care model pilots that have been running for 12 months. The next step following submission will be a Regional Selection Panel later in July to determine which one of three tracks the Application will be taken forward on – 'Fast Track'; 'Development Track'; 'Further development track'. The subsequent timescales are determined by which track the 'Application' is placed on. **The Trust is leading on the Forensics new care model on behalf of the provider collaborative, and is a key partner in the other two service areas outlined above. There is a separate paper for Trust Board consideration due to its commercially sensitive nature this will be part of the Private Board.**

- **WY&H ICS Dementia pilot site**

The ICS has been identified as one of three ICS Dementia pilot sites. The aims of the pilot include:

- Reduce non-essential acute hospital admissions for people with dementia
- Reduce length of stay in acute hospital
- Particular interest in care homes

The initial priorities include advance care planning, improve prevention, identification and management of delirium, and supporting people who present with psychological symptoms. **The Trust is a key partner in the programme.**

#### **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. **There is a separate agenda item that will provide a more detailed update on Calderdale Cares and the development of Primary Care networks in Calderdale.**

##### **4.2 The Wakefield Integrated Care Partnership and Mental Health Alliance**

The Wakefield partnership has continued to progress the integration agenda through the Integrated Care Partnership (ICP) previously the New Models of Care Board (NMoC). **This is the subject of a separate item on the Board agenda.** The Mental Health Alliance has worked together to agree the priorities for 2019/20 in line with the MH investment standard, the detailed proposals to support the priorities will be presented to the July ICP meeting for approval.

**Wakefield Primary Care Networks** - The Trust's director of provider development is the SRO for this programme (on behalf of the ICP Board). There will be seven PCHs in Wakefield, which will 'go live' on 1 July 2019, in line with the national timetable. The Trust's service offer in Wakefield is being aligned to 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 has taken place 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 the nine 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.

### **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 and**
  - **Calderdale**
  - **Wakefield**
  - **Kirklees**

## Trust Board 25 June 2019 Agenda item 7.2i

<b>Title:</b>	<b>Calderdale Cares: Moving Forward on Health and Social Care</b>
<b>Paper prepared by:</b>	Director of strategy
<b>Purpose:</b>	<p>The purpose of this paper is to:</p> <ul style="list-style-type: none"> <li>➤ Update the Trust Board on the development of Calderdale Cares.</li> <li>➤ To enable Trust Board to share feedback and discuss the progress with officers from the Calderdale Council and lead officers for Calderdale Cares. (Attached a paper that was received by the Council Cabinet that will be presented.)</li> </ul>
<b>Mission/values/objectives</b>	<p>The development of joined up care through place-based plans are central to the <b>Trust's strategy</b>. As such it is supportive of our mission, particularly to <b>help people to live well in their communities</b>.</p> <p>The development of strategic and operational partnerships <b>support the achievement of the Trust's strategic objectives</b> – to <b>improve health</b> and wellbeing through an enhanced focus on prevention and early intervention, <b>improve quality</b> and experience through more integrated ways of working, and <b>improve the use of resources</b> across the whole system.</p> <p><b>The way in which the Trust approaches strategic developments must be in accordance with our values.</b> The approach is in line with our values - being <b>relevant today and ready for tomorrow</b>.</p> <p>Calderdale Cares is a key vehicle in delivering the place based plan and integration of health and care in Calderdale.</p>
<b>Any background papers/ previously considered by:</b>	<p>The Calderdale Cares Proposal was discussed at the Trust Board in January 2018 and supported. Regular updates on place based plans and Integrated Care Partnerships including Calderdale Cares have been provided at Trust Board including April Trust Board. This update will also be further discussed in the private session of Trust Board.</p>
<b>Executive summary:</b>	<p><b>Background</b></p> <p>Calderdale Cares is one of the key mechanisms for delivering the Council's 2024 Vision and the Health and Wellbeing Strategy. While the Health and Wellbeing Strategy is currently being refreshed Calderdale Cares will remain the main delivery mechanism for the strategy. Calderdale Cares represents a place-based approach to the delivery of integrated Health and Social Care.</p> <p><b>Calderdale Cares - progress</b></p> <p>Over the last year five localities have been agreed based on GP practices, Local Council area wards have also been aligned to these Two prototypes have successfully been developed in North Halifax</p>

	<p>and Central over the last year. The locality approach reflects the Primary Care Network developments outlined in the Long Term plan and GP contract. It is anticipated that the approach developed through the prototypes will be rolled out across the remaining localities over the next six months. There is a strong emphasis on prevention, early help through primary care and care close to home.</p> <p>The CCG have confirmed their intentions to develop an Alliance approach to deliver care closer to home through the redesign of community and primary care services over a period of two years. The work of the alliance will be an integral part of delivering Calderdale Cares. The Alliance will be formed over the next few months and will include commissioners and providers working together.</p> <p><b>Update to Council Cabinet and decisions</b></p> <p>The full paper attached was received by the Calderdale Council Cabinet and the following recommendations were supported:</p> <ul style="list-style-type: none"> <li>➤ The revised Wellbeing Strategy which will focus on starting well, staying well and ageing well, will set the strategic direction for Calderdale Cares</li> <li>➤ Cabinet affirms its commitment to Calderdale Cares with a distinct brand and identity as one of the main delivery vehicles for the Wellbeing Strategy and Vision 2024</li> <li>➤ Appointments of two Members to each of the five localities should be made by Cabinet in June 2019</li> </ul> <p><b>Risk Appetite</b></p> <p>Supporting the development of strategic partnerships and place-based plans that enhance the Trusts sustainability are within the Trust's risk appetite. Risks to the Trust services in Calderdale will need to be reviewed and managed as the partnerships develops to ensure that they do not have a negative impact upon services, clinical and financial flows.</p>
<b>Recommendation:</b>	<b>Trust Board is asked to NOTE and COMMENT on the update.</b>
<b>Private session:</b>	Not applicable.

**Calderdale MBC**

**Wards Affected All**

**ITEM 14**

**Cabinet**

**18 March 2019**

## **Calderdale Cares – One Year On**

### **Report of the Chief Executive**

#### **1. Purpose of Report**

This report sets out progress in implementing Calderdale Cares since Cabinet adopted the Calderdale Cares approach when it met on 12 February 2018. The Calderdale Cares approach was set out in a report, *Calderdale Cares: Moving Forward on Health and Social Care*. The foreword stated

In Calderdale, there is a strong desire to move towards a place based approach to health and social care, harnessing the contribution of both the statutory and community sectors, ensuring effective governance both clinical and democratically accountable, and defining better the role of the primary and acute system. There is a real opportunity to harness ... the 'collaboration imperative' to develop new relationships, a parity of esteem across the system and a strong sense of place utilising the role of community anchors in early prevention and supporting wider agendas such as inclusive growth. There are important principles which are important to reaffirm; sustaining the NHS as free at the point of delivery, and commitment to what is being described as 'left shift' into the community with a strong focus on the social and wider determinants of health.

*Calderdale Cares: Moving Forward on Health and Social Care* stated that arrangements for year one of *Calderdale Cares* would have *shadow* governance arrangements. This report reviews progress in the first year and sets out steps that need to be taken in 2019 and subsequent years to move to more formal arrangements and to take forward the ambitions of a year ago.

The report asks Cabinet; to endorse the locality approach adopted, to confirm Member activity in each of the localities; to confirm officer support arrangements to *Calderdale Cares*; to endorse the partnership approach of *Calderdale Cares*; and to adopt the joint commissioning arrangements with Calderdale Clinical Commissioning Group that operate through the Integrated Commissioning Executive.

The report sets out the direction for Calderdale Cares over the next two years and Cabinet is asked to endorse that plan. Section 4.12 sets out a proposed direction for Calderdale Cares which includes; identifying the success criteria for successful Calderdale Cares localities; formally adopts Calderdale Cares as a delivery model with a distinct brand and identity; formalises the role of the Health and Care Leaders Group; and the development of high level metrics that will be used to assess the performance of the five Calderdale Cares localities.

Calderdale Cares will become one of the ways that we take forward Active Calderdale, the Anti-Poverty Action Plan, arts health and wellbeing and other system-wide initiatives.

It is planned that, if Cabinet approves this report and its recommendations, the Chief Executive will present it to the Calderdale Clinical Commissioning Group Board in April 2019.

## **2. Need for a decision**

2.1 Cabinet needs to decide the approach to Calderdale Cares over the next year.

## **3. Recommendation**

3.1 The revised Wellbeing Strategy which will focus on starting well, staying well and ageing well, will set the strategic direction for Calderdale Cares.

3.2 Cabinet affirms its commitment to Calderdale Cares with a distinct brand and identity as one of the main delivery vehicles for the Wellbeing Strategy and Vision 2024

3.3 Appointments of two Members to each of the five localities should be made by Cabinet in June 2019.

## 4. Background

4.1 Calderdale Cares is one of the key mechanisms for delivering the Council's Vision and the Health and Wellbeing Strategy.

4.2 It operates within this context, which is detailed later in this report.

- Five existing groupings of GP practices have been agreed as the localities for *Calderdale Cares*. There has been Member involvement in some of the localities. Officer support from the Council has been provided by officers from CYP, Adults and Wellbeing, Public Health and the Chief Executive's office.
- The Secretary of State for Health and Social Care has responded to the scrutiny referral of the hospital and community health reconfiguration proposals and NHS England has agreed that £197M of capital should be allocated to support improving hospital services in Calderdale and Greater Huddersfield.
- Local health and care system performance has improved significantly on delayed transfer of care from hospital and hospital readmission rates.
- The work of the Integrated Commissioning Executive, where the Council and Calderdale CCG jointly consider how health and care services are commissioned has developed and now has Member representation through the Cabinet Member for Adults Health and Social Care becoming a member of the ICE.
- Calderdale CCG is continuing to move forward and engage local providers with the implementation of its Care Closer to Home strategy through an approach based on the principles articulated in *Calderdale Cares* and which will capitalise upon the strong relationships operating between providers locally.
- The Health and Wellbeing Board has begun work on preparing a revised Wellbeing Strategy, which will identify *Calderdale Cares* as one of the main delivery mechanisms for the strategy.
- Ofsted has judged Calderdale Council's children's services to be good with outstanding features, which reflects positively the partnership working that has been established throughout the local health and care system.
- The West Yorkshire and Harrogate Health Care Partnership has been formally endorsed as an Integrated Care System. Their plan for West Yorkshire and Harrogate confirms the approach that we have adopted through *Calderdale Cares*
- NHS England has published their Long Term Plan. This is of particular significance to *Calderdale Cares* as it sets out the NHS approach to locality working, which is consistent with the approach we have taken.

### 4.3 Calderdale Cares Localities

- 4.3.1 Calderdale Cares has adopted the five groupings of GP practices already agreed by the Vanguard Board as the localities for *Calderdale Cares*. These groupings are; Central Halifax, North Halifax, Upper, Lower and South. Details of the practices within each locality, the populations served and which electoral wards fall within each locality can be found in Appendix 1.
- 4.3.2 Using the practice groupings has had the advantage of ensuring that primary care and GP's in particular are fully involved in the implementation of *Calderdale Cares*. Using two Primary Care Home sites and three Primary Care Networks as a springboard for the implementation of Calderdale Cares ensures GP's are engaged as stakeholders from the outset.
- 4.3.3 There are some challenges in implementing Calderdale Cares based on Primary Care Homes and Primary Care Networks:
- The boundaries are based on practice lists rather than precise geographical boundaries. There is also one organisation that runs practices in two localities. This presents some challenges in data management.
  - Electoral wards do not neatly fall into the five localities.
  - It risks the focus of Calderdale Cares being too "medical" and the challenge will be to ensure the localities consider the wider determinants of health, as well as lifestyle factors and also that preventive measures are identified for the whole population and not just those people already in contact with health and care services.
- 4.3.4 The localities are where we shape places and identify the needs of our distinctive communities. There is already a demonstrable passion for people to get together, agree joint priorities, collaborate and co-create joint solutions.
- 4.3.5 North Halifax and Central Halifax have been the first localities to become firmly established.

North Halifax has;

- Reviewed data to identify priority areas to begin focusing on, until a population health management approach is established within the locality.
- Amongst priority areas held a multi-agency workshop to identify key actions around mental health. A number of work streams are now in progress following the workshop.
- Healthwatch have interviewed a number of frequent users of GP services to start to identify how their needs could be better met across the system.

Some early actions in North Halifax have been:

- Sharing best practice to better meet the needs of those who need services the most to ensure better health outcomes. For example, GP practices with good annual review rates for people with learning disabilities are working together to identify what works so this can be shared across the locality.
- Arranged pop-up visits to GP surgeries of the Community Social Work Practice
- Through locality meetings, a number of links have been established amongst stakeholders. In particular, the Staying Well project has been promoted amongst GP's and the service is now receiving more referrals directly from GP's.
- Has arranged trial drop-ins from the Department of Work and Pensions in GP surgeries and this work is already proving successful. Some case studies are shared below.

#### Case Study 1

Lady who was not in work, attending GP for Fit note for sickness. Anxiety & Depression. – After talking with this lady it was apparent that she has a lot of Debts and was not addressing these. This was adding to her stress. I booked an appointment for her to meet in the Job centre one of our Personal Budgeting Support people. 06.02.19 then a follow up meeting with colleague the same week. Then a follow up with me to look at may be looking at voluntary work.

#### Case Study 2

Male, again anxiety & depression on Universal Credit, but felt he wasn't receiving his full entitlement to benefit. I looked at this with him and he was receiving full entitlement but his problem was his housing. We had a discussion around he may have to down-size as we only pay a proportion of rent and this was a financial burden on him and his wife. This could help with his anxiety if he was not stressed about bills. Also discussed Personal Independent payment claim as well.

Central Halifax has:

- Arranged a workshop of front line professionals and first-line managers from health care and third Sector agencies which attracted fifty people and identified key priorities
- Appointed a GP (Dr Helen Davies) and a Third Sector Chief Executive (Alison Haskins, Halifax Opportunities Trust) as co-chairs.
- Halifax Central Initiative and Staying Well have arranged drop in sessions at a GP practice with more to follow.

- Identified a clear focus on the wider social determinants of health
  - A clear commitment to Active Calderdale. The seven practices have committed to increasing activity in people with long term conditions and will link with practices across Calderdale working with GP activity champions from the other four localities with whom we will develop a broader primary care plan.
- 4.3.6 The other localities have taken a little more time to get established. All three have now held launch meetings. The establishment of Primary Care Networks will help establish these localities as full partnerships across the whole system. In the Lower locality there have been some discussions about the implications of the Local Plan on the health care infrastructure.
- 4.3.7 Member representation has been identified for Central Halifax and North Halifax. It is proposed that each locality should have representation of two Members. One should be a Cabinet member, which would enable issues arising in each locality to be brought into executive decision making. The other a Member whose ward falls substantially within the locality, which will facilitate community links. It is recommended that Cabinet should nominate members to these roles when it meets in June 2019.
- 4.3.8 Public Health Directorate and Adults and Wellbeing Directorate have identified staff to link with each locality. It is proposed that Children and Young People Directorate should – at this stage – become involved in *Calderdale Cares* when issues that relate to children and young people are being considered. Support in implementing *Calderdale Cares* will be provided by Public Health and the Chief Executive’s Office.

#### 4.4 NHS Long Term Plan

- 4.4.1 The NHS Long Term Plan was published on 7 January 2019.
- 4.4.2 The Long Term Plan has been accompanied by a new Primary Care Contract.
- 4.4.3 The Long Term Plan says:

*... £4.5 billion of new investment will fund expanded community multidisciplinary teams aligned with new primary care networks based on neighbouring GP practices that work together typically covering 30-50,000 people. As part of a set of multi-year contract changes individual practices in a local area will enter into a network contract, as an extension of their current contract, and have a designated single fund through which all network resources will flow. Most CCGs have local contracts for enhanced services and these will normally be added to the network contract. Expanded neighbourhood teams will comprise a range of staff such as GPs, pharmacists, district nurses, community geriatricians, dementia workers and AHPs such as physiotherapists and podiatrists/chiropractors, joined by social care and the voluntary sector. In many parts of the country, functions such as district nursing are*

*already configured on network footprints and this will now become the required norm.*

This is completely consistent with the approach that has been adopted in the Calderdale health and care system through *Calderdale Cares*.

- 4.4.4 There are provisions in the new GP contract to incentivise the introduction of Primary Care Networks across the country. The local health and care system needs ensure that the implementation of these provisions maintains the broad partnership and preventive approach that has been successfully introduced through *Calderdale Cares*.
- 4.4.5 The NHS Long Term Plan is incomplete until the long delayed Green Paper on social care is published.

#### 4.5 West Yorkshire and Harrogate Health and Care Partnership

- 4.5.1 The West Yorkshire and Harrogate Health and Care Partnership has been formally endorsed as an Integrated Care System.
- 4.5.2 This brings regulatory powers and resources to the region from the centre.
- 4.5.3 Calderdale Cares is consistent with approach adopted by West Yorkshire and Harrogate Health and Care Partnership and supported by the Partnership.
- 4.5.4 Councillor Tim Swift has been appointed chair of the Partnership Board which signals the importance of local government to the partnership.

#### 4.6 Hospital and Community Health Services Reconfiguration

- 4.6.1 In May 2018 the Secretary of State for Health and Social Care responded to the referral to him by the Calderdale and Kirklees Joint Health Scrutiny Committee of the CCG proposals to make Calderdale Royal Hospital and Huddersfield Royal Infirmary specialist hospitals and to develop further community health services through the Care Closer to Home proposals.
- 4.6.2 Calderdale CCG, Greater Huddersfield CCG and Calderdale and Huddersfield NHS Trust amended their proposals in the light of his comments and in November 2108 NHS England announced that £197M capital would be available to support implementing the proposals through increasing the capacity of Calderdale and Royal Hospital and upgrading some facilities at Huddersfield Royal Infirmary, in particular Emergency Services.
- 4.6.3 The local NHS response in particular states that there will be no changes to the overall bed base in the hospitals until community health services are demonstrably sustainable and are having an impact on supressing demand on the hospitals. This will undoubtedly have an influence over the way the Calderdale Cares develops.

#### 4.7 Delayed Transfer of Care

4.7.1 Performance on delayed transfer on care for patients from hospital home or to other community settings (DTCO) has improved dramatically from a bottom quartile position two years ago to a top quartile position now. Data now show that concerns that this may have led to an increase in re-admissions to hospital are unfounded. Improvements in DTCO preceded the implementation of Calderdale Cares, but have resulted from sustained partnership working by the Council, Calderdale CCG and CHFT to improve outcomes for local people, which is the rationale for *Calderdale Cares*.

#### 4.8 A New Approach to Community Health Services

4.8.1 Calderdale CCG is planning an *alliance* approach to take forward their vision of delivering care closer to home (CC2H). The CCG is continuing to engage with local providers with the intention of developing more integrated care arrangements particularly in relation to community and associated services.

4.8.2 In the first instance the CCG plans to develop robust alliance arrangements with existing contracted providers and the wider health and social care system to deliver CC2H in Calderdale. Integration and collaboration are essential to this approach and, as such, members entering into an “Alliance Agreement” will be equal partners – a single overarching agreement to deliver contracted services, sharing risk and responsibility to achieve better outcomes for our population.

4.8.3 An Alliance model is considered the most suitable approach here because:

- It will allow for a collaborative approach, strengthening relationships between commissioners and providers
- It recognises the contribution of the range of providers for CC2H in Calderdale, and
- It will ensure that the system works together towards achieving shared agreed outcomes

4.8.4 There will be a two year development period during which the alliance must demonstrate it is delivering the vision for *Care Closer to Home*, removing fragmentation within the system and working in a more integrated way to deliver better health outcomes for local people. This development period will help shape any necessary future commissioning plans.

4.8.5 Delivering *Care Closer to Home* is regarded by the CCG as a major contribution to achieving the vision set out in *Calderdale Cares*. They say that “*Calderdale Cares* will help health, local government, housing and other services across Calderdale work together better and organise ourselves in new ways so that we can provide more joined-up services that deliver better health outcomes for the area in a smarter, more

sustainable way. It also helps us to shift our collective focus towards prevention and early intervention.”

- 4.8.6 Both CHFT and the Council’s Adults and Wellbeing Directorate are in the process of arranging some of their services to the Calderdale Cares locality boundaries, which will be a major step forward in locality delivery.
- 4.8.7 The full involvement of providers of community services is a vital component of this approach, but as we move from a market paradigm towards a community paradigm the commissioner – provider divide will become increasingly blurred. *Calderdale Cares* should not be viewed solely as a provider element of the system but one which will increasingly influence strategic commissioning and – with local people – shape the provider response.

#### 4.9 Wellbeing Strategy

- 4.9.1 The Health and Wellbeing Board has begun work on preparing a revised Wellbeing Strategy to replace the Strategy that was agreed in 2012. The new Wellbeing Strategy will run from 2019 to 2024 and will establish Calderdale Cares as a key delivery mechanism for addressing the social determinants of health, prevention and early intervention. It will drive the priorities of the health and Wellbeing Board and its constituent organisations.
- 4.9.2 The Wellbeing Strategy will set out the health and care system approach to; starting well, staying well; and ageing well.

#### 4.10 Children and Young People Services

- 4.10.1 Ofsted has judged Calderdale Council’s children’s services to be good with outstanding features. This is a tribute to the hard work and commitment not just of Council CYP staff, but of all the partner organisations who work tirelessly to keep children safe and help them thrive. This reflects the strong partnership arrangements across the health and care system.
- 4.10.2 Social care services for looked after children and safeguarding will predominantly be arranged on a Borough-wide basis, but *Calderdale Cares* will have a significant contribution to make, particularly in relation to children’s emotional health and wellbeing. Addressing the wider determinants of health, for example making sure that as many people as possible live in warm, dry, affordable housing, benefits everyone regardless of their age.
- 4.10.3 We anticipate that each Calderdale Care locality will earmark some activities each year to ensure that proper attention is paid to the needs of children and young people.

#### 4.11 Integrated Commissioning Executive

- 4.11.1 The Integrated Commissioning Executive (ICE) is where the Council and Calderdale CCG jointly consider how health and care services are commissioned. As well as senior officers, the Cabinet Member for Adults Health and Social Care represent the Council on the ICE.
- 4.11.2 The ICE functions at a “place” level, covering Calderdale as a whole, rather than the five localities. The ICE has a trajectory of moving from transactional procurement decisions to being the place where strategic commissioning of the outcomes required by the Wellbeing Strategy can be arranged. As such, the ICE will set some of the broad direction for the five localities. It is also important that the experience of front line professionals and first line managers can influence strategic commissioning decisions, so the ICE should develop mechanisms to take account of the experience of the five *Calderdale Cares* localities. Most importantly, the localities will be a place where the public, service users and patients can contribute to the design of services and the way in which they are delivered. The ICE will make better decisions when it is informed by the views of local people.

#### 4.12 Population Health Management (PHM) Approach

Population Health is an approach aimed at improving the health of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities within and across a defined population. It includes action to reduce the occurrence of ill-health, including addressing wider determinants of health, and requires working with communities and partner agencies.

Population Health Management improves population health by using the data to inform strategic planning and improving the patient’s journey. PHM will help to target interventions with the intention of achieving the greatest impact.

Calderdale held a Population Health Management Summit in February 2019 to drive this approach in Calderdale. There is energy and commitment to the approach in Calderdale, but the challenge will be ensuring all data across the system is joined up to produce this rich picture to inform planning.

#### 4.13 The Forward Plan for Calderdale Cares

- 4.13.1 Progress on implementing *Calderdale Cares* in North Halifax and Central Halifax has been faster than in the other localities. Over the next six months it is expected the all five localities to be up, running and making a difference. Learning from the experiences of the two established localities we hope that all five will show:
- A clear focus on addressing the wider determinants of health, prevention, and early intervention.

- A strong and equal partnership of Council, CCG, NHS providers, GP's, local Third Sector organisations and pharmacy.
- Strong and committed leadership. The co-leadership in Halifax Central of a GP and a Third Sector chief executive provides a particularly powerful example.
- An evidence based approach that combines a strong local voice for stakeholders, including residents, service users and local providers with integrated data through population health management.

The Health and Wellbeing Board, through a revised Wellbeing Strategy and through dashboards setting out high level metrics will set the strategic direction for the five localities and will receive regular updates from each locality. The response of each locality will reflect the different level of need in their place and will be co-designed by local people and the professional staff who serve them.

- 4.13.2 *Calderdale Cares* will have a distinctive brand and identity, which will become recognisable and used consistently in the five localities and at place. NHS England will recognise *Calderdale Cares* as the way in which the Primary Care Networks anticipated in the Long Term Plan are delivered here.
- 4.13.3 The Health and Care Leaders Group made up of senior managers from across the health and care system will remain an important place where the local health and care system “horizon-scans” and can address difficult issues at an early stage before they escalate. It has driven much of the progress in implementing *Calderdale Cares* and other key system issues.
- 4.13.4 The five localities will adopt a population health approach and stakeholders will actively help to deliver the implementation of population health management.
- 4.13.5 The Health and Wellbeing Board has agreed a methodology to aid delivering the Wellbeing Strategy, called *Improving Outcomes and Performance*. It includes a number of report cards on; a better start in life; a healthier population; reducing the health inequalities gap; enabling people to live independently in their home environment; improving the quality of service provision and the experience of people accessing services; and improving efficiency. This will be revised and implemented during 2019.
- 4.13.6 Several parts of the system have plans to develop a digital platform which will make it easy for the public, community organisations and professionals to access the wide range of assets and services that are available in local communities to help people maintain and improve their health and wellbeing. Work is underway to ensure that a co-ordinated approach is being taken and the digital platform will become available in 2019.

4.13.7 The Wellbeing Strategy and the Inclusive Economy Strategy will complement each other and become the major drivers for achieving Vision 2024.

## **5. Options considered**

- Cabinet may choose to adopt all, some or none of the recommendations in this report
- If Calderdale Cares is to continue, Cabinet needs to set a direction for future years. *Calderdale Cares* is a Council initiative, but will only succeed if other parts of the health and care system are signed up to a consistent approach.

## **6. Financial implications**

6.1 This report has no direct financial implications. Successful prevention work and early intervention, which is one of the foundations of Calderdale Cares, should lead to a reduction or delay in the need for more formal and expensive care in the long term.

6.2 Over the next year work will begin to identify the full investment in health and care across Calderdale and to prepare information that will show how that investment is made in each of the five localities. This information will influence commissioning decisions in future years.

## **7. Legal Implications**

The Government has requires that health and care services are integrated by 2020. Calderdale Cares is the Council's approach to achieving this. If Calderdale Cares does not proceed, then alternative ways of integrating health and social care will need to be found.

## **8. Consultation**

Calderdale CCG has been consulted over the content of this report

## **9. Environment, Health and Economic Implications**

The wider determinants of health are predominantly environmental and economic. The Wellbeing Strategy and *Calderdale Cares* sit alongside the Inclusive Economy Strategy as the main contributors to delivering Vision 2014.

## **10. Equality and Diversity**

One of the key objectives of Calderdale Cares is to reduce health inequalities by proportionally delivering health and social care to people that need them the most, eg people with disabilities. In future years it is likely that resources will be redirected to those localities with the poorest health outcomes.

## **11. Summary and Recommendations**

Calderdale Cares has been introduced successfully in the "shadow year". Two of the localities, Halifax North and Halifax Central are well established. The reports sets out

how the success of year one should be consolidated and start to bring tangible improvements to the health and wellbeing of Calderdale People.

### Recommendations

- 11.1 The revised Wellbeing Strategy which will focus on starting well, staying well and ageing well, will set the strategic direction for Calderdale Cares.
  - 11.2 Cabinet affirms its commitment to Calderdale Cares with a distinct brand and identity as one of the main delivery vehicles for the Wellbeing Strategy and Vision 2024
  - 11.3 Appointments of two Members to each of the five localities should be made by Cabinet in June 2019.
- 

#### **For further information on this report, contact:**

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#### **The documents used in the preparation of this report are:**

1. Calderdale Cares: Moving Forward on Health and Social Care, Cabinet, 12 February 2018
2. NHS England Long Term Plan
3. Five Year Framework for the GP Contract, NHS England

**The documents are available for inspection at Town Hall, Crossley Street, Halifax, HX1 1UJ**

GP locality Groupings	Practice Code	Brighouse	Calder	Elland	Greetland and Stainland	Hipperholme and Lightcliffe	Illingworth and Mixenden	Luddendenfoot
<b>NORTH</b>								
Beechwood Medical Practice	B84613	5		15	11	11	2414	25
Caritas Group Practice	B84618	10		15	19	61	2684	36
Keighley Road Surgery	B84010	3		5	8	12	6568	7
Lister Lane Surgery	B84612	10		24	14	26	565	8
Plane Trees Group Practice	B84013			2	2	19	421	306
<b>SOUTH</b>								
Bankfield Surgery	B84016	1		6850	1241	2	4	
Brig Royd Surgery	B84007		2	4	926	2		85
Stainland Road Surgery	B84009			1808	8320	1	4	2
Station Road Surgery	B84001		5	6	278	4	4	347
Burley Street Surgery	B84017	15		1484	258	10	7	
Meadow Dale Group Practice	Y03112	19	6	602	159	8	120	100
<b>CENTRAL</b>								
Boulevard Medical Centre	B84019	8	1	23	41	7	136	64
King Cross Practice	B84021	4	12	19	43	14	39	140
Rosegarth Medical Practice	B84005	6	2	77	21	11	125	43
Spring Hall Medical Practice	B84012	4		18	29	5	323	66
Queens Road Surgery	B84002				10	13	29	9

Horne Street Surgery	B84610	7		15	10		5	
Park & Calder Community Practice	Y02572		431	13	4	2	40	15
<b>UPPER</b>								
Hebden Bridge Group Practice	B84004		9002	1	1	3	3	9697
Todmorden Health Centre	B84006		2986					2
<b>LOWER</b>								
Church Lane Surgery	B84011	4980		252		2490	1	1
Longroyde Surgery	B84623	449		326	2	127		
Northolme Practice	B84008	920		2	5	6762	1	
Rastrick Health Centre	B84014	424		607	2	65		
Rydings Hall Surgery	B84003	4129		145		1767		
Southowram Surgery	B84615	95		14	6	14	34	
<b>GP Population by Ward</b>		11089	12447	12327	11410	11436	13527	10953
		82%	96%	87%	92%	96%	86%	89%

	<b>UPPER</b>		<b>LOWER</b>		<b>SOUTH</b>		<b>NORTH</b>	
<b>Wards</b>	Calder, Luddendenfoot, Todmorden		Brighouse, Hipperholme and Lightcliffe, Rastrick		Elland, Greetland and Stainland, Ryburn		Illingworth and Mixenden, Ovenden	
<b>Total GP Population by Ward</b>	<b>36093</b>		<b>33872</b>		<b>36213</b>		<b>27399</b>	
<b>Councillors</b>	Lab	7	Con	8	Lab	1	Lab	6
	Con	2	Ind	1	Con	4		
					Lib	3		
					Ind	1		

	UPPER	LOWER	SOUTH	NORTH
Total GP Practice Population by GP Groupings	32287	44887	43338	43626

Northwram and Shelf	Ovenden	Park	Rastrick	Ryburn	Skircoat	Sowerby Bridge	Todmorden	Town
140	5172	59		6	84	43		366
3053	591	104	8	10	133	66		1980
65	2959	7	2	4	25	23		168
419	1943	1672	3	9	375	73		1799
183	1080	707	1	2	328	322		225
1	1	2	51	15	4	2		10
		1		8977	10	302		4
1	2	1	1	396	3	2		7
1	9	51	1	2364	314	5243	2	11
4	16	7	32	17	36			44
7	692	34	6	380	87	1131		106
128	281	1298	2	21	4914	896	1	1239
39	66	1951		120	1740	2071		363
136	203	479	3	29	4309	645	1	3380
128	587	3139	1	55	552	549		654
30	53	4326		4	470	99		72

13	32	3071	5	3	218	8		78
15	165	1407	4	18	102	40	2253	179
				41		88	23	6
							10411	
4	1	1	3241			3	1	103
			3055			3		5
6882	3	1			9	5		222
	1		2749					
			2169					
65	15	4	13	4	36	18		2638
11314	13872	18322	11347	12476	13750	11644	12693	13661
61%	80%	83%	99%	91%	80%	57%	82%	44%
34%						36%		33%
								22%

CENTRAL	
Park, Skircoat	
32072	
Lab	3
Con	3

Wards that don't fit (Below)					
Ward	Northowram and Shelf		Warley		Total
Ward Population	11314		14436		13661
Councillors	Con	3	Lab	1	Lab
			Lib	2	

**CENTRAL**

**52561**

Warley	Not recorded	Outside Calderdale	GP Practice Population
238	4	66	8659
256		172	9198
182		108	10146
591		22	7553
4844		30	8472
		117	8301
7	1	42	10363
3	1	542	11094
170	4	7	8821
5	7	102	2056
69		23	3549
884		38	9982
1291		16	7928
539		31	10040
2532		2	8644
1353		0	6468

709		14	4188
724		46	5458
23		5	18893
	29	33	13461
	27	677	11782
		370	4337
2	3	35	14852
1		867	4716
	12	278	8500
13		9	2978
14436	88	3652	<b>220444</b>
56%			
42%			

<b>80%)</b>	
wn	Sowerby Bridge
561	11644
<b>3</b>	<b>Lab</b>
	<b>2</b>
	<b>Con</b>
	<b>1</b>

## Trust Board 25 June 2019 Agenda item 7.2ii

<b>Title:</b>	<b>Wakefield's Integrated Care Partnership</b>
<b>Paper prepared by:</b>	Director of Provider Development
<b>Purpose:</b>	<p>Purpose is to:</p> <ul style="list-style-type: none"> <li>• Update the Board on the next stages for Wakefield in further integrating health and social care across the district.</li> <li>• Seek approval from the Board to be a party to the revised terms of reference for an Integrated Care Partnership, and a member of the Partnership.</li> <li>• Seek approval from the Board to be a party to the updated system partnership principles of ways of working together in Wakefield.</li> </ul>
<b>Mission/values:</b>	<p>The development of joined up care through place-based plans is central to the <b>Trust's strategy</b>. As such it is supportive of our mission, particularly to <b>help people to live well in their communities</b>.</p> <p><b>The way in which the Trust approaches strategy and strategic developments must be in accordance with our values.</b> The approach is in line with our values - <b>being relevant today and ready for tomorrow</b>. This report aims to assist the Trust Board in shaping and agreeing the strategic direction and support for collaborative developments in Wakefield that support the Trust's strategic ambitions.</p>
<b>Any background papers/ previously considered by:</b>	The Trust has been a partner in the integrated care arrangements in Wakefield – termed the Wakefield New Models of Care Board – for several years, and has received regular updates at Trust Board meetings through the agenda item on feedback from partnership Boards.
<b>Executive summary:</b>	<p>The paper comprises three parts:</p> <ul style="list-style-type: none"> <li>➤ A generic report prepared by Wakefield CCG providing an update about the next stages for Wakefield in further integrating health and social care across the District. This has been prepared for partners to take to their respective governing bodies.</li> <li>➤ The terms of reference for the newly established Wakefield Integrated Care Partnership (ICP).</li> <li>➤ An updated version of the system partnership principles of ways of working together.</li> </ul> <p>All partners, including the Trust, had the opportunity to comment on draft versions of the terms of reference and the system partnership principles. The final versions contained in this paper incorporate partners' comments on the draft.</p>

Taken together, this provides the framework for the place based integration arrangements moving forward in Wakefield.

### **Risks and Issues**

The next stages described in these papers for integrating health and social care in the Wakefield district **do not** represent for the trust a “relevant transaction” as defined in the NHS Improvement guidance *Transactions guidance - for trusts undertaking transactions, including mergers and acquisitions*, November 2017. They describe a way of multi-agency working that build on previous arrangements.

There are a number of key issues contained in the Terms of Reference of the Integrated Care Partnership (ICP) that minimise the risk for the trust of committing to actions without having prior discussion and agreement at the Trust Board. These include, for example:

- “The Wakefield ICP has no authority to bind any partner against its will”.
- “It is recognised that some decisions will need to go through each sovereign organisation for approval in line with its governance arrangements in order for decisions to be made”.
- Appendix 1 to the terms of reference provides for a dispute resolution procedure should any organisation wish to invoke it.
- Section 6 (page 4) of the *Principles of ways of working* paper sets out the responsibilities of partner organisation both individually and jointly. The values that we are being asked to exhibit in our multi agency working are consistent with our own trust’s stated values.

There are a number of risks for the trust in **not** being a party to the ICP arrangements, including for example:

- The trust would not be in the ICP “engine room” driving integration in the district, including two of the five priorities for the Connecting Care+ business plan 2018-2021 that are directly related to the trust’s services – mental health; implementation of primary care networks.
- The trust chairs the Wakefield mental health alliance currently, and this may cease as the senior responsible officer (sro) has to be from a member of the ICP partners.
- The ICP leads the Wakefield system wide organisational development strategy, including new approaches to organisational, clinical and financial governance, and the trust would not have an influence in shaping these approaches.

The development of Alliance Agreements by the end of life care alliance and the mental health alliance was put on hold until the new

	ICP framework was established. Now that this is being established, the end of life care alliance is taking an approach that involves developing a memorandum of understanding between its partners, and this will be similarly taken forward by the mental health alliance.
<b>Recommendation:</b>	<p><b>Trust Board is asked to:</b></p> <ul style="list-style-type: none"> <li>➤ <b>NOTE the update on the next stages for Wakefield in further integrating health and social care across the district;</b></li> <li>➤ <b>APPROVE a recommendation for the Trust to be a party to the revised terms of reference for the Wakefield Integrated Care Partnership, and a member of the Partnership; and</b></li> <li>➤ <b>APPROVE a recommendation for the Trust to be a party to the updated system partnership principles of ways of working together in Wakefield.</b></li> </ul>
<b>Private session:</b>	Not applicable.

## 1. WAKEFIELD'S INTEGRATED CARE PARTNERSHIP

### 2. PURPOSE OF THIS REPORT

2.1 The purpose of this report is to provide Integrated Care Partnership Board Members with an update about the next stages for Wakefield in further integrating health and social care across the District. The report also seeks approval to enter into a revised terms of reference (appendix 1) and asks partners to sign up to a set of principles of the ways our Integrated Care Partnership will work together across the system (appendix 2).

### 3. WHAT DOES THIS MEAN FOR THE WAKEFIELD DISTRICT?

The Government introduced the Better Care Fund in 2015, requiring Local Authorities and Clinical Commissioning Groups to co-operate in bringing together resources to collaborate in improving health and social care outcomes for our community and promoting greater integration and improved efficiency in public services.

Health and social care systems are being asked to come together to develop their plans for delivering the NHS Long Term Plan. This NHS Long Term Plan policy document strongly describes how integrated care is required to be delivered by 2020/2021 which can only be achieved through working with our local system partners in Wakefield. In order to do this there will be a need to have strong system leadership through which all aspects of the system are engaged and for all involved to have a shared vision for the future. All areas must ensure that primary care, social care and clinical community services move towards integration to achieve the 2020/2021 timescale of achieving integration of care across health and social care. Locally we are underway with this through the development of seven Primary Care Home sites and through our Connecting Care Hubs. By moving towards further integration of health and social care across the District there will be opportunities to improve quality of services across our District whilst maximising the system resources the District has available to develop an improved integrated care model in our District.

4 The Wakefield Health and Wellbeing Plan has recently been refreshed during 2018/2019 and the Health and Wellbeing Board has adopted four priorities that encourages local services working together, focused on people and place, we want to transform our plan to take a more proactive approach. We want to ensure that we:-

1. Give every child the best start in life
2. Prevent ill health by focusing on early intervention and prevention
3. Ensure there is a healthy standard of living for everyone
4. Create and develop sustainable communities that support local residents to become healthier, resilient and empowered.

This work programme has been agreed and two forums in Wakefield will take this work programme forward, Wakefield's Children and Young People Partnership will take forward the first priority of the Health and Well Being Board and Wakefield's Integrated Care Partnership will drive forward with partners across the system the remaining three priority areas.

## 5.0 Wakefield Integrated Care Partnership Priorities

The Connecting Care+ business plan sets out the priorities that need to be achieved during 2018-2021 and through a review of our Joint Strategic Needs Analysis for Wakefield the ICP have proposed to take these five areas forward:

Diagram 1

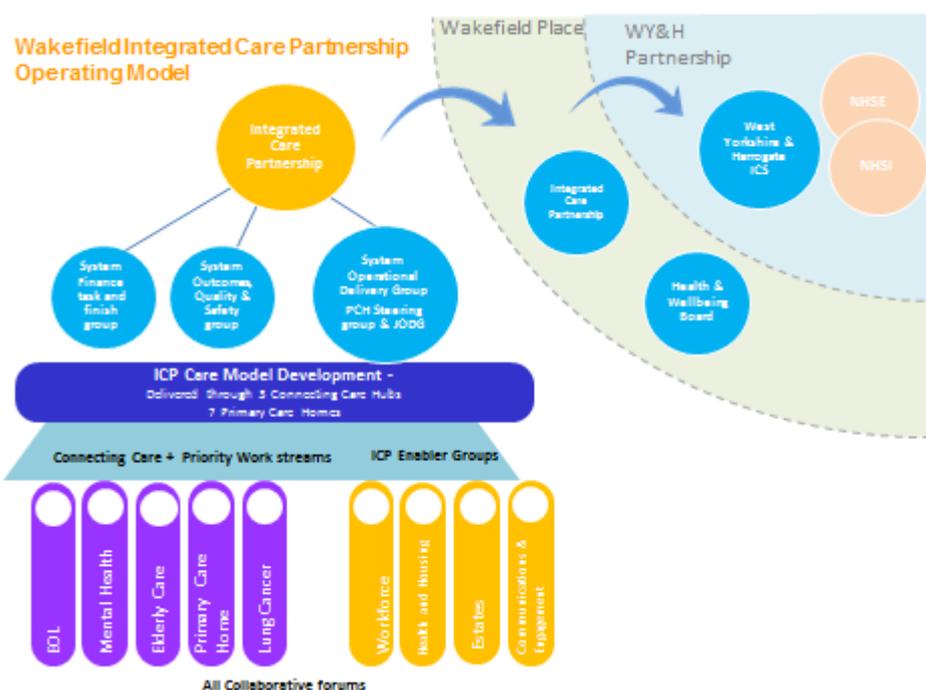


The Integrated Care Partnership Board is intended to facilitate the district-wide health and social care integration agenda and to remove historical barriers that have prevented joined-up patient care across primary, community, mental health, social care and acute services. Progress on above five priorities will be reported to the Integrated Care Partnership through Board level senior reporting officers who have agreed to lead these priority areas.

6.0 Wakefield has reviewed between February 2019- May 2019 a set of historical integrated care business rules that organisations previously signed up to in 2014 in our District. It was agreed to replace these with appendix two which is a set of Wakefield system principles of ways of working together. These outline our ambition for integrated care, our values and principles in our dealings with each other as partners, our approach to working together and our responsibilities to each other.

6.1 Wakefield's Integrated Care Partnership Operating Model is outlined below and describes how our priorities are aligned to our collaborative work with the West Yorkshire and Harrogate Health and Care partnership. The diagram below sets out our delivery model and how it will work, particularly in terms of local place our work across the Wakefield system by aligning to the work to support primary and community care.

Diagram 2



## 7.0 Revising our Integrated Care Terms of Reference

7.1 Wakefield have reviewed the previous terms of reference of the New Models of Care Board and made changes to these to reflect our system principles of ways of working together. Moving forward Wakefield will replace the New Models of Care Board with Wakefield's Integrated Care Partnership and this change of name is symbolic of our commitment to driving forward delivery of integrated care across our five priority areas. These revised terms of reference are outlined in appendix one of this document.

7.2 The proposed districtwide integrated care model is designed to dismantle divides and improve the co-ordination between separate groups of staff and organisations. It involves re-designing care around the health of the population, irrespective of existing institutional arrangements. It is about creating a new system of care delivery, supported by an effective and robust financial and business model. The partnership will develop an approach to share system level quality, performance and finance updates at our Integrated Care Partnership.

## 8.0 RECOMMENDATIONS

8.1 That the XXXX Board is recommended to:

1. Agree to sign up to the Wakefield Principles of Ways of Working Together document (appendix two)
2. Approve that your organisation will attend the Wakefield Integrated Care Partnership to drive forward Integrated Care (ICP Terms of Reference appendix one)



## Wakefield Integrated Care Partnership

### Terms of reference for the Wakefield Integrated Care Partnership

#### 1. Background

- 1.1. NHS Wakefield Clinical Commissioning Group, Wakefield Council, Mid-Yorkshire Hospitals NHS Trust, South West Yorkshire Partnership Foundation Trust, Turning Point, Spectrum Community Health CIC, VCS representation and General Practitioner Federations and other providers that deliver services that are in scope of the new model of care (the 'Parties') have agreed to move from a New Models of Care Board to developing a Wakefield Integrated Care Partnership.
- 1.2. The Wakefield Integrated Care Partnership is intended to facilitate development of an 'integrated care' system in Wakefield. The integrated care system is about integration and removing historical barriers that have prevented joined-up preventative patient care across primary, community, mental health, social care and acute services.
- 1.3. The Wakefield Integrated Care Partnership will act as a forum through which partners can reach decisions about the model of integrated health and care and to achieve these the Partnership will agree to sign up to Wakefield's Integrated Care Partnership System Principles of Working Together Document. This will help achieve a shared vision, together with agreement about how health and care services should be delivered across a whole.

#### 2. Values and Objectives

- 2.1. As system partners we will also sign up through our ICP principles of working together the following values in our dealings with each other:
  - Honesty
  - Integrity
  - Ambition
  - Mutual respect
  - Be bold
  - Develop unity
  - Deliver what we say

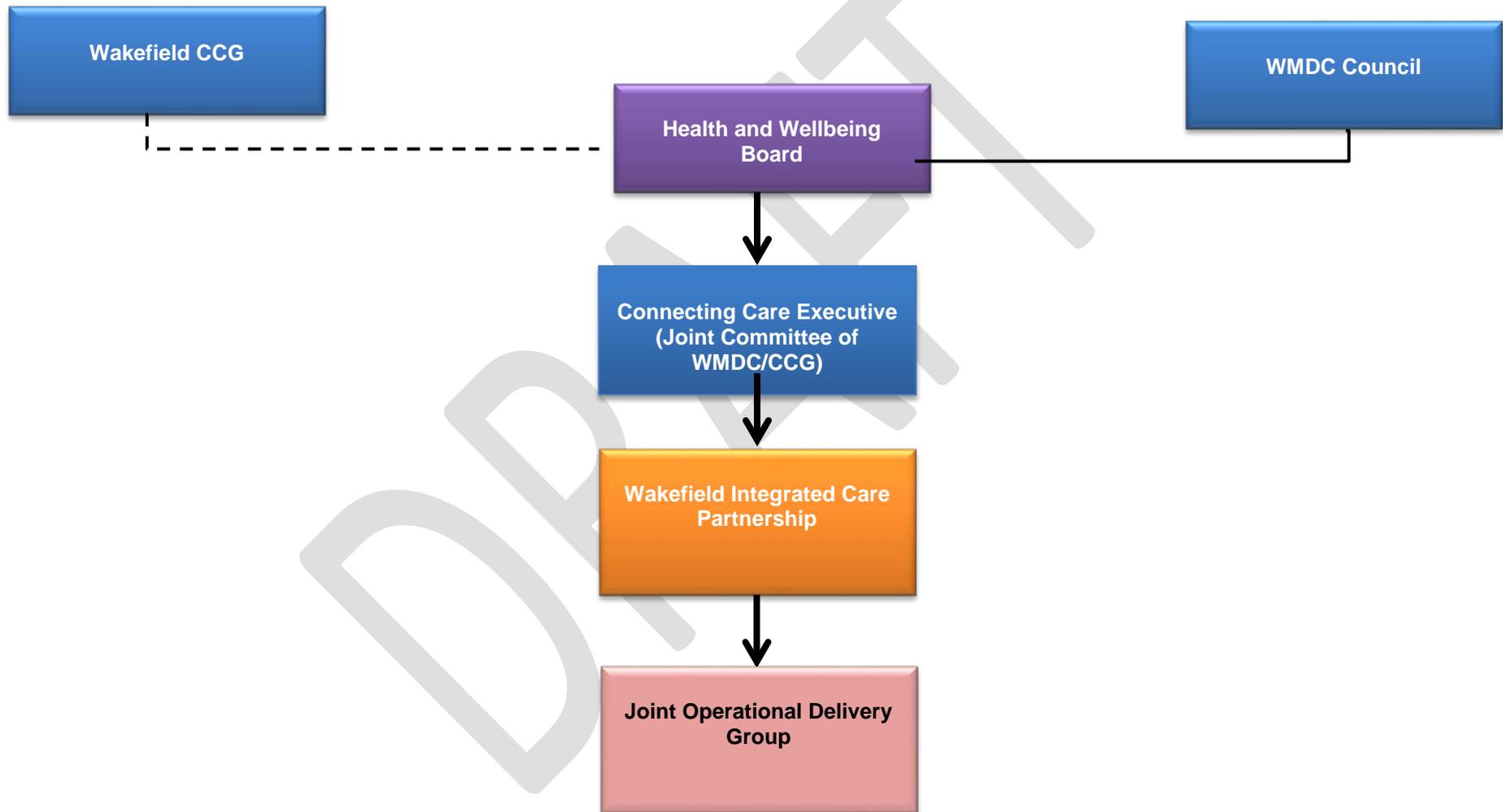
## 2.2. The Wakefield Integrated Care Partnership objectives will be:

- Provide strategic direction and leadership to ensure that the vision and objectives of the Integrated Care Partnership (ICP) are successfully delivered
- Drive the development and implementation of integrated care arrangements and work together on the most effective system and structural solutions to deliver them
- Adopt a collaborative approach to achieve greater flexibility, financial sustainability and system resilience
- Create an environment across the ICP participants which encourages and supports continuous improvement and innovation to deliver better care
- Adopt a robust and balanced approach to risk and opportunity
- Provide a 'collective' voice and response from the ICP for Wakefield's health, care & well-being challenges
- Oversee the governance arrangements under which the ICP will carry out its business
- Oversee the Connecting Care + Business Plan through a structured programme to ensure that ICP prioritised activity is shaped and delivered on time, within agreed resource and to the required quality/outcomes
- Actively champion and support the wider Wakefield 'place agenda' ambitions; being an active part of providing the right solutions for our local population
- Actively engage with and influence West Yorkshire and Harrogate Health and Care Partnership Integrated Care System
- Shape a system wide Organisational Development strategy which will enable organisations, groups and individuals to embrace new approaches to organisational, clinical and financial governance; along with developing a contemporary workforce capable of responding to existing and new challenges

## 3. Governance Structure

3.1. The diagrams below outline the proposed governance structure supporting the Wakefield Integrated Care Partnership:

## Wakefield Place Governance Arrangements





3.2. The Wakefield Integrated Care Partnership has no authority to bind any partner against its will. Each of the partner representatives will have appropriate delegated authority from their relevant organisation in order to make decisions which bind that partner (in line with 5.2). It is recognised however that some decisions will need to go through each sovereign organisation for approval in line with its governance arrangements in order for decisions to be made. Where this is the case these will be agreed with partners.

#### 4. Responsibilities

- 4.1. The Wakefield Integrated Care Partnership takes forward the agreed priorities of the Wakefield Health and Wellbeing Board and drives forward the strategic leadership required to achieve health and care integration for the Wakefield system.
- 4.2. The Wakefield Integrated Care Partnership will:
- 4.3. Provide mutual assurance to the Parties through regular reports from the Wakefield Integrated Care Partnership to the boards / governing bodies of the Parties, these will include finance, quality, safety and risk management.
- 4.4. Support the new model of care outcomes which will be developed as part of the Quality, Outcomes and Performance Framework.

- 4.5. Review progress and guide the Wakefield Integrated Care Partnership towards the overall agreed objectives and benefits.
- 4.6. Ensure the delivery of all aspects of Wakefield Integrated Care Partnership to the appropriate levels of quality, time and budget, in accordance with the agreed implementation plan and governance arrangements.
- 4.7. Ensure all risk is assessed and assure that mitigating actions are in place.
- 4.8. Adopt the dispute resolution process outlined in appendix 1 of these terms of reference.
- 4.9. In compliance with all relevant law and guidance determine the standards for clinical service and helping develop working practices that achieve them effectively.

## 5. Membership

- 5.1. The voting membership shall comprise of the following Representatives:

<b>Organisation</b>	<b>Title</b>
End Of Life Steering Group	Chief Executive representative
NHS Wakefield Clinical Commissioning Group	Chief Officer
NHS Wakefield Clinical Commissioning Group	Commissioning Director for Integrated Care
Wakefield Council	Corporate Director, Adults, Health & Communities
Wakefield Council	Director Public Health
Mid-Yorkshire Hospitals NHS Trust	Chief Executive
Mid-Yorkshire Hospitals NHS Trust	Director Community Services
South West Yorkshire Partnership NHS Foundation Partnership Trust	Chief Executive
South West Yorkshire Partnership NHS Foundation Partnership Trust	Director Provider Development
Connecting Care Clinical Lead Chairs of the five federations or PCH nominated representatives TBC: Brigantes Healthcare United Health Wakefield Alliance Trinity Health Group Limited Five Towns Health West Wakefield Health & Wellbeing	Dr Ann Carroll (Chair)  Chair Chair Chair Chair Chair
Turning Point	Managing Director
Representative for the Voluntary and Community Sector (nominated by NOVA).	Chief Executive (Nova)
Spectrum Community Health CIC	Chief Executive
Wakefield District Housing	Chief Executive
Age Uk Wakefield	Chief Executive

- 5.2. Organisation representatives may invite such other persons to attend meetings as agreed by the Chair.
- 5.3. No such persons invited to attend meetings shall be able to vote on a matter.
- 5.4. In addition to the members listed above the following individuals will be invited to be in attendance at meetings of the Wakefield New Models of Care Board:

<b>Organisation</b>	<b>Title</b>
Wakefield Council	Director of Integrated Care
Wakefield District Housing	Associate Director – Health, Housing and Transformation

**6. Frequency and notice of meetings**

- 6.1. Meetings shall be held monthly or other such frequency as agreed by the Parties.

**7. Quorum**

- 7.1. Meetings of the Wakefield Integrated Care Partnership shall be quorate when representatives from 75% or more of the Parties are present, including a representative from at least one partner organisation, one GP federation, NHS Wakefield Clinical Commissioning Group and Wakefield Council. This is subject to the members present being able to represent the views and decisions of the participants normally represented by their Board members who are not present at the meeting. The Chair will seek to ensure that any lack of consensus is resolved amongst members.
- 7.2. If a member is unable to attend a meeting of the Integrated Care Partnership, it will be the responsibility of the organisation to send a deputy (a "Deputy") on their behalf. Where an organisation sends a Deputy to take the place of the representative, the references in these Terms of Reference to representatives shall be read as references to the Deputy. The parties must ensure that the Deputy attending a meeting of the Wakefield Integrated Care Partnership has sufficient seniority and sufficient understanding of the issues to be considered to represent their organisation effectively. Deputies will be eligible to vote.

**8. Voting**

- 8.1. Section 5.1 outlines all voting membership of the ICP and for clarity members outlined in attendance in 5.4 are not voting members of the partnership.
- 8.2. The Parties acknowledge that there needs to be unanimity across all representatives in attendance in order for decisions to be determined.
- 8.3. Where unanimity is not reached, the parties agree that the matter will be referred to dispute resolution in accordance with the dispute resolution process outlined in appendix 1 of these terms of reference if the Chair is unable to reach a consensus.

## **9. Chair**

- 9.1. The Wakefield Integrated Care Partnership will formally appoint the Chair and Deputy Chair roles at the first Board meeting. The Board, as part of a committee effectiveness process will review the effectiveness of the partnership annually.
- 9.2. Nominations for the Chair and Deputy Chair roles must meet the following criteria:
  - 9.2.1. Supported by all member partners of the Integrated Care Partnership within Wakefield district.
  - 9.2.2. Supported by all commissioners within Wakefield district.

## **10. Sub-Groups**

- 10.1. The Wakefield Integrated Care Partnership may establish groups to support it in its role. The scope and membership of those groups will be determined by the Wakefield Integrated Care Partnership.

## **11. Administration**

- 11.1. The Programme Lead for Wakefield Integrated Care Partnership will be responsible for ensuring that the Board has all the administrative and programme support and advice that it requires.
- 11.2. NHS Wakefield Clinical Commissioning Group shall provide administrative support and advice including but not limited to:
  - 11.2.1. taking the minutes and keeping a record of matters arising and issues to be carried forward;
  - 11.2.2. advising the representatives as appropriate on best practice, national guidance and other relevant documents

## **12. Reporting**

- 12.1. The minutes of the ICP will be agreed by the Chair and circulated to all members for approval and ratification.
- 12.2. Minutes will be circulated to the parties' boards / governing bodies, except where, at the Chair's discretion, parts need to be redacted or withheld for reasons of commercial sensitivity or personnel confidentiality.
- 12.3. Reports and papers will be circulated a week in advance of the meeting. verbal reports will be accepted only on an exceptional and / or urgent basis and where agreed with the Chair prior to the meeting.
- 12.4. It will be the responsibility of individual members from each organisation to ensure any key decisions which require approval of their organisations Board is shared and shared through their internal governance process. The

Integrated Care Partnership will ensure that reasonable time is provided to enable organisations to undertake this.

### **13. Special Meetings**

- 13.1. Special meetings of the Wakefield Integrated Care Partnership on any matter may be called by any of the parties acting through its representative by giving at least forty-eight (48) hours' notice by e-mail to the other representatives in the following circumstances:
  - 13.1.1. where that Organisation has concerns relating to the safety and welfare of service users under a service contract;
  - 13.1.2. in response to a quality performance or financial query by a regulatory or supervisory body (including but not limited to NHS England, NHS Improvement and the Care Quality Commission);
  - 13.1.3. to convene a dispute resolution (rectification) meeting (the process is outlined in appendix 1 of this terms of reference.
  - 13.1.4. for the consideration of any matter which that Organisation considers of sufficient urgency and importance that its consideration cannot wait until the date of the next meeting.

### **14. Conflicts of Interest & Conduct**

- 14.1. Each representative and those in attendance at meetings will abide by the 'Principles of Public Life' and the NHS Code of Conduct, and the Standards for members of NHS boards and governing bodies, Principles of the Citizen's Charter and the Code of Practice on Access to Government Information.
- 14.2. Each Representative must abide by all policies of the organisation it represents in relation to conflicts of interest.
- 14.3. Where any representative has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that representative may participate and/or vote in meetings (or parts of meetings) in which the relevant matter is discussed. Where a decision is taken by the Chair to exclude a representative as a result of a declaration of interest, the relevant organisation may send a Deputy to take the place of the conflicted representative in relation to that matter, should this be appropriate. It will be the decision of the Chair on how the conflict will be managed.

### **15. Approval and Review**

- 15.1. These terms of reference have been approved by each of the Parties and are effective from 1<sup>st</sup> May 2019.
- 15.2. These terms of reference will be reviewed by end April 2020 and bi-annually thereafter.

Date Developed: 1<sup>st</sup> May 2019

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## Appendix 1

### ICP DISPUTE RESOLUTION PROCEDURE

#### 1. Avoiding and Solving Disputes

1.1 We commit to working cooperatively to identify and resolve issues to Our mutual satisfaction so as to avoid all forms of dispute or conflict in performing our obligations under our ICP arrangements.

1.2 We believe that :

- (a) by focusing on our agreed ICP Objectives and Principles;
- (b) being collectively responsible for all risks;

we will reinforce our commitment to avoiding disputes and conflicts arising out of or in connection with Our ICP.

1.3 We shall promptly notify each other of any dispute or claim or any potential dispute or claim in relation to Our ICP (each a '**Dispute**') when it arises.

#### 2.

2.1 In the first instance the JODG shall seek to resolve any Dispute to the mutual satisfaction of each of Us. If the Dispute cannot be resolved by the JODG within 10 Business Days of the Dispute being referred to it, the Dispute shall be referred to the ICP Partnership Board for resolution.

#### 3.

3.1 The ICP Partnership Board shall deal proactively with any Dispute on a Best for Service basis in accordance with this Agreement so as to seek to reach a unanimous decision. If the Partnership Board reaches a decision that resolves, or otherwise concludes a Dispute, it will advise Us of its decision by written notice. Any decision of the Partnership Board will be final and binding on Us.

#### 4.

4.1 We agree that the Partnership Board, on a Best for Services basis, may determine whatever action it believes is necessary including the following:

- (a) If the ICP Partnership Board cannot resolve a Dispute, it may select an independent facilitator to assist with resolving the Dispute; and
- (b) The independent facilitator shall:
  - i. be provided with any information he or she requests about the Dispute;
  - ii. assist the ICP Partnership Board to work towards a consensus decision in respect of the Dispute;
  - iii. regulate his or her own procedure and, subject to the terms of the terms of reference for the ICP, the procedure of the Partnership Board at such discussions;
  - iv. determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Business Days of the independent facilitator being appointed; and
  - v. have its costs and disbursements met by the Commissioner Participants.

- vi. If the independent facilitator cannot facilitate the resolution of the Dispute, the Dispute must be considered afresh in accordance after such further consideration again fails to resolve the Dispute, the ICP Partnership Board may decide to:
- vii. terminate the ICP priority or work stream: or
- viii. agree that the Dispute need not be resolved but that the ICP are comfortable that the ICP priority work stream can continue with a refreshed focus.

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# WAKEFIELD INTEGRATED CARE PARTNERSHIP

## SYSTEM PARTNERSHIP PRINCIPLES OF WAYS OF WORKING TOGETHER

### Between Partners in the Wakefield Integrated Care Partnership

#### 1. Purpose and Scope of these PRINCIPLES OF WAYS OF WORKING TOGETHER

The integration agenda in Wakefield is responding to consistent messages from our citizens who have told us that they want:

- to be supported to stay well;
- to receive coordinated care designed around them;
- to have care delivered close to home;
- to feel connected to their local community and maintain good social networks; and
- to feel like a valued individual.

A 'whole Life Course' approach will be adopted to address these expectations and to deliver the vision and integration strategy set out in this document. This document describes the ways we will work together to establish a framework for collaboration between all the partners in the Wakefield Integrated Care Partnership. They will evolve over time and in the light of experience of working together.

Our system has a shared commitment of partners to **co design and re-shape the way the whole system operates** and the cultural shifts that partners have signed up to; **the way we think and do things in Wakefield**.

#### 2. Our Ambition

Communities in Wakefield District achieve the best possible outcomes for themselves and their families, facilitated by coordinated services provided as close to home as possible.

#### 3. Values and Principles

The principles underpinning our approach to integration are:

Prevention	Partnerships	Personalisation	Evidence	Innovation	Population Health
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These principles will **drive the way we think and do things in Wakefield**.

As system partners we will also sign up to living the following values in our dealings with each other:

Honesty  
Integrity  
Ambition  
Mutual respect  
Be bold  
Develop unity  
Deliver what we say

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## 4. Our Commitments

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### 4.1 Integrating Our Service Models

- A focus on **prevention, personalisation and population health management**; providing accessible information to enable people to make informed decisions.
- Using **evidence** and **innovating** in the development of social and clinical models of care;
- Deliver integrated service models that reflect the intentions of the priorities that are driven by our Wakefield Wakefield Health and Wellbeing Board and HWB Strategy and in line with new national policy frameworks and legislative changes,
- Listening to the views of **ALL** stakeholders across the Wakefield Health and Care system,
- **Evidence** from robust patient and public involvement;
- Providing health and social care services, as close to where people live as possible where it makes sense to do so
- Tackling health inequalities and addressing the wider determinants of health
- Supporting independent living and facilitating or enabling self-care
- Ensuring our integrated care models take into account cost effectiveness and value for money

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### 4.2 The way we work together across our system

- We will **support** each other and work collaboratively
- We assume **good** intentions
- We will **implement** our shared priorities and decisions, holding each other mutually accountable for delivery and ensure our organisations develop **mutual respect** for all our organisations to ensure that the Integrated Care Partnership delivers what we say we will do together
- We will ensure **co-production** of models of care across the system is at the heart of the way we operate together;
- We will ensure we have services that deliver against **evidence** based outcomes and which demonstrate effective **prevention** as well as **personalisation** of services;
- Wakefield will achieve a **vibrant** and diverse provider market including the voluntary sector and small businesses;
- We will make investment decisions transparently **together** that optimise outcomes for our community in Wakefield to ensure that the Integrated Care Partnership can make Wakefield a better place to live and work. Citizens and partner organisations will be able to see how the Wakefield pound is being spent;
- We will create a pro-active and dynamic Integrated Care Partnership; creating an environment and model of operation that underpins clarity of purpose, **constructive challenge**, embracing innovation, robust & secure decision making, collective ownership
- Make 'every contact count' when our workforce is engaged with the public, sharing consistent messages.

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### 4.3 Objectives of the Integrated Care Partnership

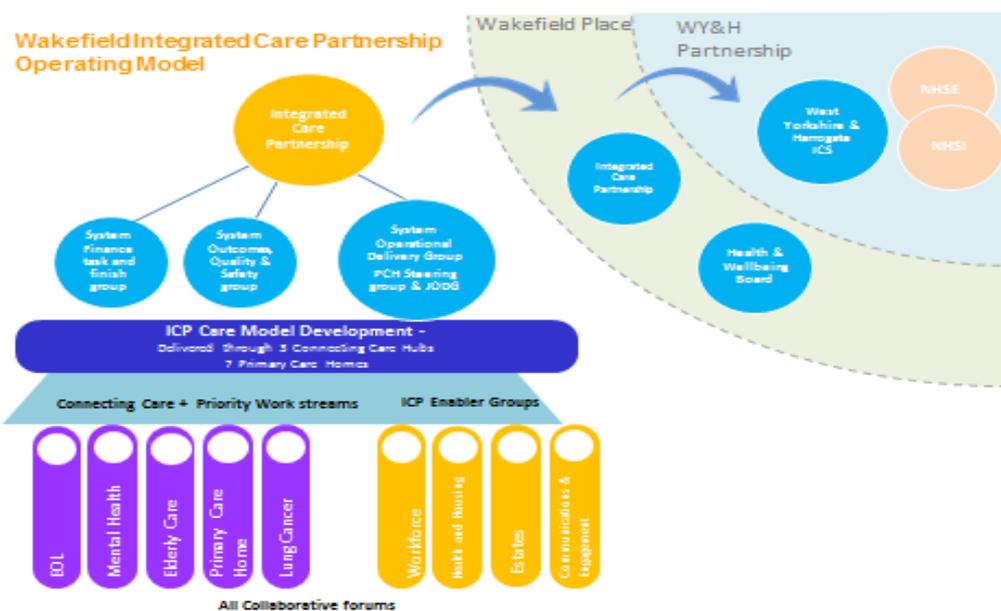
- Provide strategic direction and leadership to ensure that the vision and objectives of the Integrated Care Partnership (ICP) are successfully delivered
- Drive the development and implementation of integrated care arrangements and work together on the most effective system and structural solutions to deliver them
- Adopt a collaborative approach to achieve greater flexibility, financial sustainability and system resilience
- Create an environment across the ICP participants which encourages and supports continuous improvement and innovation to deliver better care
- Adopt a robust and balanced approach to risk and opportunity
- Provide a 'collective' voice and response from the ICP for Wakefield's health, care & well-being challenges
- Oversee the governance arrangements under which the ICP will carry out its business

- Oversee the Connecting Care + Business Plan through a structured programme to ensure that ICP prioritised activity is shaped and delivered on time, within agreed resource and to the required quality/outcomes
- Actively champion and support the wider Wakefield 'place agenda' ambitions; being an active part of providing the right solutions for our local population
- Actively engage with and influence West Yorkshire and Harrogate Health and Care partnership Integrated Care System
- Shape a system wide Organisational Development strategy which will enable organisations, groups and individuals to embrace new approaches to organisational, clinical and financial governance; along with developing a contemporary workforce capable of responding to existing and new challenges

#### 4.5 Leadership and Development of our Organisations / the Whole System

- Valuing our workforce and nurturing a sense of pride in working in Wakefield;
- **Innovation** in the use of technologies to drive improvement and efficiency;
- Being creative in the use of our assets including buildings and facilities;
- Providing space for people to explore together new and innovative ways of working
- Delivering **innovative** and transformational change through whole system leadership;
- Providing organisation and system development support across the system, respecting the unique identities of **partner** organisations;
- Supporting our people and those that deliver services in Wakefield, to continually improve the services provided; undertake shared analysis of problems and issues, creating a supportive, developmental environment for them to work in;
- To avoid duplication of systems, processes and work

#### 4.6 Wakefield's Operating Model



## 5 Parties

The founding parties to this document are listed as follows but it should be noted that the ICP is inclusive and so this list marks a point in time only and in no way excludes other organisations.

- Wakefield Metropolitan District Council
- Mid Yorkshire Hospitals NHS Trust

- NHS Wakefield Clinical Commissioning Group
- Nova Wakefield District (representing vibrant VCS in Wakefield)
- Turning Point
- South West Yorkshire Partnership NHS Foundation Trust
- Spectrum Community Health CIC
- Age UK Wakefield
- Wakefield Hospice (representing Hospices across Wakefield)
- Wakefield Metropolitan District Council
- Wakefield District Housing
- Wakefield General Practice Federations/ 7 Primary Care Homes (to be advised by GP partners)
- Conexus Healthcare Limited

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## 6 Responsibilities

The division of responsibilities will be based on the following guiding principles:

Accountability	Each partner organisation Board (or equivalent) will be accountable for its actions and the services it delivers;
Transparency	Commissioners, regulatory authorities and the public must know who is responsible for what;
Openness	Each organisation will commit to sharing information this may be clinical, operational, financial and staffing information necessary for the planning and delivery of safe, high quality and sustainable services;
Co-operation	Organisations will work closely with each other and those other stakeholders who are not party to the Business Rules where relationships / interdependencies are relevant to the delivery of the Business Rules.

Individual Partner Organisations will be individually responsible for:	Jointly the partner organisations will be proportionately responsible and accountable for:
<ul style="list-style-type: none"> <li>▪ Discharging the responsibilities of their organisation including their service, fiduciary, regulatory, corporate and clinical governance and statutory responsibilities;</li> <li>▪ Ensuring that the organisation adopts the principles and values set out in section 3;</li> <li>▪ Reporting on progress to the Health and Well Being Board via the Integrated Care Partnership and others as required.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Preparation and delivery of detailed plans for integrated models of service;</li> <li>▪ Putting in place the programme management arrangements to support robust delivery of agreed delivery plans;</li> <li>▪ Ensuring effective clinical and professional leadership;</li> <li>▪ Identifying and securing the resources required to deliver the programme management arrangements;</li> <li>▪ Reporting on progress to the Health and Well-being Board.</li> </ul>

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## 7 Governance Arrangements

Appendices 1 sets out the terms of reference the Integrated Care Partnership (our health and care system governance framework) showing the key relationships and accountability arrangements including points for escalation (for decision making and issue resolution). This shows the Wakefield Health

and Well Being Board having overall responsibility for driving forward integration across Wakefield and holding the system to account for delivery of agreed plans.

The Health and Well Being Board will be supported in their work by the Integrated Care Partnership which will be the “engine room” driving integration and ensuring agreed actions are delivered through a robust programme management approach.

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## 8 The Period

These will be operative from May 2019 and will be reviewed annually as a minimum by the partner organisation CEOs/ Chief Officers. It is proposed the terms of reference and these principles are reviewed initially in November 2019 as there are some partner discussions needed to determine representation for example for primary care moving forward.

Progress in the application will be monitored by the Integrated Care Partnership and progress will be reported to the Boards (or equivalent) of each partner organisation and the Health and Wellbeing Board.

Revised May 2019

WAKEFIELD INTEGRATED CARE PARTNERSHIP  
 PRINCIPLES OF WAYS OF WORKING TOGETHER

The following are co-signatories to this document which support delivery of the Wakefield Integrated Care Partnership

Partner	Title	Signature
Turning Point	Fiona Ritchie	
GP Federations or Seven Primary Care Homes -TBC		
		Conexus Healthcare Limited, Managing Director, Antony Nelson
Mid Yorkshire Hospitals NHS Trust	Martin Barkley CEO Mid-Yorkshire NHS Hospital Trust	
NHS Wakefield Clinical Commissioning Group	<i>chief officer</i> Jo Webster	
Nova Wakefield District	Chief Executive Officer Ian Cockerill	

Partner	Title	Signature
Turning Point	Fiona Ritchie	
South West Yorkshire Partnership NHS Foundation Trust	CHIEF EXECUTIVE Rob Webster	
Spectrum Community Health CIC	Dr Linda Harris Chief Executive	
Wakefield Age UK	Chief Executive Paula Bee	
Wakefield Council	Corporate Director Adults, Health & Communities	
Wakefield and District Housing	Kevin Dodd, Chief Executive	
Wakefield Hospice (representing Hospices across Wakefield)	Tina Turner, Wakefield Hospice	

Date.....May 2019.....

## Trust Board 25 June 2019 Agenda item 8.1

<b>Title:</b>	<b>Communications, engagement and involvement update – December 2018 to June 2019</b>
<b>Paper prepared by:</b>	Director of strategy Acting head of marketing, communications and engagement
<b>Purpose:</b>	This report provides an update on communication, engagement and involvement activity in the past six months, mid-December to mid-June.
<b>Mission/values:</b>	<p>Communication and engagement is an important part of making sure that our staff, service users, carers and stakeholders are informed and involved in what we do. This supports our value of putting people first and in the centre, encouraging openness and transparency, and helping to demonstrate that people matter.</p> <p>Our communication channels are designed to provide information and updates on Trust developments and activity. Our campaigns encourage cultural change to bring about improvement. This supports our Trust objective of being outstanding and ready for tomorrow.</p>
<b>Any background papers/ previously considered by:</b>	The communication, engagement and involvement strategy 2016-2019 was approved by Trust Board and regular updates on the delivery of key objectives outlined in the strategy are provided as part of the IPR. This strategy will be reviewed in December 2019.
<b>Executive summary:</b>	<p>Key updates include:</p> <p>Communications and marketing:</p> <ul style="list-style-type: none"> <li>➤ Comms survey results - survey was completed by 560 staff (compared to 334 in 2017/8) and showed an increase in satisfaction rates. 88% of respondents said they felt they were kept up to date with what is happening across the Trust (a 31% increase in three years); and 80% felt positive about the way we communicate and engage (up 35% in three years).</li> <li>➤ Increase in digital communications, including achieving over 6,000 followers on Twitter and 38,000 visits to our website in the past two months.</li> <li>➤ #allofus staff wellbeing campaign won a HSJ Value award for most innovative and creative campaign.</li> <li>➤ Insight-led flu campaign, contributing to achievement of Trust CQUIN target. We won a national Flu Fighter award for most innovative communications campaign.</li> <li>➤ We launched the MySWYFT staff app aimed at those that do not have access to Trust information every day. Feedback has been positive with over 200 people subscribing so far.</li> </ul>

- #allofusimprove - supported launch of new improvement toolkit and refreshed i-hub. Included new intranet section full of improvement resources, as well as key messages shared through all routine internal comms channels. Promotion of IHI training and the improvement champions scheme.
- SystemOne for mental health - comms post go-live included directing staff to helpful resources, sharing system updates and promoting CQC SystemOne support. Ongoing comms support being provided.
- Leading on the co-development of a partnership communication campaign with Barnsley Hospital, the CCG and GP Federation to promote alliance working and partnership working successes. Film on the learning from the Dearne pilot has been produced.

Engagement and involvement:

- Supporting a series of leadership and staff engagement activities including supporting the nursing directorate to develop an approach for CQC briefings, HR events around making the Trust a great place to work meeting with over 500 people to date, and developing and supporting the senior leadership engagement plan.
- Director listening events arranged in all BDU areas for June and July, along with director walkabouts in areas identified through the staff survey as wanting more director contact.
- Volunteer services have had an increase in the past year of 29% in the number of volunteers, now totalling 260. This equates to 34,164 hours per year. A volunteer celebration event held was held in Wakefield to coincide with volunteer week. 55 volunteers attended the celebration, each receiving a Trust thank you card. The annual volunteer awards were presented also.
- Working with West Yorkshire and Harrogate Partnership on learning disability services and the development of ATUs. We are also involved in the West Yorkshire Mental Health and Learning Disabilities Collaborative comms and engagement Network, and are supporting a joint programme of activity on LD service user engagement, and health population work.
- Ongoing engagement with communities around older people's transformation. This has focused on people with protected characteristics, including the LGBTQ+, African Caribbean and Sikh communities.
- Community events held in Barnsley, Calderdale, Kirklees and Wakefield as part of the Equality Delivery System assessment (EDS2). This focused on older people's transformation.

More information is provided in the full report.

	<b>Risk appetite</b> The delivery of the communication, engagement and involvement strategy supports the management of key organisational risks related to workforce, stakeholder relationships, partnership working and supporting change and improvement efforts across the Trust.
<b>Recommendation:</b>	<b>Trust Board is asked to NOTE the update.</b>

## Communications, engagement and involvement update for Trust Board December 2018 - June 2019

### Introduction

This highlight report provides a summary of the communication, engagement and involvement activity over the past six months. The update links to the main aims of the communication, engagement and involvement strategy 2016-19, which will be reviewed in December 2019.

We will increase awareness of our services, promote the organisation as a leader in the system and develop and maintain our positive reputation

### Support to services

- Supporting the launch of the [forensic outreach liaison service](#) with key messages, digital leaflets and a service directory page on our website. Promoting training for community staff to improve links with forensic services.
- [Adel Beck Secure Stairs](#) project with communications/engagement support and advice for team management to disseminate key project messages.
- [Neuro rehab unit marketing](#) materials developed and correspondence to promote available beds in the ward. Producing marketing materials for the [neurological rehabilitation service](#) open day.
- [Learning disability services](#) - support in relation to supervision, 100 years of LD nurses celebration, and marketing of Horizon beds.
- Support to the '[Thriving after surviving](#)' [safeguarding conference](#) and promoting national safeguarding campaigns.
- Project plan being developed for the [Unity Centre](#) opening in October. Films being developed with Deadline Digital showing the build progress. Development of a [roadmap](#) of estates investment across all our BDUs.
- Developing a film to promote the [autism friendly environments](#) training.
- Providing support to the nursing directorate for the [CQC](#) inspections. Promotion of CQC engagement events. Infographics produced. Well led presentation produced.
- Support for the changes to [stroke pathway in Barnsley](#), including regular updates to staff via newsletter.
- Promotion of [Calderdale memory service accreditation](#), working with Calderdale CCG.
- Comms and design support for the [Calderdale arts and health report](#) "Living a larger life".
- Launch of the [pharmacy and medicine optimisation strategy](#), including an infographic summarising the main points, and pharmacy staff stories.
- Support to our [recovery colleges](#), producing marketing materials and promoting their courses and workshops.

### Promoting the organisation as a leader in the system

- [Leading on the co-development of a partnership communication campaign](#) with Barnsley Hospital, the CCG and Local Authority to promote alliance working and partnership working successes. Film on the learning from the Dearne pilot has been produced.
- Working with [Barnsley partners](#) to provide support to the Barnsley children's vaccination and immunisation team after they achieved the best immunisation results in the region. This resulted in coverage with the Barnsley Chronicle and CCG funded Facebook advertising.



- Active supporters of the [West Yorkshire and Harrogate Health and Care Partnership](#) with the ‘Our Neighbours’ campaign, including hosting the launch event for phase two in the Mental Health Museum. Production of case studies highlighting mental health improvements (AI suicide prevention, Live Well Wakefield, recovery colleges, perinatal mental health).
- Active lead in the [Mental Health and Learning Disabilities Collaborative](#).
- Engagement with the [South Yorkshire and Bassetlaw ICS](#).
- Leading role in the development of a [Kirklees wide partnership communication and engagement](#) network. Shared strategy is currently being developed.

All staff and stakeholders will have access to relevant information so that they feel well informed

**Staff information**

- [Core comms channels](#): The Headlines, The Brief and The View. Our Year report and is currently being finalised.
- [Staff survey results comms](#) - including intranet section, and infographic. Survey was completed by 560 staff (compared to 334 in 2017/8) and showed an increase in satisfaction rates. [88% of respondents said they felt they were kept up to date with what is happening across the Trust \(a 31% increase in three years\); and 80% felt positive about the way we communicate and engage \(up 35% in three years\)](#). A summary of the survey can be found in appendix 1.
- Insight-led [flu campaign](#), contributing to achievement of Trust CQUIN target. We won a national Flu Fighter award for most innovative communications campaign.
- [#allofus staff wellbeing campaign won a HSJ Value award](#) for most innovative and creative campaign.

**Stakeholder information**

- [Proactive news sharing](#), along with coverage of support available from IAPT and recovery colleges, our high flu vaccine uptake in Barnsley schools, the nursing associates celebration event, apprentice awards and winter pressure successes.
- [Social media support for awareness/campaigns](#) including Dementia Action Week, Mental Health Awareness Week, National Day for Staff Networks, stop smoking days, Calderdale Vision 2024 and International Nurses Day.
- [Christmas countdown](#) on social media which generated excellent staff engagement (particularly on Facebook), plus coverage of Christmas activities.
- Promotion of [Members’ Council elections](#)
- Updating [appraisal](#) documentation to prepare for appraisal window.

**Service development**

- Support to [EyUp!](#) through promoting and supporting a Christmas campaign, the Christmas fayre and other events, and with fundraising manager recruitment. Development of internal and external infographic posters summarising the successful bids for 2018-19 - ‘Where has the money been spent?’
- [174 design jobs](#) were completed between December to May including SystmOne posters, service leaflets and posters for intermediate care, IAPT and pulmonary rehab, marketing materials for EyUp!, Barnsley and Kirklees IAPT leaflets, Yorkshire Smokefree materials, recovery college prospectuses and banners, pharmacy strategy infographic, and freedom to speak up guardian posters and banners.
- [Week long Trustwide photo shoot](#) to support development of recruitment marketing and social media. Photos are now being used as part of our recruitment campaign and in Trust marketing materials.

- Support and involvement in [Brexit](#) planning.

### Digital marketing and communication update

Latest digital statistics:

- [37,905 visits to our website](#) (74% of which were new visits) resulting in 132,382 page views. The most clicked web links from our social media pages were our Barnsley TB nurse becoming regional lead; nurse flies high to mark anniversary of baby daughter's passing; and the Police Superintendent's commendation for liaison and diversion lead.
- We have [increased our Twitter followers to hit our 6k](#) follower mark with 6,041; an increase of 163 from the previous period. 225,000 people saw our tweets in April and May - an average of 3,700 per day. We picked up 548 link clicks to the website in this period.
- On [Facebook](#), we've had [4,127 post engagements](#) (likes, comments, shares) and 10,343 people saw our posts. We gained 52 new likes.
- We have [2,127 followers on LinkedIn](#), an increase of 78 which resulted in 3,800 post engagements.

We completed the website [accessibility testing](#) and reviewed the finding which included three hours of footage of people navigating our website scenarios. We developed an improvement plan and we are working to implement by the end of June.

Work continues on scoping and creating a paper for Trust Board outlining the requirements for what a [new intranet](#) would look like. Extended support for the current platform ends in October 2020. Work on stabilising the current build of the intranet has been successful with colleagues from HR reporting and IT working to maintain the current service level and making minor fixes. This has saved £5K in support costs next year. This however still leaves us with an unsupported platform and we have updated the business continuity papers to emphasise this.

- We launched the [MySWYFT](#). Staff app aimed at those that do not have access to Trust information every day. So far feedback has been good but more work is being done to increase awareness in order to reach the 25% of staff members that told us they never access a Trust computer.
- We worked with [Barnsley speech and language therapy](#) to implement a new resource library on their section of the website which will allow schools and parents to search for practical resources and download in order to help with their child's individual needs.
- We are working on a suite of improvements to support [Barnsley IAPT](#) increase their presence in Barnsley and make people more aware of their services. The initial website launch has been a big success but now we are looking at the next stage of improvements. Kirklees IAPT website was developed last year. Ongoing support is being provided.

**We will develop an effective and inclusive approach to give people**

### Staff

- [Scoping and developing an approach to staff engagement](#). Supporting the nursing directorate to develop an approach for CQC briefings, HR events around workforce wellbeing meeting with over 500 people, and exploring an approach to senior leadership engagement.

**voice and opportunities to contribute to the organisation, our services, and plans for the future**

- [Director listening events](#) arranged in all BDU areas for June and July, along with director walkabouts in areas identified through the staff survey as wanting more director contact.
- [Staff networks](#). Leading development of the [BAME](#) staff network and supporting the building leadership for inclusion action research with the Tavistock institute. We are helping to raise the profile through development of lunch and chat sessions and case studies. Support also being given to the [LGBTQ+](#) and [disability](#) networks as they establish themselves and set their scope.

**Service users/ carers and community engagement**

- [Community Transformation Review](#). Leading and supporting approach to staff engagement, review and analysis, and reporting of feedback. Trustwide focus groups and drop in sessions have been held as part of the 'one year on' review. Surveys have also been carried out with service users and carers. The feedback is currently being analysed.
- Ongoing engagement with communities around [older people's transformation](#). This has focused on people with protected characteristics, including the [LGBTQ+](#), African Caribbean and Sikh communities.
- Community events held in Barnsley, Calderdale, Kirklees and Wakefield as part of the [EDS2 assessment](#) (Equality Delivery System). This focused on older people's transformation.
- Public engagement for the [perinatal mental health service](#), to raise awareness of the new service.
- Revised the [commitment to family friends and carers](#). Ongoing support to the [Kirklees Carers' Forum](#), including hosting their meetings in Folly Hall. Regular attendance and support to the Forum is provided by the Kirklees carers' development officer, and general manager for rehab and recovery.
- Targeted engagement in North Kirklees [promoting breast cancer awareness](#) for women with learning disabilities.
- Providing an open dialogue with services for the [Saharra Women's Emotional Wellbeing Group](#), raising awareness around recovery and sharing their journeys and perspective.
- Engagement with the [Barnsley deaf community](#) to raise awareness of our services and help identify potential barriers to access.
- [Transgender awareness session](#) held in Barnsley to address local issues and ensure lessons learned.
- Working with Yorkshire MESMAC to raise awareness of mental health services within the [LGBTQ+ community](#), specifically focused on Wakefield.
- [My recovery survey](#) carried out as part of the mental health service review CQUIN.
- [Compassion Hub held in Kirklees](#) in May, an informal special interest group which brings together people with an interest in the field of compassion. It is led by Spirit in Mind.

**Stakeholders**

- [Stakeholder engagement analysis](#) being carried out, which will then be developed into a stakeholder strategy and action plan. Trustwide [prospectus](#) being developed which will be used to inform stakeholders about the Trust and what our offer is in each area.
- [Co-ordinating engagement briefings](#) for EMT colleagues in advance of Overview and Scrutiny and Health and Wellbeing Board meetings and with local MPs. [MP meetings](#) included Mary Creagh, Paula Sherriff, Andrea Jenkyns, and Craig Whittaker. Joint NHS Leaders and MPs meeting supported.



- [MP Parliamentary Awards](#) nominations submitted by Andrea Jenkyns and Mary Creagh
- [Mental Health First Aid Training](#) preparation for MP researchers, taking place on 15 and 22 July.
- [Scoping and developing an approach to staff engagement](#). Supporting the nursing directorate around CQC briefings and exploring an approach to senior leadership engagement
- [Working with West Yorkshire and Harrogate Partnership](#). We are actively involved in engagement activity relating to learning disability services and the development of ATUs. We are involved in the [West Yorkshire Mental Health and Learning Disabilities Collaborative](#) comms and engagement network, and are supporting a joint programme of activity on LD service user engagement, and health population work. Taking a leading role in suicide prevention work.

**Volunteer service**

- [Volunteer services](#) – without proactively recruiting due to admin capacity we have had an increase of **29%** in the number of volunteers in the past year, now totalling **260**. This equates to **34,164** hours per year.
- Working on renewal of [accreditation and assessment](#). Continue to strengthen relationships with local partners to share best practice and coproduce developments to improve the volunteer experience.
- A [volunteer celebration](#) event held was held in Wakefield to coincide with volunteer week. 55 volunteers attended the celebration, each receiving a Trust thank you card. The annual volunteer awards were presented.
- Our befriending service, supported by volunteers, produced a [film](#) to promote their offer to service users and carers.
- The volunteer policy has been amended to accommodate the growth and development of the service, and a lone working section was introduced to ensure volunteers in the community had safe working practices and contacts with their managers.
- The age of potential volunteers was lowered from 16 to 14 years of age to accommodate our [CAMHS](#) services. All volunteers are trained and supervised within their role and have a designated supervisor.
- The service is continuing to evolve in partnerships with our partners. The service is involved in the development of [Wakefield Volunteer](#), launched on 31 May. Working alongside partners such as NOVA, this initiative will provide volunteer opportunities to our communities and to the Trust.
- We are partnering with [Thriving Kirklees](#) to establish a better offer to volunteers and services. We are currently developing policies and process to support this partnership.

**We will develop a culture in which communication, engagement and involvement is a fundamental part of delivering high quality services**

**Developing staff culture**

- Ongoing support to develop a [recruitment and retention](#) communication campaign, to attract new staff and help retain those already employed in the Trust.
- [Leadership and management development](#). Continued promotion of development courses, alongside supporting the development of a toolkit for managers.
- Working with HR colleagues on the approach to engaging staff in discussions about [bullying and harassment](#), ahead of a campaign being developed in 2019/20.
- [#Allofusimprove](#) - supported launch of new improvement toolkit and refreshed i-hub. Included new [intranet section](#) full of improvement resources, as well as key messages shared through all routine internal comms channels. Promotion of IHI training, improvement champions scheme.

- Promotion of the [#allofus](#) staff wellbeing offer.
- [Freedom to speak up guardian](#) banners and posters produced and distributed.
- Drafting of leaflets on how to support families following [bereavement](#).
- Launched the new cartoon style [finance campaign](#) to encourage staff to reduce waste and save money.
- Comms and key messages for a [campaign to reduce the number of data breaches](#).
- [Ramadan](#) leaflet produced and promoted across the Trust and on social media.
- Marketing, communications and engagement manager taking a lead role in the [LGBTQI+ staff network](#), with a formal meeting of the group scheduled for June.

#### **System development**

- [SystemOne for mental health](#). Comms post go-live included directing staff to helpful resources, sharing system updates and promoting CQC SystemOne support. Ongoing comms support being provided.
- Support for [transformation programmes](#). Trustwide older people's mental health services, Kirklees/Calderdale rehab and recovery services, and the out of area project.

#### **Changes to strengthen communication, engagement and inclusion**

- Following the departure of the 8b head of communication and involvement in May we are recruiting an 8b communication, engagement, and inclusion lead, which repurposes funding from the head of communications and involvement position. This will support the communication, engagement and inclusion/equality agendas being brought together and to develop a more integrated team.
- An acting head of marketing, communications and engagement is currently in post. This role will be recruited to substantively as an 8a role.
- Recruitment to an additional band 7 marketing, communication and engagement manager is taking place with interviews on 13 June. This post will replace the programme communication manager who leaves the Trust in July.

#### **Communications, engagement and involvement strategy**

- The communication, engagement and involvement strategy covers the period 2016-19 and will be reviewed in December 2019.
- In advance of the review we will carry out engagement with staff, service users, carers, volunteers, governors and stakeholders to ensure the strategy refresh is co-produced.

#### **Recommendation**

For Trust Board to note the above update.

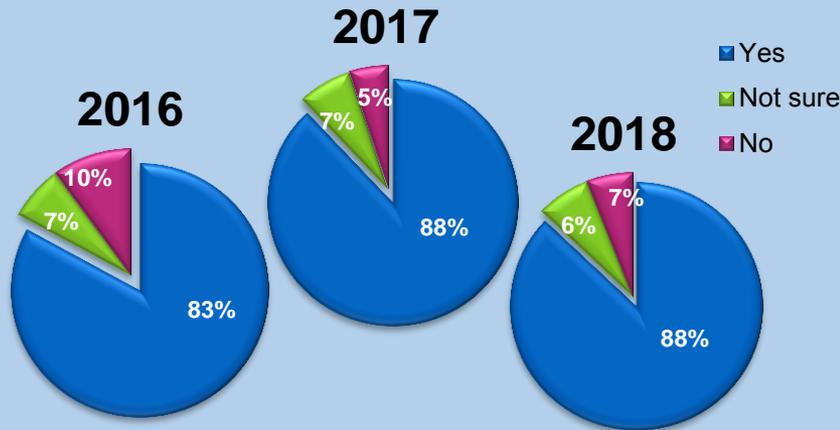
# Internal communications survey



South West  
Yorkshire Partnership  
NHS Foundation Trust

In December 2018 we surveyed staff about internal communications - 560 responses were received. This is higher than the response rate of 2016 (362) and 2017 (334). Here's a snapshot of the results, together with an action plan for further improvement.

## Do you feel that you are kept up to date with what is happening across the Trust?

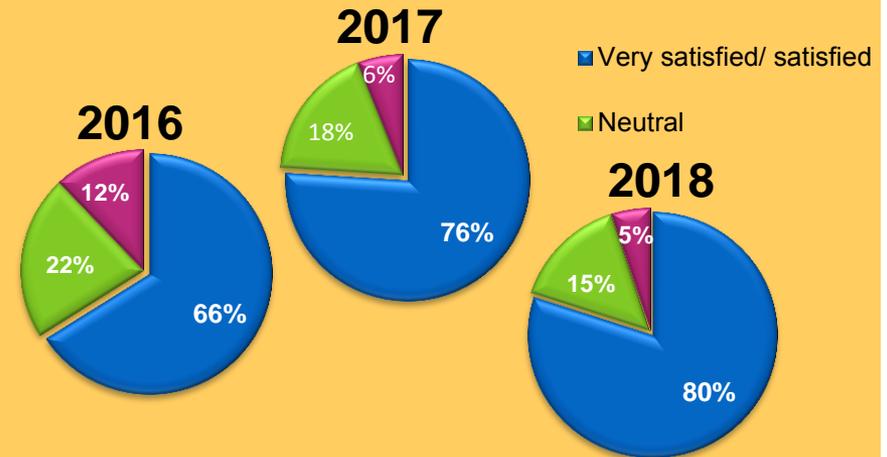


The most positive respondents were **specialist services BDU** staff with **94% saying yes**.

This was followed by 93% for forensic BDU, 91% for Wakefield, 86% for corporate, 85% for Calderdale and Kirklees and 82% for Barnsley.

Clinical nursing staff were the most positive with **91%** saying yes, followed by 89% of non-clinical managerial staff.

## How do you feel about the way the Trust communicates and engages with you?



**Specialist services** topped the satisfaction rates at **94% - up from 79% last year**. This was followed by 87% of respondents from forensic services, 79% Wakefield, 77% from Calderdale and Kirklees BDU, 76% from Barnsley 9up from 63% last year and 75% from corporate services.

In 2015 only 45% of staff said they felt satisfied/very satisfied. In 2018 **this increased to 80%**.

*Note: These results do not fully align with 2018 staff survey BDU engagement results. For example, in the above questions specialist services were the most positive. However, staff survey results show them with the lowest scores for staff engagement/ morale. This perhaps suggests that whilst specialist staff are happy with corporate communications, there needs to be a focus on what is required within the BDU.*

# Electronic channels

## The Headlines

- **89% read it every week** - with 32% reading in full and 57% briefly scanning it
- **87% find it very useful/useful** 6% said it isn't useful and 7% had no opinion
- **94% say it's the right length**, 4% too long and 2% too short.

*"I have worked somewhere where they send out constant emails about anything, its really good here that we only get one email a week. If I am short of time I know that the one thing I must read is The Headlines."*

*"Really helpful summary of what we need to do and know. I appreciate the fact that topics are short so we need only glance at them. The headline of each topic tells me whether I need to give it my attention or not. It really helps busy staff see what they need to quickly."*

*"I can't wait to read it every week - short, snappy straight to the point."*

*"Due to time constraints it is sometimes hard to read it all however I do scan and often re-read when time allows."*

## The View

- **80% read it every week** – with 20% reading in full and 60% briefly scanning it
- **74% find it very/slightly useful**, 13% had no opinion and 13% say it isn't useful
- **27% think it is too long**, 72% say it's about right.

*"The View helps me to feel that I am part of a bigger picture. It is well written and celebrates people at all levels."*

*"I always read it, it is only way an average staff member has contact with the CEO."*

*"It was good to start but it is too corporate now."*

*"A fascinating read."*

*"It is sometimes too positive and I feel that it tries to gloss over real challenges."*

*"I'm beginning to feel like I've heard it all before. Needs some new angles."*

*"I like that the View comes from the CEO or a director/board member because this breaks down boundaries and supports shared understandings."*

## The Intranet

- **42% access it weekly**, 49% few times a month
- **79% say it is useful/very useful.**
- Top improvements suggested:
  - Search function
  - More user friendly/modern
  - Up to date phone book
  - Removal of old info
  - Less space given to i-hub
  - More news on homepage

*"Useful, but not very user friendly."*

*"It is slow and hard to find anything."*

*"Decent search tool would be a start. Mobile optimisation is a dream too far for NHS technology...?!"*

*"New technology that actually works!"*

*"It's impossible to update it, it's so erratic. No idea how Comms team manage it every day, it's a bleeding nightmare."*

*"Being able to view on a mobile would be wonderful."*

*"There is a general feeling throughout C&K BDU that the 'focus' seems to be geared towards Barnsley."*

*"Needs to be more inclusive of other BDUs."*

*"It seems to be all about mental health. Community staff, especially those in Barnsley, very rarely feel included."*

*"Too focused on Wakefield."*

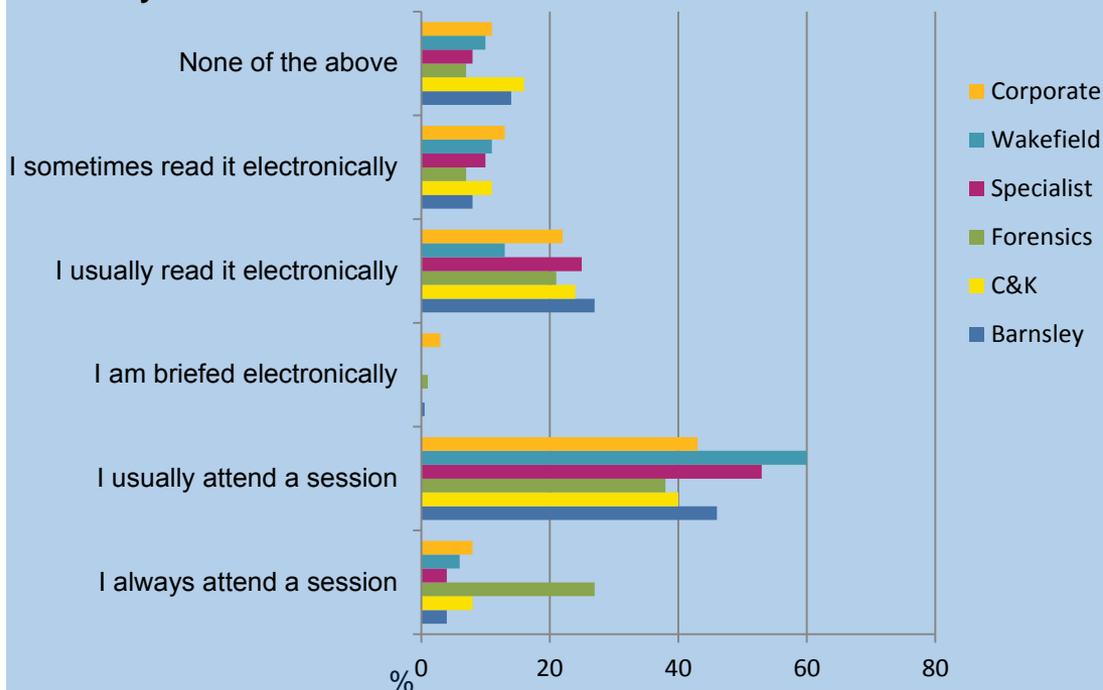
*"It doesn't routinely mention enough about my Barnsley service. We feel forgotten."*

*"It's always about Barnsley."*

There are several comments throughout the survey about where the focus of corporate comms seems to lie – the answer varies depending on where the responder is based.

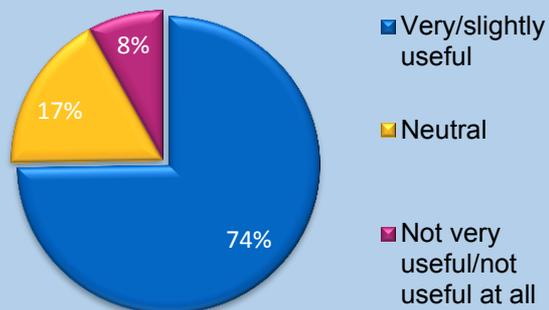
# The Brief

## How do you receive The Brief?



12% answered 'none of the above' which means they don't receive it at all.

## How useful do you find The Brief?



There has been an **increase in the number of staff saying they found it useful**, compared to last year – in 2017 it was just 66%.

**17% think it's too long** - the same as last year.

*"It's useful to help the team feel a part of the Trust and to understand the perspective of the clinical services that we work alongside."*

## Comments about improvements

- "I like the improved format, especially finance infographics."
- "It is better this year than in those previous. The information is presented clearly and explained impeccably."
- "There is more detail now - acronyms and terms are better spelt out which doesn't presume prior knowledge."
- "It's got better in the past year, more detail in the word version which makes it easier in turn for me to deliver."

## Comments about content

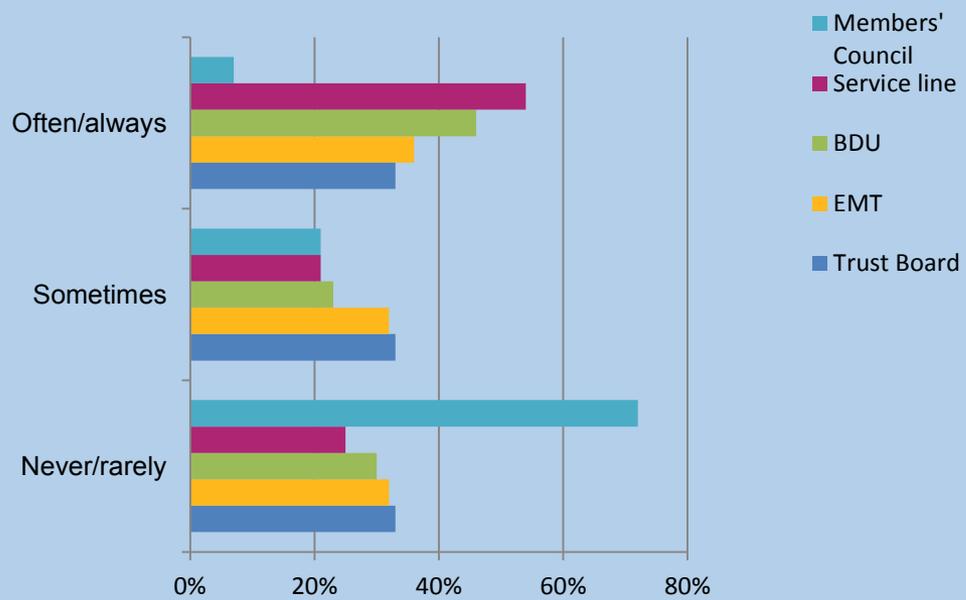
- "Great piece of comms that embraces all aspects of our business."
- "It's good to know what is happening."
- "Interesting to know what is going on - feel part of the bigger picture."
- "Useful to help the team feel a part of the Trust and to understand the perspective of the clinical services that we work alongside."
- "Excellent oversight of big issues."

## Comment about delivery

- "How good the brief is depends 100% on how it is delivered."
- "It is too long - do not need to attend a meeting to go through this when I can read it myself."
- "My manager does a good job of explaining everything in this in terms of what it actually means for us."
- "It is rather patronising to read to staff; they are all adults and can be expected to read this themselves."
- "My line manager makes this come to life and it is always interesting."
- "It's good when delivered but hard going if you just have to read it on your own."
- "I would benefit from receiving it face to face so that I can take relevant notes and ask questions."
- "It is not actually fed down through meetings as is the required intention."

# Future needs

## How frequently are you kept informed of discussions and decisions made at the following meetings?



**72% say they rarely/never hear about Members' Council.** Only 7% say they often/always hear about it.

In 2017 only 19% of people said they were kept informed from Trust Board meetings. **In 2018 this figure rose to 33%**, this increase might be attributed to the fact our Chair writes The View after every Board.

In 2017 only 25% of people said they were kept informed from BDU meetings. **This rose to 46% in 2018 perhaps reflective of BDU restructuring.**

## How would you like to be kept informed in the future?

- **55%** Internal networking platforms, like Workplace (*up from 24%*)
- **42%** Drop-in sessions with senior managers
- **39%** Social media (*up from 22%*)
- **32%** Email updates (*down from 59%*)
- **28%** Animation
- **24%** More direct communication from EMT
- **24%** Intranet
- **21%** Video
- **19%** Professional networks
- **9%** More direct communication from the chief exec
- **4%** Blogs

The interest rise in internal networking/social media coupled with a rapid decline for email updates **reflects trends in internal communications across all sectors.**

Employees in 2019 want to communicate instantly, collaborate virtually and share knowledge **in a social way that mimics the way they behave outside work.**

"We are known for good communications at our trust and that is credit to the team."

"I find the comms team very helpful and I value their support."

"Communications we get here is a million times better than where I was before."

"Comms team do an excellent job, and they are very creative and helpful."

"Communications in this organisation is superb, nothing quite like I've experienced in others."

"The comms troop are a supremely helpful and friendly bunch"

# Action plan

Issue	Approach to improve	Timeframe
Local comms in BDUs needs to improve + 42% of survey responders wanted drop-in sessions with managers.	As agreed with OMG, comms team will offer advice, insight and fresh eyes to BDU management around their staff engagement and comms challenges. Support will be offered in setting up new mechanisms – all linked to staff survey and wellbeing action planning.	Q1 and Q2 Listening events: Q1.
The View: 1 in 3 responders think it's too long and some think it's too corporate.	Work with the author of The View to keep word count to 800 or under as well as provide feedback on content and style.	Ongoing
The intranet: outdated software leading to poor user experience.	The intranet could be switched off by Daisy in October 2020 (no ongoing support for the product = cyber risk). Comms contributing to the development of a business case – also owned by HR, P&I and IT. A project lead needs to be identified.	New intranet is needed by autumn 2020.
The Brief: not all staff are receiving it face-to-face. Some not at all. When it's delivered, it's not always two-way.	Find areas of good practice for #allofusimprove case studies to encourage spread. Develop a short guide to delivering/receiving The Brief, to be included as final slide/page on every issue – reminding staff what they can expect and managers of their responsibilities.	Q1 and Q2.
All service areas/BDUs not always fully represented in routine channels.	Encourage all service areas to contribute their news/stories/info by strengthening comms team relationships/ profile with them. Make it easy to share info and prompt for this to happen via leadership - eg at OMG, ExEMT and BDU meetings.	Q1
72% of staff say they never/rarely hear about discussions and decisions made at Members' Council.	Further strengthen sharing of Council dates and papers with staff. Work with Company Secretary to ensure discussions/decisions are communicated across all channels after the meeting. Encourage staff to link with their staff rep by offering them greater profile and a newly developed web page/intranet section - making best use of any future technology for engagement (eg Workplace).	Q1
More use of internal social networking was the top answer given by responders when ask how they would like to be kept informed. (55%, up from 24% last year)	Work with staffside colleagues to re-evaluate original Workplace by Facebook proposal. Apply integrated change framework process to procedure before continuing. Concerns from IT, IG and HR to be fully mitigated – learning from other NHS Trusts/Councils/ Third Sector who have already implemented Workplace. Clearly define the purpose and scope of the channel – and ensure clear message that it is implemented with no-cost.	Launch by end of Q2. Launch to time with i-hub relaunch.
There's been a 17% increase in responders asking for greater use of social media.	Social media guidance to be confirmed with input from staffside, IT, HR and IG referencing existing policies, before discussion at OMG. Social media savvy guides produced initially for Twitter, Facebook and 'Dos&Don'ts'. Masterclasses, social media drop-ins and webinars to be held - ExEMT on forward schedule for May 2019.	Guidance, guides & session: Q1. Drop ins and webinars: Q2.
Lack of access to routine corporate communications.	The SWYPFT Staff App (zero cost, therefore with limited functionality) will give basic access to corporate comms /key info, in place of a mobile optimised intranet.	Q1

## Trust Board 25 June 2019 Agenda item 9.1

<b>Title:</b>	<b>Annual Report and accounts and Quality Account 2018/19</b>
<b>Paper prepared by:</b>	Director of Finance and Resources
<b>Purpose:</b>	<ul style="list-style-type: none"> <li>➤ To confirm the submission of the 2018/19 Annual Accounts, Annual Report and Quality Account.</li> <li>➤ To explain the process undertaken to generate these submissions and provide assurance regarding the governance of the process.</li> <li>➤ To publically table the reports generated by the external auditors Deloitte LLP following their annual audit.</li> </ul>
<b>Mission/values:</b>	The Annual Report, accounts and Quality Report form part of the Trust's governance arrangements, which support the Trust's mission and values. The Annual Report provides a summary of the Trust's performance against its mission and in line with our values, the accounts demonstrate financial probity and the quality report outlines the Trust's approach to quality, improvement in services and achievement of its quality priorities.
<b>Any background papers/ previously considered by:</b>	<ul style="list-style-type: none"> <li>➤ The draft Annual Governance Statement was reviewed and agreed by the Trust Board on 30 April 2019. The final draft was included in the annual report reviewed by the Audit Committee on 21 May 2019 and approved by the Trust Board in private session on 23 May 2019.</li> <li>➤ The draft Annual Report had input from executive directors and other senior managers and stakeholders, and was shared with all Board members for comment and feedback. The final draft was reviewed by the Audit Committee on 21 May 2019 and approved by the Trust Board in private session on 23 May 2019.</li> <li>➤ The draft Quality Account was considered by the Member's Council Quality Group in both February 2019 and May 2019 and by the Clinical Governance and Clinical Safety Committee on 12 February 2019 and 14 May 2019 before being approved by the Trust Board in private session on 23 May 2019.</li> <li>➤ The annual accounts were reviewed by the Director of Finance and Audit Committee Chair in detail, who are both qualified accountants on the Trust Board. The accounts were then reviewed in full by the Audit Committee on 21 May 2019 and approved by the Trust Board in private session on 23 May 2019.</li> </ul>
<b>Executive summary:</b>	<ul style="list-style-type: none"> <li>➤ In accordance with Department of Health and Social Care Group Accounting Manual 2018/19, the Annual Report and accounts including the Quality Account 2018/19 is not able to be published until after the document is laid before parliament which is due to take place in July 2019. It will be formally presented at the Annual</li> </ul>

	<p>Members' Meeting on 16 September 2019.</p> <ul style="list-style-type: none"> <li>➤ All documents were submitted to NHS Improvement in line with the submission deadline.</li> <li>➤ Each document was subject to significant Board scrutiny and oversight.</li> <li>➤ With regard to the accounts, Deloitte issued an unmodified audit opinion with no reference to any matters in respect of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources, or the Annual Governance Statement.</li> <li>➤ With regard to the Quality Account, the Trust was issued with the limited assurance report that is a requirement of the quality account proces.</li> <li>➤ Copies of both audit reports (accounts and Quality Account) are attached to this paper.</li> </ul>
<b>Recommendation:</b>	<p><b>Trust Board is asked to:</b></p> <ul style="list-style-type: none"> <li>➤ <b>NOTE the update and make any further COMMENTS on the process relating the annual report, accounts and quality account process and submissions; and</b></li> <li>➤ <b>RECEIVE in public the external audit reports relating to the annual accounts and quality account and comment accordingly.</b></li> </ul>
<b>Private session:</b>	Not applicable.

## **2018/19 Annual Report, Annual Accounts and Quality Account**

### **Introduction**

In line with statutory requirements the Trust has submitted an annual report, its annual accounts and quality account to NHS Improvement. Each of these has been subject to internal scrutiny and governance, and to external audit. The documents become publicly available documents once laid before parliament, which is due to occur in July 2019 and will be formally presented at the Annual Members' Meeting in September 2019. This document explains the process undertaken and provides the external audit reports.

### **Annual Governance Statement**

The Annual Governance Statement (AGS) was produced in line with guidance and instructions provided by NHS Improvement based on Treasury requirements. The draft AGS was approved by the Trust Board on 30 April and then reviewed by the Audit Committee on 21 May before being approved by the Trust Board on the 23 May 2019. The AGS contained the Head of Internal Audit overall opinion of significant assurance.

### **Annual Accounts**

The annual accounts were produced in line with accounting standards (FRS) and followed guidance and instruction provided by NHS Improvement. The draft accounts were shared with the accountant on the Trust Board and Audit Committee members for comment and feedback. Responses were provided for all questions and where appropriate amendments were made to the accounts (typically within the notes to the accounts). They were also shared with members of the Executive Management Team (EMT) for comment and feedback.

The accounts were subject to audit by Deloitte LLP and to a review at the Audit Committee on 21 May and were approved at the Trust Board on 23 May 2019. Signature took place on 23 May. A log was kept of all adjustments made from version to version. The accounts were then submitted to NHS Improvement in line with the required timescales.

### **Annual Report**

The production of the annual report was co-ordinated by the Company Secretary and included contributions from appropriate executive directors and other senior managers. The annual report was shared with non-executive directors and the lead governor for comments. As with the annual accounts the report was reviewed at the Audit Committee on 21 May and approved at the Trust Board on 23 May 2019. Signature again took place on 23 May 2019. The report was then submitted to NHS Improvement.

## Quality Account

The Quality Account 2018/19 was produced in line with the requirements of both the Department of Health, '**Quality Account Toolkit (2010)**' and NHSI, '**Detailed requirements for quality reports**' (2019).

The production of the quality account report is a year -long process. Quality priorities were agreed by EMT (2018), allocated a lead individual and monitored in relevant working groups throughout the year, for example, the Patient Safety Group. A bi -monthly progress report was submitted to Clinical Governance & Clinical Safety Committee, Members' Council Quality sub- group on a quarterly basis and Clinical Commissioning Groups Quality Boards, as requested.

The Quality Improvement and Assurance Team facilitate the production of the quality account report with input from BDU representatives and quality academy support teams such as finance, performance and information, information governance, human resources and contracting. A requirement of the quality account process is that our External Auditors (Deloitte) are required to undertake an audit of two mandated data items, in line with NHSI requirements set out in '**Detailed guidance for external assurance on quality reports 2018/19**'. Following the audit the Trust were issued with the Limited Assurance report, that is a requirement of the quality account process, and minor recommendations were made to further improve the quality of our data. A copy of the External Assurance report is attached.

A draft quality account report was produced that was commented upon by EMT, Member's Council Quality sub-group and Clinical Governance & Clinical Safety Committee before sign off by the Trust Board on 23 May as part of the Annual Report. The report was submitted to NHSI in line with the required timescales. **External Audit Report**

Deloitte LLP are the Trust's external auditors. Following completion of their audit they have produced an audit report (ISA 260). A copy of the ISA 260 is attached to this report. Key points to note from the report are:

- No significant audit adjustments or disclosure deficiencies were identified
- An unmodified audit opinion was issued with no reference to any matters in respect of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources, or the Annual Governance Statement.
- There were not any identified inconsistencies between the financial statements and the FTCs.
- With regard to areas of risk identified Trust management judgements were consistent with Deloitte's expectations.

## Conclusion and Recommendation

In conclusion the Trust met all its submission deadlines associated with its statutory returns covering the annual accounts, annual report and quality account. Input and feedback was regularly sought from all Board members and a range of other key stakeholders. External Audit provided an unmodified opinion in relation to the accounts.

Trust Board is asked to note the submission of the statutory returns, process undertaken to generate the accounts and reports and the assurance provided by our external auditors.



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# Partner introduction

## The key messages in this report

Audit quality is our number one priority. We plan our audit to focus on audit quality and have set the following audit quality objectives for this audit:

- A robust challenge of the key judgements taken in the preparation of the financial statements.
- A strong understanding of your internal control environment.
- A well planned and delivered audit that raises findings early with those charged with governance.

I have pleasure in presenting our final report to the Audit Committee for the 2018/19 audit. I would like to draw your attention to the key messages within this paper:

### Status of the audit

Our audit is substantially complete subject to completion of the following principal matters:

- completion of internal quality assurance procedures;
- Whole of Provider Accounts reporting;
- receipt and checking of final, updated, financial statements and annual report;
- our review of events since 31 March 2019; and
- receipt of signed management representation letter.

Our Independent Examination of EyUp! (formerly South West Yorkshire Partnership NHS Foundation Trust and Other Related Charities) is underway and will finalise this work over the next month.

### Conclusions from our testing

- We have not identified any significant audit adjustments or disclosure deficiencies based on our work to date. Unadjusted audit misstatements are detailed on page 16.
- Based on the current status of our audit work, we envisage issuing an unmodified audit opinion, with no reference to any matters in respect of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources, or the Annual Governance Statement.
- We have not identified any inconsistencies between the financial statements and the TACs.

# Partner introduction

## The key messages in this report (continued)

Audit quality is our number one priority. We plan our audit to focus on audit quality and have set the following audit quality objectives for this audit:

- A robust challenge of the key judgements taken in the preparation of the financial statements.
- A strong understanding of your internal control environment.
- A well planned and delivered audit that raises findings early with those charged with governance.

### **Financial sustainability and Value for Money**

The Trust reported an overall deficit for the year of £8.6m, including PSF income of £4.7m.

- CIP delivery was £10.6m against a £9.7m target;
- The Trust has a Single Oversight Framework segmentation of 1 which is in line with the planned rating. It is not currently subject to any regulatory action from either NHSI or the Care Quality Commission (CQC); and
- Subject to appropriate disclosure in the Annual Report and Annual Governance Statement we do not anticipate reporting any matters within our audit report in respect of the Trust's arrangements for securing the economy, efficiency and effectiveness of the use of resources.

### **Annual Report & Annual Governance Statement**

- We have reviewed the Trust's Annual Report & Annual Governance Statement to consider whether it is misleading or inconsistent with other information known to us from our audit work. Based on our review, we consider that the Trust has followed the format prescribed by the Foundation Trust Annual Reporting Manual.

### **Quality Accounts**

- Based on the current status of our audit work, we plan issue a clean quality report opinion. The findings from our work are set out in the accompanying paper, which will also be presented to the Council of Governors at their next meeting.

Paul Hewitson  
Lead audit director

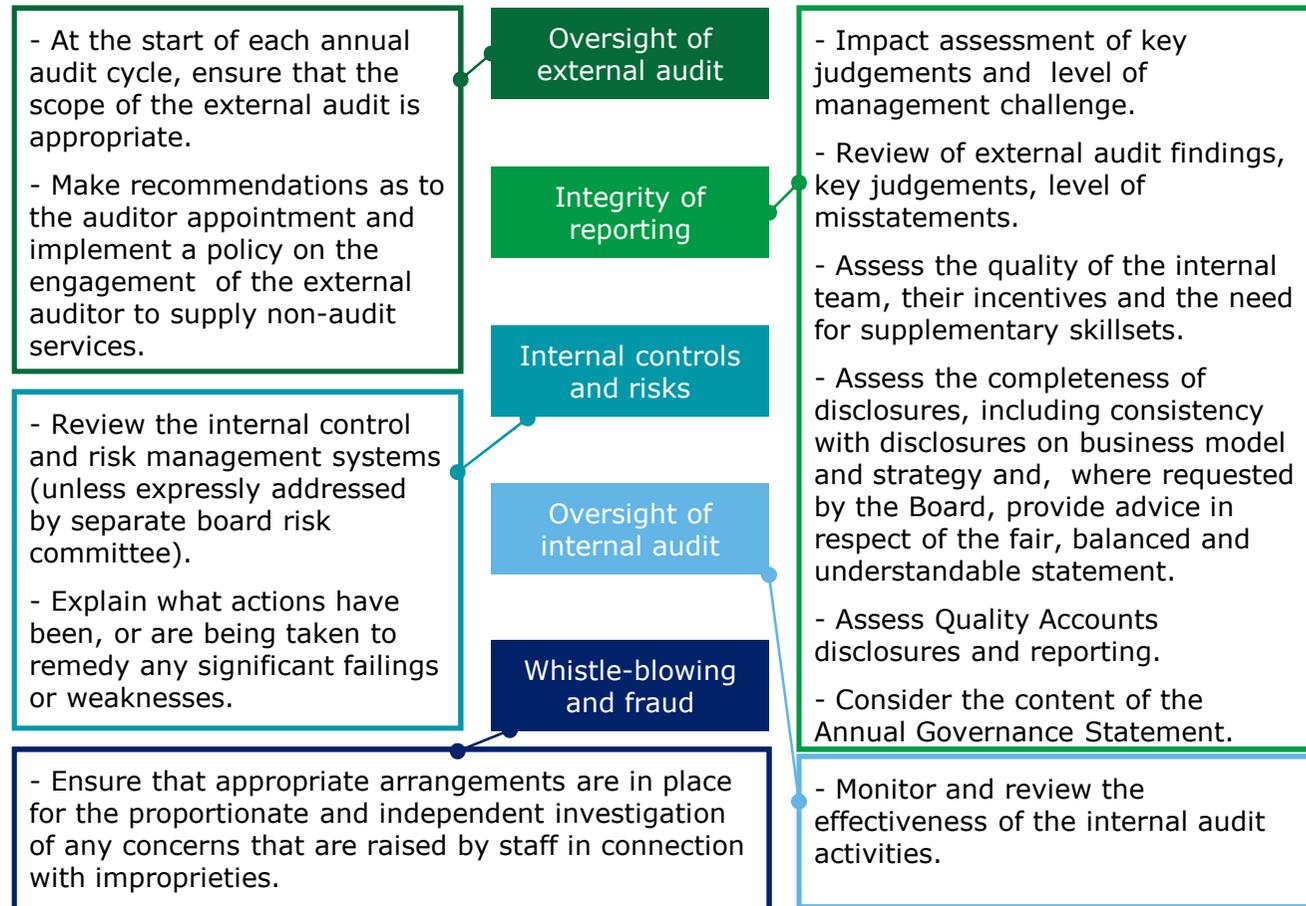
# Responsibilities of the Audit Committee

## Helping you fulfil your responsibilities as an Audit Committee

Why do we interact with the Audit Committee?

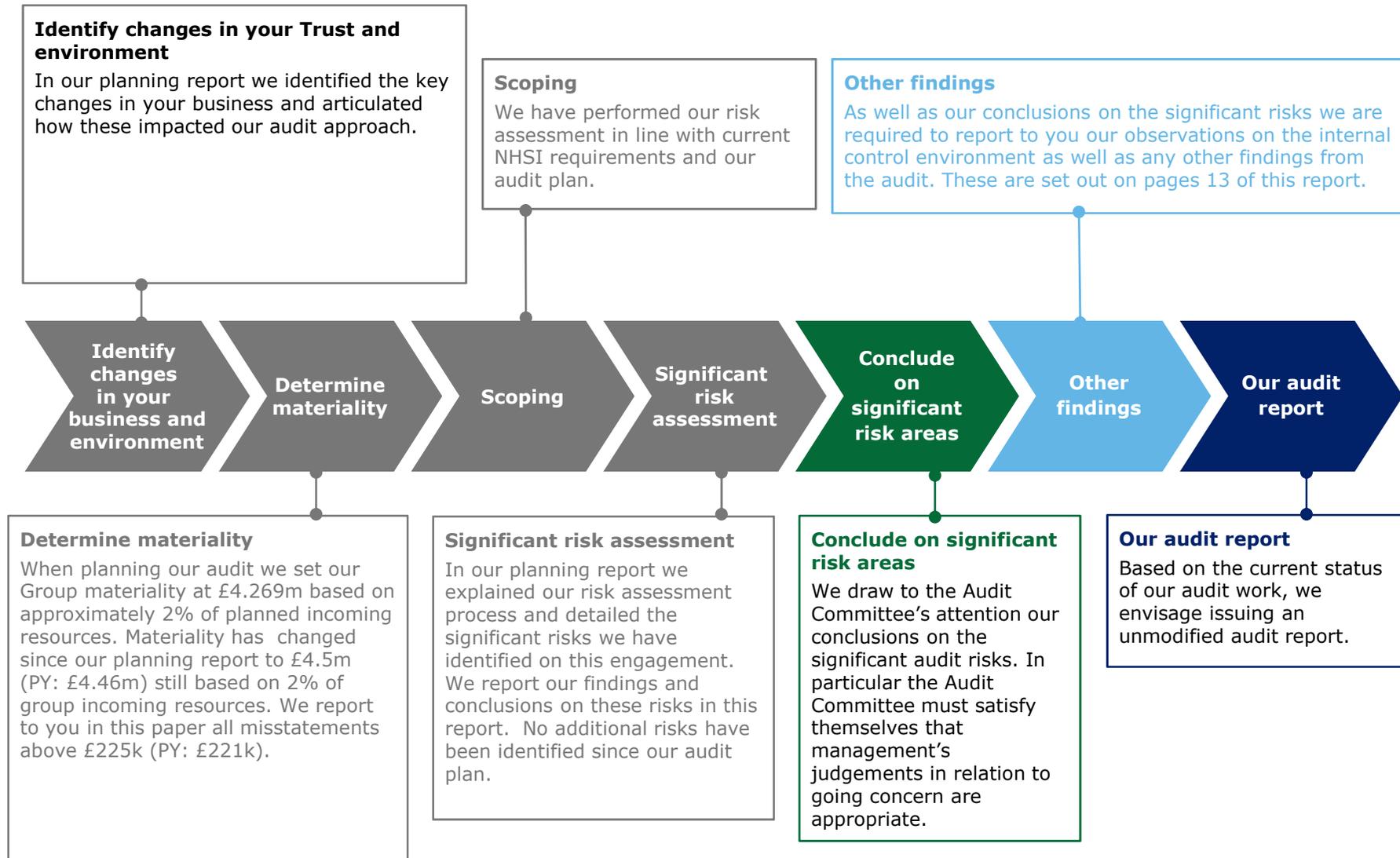


As a result of regulatory change in recent years, the role of the Audit Committee has significantly expanded. We set out here a summary of the core areas of Audit Committee responsibility to provide a reference in respect of these broader responsibilities and highlight throughout the document where there is key information which helps the Audit Committee in fulfilling its remit.



# Our audit explained

## We tailor our audit to your business and your strategy



# Significant risks Dashboard

Risk	Material	Fraud risk	Planned approach to controls testing	Controls testing conclusion	Consistency of judgements with Deloitte's expectations	Expected to be included as a key audit matter in our audit report	Slide no.
Valuation of Provisions			D+I	Satisfactory			8
Accounting for property valuations			D+I	Satisfactory			9
Management override of controls			D+I	Satisfactory			10

Overly prudent, likely to lead to future credit



Overly optimistic, likely to lead to future debit.

**D+I:** Testing of the design and implementation of key controls

**OE:** Testing of the operating effectiveness of key controls

# Significant audit risks

## Risk 1 – Valuation of Provisions

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<b>Risk identified</b>	<p>At the end of the prior year the Trust held a material balance of provisions (£6.490m) with £3.708m of this related to redundancy provision mainly in relation to the ongoing service changes within the Barnsley area.</p> <p>Discussions with management indicate that there is an expectation that provisions will be released in the year as there is an expectation that the Barnsley position will crystallise and this is the significant part of the current provision. There are also further CIP plans that require redundancy of individuals however, timings have yet to be finalised.</p> <p>We therefore conclude that there is significant management judgement involved in the continued recognition and valuation of this provision.</p>
<b>Deloitte response</b>	<p>We have:</p> <ul style="list-style-type: none"><li>• Identified and tested the processes and controls that management have put in place to;<ul style="list-style-type: none"><li>• Consider the recognition criteria for provisions set out in IAS37 and determine whether the criteria continue to be met at the year end,</li><li>• Identify the staff impacted by the decommissioning of the service,</li><li>• Estimate the value of the provision required for redundancy payments connected to the staff impacted.</li></ul></li><li>• Reviewed the status of the Barnsley service negotiations and determine whether redundancy provisions are required;</li><li>• Obtained evidence that provisions have been recognised in accordance with IAS37 and continue to require recognition;</li><li>• Reviewed the provisions recognised in the prior year and derecognised in the year to ensure that the circumstances which gave rise to the provision have changed sufficiently to require derecognition; and</li><li>• Tested the calculation of the provision and challenge any material estimates or judgements inherent in the valuation.</li></ul>
<b>Conclusion</b>	<p>We have completed our testing, and note one judgemental difference totalling £132k which would increase the provisions balance.</p>
<b>Draft audit report findings</b>	<p>We have made reference to this risk in our audit report because it had a significant effect upon our overall audit strategy, allocation of resources, and direction of the efforts of the team.</p>

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# Significant audit risks

## Risk 2 – Accounting for property valuations

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<b>Risk identified</b>	The Trust held £114.1m of property assets (land and buildings) at 31 March 2018 which increased from £100.0m as at 31 March 2017 following the updated revaluation. In 2018/19 the Trust commissioned the District Valuer (DV) to perform a full revaluation of estate, to implement amendments to the existing MEAV-AS design and is considering making changes to the basis of estimating the fair value of the estate. The complexities of the model, and in the required accounting transactions, mean that there is a risk concerning the valuation of the property assets and any UEL's subsequently adopted.
<b>Deloitte response</b>	We have: <ul style="list-style-type: none"><li>• examined the terms of engagement of the valuer, the instructions issued and the management controls within the Trust concerning the receipt, review and acceptance of the DV's report;</li><li>• reviewed the MEAV – AS assumptions and sought to corroborate the assumptions made against the Trust's estate's strategy and existing gross internal area information;</li><li>• used our valuation specialists, Deloitte Real Estate to review and challenge the appropriateness of the assumptions used in the year-end valuation of the Trust's properties;</li><li>• challenged managements assessment that the DV reported values, which were dated 1 April 2018 and 31 December 2018, remained valid as at 31 March 2019;</li><li>• commented in our reporting upon the key assumptions used in the valuation; and</li><li>• examined the accuracy on a sample basis of the posting of the valuations to the general ledger and financial statements.</li></ul>
<b>Conclusion</b>	We have not noted any issues through our testing. We have however raised a judgemental adjustment as seen on page 17 in relation to the movement in the BCIS from 31 December 2018 to 31 March 2019. In reviewing the Trust calculations of the impairment to be recognised in operating expenditure we noted a small number of errors, totalling £180k, which understate the balance recognised in expenditure.
<b>Draft audit report findings</b>	We have made reference to this risk in our audit report because it had a significant effect upon our overall audit strategy, allocation of resources, and direction of the efforts of the team.

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# Significant audit risks

## Risk 3 - Management override of controls

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<b>Risk identified</b>	<p>In accordance with ISA 240 (UK and Ireland) management override is a significant risk. This risk area includes the potential for management to use their judgement to influence the financial statements as well as the potential to override the Trust's controls for specific transactions.</p> <p>The key judgments in the financial statements are those which we have selected to be the significant audit risks overstatement of provisions and valuation of the Trust's estate. These are inherently areas in which management has the potential to use their judgment to influence the financial statements.</p>
<b>Deloitte response</b>	<p>We have considered the overall sensitivity of judgements made in the preparation of the financial statements, and our work has focused on:</p> <ul style="list-style-type: none"><li>• the testing of journals, using data analytics to focus our testing on higher risk journals;</li><li>• significant accounting estimates relating to estimates discussed above in respect of NHS revenue recognition and provisioning; and</li><li>• any unusual transactions or one-off transactions including those with related parties</li></ul> <p>In considering the risk of management override, we:</p> <ul style="list-style-type: none"><li>• assessed the overall position taken in respect of key judgements and estimates; and</li><li>• considered the rationale for the accounting estimates and assessed these for biases that could lead to material misstatement due to fraud.</li></ul>
<b>Conclusion</b>	<p>We have finished our work in relation to journals, and note no issues.</p> <p>From our work to date we have not identified any significant bias in the key judgements made by management. The control environment is appropriate for the size and complexity of the Trust.</p> <p>We have considered the tone at the top and note that there are no concerns we wish to draw to the attention of management or those charged with governance.</p>
<b>Draft audit report findings</b>	<p>We do not expect to include this risk in our audit report because it did not have a significant effect upon our overall audit strategy, allocation of resources, and direction of the efforts of the team.</p>

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# Value for money (VfM)

We have not identified any VfM significant risks.

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## Value for Money

We are required to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. VfM is assessed against the following criterion, and three sub-criteria (informed decision making, sustainable resource deployment, and working with partners and other third parties):

“In all significant respects, the audited body had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people.”

Our work takes account of the Annual Governance Statement and the findings of regulators. We are required to perform a risk assessment through the course of our audit to identify whether there are any significant risks to our VfM conclusion, and perform further testing where risks are identified.

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## Overall Financial & Quality Performance

As part of our risk assessment, we have considered how the Trust’s performance compares to plan and prior year:

	Actual 2018/19	Plan 2018/19	Variance	Plan 2019/20	Prior year 2017/18
Surplus (before impairments)	£3.2m	£0.6m	£2.5m	£1.5m	£4.0m
EBITDA margin	4.4%	4.6%	+0.2%	4.2%	5.7%
CIP target and identified to date	£10.6m	£9.7m	+£0.9m	£10.6m	£7.5m
Single Oversight Framework (finance rating)	1	1	0	1	1
CQC report conclusions	Requires Improvement				

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## Risk Assessment work performed

As part of our risk assessment, we have considered information from a combination of:

- “high level” interviews with key members of staff;
- review of the Trust’s draft Annual Governance Statement;
- consideration of issues identified through our other audit and assurance work;
- consideration of the Trust’s results, including benchmarking of actual performance (including on CIP delivery) and the 2018/19 Annual Plan;
- review of the Care Quality Commission’s report on the Trust dated July 2018;
- review of NHSI’s risk ratings;
- benchmarking of the Trust’s performance

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## Conclusion

We have not identified any specific risks in respect of Value for Money.

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# Other significant findings

## Internal control and risk management

During the course of our audit we have not identified significant internal control and risk management findings, which we have included below for information.

Area	Observation	Priority
No significant internal control or risk management issues noted during our audit.		

The purpose of the audit was for us to express an opinion on the financial statements. The audit included consideration of internal control relevant to the preparation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of internal control. The matters being reported are limited to those deficiencies that we have identified during the audit and that we have concluded are of sufficient importance to merit being reported to you.

- Low Priority
- Medium Priority
- High Priority

# Areas for monitoring in relation to our Value for Money Conclusion

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<b>Areas of monitoring</b>	As part of our planning work and discussions with the Trust we noted three areas of monitoring which were potentially relevant to our Value for Money conclusion, these were: switch from RiO to SystemOne, CIP delivery and responding to the CQC comments.
<b>Conclusion</b>	We monitored these areas throughout the year and, based on this work, we did not consider that any of these areas of crystallised into specific risks and therefore there are no issues identified that would have an impact on the Value for Money conclusion.

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# Purpose of our report and responsibility statement

## Our report is designed to help you meet your governance duties

### What we report

Our report is designed to help the Audit Committee and the Board discharge their governance duties. It also represents one way in which we fulfil our obligations under ISA (UK) 260 to communicate with you regarding your oversight of the financial reporting process and your governance requirements. Our report includes:

- Results of our work on key audit judgements and our observations on the quality of your Annual Report.
- Our internal control observations.
- Other insights we have identified from our audit.

### The scope of our work

Our observations are developed in the context of our audit of the financial statements.

We described the scope of our work in our audit plan.

### Use of this report

This report has been prepared for the Board of Directors, as a body, and we therefore accept responsibility to you alone for its contents. We accept no duty, responsibility or liability to any other parties, since this report has not been prepared, and is not intended, for any other purpose. Except where required by law or regulation, it should not be made available to any other parties without our prior written consent.

### What we don't report

As you will be aware, our audit was not designed to identify all matters that may be relevant to the board.

Also, there will be further information you need to discharge your governance responsibilities, such as matters reported on by management or by other specialist advisers.

Finally, our views on internal controls and business risk assessment should not be taken as comprehensive or as an opinion on effectiveness since they have been based solely on the audit procedures performed in the audit of the financial statements and the other procedures performed in fulfilling our audit plan.

We welcome the opportunity to discuss our report with you and receive your feedback.

**Deloitte LLP**

Newcastle Upon Tyne

17 May 2019

# Appendices



# Audit adjustments

## Unadjusted misstatements

The following uncorrected misstatements have been identified up to the date of this report which we request that you ask management to correct as required by International Standards on Auditing (UK). The net impact of these is an increase of £467k in the deficit for the period.

		Debit/ (credit) income statement £m	Debit/ (credit) in net assets £m	Debit/ (credit) prior year retained earnings £m	Debit/ (credit) in reserves £m	If applicable, control deficiency identified
<b>Misstatements identified in current year</b>						
Revaluation – update to valuation	[1]		1.584		(1.584)	
<b>Aggregation of misstatements individually &lt; £0.225m</b>						
Misstatements less than £0.225m		0.467	(0.288)		(0.179)	
<b>Total</b>		<b>0.467</b>	<b>1.296</b>		<b>(1.763)</b>	

(1) Judgemental difference noted on revaluation movement indices between the valuation date (31 December) and year end (31 March).

As part of the agreement of balance work, we note that there is a range of uncertainty. Whilst all differences are clearly trivial, on the debtors and creditors, there is a margin of uncertainty of £1.011m and on income and expenditure there is a margin of uncertainty of £1.441m. This is not raised as an error but is noted here as a range of uncertainty as a result of the agreement of balance process.

# Audit adjustments

## Disclosures

### Disclosure misstatements

The following uncorrected disclosure misstatements have been identified up to the date of this report which we request that you ask management to correct as required by International Standards on Auditing (UK).

Disclosure	Summary of disclosure requirement	Quantitative or qualitative consideration
Up to the date of this report we have not identified any significant disclosure deficiencies in the financial statements and the deficiencies identified have been corrected by management.		

### Other disclosure recommendations

Although the omission of the following disclosures does not materially impact the financial statements, we are drawing the omitted disclosures to your attention because we believe it would improve the financial statements to include them or because you could be subject to challenge from regulators or other stakeholders as to why they were not included.

Disclosure	Summary of disclosure requirement	Quantitative or qualitative consideration
Up to the date of this report we have not identified any significant disclosure deficiencies in the financial statements and the deficiencies identified have been corrected by management.		

# Fraud responsibilities and representations

## Responsibilities explained



### Responsibilities:

The primary responsibility for the prevention and detection of fraud rests with management and those charged with governance, including establishing and maintaining internal controls over the reliability of financial reporting, effectiveness and efficiency of operations and compliance with applicable laws and regulations. As auditors, we obtain reasonable, but not absolute, assurance that the financial statements as a whole are free from material misstatement, whether caused by fraud or error.



### Required representations:

We have asked the Board to confirm in writing that you have disclosed to us the results of your own assessment of the risk that the financial statements may be materially misstated as a result of fraud and that you are not aware of any fraud or suspected fraud that affects the entity or group.

We have also asked the Board to confirm in writing their responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.



### Audit work performed:

In our planning we identified the risk of fraud in management override of controls as a key audit risk for your organisation.

During course of our audit, we have had discussions with management and those charged with governance.

In addition, we have reviewed management's own documented procedures regarding fraud and error in the financial statements.

We have reviewed the paper prepared by management for the audit committee on the process for identifying, evaluating and managing the system of internal financial control.

# Independence and fees

As part of our obligations under International Standards on Auditing (UK), we are required to report to you on the matters listed below:

<b>Independence confirmation</b>	We confirm the audit engagement team, and others in the firm as appropriate, Deloitte LLP and, where applicable, all Deloitte network firms are independent of the Group and our objectivity is not compromised.
<b>Fees</b>	Details of the fees charged by Deloitte for the period have been presented below.
<b>Non-audit services</b>	In our opinion there are no inconsistencies between FRC's Ethical Standard and the Trust's policy for the supply of non-audit services or of any apparent breach of that policy. We continue to review our independence and ensure that appropriate safeguards are in place including, but not limited to, the rotation of senior partners and professional staff and the involvement of additional partners and professional staff to carry out reviews of the work performed and to otherwise advise as necessary. We have not carried out any non-audit services in the period 2018/19.
<b>Relationships</b>	We have not other relationships with the Trust, its directors, senior managers and affiliates, and have not supplied any services to other known connected parties.

The professional fees earned by Deloitte in the period from 1 April 2018 to 31 March 2019 are as follows:

	<b>Current year</b> <b>£</b>	<b>Prior year</b> <b>£</b>
Audit of Trust (including WGA)	45,672	45,672
<b>Total audit fees</b>	<b>45,672</b>	<b>45,672</b>
Quality Accounts	5,000	5,000
Independent examination of the Charity	828	828
<b>Total fees</b>	<b>52,500</b>	<b>52,500</b>

# Sector benchmarking



# Sector benchmarking

We have reviewed the Trust's performance to 31 March 2019.

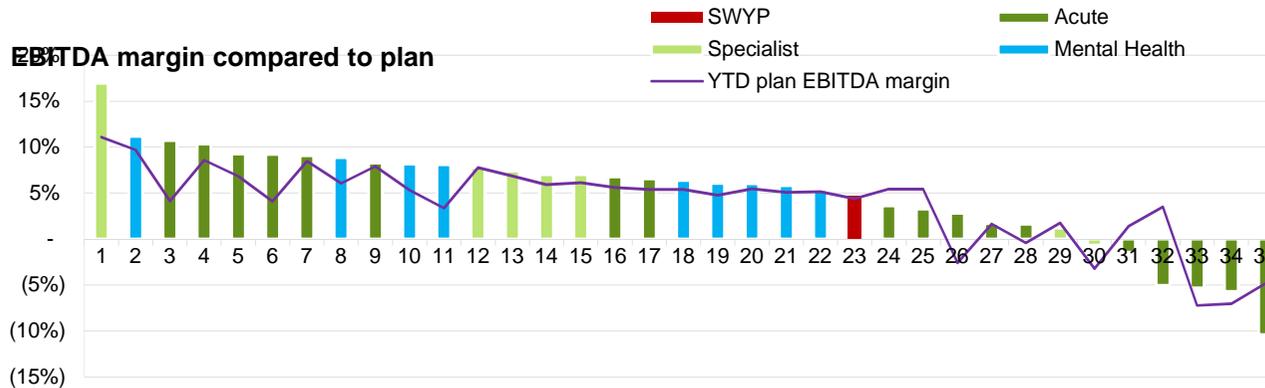
The table below shows how the Trust's results compare to other trusts we audit:

Our audit process includes an on-going assessment of internal and external factors affecting the Trust. This includes considering the Trust's actual and planned performance on financial, quality and other governance metrics compared to its peers, to enable us to identify and understand risks specific to the Trust.

We have summarised for the Audit Committee some of the comparisons we have performed as part of our concluding analytical procedures, comparing the Trust's performance to 31 March 2019 to other trusts we audit and national data from NHS Improvement.

(£m)	Trust Actual	Trust Plan	Trust Variance	MH Actual	Acute+ Specialist Actual	All Trusts average Actual
Operating income	224.6	214.7	9.9	179.5	494.2	395.3
EBITDA	10.4	9.4	1.0	12.0	19.3	17.0
EBITDA (%)	4.6%	4.4%	0.3%	7.0%	4.0%	4.9%
Surplus/deficit	(8.7)	0.6	(9.3)	3.1	4.2	3.8
Performance against control total	2.5	-	2.5	2.8	0.4	1.2

The chart below shows EBITDA margin for trusts we audit, compared to plan. The Trust's EBITDA of £10.4m compared to plan of £9.4m gives an EBITDA margin of 4.6%. This compares to an average margin for mental health trusts of 7% and all types of trust of 4.9%.



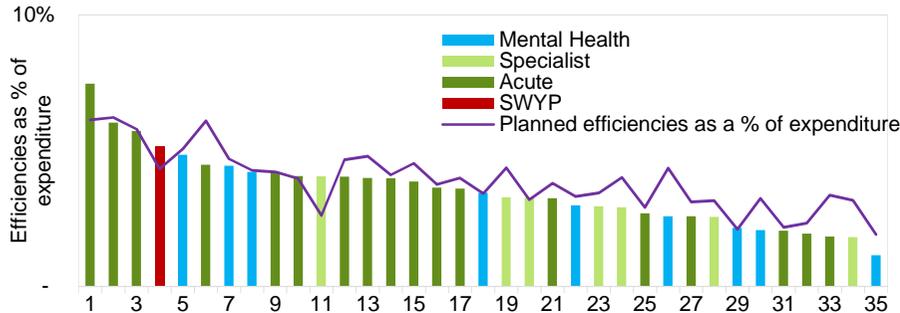
Source: Deloitte analysis of NHSI submissions

# Sector benchmarking

The sector is behind plan on delivery of efficiency savings. The trust has exceeded the planned level of savings for the year.

Nationally, providers delivered £2.1 billion of savings through efficiency (cost improvement programmes (CIPs) and revenue generation schemes during the first three quarters of the year, of which £1.5bn (71%) were from recurrent schemes. Overall, the sector forecast to finish the year was £313m behind plan with £3.3bn of savings, an increase of 3.6% of spend, compared to 3.1% for the first three quarters of the year.

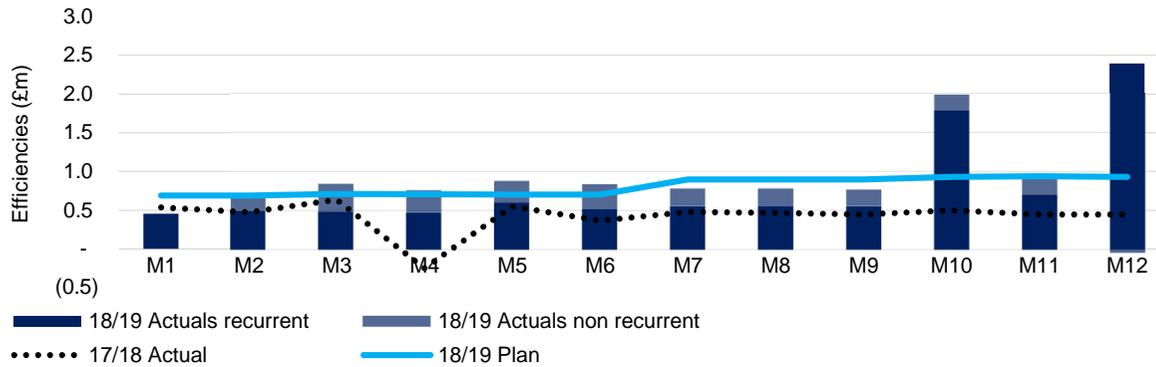
## Achieved efficiencies - year to 31 March 2019



Source: Deloitte analysis of NHSI submissions

On average, the trusts reviewed had planned to achieve efficiencies of 3.9% of operating expenses in 2018/19 (the Trust planned savings of 4.6%). The Trust has achieved efficiencies of 5.2% of operating expenses, £2.3m above plan.

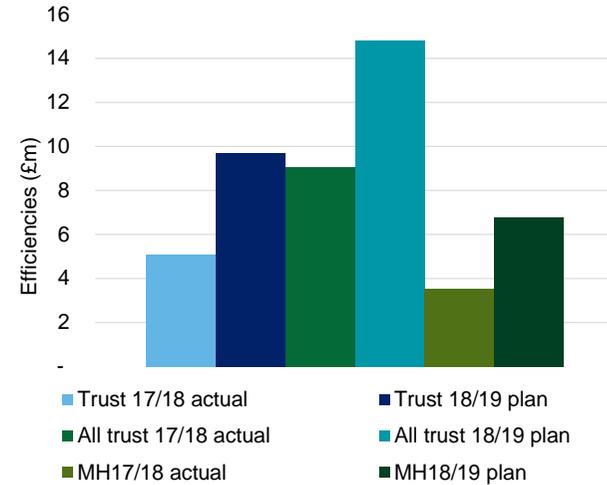
## Efficiencies



Source: Deloitte analysis of NHS Improvement submissions

Efficiencies (including revenue schemes) %/ £m	Trust	Mental Health Trusts	Acute and Specialist trusts	All Trusts
Planned efficiencies - YTD to 31 March 2019	9.7	6.8	18.5	14.8
Actual efficiencies - YTD to 31 March 2019	12.0	6.1	17.1	13.6
Actual as % of plan - YTD to 31 March 2019	123.9%	90.1%	92.3%	92.0%
Recurrent efficiencies as % of total to date	79.6%	69.4%	72.0%	71.6%
Plan CIPs as % of operating expenses	4.6%	4.1%	3.9%	3.9%
Actual CIPs as % of operating expenses	5.2%	3.5%	3.5%	3.5%

## Efficiencies



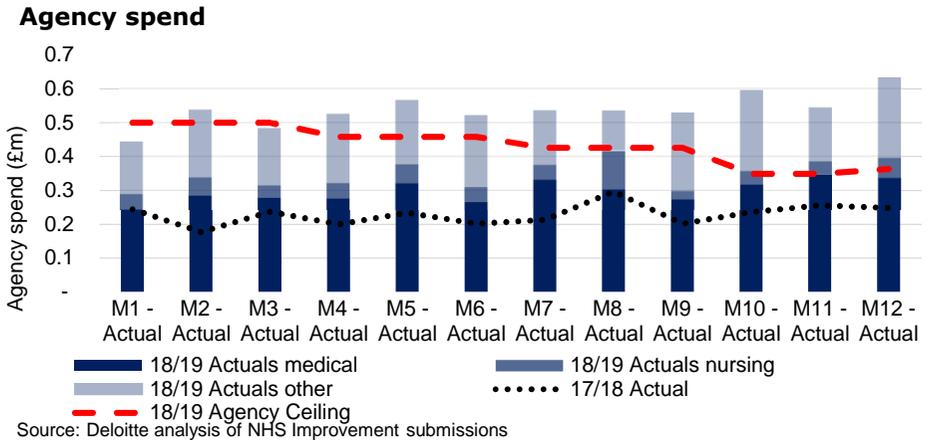
Source: Deloitte analysis of NHS Improvement submissions

# Sector benchmarking

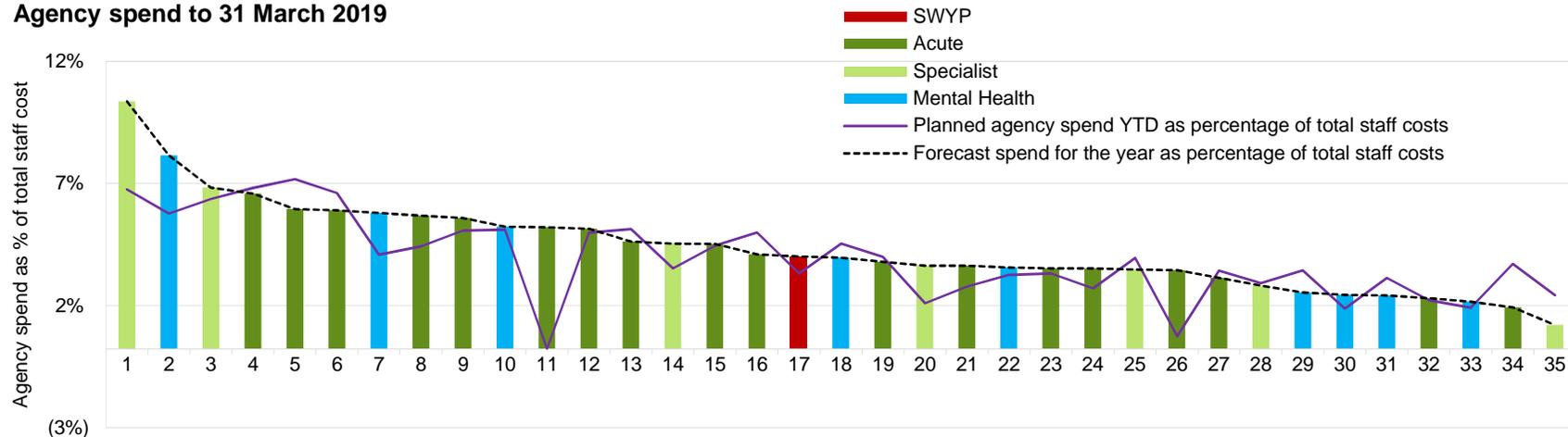
Most trusts have not delivered their planned pay savings. The Trust has achieved 89.1% of planned pay savings.

The main contributor to spending variances nationally are higher than planned pay costs. On average, trusts we audit achieved 76.7% of planned pay efficiencies compared to 89.1% for the Trust.

The Trust's agency costs of £6.5m year to date, compared to plan of £5.2m and an agency ceiling of £5.2m. The Trust's agency spend year to date is 3.8% of staff costs, compared to an average of 4.2% for trusts we audit and 4.0% for other Mental Health trusts.



## Agency spend to 31 March 2019



Source: Deloitte analysis of NHSI submissions

# Sector benchmarking

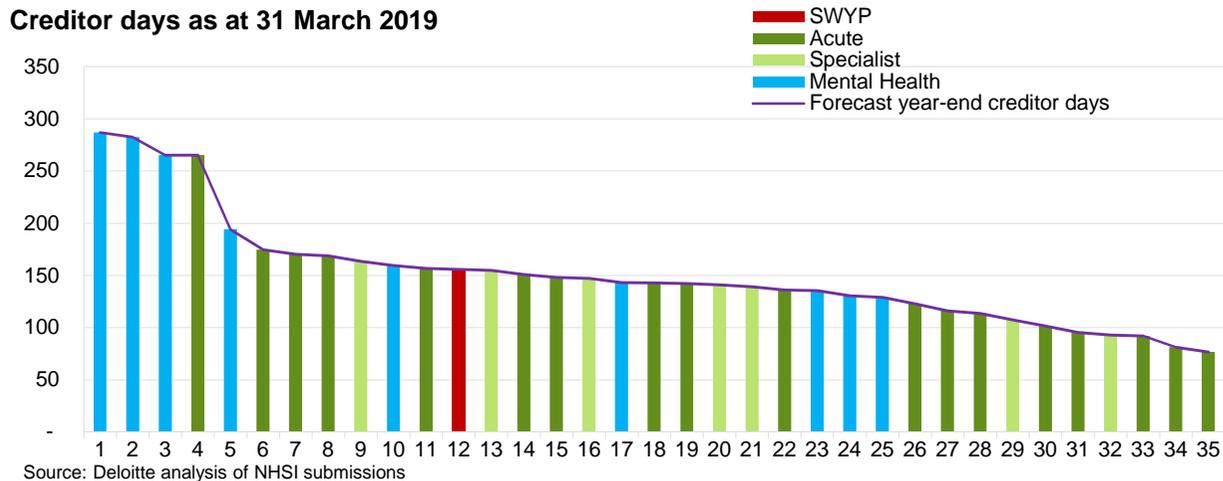
Although the sector has experienced increasing working capital pressures, most cash balances for trusts we audit are ahead of plan.

The charts to below and on the next page, show how the Trust's debtor and creditor days, as well as cash variance to plan, compare to other trusts we audit. The charts on the following page provide additional analysis on debtor aging at 31 March 2019.

The Trust's year-end cash balance was £27.8m, £9.8m above plan of £18m and £1.3m above 31 March 2018 balance of £26.6m. On average mental health trusts were £3.5m ahead of plan, and all trusts we audit were £8.9m ahead of plan.

The Trust debtor days at 31 March 2019 were 18 days compared to an average for mental health trusts of 27 and for all trusts of 37 (31 March 2018: 35).

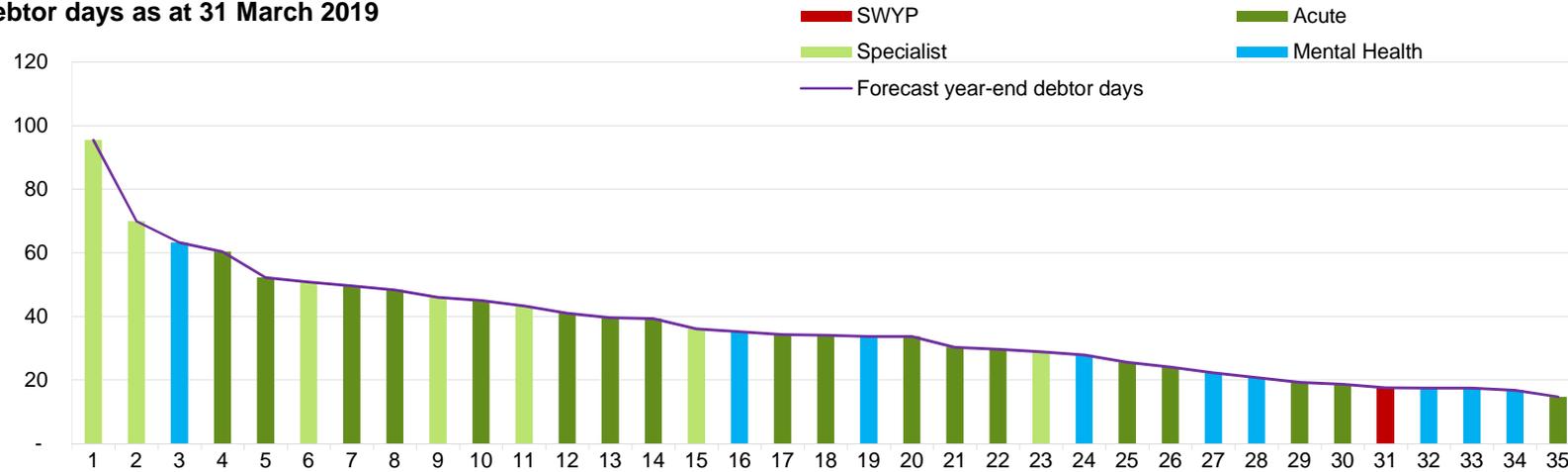
The Trust creditor days at 31 March 2019 were 156 days compared to an average for mental health trusts of 186 and for all trusts of 151 days (31 March 2018: 147).



# Sector benchmarking

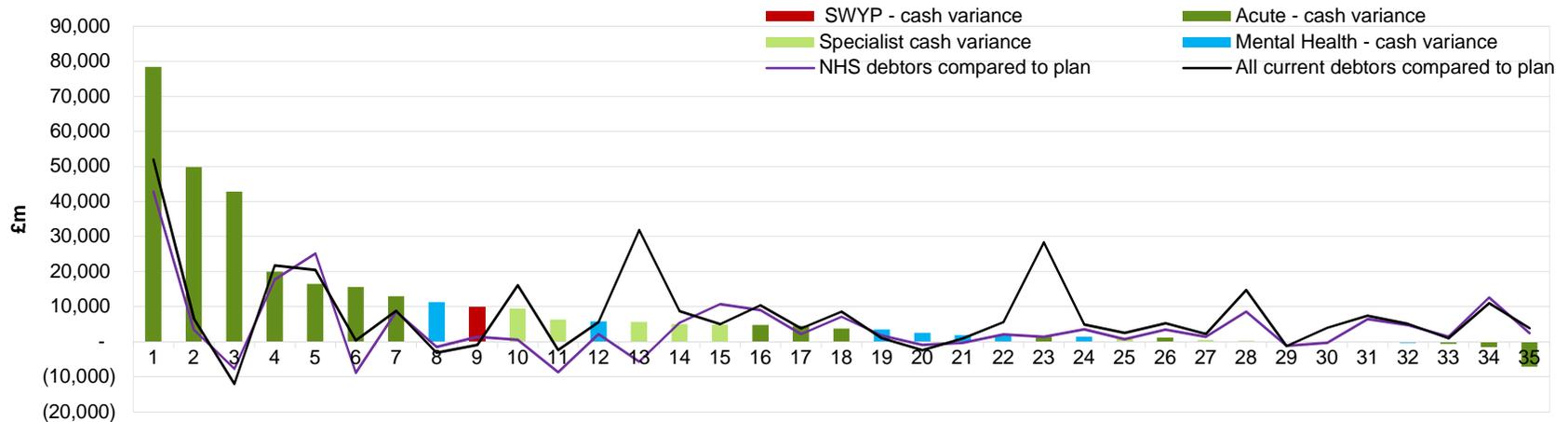
Although the sector has experienced increasing working capital pressures, most cash balances for trusts we audit are ahead of plan.

**Debtor days as at 31 March 2019**



Source: Deloitte analysis of NHSI submissions

**Cash variance to plan as at 31 March 2019**

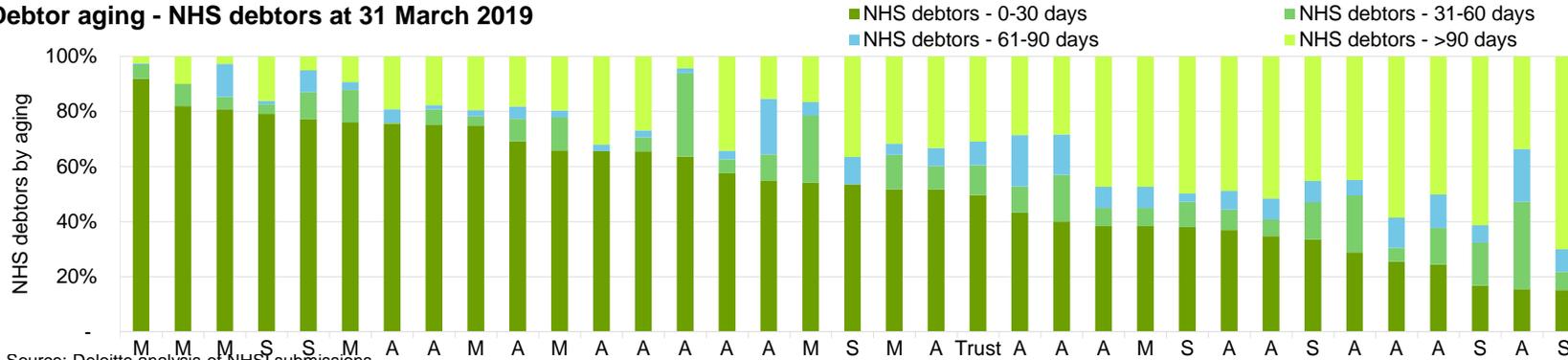


Source: Deloitte analysis of NHSI submissions

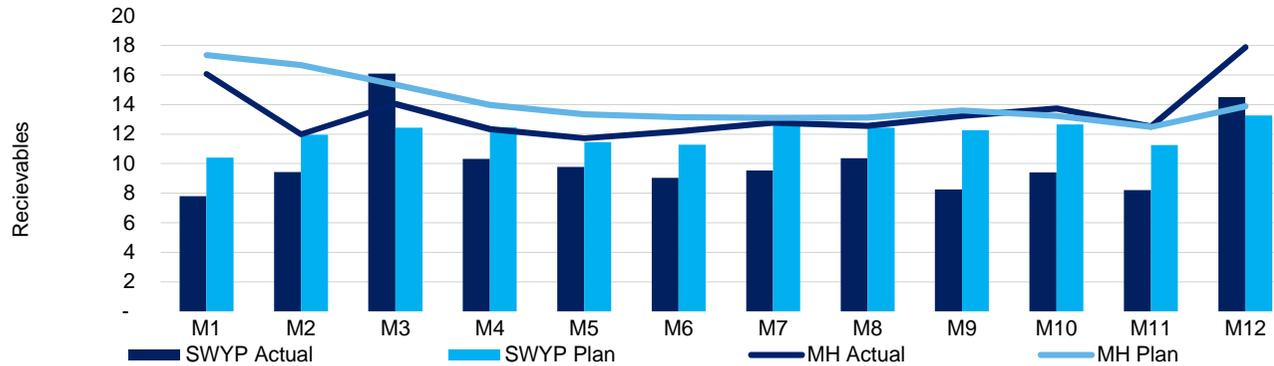
# Sector benchmarking

Although the sector has experienced increasing working capital pressures, most cash balances for trusts we audit are ahead of plan.

**Debtor aging - NHS debtors at 31 March 2019**



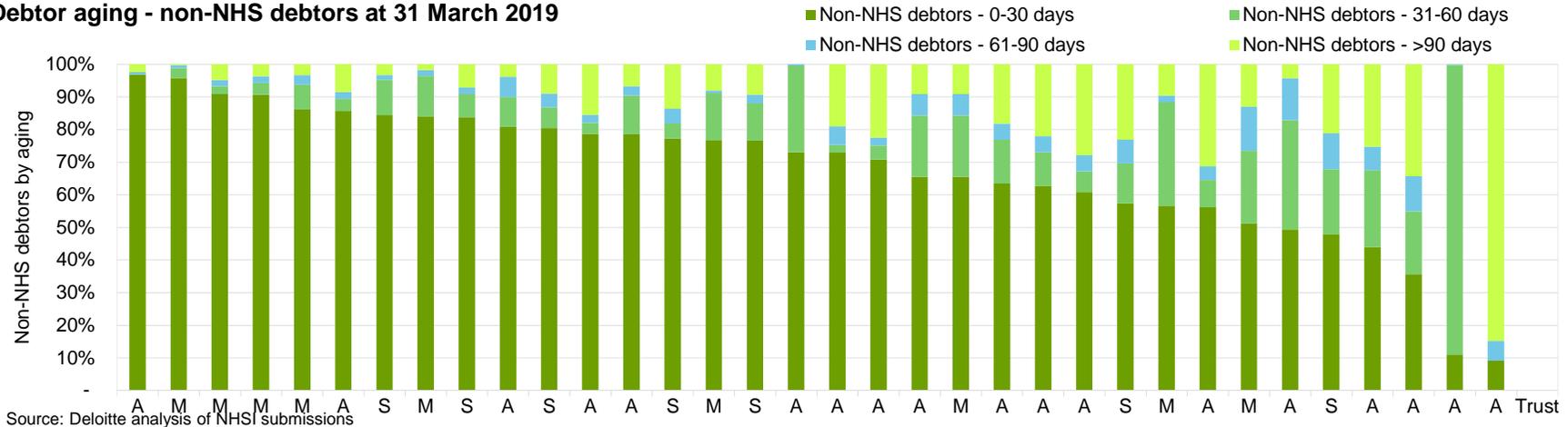
**Debtor days - current NHS and DH group debtors**



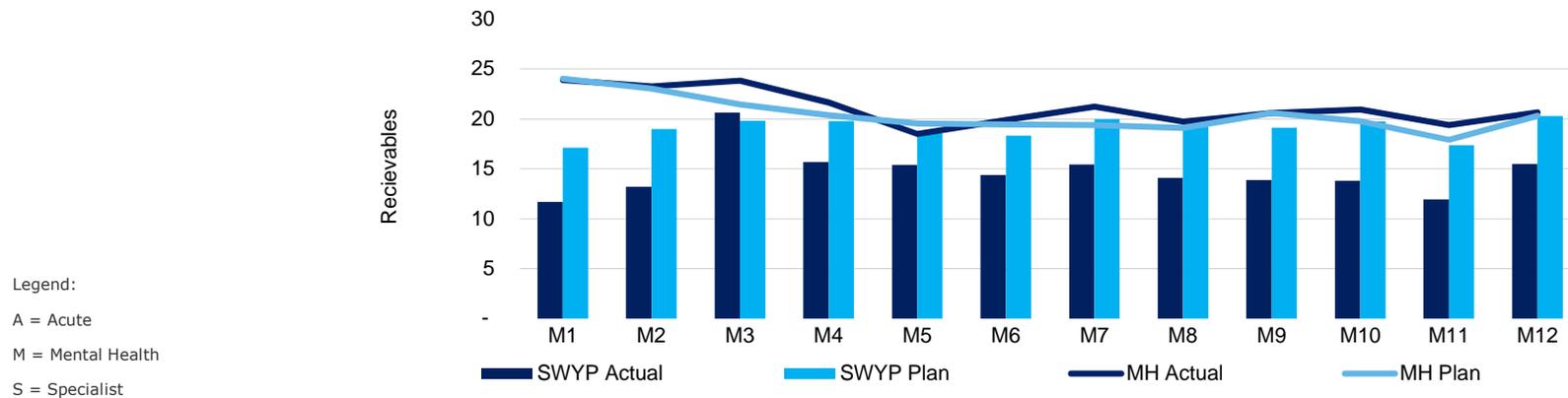
# Sector benchmarking

Although the sector has experienced increasing working capital pressures, most cash balances for trusts we audit are ahead of plan.

**Debtor aging - non-NHS debtors at 31 March 2019**



**Debtor days - total current trade and other receivables**



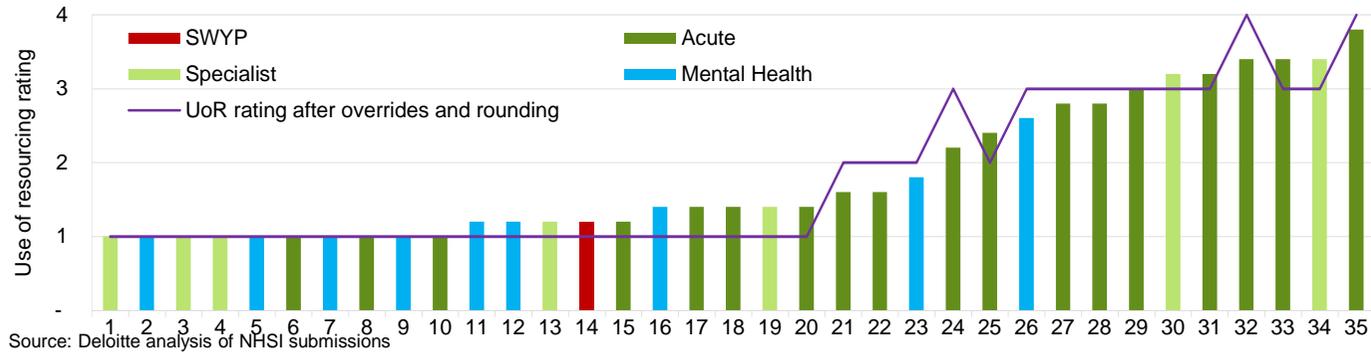
# Sector benchmarking

## Single Oversight Framework Risk Rating

The Trust has a risk rating at 31 March 2019 of 1. The table and chart below show how this compares to other trusts we audit.

Results for year to 31 March 2019				
	Trust	Trust	Mental Health	All trusts
	Plan	Actual	Actual	Actual
Capital service cover metric	1.0	1.0	1.3	2.1
Liquidity metric	1.0	1.0	1.3	1.9
I&E Margin metric	2.0	1.0	1.2	1.9
I&E Variance from plan metric		1.0	1.0	1.4
Agency staff use vs provider cap metric		2.0	2.1	1.9
<b>Overall rating (before rounding and overrides)</b>		1.2	1.4	1.8
<b>Rating after overrides</b>		1.0	1.4	1.8

Use of Resourcing rating (before overrides and rounding)





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## **South West Yorkshire Partnership NHS Foundation Trust**

### Findings and Recommendations from the 2018/19 NHS Quality Report External Assurance Review

Issued 17 May 2019 for the meeting on 21 May 2019

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# Executive Summary

We have completed our indicator testing and are finalising the consistency checks and anticipate signing an unmodified opinion.

## Status of our work

- We have completed our review, including validation of the reported indicators. We have still to receive the final signed Quality Report and letter of Representation, at which point we will issue our final report to the Governors.
- The scope of our work is to support a "limited assurance" opinion, which is based upon procedures specified by NHS Improvement in their "Detailed Requirements for External Assurance For Quality Reports for Foundation Trusts 2018/19".
- We anticipate signing an unmodified opinion for inclusion in your 2018/19 Annual Report.

The Care Quality Commission inspected during the year and graded the Trust as "Requires Improvement".

### 2018/19 (draft) 2017/18

Length of Quality Report	<b>74 pages</b>	<b>78 pages</b>
Quality Priorities	<b>19</b>	<b>32</b>

## Scope of work

We are required to:

- Review the content of the Quality Report for compliance with the requirements set out in NHS Improvement's Annual Reporting Manual ("ARM").
- Review the content of the Quality Report for consistency with various information sources specified in NHS Improvement's detailed guidance, such as Board papers, the Trust's complaints report, staff and patients surveys and Care Quality Commission reports.
- Perform sample testing of three indicators.
  - The Trust has selected Early Intervention in Psychosis (EIP) and Inappropriate Out of Area Placements as its publically reported indicators.
  - For 2018/19, all Trusts are required to have testing performed on a local indicator selected by the Council of Governors. The Trust has selected Cardio Metabolic Assessment.
  - The scope of testing includes an evaluation of the key processes and controls for managing and reporting the indicators; and sample testing of the data used to calculate the indicator back to supporting documentation.
- Provide a signed limited assurance report, covering whether:
  - Anything has come to our attention that leads us to believe that the Quality Report has not been prepared in line with the requirements set out in the ARM; or is not consistent with the specified information sources; or
  - There is evidence to suggest that the Early Intervention in Psychosis and Inappropriate Out of Area Placements indicators have not been reasonably stated in all material respects in accordance with the ARM requirements.
  - Provide this report to the Council of Governors, setting out our findings and recommendations for improvements for the indicators tested: Early Intervention in Psychosis, Inappropriate Out of Area Placements and Cardio Metabolic Assessment.

# Executive Summary (continued)

We have not identified any significant issues from our work.

## Content and consistency review



We have substantially completed our content and consistency review. From our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019 the Quality Report is not prepared in all material respects in line with the criteria set out in the ARM).

Overall conclusion	
<b>Content</b> Are the Quality Report contents in line with the requirements of the Annual Reporting Manual?	B
<b>Consistency</b> Are the contents of the Quality Report consistent with the other information sources we have reviewed (such as Internal Audit Reports and reports of regulators)?	TBC

## Performance indicator testing



NHS Improvement requires Auditors to undertake detailed data testing on a sample basis of two mandated indicators. We perform our testing against the six dimensions of data quality that NHS Improvement specifies in its guidance.

From our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019, the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the ARM and the six dimensions of data quality set out in the "Detailed Requirements for External Assurance on Quality Reports for Foundation Trusts 2018/19".

	Early Intervention in Psychosis	Inappropriate Out of Area Placements	Cardio Metabolic Assessment
<b>Recommendations identified?</b>	✓	✓	✓
<b>Overall Conclusion</b>	B Unmodified Opinion	B Unmodified Opinion	B No opinion required

The six dimensions of data quality:	
<b>Accuracy</b> Is data recorded correctly and is it in line with the methodology.	
<b>Validity</b> Has the data been produced in compliance with relevant requirements.	
<b>Reliability</b> Has data been collected using a stable process in a consistent manner over a period of time.	
<b>Timeliness</b> Is data captured as close to the associated event as possible and available for use within a reasonable time period.	
<b>Relevance</b> Does all data used generate the indicator meet eligibility requirements as defined by guidance.	
<b>Completeness</b> Is all relevant information, as specific in the methodology, included in the calculation.	

G No issues noted   
 A Requires improvement   
 B Satisfactory – minor issues only   
 R Significant improvement required

# Content and consistency findings

# Content and consistency review findings

**The Quality Report is intended to be a key part of how the Trust communicates with its stakeholders.**

**Although our work is based around reviewing content against specified criteria and considering consistency against other documentation, we have also made recommendations to management through our work to assist in preparing a high quality document. We have summarised below our overall assessment of the Quality Report.**

Key questions	Assessment	Statistics
• Is the length and balance of the content of the report appropriate?	Yes	Length: 74 pages
• Is there an introduction to the Quality Report that provides context?	Yes	
• Is there a glossary to the Quality Report?	Yes	
• Is the number of priorities appropriate across all three domains of quality (Patient Safety, Clinical Effectiveness and Patient Experience)?	Yes	Patient Safety: 5 Clinical Effectiveness: 5 Patient Experience: 9
• Has the Trust set itself SMART objectives which can be clearly assessed?	Yes	
• Does the Quality Report clearly present whether there has been improvement on selected priorities?	Yes	
• Is there appropriate use of graphics to clarify messages?	Yes	
• Does there appear to have been appropriate engagement with stakeholders (in both choosing priorities as well as getting feedback on the draft Quality Report)?	Yes	
• Does the Annual Governance Statement appropriately discuss risks to data quality?	Yes	
• Is the language used in the Quality Report at an appropriate readability level?	Yes	

## Deloitte view

Overall, the Quality Account has been prepared in all material respects with the Foundation Trust Annual Reporting Manual.

Particular areas of good practice include:

- The use of graphics throughout the report; and
- Concise presentation of information.

Possible areas for improvement next year include:

- Clearer reporting of the indicators which are subject to external audit.

# Performance and Indicator Testing

# Early Intervention in Psychosis ("EIP")

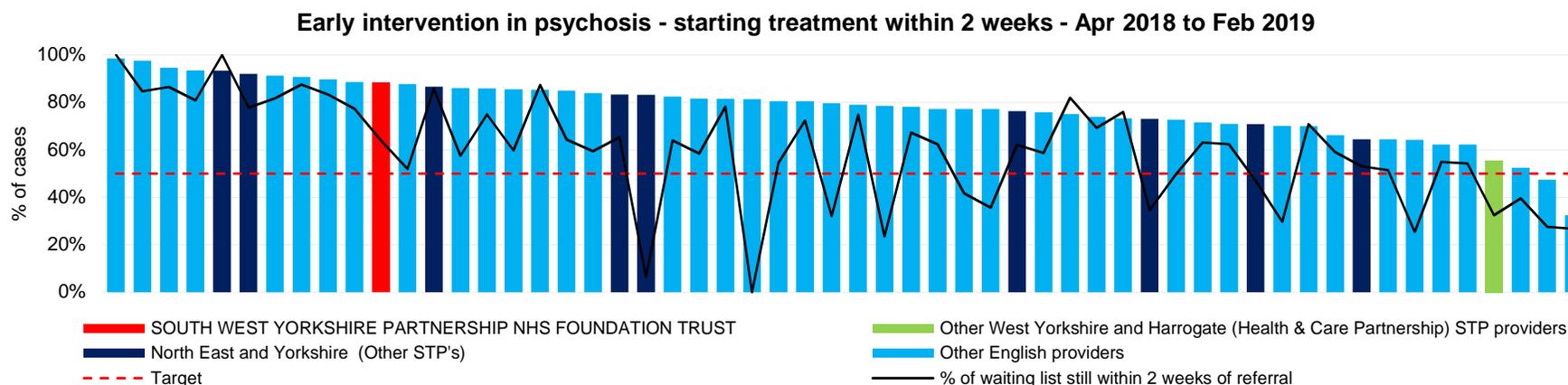
	Trust reported performance	Target	Overall evaluation
2018/19 (average)	88.1%	50%	B
2017/18 (average)	88.2%	50%	B

## Indicator definition and process

**Definition:** "The proportion of people experiencing first episode psychosis or 'at risk mental state' who wait two weeks or less to start NICE recommended package of care."

## National context

The chart below shows how the Trust compares to other organisations nationally for the first 11 months of 2018/19, based on the latest national data available.



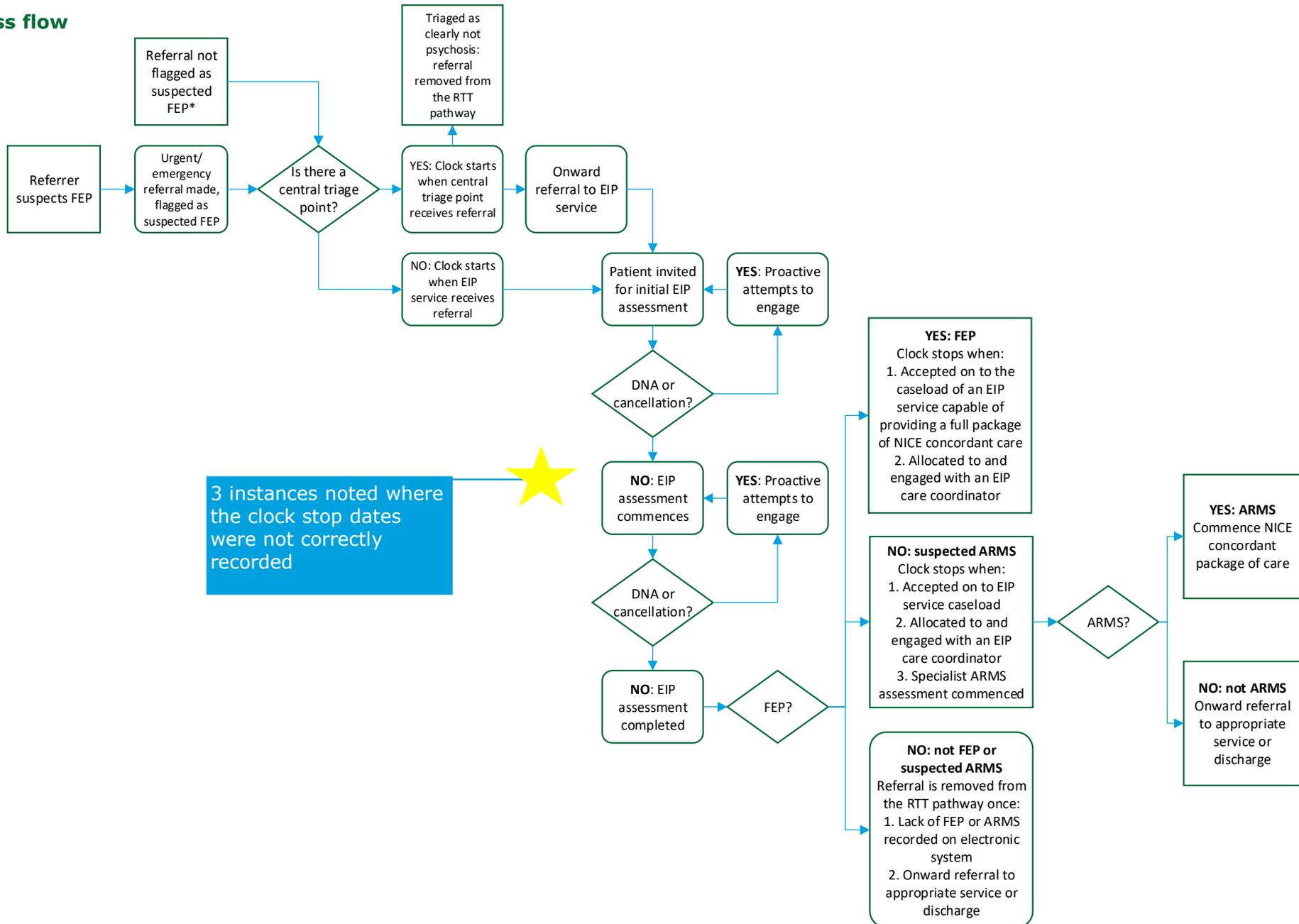
Source: Deloitte analysis of NHS England data. Percentage of waiting list still within 2 weeks of referral calculated as average of month end figures.

## National context of data quality

EIP was selected as a national indicator for the first time in 2017/18. Four out of 38 Foundation Trusts with this indicator tested received a qualification (11%).

# Early Intervention in Psychosis (continued)

## Process flow



# Early Intervention in Psychosis (continued)

## Approach

- We met with the Trust's leads to understand the process from a referral to the overall performance being included in the Quality Report. This is a newly tested indicator, and so there are no recommendations from the prior year.
- We evaluated the design and implementation of controls through the process.
- We selected a sample of 25 from 1 April 2018 to 31 March 2019 including in our sample a mixture of cases in breach and not in breach of the target. During our work we found 3 errors.
- We agreed our sample of 25 to the underlying information held within RiO and SystemOne.

## Findings

- 3 instances where the clock stop dates were incorrect based on the patient notes and information held in RiO and SystemOne however only one sample had an impact upon the indicator, with the other two having no impact.

## Deloitte View:

We have completed our testing on this indicator and do not have any issues to report. We anticipate issuing an unmodified opinion in respect of this indicator.

# Inappropriate Out of Area Placements

	<b>Trust reported performance</b>	<b>Target</b>	<b>Overall evaluation</b>
<b>2018/19</b>	<b>344 average per month</b>	<b>Progress against trajectory</b>	<b>B</b>
<b>2017/18 Q4</b>	<b>1,527</b>	<b>Progress against trajectory</b>	<b>B</b>

## Indicator definition and process

**Definition:** "Total number of bed days patients have spent out of area" on placements assessed as inappropriate, calculated as the average of the monthly position.

Out of area placements include all placements with other providers, and placements within a provider where usual frequency of contact with the care co-ordinator is not possible.

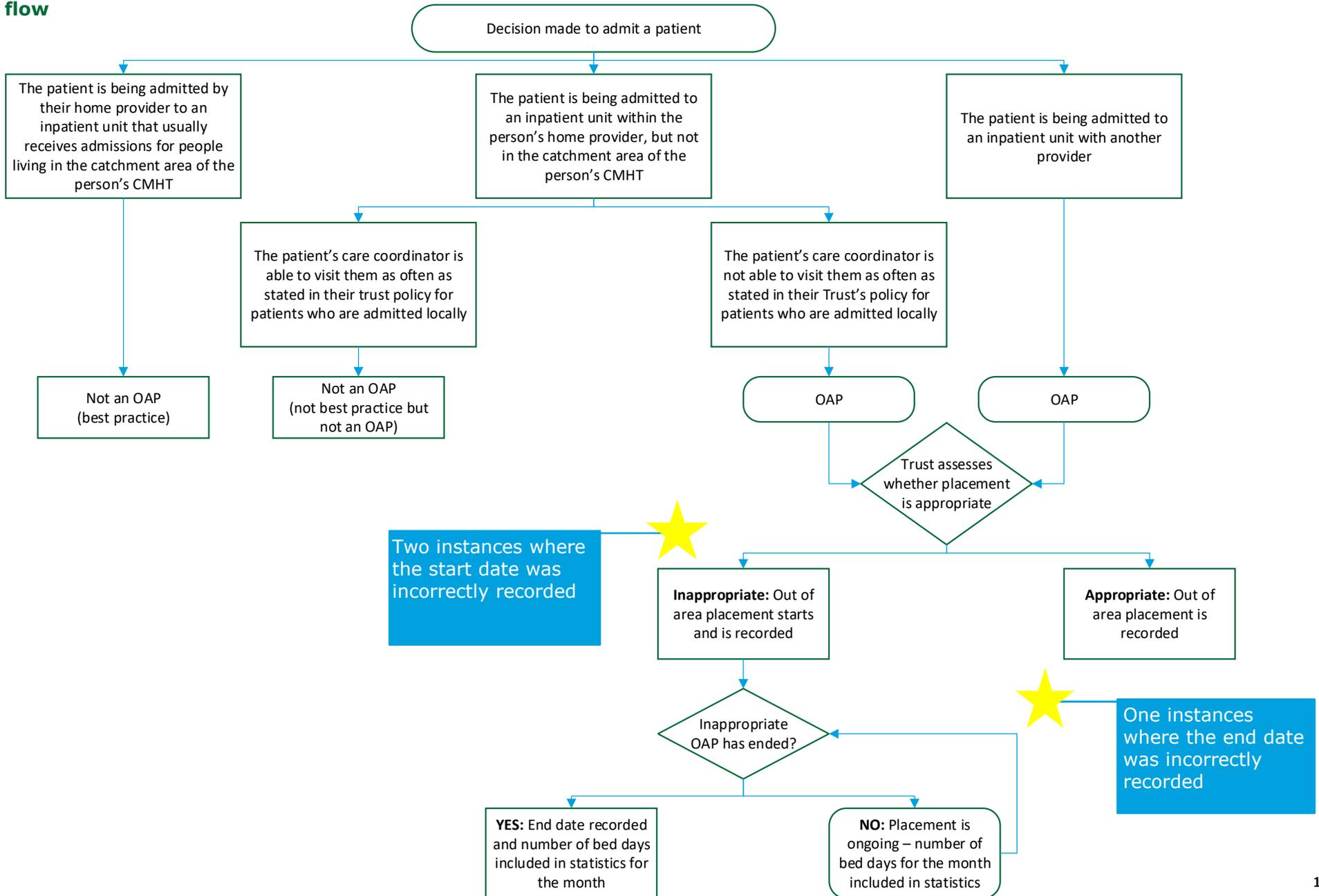
## National context

Inappropriate Out of Area Placements was selected as a national indicator for the first time in 2017/18. Three out of 29 Foundation Trusts with this indicator tested received a qualification (10%). For 2017/18, providers had a choice of reporting figures for Quarter 4 only, or for the whole year. The Trust decided to report only Quarter 4 figures, and so the comparative figure is not directly comparable.

The indicator has a number of potentially complex judgements to assess whether an Out of Area Placement is, in fact, appropriate. We understand from NHS Improvement that over 90% of placements are reported as "inappropriate", though it is not clear whether this is due to any overall issues in reporting or identifying "appropriate" placements, or reflects the actual split of cases. However, discussions in testing across our portfolio suggest that some of this may be due to less focus on classification for the metric than just reporting overall numbers of placements.

# Inappropriate Out of Area Placements (continued)

## Process flow



# Inappropriate Out of Area Placements (continued)

## Approach

- We met with the Trust's leads to understand the process from placement through to the overall performance being included in the Quality Report. This is a newly tested indicator, and so there are no recommendations from the prior year.
- We evaluated the design and implementation of controls through the process.
- We selected a sample of 25 from 1 April 2018 to 31 March 2019 including both placements with other providers and placements within the Trust. During our work we found 3 errors which affected 2 sample items.
- We agreed our sample of 25 to the underlying information held within RiO and SystemOne.

## Findings

- As part of our testing we identified one case where there was an incorrect recording of the start date and a further case where both the start and stop date were incorrectly stated.

## Deloitte View:

We have completed our testing on this indicator and do not have any issues to report. We anticipate issuing an unmodified opinion in respect of this indicator.

# Local Indicator – Cardio Metabolic Assessment

	<b>Trust reported performance</b>	<b>Target</b>	<b>Overall evaluation</b>
<b>2018/19</b>	<b>TBC</b>	<b>TBC</b>	<b>B</b>
<b>2017/18</b>	<b>TBC</b>	<b>TBC</b>	Not selected for testing

## Approach

- We met with the Trust's leads to understand the process surrounding the Cardio Metabolic Assessment. There were no recommendations from the previous auditor's review of last year's Quality Report as this indicator was not part of the external assurance work.
- We selected a sample of 25 from 1 April 2018 to 31 March 2019. During our work we found 1 error.

## Findings

- As part of our testing we identified one case where there was no evidence that an assessment had been completed.

## Deloitte View:

We have completed our testing on this indicator, and need to tie our work to the reported position in the Quality Account.

# Future changes in reporting requirements

# Clinically-led Review of NHS Access Standards

## The NHS National Medical Director has issued an interim report on recommendations for updating and supplementing current targets

### Issue

In 2018 Professor Stephen Powis, NHS National Medical Director, was asked to carry out a clinical review of standards across the NHS, with the aim of determining whether patients would be well served by updating and supplementing some of the older targets currently in use.

An interim report in March 2019 made a number of recommendations across elective care, urgent care, cancer and mental health, to replace and/or add to the existing clinical access standards. The standards are designed to support:

- shorter waiting times for a wider range of clinical services;
- more emphasis on standards that improve the quality of clinical care and outcomes;
- shorter waiting times for A&E and planned surgery, by tracking the entire wait for every patient; and
- standards that will enable trusts to modernise their care without being penalised.

The new standards are planned to be field-tested during 2019/20 and then implemented during 2020/21, with field testing to consider both the practicalities of adoption and also whether they:

- promote safety and outcomes;
- drive improvement in patient experience;
- are clinically meaningful, accurate and practically achievable;
- ensure the sickest and most urgent patients are given priority;
- ensure patients get the right service in the right place;
- are simple and easy to understand for patients and the public; and
- do not worsen inequalities.

The proposed indicators are set out on the next page. Dependant upon the final changes, this may affect the scope of Quality Report testing in from 2020/21.

### Deloitte View

The choice of specific targets to measure often involves trade-offs in what is captured, or not captured, by the indicators selected, and in the behaviours that are incentivised.

There have been a variety of responses to the proposals, reflecting in part the changes in what would be emphasised (and deemphasised) relative to the current targets and indicators.

The intention of the new indicators is to measure what is most important clinically and to patients. As the implementation of new standards progresses, it will be important that organisations do not focus solely upon achievement of performance against the selected metric, and that there is continued focus on the overall quality and timeliness of care provided to service users.

We highlight that the implementation of new metrics will require process and potentially system changes, and it will be important for the Trust to consider controls over data quality as part of implementing any changes.

# Clinically-led Review of NHS Access Standards (continued)

The NHS National Medical Director has issued an interim report on recommendations for updating and supplementing current targets

## Urgent care

The proposed standards would replace the current 4 hour wait target with a measure of the average waiting time, and a specific measure for treatment of the most critically ill patients.

- Time to initial clinical assessment in Emergency Departments and Urgent Treatment Centres (type 1 and 3 A&E departments). (The report does not include a specific target).
- Time to emergency treatment for critically ill and injured patients (complete a package of treatment in the first hour after arrival for life-threatening conditions).
- Mean waiting time in A&E (all A&E departments and mental health equivalents).
- Utilisation of Same Day Emergency Care. The aim is to complete all diagnostic tests, treatment and care that are required in a single day.
- Call response standards for 111 and 999.

## Mental health

A series of new indicators are proposed for testing, which would replace the current Early Intervention in Psychosis and Improving Access to Psychological Therapies targets. These would focus on faster access for mental health crises, with slower but timely targets for other support.

- Expert assessment within hours 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.

## Cancer

The proposed standards combine existing standards into simplified overall metrics:

- Faster Diagnosis Standard: Maximum 28 day wait to communication of definitive cancer / not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening.
- Maximum two-month (62-day) wait to first treatment from urgent GP referral (including for breast symptoms) and NHS cancer screening.
- Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.

## Elective care

The current 18 week RTT target may be revised, and a patient choice standard introduced.

- Maximum wait of six weeks from referral to test, for diagnostic tests (the current standard is to be retained).
- Defined number of maximum weeks wait for incomplete pathways, with a percentage threshold (current 18 week RTT threshold and maximum wait to be reviewed) **OR** Average wait target for incomplete pathways.
- 26-week patient choice offer (patients will be able to choose whether to access faster treatment elsewhere in a managed way).
- 52-week treatment guarantee.

# Appendices

# Appendix 1: Update on prior year recommendations

Indicator	Prior year finding	Current year status
Early Intervention in Psychosis	<b>Inappropriate start dates</b> There should be consistency in terms of the recording of start dates where there is a referral from within the Trust.	There have been no such instances noted in the current year.
Inappropriate Out of Area Placements	<b>Inappropriate start dates</b> There should be consistency of record keeping between the referral and the acceptance of an out of area placement.	There have been no such instances noted in the current year.
Local Indicator	<b>Completion of the RiO system</b> There should be consistency in terms of the dates input within the RiO system. Dates should be consistently input on the relevant screens within the RiO system.	This has been reviewed as part of training. However, this has not been reviewed in the year.

# Responsibility statement

# Purpose of our report and responsibility statement

Our report is designed to help you meet your governance duties

## What we report

Our report is designed to help the Council of Governors, Audit Committee, and the Board discharge their governance duties. It also represents one way in which we fulfil our obligations to report to the Governors and Board our findings and recommendations for improvement concerning the content of the Quality Report and the mandated indicators. Our report includes:

- Results of our work on the content and consistency of the Quality Report, our testing of performance indicators, and our observations on the quality of your Quality Report.
- Our views on the effectiveness of your system of internal control relevant to risks that may affect the tested indicators.
- Other insights we have identified from our work.

## Other relevant communications

- Our observations are developed in the context of our limited assurance procedures on the Quality Report and our related audit of the financial statements.

## What we don't report

- As you will be aware, our limited assurance procedures are not designed to identify all matters that may be relevant to the Council of Governors or the Board.
- Also, there will be further information you need to discharge your governance responsibilities, such as matters reported on by management or by other specialist advisers.
- Finally, the views on internal controls and business risk assessment in our final report should not be taken as comprehensive or as an opinion on effectiveness since they will be based solely on the procedures performed in performing testing of the selected performance indicators.

We welcome the opportunity to discuss our report with you and receive your feedback.

**Deloitte LLP**  
Newcastle Upon Tyne  
17 May 2019

This report is confidential and prepared solely for the purpose set out in our engagement letter and for the Board of Directors, as a body, and Council of Governors, as a body, and we therefore accept responsibility to you alone for its contents. We accept no duty, responsibility or liability to any other parties, since this report has not been prepared, and is not intended, for any other purpose. Except where required by law or regulation, it should not be made available to any other parties without our prior written consent. You should not, without our prior written consent, refer to or use our name on this report for any other purpose, disclose them or refer to them in any prospectus or other document, or make them available or communicate them to any other party. We agree that a copy of our report may be provided to NHS Improvement for their information in connection with this purpose, but as made clear in our engagement letter dated, only the basis that we accept no duty, liability or responsibility to NHS Improvement in relation to our Deliverables.



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## Trust Board 25 June 2019 Agenda item 9.2

<b>Title:</b>	<b>Trust Board self-certification (FT4) – corporate governance statement 2018/19</b>
<b>Paper prepared by:</b>	Director of Finance & Resources Company Secretary
<b>Purpose:</b>	To provide assurance to Trust Board that it is able to make the required self-certifications that the Trust complies with the conditions of the NHS provider license.
<b>Mission/values:</b>	Good governance supports the Trust to deliver its mission and adhere to its values.
<b>Any background papers/ previously considered by:</b>	Trust Board approved the operational plan for 2019/20 in March 2019 which was formally received in public in April 2019 The Trust Board reviewed compliance with NHS Constitution on 18 December 2018. The first part of the required self-certification (G6/CoS7) was approved by Trust Board on 30 April 2019. The attached document has been reviewed by the Executive Management Team.
<b>Executive summary:</b>	<p><b>Background</b></p> <p>NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements.</p> <p>As part of the annual planning arrangements, NHS Improvement requires the Trust to make a number of governance declarations. The Trust Board approved the first self-certifications (G6/CoS7) on 230 April 2019 in relation to:</p> <ul style="list-style-type: none"> <li>➤ The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (as required by condition G6(3) of the NHS Provider Licence); and</li> <li>➤ If providing commissioner requested services (CRS), the provider has a reasonable expectation that required resources will be available to deliver the designated service (as required by condition CoS7(3) of the NHS Provider Licence).</li> </ul> <p>Further self-certifications (FT4) are required by 30 June 2019:</p>

- The provider has complied with required governance arrangements (as required by condition FT4(8) of the NHS Provider Licence) (appendix 1 – Corporate Governance Statement); and
- The training of Governors (as required by s151(5) of the Health and Social Care Act 2012) (see below).

**Self-certification - part two (FT4)**

Draft Corporate Governance Statement 2018/19

The attached paper (appendix 1) sets out the statements (numbered 1-6) Trust Board is required to make and the assurance to support self-certification against the statements. From the assurance provided, Trust Board is asked to certify that it is satisfied with the risks and mitigating actions against each area of the required six areas within the Trust's Draft Corporate Governance Statement. The rationale for this assurance is set out in the accompanying detailed statement.

Training of Governors

Starting in 2013, the Trust has developed, through the Members' Council Co-ordination Group, a programme of training and development to ensure governors have the skills and experience required to fulfil their duties. The Trust has supported the training and development of governors in a number of ways:

- Each new governor had an induction meeting with the Chair and all other governors had an annual review meeting to discuss individual performance and training and development needs.
- The Trust offered 1:1 support and 'buddying' as part of the induction programme for new Governors.
- Attendance at national GovernWell training modules was also encouraged and the Trust facilitates attendance.
- There was an annual session to evaluate the contribution and work of the Members' Council in February 2019 which included a self-assessment by governors, both individually and collectively, of their contribution and effectiveness.
- Most formal Members' Council meetings include a discussion item or development session, which allows governors, with the support of Trust Board, to look at a particular area of Trust services or activity in more detail.
- Each governor has an annual performance review which includes attendance at meetings and training requirements

In 2014, the Members' Council signed up to the principle that there should be a level of minimum commitment and contribution from Governors at two levels:

*Required*

- Attendance at a minimum of three out of four formal Members'

	<p>Council meetings.</p> <ul style="list-style-type: none"> <li>➤ Attendance at the annual evaluation session.</li> <li>➤ 1:1 introductory meeting with the Chair.</li> <li>➤ Annual review meeting with the Chair.</li> <li>➤ Attendance at the Annual Members' Meeting.</li> </ul> <p><i>Desirable</i></p> <ul style="list-style-type: none"> <li>➤ Attendance at Trust Board meetings.</li> <li>➤ Attendance at training and development sessions organised by the Trust.</li> <li>➤ Attendance at the Foundation Trust Network's GovernWell modules.</li> <li>➤ Membership of formal groups (currently Members' Council Co-ordination Group, Quality Group and Nominations Committee).</li> </ul> <p>From the assurance provided, Trust Board is asked to certify this it <b><i>"is satisfied that, during the financial year most recently ended, the Trust has provided necessary training to its governors, as required by S151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role."</i></b></p>
<b>Recommendation:</b>	<p>Trust Board is asked to <b>NOTE</b> the outcome of the self-assessments against the Trust's compliance with the terms of its Licence and with Monitor's Code of Governance and <b>CONFIRM</b> that it is able to make the required self-certifications in relation to:</p> <ul style="list-style-type: none"> <li>➤ <b>the Corporate Governance Statement 2018/19; and</b></li> <li>➤ <b>the training for Governors 2018/19.</b></li> </ul>
<b>Private session:</b>	Not applicable.

Trust Board 25 June 2019  
Corporate Governance Statement 2018/19

**1. The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.**

The Trust continues to implement, develop and improve its arrangements to ensure it meets the principles and standards of good corporate governance and to ensure it has the systems and processes in place to meet these as well as its statutory, legal and regulatory duties and requirements. As part of this continuous improvement process, Trust Board last undertook a well-led governance review during 2015, which has been followed up by CQC well led reviews in each of 2017, 2018 and 2019.

In summary, following a robust and thorough review and scrutiny of the Trust's governance arrangements, which included interviews and focus groups with Trust Board, key stakeholders, the Members' Council and staff, the review concluded that there were no 'material governance concerns'. Out of the ten areas assessed, two areas were RAG rated as green (in relation to Board engagement with patients, staff, governors and other stakeholders, and the Board having the skills and capability to lead the organisation) and eight RAG rated as amber/green. In terms of the outcome, this reflected the developmental approach taken by Trust Board and the report very much reflected Trust Board's own assessment of the Trust's arrangements. The report identified a series of areas for development around clear articulation of our strategic priorities and strengthening how these are communicated, clear monitoring and reporting against these, further development of the Board Assurance Framework (BAF), monitoring and assurance of the Trust's transformation programme, and strengthening and enhancing staff engagement. A final report on the completion of the action plan was received by Trust Board in September 2016. Internal audit undertook a review of implementation in 2016/17 which received **significant assurance**. A further internal audit was undertaken in 2017/18 on the Trust's risk management and BAF which received **significant assurance**. The most recent CQC well review provided a rating of **good**.

Risks

*The Trust does not apply or applies inconsistently good corporate governance. Mitigated by robust scrutiny through the Trust's governance and assurance processes.*

The Trust was also subject to an inspection by the Care Quality Commission (CQC) in March 2016 and re-inspection in both 2017 and 2018. The most recent rating is that of requires improvement with a **good** rating for the well-led domain. The Board is due to undertake a structured development programme, using the NHSI framework, starting in the summer of 2019.

Risk

*The outcome of the inspection required some areas that require improvement. Mitigated by an action plan to address areas for improvement.*

There are a number of areas to provide assurance that the Trust applies the principles, systems and standards of good corporate governance.

- The Trust's Constitution, based on Monitor's model constitution, underpins its governance arrangements and the Trust operates within its Constitution at all times. Where necessary, the Trust seeks external advice on any changes, and ensures amendments are approved in line with the process set out in the Constitution. A review of the Trust's Constitution was conducted in 2016/17 and the update approved by the Trust Board and Members' Council in February 2017. It is next due for review in 2019.
- The Trust complies with all relevant rights and pledges set out in the NHS Constitution with the exception of the pledge "The NHS commits to make the transition as smooth as possible where you are referred between services, and to include you in the relevant discussions". The Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care; however, there are occasions where the nature of an individual's illness makes this inappropriate. The annual self-assessment was presented to Trust Board in January 2019.
- The Trust undertakes an annual assessment of compliance against NHS Improvement/Monitor's Code of Governance which is reported to Trust Board.
- The Trust has a register of interests in place for both Trust Board and the Members' Council, which is reviewed annually and both Directors and Governors are proactively asked to update their declarations. Directors and Governors are expected to declare any additions or changes to their declarations. The Chair of the Trust reviews the declarations and considers whether there are any conflicts of interest presenting a risk to the Trust. Non-Executive Directors also make a declaration of independence on an annual basis. All Non-Executive Directors have made a positive declaration. From April 2015, members of Trust Board have also been asked to make a declaration that they meet the fit and proper person requirement introduced in response to a recommendation made in the Francis Report. All members of Trust Board have made such a declaration and the Trust undertakes appropriate enquiries to ensure that newly appointed Directors meet the requirements as well as seeking an individual declaration. All members of Trust Board and the Executive Management Team have disclosure and barring (DBS) checks in place.
- All elections made to the Members' Council are held in accordance with the Model Election Rules in the Trust's Constitution. Elections are overseen by an external organisation (currently Electoral Reform Services) to ensure independence and transparency, and to ensure the Trust meets its statutory duties.
- The Trust was awarded a Licence on 1 April 2013. The Trust ensures it meets the conditions of its Licence through a process of self-assessment. There are no major issues or risks identified in relation to the Trust's continued compliance with its Licence.

Risk

*The Trust does not comply with the requirements of its Licence. Mitigated by ongoing review of Trust compliance and reporting to Trust Board as part of the NHS Improvement/Monitor requirements.*

The following also provide assurance to Trust Board that the Trust has good corporate governance arrangements in place.

- The Head of Internal Audit Opinion for 2018/19 provides **significant assurance** on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.
- As Accounting Officer, the Chief Executive prepares an Annual Governance Statement. This document describes the risk and assurance processes for the Trust and meets the requirements set out in NHS Improvement's Foundation Trust Annual Reporting Manual. The Statement for 2019/19 was assessed as fit for purpose and meeting guidance as part of the audit of the Trust's annual report and accounts.
- The Trust's Board assurance framework and risk register have been assessed as appropriate as part of an internal audit of the Trust's risk management

processes in 2017/18 which received **significant assurance**.

Risk

*The Trust does not continue to have good corporate governance arrangements in place. Mitigated by close scrutiny of NHS Improvement performance targets by the Executive Management Team quarterly reporting to Trust Board as part of the NHS Improvement reporting process.*

**2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time-to-time.**

The Accounting Officer and Company Secretary ensure that Trust Board is made aware of guidance on good corporate governance from NHS Improvement, an assessment of the Trust's immediate position is undertaken and any action or development required to ensure compliance is initiated.

Risk

*Trust does not have regard to guidance. Mitigated by the Company Secretary having oversight of the systems and processes in place to ensure guidance is identified, captured, assessed and implemented.*

**3. The Board is satisfied that the Trust implements:**

- a) effective board and committee structures;**
- b) clear responsibilities for its board, for committees reporting to the board and for staff reporting to the board and those committees; and**
- c) clear reporting lines and accountabilities throughout its organisation.**

Trust Board is clear that its role is to set the strategic direction and associated priorities for the organisation, ensure effective governance for all services and provide a focal point for public accountability. The general duty of Trust Board, and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for members of the Trust as a whole and the public. Trust Board is clear of its accountability and responsibility.

Trust Board and committee structures in place are effective and meet the requirements of the Trust's Constitution. Committees are supported by terms of reference and annual work plans and have clear reporting mechanisms to Trust Board. The Trust Board has a work programme and agenda is drawn up with reference to the board assurance framework, and cycle of meetings. The Trust has six committees:

- Audit Committee;
- Clinical Governance and Clinical Safety Committee;
- Mental Health Act Committee;
- Workforce and Remuneration Committee (previously call Remuneration and Terms of Service Committee);
- Equality and Inclusion Committee;
- Charitable Funds Committee (Committee of the Corporate Trustees)

The committees and forum are chaired by a Non-Executive Director and, with the exception of the Audit Committee, have Non-Executive and Executive

Director membership. The Audit Committee membership comprises exclusively of Non-Executive Directors. Agendas, which are risk-based, are compiled and agreed by the Chair of the committee in conjunction with the lead Director. Each committee has an annual work programme, which is incorporated into agendas as appropriate. Lead Directors are responsible for ensuring, with the Company Secretary, that papers are commissioned to meet the requirements of the committee, to provide assurance that risk is mitigated within the Trust and to provide assurance that the Trust is working to deliver and continuously improve the services it provides whilst achieving value for money and best use of resources.

The membership of committees is reviewed regularly by the Chair of the Trust in terms of Non-Executive Directors. The committee structure is reviewed for appropriateness from time-to-time by the Chair. An update to the internal meeting governance framework was approved by Trust Board in April 2019.

Each committee is required to prepare an annual report, which is presented to the Audit Committee. The Audit committee reviews overall effectiveness of committee structure This provides assurance to Trust Board that each committee is meeting its terms of reference and is seeking assurance on areas of risk in line with its terms of reference. The outcome is reported to Trust Board annually in April.

The Executive Management Team's (EMT) role is to ensure that resources are deployed to support the delivery of the Trust's plan, to ensure that the Chief Executive can discharge their accountability to best effect through effective delegation and prioritisation of work, to support each other to find appropriate linkages and synergies, to ensure performance is scrutinised and challenged, both Trust-wide and by Business Delivery Units (BDUs), and to ensure the work of the EMT is aligned with that of Trust Board.

Trust Board is supported by an involved and proactive Members' Council, which forms a key part of the Trust's governance arrangements. The Members' Council is clear that its role is to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors and to represent the interests of the members of the Trust as a whole and the interests of the public. The Members' Council continues to develop its skills and experience in its ability to challenge and hold Directors to account for the Trust's performance.

The Trust works within a framework that devolves responsibility and accountability throughout the organisation through robust service delivery arrangements. There are clear structures with clear responsibility and accountability below Director level. Within BDUs, deputy directors provide operational leadership and management allowing BDU Directors to focus on building and managing strategic and partner relationships and to lead the transformation agenda. BDUs are supported by arrangements at service line level where a clinical lead, general manager and practice governance coach work together and carry responsibility at ward, unit and department level to ensure excellence in service delivery and quality and to enact the service change required to achieve transformation.

BDUs are supported by corporate directorates, which provide co-ordinated support services linked to the accountabilities of executive directors. There are six domains comprising financial management, information and performance management, people management, estates management, compliance, governance and public involvement and engagement, and service improvement and development.

#### Risk

*The Trust does not have effective structures at Trust Board level. Mitigated by annual committee review process, independent review by internal audit of effectiveness, clear view of roles and responsibilities, and clear approach to leadership and management throughout the Trust.*

#### **4. The Board is satisfied that the Trust effectively implements systems and/or processes:**

- a) to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively;
- b) for timely and effective scrutiny and oversight by the Board of the Licence holder's operations;
- c) to ensure compliance with healthcare standards binding on the Licence holder, including, but not restricted to, standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of healthcare professions;
- d) for effective financial decision-making, management and control (including, but not restricted to, appropriate systems and /or processes to ensure the Licence holder's ability to continue as a going concern);
- e) to obtain and disseminate accurate, comprehensive, timely and up-to-date information for Trust Board and Committee decision-making;
- f) to identify and manage (including, but not restricted to, manage through forward plans) material risks to compliance with the conditions of its Licence;
- g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and, where appropriate, external assurance on such plans and their delivery; and
- h) to ensure compliance with all applicable legal requirements.

As part of its annual audit, the Trust's external auditor, Deloitte, was satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources in 2018/19. There were no issues identified to report in the audit opinion.

Risk

*The Trust does not have the systems and processes to ensure compliance with its Licence. Mitigated by performance reporting arrangements to Trust Board, including exception reports on areas of risk or concern, quarterly exception reports, robust committee arrangements in place providing assurance that the systems and processes in place are effective.*

The Trust's internal audit plan is risk-based to enable the Trust to identify areas where improvement is sought and to learn from best practice. The Audit Committee approved the internal audit plan for 2018/19. The plan included core reviews to inform the Head of Internal Audit Opinion relating to core financial controls, corporate governance arrangements, which was focus on Board committee arrangements, and data security and protection toolkit. This was supported by a number of cyclical and risk reviews covering cost improvement process and reporting. Cyber security, data quality framework, performance management framework, patient experience (focus on complaints) and compliance with legislation. Internal Audit also conducted a survey of all Board members in respect of governance, risk management and culture.

The Trust continues to develop and implement service line reporting, which is monitored and scrutinised by the Audit Committee on behalf of Trust Board. Further work will be undertaken in the coming year to use the information to benchmark internally and learn from best practice.

Trust Board receives an Integrated Performance Report (IPR) on a monthly basis. This enables Trust Board to satisfy itself that the Trust is meeting its financial and quality performance targets. Other reports to Trust Board and its committees provide further assurance that the Trust is fulfilling its purpose in an effective and efficient manner.

The Trust was (and continues to be) registered with the Care Quality Commission (CQC) with no conditions. The Trust has a robust process in place to ensure that it meets the requirements of its registration. The Trust was subject to an inspection by the CQC in March 2016 and re-inspected in both January 2017 and March 2018. Action plans were developed in response to recommendations included in the inspection reports. For 2018/19, the Trust's programme of visits to services focused on areas 'requiring improvement' in the reports. Mental Health Act visits occur regularly and, following each visit, an

action plan is submitted to the CQC to address any issues raised. The action plans and progress against these are monitored and scrutinised by the Mental Health Act and Clinical Governance and Clinical Safety Committees. Local actions have also been implemented in relation to any identified concerns arising from the Trust's own unannounced visit programme.

Based on evidence provided by finance and performance reports and the Trust's operational plan for 2019/20, supported by Audit opinion, the Trust will remain a going concern. As part of its accounts audit for 2018/19, the Trust's external auditor was able to agree with management's view that the Trust could account on a going concern basis. The coming year presents a challenge to the Trust in meeting its operational and financial plans. Trust Board will regularly review the Trust's position and it is planned to introduce a finance committee during the year.

Risk

*The Trust is unable to meet the requirements of its operational and financial plans for 2019/20. Mitigated by regular review at finance oversight group until a new finance committee is fully established to ensure its plans provide sufficient investment in services and to consider the planned end-of-year outturn position.*

The Trust has policies and procedures in place to ensure it complies with legislation both as an employer and as a provider of NHS services.

**5. The Board is satisfied that:**

- a) there is sufficient capability at Trust Board level to provide effective organisational leadership on the quality of care provided;**
- b) Trust Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;**
- c) the collection of accurate, comprehensive, timely and up-to-date information on quality of care;**
- d) Trust Board receives and takes into account accurate, comprehensive, timely and up-to-date information on quality of care;**
- e) the Trust, including Trust Board, actively engages on quality of care, with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and**
- f) there is clear accountability for quality of care throughout the Trust, including, but not restricted to, systems and/or processes for escalating and resolving quality issues, including escalating them to Trust Board where appropriate.**

The Trust continues to regularly reviews processes against governance best practice, including:

- policies developed, reviewed and in place;
- governance systems;
- the assurance framework and risk register presented to Trust Board quarterly;
- audits undertaken both internally and externally;
- the programme of unannounced visits; and
- reports submitted to Trust Board and its Committees, as well as the Members' Council.

The Trust's Quality Account for 2018/19 provides a summary of the Trust's quality achievements and challenges, demonstrating how it meets its statutory and regulatory requirements as well as how it meets the expectations of its service users, carers, stakeholders, its members and the public. The report was externally audited. This provided the required limited assurance opinion on the content and consistency of the report, that the content was in line with the Annual Reporting Manual 2018/19 issued by NHS Improvement and consistent with documents reviewed.

The process introduced by the Director of Nursing and Quality to assess risk to and impact on quality and safety of the cost improvement and efficiency savings proposed by BDUs was again applied in 2018/19. The Quality Impact Assessment process, led by the Director of Nursing and Quality and undertaken in conjunction with clinical and general management within BDUs, provides assurance throughout the process to the Executive Management Team (EMT) and, through regular reports, to the Clinical Governance and Clinical Safety Committee and Trust Board that cost improvements do not have an adverse effect on Trust services. In 2018/19, assessment of the impact of substitutions or mitigating action are included in the process as well as cost pressures.

The Trust's approach to quality improvement is clear that quality is the responsibility of all staff from 'ward to board'. Reporting processes and mechanisms through Trust Board, its committees, EMT and through to BDUs and their governance processes reflects this approach. Accountability for quality is also clear through the leadership and management arrangements within the Trust. BDUs continue to enable better and more rapid decision-making, as close as possible to the point of care delivery, which, in turn, enables more effective clinical engagement and leadership in service development and delivery as well as providing service users with greater access to decision-making.

The Trust's approach to clinical quality improvement is supported by the Quality Academy approach, which is based on continuous service improvement, working in innovative ways to meet local priorities, to ensure compliance with national standards and external regulation, adoption of lean systems thinking, and making the most of shared learning opportunities across the healthcare system, using quality to deliver best value. The Trust's strategic priorities and combined support service offer aligns clinical services and support functions to deliver the best care possible to those who use Trust services. The approach also links to the national Quality, Innovation, Productivity and Prevention (QIPP) agenda.

Trust Board receives regular reports, directly and through the Clinical Governance and Clinical Safety Committee, on all aspects of clinical quality and safety including management of incidents and complaints, equality and diversity, service user experience, control of infection and research and development. The Clinical Governance and Clinical Safety Committee provides assurance to Trust Board that issues and risks identified in a number of portfolio areas, such as managing aggression and violence, safeguarding adults and children, infection prevention and control, reducing restrictive practice, and information governance, are being addressed. Where the Clinical Governance and Clinical Safety Committee identifies an area of concern which has been raised at a particular time, it is scrutinised on behalf of the board by receiving regular reports for a period.

Performance reports to Trust Board provide assurance against a range of Key Performance Indicators (KPIs\_ relating to service quality and, where reports indicate underperformance, action plans are provided to and monitored by Trust Board.

The Trust has a range of arrangements in place for monitoring service user experience as an indicator of service quality. This includes surveys, consultations and engagement events. The Trust's approach to insight and service user experience is set out in its Communication, Engagement and Involvement Strategy. Regular meetings are also held in community and ward settings to receive service user and carer feedback. The Trust continues to look for innovative ways to capture service user and carer feedback at the point of contact.

The Trust is compliant with the Health Act 2006: Code of Practice for the Prevention and Control of Healthcare Associated Infection (Hygiene Code). The Trust has an Infection Control Strategy in place and the infection control annual plan and annual report are considered by the Clinical Governance and Clinical Safety Committee on behalf of Trust Board. Trust Board monitors infection control through the monthly performance reports and the quarterly compliance report. Hygiene and quality of environment are maintained through cleaning schedules and through service level agreements and regular visits to

clinical areas by the Director of Nursing and Quality, include checks for cleanliness.

The Trust publishes information in relation to the Friends and Family test for service users and staff.

The Trust actively engages with its service users, their carers, staff and stakeholders on the quality of its services through the development of its Quality Accounts and in the development of its services.

The Trust has a whistleblowing policy in place, which sets out clearly staff responsibility to raise concerns and how they can do this. The policy is clear on the escalation process and who concerns should be reported to. The policy is supported by information on the Trust's intranet and in associated documentation, such as the fraud and bribery act policy, safeguarding policies, and serious incident reporting and management policy. Arrangements are scrutinised by the Audit Committee. The Trust has also appointed its staff Governors on the Members' Council as a network of Freedom to Speak Up Guardians (FTSUG) rather than one individual due of the diverse nature of services and large geographical spread of the Trust, the FTSUG provide staff with another way to raise concerns at work. From 2019/20 an expanded FTSUG role is being advertised on a secondment basis. Trust Board has also identified the Deputy Chair as the Senior Independent Director.

Risk

*The Trust does not have the capacity and capability at Trust Board level. Mitigated by quality performance reporting to Trust Board, annual quality report, customer services processes and ongoing engagement with stakeholders, service users/carers and staff, clear process in place for whistleblowing and raising concerns, and processes in place for recruitment and selection of Trust Board members.*

**6. Trust Board effectively implements systems to ensure that it has in place personnel on Trust Board, reporting to Trust Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of the Trust's NHS provider licence.**

Trust Board is satisfied that all Directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability.

The Chair and Non-Executive Directors have a broad base of skills and experience, including financial, commercial, marketing, legal, community engagement, and health and social care. It is the role of the Nominations Committee to assess the mix of skills and experience across Trust Board annually and when appointing Non-Executive Directors to the Board and to ensure a balance is maintained with skills complementing those of Executive Directors. To inform this process and to ensure Trust Board retains a balance of skills and experience to operate effectively as a unitary board, a review of Trust Board skills and experience will be undertaken as part of the Trust Board development plan. The recruitment process for new members of the Trust Board incorporates testing against the values of the organisation and discussion panel including staff (with representation from staff equality networks), governors and service users/carers.

All new Non-Executive Directors have a detailed induction programme tailored to individual requirements and Board responsibilities. The Chair is subject to an annual assessment of performance by the Members' Council, led by the Senior Independent Director, and involving Non-Executive Directors, Executive Directors and Governors. Trust Board undertakes ongoing Board development, using external expertise where required.

The Chief Executive is subject to formal annual appraisal by the Chair. Executive Directors are subject to annual appraisals by the Chief Executive, and Non-Executive Directors are subject to annual appraisal by the Chair, both of which inform individual development plans for all Board members. The outcome of the Non-Executive Director appraisals is reported to the Members' Council.

Continuous professional development of clinical staff, including medical staff, supports the delivery of high quality clinical services. The Trust has policies, processes and procedures in place to ensure all medical practitioners providing care on behalf of the Trust have met the relevant registration and re-validation requirements. This process of assessing the organisation's readiness for medical and nursing re-validation has been scrutinised both by Trust Board and by the Clinical Governance and Clinical Safety Committee.

Trust Board satisfies itself that the management team has the necessary skills and competencies to deliver the Trust's strategic objectives. Where gaps are perceived, the Chief Executive will seek to address Trust Board concerns, supported by the Workforce and Remuneration Committee.

All appointments to senior management positions are subject to rigorous and transparent recruitment processes. Senior managers have objectives linked to the delivery of the strategic objectives and operational plan. The Chair and Chief Executive continue to review the capacity of senior managers within the Trust to ensure there is the required and necessary balance to deliver and maintain high quality and safe services during a time of unprecedented transformational change within the organisation and wider NHS and succession planning. Professional and clinical leadership is devolved into the organisation under the leadership of the Director of Nursing and Quality, and the Medical Director.

The Trust also has various leadership and management development pathways in place including a programme for all managers within the Trust at bands 7 and above, Middleground, which aligns effort and resources to shared organisational goals, ensures all effort and initiatives link together to create added value, ensures behaviours and actions are aligned to the organisational vision, values and goals, and ensures behaviours help produce performance, assurance and improvement at individual, team and organisational level.

Risk

*The Trust does not have suitably qualified individuals at all levels of the organisation. Mitigated by recruitment and selection processes for Trust Board, Director-level appointments and staff at all levels.*

## Trust Board 25 June 2019

### Agenda item 9.3

<b>Title:</b>	<b>Annual Safety Services Report 2018/2019 and 2019/2020 Action Plans</b>
<b>Paper prepared by:</b>	Director of Human Resources, Organisational Development and Estates
<b>Purpose:</b>	The purpose of the paper is to provide assurance to the Trust Board that robust arrangements are in place around health and safety, security and emergency planning and to provide an overview of arrangements that take place within the Trust.
<b>Mission/values:</b>	The report demonstrates the Trust's commitment to delivering safe and effective services.
<b>Any background papers/ previously considered by:</b>	Executive Management Team and Clinical Governance and Clinical Safety Committee have received this report and the Safety Trust Action Group (TAG) meets quarterly in the organisation to provide oversight to the workings of the safety services teams and their activity.
<b>Executive summary:</b>	<ul style="list-style-type: none"> <li>➤ For the third year running, Health &amp; Safety management across the Trust has improved following analysis from the Annual Health &amp; Safety Monitoring Tool. A programme of audits has been established to ensure continued improvement is maintained;</li> <li>➤ Partnership working continues to be well established with third party Trusts, Local Authorities, the Health &amp; Safety Executive (HSE), Clinical Commissioning Groups (CCG's), Police forces and Fire &amp; Rescue Services;</li> <li>➤ The development and implementation of the Significant Event Analysis procedure;</li> <li>➤ The installation of a fire suppression system in the Melton PICU ward at Kendray;</li> <li>➤ The replacement and upgrade of the fire detection system at Kendray;</li> <li>➤ The continued support to Lockdown implementation across the Trust, with new procedures being implemented at Trust Hubs;</li> <li>➤ The successful delivery of the Flu campaign which has seen the Trust obtain full Flu CQUIN delivery for the third year running;</li> <li>➤ Achieving Substantial compliance against the NHS England Core Standards for Emergency Preparedness, Resilience and Response.</li> </ul>
<b>Recommendation:</b>	<b>The Trust Board is asked to APPROVE the Annual Safety Services Report 2018/2019 and 2019/2020 Action Plans</b>
<b>Private session:</b>	Not applicable.

# Safety Services

**Annual Report 2018/2019 and 2019/20 Action Plans**

**April 2019 Nick Phillips, Head of Estates & Facilities**

Produced in conjunction with Specialist Safety Service Advisers

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## 1. Executive Summary

This report has been produced in order to provide an overview of the activity within safety and security services in 2018/19 and to provide assurance to the Board on activity in 2018/19. Overall safety and security management has been in line with annual plans with the notable addition of leading on the operational response to Brexit which is ongoing. Overall the following points are of particular note:-

- For the third year running operational health & safety management across the Trust has improved this has been shown following analysis of the annual health & safety monitoring tool. A programme of audits has been established to ensure continued improvement is maintained;
- Partnership working continues to be well established with third party Trusts, Local Authorities, the Health & Safety Executive (HSE), CCG's, Police forces and Fire & Rescue Services;
- The development and implementation of the Significant Event Analysis procedure;
- The installation of a fire suppression system in the Melton PICU ward at Kendray;
- The replacement and upgrade of the fire detection system at Kendray;
- The continued support to Lockdown implementation across the Trust, with new procedures being implemented at Trust Hubs;
- The successful delivery of the Flu campaign which has seen the Trust obtain full Flu CQUIN delivery for the third year running;
- Achieving Substantial compliance against the NHS England Core Standards for Emergency Preparedness, Resilience and Response.
- The instigation of a Brexit planning group to deal with operational issues which could affect the Trust.

The 2019/2020 action plans build on the previous years and are designed to:-

- Continue to embed a robust risk based monitoring and audit programme across all areas;
- Review and implement all policies and procedures for safety and resilience, whilst ensuring they continue to be fit for purpose;
- Further strengthen fire training provisions further to allow improvement of attendance from Ward based staff and also direct attention to reducing localised fire incidents;
- Review all risk assessments following building closures and departmental relocations;
- Continue to strengthen EPRR links and business continuity plans by way of table top exercises, audits and inspections.

## 2. Introduction

This report is designed to provide an overview of the key achievements from all respective areas of health & safety, security, fire safety and emergency preparedness, during 2018/2019, and any areas of development within 2019/2020. Areas of development will be provided by way of action plans and added as appendices to this document.

The report furnishes the Executive Management Team (EMT) with an up to date summary on Trust activities during the previous financial year and also proposed work streams for 2019/2020.

All teams have worked throughout the year to achieve both internal and external targets and legislation, for instance, Fire Safety Legislation, Mandatory Training targets and the Care Quality Commission (CQC) standards; to name a few. Details of such achievements will be referenced throughout the report.

The team work consistently towards implementing national safety legislation into policy, procedure and practice, including the Health & Safety at Work etc. Act 1974 and the Management of Health & Safety at Work Regulations 1999.

These two pieces of legislation are key in managing general health and safety and along with the Fire Regulatory Reform Order 2005 provide the overarching umbrella for safety management in the Trust. Each year the Trust Board discharges its duties by having a Health and Safety Management Plan in place and providing the resources to manage that plan, in addition the Board receives regular quarterly updates through the Clinical Governance and Clinical Safety Committee on Health and Safety. In addition the Board receives an annual health and safety briefing and training session to keep them abreast of developments and to explain their obligations under the law. This reporting framework ensures that Board can receive assurance around the discharge of its duties under the overall Health and Safety Act 1974.

A comprehensive list of health and safety legislation is included at appendix 7.

## 3. Health & Safety

2018/19 has continued to be a busy and successful year for the Health & Safety Team. The annual action plan provided a solid platform for the prioritisation of works; all planned objectives were achieved by the end of Q4.

### Achievements

The annual audit of health and safety provisions, of all Trust premises and teams was undertaken to assess safety provisions across the Trust including areas such as the completion and implementation of risk assessments, training and reporting of accidents/incidents. This year the audit was targeted to identified managers which resulted in a response of 178 returns; some managers provided responses for combined teams/bases ensuring comprehensive cover across the Trust. The audits were targeted so that responses could be monitored.

All Business Delivery Units achieved between 81% and 89% compliance with standards, with a Trust wide compliance of 88%, measured against an overall 80% target. This allowed the teams to undertake targeted assistance to the services as well as undertaking sense checking on responses received to ensure accuracy.

The Trust has a standard measure of percentage compliance scores as described below. Each standard in the survey was assessed against the compliance levels described below.

	91% - 100% compliance achieved (fully compliant)
	81% - 90% compliance achieved (partially compliant requires some improvement)
	Less than 81% compliance achieved (requires further work to achieve significant improvement)

A total of 178 responses were received in 2018. These were split as follows;

- 50 (28%) Barnsley BDU
- 36 (20%) Calderdale and Kirklees BDU
- 17 (10%) Forensic BDU
- 15 (8%) Specialist Services BDU
- 20 (11%) Wakefield BDU
- 40 (22%) Corporate and Support Services

All Deputy Directors assisted with the process to ensure all services and teams were covered.

The audit results were received and analysed by key specialist advisers with any gaps in assurances being addressed accordingly. Audit results are also shared with the Safety & Resilience TAG

Surveys were answered openly and honestly by the services resulting in inevitable minor gaps in health & safety provision as services evolve. These are all being addressed by pro-active support and communication between the health & safety team and services concerned to aim for full compliance.

Other key achievements include:

- The development and implementation of the significant event analysis procedure, to enable managers and staff to review adverse incidents and to learn lessons from these;
- Over 3000 COSHH assessments seamlessly reviewed and migrated from former contractors to in house system.
- Continued partnership working with third party organisations, with robust working arrangements now established;
- Partnership working with internal functions, including Staff Side, Specialist Advisers and Trust functions working effectively;

- Audited and reviewed numerous health & safety policies and identified actions to update. These policies included:
  - Health & Safety Policy
  - Control of Substances Hazardous to Health (COSHH) Policy
  - Environmental Policy & Guidance
  - Health & Safety Risk Assessment Policy
  - First Aid Policy

## Lessons Learned

The lone worker contract and processes are being reviewed, strengthened further and updated, to incorporate new ways of working and requirements from teams across the Trust.

**Lone Worker arrangements**– A programme of risk assessments reviews have been undertaken alongside services, teams & staff involved to ensure lone worker arrangements are fit for purpose. This review has particularly emphasised the role of technology in ensuring staff feel, and are safe.

This review is being undertaken by the health and safety adviser with regular reports into the Operational Management Group for governance purposes and to ensure that managers are sighted on any changes and can ensure that the services are complying with the risk assessments they have undertaken, the revised process has received praise during CQC inspections for its approach.

Works to strengthen the lone worker provision for the Trust continues into the new financial year.

## Significant Event Analysis

Working with the Patient Safety and RPPI Staff, development and adoption of the new Significant Event Analysis procedure encourages staff and managers to review incidents in an open positive manner.

## Community Ligature Audits

A programme of community, environmental ligature audits was completed in Q4 revealing minor works required in some areas, i.e. changing flexible pull cords in toilets for rigid versions. However, overall it was felt existing control measures including clinical risk assessment & management of service users during appointments, along with planning, observation and subsequent control of service users during appointments ensured premises are being utilised safely.

## Regional Learning

Working with partners across the Yorkshire & Humberside Region, has identified opportunities to enhance corporate, overarching risk assessments, particularly in MSK/Moving & Handling and Violence and Aggression. This has been programmed in for completion in Q1 of the new financial year – see 2019/2020 action plan.

## Future Planning

The following areas have been highlighted as priority for the financial year 2019/2020, many of which are listed in the Health & Safety Action Plan at Appendix 1.

- Review the Lone Worker Policy and procedures to ensure that they are fit for purpose and meet the needs of the Trust to ensure staff safety;
- A number of priorities for healthcare organisations has been highlighted by the Health & Safety Executive (HSE) including, falls from windows, legionella prevention and management and the safe use of bed rails, to name a few. As such these will be addressed to identify any relevant actions for the Trust;
- The HSE will be undertaking inspections of refurbishment works in October in the Trust geographical footprint and therefore communication and effective liaison with all contractors will remain a priority;
- Review and update health & safety policies including the control of contractors and working at heights to ensure they are effective and incorporate all current legislation and requirements;
- Undertake audits and inspections, based on the outcomes of the 2018/2019 annual monitoring tool, providing support to teams where required.

## 4. Fire Safety

2018/2019 was a challenging year for the fire safety team, adjusting to staff changes and also training new staff. Throughout the year many challenges were overcome and numerous achievements noted.

### Achievements

- The continued provision of support to the Capital Planning Team; providing advice and guidance from a fire safety capacity with regards to a major new development. The completion of Stanley Ward and development of phase 3 (Crofton) of the Unity building occurred during the reporting period; the advice and guidance provided helped to ensure a safe place to reside and work for patients and staff.
- The installation of a fire suppression system in the Melton PICU ward at Kendray was achieved. The importance of this achievement cannot be underestimated given that the sprinkler system would activate in the event of a fire, extinguishing the risk of fire damage and threat to life. Funds have been allocated in the 2019/20 minor capital schemes to extend the programme to install fire suppression in further in-patient areas. This is part of a longer term programme to retrofit this into all ward areas.
- The replacement and upgrade of the fire detection system at Kendray was undertaken as equipment came to the end of its life. This will reduce the risk of unwanted fire signals through false alarm activations.
- The continued review of fire risk assessment which are all now easily accessible to all staff on the K-Drive safety pages.
- The fire safety training target of 80% was exceeded this year with 84.6% being achieved.
- Continued to provide fire safety services under Service Level Agreements to external organisations including, Wakefield CCG and Spectrum CIC.
- The Trainee Fire, Health & Safety Adviser, successfully completed all training and undertakings to fill the position of Fire, Health & Safety Adviser.

## Lessons Learned

A number of lessons learned have been recorded during the year, which includes some of the following areas:

- 7 minor fire incidents were reported on Datix. All reported incidents were dealt with in a timely and appropriate manner by staff, resulting in the cancellation of Fire Service attendance. This remains a continued significant risk to property and the safety of service users as a result of deliberate ignition together with non-compliance of the Smoke Free Policy, where service users have access to contraband lighters or matches. The main risk is within ward bedrooms. The continued review of policy, procedures and training is of paramount importance.
- The risk of arson prior to the disposal of unoccupied Trust buildings remains high, however the installation of surveillance systems has helped manage this risk accordingly. Arson of empty premises is a nationwide issue.
- Fire Safety training attendance for ward based staff was 86.7% which is below the target of 95%. This has been raised at relevant meetings and on-going monitoring will take place.

## Future Planning

So to continue to provide a high level of Fire Safety provision, the following actions have been incorporated into the Fire Safety Annual Action Plan for 2019/2020:

- Continue to provide sufficient training sessions in order to maintain and exceed the minimum target attendance of 80%;
- To offer practical fire training sessions specifically for ward based staff in the Fire Training Unit at Fieldhead. Training includes practical demonstration of smoke behaviour, use of rescue equipment and practical use of fire extinguishers;
- To review and update fire risk assessments to take account of re-location of staff following closure of premises;
- To support the Capital Planning team with regard to the proposals to retro fit fire sprinklers in high risk patient areas.

## 5. Security

The security team continues to grow from strength to strength, delivering targets throughout the year and providing support to staff and patients across the Trust.

## Achievements

- The successful update of the Preventing Violence & Aggression Policy, following release of a new Assaults on Emergency Workers Act 2018 in parliament and also a review of how incidents are reported to police in line with Secretary of States Strategy (Oct 2018) to reduce violence against NHS staff. The main areas for action detail the need to work with police and the Crown Prosecution Service to help victims give evidence; the CQC scrutinizing violence in their inspections and improving training for staff that deal with violence when caring for patients with dementia or mental illness.

- The excellent relationship with the external security contractor Active Response Security Ltd who provides key holding, alarm response and patrol services to numerous properties across the Trust geographical footprint. Ongoing monitoring of Key Performance Indicator's and monthly reviews indicate a successful partnership, and continuous meeting of targets.
- Continued support to lockdown implementation across the Trust. A combination of communications tests and emergency response tests have been completed at Fieldhead, Kendray, Folly Hall and Laura Mitchell with future works expected across other sites.
- Security assessments throughout the Trust had identified certain issues, notably environmental weaknesses within the Dales Unit, allowing ongoing Absent without Leave (AWOL's). Access control, CCTV, video entry system and interlocking air lock have now been installed.

### Lessons Learned

- A number of Trust premises have either been sold or vacated. This has placed an increased pressure on parking availability on a number of Trust premises. A Car Parking Group has been established to look at various strategies to improve accessibility to car parking provision. As a result, a significant number of additional parking bays have been created in a number of car parks across the Trust so to alleviate this pressure notably;
- Parking Notices placed on car for inconsiderate parking seems to have taken affect and managers are now supporting this process, with support from the security team.
- Continue to monitor AWOL's across the Trust and provide support where necessary.
- Introduced and amended building closure checklists to ensure all goods are removed and buildings secured appropriately to ensure a greater premise security.

### Future Planning for 2019/20

- Implementation and review of lockdown processes and procedures across various locations of the Trust; strengthening of relationships with departments is key to achieve this;
- Focus resources to support Trust staff involved in violence and aggression incidents and also a review on how incidents are reported to the police and followed up in line with Secretary of State Directions 2018 "Assaults on Emergency Workers (Offences) Act 2018".
- The review and support of AWOL's from Trust locations
- Ongoing support to community premises to address safety concerns when self-presenters attend sites and continued support for Lockdown procedures.

## 6. Emergency Preparedness

The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) Framework 2018/2019 saw a number of additions including new standards relating to regional compliance in preparedness for mass casualty events and shelter and evacuation. Whilst works to comply with this framework rolls over year on year, the Emergency Planning Team must review and ensure standards continue to be achieved.

## Achievements

2018/19 was a very busy year for EPRR with the following key achievements noted:

- The substantial compliance declared against the 2018/19 NHS England Core Standards for Emergency Preparedness, Resilience and Response, with continued progression to achieve outstanding standards;
- The successful implementation and achievement of the annual Flu CQUIN. The target was 75% uptake of frontline staff, to which the Trust achieved 76.2%;
- The establishment of excellent networks with EPRR colleagues across the geographical footprint of the Trust and wider Yorkshire and Humber area, including Barnsley Council, Public Health Barnsley, Wakefield Public Health, Calderdale CCG, Bradford District Care Trust, were re-established, to enable understanding and involvement in partner plans;
- An EU Exit Working Group was established to mitigate risks identified in advance of BREXIT. The group consists of key areas from across the Trust including Pharmacy, Procurement, HR, Estates and Facilities, EPRR, Nursing, IM&T and Communications who maintain regional updates by way of action plan and risk assessment. This group remains constituted as the departure date remains unknown.
- The successful creation of a supplier Business Continuity framework system, implemented with colleagues in procurement. The framework maps out all suppliers that provide goods to the Trust and identifies whether assurances have been received regarding their Business Continuity arrangements. Where assurances are not noted, as system is in place to obtain these on a risk based approach.

## Lessons Learned

- Although excellent figures for flu vaccinations were achieved at 76.2%; it was agreed that there was a need to ensure the timely recording of information in the following years campaigns. A lessons learned event recommended that peer to peers recorded vaccinations statistics to help improve this issue. It was further noted that meeting attendance from BDU leads was sporadic due to meeting conflicts and therefore agile technology was and continues to be utilised along with siting meetings in all BDU areas across the Trust.
- Exercise ANTON, an exercise developed to test partner plans in the event of an outbreak, was run by Barnsley Council, with partners from across the borough, identified that there was a greater need for clinical staff provision from SWYPFT in the event of an outbreak. Barnsley BDU subsequently identified availability of community staff and future training needs so to support this requirement in any future event.

## Future Planning for 2019/20

- Following a programme of works to satisfy EU Exit at a regional level, a Fuel Plan was implemented within the Trust. Local Business Continuity plans (BCPs) do not reference what services would do in the event of a fuel crisis, in particular critical services. All BCP authors are being contacted and provided with example action cards to strengthen their BCP's in advance of EU Exit in October 2019.

- EU Exit (BREXIT) – although current reporting and contingency arrangements have been stood down, given the deadline extension to October 2019, there is an expectation that regional & national planning arrangements will re-commence in August to ensure arrangements are still in place and fit for purpose for BREXIT. The national and regional reporting guidelines will dictate future planning and actions.
- The national Flu CQUIN target has increased to 80%; whilst there are strong networks in place to support the flu campaign, the increase of 5% is a challenge for all BDU's. Planning works commenced in April 2019 via the Influenza Working Group with a view to enhance the availability of the vaccines and streamline the recording and paperwork process.
- To continue to fulfil the NHS England Core Standards for Emergency Preparedness, Resilience and Response, the Emergency Planning and Safety team need to continue to monitor systems that are already in place. There is also a need to plan to implement any changes to core standards released in summer 2019;
- Liaise with BCP authors to ensure critical functions update their BCP's to include the Trust Fuel Crisis Plan, detailing how services would continue to operate in the event of;
- Write and implement a Shelter and Evacuation plan that encompasses whole site evacuation;
- Continue to identify and train decision making loggists that would support an incident control room;
- Write and Implement an Industrial Action Business Continuity plan in liaison with HR colleagues;
- Write and implement a HAZMAT (Hazardous Materials)/CBRNe (Chemical, Biological, Radiological, Nuclear and Explosions) plan that supports the current Trust procedures.

## 7. Conclusion

2018/2019 has been a productive and challenging year across the Safety Service function, with a number of notable achievements recognised from each work stream. The success of the Health & Safety Monitoring Tool roll out; the Fire Safety Specialist Adviser involvement and input into the sprinkler system installations and works at the new Unity Centre; the strengthening of the external Security contract; and achieving the Trust Flu CQUIN target of 75%, are a number of key achievements discussed within this report.

2019/2020 will be just as challenging if not more for staff within the function, with need to redesign training packages to meet the changing workforce; the creation of suitable support mechanisms for community premise staff and service users and also the implementation of new standards to achieve compliance against. New targets will be implemented to enable the teams to meet the requirements of the Trust, its staff and external standards throughout the next reporting year.

**Health & Safety Action Plan – 2018/2019 – Summary of Achievements**

Task/objective	Lead Director/ Senior Manager	Lead Officer(s)	Rationale	Target For Completion	Comments
1. Audit/Inspection spreadsheet held by Health & Safety Team to be updated from results of H&S 17/18 Monitoring programme. Visits To be planned for 18/19	Alan Davis/Nick Phillips	Roland Webb/Alan Ryding/Steph Bates	To ensure support can be accurately and promptly targeted to services & teams	Q1	Planned audits, inspections and visits to teams are a fundamental element of the Trust's approach to HSG65. <b><i>(Completed on time)</i></b>
2. Revise & Update Trust Health & Safety Policy	Alan Davis/Nick Phillips	Roland Webb	A written Health & policy is a legal requirement. – The present policy is due for formal review in May 2018	Q1	Revised policy will take into account transformation and reflect Governance arrangements for 2018. <b><i>(Completed on time)</i></b>
3. Revise & Update Trust COSHH Policy	Alan Davis/Nick Phillips	Roland Webb	COSHH provides a legal framework to protect people against health risks arising from hazardous substances used or encountered at work.	Q2	This Policy details SWYPFT's approach to meeting its legal and moral and moral duties <b><i>(Completed in Q4, following cancellation of previous external COSHH contract and thorough review of Trust COSHH requirements)</i></b>

<p>4. Revise &amp; Update Trust Environmental Policy &amp; Guidance</p>	<p>Alan Davis/Nick Phillips</p>	<p>Roland Webb</p>	<p>The Environmental Policy &amp; Guidance document is a guide on the environmental aspects to be considered in Trust activities to minimise the environmental impacts by reducing wastage of energy, water, resources, and establishing compliance with environmental legislation as the minimal level of performance.</p>	<p>Q2</p>	<p>The Policy will complement the Green Transport plan, also being developed during 18/19 supporting the Trust in bids for new business, where environmental safety is increasingly becoming a prerequisite of commissioners. <b>(Completed on time)</b></p>
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5. Revise & Update Trust Health & Safety Risk Assessment Policy	Alan Davis/Nick Phillips	Roland Webb	The Trust Health & Safety Risk Assessment approach supports a reasonable and pragmatic approach to continued safe working practices	Q3	The Trust Health & safety Trust Risk Assessment Policy details SWYPFT's approach to meeting its legal and moral and moral duties and is due for review in November 2018 <b>(Completed on time)</b>
6. Revise & Update Trust First Aid Policy	Alan Davis/Nick Phillips	Roland Webb	The HSE have issued minor guidance updates in April 2018 towards First Aid Provision	Q4	The Trust First Aid Policy details SWYPFT's approach providing effective First Aid cover and is due for review in January 2019 <b>(Completed on time)</b>
7. Implement and complete audit/inspection programme by end of March and prepare for 2019/2020 monitoring programme	Alan Davis/Nick Phillips	Roland Webb/Alan Ryding/Steph Bates	Ensure effective Trust wide approach to health & safety monitoring/inspections for Trust Board assurance.	Q4	The annual health & safety monitoring programme, including the audit and inspection schedule all underpin Trust Board re-assurance of effective health & safety measures within the Trust. <b>(Completed on time)</b>
8. Update Health & Safety Intranet pages and ensure policies and all H&S Information is current with correct contact details	Alan Davis/Nick Phillips	Roland Webb	To ensure Trust staff have reliable and pertinent access to Health & Safety Information	Q4	As the roll out of new services evolve and working practices modernised Health & Safety information will be updated as required. <b>(Completed on time)</b>

**Security Management Action Plan 2018/19**

<b>Task/objective</b>	<b>Lead Director/ Senior Manager</b>	<b>Lead Officer(s)</b>	<b>Rationale</b>	<b>Target Date</b>	<b>Comments</b>
Complete SRT on behalf of the Trust and submit to the LSMS Working Group	Martin Brandon	John Sanderson/ Johan Celliers	To ensure that the Trust is compliant with the NHS Standard contract and meet CQC requirements and general good practice	Q1	<b>Complete</b>
Complete Crime Reduction Surveys on all Trust premises as per the 3 year schedule.	Martin Brandon	Johan Celliers/ John Sanderson	Meet SRT actions and to support the Estates Strategy and agenda.	Q4	<b>Complete</b>
Improve lone worker device usage across the Trust by improving communication with BDU Governance leads; implementing more robust reporting mechanisms in conjunction with the Key Account Manager at Reliance and arranging refresher training to those areas that advise of need	Martin Brandon	Johan Celliers/ John Sanderson/ Emma Hilton	Supporting risk assessed teams in transformation and lone working.	Q3	<b>Complete</b>
Implementation and installation of air lock security measures at the Dales Unit, to ensure reduction of AWOL's from wards	Martin Brandon	Johan Celliers/ John Sanderson	To reduce clinical risk by way of environmental and operational changes	Q1	<b>Complete</b>
Ongoing support to community premises to address safety concerns when self-presenters attend sites	Martin Brandon	Johan Celliers/ John Sanderson	To reduce clinical risk by way of environmental and operational changes	Q3	<b>Completed</b> Note this will be an ongoing task
Implementation of SIRS module on the Datix system.	Martin Brandon	Johan Celliers/ John Sanderson/ Emma Hilton	To ensure that the Trust is compliant with the NHS Standard contract and meet CQC requirements and general good practice	Q2	<b>Completed in Q4</b>

**Appendix 3**

**Emergency Preparedness Action Plan 2018/2019**

<b>Task/objective</b>	<b>Lead Director/ Senior Manager</b>	<b>Lead Officer(s)</b>	<b>Rationale</b>	<b>Target Date For Completion</b>	<b>Comments</b>
All new employees and existing staff to receive EPRR training. Discussions are underway with Learning and Development as to how this can be facilitated.	Alan Davis	Martin Brandon	Links to core standards that staff on induction receive training	May 2018	<b>Complete</b> EPRR on welcome day
Fulfil the NHS England Core Standards for Emergency Preparedness, Resilience and Response,	Alan Davis	Alan Davis	the Emergency Planning and Safety team need to continue to monitor systems that are already in place and further embed more documentation into the individual standards for a more robust evidenced response	March 19	<b>Complete</b> – We have declared substantial compliance and continue to work towards full compliance
Table top exercises to continue be run across the BDU's, so that Senior Managers have assurances that services can operate in an emergency situation/incident;	Alan Davis	Martin Brandon	Through the regular testing of plans allows learning to be evaluated and shared with other areas to try and ensure that the Trust becomes as resilient as possible over time	March 19	<b>Complete</b>

**Health & Safety Action Plan 2019/2020**

No.	Action	Lead	RAG Rating/ Progress	Target Date for Completion	Comments
1	Audit/Inspection spreadsheet held by Health & Safety Team to be updated from results of H&S 18/19 Monitoring programme. Visits To be planned for 19/20	RW/AR/SB		<b>Quarter 1</b>	Planned audits, inspections and visits to teams are a fundamental element of the Trust's approach to HSG65
2	Revise & Update Trust Lone Worker Policy & Guidance	RW		Quarter 1	The revised policy & guidance will be split documents with a focus on addressing inertia in Lone Working Device Use
3	Implement procedure for use of Executive Level Risk Assessment	RW		Quarter 1	To ensure procedure is flexible, permitting effective two way communication across all levels of the Trust
4	Revise & Update Working at Heights Policy & Guidance	RW		Quarter 2	The revised Policy will reflect learning over the last three years and be in line with current HSE guidance
5	Joint Working Protocols	RW		Quarter 3	Ensures proof of joint cooperation with partner organisations in line with HSE expectations
6	Noise & HAV Assessments	RW/AR/SB		Quarter 3	Complies with current Health & Safety legislation
7	Revise & Update Trust Control of Contractors Policy	RW		Quarter 4	The Trust Control of Contractors Policy details SWYPFT's approach to meeting its legal and moral and moral duties and is due for review in February 2020
8	Implement and complete audit/inspection programme by end of March and prepare for 2020/2021 monitoring programme	RW/AR/SB		Quarter 4	The annual health & safety monitoring programme, including the audit and inspection schedule all underpin Trust Board re-assurance of effective health & safety measures within the Trust.
9	Update Health & Safety Intranet pages and ensure policies and all H&S Information is current with correct contact details	RW		Quarter 4	As the roll out of new services evolve and working practices modernised Health & Safety information will be updated as required.

**Fire Safety Action Plan 2019/2020**

No.	Action	Lead	RAG Rating/ Progress	Target Date for Completion	Comments
1	Continue to provide sufficient training sessions in order to maintain and exceed the minimum target attendance of 80%;	IC/SB		Quarter 4	Mandatory sessions (organised by L&D) and Kendray/Fieldhead sessions (organised by facilities) are scheduled throughout the year.
2	To offer practical fire training sessions specifically for ward based staff in the Fire Training Unit at Fieldhead. Training includes practical demonstration of smoke behaviour, use of rescue equipment and practical use of fire extinguishers	IC/SB		Quarter 2	Sessions scheduled and advertised on the Intranet. Publicity via weekly comms, supported by e-mails to ward managers and included on BDU agendas.
3	To review and update fire risk assessments to take account of re-location of staff following closure of premises	IC/SB		Quarter 4	Ongoing throughout the year.
4	To support the Capital Planning team with regard to the proposals to retro fit fire sprinklers in high risk patient areas	IC/SB		Quarter 4	Target premises for next phase to be identified, based on risk assessment.

**Key**

	Complete
	On Target
	In progress, some risks
	Not on target
	Not yet started

**Security Action Plan 2019/20**

No.	Action	Lead	RAG Rating/ Progress	Target Date for Completion	Comments
1	Implementation of lockdown processes and procedures across various locations of the Trust; strengthening of relationships with departments is key to achieve this	JS/JC		Quarter 4	Liaise with EPRR, Estates and BDUs to best achieve appropriate lockdown in highlighted areas.
2	Focus resources to support Trust staff involved in Violence and aggression incidents and also a review on how incidents are reported to the police and followed up in line with Secretary of State Directions 2018 "Assaults on Emergency Workers (Offences) Act 2018".	JS/JC		Quarter 4	Engage with managers to ensure incidents are reported staff are supported and appropriate sanctions are sought by the Trust and Police.
3	The review and support of AWOL's from Trust locations	JS/JC		Quarter 4	Continue to discuss incidents with units act as a conduit between Estates and units as to Capitol bids and continue to engage fully with affected agencies.
4	Ongoing support to community premises to address safety concerns when self-presenters attend sites and continued support for Lockdown procedures	JS/JC		Quarter 4	Continue to address lockdown communication and hard FM to enable staff to best deal with situations that may arise.

**Key**

	Complete
	On Target
	In progress, some risks
	Not on target
	Not yet started

Emergency Preparedness, Resilience & Response Action Plan 2019/20

No.	Action	Lead	RAG Rating/ Progress	Target Date for Completion	Comments
1	<b>Mass Countermeasures</b> Provide evidence of involvement of partner plans in the event of an Outbreak	EH		April 2019	<p>The Trust have action cards in the following partner documents:</p> <ul style="list-style-type: none"> <li>• BMBC Mass Vaccination and Treatment Plan and Multi-Agency Outbreak Plan. Draft Outbreak Matrix under consultation at the Health Protection Board which identifies all supporting agencies and resources for particular outbreaks across Barnsley.</li> <li>• Kirklees Outbreak Plan</li> <li>• Wakefield – Draft Outbreak Incident Agreement commented on in February 2019 – awaiting final version to be circulated.</li> </ul> <p><i>COMPLETE</i></p>

2	<b>Shelter and Evacuation</b> Put in place an Evacuation Plan that includes whole site evacuation	EH		August 2019	Works commenced to draft a plan for Evacuation, working with Bradford District Care Trust. Plan to link into fire risk assessments for Fire Evacuation; Low and Medium Secure Evacuation Plan for Forensics, the Bomb and Suspect Packages procedure and historic work undertaken by Fire Safety Officer.
3	<b>Loggist</b> Ensure a provision of 24/7 loggists are available in the Trust to support an ICC room in the event of an incident/event.	EH		March 2020	1 Loggist available 24/7 (Emma Hilton). Initial bank of staff interested in becoming a loggist has reduced. 1 staff member attending training with Calderdale CCG on 23 <sup>rd</sup> May 2019; same training offered to second staff member. A call out for further volunteers will be made once the training package is in place.
4	<b>Fuel Crisis Plan</b> Ensure a fuel crisis plan is in place and understood by all. The need to ensure this is referenced in critical services Business Continuity Plans is key.	EH		October 2019	Fuel Crisis Plan published March 2019  To contact BDU Leads to request that Critical Functions update their Business Continuity Plan to taken into account Fuel Crisis under Loss of Staff scenario's and action plan. Provide District Nursing draft document as an example to be adapted. All BCP's to be submitted for review.
5	<b>Industrial Action Plan</b> To write/implement/update current Industrial Action BCP	EH		March 2020	Liaise with HR to identify whether a plan is already in place and also look at BDCT plan to ensure plan is in line with CCA requirements.
6	<b>CBRN/HAZMAT Plan</b> Write plan to support current HAZMAT procedures	EH		March 2020	Liaise with MB and BDCT plans to ensure meet CCA guidelines.

**Key**

	Complete
	On Target
	In progress, some risks
	Not on target
	Not yet started

## Incident Statistics

### The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)

RIDDOR requires the Trust to report all over seven day injuries to the Health & Safety Executive; a total of 22 such incidents were reported during 2018/2019, half the rate compared to 2016/2017. This shows an encouraging reduction, possibly helped in part by the adoption of the new Significant Event Analysis procedure that encourages staff and managers to review incidents in an open positive manner.

### Safety Related Incidents

A total of **6045** of safety related incidents were recorded in 2018/2019, with **68%** of these relating to violence and aggression (**4132**) The Health & Safety and RPPI Teams continue to work closely together with excellent attendance at both the Safety & Resilience & RPPI TAG's.

Health & Safety Related incidents showed a reduction to 822 from 882 the previous year, the main category of reported staff shortages due to acuity, sickness etc accounting for 18% of this total.

### Slips, Trips & Falls

A total of **652** reports of Slips, Trips and Falls reflected the continuing downward trend in recent years (719 in 17/18) and is testament to joint working with Health & Safety/Clinical staff to ensure work environments and procedures support safe working conditions as far as reasonably practicable.

The majority of reported Slips, Trips & Falls affected clients within the clinical setting, followed by staff members sustaining injury whilst undertaking their daily tasks.

### Security Related Incidents

439 security related incidents were recorded during the financial year, with, broadly on a par with previous years

All incidents were investigated accordingly with support provided where necessary to affected staff members.

## Appendix 9

### Key Health and Safety Legislation

- **“HSG65”** – Guidance provided by the HSE for the structure of Health & Safety Management Systems, commonly known as “Plan Do Check & Act” approach. The annual report being fed back to Trust Board is an integral part of this process
- **The Health and Safety at Work etc. Act 1974.** The main Health & Safety Legislation. Most prosecutions come under S2, S3 or S37. Both the Trust and individuals can be prosecuted
- **The Regulatory Reform (Fire Safety) Order 2005** – Covered by the Fire Enforcing Bodies, this covers a requirement that the Trust has effective Fire Prevention measures in place, including Risk Assessments, Training and Local Management of premises
- **The Corporate Manslaughter and Corporate Homicide Act 2007** – Where the Trust as a corporate body could be prosecuted if a member of staff (or service user in some cases) is killed. For a successful prosecution, the CPS would need to prove that the Board, or individual Senior was reckless or otherwise complicit in permitting High Risk work activities or care. Fines could be from £3 million +, but no individual would be prosecuted under this legislation
- **Health and Safety (Offences) Act 2008** – Specific Legislation that individual managers could be prosecuted. Fines and imprisonment are options for both Magistrates & Crown Courts and cases do not need to involve a fatality
- **The Management of Health and Safety at Work Regulations 1999** – Regulations that make it clear we should ensure Risk Assessments are carried out and include reference to Pregnant/Nursing mothers
- **Provision and Use of Work Equipment Regulations 1998** – Regulations covering equipment provided to people at work. Very wide ranging from Lone Working Devices, to Vehicles and all other work equipment
- **The Control of Asbestos Regulations 2012** - Provides an obligation on the Trust to inform and protect people from Long Term effects of Asbestos exposure. It mean we have to be proactive with asbestos monitoring and controlling contractors
- **Legionnaires’ disease. The control of legionella bacteria in water systems. Approved Code of Practice and guidance L8** – HSE would test the organisation against this if there was ever an outbreak attributed to Trust water management procedures
- **The Control of Substances Hazardous to Health Regulations 2002 (As Amended)** – Links to other legislation but the Trust has an obligation to control potentially hazardous substances staff/service users may be exposed to. Includes micro-organisms from clinical waste to latex, dusts and cleaning chemicals
- **Workplace (Health, Safety and Welfare) Regulations 1992** – Provides an obligation to ensure myriad of facilities from sufficient space to people to work in, workplace temperature, toilet and welfare facilities to ensuring the Estate remains in good repair. CQC take a particular interest in the this as the regulations overlap with Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

## Trust Board 25 June 2019 Agenda item 9.4

<b>Title:</b>	<b>Finance Oversight Group</b>
<b>Paper prepared by:</b>	Director of Finance and Resources
<b>Purpose:</b>	To agree the terms of reference for the newly created Finance Oversight Group
<b>Mission/values:</b>	Use of resources
<b>Any background papers/ previously considered by:</b>	All Board members were consulted with in respect of the need for additional financial scrutiny and the ultimate creation of a Finance Committee.  The draft terms of reference were reviewed at the inaugural meeting of the Financial Oversight Group.
<b>Executive summary:</b>	<ul style="list-style-type: none"> <li>➤ The Trust Board has agreed to establish a separate finance committee upon the recruitment of an additional non-executive director with a finance background.</li> <li>➤ In the intervening period a Finance Oversight Group has been established to ensure there is increased scrutiny of the Trust's financial position and development and delivery of the financial sustainability plan.</li> <li>➤ Terms of reference have been generated for the Finance Oversight Group which are attached to this paper.</li> <li>➤ The main feedback from the Financial Oversight Group is with regard to the composition of the membership. There is a suggestion that either the group's membership is increased by one non-executive and executive director to ensure clinical membership or that one of the executive clinical directors replaces the Director of Finance.</li> </ul> <p><b>Risk appetite</b></p> <p>In line with the Trust risk appetite statement which aims for financial risk of 4-6. Any implications on clinical risk must also be taken into account.</p>
<b>Recommendation:</b>	<b>Trust Board is asked to APPROVE the terms of reference for the Finance Oversight Group, subject to any amendments agreed in the Trust Board meeting.</b>
<b>Private session:</b>	Not applicable.

**FINANCE OVERSIGHT GROUP MEETING AT EMT**  
**Terms of Reference**

*To be approved by Trust Board 25 June 2019*

**1. Introduction**

- a. The Finance Oversight Group (FOG) was established by the Trust Board in June 2019 as an interim measure. The intention is that it will operate until a Non-Executive Director-led Finance and Performance Committee has been established, after which it will be stood down. The FOG is a sub-group of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by the Trust Board.
- b. All Trust governance groups are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

**2. Purpose**

The Finance Oversight Group's prime purpose is to oversee financial performance, delivery of the Trust's finance and investment strategy, and delivery of the financial sustainability programme.

**3. Membership**

- a. The FOG is chaired by a Non-Executive Director. At least one other Non-Executive Director also sits on the Group plus the Chief Executive and Director of Finance and Resources. All other members of the EMT are expected to be in attendance and all NEDs are also invited to be in attendance.
- b. *Membership as at 25 June 2019:*
  - Non-Executive Director – Laurence Campbell (Chair)
  - Non-Executive Director – Sam Young
  - Chief Executive - Rob Webster;
  - Director of Finance and Resources – Mark Brooks

**4. Attendance**

Other relevant officers attend the Group by invitation. Administrative support is provided by the PA to the Director of Finance and Resources. Members and attendees may join the meeting via telephone or video link.

**5. Quorum**

- a. The quorum will be half of the membership, which must include at least one Non-Executive Director; however, members are expected to attend all meetings.
- b. In the unusual event that the Chair is absent from the meeting, the Group will agree another Non-Executive Director to take the chair. In the absence of executive Director members, deputies are permitted to attend, however they will not form part of the quorum.

## **6. Frequency of meetings**

The Group will meet fortnightly on the same day as the Executive Management Team meeting.

## **7. Duties**

- a. Oversee and evaluate financial strategy.
- b. Seek assurance on delivery of financial targets.
- c. Consider forecasts for financial information along with identification and oversight of risks and opportunities associated with the forecast.
- d. Assess risks aligned to the Group by the Board and seek assurance on mitigating action.
- e. Review proposed annual financial plan including capital programme.
- f. Seek assurance on delivery of cost improvement programmes fully aligned to financial sustainability programme.
- g. Oversee the prioritisation of capital schemes within financial resources available
- h. Review service line reporting on a regular basis.
- i. Approve business cases related to the financial sustainability programme, as required by SFIs, and oversee the post-implementation review process for these.
- j. Request and consider detailed reviews where there are issues causing significant financial variance and/or concern.

## **8. Monitoring**

- a. The Group will monitor its performance, both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference, through agreement of a work plan.
- b. The work plan will include any items delegated to the Group by Trust Board and through the Assurance Framework, monitoring implementation of the work plan, assessment of the Group's performance through an annual self-assessment (if appropriate), and an evaluation of the Group's performance through an annual report to Trust Board (if appropriate), as part of the annual governance review.
- c. The Group will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to the Audit Committee and to Trust Board.

## **9. Reporting to Trust Board**

- a. Trust Board will receive a report from the Group at the next Trust Board meeting following the Group meeting and the minutes when available. Group will also report to the Board annually on its work (see above).
- b. All Trust Board groups have a responsibility to ensure they foster and maintain relationships and links between the groups/committees and Trust Board. Each group also has a responsibility to ensure actions identified and agreed are placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups (TAGs).

## 10. Authority

- a. The Group is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed by Trust Board to co-operate with any request made by the Group.
- b. The Group is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

**To be approved by Trust Board: 25 June 2019**  
**Next review due: December 2019**

DRAFT

Trust Board 25 June 2019

Agenda item 10 – Receipt of public minutes of partnership boards

**Barnsley Health and Wellbeing Board**

<b>Date</b>	4 June 2019
<b>Member</b>	Chief Executive / Director of Strategy
<b>Items discussed</b>	<ul style="list-style-type: none"> <li>➤ To be confirmed.</li> <li>➤ Health and Wellbeing Board Membership: engagement review of wider providers</li> <li>➤ Health and Wellbeing Strategy: Review &amp; Development Proposal</li> <li>➤ Implementing the Physical Activity Plan</li> <li>➤ Sexual Health Needs Assessment</li> </ul>
<b>Minutes</b>	Papers and draft minutes (when available): <a href="http://barnsleymbc.moderngov.co.uk/mgCommitteeDetails.aspx?ID=143">http://barnsleymbc.moderngov.co.uk/mgCommitteeDetails.aspx?ID=143</a>

**Calderdale Health and Wellbeing Board**

<b>Date</b>	20 June 2019
<b>Non-Voting Member</b>	Medical Director / Director of Nursing & Quality
<b>Items discussed</b>	<ul style="list-style-type: none"> <li>➤ Calderdale Cares - Update</li> <li>➤ Update on Outpatient Transformation</li> <li>➤ Digitalisation Update</li> <li>➤ Update on the CHFT Strategic Outline Case</li> <li>➤ Update from the Chair of the West Yorkshire &amp; Harrogate Health &amp; Care Partnership</li> <li>➤ Update on Membership</li> <li>➤ Prevention Concordat for Better Mental Health</li> </ul>
<b>Minutes</b>	Papers and draft minutes (when available): <a href="https://www.calderdale.gov.uk/council/councillors/councilmeeting/agendas-detail.jsp?meeting=27416">https://www.calderdale.gov.uk/council/councillors/councilmeeting/agendas-detail.jsp?meeting=27416</a>

**Kirklees Health and Wellbeing Board**

<b>Date</b>	13 June 2019
<b>Invited Observer</b>	Chief Executive / Director of Nursing & Quality
<b>Items discussed</b>	<ul style="list-style-type: none"> <li>➤ Appointment of Deputy Chair</li> <li>➤ Loneliness Strategy for Kirklees</li> <li>➤ Domestic Abuse Strategy</li> <li>➤ Opportunities for Oral Health Improvement</li> <li>➤ Development of the West Yorkshire &amp; Harrogate 5 Year Plan Strategy for Health and Care</li> <li>➤ Kirklees Primary Care Network registration and development</li> </ul>

	update ➤ West Yorkshire & Harrogate Health & Care Transformation Funding
<b>Minutes</b>	Papers and draft minutes (when available): <a href="https://democracy.kirklees.gov.uk/ieListMeetings.aspx?CId=159&amp;Year=0">https://democracy.kirklees.gov.uk/ieListMeetings.aspx?CId=159&amp;Year=0</a>

### Wakefield Health and Wellbeing Board

<b>Date</b>	Next meeting scheduled for 18 July 2019 (last update from meeting 21 March 2019)
<b>Member</b>	Chief Executive / Director of Provider Development
<b>Items discussed</b>	➤ To be confirmed.
<b>Minutes</b>	Papers and draft minutes are available at: <a href="http://www.wakefield.gov.uk/health-care-and-advice/public-health/what-is-public-health/health-wellbeing-board">http://www.wakefield.gov.uk/health-care-and-advice/public-health/what-is-public-health/health-wellbeing-board</a>

### South Yorkshire & Bassetlaw Integrated Care System Collaborative Partnership Board

<b>Date</b>	10 May 2019
<b>Member</b>	Chief Executive
<b>Items discussed</b>	➤ ICS System Leader update ➤ Priorities of Joint Working for Local Authorities ➤ Towards a SYB New Collaborative Partnership System ➤ Update on ICS Prevention and Prevention priorities within the Long Term Plan ➤ Population Health Management ➤ ICS Finance update ➤ ICS Highlight Report
<b>Minutes</b>	Approved Minutes of previous meetings are available at: <a href="https://www.healthandcaretogethersyb.co.uk/about-us/minutes-and-meetings">https://www.healthandcaretogethersyb.co.uk/about-us/minutes-and-meetings</a>

### West Yorkshire & Harrogate Health & Care Partnership System Oversight and Assurance Group

<b>Date</b>	24 April 2019 & 21 June 2019
<b>Member</b>	Chief Executive
<b>Items discussed</b>	➤ Programme updates ➤ Review of System Performance and Delivery ➤ Wider system risks and issues
<b>Further information:</b>	Further information about the work of the System Oversight and Assurance Group is available at: <a href="https://www.wyhpartnership.co.uk/blog">https://www.wyhpartnership.co.uk/blog</a>

### West Yorkshire & Harrogate Health & Care Partnership System Leadership Executive

<b>Date</b>	7 May 2019
<b>Member</b>	Chief Executive
<b>Items discussed</b>	➤ Working collaboratively across WY&H ICS: current ➤ Reality - Mixed table group discussion, Facilitated plenary

	<p>discussion</p> <ul style="list-style-type: none"><li>➤ Operational Planning for 2019/20: Concluding the Planning Round</li><li>➤ ICS Financial Framework</li><li>➤ Developing our 5-year strategy: Update and next Steps</li><li>➤ HEE Workforce Development Funding 2019/20</li></ul>
<b>Further information:</b>	<p>Further information about the work of the System Oversight and Assurance Group is available at: <a href="https://www.wyhpартnership.co.uk/blog">https://www.wyhpартnership.co.uk/blog</a></p>

## Trust Board 25 June 2019

### Agenda item 11 – Assurance from Trust Board committees

#### Audit Committee

<b>Date</b>	21 May 2019
<b>Presented by</b>	Laurence Campbell, Non-Executive Director (Chair of Committee)
<b>Key items to raise at Trust Board</b>	<ul style="list-style-type: none"> <li>➤ Review of the Annual Report and accounts 2018/19 including the external auditors ISA260 and internal auditors Head of Internal Audit Opinion.</li> <li>➤ Internal Audit annual report 2018/19.</li> <li>➤ Counter Fraud annual plan 2019/20.</li> </ul>
<b>Approved Minutes of previous meeting/s for receiving</b>	<ul style="list-style-type: none"> <li>➤ Minutes of the Committee meeting held on 9 April 2019 and 21 May 2019 to be approved at the next Committee meeting.</li> </ul>

#### Clinical Governance & Clinical Safety Committee

<b>Date</b>	14 May 2019 and 11 June 2019
<b>Presented by</b>	Charlotte Dyson, Deputy Chair / Senior Independent Director (Chair of Committee)
<b>Key items to raise at Trust Board</b>	<ul style="list-style-type: none"> <li>➤ Review of draft Quality Account.</li> <li>➤ Receipt of annual incident and RRPI report, positive quality and noted links to patient safety strategy work.</li> <li>➤ Update on Care Quality Commission (CQC) inspection.</li> <li>➤ Child and Adolescent Mental Health Services (CAMHS) reviewed in detail.</li> <li>➤ Health and safety annual report received.</li> <li>➤ Infection prevention and control report received.</li> <li>➤ Freedom to Speak Up Guardians action plan.</li> </ul>
<b>Approved Minutes of previous meeting/s for receiving</b>	<ul style="list-style-type: none"> <li>➤ Approved Minutes of the Committee meeting held on 2 April 2019 and 14 May 2019 (attached).</li> </ul>

#### Equality & Inclusion Committee

<b>Date</b>	4 June 2019
<b>Presented by</b>	Angela Monaghan, Chair (Chair of Committee)
<b>Key items to raise at Trust Board</b>	<ul style="list-style-type: none"> <li>➤ To be confirmed.</li> </ul>
<b>Approved Minutes of previous meeting/s for receiving</b>	<ul style="list-style-type: none"> <li>➤ Approved Minutes of the Forum meeting held on 5 March 2019. (attached).</li> </ul>

## Mental Health Act Committee

<b>Date</b>	14 May 2019
<b>Presented by</b>	Kate Quail, Non-Executive Director (Chair of Committee)
<b>Key items to raise at Trust Board</b>	<ul style="list-style-type: none"> <li>➤ Amendment to Mental Capacity Act, review of Mental Health Act – two significant pieces of work representing organisational change, ie training, assurance, clinical impact.</li> <li>➤ Taking forward the findings from the Care Quality Commission (CQC) annual report.</li> <li>➤ Task and finish approach to dealing with some of the issues in the annual plan.</li> <li>➤ Update on Reducing Restrictive Practice – the presentation being a good example.</li> <li>➤ Positive feedback from partners.</li> </ul>
<b>Approved Minutes of previous meeting/s for receiving</b>	➤ Approved Minutes of the Committee meeting held on 12 March 2019 (attached).

## Workforce & Remuneration Committee

<b>Date</b>	7 May 2019
<b>Presented by</b>	Sam Young, Non-Executive Director (Chair of Committee)
<b>Key items to raise at Trust Board</b>	<ul style="list-style-type: none"> <li>➤ Medical vacancy to review at the next meeting</li> <li>➤ Development of Forensics and Child and Adolescent Mental Health Services targeted support plan</li> <li>➤ NHSI Very Senior Managers Pay Guidance</li> <li>➤ Risk Management: Equality and Inclusion Committee</li> <li>➤ Staff Survey: ensure that Clinical Governance and Clinical Safety Committee pick up Safety Culture feedback</li> </ul>
<b>Approved Minutes of previous meeting/s for receiving</b>	➤ Approved Minutes of the Committee meeting held on 12 February 2019 (attached).

## West Yorkshire Mental Health Collaborative Committees in Common

<b>Date</b>	Next meeting scheduled for 28 June 2019
<b>Presented by</b>	Angela Monaghan, Chair (Chair of Committee)
<b>Key items to raise at Trust Board</b>	➤ To be confirmed.
<b>Approved Minutes of previous meeting/s for receiving</b>	➤ To be confirmed.

**Minutes of Clinical Governance and Clinical Safety Committee held on  
2 April 2019  
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)
Alan Davis (AGD)	Director of Human Resources, Organisational Development and Estates
Kate Quail (KQ)	Non- Executive Director
Dr Subha Thiyagesh (SThi)	Medical Director

**Apologies:** No apologies received

**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 (Item 14.1)
Carol Harris (CH)	Director of Operations
Sue Barton (SB)	Deputy Director of Strategy & Change (for item 7.1- 7.2)
Kate Dewhirst (KD)	Chief Pharmacist (for item 22.1)
Sue Threadgold (ST)	Deputy Director of Forensic Services (for item 14.2)
Yvonne French (YF)	Assistant Director Legal Services
Adrian Deakin (ADe)	Forensic Security Lead (for item 18)
Estelle Myers (EM)	Associate Practice Governance Coach (for item 18)
Laurence Campbell (LC)	Non-Executive Director (in attendance)

**CG/19/30 Welcome, introductions and apologies (agenda item 1)**

The Chair Charlotte Dyson (CD) welcomed everyone to the meeting. There were no apologies to note. It was noted that there were several people attending to cover items on the agenda, as noted above. Timings had been added to the agenda in line with internal audit recommendations.

**CG/19/31 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 2019 or subsequently.

**CG/19/32 Minutes of previous meeting held on 12 February 2019 (agenda item 3)**

Minutes of the previous meeting were agreed. CD informed the Committee that the Chantry Report action plan would be monitored through Operational Management Group (OMG). The Committee also noted that the scheduling of the meetings had been a lot earlier for 19/20 leading to some timing issues with some documents listed in the work plan.

**It was RESOLVED to APPROVE the minutes of the meeting held on 12 February 2019**

### **CG/19/33 Matters Arising (agenda item 4)**

Actions from the meeting held on 12 February 2019 were noted and the action log was updated as appropriate.

- CG/19/05 Risk Register - Out of Area. Carol Harris (CH) informed the Committee that their risk register had been updated and would be discussed at EMT on 04.04.19.
- CG/19/08 CQC Action Plan – Mike Doyle (MD) informed the Committee that an update would be brought to the June Committee Meeting but wanted to note that there were two different measures to be considered.
- CG/19/26 Consideration of any Risk relevant to CGCS – Tim Breedon (TB) informed the Committee that this would be discussed at EMT and then taken to Trust Board in April.

### **CG/19/34 Consideration of items from the organisational risk register relevant to the remit of the Clinical Governance & Clinical Safety Committee (agenda item 5)**

TB highlighted to the Committee that this was the same risk register as brought to the last Committee in February as there had been no update since that meeting due to the close proximity of the two Committee meetings.

CD suggested that the Committee discussed how / if the risk register adequately reflects the Committees' key areas of interest / concern. CD noted some items for horizon scanning.

- Community mental health transformation review
- Risk ID 695 – Clinical Services
- Risk ID 905- Safer Staffing

Risk ID 1151 Safer staffing. The Committee looked at the mitigating actions regarding Safer staffing in the Community and the impact on clinical services. MD informed the Committee that there is a specific group for community regarding safer staffing and this would be picked up later in the meeting during the Safer Staffing report.

RISK ID 695 Clinical Services - The Committee enquired as to whether this was within the risk. TB to enquire.

**Action: Tim Breedon**

Angela Monaghan (AM) highlighted to the Committee a Board discussion regarding bullying & harassment and queried if there was a clinical risk element to this and whether this was covered in workforce & remuneration. Alan Davis (AD) advised that Service Users and Carers could be brought into this as a different approach to staffing as this is covered via Human Resources (HR).

AM asked that this be taken to EMT for a view and the Committee agreed.

**Action: Alan Davis**

CD asked if the risks relating to difficulties when engaging family and carers in care planning are adequately reflected in BDU risk registers. To be reviewed by OMG.

**Action: Carol Harris**

Dr S Thiyagesh (SThi) advised that the MHA Committee members will be considering whether the need for an organisational level risk around MHA compliance is required. SThi to update at next Committee meeting.

**Action: Subha Thiyagesh**

**It was RESOLVED to NOTE that the items on the ORR relevant to the CGCS have been considered.**

### **CG/19/35 Quality Accounts, Including Quality Priorities (agenda item 6)**

TB gave a brief update to the Committee on the current position of the Quality Accounts. TB informed that the position is similar to that of the February meeting in that the accounts are progressing on time. It was noted that it would be around the third week in April before the information would start to materialise. The action plan is on track with a key focus on a quick turnaround with partners.

MD also reminded the Committee that the Quality Accounts are aligned to the Quality Strategy (QS) and the QS update will be included in the next meeting on 14 May 2019.

**It was RESOLVED to NOTE the progress on the production of the Quality Account.**

### **CG/19/36 Transformation & Priority Programmes Update (agenda item 7)**

#### **7.1 Community Mental Health**

Sue Barton (SB) provided a brief overview to the Committee. In April 2017, the Trust went live with a new integrated care pathway model in community adult mental health services. The review of this community mental health transformation took place through Autumn 2018.

The summary of the findings are:

- Service user feedback has been very positive
- Staff feedback has highlighted capacity concerns particularly around core pathway.
- The main topics that formed part of staff feedback were:
  - Service user pathway and getting people to the right service
  - Achieving the right workforce model
  - Managing change and adopting a new ways of working
- Whilst some of the initial objectives of transformation have been met others are yet to be achieved.
- The enhanced pathway is generally working as per plan.
- The Core teams are delivering mostly against the standard operating procedures but some key elements are missing (general feedback that lack of capacity causes these issues), meaning the model hasn't been fully implemented as intended in some areas.
- Data analysis supports the hypothesis that there are increasing referrals into the system from Primary care.
- A key priority for improvement is to ensure there is capacity in the system to support all people when their needs increase.

CD noted that transformation had been successful but there were significant issues regarding demand, workforce and capacity and queried how this would be taken forward. SB informed the Committee that they are included as part of a key workstream in the plan to stop sending people out of area. This work would initially focus on Calderdale & Kirklees. It included work with Commissioner colleagues who are looking at the high levels

of referrals. CD queried how this would be tracked and SB informed that the governance structure includes an internal group as well as a partnership group which would consider the joint pieces of work.

AM and the Committee enquired whether we have the right resources available to deliver the plan. SB informed them that a paper is going to EMT which outlines the internal resources which are needed. SSG are also returning to support this work.

Laurence Campbell (LC) enquired if Commissioners are helping with funding and CH informed that they are not. AM asked if QIA's are built into this and SB informed there is a plan in place to build this in.

The Committee asked if this would come back through the Priority Programmes update and SB confirmed that it would.

It was noted that this is complex and therefore we need to present it in a simplified way to help with engagement. SB explained that the plan has been developed as a driver diagram which should help.

## **The Committee RECEIVED the report and NOTED the next steps identified**

### **7.2 Perinatal**

SB updated the Committee regarding the Perinatal Mental Health Service.

- The Trust received external funding to establish a new Perinatal Mental Health service
- The service was launched in December 2017
- The post implementation review has concluded that
  - It was delivered on time.
  - It was delivered within budget
  - There is limited outcome data available but service user feedback is extremely positive
  - The service is achieving 96% against the activity target
  - There are areas of ongoing learning that are being addressed
  - There are areas of continued service development

SB noted that it was still early days for this service but early evidence of implementation showed that this is going well.

TB highlighted links to tier 4 CAMHS and eating disorder beds, as part of a specialist commissioning issue.

CD noted that it was important that we have met and achieved objectives against the original specification.

AM queried the workforce model and how we arrived at this model. SB informed this is a national model. Local learning has meant that we are adapting this as historically it was more medically led due to the concerns around risk.

**The Committee NOTED and RECEIVED the update.**

### **7.3 Clinical Records System**

MD briefed the Committee regarding the Clinical Record System (CRS) for MH Clinical Safety Design Group (CSDG) which considers options and makes the clinical safety design decisions relating to the Trust wide configuration of the CRS for MH, SystmOne.

Membership includes a range of senior clinicians, technical staff and managers and is chaired by the Deputy Director of Nursing and Quality.

Since April 2018, the group had met regularly to identify, assess and manage clinical risks arising from the planned transition to SystmOne, working closely with the Clinical Reference Design Group and Clinical Reference Groups.

By time of SystmOne go live on 25<sup>th</sup> February 2019, the group had identified, assessed, mitigated and closed 21 risks.

The CSDG would continue to meet to oversee clinical risks arising from Go Live and transition to SystmOne and to support SystmOne optimisation, where new and improved templates (e.g. risk assessments, care plans) would be integrated into the system.

The Committee were assured that there is clear a governance system in place. AM noted that the risk appetite on the cover sheet stated 1-3 and should say 1-6 on all cover sheets. CH informed the Committee that the system was running slowly at times and internal work was undertaken to fix the issue. TPP applied a fix and staff reported that the system has been running much better since this intervention. Subha Thiyagesh (STHi) also highlighted the positive feedback from Medical Staff across the Trust. Yvonne French (YF) informed the Committee that MHA office had come across some data migration issues however an action plan has been put in place and it has been escalated to TPP for resolution.

**The Committee NOTED progress in managing clinical risks associated with transition to SystmOne.**

### **CG/19/37 Care Quality Commission Action Plan (agenda item 8.1)**

TB gave a brief update to the Committee.

There are **12 actions** that have been rated as amber/ red in February 2019.

- **Forensic core service:**
- The Trust **SHOULD** ensure that staff working on Ryburn and Newhaven wards can access support from others quickly when needed.
- **CAMHS core service:**
- The Trust **MUST** ensure that staffing issues around the out of hours on call service are monitored, reviewed and resolved.
- The Trust **SHOULD** ensure that the lone working policy clearly identifies how staff are to keep themselves safe when lone working. Where lone working devices are used, the Trust should ensure that action is taken to monitor and improve compliance. Where staff have no device robust local measures should be implemented.
- The Trust **SHOULD** ensure that effective governance processes are implemented to monitor, review and improve systems and
- processes within the service.
- **Acute & PICU core pathway**

- The Trust **MUST** ensure that staff adhere to their policy and the Mental Health Act Code of Practice in the care and treatment of patients in seclusion
- The Trust **MUST** ensure that staff adhere to their policies in the safe management of medicines and that medication administration records are signed when medication is being administered
- Staff **MUST** ensure they assess patients' risk at the intervals outlined in the trust policy and that this is reflected on the risk assessment tool
- The trust **MUST** ensure that patient and carer involvement in care and discharge planning is accurately reflected in records. The trust must ensure that the systems and process in place to monitor the performance of the ward are effective and are used to improve the care and treatment provided
- The Trust **SHOULD** ensure that discharge planning meets the requirements of the Trusts policy and evidences the involvement of the patient, their carer's and other professionals
- The trust **SHOULD** ensure that patients and their families and carers are involved in the planning of their care and treatment. The trust should ensure that care plans are personalised and reflect the patient's voice
- **Community mental health teams for people of working age**
- The Trust **SHOULD** ensure that all staff are fully familiar about actions to take in the event of security incidents on premises
- The Trust **SHOULD** ensure that people have sufficient information and opportunity to provide feedback about the service. This should include ensuring carers are aware of, and have access to, carers assessments

The number and red /amber ratings had risen and this is because timescales have not been met. A workshop held on 27.3.19 identified priorities for action, which are being developed into improvement plans to expedite required improvement. OMG will have oversight of the plan and will escalate concerns accordingly.

MD informed the Committee that these ratings are retrievable. CD queried as to why these have slipped (12 red/ambers) as they should have been dealt with initially.

MD informed the Committee that the receipt of the PIR (provider information request) put SWYPFT on notice so this had made us more vigilant.

The Committee expressed disappointment in the 12 red/ambers and noted that issues should have been addressed and actions taken. The Committee required assurance that these issues were being followed up and monitored and that self-assessments were being embedded

TB gave assurance to the Committee that work is underway through the workshop event that was instigated to address barriers that were raised and ensure that action is taken through OMG.

There was a query noted regarding the end dates on the action plan as some are showing as "past" and require updating.

Committee agreed that future reports need stripping down to the amber/reds and to remove blue and green.

**Action: Mike Doyle**  
**CQC action plan & exception report to be updated**

**The Committee RECEIVED and COMMENTED on the CQC action plan and NOTED the areas of risk.**

### **8.2 CQC Community Survey**

MD provided a brief overview of the report to the Committee.

The National reports are published by the CQC and publicly available, this report provided a local breakdown of the results by Care Commissioning Group.

It was important to note that at the time of data collection, services had recently undergone Transformation.

The annual Community Mental Health Service User Survey continued to be an important source of feedback on the services received by service users. The results indicated that there had been an improvement in some areas and a decline in others. Benchmarking against the national average the Trust is 'about the same' compared with other Trusts in all areas of the survey. The comments were also a valuable source of feedback and indicated a level of satisfaction with the care provided by the staff. There were a number of comments indicating that the Transformation of services had been disruptive and affected the quality of care.

The concerns that were highlighted:

- Waiting times
- Continuity of care
- Communication
- Access to services

BDU's have been asked to review the report, note conclusions and recommendations and develop action plans to address areas for improvement.

AM noted some variations and CH will discuss in OMG as to how best to represent this and would then bring back to CGCS.

**Action: Carol Harris**

AM queried if this survey is in relation to Adults. MD to confirm.

**Action: Mike Doyle**

**The Committee REVIEWED the report, NOTED the action required by BDU and the need for feedback to CGCS.**

### **CG/19/38 Care Quality Commission Mental Health Act (agenda item 9)**

There was nothing to highlight to CGCS on this occasion.

### **CG/19/39 Trust achievements (agenda item 10)**

The Committee noted the significant number of Trust achievements across all areas of the organisation and also the importance of sharing our achievements externally.

**The Committee RECEIVED and NOTED the update**

### **CG/19/40 Quality Strategy Update (agenda item 11)**

Progress against Quality Strategy Implementation Plan is included in the Quality Account report and will be provided in the report to June Committee meeting following Quality Account completion.

**The Committee RECEIVED and NOTED the update**

### **CG/19/41 Issues arising from Performance report (agenda item 12)**

TB provided an update on the following:-

- Restrictive Practices. TB provided a brief overview of the current work in this area and advised that further details will be provided in the routine patient safety report. KQ noted the progress but commented on the fact that the governance is strong but we require an enhanced message regarding our long term ambition. TB advised that this will be included in the update.

### **CG/19/42 Update on topical, legal and regulatory risks (agenda item 13)**

TB briefed the Committee on the following:-

- Long Term Plan – TB advised the committee of the publication and explained that the recent strategy board has included a discussion around the alignment of our Trust Strategy to the Long Term Plan. It is clear that we are well aligned however further work is required to provide that level of clarity for all stakeholders. TB to provide update to next meeting.

**Action Tim Breedon**

- Letter received Friday 29 March 2019 from Paul Lelliot, Deputy Chief Inspection for Hospital for Mental Health. The letter explains how the CQC will be strengthening its assessment of mental health wards in response to their continued concern about the quality and safety of care within inpatient services. The letter highlights concerns in relation to restrictive interventions, high numbers of assaults on patients and staff and compounded by poor physical fabric of the wards and the quality / quantity of staff available. The CQC plan to provide new guidance to inspectors and will focus upon the work undertaken by providers around the restrictive intervention agenda. The letter will be made available to operational teams in preparation forthcoming inspection.

### **CG/19/43 Child and adolescent mental health services - update (agenda item 14.1)**

CH gave a brief overview of the report to the Committee accompanied by data on waiting lists and waiting times. CH informed the Committee that the inclusion of caseload data had not been incorporated into the report in time for this meeting.

CH noted that commissioners had demonstrated a commitment to CAMHS through investments in 2019/20

### **Calderdale**

The CCG has committed to increased investment of £182k in 2019/20 to support the development of a THRIVE-based service offer. This will involve continuing to work with the CCG and provider partners to further strengthen relationship and embed cultural as well as system change. As part of this process we have agreed in principle to an ambition to establish an integrated workforce strategy. This includes the potential to manage posts and finances across the system. Detail regarding the proposed 2020/21 procurement is still awaited.

As previously reported the CCG has invested in an ASC waiting list initiative (£200k) to increase capacity from 5 to 15 diagnostic assessments per month for 12 months. An additional £100k has now been agreed for a further 52 assessments and with a specific focus on younger children (4-6 years).

### **Kirklees**

Kirklees was successful in bidding for Trailblazer status. This will see investment of approximately £500k per year (for two years) in strengthening school based support. The new staff have been recruited and recently commenced training.

Further ASC waiting list investment (£100k) has been secured. This will support reduction of waiting times for diagnostic assessment to no more than 6 months by September 2019.

### **Wakefield**

As noted previously Wakefield Safeguarding Board is undertaking a review in relation to a number of recent deaths of young people aged 16-21 through apparent suicide. Initial learning is being fed back across all CAMHS teams and a related action plan is being developed.

In addition, a Child Adolescent Mental Health Services Oversight and Assurance Forum has been established to understand learning at a local system level and ensure this underpins improvement in service delivery. The agreed remit of the forum also includes overseeing new investment in CAMHS – most notably with respect to reducing waiting times and strengthening crisis/home based treatment capacity. It is expected the forum links with the Wakefield Mental Health Alliance work streams and serves to underpin assurance for the Children's Improvement Board, Wakefield CCG Governing Body and SWYPFT Board.

CD queried as to whether ASD funding could be used to help with the backlog. CH confirmed that waiting list initiative funding was targeted at backlog and new investments were based on current activity with a revised care pathway.

AM asked for an update on the trailblazer in Kirklees and details regarding the schools involved. CH agreed to provide this outside the meeting.

**Action Carol Harris**

AM asked for more information regarding resources to self-manage and the work that was taking place with Young Creative Minds.

The spike in reported incidents in Calderdale was noted and TB agreed to provide committee with further information through quarterly incident report.

**Action: Tim Breedon**

The Committee queried as to why the CPR training in Barnsley has a large fluctuation from 80%-68%. MD suggested that the training was annual and that it is likely that a number of people completed the training together and therefore expired at a similar time. CH will follow this up.

**Action: Carol Harris**

**It was RESOLVED to NOTE the update paper.**

#### **Item 14.2 Forensic CAMHS Wetherby YOI Independent Report update**

Sue Threadgold (ST) gave a brief update to the Committee since the last meeting. ST informed that we are still waiting for a full sign off of the recovery plan from NHS England and that there is an Improvement Board later this week where we are confident that the plan would be signed off. However work continues on improvements in the recovery plan. At the moment SWYPFT concentration is around development of the Organisational Development plan and the revised final version is ready for submission 02.04.19.

Since the last CGCS SWYPFT have had the HMIP and CQC visits which were very thorough as 15-20 people undertook this inspection. At present verbal feedback received from the visits is generally positive however acknowledges some difficulties and a further review into harmful sexual behaviour (HSB) service. A couple of Sainsbury's risk assessments were noted as missing / late and this had been picked up immediately with the manager.

There was a highlighted concern around secure STAIRS implementation. NHS England have deployed funds that provides extra staff based on the concerns in the independent review (secure STAIRS) this work has now been done and pressure on NHS England to release the funds.

ST highlighted to the Committee the Enhanced Support Unit (ESU), which is for 6 boys already in Wetherby Drive model, which is going very well and is being pushed through.

It was noted that SWYPFT now have a stronger presence in Wetherby and relationships are more positive.

It was noted that overall the pace is progressing well and internal governance framework embedded.

AM and the Committee agreed that it was good to hear the verbal findings and that relationships are improving with LCH and was assured.

The report is expected in around 6 weeks' time and again it was noted that generally feedback was very positive.

The Committee agreed that they would like an update to come back to the June Committee along with an action plan.

**Action: S Threadgold**

There was a query regarding the risk register and ST confirmed that it is on the forensic risk register. The Committee advised that EMT give consideration to inclusion on the Organisational Risk Register.

**Action: Carol Harris**

**The Committee RECEIVED and commented on the update report on the Independent Review and NOTED the next steps identified.**

#### **CG/19/44 Quality Impact Assessment review (agenda item 15)**

TB provided a brief overview of the Quality Impact Assessment paper.

It was noting the position for the closure of the 18/19 assessments and highlighting the current position in respect of 19/20.

TB drew attention to the section relating to Kirklees / Calderdale community vacancies as this has been an area of interest for the Committee. It is clear that the BDU had reviewed the impact of vacancies as a result of transformation and worked to mitigate any presenting risks. The major impact relates to the waiting list position and this is subject to dialogue with Commissioners.

The Committee felt that this was a robust process and understood the current position.

**It was RESOLVED to RECEIVE and NOTE the update and the areas of risk**

#### **CG/19/45 Safer Staffing (agenda item 16)**

The national commitment to safer staffing is ongoing and the Trust needs to maintain the progress already made in delivering safer staffing. At a national level, there continues to be key changes around the delivery of this agenda. An acuity and establishment review tool for mental health/LD wards has been developed and we await the publication of the Safe Care Tool.

The inpatient wards in SWYPFT required a 17% uplift on establishment and planned staffing. As part of a new NHS Improvement initiative, SWYPFT 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 terms of reference meeting and further monthly meetings have been scheduled from April.

Care Hours Per Patient Day has been published on NHS Choices and has led to a teleconference to look at differences within our services being set up with NHSi.

Plans going forward for 2019/20 include:

- SWYPFT 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
- Continue to review the Medical Bank capability
- Publish the new staff bank procedure and hold engagement events with bank only staff
- 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 SWYPFT Recruitment & Retention Strategy

MD noted that there are still some challenges however progress is being made. MD informed the Committee that a loss of 25% of new nurses in the first year came out of a workforce planning workshop and that a deep dive into this issue is being considered. Committee noted concerns and asked for further updates in the next report. It was noted that this area is also discussed in the Workforce Committee.

STHi suggested that open events / engage & listen could be organised regarding recruitment and retention and AD informed that we have career events in schools. This has been discussed in EMT and OMG and a business case produced.

The Committee discussed the report in detail and comments as follows:-

- The report provides a comprehensive review of Safer Staffing activity.
- The positive work around recruitment and retention is noted.
- The exception reporting of planned versus actual fill rates continues to be an important part of the routine assurance.
- The establishment review is an important part of maintaining assurance and will be addressed through workforce planning
- The challenges in recruitment and retention of registered nurses remains a concern.

**The Committee NOTED the report and action taken to ensure safe staffing levels.**

### **CG/19/46 Serious Incidents Quarterly Report Q3 (agenda item 17)**

TB updated the Committee on the Q3 Serious Incidents report

Overall figures for incident reporting. Q3 had 3163 incidents; lower than the previous quarter.

- 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 (31% (1002) of all incidents, similar to the previous quarter)
- “Physical aggression/threat (no physical contact): by patient” remains as the most reported category of all violence and aggression incidents (281)
- There have been no ‘Never Events’ reported in the Trust during Q3; the last Never Event reported was in 2010/11.
- 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 and BDU governance groups and learning is shared.

AM queried the figures showing a rise in incidents rather than a reduction. This was reported to be human error and MD to clarify.

**Action: Mike Doyle**

The Committee questioned as to whether SWYPFT were below the national average on comparative data and MD advised that this will be revised and included in future reports.

AM noted a concern in the increase of amber incidents. MD reported that SWYPFT pressure ulcers are now recorded as amber which accounts for the increase.

CH advised that the triangulation between bullying harassment and other incidents takes place in OMG and informed discussion at EMT

AM made the Committee aware of a table at the top of page 22 which did not mention Calderdale. MD suggested that this was possibly down to human error and would check the information on all the tables.

**Action: Mike Doyle**

### **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.
- The policy on learning from deaths came into effect from 1 October 2017, which has resulted in less deaths being reported, but more of those deaths being in scope for review from Quarter 3 17/18 onwards.
- The Trust has adopted the three levels of scrutiny suggested in the National Quality Board guidance:
  - Death Certification
  - Case record review, including Structured Judgment Review. The managers 48 hour review on Datix is also classed as a first stage case record review.
  - Investigation – that could be service level, serious incident reported on STEIS or other review e.g. Learning Disability Mortality Review (LeDeR), safeguarding.
- The total number of deaths reported on SWYPFT clinical systems where there has been system activity within 180 days of death, where the service user had had any form of contact with NHS services was 578.
- Total number of deaths reported on Datix by staff between 1/4/2018 – 30/9/2018 (by reported date, not date of death) = 78, all of which have been reviewed.
- Total in scope as described in report = 57
- Learning from Structured Judgment Record Reviews and Investigations completed to date is included in the report.
- A Clinical Mortality Review Group was help on the 29 March 2019 and have been organised now on a quarterly basis to gain more understanding and learning.

The Committee left assured that learning was being taken forward. MD also informed the Committee that Helen Roberts produced some slides to show the pathway of learning from deaths and agreed to share with the Committee

**Action: Mike Doyle**

### **CG/19/47 Whistleblowing & Freedom to Speak Up Guardians Position Update (agenda item 18)**

Adrian Deakin (ADe) and Estelle Myers (EM) gave a brief update to the Committee.

They reported 15 cases which had come to light regarding whistleblowing, bullying and harassment, patient safety concerns and staff wellbeing. The majority of which were

bullying & harassment. CD queried as to whether any themes were evident with other Trusts and it was noted from ADe that we are comparable with other Trusts.

The Committee questioned whether the people that have come forward were comfortable in doing so and it was reported that this was the general feeling. Both agreed that it was definitely the case with the cases that they have dealt with and argue that it's the cases that don't come forward that are more worrying. EM was concerned with the cases/people that were not comfortable in reporting issues as it could involve a person in a higher position. All agreed that more work needed to be done around this issue. ADe suggested a promotion of this service together with the secondment of an additional 20 hours will assist. EM suggested a hotline for people to ring which is anonymous.

CD has a meeting with ADe & EM where these issues could be discussed.

AD agreed that we needed more time and noted that EM has moved this agenda on considerably. The new appointment of 20 hours would give a chance to progress this.

Committee thanked both ADe and EM for all their hard work on this and agreed that it needed to stay high profile.

AM noted that there was still an issue with the link with governors which is not clear regarding the options regarding guardians and asked for some clarity on this

**Action Alan Davis**

**The Committee NOTED the FTSUG update.**

#### **CG/19/48 Internal Audit Report (agenda item 19)**

The Committee noted that there were no Internal Audit reports to discuss.

#### **CG/19/49 Annual Reports (agenda item 20)**

The Committee noted that there were no Annual reports to discuss.

#### **CG/19/50 Review of Healthcare Deaths Policy (agenda item 21)**

TB provided a brief overview to the Committee The revised policy has been scrutinised by Executive Management Team (EMT). The original policy was also scrutinised by CGCS previously.

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.

- 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 was 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..

Clarity was requested regarding the name of the policy and it was agreed that learning from healthcare deaths was correct.

The outcome from the Mortality reviews will continue to be included in the quarterly reports and published on our website.

**The Committee RECEIVED the Healthcare Deaths policy as approved by the Trust Board 26.3.19 and NOTED the next steps**

### **CG/19/51 Sub-groups – exception reporting (agenda item 22)**

#### Drug & Therapeutic (agenda item 22.1)

Kate Dewhirst (KD) gave a brief overview to the Committee.

Annual prescription chart audit 2018, there has been a general decline in the standards of completion of prescription and administration charts. Data collection was October 2018. The report includes recommendations and will be shared at BDU governance groups for local action plans. D&TC will monitor trust wide actions.

Annual Antimicrobial – Prescribing Audit 2018, Antimicrobial stewardship is a priority for all areas of healthcare. Usage of antimicrobials is scrutinised continually by the pharmacy team and audited regularly.

Across all wards there is an improvement with regards to indication for antibiotics recorded and length of treatment recorded. However there is ongoing concern with regards to doses not being offered or taken as prescribed. There is on-going work being done across the trust with regards to this indicator for all prescribed medicines.

There has been an improvement in omissions figures which was noted at Trust Board

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

#### Safety & Resilience (agenda item 22.2)

There has been a lot of activity around lone worker devices A dip in usage for December 2018 was reported, along with 370 devices not being used at all from 2016/2017. Roland Webb is looking at starting to take some of these devices off the contract where these are not required.

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

Infection Prevention and Control (agenda item 22.3)

Nothing to highlight

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

Safeguarding adults & children (agenda item 22.4)

Safeguarding conference well attended last Friday and good examples of leadership have been noted across the system

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

Managing Aggression and Violence (agenda item 22.5)

A lot of scrutiny around MAV and the team have been working hard ahead of the annual report due in June. There have been some issues on figures which are being looked into more closely. Extended EMT has a focus on this.

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

Any feedback from other TAGs/groups (agenda item 22.6)

None.

### **CG/19/52 Serious Incidents Update (agenda item 23)**

TB gave a brief update to the Committee on key Serious Incidents.

1. Recent meeting with MP to result in a meeting with family supporting closure.
2. An inpatient death on Appleton Ward, Newton Lodge.
3. External Homicide Review progress noted
4. Child suicide - Wakefield. The child was not known to our services, however supported offered to local system.

**It was RESOLVED to NOTE the update and the action described.**

### **CG/19/53 Issues and items to bring to the attention of Trust Board and other Committees (agenda item 24)**

Issues were identified as:

- CQC action plan
- CQC letter – Paul Lelliott
- Wetherby YOI report
- Whistleblowing Freedom to Speak up Guardians
- Bullying & Harassment – Workforce Remuneration Committee

### **CG/19/54 Consideration of any changes from the organisational risk register relevant to the remit of the Clinical Governance & Clinical Safety Committee (agenda item 25)**

Points already discussed earlier in the agenda.

**CG/19/55 Work Programme (agenda item 26)**

Scheduling of meetings were discussed as these appear to be earlier than previous years.  
TB and CD to discuss with Emma Jones

**Action: Tim Breedon / Charlotte Dyson**

- The Committee wanted to reiterate the importance of not embedding documents within papers submitted to the Committee and that papers will be returned should they be sent with embedded attachments. It was also reiterated that front sheets must be completed in full as per the example circulated with the draft agenda.

**CG/19/56 Date of next meeting (agenda item 27)**

The next meeting will be held at 10.30 – 13.00 in Meeting room 1, Fieldhead Hospital, Ouchthorpe Lane, Wakefield WF1 3SP. **Quality Accounts**

## Minutes of Clinical Governance and Clinical Safety Committee meeting held on 14 May 2019

<b>Present:</b>	Dr Subha Thiyagesh (ST)	Medical Director
	Tim Breedon (TB)	Director of Nursing and Quality
	Charlotte Dyson (CD)	Non-Executive Director (Chair)
	Kate Quail (KQ)	Non-Executive Director
	Angela Monaghan	Chair
<b>Apologies:</b>	<u>Members</u>	
	Alan Davis	Director of Human Resources, OD and Estates
<b>In attendance:</b>	Karen Batty (KB)	Associate Director, Nursing and Quality
	Mike Doyle (MD)	Deputy Director, Nursing and Quality
	Carol Harris (CH)	Director of Operations
	Sarah Millar (SM)	PA to Medical Director (author)

### **CG/19/57 Welcome, introduction and apologies (agenda item 1)**

The Chair, Charlotte Dyson (CD) welcomed everyone to the meeting and the apologies were noted.

### **CG/19/58 Consideration and approval of the Quality Account 2018/2019 (agenda item 2)**

Tim Breedon (TB) introduced the item and gave a summary position.

- The approach to production of the Quality Account was tried and tested which should provide significant assurance to Committee.
- The draft report had been subject to regular updates and the tight timescale with Trust Board being earlier in the month was noted.
- Clinical Governance and Clinical Safety Committee (CGCSC) were asked to take account of the transition to SystemOne coinciding with production of the report.
- A two page summary would be produced, in accessible form to assist the public in holding the Trust to account.

The report had been circulated to Committee prior to the meeting and typo amendments would be dealt with separately. The purpose of the meeting today was to review the content. Karen Batty (KB) reported that there were sections of the report that were mandated and we therefore had no control over the layout. It was noted that Section 3 mirrored the Quality Strategy and there was an implementation plan to ensure that the two were aligned.

Charlotte Dyson (CD) suggested adding information on the Trust's approach to quality improvement, specifically the improvement academy and #allofusimprove. It was agreed that there should also be emphasis on the reducing restrictive practice work and suicide prevention. KB indicated that whilst priorities had been set, there may be opportunity to reference the above.

KB reported that stakeholders had not yet responded to the request for statements and TB asked Sarah Millar (SM) to send a reminder e-mail.

**Action: Sarah Millar**

KB would make the necessary changes and asked Committee to note that there had been really positive engagement with the Quality Group in the production of the report.

**It was RESOLVED, subject to the above and any minor processing amendments, to APPROVE the final draft of the Quality Account for 2018/19 and to RECOMMEND their approval to the Audit Committee as part of the Annual Report and accounts for 2018/19.**

**CG/19/59 Date of next meeting (agenda item 3)**

The next Committee meeting will be held on Tuesday 11 June 2019 at 2.00pm in Meeting Room 1, Block 7, Fieldhead, Wakefield.

### Equality and Inclusion Forum held on 5 March 2019

<b>Present:</b>	Angela Monaghan (AM) Tim Breedon (TB) Alan Davis (AGD)	Chair of the Trust (Chair) Director of Nursing and Quality (lead Director) Director of Human Resources, Organisational Development & Estates
	Erfana Mahmood (EM) Sam Young (SYo)	Non-Executive Director Non-Executive Director
<b>In attendance:</b>	Afsana Aslam (AA)	Involvement & Engagement Manager and Chair of the BAME Network
	Aboo Bhana (AB) Aimee Gray (AG) Claire Hartland (CH) Zahida Mallard (ZM) Elaine Shelton (ES)	Equality & Engagement Development Manager Corporate Governance Manager (notes) Human Resources Business Manager Equality & Engagement Development Manager Staff Side Chair – Equality Lead and Chair of the Disability Network
<b>Apologies:</b>	<u>Members</u> Nasim Hasnie (NH) Sean Rayner (SR) Rob Webster (RW)	Public Governor, Members' Council Director of Provider Development Chief Executive
	<u>Attendees</u> Dr Subha Thiyagesh (SThi)	Medical Director

#### **EIF/19/01 Welcome, introduction and apologies (agenda item 1)**

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

#### **EIF/19/02 Declaration of interests (agenda item 2)**

There were no further declarations over and above those made in the annual return to Trust Board in March 2018 and Members' Council in April 2018 or subsequently.

#### **EIF/19/03 Minutes from the meeting held on 2 October 2018 (agenda item 3)**

The minutes of the previous meeting held on 2 October 2018 were approved. Sam Young (SYo) noted that she was not listed as attendee but was present at the last meeting.

**Action: Aimee Gray**

#### **EIF/19/04 Matters arising (agenda item 4)**

##### Action log from the meeting held on 2 October 2018

The following matters arising were discussed:

- Agreed all completed actions highlighted in blue can now be removed from the action log.  
**Action: Aimee Gray**
- EIF/18/37 Lesbian, gay, bisexual and transgender (LGBT) Plus staff network - The LGBT+ network work programme will be added to the agenda for the next E&I Forum meeting. Aboo Bhana (AB) to provide.

**Action: Aboo Bhana**

- EIF/18/25 Equality Impact Assessments (EIA) update (EMT policy proforma) - Tim Breedon (TB) updated that work was underway with updating the policy proforma to confirm that an EIA had been completed. Emma Jones to confirm timescale.

**Action: Emma Jones**

### **EIF/19/05 Consideration of items from the corporate / organisational risk register aligned to the Forum (agenda item 5)**

The risk aligned to the Forum was discussed. It was agreed that the risk level reflected the current position and the Forum is comfortable with this.

Erfana Mahmood (EM) suggested that the risk description does not pick up issues that BAME staff experience moving into more senior roles within the Trust. Alan Davis (AGD) noted that this is picked up through the staff survey results and in the WRES action plan, but agreed that an additional action should be added to the risk in relation to this. AGD noted that the Trust is average for a Trust of this size in most areas of the staff survey.

It was also suggested that there should be an action and a control for the delivery of the WRES and EDS2 action plans.

**Action: Alan Davis**

SYo queried what actions would be required to reduce the risk rating to the target risk level. AGD to review as part of the next risk register review at EMT.

**Action: Alan Davis**

AB noted that some Trusts have improved against the WRES. AB to circulate information to the Forum.

**Action: Aboo Bhana**

### **EIF/19/06 Performance reports (agenda item 6)**

#### EIF/19/06a Draft equality and inclusion dashboard (agenda item 6.1)

TB explained that the dashboard version presented to the Forum was a first draft and welcomed any comments / feedback.

The Forum discussed the dashboard and made the following suggestions:

- Staff data categorised by banding.
- Are we able to show disparities in data for BAME service users regarding when they enter services, and how they are presenting?
- Are there ways to improve data records in relation to ethnicity?
- Areas the Trust is required to meet a target should be included in the dashboard – accommodation, employment status and ethnicity.
- Areas that are already under review by the Trust Board should be highlighted.

SYo suggested breaking the dashboard down into three sections of workforce, service users and corporate process, with five (or fewer) key focus areas under each section, what the targets are in each of those sections and what data sets are required.

AGD noted that there is often more detailed staff data as it is easier to collate the staff data than public / service user data.

The Forum discussed SystmOne and if this would help with data collection. TB confirmed that it should support a better position, however there will still be some occasions where service users do not wish to disclose equality monitoring information.

Syo queried if there is any guidance for staff to assist with how to ask questions regarding the protected characteristics. Claire Hartland (CH) to advise.

**Action: Claire Hartland**

CH noted that data is not recorded on application for some of the protected characteristics and that this data can only be collected by the Trust when an applicant is successful. CH advised that work is ongoing with NHS Jobs to try and improve this data collection for applicants.

The Forum agreed for TB to amend the dashboard as appropriate following the feedback from the discussion and to review again at the next E&I Forum meeting.

**Action: Tim Breedon**

**EIF/19/06b Equality standards updates (by exception) (agenda item 6.2)**

CH reported that the Workforce Disability Equality Standard (WDES) follows a similar reporting system to the WRES, however noted that the publication timescale is different and an online template will be provided. The WDES submission will be published on 1 August therefore the data is required prior to this. No deadline received as yet for WRES, however CH anticipates this will be the end of September, as in 2018.

**EIF/19/06c Equality Impact Assessments (EIA) update (agenda item 6.3)**

Zahida Mallard (ZM) noted that there are fewer issues with completion of EIAs for clinical policies as they are completed and reviewed as part of the clinical policy group. It was felt that the EIA is seen as an additional paper exercise rather than part of the policy completion.

The Forum discussed the report provided and ZM highlighted that amber EIAs are work in progress and red are outstanding. It was discussed that previous outstanding EIAs were discussed at Operational Management Group and suggested that this should take place again.

**Action: Tim Breedon**

The Forum discussed the requirement for training around EIA completion and raising awareness of the importance of EIAs and the reason that they are completed. AB suggested a campaign through Comms to promote. It was also noted that there is a session at Extended EMT before the next Forum meeting.

**Action: Aboo Bhana / Zahida Mallard / Afsana Aslam**

**EIF/19/06d Equality Delivery System (EDS2) update (agenda item 6.4)**

ZM informed the Forum that the first EDS2 panel meeting is on 6 March. The Trust has also received an invitation to attend an event regarding EDS3 consultation process.

ZM advised that the paperwork for Wakefield is now complete and agreed to share this with the Forum.

**Action: Zahida Mallard**

ZM informed the Forum that the Trust is 'achieving' goals 1 and 2, but that the staff indicator is assessed as 'developing'.

**EIF/19/06e Equality strategy – update on action plan (agenda item 6.5) *deferred to next meeting***

#### EIF/19/06f Forum annual report 2018/19 (agenda item 6.6)

AM noted that this is the first Forum annual report and advised that it would be presented to the Audit Committee as part of the process of providing assurance to the Board that the Forum is meeting its duties. It was agreed that the annual report accurately reflected the Forum's work over the past year.

The Forum discussed the self-assessment. AM asked the newest members of the group (SYo and EM) if there were any improvements that could be made to the induction to joining the Forum. It was felt that the induction was satisfactory.

It was noted that the Forum met three times per year previously, however it was suggested that this should increase to four times per year. All attendees agreed with this suggestion.

The Forum discussed the Terms of Reference in detail. The updates were noted. A lengthy discussion took place regarding if the Forum should be changed to a formal Committee of the Board and it was agreed to make a proposal to the Board that the Forum should change to a Committee.

**Action: Angela Monaghan / Emma Jones**

It was agreed that the Terms of Reference need to clearly reflect the purpose and role of the Forum, should it change to a Committee.

AM highlighted that if the Forum is changed to a Committee that a governor would no longer be able to be a member, however that a governor could be appointed as an attendee through the process that is now in place to appoint governors to groups. AM to discuss with Nasim Hasnie (NH), current governor Forum member. SYo noted that NH was not present at the meeting to take part in this discussion.

**Action: Angela Monaghan**

Additional core attendees were agreed to be those currently in attendance at the Forum, and to include an invitation to the staff network Chairs.

SYo suggested holding one strategic session as one of the four meetings per year. It was also noted that the timing and scheduling of the meetings may need to be reviewed in line with the work of the Forum.

**Action: Angela Monaghan/Emma Jones**

#### **EIF/19/07 Feedback from staff networks and development programme (agenda item 7)**

##### EIF/19/07a Feedback from staff equality networks (agenda item 7.1)

Elaine Shelton (ES) provided an update regarding the staff disability network. The first steering group meeting has taken place and the work plan for the next 12 months is being agreed, including promoting the awareness of issues relating to disability and looking at educational needs. The first big meeting will be planned in April / May 2019, which will hopefully include a guest speaker and a relaunch of the group.

Afsana Aslam (AA) provided an update regarding the BAME network. The network is well established, and the steering group has recently met to discuss what members want from the group, and for development and career progression opportunities.

AD provided an update regarding the LGBTQ+ staff network. Work is ongoing to establish this network and an engagement session will take place on 5 April.

AB provided an update on the carers' network. A meeting took place last month with six attendees. Some good discussions took place and work is ongoing with Comms to promote the network.

EIF/19/07b Inclusive leadership and development programme updates (agenda item 7.2)  
AD provided an update. There is currently no programme, however an engagement session with Extended EMT was successful and demonstrated some of the good work that has been done.

AM noted that the Trust will have a new Insight Programme attendee soon.

**EIF/19/08 National issues and impact locally (agenda item 8)**

The EDS3 update discussed earlier in the meeting was noted.

**EIF/19/09 Any other business (agenda item 9)**

ES requested that John Pittam is now removed from the attendee list, and that ES is added as she is now the Staff Side equality lead.

**Action: Emma Jones**

**EIF/19/10 Consideration of any changes to the corporate / organisational risk register relevant to the remit of the Forum (agenda item 10)**

The Forum agreed there were no further changes to recommend to the risk register.

**EIF/19/11 Items to bring to the attention of Trust Board / Committees (agenda item 11)**

The Forum agreed the following:

- 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.

**EIF/19/12 Work programme 2018/19 (agenda item 12)**

The Forum agreed that the proposed work programme should include the suggested structuring of the meetings.

**Action: Angela Monaghan/Emma Jones**

**EIF/19/13 Date of next meeting (agenda item 13)**

The next meeting of the Forum will be held on Tuesday 4 June 2019 at 10.30am to 1.00pm, Meeting room 1, Block 7, Fieldhead, Wakefield

**Minutes of the Mental Health Act Committee Meeting held on  
 12 March 2019**

<b>Present:</b>	Dr Subha Thiyagesh Kate Quail Tim Breedon Erfana Mahmood Salma Yasmeen Laurence Campbell	Medical Director (lead Director) Non-Executive Director (Chair) Director of Nursing and Quality Non-Executive Director Director of Strategy Non-Executive Director
<b>Apologies:</b>	<u>Attendees</u> Shirley Atkinson  Andy Brammer  Julie Carr Terry Hevicon-Nixon  Deborah Longmore Stephen Thomas	Professional Development Support Manager (Barnsley) – local authority representative Mental Health Act Professional Lead (Wakefield) – local authority representative Clinical Legislation Manager Operations Manager - Working Age Mental Health (Calderdale) – local authority representative Adult Safeguarding Named Nurse, Barnsley – acute trust MCA/MHA Team Manager (Wakefield) – local authority representative
<b>In attendance:</b>	Yvonne French Carol Harris Anne Howgate David Longstaff Karen Riordan Sarah Millar Victoria Thersby	Assistant Director, Legal Services Director of Operations AMHP Team Leader (Kirklees) – local authority Independent Associate Hospital Manager Modern Matron (item 2 only) PA to Medical Director (author) Head of Safeguarding (Calderdale and Kirklees) – acute trust representative

**MHAC/19/1 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/19/2 The Act in Practice (agenda item 2)**

MHAC/19/2a Mental Capacity Act – General Operations (agenda item 2.1)

Presentation from Karen Riordan (KR), Modern Matron in Barnsley on the use of the Mental Capacity Act in Neuro Rehabilitation and Stroke Rehabilitation services.

Committee discussed the differences in these services compared to the mental health services provided in other areas of the Trust. It was noted that in the case of brain injury the situation can change rapidly and DOLS may be used for specific things such as low stimulation to enable the brain to heal and communication around this with patients and families is key. KR indicated that there are benefits of being part of a mental health trust

despite the physical health patient group and Committee noted the positive working between staff groups.

KR highlighted that it is sometimes difficult to get a DOLS assessor and Victoria Thersby (VT) queried if the standard authorisation often expired before a DOLS assessment was possible. KR advised that the wait can be up to 3 weeks but that the service feels supported during that time.

There was further discussion around differences such as environmental security and MAV training and KR indicated that if anyone wanted to visit the services, they would be welcome to do so.

The Committee thanked KR for her presentation.

### **MHAC/19/3 Legal updates (agenda item 3)**

#### **MHAC/19/3a Mental Health Units (Use of Force) Act (agenda item 3.1)**

Yvonne French (YF) reported that the Act, in response to a death in 2010 of an individual who had been restrained by 11 police officers, had received Royal Assent on 1 November 2018. The key provisions of the Act are;

- All mental health units will need to appoint a 'responsible person' for the purposes of the Act. This person needs to be employed by the unit and be of sufficient seniority.
- The responsible person must publish a policy on the use of force by staff and also publish information for patients about their rights in relation to the use of force by staff.
- Training must be provided to staff on the use of force.
- Any use of force by a member of staff must be recorded (unless it is deemed to be 'negligible') and records kept for three years from the date of the event.
- An annual report is to be published based on the records of the use of force.
- Police officers attending a mental health unit in order to assist staff must take with them and wear a body camera if this is reasonably practicable.

It was suggested that Tim Breedon (TB) would be the most appropriate 'responsible person'.

There was discussion on police wearing body cameras and the need to consider whether this might have an adverse effect on an acute situation. Subha Thiyagesh (SThi) suggested that clear guidance should be issued to ward staff on asking police to either wear a camera or to remove it if deemed appropriate. YF advised that this would be done once the regulations were published and training was updated. Carol Harris (CH) advised that there had been some discussion in local networks about mental health hospitals adopting the use of body cameras and a couple of trusts have already done so.

Erfana Mahmood (EM) queried where SWYPFT sat against other trusts in relation to restraint episodes and it was noted that we were consistent with other organisations.

It was noted that the implementation date for the Act was awaited and ward staff would be made aware of this.

**It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.**

### MHAC/19/3b Conditional Discharge and DOLS (agenda item 3.2)

YF reported that the Ministry of Justice (MoJ) had provided guidance following a judgement that determined that it is unlawful for a patient who is subject to a conditional discharge to have conditions that amount to the patient continuing to be deprived of their liberty.

Committee noted that this would predominantly affect secure services who would be unable to conditionally discharge patients to the community, as the necessary conditions would amount to a Deprivation of Liberty. However, it was suggested that the law allows for extended Section 17 leave and this had been utilised in the past. In such a case the patient would remain on a hospital section and the Section 17 leave would be monitored through the Mental Health Act office.

YF advised that the guidance from the MoJ had been circulated to all Forensic Psychiatrists and a review of all conditionally discharged patients had identified no patient under the care of the Trust to be affected by this judgement. YF would liaise with social supervisors to check their caseloads.

**Action: Yvonne French**

YF added that as of now Tribunals are not allowed to discharge if liberty may be deprived.

**It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.**

### MHAC/19/3c Independent Review of the MHA 1983 (agenda item 3.3)

YF reported the outcome of the Independent Review of the MHA which was published on 6 December 2018.

A small group had been set up to consider the new NICE guidance which links to key recommendations. Of note, it had been recommended that the Hospital Managers' power of discharge be taken over by Tribunal which would represent a significant change with a lot more legal scrutiny and oversight. Also, reducing the use of CTOs by tightening criteria and limiting use for over two years – David Longstaff (DL) indicated that CTOs are a useful tool in improving the quality of life of patients from a Hospital Manager's perspective.

YF indicated that it would be more difficult in future to detain in general and the clinical governance subgroup are considering the potential impacts of the changes and what would need to be included on SystemOne.

**It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.**

### MHAC/19/3d Mental Capacity (Amendment) Bill (agenda item 3.4)

YF reported that amendments to the Bill continue to be tabled and we await government agreement. YF advised that this links in with other work and the NICE guidance group.

**It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.**

### **MHAC/19/4 Local Authority and partner agencies (agenda item 4)**

Anne Howgate (AH) reported a case of a 15 year old who had been involved in an allegation of rape and stabbing of other children. NHS England (NSHE) had indicated that the young person was too dangerous for PICU but not dangerous enough for medium security and had suggested an adult acute bed. CAMHS are currently managing the patient but not easily.

CH advised that it had been agreed as part of the New Care Models that 16 new beds would be created but this was not an immediate solution to the current difficulties caused by a lack of bed space.

AH added that there was also an absconson risk with this young person so there was a request for a bed to be available prior to a Mental Health Act assessment, however NHSE had advised that there would be no bed until an assessment had been carried out. TB and CH reported that they would be attending a CAMHS meeting with NHSE and CCG colleagues and would raise the difficulties there.

**Action: Tim Breedon/Carol Harris**

VT reported really good joint working with the liaison team. Following CQC feedback a strategy had been developed and a joint working group implemented. Section packs had also been developed for 5/2 and 2/3 and these had been positively received. The Committee noted the positive feedback on recent mental health involvement.

KQ raised that engagement with partner organisations had been noted as part of the MHAC audit and queried if feedback was provided to the meeting if someone was unable to attend. It was noted that there was no formal procedure and KQ would develop a template to be circulated in advance of the meetings.

**Action: Kate Quail**

There was discussion on engaging police partners and potentially asking them to attend to provide an Act in Practice presentation. Salma Yasmeen (SY) reported that she attends a quarterly regional joint mental health and police meeting that is well attended and also involves CCG representation. It was agreed that it would be useful to have feedback from that meeting in this section.

**Action: Salma Yasmeen**

AH referred to the difficulties with conveyance and EM advised that the Yorkshire Ambulance Service were aware and were developing a new pathway. It was noted that there is an annual forum meeting and Committee agreed that it would be useful if someone could attend. YF would forward details from EM to AH and AH would attend the meeting.

**Action: Yvonne French/Anne Howgate**

#### **MHAC/19/5 Minutes of previous meeting held on the 13 November 2018 (agenda item 5)**

**It was RESOLVED to APPROVE the notes of the meeting held on 13 November 2018 as a true and accurate record of the meeting.**

#### **MHAC/19/6 Matters arising (agenda item 6)**

##### **MHAC/19/6a Action points (agenda item 6.1)**

The action points were noted and the following items raised:

- MHAC/18/45b – DL advised that changes to capacity in relation to Tribunal proceedings had been discussed at the Hospital Managers' Forum. Information had also been circulated and training updated.
- MHAC/18/46 – It was agreed that an update report on the work of the NICE Steering Overview Group would be brought to the May MHAC meeting.

**Action: Yvonne French**

- MHAC/18/49a – An e-mail had been circulated to medical staff requesting sight of any existing guidance and there were two outstanding actions – to draft a checklist and liaise with medics in relation to a guidance note. The action points would be updated accordingly.
- MHAC/18/52b – YF confirmed that all mental health patients now had access to WiFi.
- MHAC/18/54 – There had been discussions in MHAC agenda setting and SThi had agreed to approach EMT with recommendations for 5 key MHAC areas to be included in the Integrated Performance Report (IPR) to Trust Board.

**Action: Subha Thiyagesh**

These would relate to top risks from a CQC perspective;

- Restrictive practice (Blanket restrictions)
- Section 132 Patient rights
- Section 17 leave – relating to the second page not being completed. The Mental Health Act office are now monitoring this and returning any forms not correctly filled in. The implementation of SystemOne should also improve the position
- Assessment of capacity to consent to treatment – specifically quality of recording and detail of information included
- Advance care planning under the Mental Capacity Act

It was noted that the above were BDU level risks so would not be included on the organisational risk register. Inclusion in the IPR, however, would focus discussion at Board level.

**MHAC/19/6b Consideration of items from the organisational risk register relevant to MHA Committee (agenda item 6.2)**

It was noted that there were no specific items for MHA Committee.

**MHAC/19/6c Mental Health Act Committee annual report to Trust Board (agenda item 6.3)**

Committee received the draft report and KQ advised that it would be taken to Audit Committee on 9 April 2019.

- MHA Committee self-assessment – it was noted that the majority of responses were positive and there was discussion on the following:-
    - *Q5: Has the Committee been provided with sufficient membership, authority and resources to perform its role effectively and independently?*  
It was noted that one respondent had answered ‘no’ and it was suggested that this linked to the discussion around involvement with agencies such as police, etc which was being addressed.
    - *Q9: Are members, particularly those new to the Committee, provided with training?*  
Again, one respondent had answered ‘no’. It was noted that YF provides a session as part of the Trust induction as well as a session at Board. It was agreed to include a statement in the annual report in relation to the competency of Committee members and the Chair’s ability to discharge their duties effectively.
- Action: Kate Quail**
- *Q12: Has the Committee formally assessed whether there is a need for the support of a ‘Company Secretary’ role or its equivalent?*  
It was noted that Emma Jones is available for support to the MHAC and supports the Trust overall.
  - *Q14: Has the Committee formally considered how it integrates with other Committees, particularly the Audit Committee, that are reviewing risk?*  
There had been a 100% positive response to this question and it was noted that each of the Executive and Non-Executive members attend other Committees and

there is particularly close working with Clinical Governance and Clinical Safety Committee to ensure there is no duplication.

- MHA Committee Terms of Reference – draft agreed
- MHA Committee Work Programme – draft agreed.

### **MHAC/19/7 Statistical information use of the Mental Health Act (MHA) 1983 and Mental Capacity Act (MCA) 2005 (agenda item 7)**

#### MHAC/19/7a Performance report – Monitoring information Trust wide October-December 2018 (agenda item 7.1)

The report was considered and the following noted:

- 136 activity unpredictable – being discussed in multiagency 136 group. Local Authority reps feedback when called to do assessment by police, maybe appropriate use that power. 136 group picking up why people not needing our services.
- A3 failed medical scrutiny. A further assessment was completed to enable detention of the patient under Section 2.
- Patient was admitted to the ward under a Section 2 with the nurse completing the H3 on the basis of 2 medical recommendations and no application by the AMHP. The papers were filed on the ward for two days before being brought to the attention of the MHA Office. MHA Office located the AMHP who later supplied the application and a new H3 was completed. The ward manager has reviewed the process for prompt delivery of MHA documentation to the MHA Office.
- The RC was prompted by MHA Office for the end of the Section 2. The RC failed to act on the notice and the Section 2 lapsed. Duty of Candour completed and the patient agreed to remain as an informal patient.
- Staff were seen escorting a patient to local shops when no Section 17 leave was authorised. The nursing staff have been reminded of the scope, limitation and authority of Section 17 leave.
- Completed Section 17 leave form received by MHA office for an informal patient. The RC and nursing staff have been reminded of the scope, limitation and authority of Section 17 leave. Duty of Candour has been requested.
- Trust notified that an AMHP had been practicing without a current warrant to act. MHA have reviewed all MHA involving the AMHP and identified one current patient affected by the incident. A letter has been sent from the Trust to this patient. The Local Authority is investigating how the incident occurred and their legal position. YF confirmed that robust checks are in place to prevent this from recurring.
- There was one exception report for Forensic sections that should be noted for Q3: Patient was discharged in their absence by Blackpool Magistrates court, however the RC was not informed by either the court or the patient's solicitor. He was alerted to the decision 6 days later by letter. A MHA assessment was completed. The patient was made subject to a Section 3 and Duty of Candour was completed.

There was discussion and it was agreed that changes should be made to the process for reporting performance to MHAC. Currently, feedback was not being received on the recommendations made at the meeting and CH was being asked for information that had not yet been sought. CH indicated that from 1 April there would be changes to the management structure and it was anticipated that this would improve consistency of practice across BDUs and enable identification of key themes for MHAC and the organisation as a whole. CH agreed to review the report to ensure that Committee are receiving meaningful data and to line up timescales to ensure that narratives match up with the available data.

**Action: Carol Harris**

LC queried the low number of admissions in Kirklees despite high acuity. YF suggested that this may be due to Out of Area cases not being captured or patients being admitted informally who were later detained. YF would liaise with Mike Garnham to check what data is currently being included.

**Action: Yvonne French**

**It was RESOLVED to RECEIVE the findings of the monitoring report and AGREE that the recommendations within the paper be included in the report to the next meeting.**

**MHAC/19/7b Local Authority Information (agenda item 7.2)**

Figures were received from the Local Authority in Kirklees and noted by the Committee.

AH advised that changes had been made to the monitoring form to make it clearer and to provide more information to MHAC in case AH was unable to attend.

There was nothing of note from Barnsley or Wakefield.

**MHAC/19/8 CQC compliance actions (agenda item 8)**

**MHAC/19/8a 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.

It was noted that a 136 MHA policy had been finalised for South Yorkshire. The West Yorkshire version, however, remained in draft with little progress being made. It was agreed that this should be escalated and SY would liaise with Mike Doyle to raise in an appropriate regional meeting.

**Action: Salma Yasmeen**

YF advised that the CQC were aware that this is a multi-agency document and outwith our control. It was suggested that a more formal approach may be required via the Mental Health Programme Board at a later stage.

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

**MHAC/19/8b MHA/MCA/DoLS mandatory training update (agenda item 8.2)**

YF reported the current position as:

- Mental Capacity Act/DoLS training – 92.71% compliant
  - Mental Health Act training – 86.70% compliant
- against an 80% target.

It was noted that e-learning was now available for both MHA and MCA training. YF reported that the legal team were low on staff for face to face training currently due to vacancies and sickness.

**It was RESOLVED to RECEIVE the report and to NOTE the level of compliance with mandatory training target and plans for future training.**

**MHAC/19/9 Audit and Compliance Reports (agenda item 9)**

**MHAC/19/9a Section 17 Thematic review (agenda item 9.1)**

YF reported on the thematic review of the last two years and it was noted that there had been much improvement, mainly due to the Mental Health Act office managing the process and forms being included on SystmOne. MHAC were asked to consider the type and focus

of future audit of Section 17 activity and it was suggested that this should form part of the work programme as a re-audit for next year.

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

### **MHAC/19/10 Care Quality Commission visits (agenda item 10)**

#### MHAC/19/10a Visits and summary reports received in Quarter 3 (agenda item 10.1)

YF reported that there were 5 CQC Mental Health Act visits in Quarter 3.

Within the quarter, 5 MHA monitoring summary reports were received relating to ward visits made to; Clark ward, Ward 19 (female), Nostell, Poplars and Ryburn.

6 responses were submitted to the CQC; Ashdale, Priestley ward, Thornton ward, Clark ward, Nostell and Poplars.

The Committee received detailed information about the outstanding issues.

YF reported that positive feedback was also being received from the Mental Health Act visits, not just negative although if just one record was missing, it would be noted as a less than 100% compliance. LC queried how we compare to other organisations and YF advised that according to the annual CQC report we were consistent although there was no specific benchmarking against other organisations. VT indicated that in the 2018 inspection the CQC had said that CHFT do not routinely audit outcomes for mental health patients and are developing this. DL reported consistently positive feedback about the care delivered at the Poplars.

YF indicated that the audit outcomes would be managed through the Quality Improvement and Assurance Team.

**It was RESOLVED to RECEIVE the report and to NOTE the update.**

#### MHAC/19/10b Update on MHA action plans (agenda item 10.2)

YF presented a new format of providing update on action plans to MHAC. This included an overview of key themes with more detail behind to show what each BDU was doing.

The key themes were noted as follows:-

- **Managing restrictive practice (blanket restrictions)**  
A 'managing restrictive practice' group is in place and has developed a policy and guidance to support staff to identify and manage restrictive practice where necessary. The Group will monitor and advise services on the use of restrictions on service users.
- **Section 17 leave**  
Section 17 has been a feature of a number of actions from the CQC, generally in respect of part 2 of the record not being fully completed. The monitoring of the forms has now been moved to MHA administration. This is to support clinical staff with the compliance with requirements of the MHA Code of Practice.
- **Seclusion reviews**  
A dip sample of records was undertaken in respect of the timeliness of all seclusion reviews. It showed that there was varying practice and in some cases understanding of the reviews that were required. A task and finish group looked at the guidance

and documentation and this has now been streamlined to make it easier to follow. This is being piloted during February 2019 on the UNITY centre. Initial feedback is that staff are finding it easier to follow.

➤ **Risk assessment tool**

The Trust is currently reviewing the use of the Sainsbury risk assessment level 1 and 2 and are developing a single risk assessment instead.

➤ **Care Planning**

A review of the current care planning within Mental Health has been ongoing since the decision to move to SystmOne. It is planned that a new format for care planning will form part of the new clinical record.

YF asked for comments on the new format and Committee agreed that the overview was helpful. It was agreed that it had been useful to see the summary action plan but that that level of detail did not need to come routinely to MHAC. The Committee did, however, require assurance that work was ongoing in BDUs. YF advised that the full action plan held all necessary detail to provide assurance.

LC suggested developing a simple tracker style table, similar to one used in Audit Committee, to provide overview to the next meeting. LC would liaise with YF on the format.

**Action: Laurence Campbell/Yvonne French**

It was queried why the CQC were requesting sight of AMHP reports when there was no legal requirement for them to provide same. AH added that the Code of Practice requires an outline of the AMHP report to be kept with section papers.

**It was RESOLVED to RECEIVE the report and to NOTE the update.**

**MHAC/19/11 Policy Development (agenda item 11)**

➤ **Reducing restrictive practice**

YF reported that a new policy had been developed following a number of CQC visits where issues had been raised because of blanket restrictions across a ward/service or the Trust. The policy had been approved at EMT in January 2019 and had gone out to services. A clinical reference group was overseeing the implementation of the policy and a quarterly report would be produced for MHAC.

➤ **Locked doors on wards**

YF advised that an existing policy had been reviewed and updated with minor amendments. The policy had been approved by EMT.

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

**MHAC/19/12 Monitoring Information (agenda item 12)**

**MHAC/19/12a Hospital Managers' Forum Notes 30 November 2018 (agenda item 12.1)**

The Committee received the notes of the last Forum. DL again raised that, despite some soundproofing works, the Tribunal Room in the Unity Centre was still very noisy. This would need to be resolved.

DL advised that Rob Webster had attended the meeting to present long service awards which was appreciated.

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

### **MHAC/19/13 Key Messages to Trust Board (agenda item 13)**

The key issues to report to Trust Board were agreed as:

- Development of a MHAC section in the IPR
- Key issues to be included on a Risk Register
- Development of the Annual Report
- Preparedness for upcoming legislation
- Ongoing issues and challenges in relation to documents.

### **MHAC/19/14 Date of next meeting (agenda item 14)**

The next Committee meeting will be held on 14 May 2019 in Meeting Room 1, Block 7, Fieldhead Hospital, Wakefield from 2.00-4.30 pm.

**Minutes of the Workforce and Remuneration Committee  
held on 12 February 2019**

<b>Present:</b>	Rachel Court Angela Monaghan Charlotte Dyson Rob Webster	Non-Executive Director (Chair) Chair of the Trust Non-Executive Director Chief Executive
<b>In attendance</b>	Sam Young Alan Davis Ranjit Das Janice White	Non-Executive Director Director of HR, OD and Estates Insight programme participant PA to Director of HR, OD and Estates (author)

**WRC/19/1 Welcome, Introductions and Apologies (agenda item 1)**

The Chair, Rachel Court (RC) welcomed everyone to the meeting.

**WRC/19/2 Declaration of Interests (verbal item)**

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

Alan Davis (AGD) declared an interest in the confidential minute number WRC/18/72 from the meeting held on 18<sup>th</sup> December 2018.

**WRC/19/3 Minutes of the meetings held on 23 October 2018, 18<sup>th</sup> December 2018 (excluding minute WRC/18/72) and confidential minute WRC/18/72 (sent under separate cover to members of the Committee excluding Alan Davis) (agenda item 3)**

It was **RESOLVED** to **APPROVE** the minutes of the meetings held on 23<sup>rd</sup> October 2018 and 18<sup>th</sup> December 2018, subject to the amendments made by Rob Webster (RW) to confidential Minute number WRC/18/72 which had been previously circulated to members of the Committee excluding Alan Davis).

**Ranjit Das joined the meeting as an observer as part of his placement on the Insight Programme for perspective Non-Executive Directors**

**WRC/19/4 Matters arising (agenda item 4)**

The Committee discussed the schedule of matters arising and the following points were made:

- a. WRC/17/51 Recruitment of Non-Executive Directors (NEDs) to sit on Appeals and Consultant Recruitment Panels  
AGD informed the Committee that he had been looking at the recruitment process with Subha Thiyagesh (ST) and whether it could involve lay members rather than a NED. The feeling was that it was important to still involve NEDs on the panel as these are key appointments and a connection with the Board, shows a strong organisational

commitment and gives panel members an important insight into the services. A lengthy discussion took place and it was agreed that NEDs should be the first port of call but that it would be good to have a second tier with the appropriate skill set to not hold up the process. Angela Monaghan (AM) agreed to discuss this further with the Non-Executive Group.

**Action: Angela Monaghan**

b. WRC/17/58 Workforce Strategy 2017/18 – Staff Survey and Action Plan

AGD informed the Committee that the results have recently come in and are in a completely different format but has the same detail as the old format. He confirmed he will bring the full report and action plan to the next meeting.

**Action: Alan Davis**

c. Sam Young (SY) informed the Committee that she and Rachel Court (RC) had a handover session on the 5<sup>th</sup> February.

d. WRC/18/54 Organisational Development Oversight Summary

AGD provided the Committee with the Organisational Development (OD) Oversight Summary as agreed at the last meeting which showed how the various actions link to different sub committees and executive groups. It was noted that the Trust Board had the overall oversight of the OD Strategy.

RC felt that it was important that for the next OD Strategy and action plan to think about the key strands that are specific to this Committee.

Charlotte Dyson (CD) said it is key that to make sure the culture of organisation is moving in the right direction and staff are signed up to the visions and values. She felt that there is a lot of pressure within the organisation at the moment and it was crucial that the right messages are reinforced to all parts of the Trust. RW mentioned that the Trust has come a long way aligning all the work and focusing on the key priority areas and this still needs to be part of the future OD strategy.

AGD felt as part of the development of the organisation the initial OD Strategy had quite rightly had a strong focus on alignment of Structures and Systems e.g. Directors Portfolios, Operational Management Structures, Streamlining Priority Programmes, Implementing SystemOne and Financial Recovery Plan etc, but that the next should have a stronger focus on People and a positive culture of respect and compassion.

The Committee suggested having a Board strategic session on the OD Strategy and action plan including how the Board ensures oversight of the various strands.

RW mentioned whilst there are many priority areas it was vital to have three or four obsessions for example bullying and harassment, appraisals and staff engagement.

RC mentioned a lot of the issues are cultural and we need to try and keep cultural aspects at the forefront.

After a lengthy discussion, it was agreed to put the OD Strategy on a future agenda a Trust Board Strategy session.

The Committee agreed that using the McKinsey 7S model as the framework for the OD Strategy still feels right.

**Action: Alan Davis**

## **WRC/19/5: Workforce Strategy 2018/2019 Action Plan: Updating on Coaching and Mentoring (agenda item 5)**

AGD presented the Workforce Strategy Action Plan update and said that following discussions at a previous meeting it was agreed to focus on coaching and mentoring. The paper included a presentation from Andrew Cribbis on the progress of the coaching and mentoring framework which is part of the 18/19 workforce Strategy Action Plan.

AGD reminded the Committee that the Workforce Strategy is designed to provide a three year approach to the leadership, management and development of the Trust's workforce and that regular updates have been provided throughout the year. He said whilst the updates has shown that most of the agreed actions have been achieved and that there has been a lot of activity going one area that had not progressed as far as it was hoped is coaching and mentoring.

The Committee felt that Andrew's presentation shows that there has been some good pieces of work for example; executive coaching, crucial conversations, links to the moving forward and shadow board programmes but thought it would be helpful to put it in an organisational framework to give an understanding of what has been done and what is planned for 19/20. RW said that Andrew and Jude had done a great piece of work on the leadership and management framework and the SWYPFT leader and manager pathway. He felt it would be good for Jude and Andrew to work together on how the leadership and management development framework and the Trust's approach to coaching and mentoring all fit together.

The Committee recognised that there had been positive developments in terms of coaching and mentoring but felt that for 19/20 it would be good to have a clear organisational framework with links to leadership and management development framework.

**It was RESOLVED to NOTE the Workforce Strategy 2018/2019 action Plan**

## **WRC/19/6: Strategic Workforce Plan Update (agenda item 6)**

AGD informed the Committee that business delivery unit (BDU) workforce planning workshops are currently being undertaken as part of the annual planning process and updating the Strategic Workforce Plan. The discussions in the workshops have so far has been really positive and constructive and the feedback from the BDUs is that they are welcoming the opportunity to go through workforce issues. Richard Butterfield is working hard on the plans to go into the Annual Plan for NHSI and will be updating the Strategic Workforce Plan over May/June.

**The Committee RESOLVED to NOTE the update.**

## **WRC/19/7: 2017/18 Pay Audits based on Gender, Ethnicity and Disability (agenda item 7)**

AGD explained that this paper confirms the results of three pay audits and has a proposed action plan to reduce the pay gaps identified in the audits. Whilst the Trust is not required to produce an action plan, the Committee felt it was important to take positive action to ensure equality and fairness in the workplace. AGD confirmed that in developing the action plan there had been a review of what other large public and private sector organisations actions to reduce the gender pay gap. He said that the recent removal of band 1 under agenda for change, which is predominately occupied by female staff, will have a positive impact in reducing the gender pay gap. It was noted there appears to be a common theme in the gender and BAME audits which is progression above band 5 and this is the focus of the action plan. The disability pay audit shows a more balanced position with no drop off of staff with a disability above band 5, however, it was recognised that from the NHS staff surveys health and wellbeing is the biggest issue for staff with a disability.

The Committee felt that it was important that we are able to attract a diverse and talented workforce and to do this there needs to be action to increase BAME staff representation in senior roles. There is an issue as across Yorkshire and Humber as the number of BAME staff above 8b is very low and therefore it was felt collective action across the region was important. Focus needs to be on what can be done differently i.e leadership and management development. It was agreed as important that there is more focus on career pathways for nursing and professional staff which could be part of the Nursing and AHP strategies.

A lengthy discussion took place on the paper and it was agreed that AGD would keep the Committee informed of progress.

**Action: Alan Davis**

It was RESOLVED to note the report and support the action plan.

### **WRC/19/8 Preventing Bullying and Harassment: A Call to Action (agenda item 8)**

AGD presented a paper which updates the Committee on the Trust's approach to the prevention of bullying and harassment in the workplace. He said that a starting point was to recognise that it is not a policy driven approach but we need to engage all staff in not tolerating bullying and harassment in whatever form. The NHS staff survey shows the Trust having lower levels of bullying and harassment within the organisation compared to the average for similar organisations. AGD said the ambition is to try to engage with 1000 members of staff through a variety of different channels and forums. This engagement work will then lead to the development of a framework which articulates rights and responsibilities of all staff in preventing bullying and harassment. RW felt that it would be really helpful to also use iHub to engage with staff and get their ideas on improvement in this area. AM said need to be clear about how the Trust Board and EMT could support this and it was also mentioned to ensure it is in directors objectives. The Committee also discussed getting permission from staff that have been bullied and harassed to anonymously communicate about issues that have been raised.

The Committee felt that this was a key priority for the Trust and needs to fit into the Workforce and OD Strategy action plans.

**It was RESOLVED to SUPPORT the call to action to prevent bullying and harassment in the workplace**

### **WRC/19/9 HR Exception Reports (agenda item 9)**

#### **(a) Recruitment and Retention**

AGD informed the Committee that the Recruitment and Retention Steering Group who oversees the agreed action plan met in December 2018 and outlined a number of headlines. He said that this was a big challenge for the Trust and we need to be able to market ourselves as a model employer, which links strongly to the staff wellbeing and engagement agenda. AGD reported that there has been good work in trying to streamline the recruitment process and reduce the time from someone leaving to a new employee starting. He said that one of the biggest delays is the time from people handing in their notice and managers filling in the recruitment form and this needs performance figures. Another area of work is communication with candidates from offering a post to them starting and an On Boarding system is being look at to improve the process.

The Committee noted the report and recognised that a lot of good work had taken place but that further work was required and that it was important that the Workforce and Remuneration Committee (WRC) keeps a focus on Recruitment and Retention.

**(b) Sickness Absence**

AGD informed the Committee that each BDU has reduced its sickness rate except Forensics. The Committee agreed that there need to be a targeted action plan for Forensic Service to support them in reducing absence.

It was felt important that managers follow up on unknown causes as reason for sickness and mentioned that it might be helpful to remove this option on the recording form.

RW mentioned the Committee would have a right to ask for the BDU update report in the integrated performance report (IPR), which addresses some of the issues.

**Action: Alan Davis**

**(c) Agency Expenditure**

AGD presented a monthly agency expenditure report that goes to the Operational Management Group (OMG). He said there was a focus on agency cap but also on the temporary staff payroll. He said that medical staff are continuing to be the area of highest agency spend.

**It was RESOLVED to NOTE the HR Exception Report.**

**WRC/19/10 NHSI Very Senior Managers Pay (agenda item 10)**

AGD updated the Committee on guidance from the NHSI on pay uplifts for very senior managers. He informed the Committee that on the 19<sup>th</sup> December NHSI wrote a letter to Trusts regarding Very Senior Managers. He explained that this is now broadened to mean Directors in FTs

Committee noted that it had already decided on the pay award for Directors prior to the NHSI letter, however, it did take a similar approach by linking it to the agenda for change award. The Committee were happy with the Trust approach and said it would take account of the guidance when considering the 19/20 pay award for Directors.

**It was RESOLVED to NOTE the update**

**WRC/19/12 Workforce Risk Register**

The Committee went through the Workforce Risk Register in some detail and felt that the risks identified were consistent with the challenges facing the Trust. The Committee agreed that risk 1155 should be closed given the national settlement on agenda for change.

**It was RESOLVED to NOTE the Workforce Risk Register.**

**WRC/19/13 Committee Annual Report 18/19**

**(a) Self Assessment**

**Question 7: Are Committee members independent of the management team?**

There are two attendees not independent of the management team who are the Chief Executive and Director of Human Resources, Organisational Development and Estates. The Committee agreed it works well and compliant with guidance.

**Question 9: Are members, particularly those new to the Committee provided with training?** Sam Young is new to the Committee and said she thought the training was good and wouldn't change anything.

**Question 11: Does at least one Committee member have a financial background?** The Committee said there are members with a financial background but they are not qualified accountants. The Committee felt it was not necessary to have a qualified accountant on the Committee but said that Laurence Campbell could attend any meeting if he felt that it was appropriate.

**Question 13: Has the Committee formally assessed whether there is a need for the support of a 'Company Secretary' role or its equivalent?** The Committee agreed they have got the required Company Secretary support for this Committee.

**Question 14: Does the Committee have a mechanism to keep it aware of topical, legal and regulatory issues?** The Committee agreed that Horizon Scanning should be added to the agenda as a standing item and included on the Work Programme.

**Question 18: Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its internal control and risk management responsibilities are discharged?** The Committee agreed that the reports were both timely and in an appropriate format.

**(b) Terms of Reference**

The Committee confirmed they are happy with the changes, subject to under **Quorum** to read that in the absence of the Chief Executive the Chair of the Committee will decide whether it is appropriate for the Deputy Chief Executive to attend.

**(c) Annual Work Programme 19/20**

The Committee agreed the Work Programme subject to the following changes:

Standing items

add

- **Horizon Scanning**

Other items

- **Gender Pay Gap Audits**

Ad hoc duties

- **Remuneration arrangements for senior management posts outside of agenda for change**

add

- **Workforce Internal Audit Reports**

**It was RESOLVED to APPROVE the Committees Annual Report 2018/19 subject to actions identified above on the self-assessment, Update to the Terms of Reference, subject to the suggested amendments made above and Work Programme subject to the amendments made above.**

**WRC/19/14 Matters to report to the Trust Board and other Committees (agenda item 14)**

These were agreed as:

- 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.
- 017/18 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 18/19 including self-assessment, Terms of Reference and Annual Work Programme 19/20.

**WRC/19/16 Date and Time of next meeting**

The next meeting will be held at 9.00am on 7<sup>th</sup> May 2019 9.00 am in the Chair's office, Block 7, Fieldhead Hospital.

DRAFT

## Trust Board 25 June 2019 Agenda item 12

<b>Title:</b>	<b>Use of Trust Seal</b>
<b>Paper prepared by:</b>	Company Secretary on behalf of the Chief Executive
<b>Purpose:</b>	The Trust's Standing Orders, which are part of the Trust's Constitution, require a report to be made to Trust Board on the use of the Trust's seal every quarter. The Trust's Constitution and its Standing Orders are pivotal for the governance of the Trust, providing the framework within which the Trust and its officers conduct its business. Effective and relevant Standing Orders provide a framework that assists the identification and management of risk. This report also enables the Trust to comply with its own Standing Orders.
<b>Mission/values:</b>	The paper ensures that the Trust meets its governance and regulatory requirements.
<b>Any background papers/ previously considered by:</b>	Quarterly reports to Trust Board.
<b>Executive summary:</b>	<p>The Trust's Standing Orders require that the Seal of the Trust is not fixed to any documents unless the sealing has been authorised by a resolution of Trust Board, or a committee thereof, or where Trust Board had delegated its powers. The Trust's Scheme of Delegation implied by Standing Orders delegates such powers to the Chair, Chief Executive and Director of Finance of the Trust. The Chief Executive is required to report all sealing to Trust Board, taken from the Register of Sealing maintained by the Chief Executive.</p> <p>The seal has been used two times since the report to Trust Board in March 2019 in respect of the following:</p> <ul style="list-style-type: none"> <li>➤ Lease for retail unit in Barnsley Market, May Day Green and Cheapside, Barnsley between Barnsley Metropolitan Council and the Trust.</li> <li>➤ Lease for Airedale Health Centre, The Square, Airedale, Castleford between the Trust and Airedale Dental Practice.</li> </ul>
<b>Recommendation:</b>	<b>Trust Board is asked to NOTE use of the Trust's seal since the last report in March 2019.</b>
<b>Private session:</b>	Not applicable.

Trust Board annual work programme 2019-20

Agenda item/issue	Apr	June	July	Sept	Oct	Dec	Jan	Mar
<b>Standing items</b>								
Declaration of interest	x	x	x	x	x	x	x	x
Minutes of previous meeting	x	x	x	x	x	x	x	x
Chair and Chief Executive's report	x	x	x	x	x	x	x	x
Business developments	x	x	x	x	x	x	x	x
STP / ICS developments	x	x	x	x	x	x	x	x
Integrated performance report (IPR)	x	x	x	x	x	x	x	x
Serious Incidents (private session)	x	x	x	x	x	x	x	x
Assurance from Trust Board committees	x	x	x	x	x	x	x	x
Receipt of minutes of partnership boards	x	x	x	x	x	x	x	x
Question from the public	x	x	x	x	x	x	x	x
<b>Quarterly items</b>								
Corporate/organisational risk register	x		x		x		x	
Board assurance framework	x		x		x		x	
Serious incidents quarterly report		x		x		x		x
Use of Trust Seal		x		x		x		x
Corporate Trustees for Charitable Funds# (annual accounts presented in July)	x		x		x		x	
<b>Half yearly items</b>								
Strategic overview of business and associated risks	x				x			
Investment appraisal framework (private session)	x				x			
Safer staffing report	x				x			
Digital strategy (including IMT) update	x				x			
Estates strategy update			x				x	
<b>Annual items</b>								
Draft Annual Governance Statement	x							
Audit Committee annual report including committee annual reports	x							

Agenda item/issue	Apr	June	July	Sept	Oct	Dec	Jan	Mar
Compliance with NHS provider licence conditions and code of governance - self-certifications <i>(date to be confirmed by NHS Improvement)</i>	x	x						
Guardian of safe work hours	x							
Risk assessment of performance targets, CQUINs and Single Oversight Framework and agreement of KPIs	x							
Review of Risk Appetite Statement	x							
Annual report, accounts and quality accounts - update on submission		x						
Health and safety annual report		x						
Patient experience annual report		x						
Serious incidents annual report		x						
Equality and diversity annual report			x					
Medical appraisal/revalidation annual report			x					
Sustainability annual report				x				
Workforce Equality Standards				x				
Assessment against NHS Constitution						x		
Eliminating mixed sex accommodation (EMSA) declaration								x
Data Security and Protection toolkit								x
Strategic objectives								x
Trust Board annual work programme								x
Operational plan	x					x <small>(draft / private)</small>	x <small>(draft / private)</small>	x <small>(draft / private)</small>
Five year plan				x				
<b>Policies and strategies</b>								
Constitution (including Standing Orders) and Scheme of Delegation					x			
Communication, Engagement and Involvement strategy		x <small>(update)</small>				x		
Organisational Development Strategy						x		
Risk Management Strategy	x							
Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies)							x	
Treasury Management Policy							x	
Workforce Strategy								x

Policies/strategies for future review:

- Trust Strategy *(reviewed as required)*
- Standing Financial Instructions *(reviewed as required)*
- Membership Strategy *(next due for review in April 2020)*
- Customer Services Policy *(next due for review in June 2020)*
- Equality Strategy *(next due for review in July 2020)*
- 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
	Performance and monitoring
Strategic sessions (including Board development work) 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.	