South West Yorkshire Partnership NHS Foundation Trust

Trust Board (performance and monitoring)
Tuesday 24 September 2019 at 9.30am
Small conference room, Wellbeing & learning centre, Fieldhead, Wakefield, WF1 3SP

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	**Paper**	3	To receive
3.	**9.35**	**Minutes and matters arising from previous Trust Board meeting held 30 July 2019**	Chair	**Paper**	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 Month 5 2019/20	Director of Finance & Resource and Director of Nursing & Quality	**Paper**	60	To receive
	11.05	*Break*				
	11.15	6.2 Serious incident report Quarter 1 2019/20	Director of Nursing & Quality	**Paper**	10	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	11.25	6.3 Brexit update	Director of HR, OD & Estates	**Paper**	5	To receive
7.	**11.30**	**Business developments**				
	11.30	7.1 South Yorkshire update including South Yorkshire & Bassetlaw Integrated Care System (SYBICS)	Director of HR, OD & Estates and Director of Strategy	**Paper**	10	To receive
	11.40	7.2 West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP)	Director of Strategy and Director of Provider Development	**Paper**	10	To receive
	11.50	7.2.1 Calderdale Health & Wellbeing Plan	Director of Strategy	**Paper**	10	To receive
8.	**12.00**	**Governance matters**				
	12.00	8.1 Medical Appraisal / Revalidation Annual Report 2018/19	Medical Director	**Paper**	10	To approve
	12.10	8.2 Sustainability Annual Report 2018/19	Director of HR, OD & Estates	**Paper**	10	To receive
	12.20	8.3 Workforce Equality Standards	Director of HR, OD & Estates	**Paper**	10	To approve
	12.30	8.4 Care Quality Commission (CQC) inspection update	Director of Nursing & Quality	**Paper**	5	To receive
	12.35	8.5 Five year plan	Director of Finance	**Paper**	5	To receive
	12.40	8.6 Finance, Investment & Performance Committee	Director of Finance	**Paper**	10	To approve

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
9.	**12.50**	**Receipt of public minutes of partnership boards**	Chair	**Paper**	5	To receive
10.	**12.55**	**Assurance and receipt of minutes from Trust Board Committees** - Clinical Governance & Clinical Safety Committee 10 September 2019 and, including ratified Minutes from 11 June 2019 - Equality & Inclusion Committee 10 September 2019, including ratified Minutes from 4 June 2019 - Mental Health Act Committee 29 August 2019, including ratified minutes from 14 May 2019	Chairs of committees	**Paper**	10	To receive
11.	**13.00**	**Use of Trust Seal**	Chair	**Paper**	5	To receive
12.	**13.05**	**Trust Board work programme**	Chair	**Paper**	3	To receive
13.	**13.08**	**Date of next meeting** The next Trust Board meeting held in public will be held on Tuesday 29 October 2019, Room 49/50, Folly Hall, St Thomas Road, Huddersfield, HD1 3LT	Chair	**Verbal**	2	To note
14.	**13.10**	**Questions from the public**	Chair	**Verbal**	10	To receive
	13.20	*Close*				

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 24 September 2019
Agenda item 2

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

	relationships or circumstances which are likely to affect, or could appear to affect, the Director's judgement. This Trust considers all its Non-Executive Directors to be independent and the Chair and all Non-Executive Directors have signed a declaration to this effect. **Fit and proper person requirement** There is a requirement for members of Boards of providers of NHS services to make a declaration against the fit and proper person requirement for Directors set out in the new fundamental standard regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which came into force on 1 April 2015. Within the new regulations, the duty of candour and the fit and proper person requirements for Directors came into force earlier for NHS bodies on 1 October 2014. Although the requirement is in relation to new Director appointments, Trust Board took the decision to ask existing Directors to make a declaration as part of the annual declaration of interests exercise. All Directors have signed the declaration stating they meet the fit and proper person requirements. The Company Secretary is responsible for administering the process on behalf of the Chief Executive of the Trust. The declared interests of the Chair and Directors are reported in the annual report and the register of interests is published on the Trust's website. In February 2017, NHS England released new guidance on Managing Conflicts of Interest in the NHS including a model policy which took effect from 1 June 2017. The Standards of Business Conduct Policy (conflict of interest policy) for staff was updated to align with the model policy and approved by Trust Board in October 2017. A revised version of the Policy for Trust Board declaration and register of fit and proper persons, independence, interests, gifts and hospitality was approved in March 2018, with minor amendments to align it to the staff policy. **Further declarations received** The annual declarations were made at the Trust Board meeting on 26 March 2019. The attached declarations relate to Chris Jones, Non-Executive Director, who was appointed by the Members' Council on 2 August 2019. **Risk appetite** The mission and values of the Trust reflect the need for the Trust to be open and act with probity. The Declaration of Interests and independence process and the fit and proper person declaration undertaken annually support this.
Recommendation:	**Trust Board is asked to CONSIDER the attached summary, particularly in terms of any risk presented to the Trust as a result of a Director's declaration, and, subject to any comment, amendment or other action, to formally NOTE the details in the minutes of this meeting.**

Private session:	Not applicable

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 24 September 2019

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

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

The following additional declarations of interest have been made by the incoming Non-Executive Director appointed by the Members' Council on 2 August 2019:

Name	Declaration
Non-Executive Directors	
JONES, Christ Non-Executive Director	Director, Chris Jones Consultancy Ltd.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Trust Board meeting held on 30 July 2019
Conference centre boardroom, Kendray, Barnsley

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

TB/19/63 Welcome, introduction and apologies (agenda item 1)

The Chair, Angela Monaghan (AM) welcomed everyone to the meeting. Apologies as above were noted. At the commencement of the meeting there were five members of the public in attendance which included one staff member and two governors from the Members' Council. AM reminded the members of the public that there would be an opportunity at the end of the meeting for questions and comments from members of the public. Questions asked and responses would be included in the meeting minutes going forward, and a form was available for completion if members of the public preferred to raise their questions in that way and to enable a response to be provided outside of the meeting.

TB/19/64 Declarations of interest (agenda item 2)

There were no further declarations over and above those made in the annual return in March 2019 or subsequently.

TB/19/65 Minutes of and matters arising 30 April 2019 and 25 June 2019 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 30 April 2019 as a true and accurate record and the 25 June 2019 as a true and accurate record with the correction of a typographical error. The following matters arising were discussed.

- TB/19/36a Guardian of safe working hours annual report - Alan Davis (AGD) will provide an update following the regional meeting for safeguarding. Date of action to be changed to September 2019.
- TB/19/42 Receipt of minutes of partnership boards - once terms of reference finalised and received they would formally be presented to Trust Board.

TB/19/66 Service User Story (agenda item 4)

The Trust Board heard a service user story in relation to the neighborhood rehabilitation and crisis team. Rachel, an Occupational Therapist with the team, attended to present the service user story regarding an elderly lady who was admitted from acute services after treatment over three years for cancer. As a result of her treatment she could not eat and even drinking fluids was very painful. Peg feeding had been tried and was unsuccessful and at the time of contact with the team she had pneumonia following a chest infection, was incontinent and had developed pressure ulcers. Initially staff questioned where she should receive care in the community but she wanted to be at home and to self-care where possible. Through a Multi-Disciplinary Team (MDT) approach including the service user, family, care home staff, therapy assistants, and the cook, they looked at what could be provided. She was initially nursed in bed and the cook suggested liquidised food, which was tolerated, and eventually she was able to have a normal diet. Passive bed exercises were done which she was then able to progress to do them unaided, and eventually increased in strength until she was able to walk to the toilet and use it by herself. When the service user returned home the team followed her out, conducting assessments, getting the re-enablement services in from the council who could support her in certain areas. She had got to a point where she was able to get in and out of bed, had no pressure ulcers, and could shower and dress herself, which is where she wanted to be. She had four weeks at home until she sadly died from a stroke. The family wanted her story to be shared as they felt she had a good quality of life following the support provided.

Carol Harris (CH) commented that the story provided an example of why it was really important to work with service users and their families to understand people's aspirations and what was important to them, in order to restore that for them and their families.

Tim Breedon (TB) asked for Rachel's thoughts on what the service user's quality of life may have been if there had not been an MDT approach to care. Rachel commented that initially it was thought a hospice may have been the appropriate place to provide care. Without everyone's input and encouragement, as well as the service user themselves, she felt they would have remained in bed until they passed away. TB commented that the story highlighted the importance of people working together. Sometimes the roles and responsibilities may become blurred, which did not matter if the right treatment could be provided. Rachel commented that it was important to allow for roles and boundaries to be blurred to work out how to best support someone in the way that they want.

AM asked how the joint working with councils was working. Rachel commented that it was getting better, with more joint working and meetings taking place with other organisations along with the third and voluntary sector to understand what services are available and options that could be brought in to support people. She commented that she felt lucky to work in an environment that was patient centred.

AM asked if there were there any barriers or problems in putting the package of care in place for the service user. Rachel commented that the main barriers were getting her home with a re-enablement service due to the waiting times and capacity pressures. With some forward planning this was overcome by working as an alliance and this is getting better.

The Board thanked Rachel for attending, and to the family of the service user for allowing the sharing of the story.

It was RESOLVED to NOTE the Service User Story.

TB/19/67 Chair and Chief Executive's remarks (agenda item 5)

Chair's remarks

AM highlighted the following:

- A recruitment process has taken place for a financially-qualified Non-Executive Director on the Trust Board. The Nominations Committee had met to discuss the recommendation from the final interview panel and a recommendation for appointment will go to the Members' Council meeting on 2 August 2019.
- The Members' Council meeting will be held in public on 2 August 2019 at The Shay Stadium in Halifax.
- There will be issues that are being discussed in the private session of the Trust Board, and there was also a private strategic board meeting in May. These are items that have met the test of being discussed in private before they come into the public agenda, typically for reasons of commercial confidentiality.
- Today the Board will discuss the following items in private:
  - Those aspects of financial performance considered to be commercial in confidence.
  - Serious incidents under investigation.
  - Aspects of the care closer to home programme considered to be commercial in confidence.
  - Commercially confidential business developments in West Yorkshire and South Yorkshire including the Integrated Care Systems (ICSs).
  - Minutes of private partnership board meetings.
- There will also be a meeting of the Corporate Trustee for charitable funds today, which meets on a quarterly basis.

Chief Executive's report and Deputy Chief Executive's remarks

TB commented that "The Brief" communication to staff was included in the papers and provided an update on the local and national context as well as what was happening across the organisation and highlighted the following since its publication:

- The Trust was keeping a close eye on significant government changes taking place particularly in relation to the health and social care agenda. It was helpful that Matt Hancock had remained in post along with the suicide prevention minister appointment.
- The Green paper on social care delayand potential impact on families and support available outside the service.
- Changes around the current request for reduced capital expenditure, with the Trust considering how that may impact our services, ensuring the right Quality Impact Assessment (QIA) process was taking place.
- Maturity of Primary Care Networks (PCNs) which over the next few months would become more significant and consideration of how the Trust works with those networks. The Executive Management Team (EMT) discussed this at the quarterly timeout meeting to ensure the right engagement plans were in place.
- Despite the fact it was summer holidays, the levels of acuity and demand within the system remained the same, along with some extreme weather conditions.

Charlotte Dyson (CD) asked, in relation to the PCNs, how work the Board will be kept up to date about the different approaches in each district and how the Trust works with them. Salma Yasmeen (SY) commented that there was an update within the papers under the Business Development agenda item.

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

TB/19/68 Risk and assurance (agenda item 6)

TB/19/68a Board Assurance Framework (BAF) (agenda item 6.1)

Mark Brooks (MB) reported that the fourth strategic objective in relation to 'making SWYPFT a great place to work' had been included along with further changes as discussed by Board members at the February 2019 Trust Board strategic session and Trust Board meeting on 30 April 2019. Lead Directors had reviewed and updated the information within the report with the majority of areas RAG rated as yellow based on self-certifications and achieving targets for 2018/19. In relation to strategic risk 3.4 - Capacity / resource not prioritised leading to failure to meet strategic objectives, the Executive Management Team (EMT) felt the current RAG rating remained green however it was an area to keep in focus noting the numerous priority areas.

Laurence Campbell (LC) ask for further information regarding the amber RAG rating of strategic risk 1.4 - Impact of the Trust not having a robust and compelling value proposition leading to under-investment in services. MB commented that when this was discussed by EMT it was felt that a lot of work had taken place to understand what the Trust provides and the propositions being developed. Due to the document not being complete it was felt that an amber rating was most appropriate. SY commented that the work was being done in two parts. A prospectus had been developed with a value proposition as a whole Trust which should be completed by September 2019. In relation to specific services, this would be coproduced with services and would be an area of priority once a new engagement manager commenced with the Trust. CD commented that September felt like too tight a timescale and when looking at the controls it did not fully describe what gaps need to be addressed and the amount of work identified. SY commented that it would be the individual specific service prospectus which would take time. TB commented that these would also need to be aligned to long term plan.

CD asked for further information regarding the yellow RAG rating of strategic risk 2.3 - Increased demand for and acuity of service users leads to a negative impact on quality of care, as acuity had not improved. MB commented that the risk was in relation to the negative impact on quality of care and it was not felt that there was a significant impact on quality and care. Focus needed to continue on whether the mitigations and controls in place were successfully mitigating the risk.

LC acknowledged in relation to strategic risk 2.1 - Lack of suitable and robust information systems backed by strong analysis leading to lack of high quality management and clinical information, that there was a lack of strong analysis and queried whether a yellow RAG rating reflect that along with the greed RAG rating of strategic risk - 3.4 - Capacity / resource not prioritised leading to failure to meet strategic objectives. MB commented in relation to 3.4 that through the cyclic review of the BAF it was felt by EMT at the time that the RAG rating was yellow. In the last few weeks with a heightened risk in relation to some of the CIPs it could potentially be considered as amber, however the forecast was still to achieve the control total. In relation to 2.1, the analysis was only part of the overall risk and there are suitable and robust clinical record systems in place along with accessing further support when requested for high level pieces of work. . The Performance and Improvement team had a high level of focus on the implementation of SystmOne and the optimisation phase would

have a slightly different approach allowing some of the team to focus on business intelligence and the data warehouse which would assist with benchmarking. Due to the plans in place EMT felt that the RAG rating was yellow.

LC commented in relation to controls under 3.1, the Finance Oversight Group (FOG) is not mentioned. MB commented this was in relation to when the paper was written and reference would be included going forward.

Action: Mark Brooks

Sam Young (SYo) commented that there were some gaps in assurance and controls where there was no date or a year rather than a month and requested further clarification of due dates.

Action: All

AM commented that the BAF included all the issues that were high on the Trust Board agendas in terms of focus and were also reflected in the Corporate/Organisational Risk Register, noting that it would develop further through the financial year.

It was RESOLVED to:

- **NOTE and the controls and assurances against the Trust's strategic objectives for Quarter 1 2019/20; and**
- **AGREE to an ongoing target for addressing gaps in control given the nature of the gaps and risks identified.**

TB/19/68b Corporate / organisational risk register (ORR) (agenda item 6.2)
MB reported that the review of the ORR by EMT followed a cyclic approach with changes that had taken place in the last quarter reflected. A specific recommendation had also been made by EMT on risks for realignment to the fourth strategic objective.

LC/AM/CD asked for further information on Risk ID 1078 in relation to children and young people waiting for treatment, regarding the reduction in likelihood. CH commented that the description of the risk had been reworded to focus on potential harm as a result of waiting for treatment. LC queried whether there was a need to split the risk into two risks. CH commented that there was a broader risk in relation to waiting list numbers and this one focused on the potential harm. Waiting lists which were outside the 18 week wait standard were reported to the Clinical Governance & Clinical Safety Committee. CD asked how the evidence of harm would be known and how the Trust manages the potential harm. CH commented that whilst the Trust was working on addressing the waiting list it also needed to work on how to minimise the likelihood of there being harm and there were a lot of actions in relation to the waiting list. Kate Quail (KQ) commented that it could depend on how harm was defined. AM commented that it needed to be clear that just because the risk level had changed it did not change the level of focus. CH commented that the risk did not reflect the individual risks which remain on the local level. TB commented that it still remained an area of focus and reporting to the Clinical Governance & Clinical Safety Committee. CD requested that any evidence be incorporated in the reporting to Clinical Governance & Clinical Safety Committee for further discussion. The Board noted the change and requested that the risk scoring be kept under review.

Action: Carol Harris

AM asked if there was a similar separate risk for people who are on other waiting lists. CH commented that the risk to children and young people was at the forefront when the risk was updated. The wording for Risk ID 1132 in relation to long waiting lists could be reviewed in a similar light when discussed by the Clinical Governance & Clinical Safety Committee.

Action: Carol Harris

KQ requested that the impact on carers and family be captured when discussed at the committee and included in the controls and assurances.

Action: Carol Harris

KQ asked for further information on Risk ID 1158 in relation to over reliance on agency staff, regarding whether the risk should be split because there is an impact on finance, the risk on quality. MB commented that the impact on finances was typically in certain specialties such as agency medical locums.. The agency spend can impact the Trust's financial risk rating which was a different issue as if the agency cap is exceeded by more than 50% the Trust will have an overall financial risk rating of 3 and 4 for that particular metric.. It was noted that when the Trust met with the regulators and they were impressed with the actions taken to reduce the reliance on agency staffing and they also offered some helpful advice which has been incorporated in the Trust plan. MB felt that in terms of the most significant financial risks they would be out of area beds, inpatient staffing, and ensuring we get paid appropriately for the services we provide. Agency spend has increased, however if substantive staff were in place the net impact wouldn't necessarily be large when compared to some other financial risks.

Erfana Mahmood (EM) asked for further information on Risk ID 1335 in relation to out of area placements, regarding how long it could remain as an amber risk. MB commented that it would remain amber until they were not excessively used. There was a more detailed report in the private session of Trust Board which showed there had been a reduction quarter on quarter compared to individual months which can fluctuate. The overall level of risk remains amber although there was a high number of actions in place and joint working appeared to be improving the issue with Quarter 1 39% lower than last year. SY commented that the quality improvement approach was looking at data all the time rather than quarterly. It was currently low however it could spike and one of the areas of focus was on minimising variation. AM suggested the Board consider whether any changes were needed to the risk following discussion on the paper in the private session.

KQ asked for further information on Risk ID 1158 in relation to over reliance on agency staff, regarding whether the use of agency was having an impact on the quality of care. TB commented that any changes in the complaints profile is considered by the trios, and in relation to medics it could also relate to any changes in staff and the continuity of care. AGD commented that we have the numbers of staff to keep care safe, however it was the continuity of care which needed focus which was why the work on safer staffing was important. SYo commented that the controls and actions did not provide a sense of the work taking place. LC commented that the Finance Oversight Group received an update on the amount of work that was taking place to reduce agency usage which seemed to be quite innovative and having an impact.

CD asked if Risk ID 1369 in relation to Brexit had been reviewed in relation to the latest developments. AGD commented that there were national developments with time spent locally to develop business continuity plans. A lot of assurance had been provided with central plans in place which needed to be tested. From a workforce point of view, while there may not been an immediate risk there may be one in the medium to long term, as even a change in currency exchange rates could impact workers from the EU. AM commented that there was an important communications element in terms of assurance and guidance to address any concerns for staff and service users and requested that an update on Brexit be provided at the next Trust Board meeting.

Action: Alan Davis

CD commented that Risk ID 1424 in relation to patient safety would be reviewed by the Clinical Governance & Clinical Safety Committee following the CQC report to see if any amendments were needed.

AM asked for further information on Risk ID 1368 in relation to children and young people in adult beds, where the likelihood had reduced although admissions continued. CH commented that when discussed by EMT it was noted that while admissions were taking place, there were lots of children who were admitted to the right beds at the right time. AM commented that it was important to maintain the focus on the issue and raised concern that if the scoring was reduced the level of focus may reduce. CH commented that the new care model had demonstrated that overall the numbers requiring admission have reduced, along with service users being brought back from out of area placements, and some positive investment. The change in level of risk was not in relation to acceptance and management focus remains. AM requested that the risk scoring be reviewed in line with the previous scoring.

Action: Carol Harris

AM requested that the EMT reflect on the risk profile heat map and whether the average risk score, which is reducing, reflects the environment in which the Trust is operating. SY commented that an example of how the level of risk has reduced was in relation to the development of integrated care partnerships and actions taken place to make these stronger. MB commented that if they had not reduced it may raise questions as to whether actions were taking place. Two further examples were in relation to the falsified medicines directive and GDPR were the level of risk had reduced due to the actions which had taken place.

Action: Executive Management Team

LC commented that a potential new risk for consideration, which was raised by the Audit Committee, was in relation to partnership working as people become dependent on other partners' performance.

Action: Salma Yasmeen

AM asked if it would be helpful for a deep dive to take place on a couple of risks at each business and risk Trust Board meeting. LC commented that this was currently taking place at committee meetings. MB suggested that committee chairs lead the discussion at Trust Board following on from the discussions taking place at committees.

Action: Committee chairs

KQ asked if risks would be realigned to the Finance Oversight Group (FOG). AM commented that when the FOG became a committee of the Trust Board this may take place.

The Board discussed the realignment of risks to the fourth strategic objective for 2019/20 'Making SWYPFT a great place to work' and agreed that these should be Risk ID 1151, Risk ID 1154 and Risk ID 1157.

It was RESOLVED to:

- **NOTE the key risks for the organisation subject to any changes / additions arising from papers discussed at the Board meeting around performance, compliance and governance;**
- **DISCUSS if the target risk levels that fall outside of the risk appetite are acceptable or whether they require review; and**
- **AGREE that Risk ID 1151, Risk ID 1154 and Risk ID 1157 should be realigned to the fourth strategic objective for 2019/20 'Making SWYPFT a great place to work'.**

TB/19/69 Business developments (agenda item 7)

TB/19/69a South Yorkshire update including South Yorkshire & Bassetlaw Integrated Care System (SYBICS) (agenda item 7.1)

AGD reported that he attended a stakeholder workshop along with SY and AM which aimed to help shape the SYBICS approach to long term plan which was helpful. Mental health was identified as a priority area with a lot of commitment in the room to ensure we get that right for service users. AM added that there was also a strong commitment around addressing health inequalities and working with the third sector.

SY commented that across the SYBICS there would be 30 PCNs, with Barnsley officially registering one super PCN hosted by the Barnsley Healthcare Federation, with 6 neighbourhood networks, which would be responsible for delivering the seven service specifications. CD commented that the PCNs seemed to be taking different approaches which was challenging in terms of the impact on the Trust. SY commented that there would be a further discussion in the private session of Trust Board.

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

TB/19/69b West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) (agenda item 7.2)

SY highlighted the following:

- The System Oversight & Assurance Group (SOAG) meeting in June 2019 included information on the deep dive on mental health, learning disabilities, and suicide prevention which had received some additional funding.
- 55 Primary Care Networks (PCNs) had been formed with substantial work taking place leading to this.
- Work was taking place on the workforce people plan.
- A review is taking place on the terms of reference for the WYHHCP, with the Finance Group of directors of finance, who had been acting in an advisory capacity, now having formal terms of reference in place.
- All integrated care systems were asked nationally to reduce their capital spending, including 21% for the WYHHCP. The Trust has been asked to reduce spending as a result. MB commented that a paper highlighting the Trust response to this request was discussed by the Finance Oversight Group.
- Improving Access to Psychological Therapies (IAPT) performance in Kirklees required some focus.
- Transformation funding was available for mental health, children and young people, and health inequalities, with proposals to be discussed by programme boards. Sean Rayner (SR) commented that the mental health funding applications for community crisis care were accepted and were in the process of implementing. In relation to the community mental health proposal, discussions were continuing with NHS England regarding implementation. The application for adult secure new models of care was submitted on time to NHS England as a collaborative with feedback to be provided.
- Work continues to develop the five year plan.

EM asked why the IAPT performance in Kirklees was not raised through conventional management channels. SY commented that it had been raised and nationally they have agreed what should be reported formally. RW commented that it was escalated to SOAG. CH commented in relation to performance indicators it was an issue for Kirklees place in relation to prevalence and the Trust was working with commissioners on that.

CD commented that the Board needed to be clear on what the Trust was accountable for as part of the WYHHCP. SY commented that a dashboard had now been developed. MB commented that they would need to be included in the Trust's IPR.

Action: Salma Yasmeen

AM commented that she understood a children and young person's programme had been established with some funding allocated and requested feedback be provided to a future Trust Board meeting. SY commented that there was a focus on pathways of care and joint up care in terms of suicide prevention with a tool that was being piloted.

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

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

TB/19/70 Performance reports (agenda item 8)

TB/19/70a Integrated performance report M3 2019/20 (agenda item 8.1)

TB highlighted the following in relation to the Summary and Quality dashboards:

- Children & young people in adult beds - usage was still occurring in the system with no particular trend other than it was occurring with unwelcome regularity. The Trust was keeping in focus and determined to ensure proper processes and capacity were in place to access Tier 4 facilities.
- Prone restraint - significant focus on the use of prone restraint and further positive progress. This was an area of interest of the Clinical Governance & Clinical Safety Committee.
- Safer staffing - numbers look positive, however demand and acuity issues continue and some underlying difficulties in fulfilling shifts. The establishment review has concluded.
- Medicines omission - work taking place with the pharmacy team which was showing some improvement.
- Supervision - there is some evidence that some may not have been recorded appropriately, this is being addressed through OMG and is coupled with the quality of supervision which formed a larger piece of work.

LC asked when Mental Health Act related performance indicators would be included. MB commented that metrics had been agreed but the data was not available in time for the month 3 report.

LC asked for clarification on the areas where the year-end forecast was RAG rated green with the number 4. MB commented that this did not relate to the NHS Improvement indicators, with definitions to be provided. TB commented that the rating of 4 in relation to Quality areas indicated that a plan existed and was on target for achievement.

Action: Mark Brooks

LC asked for confirmation that the year to date financial risk was £2.8m. MB commented when looking at the current level of risks and upsides, £2.8m was the net difference between outturn and control total.

CD asked, in relation to learning disabilities where the indicator was RAG rated amber and the data was not yet available, what was the Trust doing that would make a difference in performance. CH commented that the Trust was confident that work was taking place which would make a difference with the forecast to be reviewed including what has been achieved, recorded, and delivered to meet the standard.

AM asked, in relation to the staff Friends & Family Test (F&FT), what was needed to improve. TB commented that the new strategic objective to make SWYPFT a great place to work was a key part of this. AGD commented that engagement with staff had commenced about what would make the Trust a great place to work. This had been discussed by the Workforce & Remuneration Committee with themes including supporting staff to keep fit and well, developing people, and making sure people's voices count. AM commented that she was struck by the difference in service user and staff feedback and insight was needed into what was driving the difference. TB commented that, in relation to staff, sometimes it was around their aspirations of what care they would like to be able to provide. CH provided some examples including that staff did not want service users to be placed out of area or be on a waiting list, compared to service users who felt satisfied when they had used the Trust's services. AGD commented that one of the benefits of the engage and listen events with staff is being able to receive this feedback. An annual staff engagement plan would be established and this could be an area of focus.

CD asked for an update on complaints closed within 40 days. TB commented that there was a plan in place to improve performance, however some management capacity needed to be diverted temporarily due to the CQC inspection which had delayed progress. It was hoped that by the end of September 2019 the performance would show improvement.

KQ asked if delayed transfers of care, which was RAG rated green, was linked to out of area placements. CH commented that 'delayed transfers of care' is a specific performance indicator which relates to older people, focusing on overall length of stay.

MB highlighted, in relation to the National metrics, that data completeness and quality remained an issue, which would be realigned towards the end of September 2019. Performance was improving but not where it needed to be.

CH highlighted the following in relation to Locality:

- Barnsley - acuity in relation to bed management, experiencing pressure which has been unprecedented.
- Calderdale and Kirklees - pressures in older adults inpatients.
- CAMHS Forensic services - work taking place with Leeds Community Healthcare Trust in relation to a performance notice.
- Specialist services - work taking place on draft Child & Adolescent Mental Health Services (CAMHS) Intensive Support Team (IST) review reports.
- Wakefield - Nostell ward in Wakefield has been participating in the national reducing restrictive practices collaborative and the latest performance has shown a 50% reduction.

CD asked if the cause of pressures in bed management in Barnsley was understood. CH commented that the wards were more acute and through the work taking place to reduce out of area placements, service users were being placed internally across the total bed base rather than by locality. Further work was taking place to understand what may have caused the increase.

SYo asked if the learnings from the success of the Nostell ward were being used in other areas. CH commented that Ward 18 had signed up for a similar programme in relation to sexual safety and a discussion had taken place by the risk panel around sharing the learning from Nostell to support the way that care is provided across the Trust.

SY highlighted the following in relation to Priority programmes:

- Significant emphasis on joined up work and the development of Primary Care Networks (PCNs).
- Access to transformational funding for new models of care, suicide prevention, and community elements.
- Systmone work continuing to stabilise the system and develop the optimisation plan.

MB highlighted the following in relation to Finance/contracts:

- Discussed in detail at the Finance Oversight Group (FOG) meeting.
- Pre Provider Sustainability Funding (PSF) deficit in month 2 of £145k, which is £37k favourable to plan. Cumulative deficit is £1.3m which is £150k favourable to plan. The cumulative position includes £0.7m of pay increases paid fully in April.
- Cumulative income is £0.3m lower than due to creation of a number of reserves relating to CQUIN and occupancy, and also income received from the spot purchase of beds which was improving in relation to neuro-rehab.
- Out of area bed costs were £158k, which is the lowest value for some time. Cumulative spend is 39% lower than the corresponding period last year.
- Agency staffing costs continue to be higher than plan and the cap at £0.6m in month. Cumulative agency spend is 41% above the cap. This was the biggest area of risk is in terms of the Trusts risk rating which was currently 3.
- Net savings on pay amounted to £268k in-month and £0.7m year-to-date.
- Cost improvement plan (CIP) delivery of £2.0m is virtually in line with plan at this stage of the year.
- Cash increased to £25.2m in June with 2018/19 PSF monies expected in July to increase the short term cash balance.

CD asked for further clarification on CIP delivery. LC commented that feedback from the FOG meeting would be provided in the private session. MB commented that there was a target of £10.6m and at the beginning of the year £1.3m was unidentified. The Trust's percentage of CIP delivery is higher than many trusts. The £1.3m had increased to £1.8-1.9m due to slippages and areas that were more difficult to address such as drug spend and work was taking place to understand whether some CIPs had been delivered but not recognised as such. Work continued to look at both current and non-recurrent CIPs which each BDU to provide an update to their forecast by the end of August 2019.

AGD highlighted the following in relation to Workforce:

- Sickness absence - hotspots were acute inpatient and forensic low-secure focused with a lot of work taking place.
- Appraisals - there was a lag in reporting with work taking place to ensure data was up to date.

AM asked if there was more recent comparative data to other trusts. AGD commented that the most recent received data from the national system was used.

LC commented that the report indicated an increase in turnover in month. AGD commented that the reporting in the first quarter used a projection. This is an area that is reviewed by the Workforce & Remuneration Committee which receives more detailed reports to ensure focus.

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

TB/19/71 Strategies and policies (agenda item 9)

TB/19/71a Estate Strategy progress update (agenda item 9.1)

AGD highlighted the following:

- The quality of the Trust's estate had been greatly improved since the strategy commenced in 2012.
- When the Trust became a foundation trust one of the reasons was to create a surplus for the purpose of investment in the estate which previously wasn't there.
- As a result the inpatient units were better, the right community infrastructure was in place, and surplus properties were disposed of.
- The Trust also invested in the installation of sprinkler systems although not a formal requirement at the time.
- The Trust had now delivered all the agreed projects in the estate strategy with the completion of the Fieldhead inpatient development in May 2019.
- Whilst the current strategy runs to 2022 it felt appropriate to bring forward the planning for a new strategy to cover the next ten years, which reflects the changing clinical and commissioning environment.

AM commented that as work on the Sustainability Strategy developed, it would influence the new Estate Strategy, along with good staff engagement.

TB commented that the early completion of the agreed projects within the strategy was a testament to the work that we have done as a Trust. The Clinical Governance and Clinical Safety Committee received a report in relation to the CQC with a particular focus on estate and the environment. At a coproduction event some information was shared on the estates position across England and Wales and there were still a number of places where there are multi bed bays and services operating out of old Victorian buildings. There were still some major estates issues across the system. However the Trust was not in that position due to the approach that has been taken over a number of years.

CD commented that it was important to make sure areas that were considered minor capital improvements continue so that there was a quick response. In terms of community and the long term plan, how that feeds into our plans would need to be considered along with working in partnership. AGD commented that these areas would be more important as the capital provisions and disposal of property become tighter. These would be an important part of the future strategy. AM commented that a draft of a new Estate Strategy would be due in December 2019. LC asked if the learning from the current strategy could be included.

Action: Alan Davis

It was RESOLVED to NOTE the content of the report.

TB/19/72 Governance matters (agenda item 10)

TB/19/72a Equality and diversity annual report 2018/19 (agenda item 10.1)

TB reported that the annual report had been discussed by the Equality & Inclusion Committee and highlighted the following:

- The Equality & Inclusion Committee liked the style of the report, which provided a good narrative, and recognise that there needs to be a better balance between qualitative and quantitative information in the future.
- The Trust was meeting the reporting requirements of EDS2.
- Work is taking place to support family, friends, and carers including the development of the Carers' Charter.
- Updates on the development of staff equality networks.

EM commented that the format of the report was good and asked if this style of reporting could be used for other reports. TB commented that some annual reports were mandated, however this one did not have a prescriptive format which allowed for a presentation style on the key points.

AM asked for an update on the arrangements for the 2019/20 process. TB commented that the Trust had appointed a new equality and inclusion lead and would use consultation arrangements as referred to in the report. A draft of the approach would go to the Equality & Inclusion Committee meeting in September 2019 with the first draft due in February 2020.

CD commented that within the report it noted that the equality agenda portfolios appeared fragmented and impacted performance and asked what the Trust had done to receive greater clarity. TB commented that as a result a report was provided to the Equality & Inclusion Committee regarding the development of the equality & inclusion lead post. Two years ago, when director portfolio changes took place, a matrix approach to working was established. This would now be brought together under one lead to give it more focus.

AM commented that a Trust Board training session on equality and diversity was due to be rescheduled.

Action: Tim Breedon

It was RESOLVED to NOTE the progress report and the COMMENTS from the Equality & Inclusion Committee.

TB/19/72b Committee membership (agenda item 10.2)

AM reported that, subject to the appointment of a financially-qualified Non-Executive Director (NED) being approved by the Members' Council, the Board is asked to approve the following changes to committee membership, the outcome of which will be that all NEDs will be chairing a committee:

- Audit Committee - add the new NED, remove Erfana Mahmood
- Equality and Inclusion Committee - add the new NED, remove Sam Young
- Finance Oversight Group (future Finance and Performance Committee to be confirmed) - add the new NED as the chair, add Kate Quail as a member, remove Laurence Campbell
- Charitable Funds Committee (subject to ratification by the Corporate Trustee for charitable funds) - add Erfana Mahmood as chair, remove Kate Quail, Charlotte Dyson remains on the committee as a member rather than Chair.

It was RESOLVED to APPROVE the changes to the committees as detailed in section 4 above, subject to the appointment of a financially-qualified NED being approved by the Members' Council.

LC left the room.

TB/19/72c Five year plan (agenda item 10.3)
MB commented that the five year plan was originally due to be published in April 2019. Each ICS would be required to have a five year plan that places and organisations feed into, in relation to WYHHCP this was by place and aggregated by organisations. For the SYBICS it would have an impact on the Trust's workforce and financial assumptions. It was requested that the timescales be extended to first week of September 2019 for first draft, with the final plan due for submitting mid November 2019. Some national guidance has been provided with further to follow. WYHHCP were due to issue some guidance on 12 August 2019. There would also be some further workforce requirements.

LC returned to the room.

SYo asked where the draft plans would be discussed. AM commented that there would be some discussion at the Trust Board strategic session on 3 September 2019 on the plans for the draft, followed by the Trust Board meetings on 24 September 2019 and 29 October 2019. Where appropriate, some areas may be discussed by the Finance Oversight Group and committees, such as quality aspects by the Clinical Governance & Clinical Safety Committee.

It was RESOLVED to:

- **DISCUSS and COMMENT on the paper; and**
- **CONSIDER how Board members wished to be kept informed of and be able to engage with the development of the five year plan and what governance needs to be in place to enable appropriate approvals to take place at each stage of submission.**

TB/19/73 Receipt of minutes of partnership boards (agenda item 11)

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

- Calderdale Health and Wellbeing Board - TB commented that at an informal session there was discussion on role of the arts in supporting health and wellbeing and actions that organisations were taking to keep staff well and at work. In relation to our Trust the Creative Minds linked charity was discussed along with the strategic objective of making SWYPFT a great place to work.
- Kirklees Health and Wellbeing Board 25 July 2019.
- Wakefield Health and Wellbeing Board 18 July 2019 - SR reported that the meeting was the first of a new style with focus discussion. The discussion highlighted that different partners had different projects that others were not aware of and actions needed as a result.
- South Yorkshire & Bassetlaw Integrated Care System Collaborative Partnership Board 12 July 2019 - updated included under agenda item 7.1.
- West Yorkshire & Harrogate Health & Care Partnership System Oversight and Assurance Group 24 July 2019 - updated included under agenda item 7.2.
- West Yorkshire & Harrogate Health & Care Partnership System Leadership Executive 4 July 2019 - update included under agenda item 7.2.

AM commented that the format of receipt of the minutes of partnership board would be reviewed through agenda setting to consider whether these could be incorporated under other agenda items.

Action: Angela Monaghan

It was RESOLVED to RECEIVE the updates provided.

TB/19/74 Assurance from Trust Board Committees (agenda item 12)

Audit Committee 9 July 2019
LC highlighted the following:

- Resource constraints could prevent vital project activity.
- Propose exercise to test whether identified actions reduce organisational level risks to projected target level.
- Is there a new organisational level risk needed regarding partnership working.
- Outstanding actions arising from partial assurance internal audit of Complaints.
- Charity Accounts - how do we fully demonstrate social value created
- Head of Internal Audit Opinion - importance of hitting original dates, currently only 66% against a minimum of 75%.
- Partial assurance on part of Compliance with Legislation internal audit - ownership of new legislation issue.
- Increase in potential fraud reporting, shows a positive reporting culture.

Nominations Committee 15 July 2019 and 26 July 2019
AM highlighted the following:

- Non-Executive Director (NED) appointment process.
- Update on NED recruitment.
- Recommendation to Members' Council on Chair and Non-Executive Director remuneration process and timescales.
- Recommendation to Members' Council on Lead Governor appointment.
- Recommendation to Members' Council on NED appointment.

Workforce & Remuneration Committees 22 July 2019
SYo highlighted the following:

- NHS Staff Survey Action Plans and Engage and Listen Events - Key messages, staff consultation, 800 people seen.
- Workforce Strategy Action Plan 2019/2020 - Reviewed and aligned against NHS People Plan and Engage and Listen Events.
- Organisational Development Strategy 2019/20211 - Reviewed and aligned against NHS People Plan.
- Strategic Workforce Plan 2019/2020 - Reviewed and aligned against NHS People Plan.
- NHS Improvement: Learning Lessons – Identified where there are differences and reviewed.

West Yorkshire Mental Health Services Collaborative (WYMHSC) Committees in Common (C-in-C) 28 June 2019
AM highlighted the following from the Chair's report:

- Detailed meeting, with some more significant decisions and felt like a positive collaborative discussion with business carried out in the right way.

- Joint NED/Governor event feedback from the well-attended event, one area for focus was in relation to the branding of the collaborative.
- Updates around transforming care partnerships work.
- Bids for the new care model developments and agreed to go forward with Forensic services bid.
- Assessment and treatment units.
- Noted the need to capture the added benefits of working in the collaborative.

It was RESOLVED to RECEIVE the updates provided.

TB/19/75 Trust Board work programme (agenda item 13)

The Board discussed the following changes to the work programme.

- Annual revalidation report - would come to the September meeting, following discussion at the Clinical Governance & Clinical Safety Committee.
- Trust Constitution - review currently scheduled for October 2019, will be looking at the process to ensure engagement and may be moved to January 2020. This would also take into account any national changes if complete by this time.
- December meeting - due to early date of the December meeting and the availability of data, it was agreed to swap the November and December meetings, with the December meeting becoming a strategic session and the November meeting becoming a performance and monitoring meeting held in public.

Action: Emma Jones

It was RESOLVED to AGREE the changes to the work programme.

TB/19/76 Date of next meeting (agenda item 14)

The next Trust Board meeting held in public will be held on 24 September 2019, Small Conference Room, Wellbeing & Learning Centre, Fieldhead Hospital, Ouchthorpe Lane, Wakefield, WF1 3SP.

TB/19/77 Questions from the public (agenda item 15)

No questions were asked from members of the public in attendance.

Signed: **Date:**

South West Yorkshire Partnership NHS Foundation Trust

TRUST BOARD 30 JULY 2019 – ACTION POINTS ARISING FROM THE MEETING

= completed actions

Actions from 30 July 2019

Min reference	Action	Lead	Timescale	Progress
TB/19/68a Board Assurance Framework (BAF)	LC commented in relation to controls under 3.1, the Finance Oversight Group (FOG) is not mentioned. MB commented this was in relation to when the paper was written and reference would be included going forward.	MB	October 2019	Next Board Assurance Framework (BAF) report due to Trust Board on 29 October 2019.
	Sam Young (SYo) commented that there were some gaps in assurance and controls where there was no date or a year rather than a month and requested further clarification of due dates.	All	October 2019	Next Board Assurance Framework (BAF) report due to Trust Board on 29 October 2019.
TB/19/68b Corporate / organisational risk register (ORR)	Risk ID 1078 - The Board noted the change and requested that the risk scoring be kept under review.	CH	October 2019	Next Corporate / organisational risk register (ORR) report due to Trust Board on 29 October 2019.
	Risk ID 1132 - The wording for Risk ID 1132 in relation to long waiting lists could be reviewed in a similar light when discussed by the Clinical Governance & Clinical Safety Committee. KQ requested that the impact on carers and family be captured when discussed at the committee and included in the controls and assurances.	CH	October 2019	Next Corporate / organisational risk register (ORR) report due to Trust Board on 29 October 2019.
	Risk ID 1369 - AM commented that there was an important communications element in terms of assurance and guidance to address any concerns for staff and service users and requested that an update on Brexit be provided at the next Trust Board meeting.	AGD	September 2019.	Complete. Update on Brexit included on the agenda for Trust Board on 24 September 2019.
	Risk ID 1368 - AM requested that the risk scoring be reviewed in line with the previous scoring.	AGD	October 2019	Next Corporate / organisational risk register (ORR) report due to Trust Board on 29 October 2019.

Min reference	Action	Lead	Timescale	Progress
	AM requested that the EMT reflect on the risk profile heat map and whether the average risk score, which is reducing, reflects the environment in which the Trust is operating.	EMT	October 2019	Next Corporate / organisational risk register (ORR) report due to Trust Board on 29 October 2019.
	LC commented that a potential new risk for consideration, which was raised by the Audit Committee, was in relation to partnership working as people become dependent on other partners' performance.	SY	October 2019	Next Corporate / organisational risk register (ORR) report due to Trust Board on 29 October 2019.
	AM asked if it would be helpful for a deep dive to take place on a couple of risks at each business and risk Trust Board meeting. LC commented that this was currently taking place at committee meetings. MB suggested that committee chairs lead the discussion at Trust Board following on from the discussions taking place at committees.	Committee chairs	October 2019	Next Corporate / organisational risk register (ORR) report due to Trust Board on 29 October 2019.
TB/19/69b West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP)	CD commented that the Board needed to be clear on what the Trust was accountable for as part of the WYHHCP. SY commented that a dashboard had now been developed. MB commented that they would need to be included in the Trust's IPR.	SY		
TB/19/70a Integrated performance report M3 2019/20	LC asked for clarification on the areas where the year-end forecast was RAG rated green with the number 4. MB commented that this did not relate to the NHS Improvement indicators, with definitions to be provided. TB commented that the rating of 4 in relation to Quality areas indicated that a plan existed and was on target for achievement.	MB		
TB/19/71a Estate Strategy progress	AM commented that a draft of a new Estate Strategy would be due in December 2019. LC asked if the learning from the current strategy could be included.	AGD		
TB/19/72a Equality and diversity annual report 2018/19	AM commented that a Trust Board training session on equality and diversity was due to be rescheduled.	TB		
TB/19/73 Receipt of minutes of	AM commented that the format of receipt of the minutes of partnership board would be reviewed	AM		

Min reference	Action	Lead	Timescale	Progress
partnership boards	through agenda setting to consider whether these could be incorporated under other agenda items.			
TB/19/75 Trust Board work programme	The Board discussed the following changes to the work programme. ➢ Annual revalidation report - would come to the September meeting, following discussion at the Clinical Governance & Clinical Safety Committee. ➢ Trust Constitution - review currently scheduled for October 2019, will be looking at the process to ensure engagement and may be moved to January 2020. This would also take into account any national changes if complete by this time. ➢ December meeting - due to early date of the December meeting and the availability of data, it was agreed to swap the November and December meetings, with the December meeting becoming a strategic session and the November meeting becoming a performance and monitoring meeting held in public.	EJ		Complete. Work programme updated to reflect change in November and December meeting.

Outstanding actions from 25 June 2019

Min reference	Action	Lead	Timescale	Progress
TB/19/52 Performance reports	CH to identify if there is a suitable patient story to come to the Trust Board.	CH	September 2019	This has been requested from the inpatient service matron. When a story with consent is available, this will be prepared.
	Board statement on agency controls to be updated.	CH/MB	September 2019	
TB/19/53a Update on Learning Disability Services and National Context	AGD/TB to report back on the potential training solution for all staff	AGD/TB	September 2019	Under consideration in education governance group meeting. Recommendation awaited.
TB/19/53b Incident Management Annual Report 2019/19	TB to report on the causes of the increased number of incidents of violence against staff	TB	September 2019	TB confirmed this is on track to be reported in IPR.

Outstanding Actions from 30 April 2019

Min reference	Action	Lead	Timescale	Progress
TB/19/36a Guardian of safe working hours annual report	RW commented that AGD, in his role as lead across West Yorkshire & Harrogate, could feed into the discussions to see if these areas could be resolved collectively.	AGD	September 2019	AGD stated the three HR directors and medical directors across West Yorkshire are meeting and that he would provide an update in July. AGD has confirmed that this meeting has been arranged for the 21 August 2019.
TB/19/37a Strategic overview of business and associated risks	Laurence Campbell (LC) commented that it was important that there was a coherent alignment between the corporate/organisational level risks and the Board Assurance Framework (BAF) to pick up the strategic risks. SY commented that this was being looked at further. AM commented that it should also be cross referenced with the investment appraisal framework. RW commented that the paper showed a significant update as the context was changing all the time. It was important to consider cross referencing without making it too difficult to read.	SY	October 2019	Next Strategic overview of business and associated risks report due to Trust Board on 29 October 2019.
	CD commented that it reflects the organisation, priorities and risks, however the commercial point of view needed further work. Sam Young (SYo) commented that she had some further comment on areas for inclusion in the next update. AM requested that any comments on detail be fed back to SY.	All/SY	October 2019	Next Strategic overview of business and associated risks report due to Trust Board on 29 October 2019.
TB/19/42 Receipt of minutes of partnership boards	RW commented that the Board would need to receive the revised terms of reference if it became a formal member.	SY		

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 24 September 2019
Agenda item 5

Title:	**Chief Executive's report**
Paper prepared by:	Chief Executive
Purpose:	To provide the strategic context for the Trust Board conversation.
Mission/values/Objectives:	The paper defines a context that will require us to focus on our mission and lead with due regard to our values.
Any background papers/ previously considered by:	This cover paper provides context to several of the papers in the public and private parts of the meeting and also external papers and links.
Executive summary:	The Brief, provided monthly to all staff and cascaded through the Extended Executive Management Team (EEMT), delivers a summary of the Trust's context, performance and finances. The August version of this is attached **[Annex A]**. This included a summary of the outcome of the Care Quality Commission (CQC) inspection into the Trust. Following the Brief there have been a number of developments and updates: ➢ Planning for Brexit continues with regular reporting to and briefing from the centre. Planning is supported by local resilience arrangements. The Trust continues to play a full part in these. In September the national lead on Brexit planning for the NHS held roadshows for NHS organisations on the substantial work being undertaken nationally, and he also attended the NHS Assembly meeting to discuss these matters. The NHS Confederation coordinate the Brexit Health Alliance and represents our interests in lobbying government to help manage the consequences of Brexit. Board members may have seen the letter from a number of respected think tanks on the consequences of a no-deal Brexit for the NHS. The latest Brexit Bulletin from the NHS Confederation is available at https://www.nhsconfed.org/regions-and-eu/nhs-european-office/brexit-and-the-nhs/brexit-bulletin as **[Annex B]**. ➢ The NHS continues to develop long-term plans based on Integrated Care Systems (ICS) / Sustainability Transformation Plan (STP) footprints. These medium-term plans are covered in the main agenda. It is helpful to note that the West Yorkshire & Harrogate (WY&H) draft plan is already being debated publicly in each place and through the Partnership Board. ➢ Operational plans for 2020/21 will be developed in detail towards the end of the year. Draft control totals for next year have been issued to all ICS including the constituent organisations like ours. These will be subject to further discussion between partners before being finalised. ➢ NHS England (NHSE) and NHS Improvement (NHSI) continue with

	their restructure and have entered the next phase of consultation with their staff over roles and responsibilities. A new single oversight framework has been published to reflect the changing rules of NHSE/I. A helpful briefing on this is attached at **[Annex C]** ➢ The People Plan continues to be developed for publication later this year building on the Interim NHS People Plan. I am leading the work on a new operating framework for the workforce. As part of this WY&H have been working with national bodies to test what roles and functions can be delivered locally rather than nationally. The report into this will be available shortly but shows a strong desire to lead on workforce locally and the need for better capacity and data if we are to do so. ➢ The workforce plan for WY&H formed a significant part of the last Partnership Board debate. There is a strong focus on developing a diverse leadership which embraces all of the talent available. A follow up session on this will take place on the October leadership day and the national director of people, Prerana Issar will be in attendance. Several of our staff are involved in the development of that session. ➢ Governance arrangements in South Yorkshire & Bassetlaw (SY&B) continue to develop. The ICS now undertakes quarterly performance reviews with the Barnsley system. The latest of these had a focus on cancer where improvements in performance are required. At that meeting it was useful to note that Barnsley continues to be the strongest performing system in SY&B, with the Trust playing a full role. ➢ The development of a mental health provider alliance in SY&B is being discussed, building on the arrangements that we have in WY&H. ➢ Kevan Taylor will step down as Chief Executive of Sheffield Health and Social Care NHS Foundation Trust shortly. Kevan has been an effective and supportive partner who has played a strong role in our system, for example chairing the North East Yorkshire and Humber Mental Health Chief Executive Group. ➢ The shortlist for our Excellence Awards has been published following a record number of nominations. Congratulations to all of those nominated and shortlisted. The awards ceremony will take place on 19 November 2019. ➢ Board papers reflect that the Trust is working on all elements of our strategy and making good progress in doing so. We will need to continue to focus on developments in place, improvements in quality, management of resources and making the Trust a great place to work.
Recommendation:	**Trust Board is asked to NOTE the Chief Executive's report.**
Private session:	Not applicable.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

The Brief

29 August 2019

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

With **all of us** in mind.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Our mission and values

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

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

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

Our LGBT+ staff network painted the cabin at Fieldhead entrance with the rainbow flags to celebrate Pride month

With **all of us** in mind.

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

NHS
South West Yorkshire Partnership
NHS Foundation Trust

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.

JOB NO 1019 APR19

Improving Health:
Joining up care in every place

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Developments in our work to join up care include:

The **Calderdale** Arts and Health report has been discussed as part of the District's Health and Wellbeing development session and will formally go to the Health and Wellbeing Board in October. Provider alliance work is continuing.

We are working with our partners in **Kirklees** to strengthen our partnership approach to delivering localised joined up care in communities. The development of the Mental Health Alliance is progressing well.

We continue working together with partners in **Barnsley** to improve joined up care, working on a revised community service specification that will include stronger integration with primary care and move towards shared care records and single point of access. We continue to develop wellbeing teams in each neighbourhoods.

In **Wakefield** we continue to work with partners and lead the Mental Health Alliance.

With **all of us** in mind.

Improving Health:
Joining up care in every place

South West Yorkshire Partnership NHS Foundation Trust

NHS lead provider collaborative for adult secure services
Working with the West Yorkshire & Harrogate ICS we are on the “further development track” to become lead provider for adult secure services by April 2021; and have submitted a bid to be a pilot site for a specialist community forensic trial site.

CAMHS investment for West Yorkshire
Calderdale and Kirklees CAMHS have secured £86k for 7 months for additional clinical leadership and project support and £94k for 7 months to trial parent support groups.

Crisis funding
Wakefield, Calderdale, Kirklees and Barnsley have been successful in gaining additional investment for crisis services. This is £959k in 2019/20 and £1.2m recurrently after that.

Wakefield CAMHS business cases
The Trust have received confirmation of additional funding for the Wakefield CAMHS Primary Interventions Team and for expansion of CAMHS crisis provision at £726k per year.

Yorkshire Smoke Free Barnsley
We have been successful in retaining our stop smoking service in Barnsley. This is a 3 year contract with value of £343k in year 1. Work is underway to implement the new service model.

Improving Care: Safety and quality

NHS South West Yorkshire Partnership NHS Foundation Trust

In July we had:

- 1164 incidents - 1022 rated green (no/low harm)
- 127 rated yellow or amber
- 15 rated as red
- 6 serious incidents – 6 apparent suicides. Please look at the suicide prevention plan.

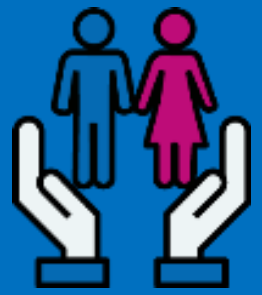
There were **5 confidentiality breaches in July**, significantly down from last month.

Most security breaches happen because of distractions or mistakes.

Always **think, check, share.**

Check the intranet for help and support or contact our information governance team.

Collaborative care planning in Wakefield has helped to reduce out of area placements and give meaningful and patient centred collaborative care.



With **all of us** in mind.

Improving care:
Our performance in July

NHS
South West Yorkshire Partnership
NHS Foundation Trust

- **97%** of people recommend our community services
- **91%** of people recommend our mental health services
- **151** out of area bed days
- **93.3%** inpatients with Cardiometabolic Assessment (CMA)
- **1.2%** delayed transfers of care
- **32.7%** referral to treatment in CAMHS timescales (June)
- **1** person under 18 admitted onto adult inpatient wards
- **94.4%** of prone restraint lasted less than 3 minutes
- **190** restraint incidents
- **17.1%** medicines omissions
- **97.7%** of service users followed up within 7 days

Medicines omissions rose slightly in July to **17.1%.** This is still significantly better than it has been in the previous quarters.
Following CQC feedback this will continue to be one of our priorities in the next year.

All five of our **early intervention in psychosis (EIP)** teams have been named as some of the best performing in the country, with 4 of them in the top 7% and rated as 'top performing'. Well done to everyone involved.

With **all of us** in mind.

CQC Headlines

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Our Well led Review considered the senior leadership and governance arrangements and is Good

4 core services were visited. Of the services visited one improved to Good and three stayed the same, showing real improvements in several areas.

- Our community mental health services for people of working age have **improved** and is now rated **Good**
- Our acute mental health / psychiatric intensive care wards have **improved** with the removal of a single inadequate rating but remain **Requires Improvement** overall
- CAMHS has remained **Requires Improvement**
- Our services for Older Adults have remained **Good**

Our Well Led review is rated **Good**

93% of our services are rated as Caring and Responsive

With **all of us** in mind.

What did the CQC tell us?

- We have improved overall
- 4 of our 5 Trust domains are rated Good
- 12 of 14 service lines rated Good
- Over 87% of our domains are Good or Outstanding

And its all thanks to you…

2018

	Safe	Effective	Caring	Responsive	Well led	Overall
Community health services for children, young people and families	Good	Good	Outstanding ☆	Good	Good	Good
Community health services for adults	Good	Good	Good	Good	Good	Good
Community health inpatient services	Good	Good	Good	Good	Good	Good
End of life care	Good	Outstanding ☆	Good	Good	Good	Good
Community-based mental health services for adults of working age	Good	Good	Good	Good	Good	Good
Community mental health services for people with learning disabilities or autism	Good	Good	Good	Good	Good	Good
Community-based mental health services for older people	Good	Good	Good	Good	Good	Good
Specialist community mental health services for children and young people	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Long stay / rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Requires improvement	Good	Good	Good	Good	Good
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement
Mental health crisis services and health-based places of safety	Good	Good	Good	Good	Good	Good
Forensic inpatient / secure wards	Requires improvement	Good	Good	Good	Good	Good
Wards for people with learning disabilities or autism	Good	Good	Good	Good	Requires improvement	Good

2019

With **all of us** in mind.

Our new CQC ratings

South West Yorkshire Partnership NHS Foundation Trust

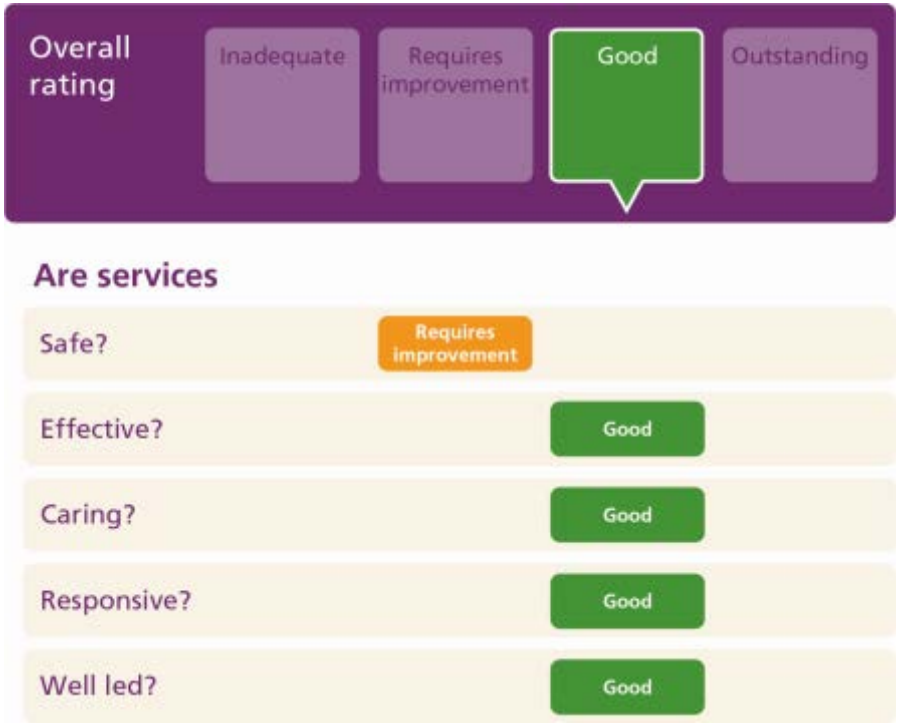
Overall, we have been rated **Good** for:

- Responsive
- Caring
- Effective
- Well led

We have been rated **Requires Improvement** for:

- Safe

This means that we have been rated Good as a Trust.



2019 overall rating

With **all of us** in mind.

CQC next steps

We need to build on the work that led to our new rating and make sure we improve further:

Improvement plans will now be developed to take the learning from the report and make our services better. These will go to the CQC by 20 September.

The Nursing and Quality directorate are working with all parts of the trust, focusing on how we can embed quality improvement. This will include:

- Using a quality improvement approach
- Strengthening early warning signs to identify risk
- Digitalisation for quality control
- Visibility of senior staff in services
- Closing the loop on plans and ensuring sustainability
- Staff and service user engagement
- Sharing lessons across services

With **all of us** in mind.

Improving resources: Our finances in 2019/20

South West Yorkshire Partnership NHS Foundation Trust

Performance Indicator		Year To Date	Forecast
1	NHS Improvement Finance Rating	3	2
2	Normalised Deficit (excl PSF)	(£1.5m)	(£0.2m)
3	Agency Cap	£2.6m	£7.3m
4	Cash	£30.3m	£27.8m
5	Capital	£1.6m	£6m
6	Delivery of CIP	£2.9m	£10.6m
7	Better Payment	99%	

The overall risk rating is a 3 (out of 4 with 1 being the highest). This is planned to gradually improve over the course of the financial year in line with our forecasted improvement.

July 2019 finance performance is ahead of our plan but remains in deficit. In this month we spent £0.1m more than the income we received. **Financial control and limitation on expenditure is needed to ensure that the Trust returns to surplus.**

Agency expenditure continues to be a financial pressure. We spent £0.7m in July which is the highest single month since 2016/17.

The Trust cash position remains healthy at £30.3m.

The Trust capital programme has been reduced to £6m (from £7m) as part of a national exercise. Some schemes will be delayed until the early part of next year; the operational impact has been assessed.

Cost reduction plans (CIPs) are in line with our plan. To achieve the £10.6m target a further £1.6m of schemes need to be identified and delivered.

Improving Resources: Reducing Waste

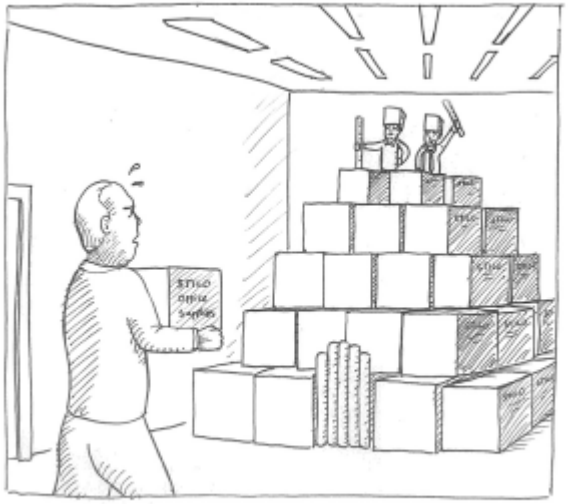
NHS
South West Yorkshire Partnership
NHS Foundation Trust

Have you seen our new campaign?

This month we're asking everyone to be vigilant when ordering stationery. We spend over £100,000 just on stationery every year.

So be careful when ordering. Check stock sizes, use up old stock before reordering, and make sure you use the new unbleached and recycled paper.

For help and support contact Procurement.



"When you said we were short on stationery..."

To save money post to go out business class

All of our external post will now be sent by ***2nd class business post*** by default. This will provide us with the same level service as first class but will cost a lot less.

Out of area placements cost us £3.9m in 18/19. This month we used **151** out of area bed placement days, the lowest it has been this year

With **all of us** in mind.

Improving Resources:

SystmOne Phase 2: Optimisation

NHS
South West Yorkshire Partnership
NHS Foundation Trust

This month is focused on finalising the phase 2 **co-design** and the agreeing of priorities with staff , which will be approved in early September.

Thank you to those who attended the SystmOne Optimisation workshop on 9 August and worked on co- designing the optimisation work programme.

There is a SystmOne optimisation event for General Community Services on 2 Sept between 10am-12pm in the Boardroom at Kendray Hospital Barnsley.

Get involved in optimisation:

We are looking for clinical and clinical admin volunteers to work with us to review the new mental health care plan functionality for ease of use and accessibility, and to test the training materials. To volunteer email Stephen Pidgeon in IM&T.

Next steps: We are working on the co-creation of **risk assessments** which is scheduled for roll out in December and on **mental health care plans** scheduled for October.

Have your say: If you have any ideas and/or would like to take part then speak to your line manager or contact Sharon Carter.

With **all of us** in mind.

Making this a great place to work

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Sickness absence was 5% in July above our target. Turnover was up at 12.6%. There's support for #allofus

We had over 220 entries into our Excellence awards. Help us to shortlist by becoming a judge.

Attend our Annual Member's Meeting on 16 Sept. Staff are members too so come and have your say.

Make sure you know who your freedom to speak up guardians are and how they can help you.

Download our MySWYFT staff app. Found out more by watching out 'how to' films on the intranet

New updated Total Reward Statements and Annual Benefit Statements are now available on ESR.

Have a look to see what information and offers are available to you.

Have you teamed up to raise funds for EyUp! yet? Team Newhaven have pledged to raise £300 by holding a spooktacular Halloween event. What will your team challenge be?

With **all of us** in mind.

Take home messages

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Be proud of our new CQC ratings. It's thanks to you. Make sure you display the new ratings posters when you get them.

Integration is happening, make sure you are briefed on what this means for your team. New investments for services are coming through.

Don't forget - safety first and quality counts. Focus on the basics to make sure things are done right.

Always check before sending letters and emails. Treat everyone's information as your own.

Get involved in SystmOne optimisation and give us your ideas on how S1 can be improved

Help us to reduce waste by only buying what you need, and keeping costs low where you can.

Join the team challenge and help raise some brass for EyUp!

With **all of us** in mind.

29 August 2019

South West Yorkshire Partnership NHS Foundation Trust

The Brief

Our mission and values

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

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

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

This month we are sharing that the LGBT+ staff network painted the cabin at the entrance of Fieldhead with the rainbow and transgender flags to celebrate Pride month. You can find more information on the LGBT+ network on the intranet.

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.

#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

Developments in our work to join up care include:

Barnsley
We continue to work with partners in Barnsley to improve joined up care and are working on a revised community service specification which will move us towards stronger integration with primary care. This will include shared care records and a single point of access. We also are continuing to develop wellbeing teams in each neighbourhood.

This is the planned timetable:

- 2018 – different teams in the Dearne come together to develop an approach to team working in a defined area.

- July – September 2019 – development of a single specification for neighbourhood teams.
- September 2019 – review of feedback and final specification by Barnsley CCG governing body, which will inform costings.
- September – March 2019 – mobilisation phase of an agreed neighbourhood team model.
- April 2020 onwards – start new way of working.

More details on the integrated care proposals in Barnsley, including a presentation and frequently asked questions, can be found on the intranet.

Calderdale

The Calderdale arts and health report has been discussed as part of the District's health and wellbeing development session and will formally go to the Health and Wellbeing Board in October. We continue to work closely with partners across Calderdale. Provider alliance work is progressing.

Kirklees

We are working with our partners in Kirklees to strengthen our partnership approach to delivering localised joined up care in communities. The development of the Mental Health Alliance is progressing well.

Wakefield

In Wakefield we continue to work with partners and lead the mental health alliance.

Improving health: Joined up care in every place
Commissioning update

NHS lead provider collaborative for adult secure services

In July 2019, working with our partners in the West Yorkshire & Harrogate ICS the Trust responded to a call for applications from NHSE to be a NHS lead provider collaborative for adult secure care. Following evaluation by NHSE the application has been placed on the "further development track" to become lead provider from April 2021.

In addition we submitted a bid to be a pilot site for a specialist community forensic trail site. Following feedback from NHSE we are working on a revised proposal to be submitted September 2019.

CAMHS investment- West Yorkshire

Following implementation of the West Yorkshire and Harrogate CAMHS new care model, the Trust submitted business cases for additional investment in the community offer and for Wakefield, Calderdale and Kirklees. We have secured £86k for 7 months for additional clinical leadership and project support and £94k for 7 months to trial parent support groups.

Crisis funding

Following on from bids to NHSE the Trust has been successful in gaining additional investment for crisis services in Wakefield, Calderdale, Kirklees and Barnsley. This is £959k in 2019/20 and £1.2m recurrently after that.

South West Yorkshire Partnership NHS Foundation Trust

Wakefield CAMHS business cases
The Trust have received confirmation of additional funding for the Wakefield CAMHS Primary Interventions Team and for expansion of CAMHS Crisis provision at £725,510 per year.

Yorkshire Smoke Free Barnsley
The Trust have been successful in retaining our stop smoking service in Barnsley. Our existing contract for stop smoking services in Barnsley is due to end 31 October 2019. In May 2019 Barnsley Council published the tender for the new service in order that a new contract be in place for November 2019.

A tender was prepared and submitted for this opportunity which was successful (this is a 3 year contract with value of £343k in year 1). Work is underway to implement the new service model.

Improving care: Safety and quality

We put safety first, always.

In July we had:

- 1164 incidents - 1022 rated green (no/low harm)
- 127 rated yellow or amber
- 15 rated as red
- 6 serious incidents – 6 apparent suicides. Please look at our suicide prevention plan.

Collaborative care planning in Wakefield
As part of our Trust priority to provide care as close to people's homes as possible we have been working on building a greater community focus and reducing the need for service users to spend time in hospital beds.

The acute pathway in Wakefield has been working under considerable pressures over the last number of years. Despite this, staff work collaboratively with service users and their carers across the pathway to provide safe and effective care.

A key development has been a multi-disciplinary forum called the Collaborative Care Planning meeting where care coordinators, medics, team leaders and other professionals meet to begin the process of providing a service user focused care plan. During this meeting plans for risk, contingency plans, crisis intervention and a pathway in and out of in-patient services are formulated. The service user is fully engaged in this process; the care plans are collaborative and include carers. They also invite external agencies (e.g. neighbourhood policing teams, housing teams and leaving care teams) to contribute to the care plans. By all relevant agencies working in partnership together we are ensuring that care delivered to our service users remains consistent, inclusive and safe.

Information governance
There were **5 confidentiality breaches in July,** down from 12 last month.

Most IG incidents happen because of distractions or mistakes. The majority of these incidents relate to mail (either post or email) being sent to the wrong address or recipient, or other people's documents being sent in error.

Please ensure that your area has a system in place for checking outgoing correspondence for:

- The correct recipient
- That all the information contained in the envelope relates to that individual
- That you are using the correct address for that individual.

Always think and check before you share.

If you have any concerns around information governance in your area then please contact the Information Governance team.

Improving care: Performance (July)

- **97%** of people recommend our community services
- **91%** of people recommend our mental health services
- **151** out of area bed days
- **93.3%** inpatients with Cardiometabolic Assessment (CMA)
- **1.2%** delayed transfers of care
- **32.7%** referral to treatment in CAMHS timescales (June)
- **1** person under 18 admitted onto adult inpatient wards
- **94.4%** of prone restraint lasted less than 3 minutes
- **190** restraint incidents
- **17.1%** medicines omissions
- **97.7%** of service users followed up within 7 days

While the people recommending our community services is high the target is 98% so remains amber for this month. **It is 98% year to date.** The target for mental health is 85% meaning this is green this month. The difference in target is due to the difference in service user numbers and their demographics.

97% of service users were followed up within 7 days. From October we will also be measured on a CQUIN to follow up within 72 hours. This will help reduce risk and improve safety in line with our suicide prevention work.

Medicines omissions performance rose slightly to **17.1%.** This is significantly better than it has been in previous quarters. Pharmacy and medicine optimisation was raised during our recent CQC inspection as a concern so will form a part of our CQC action plan. It will continue to be a priority for us in the coming year.

Outstanding result for Trust's psychosis services
Five of our early intervention in psychosis (EIP) teams have been named as some of the best performing in the country. All of our teams achieved the National Clinical Audit of Psychosis (NCAP) standard, with four of the five teams rated as 'Top performing'. Only 11 teams (7%) in the whole country were rated as 'Top performing'.

EIP teams provide early and intensive support for people experiencing their first episode of psychosis, helping people to recover and reducing the risk of relapse. To meet the standard, Trusts must demonstrate that they provide rapid access to services; use evidence-based psychological treatments; assess and treat people's physical health

needs and measure outcomes. The annual NCAP audit measures the quality of services and is one of the ways that improvements to EIP services are being monitored as part of the national NHS Five Year Forward View for mental health.

CQC update

2019 well-led inspection results
The Care Quality Commission (CQC) has rated our Trust as Good, recognising the improvements we have made since their last inspection and the strength and quality of the services we provide. We delivered on the actions from the last report, which has led to four of the five overall domains now being rated as Good. We are also pleased that our mental health community services have improved and are now rated Good.

Overall, we are now rated Good for being responsive, caring, well led and effective, and Requires Improvement for being safe. This means that overall we have been rated Good as a Trust.

They found that 12 of our 14 core services are rated Good, and over 87% of our individual domains have been rated as Good or Outstanding.

Find out more about the CQC's findings along with an infographic summarising the main points on the intranet.

Next steps
We need to build on the work that led to our new rating and make sure we improve further: Improvement plans will now be developed to take the learning from the report and make our services better. These will go to the CQC by 20 September.

The Nursing and Quality directorate are working with all parts of the trust, focusing on how we can embed quality improvement. This will include:

- Using a quality improvement approach
- Strengthening early warning signs to identify risk
- Digitalisation for quality control
- Visibility of senior staff in services
- Closing the loop on plans and ensuring sustainability
- Staff and service user engagement
- Sharing lessons across services

Posters will be coming out to all areas soon, and it is a legal requirement that these are displayed in any area where service users either visit or are staying, such as our wards. When you receive your posters please put them up straight away.

Thank you to everyone for your work on the CQC preparation and follow ups. Our new rating is thanks to you.

South West Yorkshire Partnership NHS Foundation Trust

Improving resources: Our finances 2019-20

The overall risk rating is a 3 (out of 4 with 1 being the highest). This is planned to gradually improve over the course of the financial year in line with a forecasted improvement.

July 2019 finance performance is ahead of our plan but remains in deficit. This month we spent £0.1m more than the income we received. **Financial control and limitation on expenditure needs to occur to ensure that the Trust returns to surplus.**

Agency expenditure continues to be a financial pressure. We spent £0.7m in July which is the highest single month since 2016/17.

The Trust cash position remains healthy at £30.3m.

The Trust capital programme has been reduced to £6m (from £7m) as part of a national exercise. Some schemes will be delayed until the early part of next year; the operational impact has been assessed.

Cost reduction plans (CIPs) are in line with our plan. To achieve the £10.6m target a further £1.6m of schemes need to be identified and delivered.

Improving our resources: Reducing waste

Reducing waste by focusing on stationery
We spend £100,000 on stationery every year. You can help reduce this cost:

- Switch to 100% recycled printing paper when ordering on Agresso - it's cheaper and more sustainable.
- Be careful when ordering - check pack sizes, use up your old stock before buying more and only order what you need.
- Have a spring clean! Email procurement if you have unwanted stationery so they can give it to a team in need.

For help and support on stock control, please contact Procurement.

Post to go out business class from now on
All of our external post will be sent by 2nd class business post by default from now on. This will provide us with the same level of service as first class but will cost a lot less. Only in exceptional circumstances where it can be demonstrated it is necessary will post go out first class.

Care closer to home - out of area placements
Out of area placements cost us £3.9m in 18/19. This month we used **151** out of area bed placement days – the lowest it has been this year.

Join conversations on the i-hub and share your ideas for reducing waste.

South West Yorkshire Partnership NHS Foundation Trust

Improving resources: SystmOne for mental health Phase 2 – Optimisation

Following completion of the implementation phase 1, co-design of phase 2 optimisation has commenced. This will make best use of the new system to help you do your job.

This month is focused on finalising the phase 2 co-design and the agreeing of priorities with staff , which will be approved in early September.

Thank you to those who attended the SystmOne Optimisation workshop for mental health and learning disability services on h August and worked on co- designing the optimisation work programme.

There is a SystmOne optimisation event for General Community Services on 2 September 10am-12pm in the Boardroom at Kendray Hospital Barnsley.

Get involved
We are looking for clinical and clinical admin volunteers to work with us to review the new MH care plan functionality for ease of use and accessibility, and to test the training materials. To volunteer email IM&T.

Next steps
We are working on the co-creation of **risk assessments** which is scheduled for roll out in December and on **mental health care plans** scheduled for October.

SystmOne Improvements - If you have any ideas and/or would like to take part in championing improvements in your service area then speak to your line manager to get involved.

Making this a great place to work

- Sickness absence was **5%** in July, above our target of **4.5%.** Turnover was **12.6%.** Remember there is wellbeing support available to #allofus.
- We have received over 220 entries into the **Excellence awards** this year. If you would like to help us whittle this down to a shortlist and then chose the winners then volunteer to be a judge. Judging is taking place in Fieldhead on 10 September. Email Excellence for more details.
- **Annual Members' Meeting (AMM) on Monday 16 September 2019.** This year it will be held at Fieldhead in the large conference room. We are also looking for teams/services to be a part of the showcase/marketplace prior to the formal meeting so our members can find out more about the services we provide.
- Make sure you know who your freedom to speak up guardian is and what they can do to help you.
- **MySWYFT -** 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.

South West Yorkshire Partnership NHS Foundation Trust

- **Our charity EyUp**! Has launched a new team challenge for 2019. This is an opportunity to help raise some money what will help make our service users and carers' experiences with us better. Teams have already volunteered to take part, but it is not too late if you want to too. You can find out more detail on the team challenge on the intranet.

Refreshed Total Reward Statements & Annual Benefit Statements available now
Your Total Reward Statement is a personalised summary that shows information that is personal and unique to you, including:

- Your basic pay
- Any additional allowances
- Annual Leave entitlement (for Employers who use ESR only)
- Your pension benefits (for NHS Pension Scheme members)

These are the other benefits that are included in the statement:

- Bikes for Staff
- Home electronics for staff
- Phones for staff
- NHS Car Scheme
- Buy additional annual leave
- Staff counselling & therapy service
- Child/adult care support schemes
- Occupational health and wellbeing service
- Corporate discounts

For further information about the Total Reward Statement is available on the website.

29 August 2019

South West Yorkshire Partnership NHS Foundation Trust

Take home messages

1. *Be proud of our new CQC ratings, they are thanks to you. Make sure you display the new ratings when you get them.*
2. *Integration is happening, make sure you are briefed on what this means for your team. New investments for services are coming through*
3. *Don't forget – safety first and quality counts. Focus on the basics to make sure things are done right.*
4. *Always check before sending letters and emails. Treat everyone's information as you would like your own to be.*
5. *Get involved in SystmOne optimisation and give us your ideas on how S1 can be improved.*
6. *Help us to reduce waste by only buying what you need and keeping costs low where you can.*
7. *Join the team challenge and help raise some brass for EyUp!*

With **all of us** in mind.

NHS Oversight Framework for 2019/20

NHS England and NHS Improvement (NHSE/I) have published the new NHS Oversight Framework for 2019/20. It outlines the joint approach the two organisations will take to oversee organisational performance and identify where providers and commissioners may need support. The NHS Oversight Framework has replaced the NHS single oversight framework (SOF) for providers and improvement and assessment framework (IAF) for clinical commissioning groups (CCGs).

Alongside the NHS Oversight Framework NHSE/I have published a document outlining the provider oversight approach in detail and a document setting out the metrics used to monitor and assess provider performance.

Key points

- NHSE/I are aligning their operating models to support system working. 2019/20 will be a transitional year, with NHSE/I regional teams coming together to support local systems. The existing statutory roles and responsibilities of NHSE/I in relation to providers and commissioners remain unchanged. However these roles and responsibilities will be carried out by working with and through system leaders where possible.
- Four metrics have been added to the set used to identify issues at providers. These are based on the annual NHS Staff Survey and cover bullying and harassment, teamwork and inclusivity. This aspect will be developed over the course of 2019/20, and will include exploring metrics beyond the staff survey. Those organisations that most need it will begin to receive support via NHSE/I's culture and leadership programme.
- Regional directors (RDs) and their teams will lead on system oversight, working closely with organisations and systems and drawing on the expertise and advice of national colleagues.
- In line with the move to greater autonomy for better performing local systems, oversight arrangements will reflect both the performance and relative maturity of ICSs. In 2019/20 it will be for regional teams to determine the level of oversight that best meets their assurance needs.
- The specific dataset for 2019/20 set out in the Oversight Framework (see Appendix 1) broadly reflects existing provider and commissioner oversight and assessment priorities. They are split by their alignment to priority areas in the NHS long term plan. Where appropriate these will be aggregated across system level and are likely to be complemented by purpose-built system metrics.
- Regional teams will use data from these metrics as well as local information and insight to identify where commissioners and providers may need support. The regional team will involve system leads in

the process of considering why the trigger has arisen and whether a support need exists. It is up to regional teams to allocate providers/CCGs to a support 'segment' or category. For ICSs, support decisions should be taken having regard to the views of system leadership governance.

- From 2019/20, ICSs and emerging ICSs will be increasingly involved in the oversight process and support of organisations in their system.

Oversight in 2019/20

- The existing statutory duties and responsibilities of NHSE/I have not changed. However they will now be applied in the context of several key principles:
  - NHSE/I teams speaking with a single voice, setting consistent expectations of systems and their constituent organisations
  - A greater emphasis on system performance, alongside the contribution of individual healthcare providers and commissioners to system goals
  - Working with and through system leaders, wherever possible, to tackle problems
  - Matching accountability for results with improvement support, as appropriate
  - Greater autonomy for systems with evidenced capability for collective working and track record of successful delivery of NHS priorities.
- Oversight will seek to identify and address both performance issues in organisations directly affecting system delivery and development issues which may, if not addressed, threaten future performance.
- Leadership and culture at organisations and systems will form a core part of oversight conversations
- Regional directors and their teams will lead on system oversight, drawing on the expertise and advice of national colleagues. Existing tools such as licence breach, powers of direction, special measures, will continue to be used where necessary
- ICSs will be supported to take on greater collaborative responsibility for use of resources, quality of care and population health. Oversight arrangements will reflect the performance and relative maturity of ICSs. The level of oversight will be determined by regional teams, depending on their assurance needs. Arrangements already in place in regions will continue.
- Oversight will incorporate:
  - System review meetings – discussion between the regional team and system leaders, covering:
    - Performance against a core set of national requirements at system and/or organisational level
    - Any emerging organisational health issues that may need addressing
    - Implementation of transformation objectives in the NHS long term plan.
- In the absence of material concerns, these meetings will be held quarterly, but regional teams will engage more frequently where necessary. They will also engage with the system and relevant organisations where specific issues emerge outside these meetings.
- During 2019/20, NHSE/I will make their reporting and dashboards, integrated performance data on activity and quality standards, available to organisations, regional and national teams.
- The specific dataset for 2019/20 (see Appendix 1) broadly reflects existing provider and commissioner oversight and assessment priorities and are split by their alignment to priority areas in the NHS long term plan. Where appropriate these will be aggregated across system level and are likely to be

complemented by purpose-built system metrics. From 2020/21, the metrics for oversight and assessment purposes will include the headline measures described in the NHS long term plan implementation framework against which the success of the NHS will be assessed. These measures will be used as the cornerstone of the mandate and planning guidance for the NHS for the next five years.

- Four metrics have been added to the 2019/20 set used to identify issues at providers, based on the annual NHS Staff Survey and covering bullying and harassment, teamwork and inclusivity. This will be developed throughout 2019/20, and will include exploring metrics beyond the staff survey. Those organisations that most need it can begin to receive NHSE/I's culture and leadership programme.

Identifying support needs and organisational segmentation

- Regional teams will use data from the metrics and local information and insight to identify where organisations need support. Where a CCG or provider is triggering concern, the regional team will consider why the trigger has arisen and whether a support need exists. System leads will be involved in this process, both to identify the factors behind the issue and whether local support is available.
- From 2019/20 ICSs and emerging ICSs will be increasingly involved in the oversight process and support of organisations in their system. NHSE/I are developing a maturity matrix for systems that will determine the relative responsibilities and freedoms at each stage of system maturity, and the support available. Regional teams will take the maturity of the system into account when determining the extent to which the system is expected to support or lead on improvement activity.
- Regional teams will consider:
  - the extent to which the CCG and/or provider is triggering a concern under leadership capacity and capability, quality of care, financial management, and/or operational performance
  - any associated circumstances the CCG and/or provider is facing o the degree to which the CCG and/or provider understands what is driving the issue
  - views of system leadership and governance o the CCG's and/or provider's capability and the credibility of plans to address the issue
  - the extent to which the CCG and/or provider is delivering against a recovery trajectory.
- Regional teams will allocate CCGs/providers to a support 'segment' or category, determined by the level of support teams have decided is appropriate (universal, targeted or mandated). It does not necessarily mirror the annual assessment for CCGs or the most recent Care Quality Commission (CQC) inspection rating for providers.
- The relationship between a CCG and/or provider's identified support needs, and the type of support made available is summarised in the oversight framework document. For providers, the categories reflect the existing categories in the SOF:

1 maximum autonomy (no actual support needs)
2 targeted support (support needed in one or more of the five themes, but not in breach of licence)
3 mandated support (significant support needs and in actual or suspected breach of licence but not in special measures)
4 special measures (in actual or suspected breach of licence with very serious/complex issues

Developing a new oversight framework for 2020 onwards

- NHSE/I intend to use 2019/20 to develop proposals for a new framework. The specific metrics that will be used for oversight and assessment will include the measures identified in the NHS long term plan implementation framework. NHSE/I say they will involve partners at key stages of the design work, to consider the purpose of the framework, its scope and the methodologies for monitoring, escalation and taking formal or informal action with organisations.
- The framework will incorporate the commitments in the NSH People Plan to develop a leadership compact; this will be an important component of future oversight and will set out how the regional, rational and local teams commit to behave towards each other.
- The framework will also consider the balance between organisational and system oversight, and how system maturity will affect this.

NHS Providers view

We welcome the publication of the new NHS Oversight Framework and the steps NHSE/I are taking to bring together their approaches to reflect the move to system working and priorities in the long term plan. Trust leaders have told us for some time that they would like greater collaboration between the two bodies.

Trusts are already working with commissioners and partners in local systems, and have been concerned that the regulatory framework is not keeping pace with developments on the ground. This framework should help to support collaboration and ensure there are consistent messages and approaches from the national bodies.

However, much will depend on ways of working and the development of positive relationships, particularly between frontline organisations, system leaders and NHSE/I's new regional teams.

It is also important that the framework continues to recognise the statutory responsibilities and accountabilities of trust boards and that sustainability and transformation partnerships (STPs) and integrated care systems (ICSs) derive their authority from the individual organisations that comprise them. There are issues that still need to be worked through, including the potential conflict of interest arising from a situation in which STPs/ICSs, which derive their decision making powers from the statutory bodies which comprise them, is holding those organisations to account.

It is vital that the next phase of work to further develop the framework for 2020/21 is done with the full involvement of providers and commissioners. This is something we have raised with NHSE/I and we look forward to working with the national bodies to shape and support the engagement process.

Appendix 1: Oversight metrics

New metrics for 2019/20 are highlighted in bold.

1. New service models		
	Integrated primary care and community health services	
1	Patient experience of GP services	CCGs
2	Patient experience of booking a GP appointment	CCGs
3	Emergency admissions for urgent care sensitive conditions	CCGs
	Acute emergency care and transfers of care	
4	Percentage of patients admitted, transferred or discharged from A&E within four hours	CCGs and providers
5	Achievement of clinical standards in the delivery of 7-day services	CCGs and providers
6	Delayed transfers of care per 100,000 population	CCGs
7	Population use of hospital beds following emergency admission	CCGs
8	Percentage of NHS continuing healthcare full assessments taking place in an acute hospital setting	CCGs
	Personalisation and patient choice	
9	Personal health budgets	CCGs
10	Use of the NHS e-referral service to enable choice at first routine elective referral	CCGs
2. Preventing ill health and reducing inequalities		
	Smoking	
11	Maternal smoking at delivery	CCGs
	Obesity	
12	Percentage of children aged 10-11 classified as overweight or obese	CCGs
	Falls	
13	Injuries from falls in people aged 65 and over	CCGs and providers
	Antimicrobial resistance	
14	Antimicrobial resistance: appropriate prescribing of antibiotics in primary care	CCGs
15	Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care	CCGs
	Health inequalities	
16	Proportion of people on GP severe mental illness register receiving physical health checks in primary care	CCGs
17	Inequality in unplanned hospitalisation for chronic ambulatory care sensitive and urgent care sensitive conditions	CCGs
3. Quality of care and outcomes		
	General	
18	Provision of high-quality care: hospitals	CCGs and providers
19	Quality of Care metrics: a set of 30 quality proxies to identify any emerging	Providers

	quality concerns at acute, mental health, ambulance and community trusts – see Provider annex for more details	
20	Provision of high-quality care: primary medical services	CCGs
21	Evidence that sepsis awareness raising among healthcare professionals has been prioritised by CCGs	CCGs
22	**Evidence-based interventions**	**CCGs**
	Maternity services	
23	Neonatal mortality and stillbirths	CCGs
24	Women's experience of maternity services	CCGs
25	Choices in maternity services	CCGs
	Cancer services	
26	Cancers diagnosed at an early stage	CCGs
27	People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	CCGs and providers
28	One-year survival from all cancers	CCGs
29	Cancer patient experience	CCGs
	Mental health	
30	Improving Access to Psychological Therapies – recovery	CCGs and providers
31	Improving Access to Psychological Therapies – access	CCGs and providers
32	People with first episode of psychosis starting treatment with a National Institute for Health and Care Excellence (NICE) – recommended package of care treated within two weeks of referral	CCGs and providers
33	Mental health out-of-area placements	CCGs and providers
34	Quality of mental health data submitted to NHS Digital (DQMI)	CCGs and providers
	Learning disability and autism	
35	Reliance on specialist inpatient care for people with a learning disability and/or autism	CCGs
36	Proportion of people with a learning disability on the GP register receiving an annual health check	CCGs
37	Completeness of the GP learning disability register	CCGs
38	**Learning disabilities mortality review: the percentage of reviews completed within 6 months of notification**	
	Diabetes	
39	Diabetes patients that have achieved all the NICE recommended treatment targets: three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) for children	CCGs
40	People with diabetes diagnosed less than a year who attend a structured education course	CCGs
41	Estimated diagnosis rate for people with dementia	Providers
42	Dementia care planning and post-diagnostic support	CCGs
43	The proportion of carers with a long-term condition who feel supported to	CCGs

	manage their condition	
44	Percentage of deaths with three or more emergency admissions in last three months of life	CCGs
	Planned care	
45	Patients waiting 18 weeks or less from referral to hospital treatment	CCGs and providers
46	**Overall size of the waiting list**	**CCGs**
47	**Patients waiting over 52 weeks for treatment**	**CCGs**
48	Patients waiting six weeks or more for a diagnostic test	CCGs and providers
4. Leadership and workforce		
49	Quality of leadership	CCGs and providers
50	Probity and corporate governance	CCGs and providers
51	Effectiveness of working relationships in the local system	CCGs and providers
52	Compliance with statutory guidance on patient and public participation in commissioning health and care	CCGs
53	Primary care workforce	CCGs
54	Staff engagement index	CCGs
55	Progress against the Workforce Race Equality Standard	CCGs and providers
56	Effectiveness of shared objective-setting and teamworking	Providers
57	Providing equal opportunities and eliminating discrimination	Providers
58	Black and minority ethnic (BME) leadership ambition for executive appointments	Providers
59	Reducing/eliminating bullying and harassment from managers and other staff	Providers
5 Finance and use of resources		
60	In-year financial performance	CCGs and providers
61	Delivery of the mental health investment standard	CCGs
62	**Children and Young People and Eating Disorders investment as a percentage of total mental health spend**	**CCGs**
63	Expenditure in areas with identified scope for improvement	CCGs
64	Children and young people's mental health services transformation	CCGs
65	**Reducing the rate of low priority prescribing**	CCGs

Contact: Ella Jackson, policy advisor, ella.jackson@nhsproviders.org

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 24 September 2019
Agenda item 6.1

Title:	**Integrated Performance Report Month 5 2019/20**
Paper prepared by:	Director of Finance & Resources and Director of Quality & Nursing
Purpose:	To provide the Board with the Integrated Performance Report (IPR) for August 2019.
Mission/values/objectives	All Trust objectives
Any background papers/ previously considered by:	➢ IPR is reviewed at Trust Board each month ➢ IPR is reviewed at Executive Management Team (EMT) meeting on a monthly basis
Executive summary:	**Quality** ➢ Care Quality Commission (CQC) action plan submission completed ➢ Deterioration in medicines omissions under investigation ➢ Increase in moderate / severe harm incidents requires review ➢ Prone restraint performance continues to be positive ➢ Under 18 admissions remain at a low number for this month, work continues to eradicate this **NHSI Indicators** ➢ A data quality rating column has been added to the report to identify where are issues that could potentially be impacting on reported performance ➢ Breaches have taken place in the last two months in relation to the maximum 6 week wait for diagnostic procedures in paediatric audiology. ➢ 1 children and young person was placed in an adult ward during the month, amounting to 21 bed days ➢ The data quality maturity index has fallen marginally below the 95% threshold ➢ Treatment within 6 weeks of referral for Improving Access to Psychological Therapies (IAPT) has also dipped slightly below the 75% target. This is only a provisional figure and subject to further work. Typically the final percentage improves from the provisional figure. **Locality** ➢ In Barnsley the neighbourhood team specification has been approved. Phase 1 implementation is due to take effect from April 2020. ➢ Barnsley smoke free mobilisation is underway

	➢ Demand and acuity pressures continue across all inpatient wards ➢ Focused work on IAPT in Barnsley and Kirklees to ensure access targets are met ➢ Much improved performance regarding waiting time reduction in Kirklees memory services following the introduction of 3 advanced practitioners ➢ A bid for a forensic community service has been updated and submitted to NHS England & Improvement ➢ Wakefield has secured a place as a field leader tester pilot site as part of the national urgent and emergency mental health clinical reviews standards programme **Priority Programmes** ➢ The Trust is engaging fully with the development of a single service specification that will cover general community services in Barnsley ➢ Partnership working remains a key area of focus and includes the formation of primary care networks in each place and how the Trust interacts with them ➢ Intense focus remains on developing sustainable solutions that will result in reduced use of out of area bed placements ➢ High level optimisation plan for SystmOne for mental health approved ➢ An independent review of the proposed stroke model in Barnsley is taking place towards the end of September **Finance** ➢ Pre Provider Sustainability Funding (PSF) surplus in month 5 of £188k, which is £133k favourable to plan. Cumulative deficit is £1.3m which is £0.4m favourable to plan. The cumulative position includes £0.7m of pay increases paid fully in April. ➢ Cumulative income is £0.4m lower than plan due to the recognition of a number of risks relating to CQUIN, occupancy, and also income received from the spot purchase of beds. ➢ Out of area bed costs were £75k in month and £837k year-to-date, which whilst not yet a sustainable position cumulatively represents less than half of the cost incurred compared to the same period last year. ➢ Agency staffing costs continue to be higher than plan and the cap at £0.6m in month. Cumulative agency spend is 46% above the cap. If spend exceeds 50% of the cap this will have an adverse impact on our financial risk rating ➢ Net underlying savings on pay amounted to £450k in-month and £1.6m year-to-date ➢ CIP delivery of £3.6m is in line with plan. Currently £1.1m CIPs are unidentified for the full year. ➢ Cash balance increased to £31.5m in August ➢ Given the improvement in margin the financial risk rating improved

	from 3 to 2 **Workforce** ➢ Sickness absence up to the end of August is 5%, which is higher than the same period last year ➢ Staff turnover reduced from 12.6% to 11.1% month on month and is almost 2% lower than the same period last year ➢ Appraisal completion for band 6 and above is 80.3% compared to a target of 95% ➢ Overall performance against mandatory training targets remains good ➢ Gross level of vacancies before backfill has increased to 13.2% largely as a result of the need to recruit staff into positions created by additional investment and the time this takes
Recommendation:	**Trust Board is asked to NOTE the Integrated Performance Report and COMMENT accordingly.**
Private session:	Not applicable.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report
Strategic Overview

August 2019

With **all of us** in mind.

NHS
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Yorkshire Partnership
NHS Foundation Trust

Table of Contents

Introduction

Please find the Trust's Integrated Performance Report (IPR) for July 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 fo 2019/20 to ensure it remains fit for purpose and aligns to the Trust's updated objectives for 2019/20. 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 during quarter 2. The Trust Executive Management Team (EMT) has identified a number of metrics currently without targets and is assessing whether targets for these metrics should be added. These will be updated where appropriate for the October Trust Board. The provider oversight framework for 2019/20 has recently been published and there will be a requirement to report against a number of measures in relation to leadership and workforce based on the staff survey. It is also expected there will be further development of the oversight framework for 2020/21 onwards to include measures identified in the long term plan.

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 relatively early timing of this Trust Board coupled with some residual additional checking following the SystmOne implementation means not all metrics were available at the time of issuing this report.

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	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Year End Forecast
Single Oversight Framework metric	2	2	2	2	2	2	2	2
CQC Quality Regulations (compliance breach)	Green	Green	Green	Green	Green	Green	Green	Green
Improve people's health and reduce inequalities	**Target**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Year End Forecast**
% service users followed up within 7 days of discharge	95%	98.2%	96.2%	97.2%	100%	97.7%		4
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks 1	90%	82.8%	77.5%			Due Oct 19		95%
Out of area beds 2	19/20 - Q1 576, Q2 494, Q3 411, Q4 329	154	207	303	193	151	146	1
Physical Health - Cardiometabolic Assessment (CMA) - Proportion of clients with a CMA Community	Community 75% Inpatient 90%	88.1%	88.0%	87.6%	87.1%	*86.7%*	*86.8%*	4
Inpatient 9		90.2%	92.6%	91.5%	92.1%	93.3%	92.0%	4
IAPT - proportion of people completing treatment who move to recovery 5	50%	57.0%	54.4%	55.4%	51.9%	52.2%	*52.5%*	4
Number of suicides (per 100,000) population 6	tbc	Reporting to commence for 19/20		0.67%		Due Oct 19		N/A
Delayed Transfers of Care	3.50%	1.6%	1.4%	0.4%	0.6%	1.2%	1.6%	4
Improve the quality and experience of care	**Target**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Year End Forecast**
Friends and Family Test - Mental Health	85%	95%	95%	86%	86%	91%	86%	85%
Friends and Family Test - Community	98%	99%	98%	99%	97%	97%	96%	98%
Patient safety incidents involving moderate or severe harm or death (Degree of harm subject to change as more information becomes available) 4	trend monitor	29	23	36	32	36	40	
IG confidentiality breaches	<=8 Green, 9 -10 Amber, 11+ Red	9	3	11	12	5	11	
Proportion of people detained under the MHA who are Black, Asian & Minority Ethnic 7	trend monitor	16.6%		14.5%		Due Oct 19		N/A
Total number of Children and Younger People under 18 in adult inpatient wards	*TBC*	1	1	5	3	1	1	
CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks 3	trend monitor	23.2%	31.8%	35.8%	36.9%	38.7%	36.0%	
Psychology waiting times 12	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		Reporting to commence in 19/20						
Improve the use of resources	**Target**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Year End Position**
Surplus/(Deficit)	In line with Plan	(£1240k)	(£728k)	(£457k)	(£145k)	(£149k)	£188k	(£240k)
Agency spend	In line with Plan	£634k	£613k	£641k	£691k	£722k	£629k	£7.3m
CIP delivery	£1074k	£10574k	£670k	£1353k	£2018k	£2776k	£3487k	£10.7m
Staffing costs compared to plan 10	tbc	Reporting to commence in 19/20	(£367k)	(£124k)	(£268k)	(£448k)	(£450k)	tbc
Completion of milestones assumed in the optimisation of SystmOne for mental health 11	tbc	Reporting to commence in 19/20						
Financial risk in forecast	0	Reporting to commence in 19/20	£1.5m	£1.5m	£2.8m	£3.1m	£3.3m	-
Making SWYPFT a great place to work	**Target**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Year End Position**
Sickness absence	4.5%	5.0%	4.7%	4.6%	4.8%	5.0%	5.0%	5.0%
Staff Turnover 6	10%	11.9%	11.9%	10.4%	12.0%	12.6%	11.1%	
Staff FFT survey - % staff recommending the Trust as a place to receive care and treatment	80%	75%	N/A	N/A	75%	N/A	N/A	
Staff FFT survey - % staff recommending the Trust as a place to work	65%	65%	N/A	N/A	66%	N/A	N/A	N/A
Actual level of vacancies	tbc	Reporting to commence in 19/20	10.4%	10.3%	10.7%	11.9%	13.2%	
% leavers providing feedback	tbc	Reporting commenced 19/20			25.0%			

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

Notes:
1 - Please note: this is a proxy definition as a measure of clients receiving timely assessment / service delivery by having one face-to-face contact. It is per referral. This KPI counts first contact with service post referral. Under performance is generally due to waiting list issues. Q1 data has been impacted by some data quality issues as a result of transition to SystmOne and continuing challenges in recruiting specialist practitioners timely due shortage of LD specialists/applicants, this is a national issue - currently impacting on psychologists in Wakefield & Barnsley and LD nurses / speech & language therapists across all localities.
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 psychiatric intensive care unit 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 19 each month. Excludes ASD waits. Treatment waiting lists are currently impacted by data quality issues following the migration to SystmOne. Data cleansing work is ongoing within service to ensure that waiting list data is reported accurately.
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 - Calculation for this is the number of suicides of services users under the care of the Trust during the reporting period (as recorded on our risk management system), divided by NHS registered population as per office of national statistics data.
7 - Introduced into the summary for reporting from 18/19. Black, Asian & Minority Ethnic (BAME) includes mixed, Asian/Asian British, black, black British, other
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.
11 - Milestones assumed in the optimisation of SystmOne for mental health - reporting of this will commence in quarter 3 once the optimisation plan is agreed in quarter 2.
12 -Psychology waiting times - reporting of this will commence once the SystmOne optimisation plan is agreed. We anticipate this will be at some point during quarter 3.

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
• CQC action plan submission completed
• Deterioration in medicines omissions under investigation
• Increase in moderate / severe harm incidents requires review
• Prone restraint performance continues to be positive
• Under 18 admissions remain at a low number for this month, work continues to eradicate this as a least worst option.

NHSI Indicators
• A data quality rating column has been added to the report to identify where are issues that could potentially be impacting on reported performance
• Breaches have taken place in the last two months in relation to the maximum 6 week wait for diagnostic procedures in paediatric audiology.
• 1 children and young person was placed in an adult ward during the month, amounting to 21 bed days
• The data quality maturity index has fallen marginally below the 95% threshold
• Treatment within 6 weeks of referral for IAPT has also dipped slightly below the 75% target. This is only a provisional figure and subject to further work. Typically the final percentage improves from the provisional figure.

Locality
• In Barnsley the neighbourhood team specification has been approved. Phase 1 implementation is due to take effect from April 2020.
• Barnsley smoke free mobilisation is underway
• Demand and acuity pressures continue across all inpatient wards
• Focused work on IAPT in Barnsley and Kirklees to ensure access targets are met
• Much improved performance regarding waiting time reduction in Kirklees memory services following the introduction of 3 advanced practitioners
• A bid for a forensic community service has been updated and submitted to NHS England & Improvement
• Wakefield has secured a place as a field leader tester pilot site as part of the national urgent and emergency mental health clinical reviews standards programme

Priority Programmes
• The Trust is engaging fully with the development of a single service specification that will cover general community services in Barnsley
• Partnership working remains a key area of focus and includes the formation of primary care networks in each place and how the Trust interacts with them
• Intense focus remains on developing sustainable solutions that will result in reduced use of out of area bed placements
• High level optimisation plan for SystmOne for mental health approved
• An independent review of the proposed stroke model in Barnsley is taking place towards the end of September

Finance
• Pre Provider Sustainability Funding (PSF) surplus in month 5 of £188k, which is £133k favourable to plan. Cumulative deficit is £1.3m which is £0.4m favourable to plan. The cumulative position includes £0.7m of pay increases paid fully in April.
• Cumulative income is £0.4m lower than plan due to the recognition of a number of risks relating to CQUIN, occupancy, and also income received from the spot purchase of beds.
• Out of area bed costs were £75k in month and £837k year-to-date, which whilst not yet a sustainable position cumulatively represents less than half of the cost incurred compared to the same period last year.
• Agency staffing costs continue to be higher than plan and the cap at £0.6m in month. Cumulative agency spend is 46% above the cap. If spend exceeds 50% of the cap this will have an adverse impact on our financial risk rating
• Net underlying savings on pay amounted to £450k in-month and £1.6m year-to-date
• CIP delivery of £3.6m is in line with plan. Currently £1.1m CIPs are unidentified for the full year.
• Cash balance increased to £31.5m in August
• Given the improvement in margin the financial risk rating improved from 3 to 2

Workforce
• Sickness absence up to the end of August is 5%, which is higher than the same period last year
• Staff turnover reduced from 12.6% to 11.1% month on month and is almost 2% lower than the same period last year
• Appraisal completion for band 6 and above is 80.3% compared to a target of 95%
• Overall performance against mandatory training targets remains good

Quality Headlines

Section	KPI	Objective	CQC Domain	Owner	Target	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Year End Forecast
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	Improving Health	Responsive	CH	TBC	23.2%	31.8%	35.8%	36.9%	38.7%	36.0%	N/A
Complaints	Complaints closed within 40 days	Improving Health	Responsive	TB	80%	50% 1/2	31% 4/13	44% 4/9	26% 4/15	40.0%	53.0%	1
	% of feedback with staff attitude as an issue	Improving Health	Caring	AD	< 20%	11%	36% 4/11	28% 5/18	17% 12/71	20% 4/20	12% 2/17	4
Service User Experience	Friends and Family Test - Mental Health	Improving Health	Caring	TB	85%	95%	95%	86%	86%	91%	86%	4
	Friends and Family Test - Community	Improving Health	Caring	TB	98%	99%	98%	99%	97%	97%	96%	4
Quality	Staff FFT survey - % staff recommending the Trust as a place to receive care and treatment	Improving Health	Caring	AD	80%	75%	N/A	N/A	75%	N/A	N/A	N/A
	Staff FFT survey - % staff recommending the Trust as a place to work [13]	Improving Health	Caring	AD	65%	65%	N/A	N/A	66%	N/A	N/A	N/A
	Number of compliments received	Improving Health	Caring	TB	N/A		15	64	14	10	34	N/A
	Number of Duty of Candour applicable incidents [4]	Improving Health	Caring	TB	N/A	*308*	21	39	30	Due Sept 19		N/A
	Duty of Candour - Number of Stage One exceptions [4]	Improving Health	Caring	TB	N/A	11	1	4	7			N/A
	Duty of Candour - Number of Stage One breaches [4]	Improving Health	Caring	TB	0	0	0	0	0			
	% Service users on CPA given or offered a copy of their care plan	Improving Care	Caring	CH	80%	Due July 19						4
	Number of Information Governance breaches [3]	Improving Health	Effective	MB	<=9	9	3	11	12	5	11	
	Delayed Transfers of Care [10]	Improving Care	Effective	CH	3.5%	1.6%	1.4%	1.4%	0.5%	1.2%	1.6%	4
	Number of records with up to date risk assessment - Inpatient [11]	Improving Care	Effective	CH	95%	Due July 19						N/A
	Number of records with up to date risk assessment - Community [11]	Improving Care	Effective	CH	95%							N/A
	Total number of reported incidents	Improving Care	Safety Domain	TB	trend monitor	1098	1158	1266	1084	1187	1196	N/A
	Total number of patient safety incidents resulting in Moderate harm. (Degree of harm subject to change as more information becomes available) [9]	Improving Care	Safety Domain	TB	trend monitor	19	19	27	25	23	31	N/A
	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) [9]	Improving Care	Safety Domain	TB	trend monitor	3	1	5	1	2	3	N/A
	Total number of patient safety incidents resulting in death harm. (Degree of harm subject to change as more information becomes available) [9]	Improving Care	Safety Domain	TB	trend monitor	7	3	4	6	11	6	N/A
	MH Safety thermometer - Medicine Omissions	Improving Care	Safety Domain	TB	*17.7%*	17.7%	24.5%	27.0%	15.8%	17.1%	24.7%	3
	Safer staff fill rates	Improving Care	Safety Domain	TB	90%	118%	118%	117%	116%	116%	116%	4
	Safer Staffing % Fill Rate Registered Nurses	Improving Care	Safety Domain	TB	80%	96.5%	96.6%	94.9%	92.1%	91.8%	91.8%	4
	Number of pressure ulcers (attributable) [1]	Improving Care	Safety Domain	TB	N/A	44	41	46	34	41	10	N/A
	Number of pressure ulcers (avoidable) [2]	Improving Care	Safety Domain	TB	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	4
	% of prone restraint with duration of 3 minutes or less [8]	Improving Care	Safety Domain	CH	80%	88.0%	75.8%	87.5%	90.6%	94.4%	92.5%	4
	Number of Falls (inpatients)	Improving Care	Safety Domain	TB	TBC	59	52	37	41	56	55	N/A
	Number of restraint incidents	Improving Care	Safety Domain	TB	N/A	207	287	303	193	190	262	N/A
	No of staff receiving supervision within policy guidance [7]	Improving Care	Well Led	CH	80%	86.7%	72.4%			Due Oct 19		4
	% people dying in a place of their choosing	Improving Care	Caring	CH	80%	82.6%	82.6%	86.1%	100.0%	96.6%	85.7%	
	Smoking Cessation - 4 week quit rate 12	Improving Care	Effective	CH	tbc	67%	Due Oct 19			Due Jan 20		N/A
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	Improving Care	Safety Domain	TB	6	0	0	0	0	0	0	4
	C Diff avoidable cases	Improving Care	Safety Domain	TB	0	0	0	0	0	0	0	4

Quality Headlines

** 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 SystmOne implementation impacting on reported performance.*

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 confidentiality 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. Data quality (DQ) issues are impacting on the reported data from March 19. Some improvement in dq has seen in the latest month and this is expected to continue.
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. 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. The national quit rate for quarters 1-3 2018-19 was 52%. Q1 data will be available in October 19.
13. The national benchmark (65%) for this indictaor has been used to monitor Trust performance against.

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 August has increased compared to the previous months (262) compared to previous months. Further detail can be seen in the managing violence and aggression section of this report.

• NHS Safety Thermometer - medicines omissions – performance has deteriorated this month and has now droppped below threshold. Work continues across services to improve performance. The brief for the data collectors was not re-issued this month as it has been issued for the last three months, this may have had an impact on the performance. A number of the records have been reviewed across all localities and services. There were 36 omissions in the records selected 15 refused, 9 valid clinical reason (all one ward and unusually high), Absent from the ward 7. There was only a small proportion due to practice or supply (Not documented 3 medicine not available 2). The wards are self-monitoring weekly using the safety cross quality improvement tool and QIAT and pharmacy are doing some advisory visits to wards which are identified as hotspots from these.

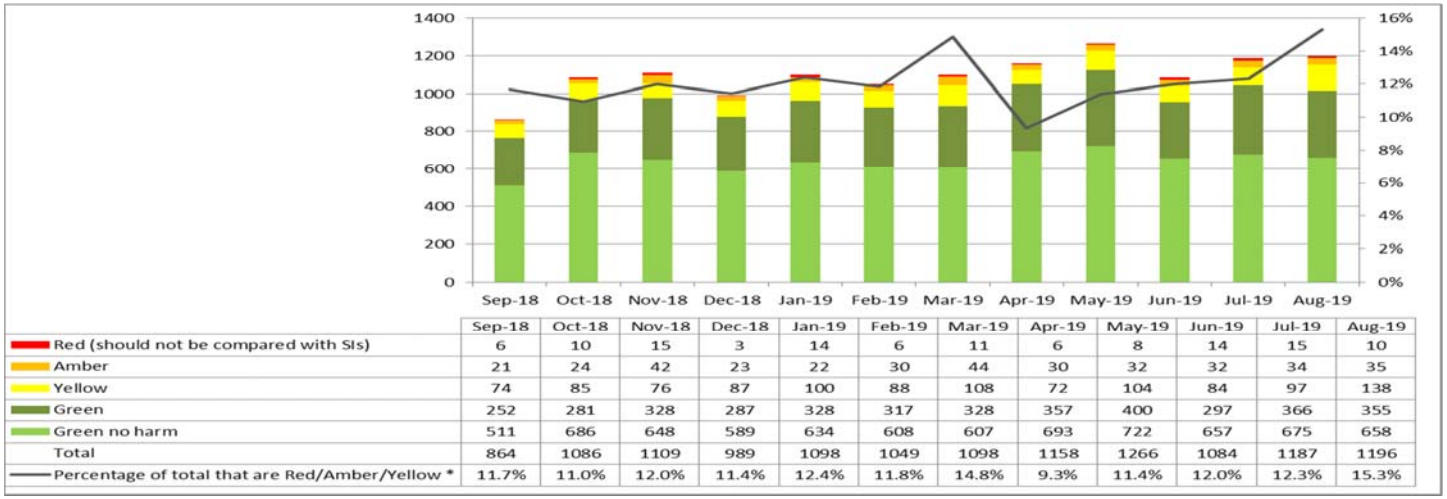
• Number of falls (inpatients) - August 19 remains at a similar level to last month with 55 incidents reported compared to 41 in June 19. The level of incidents continues to mostly relate to Wakefield BDU and predominantly due to an increase in service users with high acuity high and as such increased levels of observations are 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.

• In recognition of the continued over achievement on fill rates an establishment review has been conducted and the implementation plan is now underway. The establishment changes will result in a change in our fill rate achievement levels and this is being assessed through the safer staffing group. Reporting arrangements against the new establishment levels are being finalised.

Safety First

Summary of Incidents since September 2018

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



	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Red (should not be compared with SIs)	6	10	15	3	14	6	11	6	8	14	15	10
Amber	21	24	42	23	22	30	44	30	32	32	34	35
Yellow	74	85	76	87	100	88	108	72	104	84	97	138
Green	252	281	328	287	328	317	328	357	400	297	366	355
Green no harm	511	686	648	589	634	608	607	693	722	657	675	658
Total	864	1086	1109	989	1098	1049	1098	1158	1266	1084	1187	1196
Percentage of total that are Red/Amber/Yellow *	11.7%	11.0%	12.0%	11.4%	12.4%	11.8%	14.8%	9.3%	11.4%	12.0%	12.3%	15.3%

** 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	Q2 19/20	Q3 18/19	Q4 18/19	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Total
Suicide (incl apparent) - community team care - current episode	4	7	4	11	0	2	1	1	5	3	3	1	1	2	5	2	26
Death - cause of death unknown/ unexplained/ awaiting confirmation	3	0	0	1	0	0	0	0	0	1	0	1	2	0	0	0	4
Suicide (incl apparent) - community team care - discharged	1	1	0	2	0	0	0	0	2	0	0	0	0	1	1	0	4
Self harm (actual harm) with suicidal intent	2	0	1	0	0	1	0	0	0	0	0	0	1	1	0	0	3
Homicide by patient	2	1	0	0	0	0	0	0	0	0	0	1	0	1	1	0	3
Pressure Ulcer - Category 3	1	0	0	2	0	0	0	0	0	0	2	0	1	0	0	0	3
Suicide (incl apparent) - inpatient care - current episode	0	0	1	1	0	1	0	0	0	0	1	0	0	0	0	0	2
Physical violence (contact made) against staff by patient	1	0	1	0	0	1	0	0	0	0	0	0	0	1	0	0	2
Information disclosed in error	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Lost or stolen paperwork	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Unwell/Illness	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Total	14	9	10	17	0	6	2	2	7	4	6	3	5	6	7	2	50

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

Mortality

The clinical mortality review group was held on 02/08/19 which focussed on learning and action from outcomes from learning from deaths reviews, including serious incidents, structured judgement reviews and other investigations. The group discussed low level self-harm and the emotionally unstable personality disorder (EUPD) pathway, incidents of Violence and Aggression and focused on the theme 'Threat Assessment Investigation' and produced four learning library templates which will be shared with comms and promoted across the Trust.
Regional work: The Trust has completed a structured judgement review (SJRR) case study which will be published as part of the regional mortality work.
Training: Further structured fudgement reviewer training is being arranged for September 2019.
Reporting: The Trusts 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 (2018/19).
-Structured judgement reviews – There are currently 4 SJRRs to be allocated, all reviews are currently being completed within the allocated timescale. There are 2 cases awaiting second review.

Safer Staffing

Overall Fill Rates: 116%
Registered fill rate: (day + night) 91.8%
Non Registered fill rate: (day + night) 141.8%

BDU Fill rates - June 19 - August 19

Overall Fill Rate	Month-Year		
Unit	Jun-19	Jul-19	Aug-19
Specialist Services	118%	117%	117%
Barnsley	110%	115%	115%
C & K	115%	112%	110%
Forensic	106%	109%	108%
Wakefield	140%	134%	141%
Overall Shift Fill Rate	**116%**	**116%**	**116%**

The figures (%) for August 2019:
Registered staff - Days 80.2% (a decrease of 3.4% on the previous month); Nights 93.7% (a decrease of 6.3% on the previous month);
Registered average fill rate - Days and nights 91.8% (same as last month)
Non Registered Staff: Days 137.9% (an increase of 2.7% on the previous month); Nights 146.8% (an increase of 4.4% on the previous month)
Non Registered average fill rate: Days and nights 141.8% (an increase of 3.0% on the previous month)
Overall average fill rate all staff: 114.3% (a decrease of 1.4 on the previous month)

Two wards, Appleton and Priestley within the Forensic BDU, fell slightly (both 0.2%) below the overall fill rates of 90% or above which is an increase of one on the previous months. This was due to a reduction in filled beds, reallocations to other areas, vacancies and sickness as well as a seasonal decrease in temporary resources.

• In recognition of the continued over achievement on fill rates an establishment review has been conducted and the implementation plan is now underway. The establishment changes will result in a change in our fill rate achievement levels and this is being assessed through the safer staffing group. Reporting arrangements against the new establishment levels are being finalised.

Summary
As above two wards have fallen below the 90% overall fill rate. Of the 31 inpatient areas 21, a decrease of three wards on the previous month, (67.2%) achieved greater than 100%. Indeed of those 21 areas, 14 (44.8% of 31 wards) achieved greater than 120% fill rate. This was an increase of four wards on the previous month.
Registered On Days (Trust Total 83.6%)
The number of wards that have failed to achieve 80% increased by five to 17 (54.4%) on the previous month. These were spread throughout all BDUs. There were various factors cited including vacancies, sickness and supporting acuity across the BDU. This is traditionally also a High Holiday point where there is less availability of bank and agency staff to provide any back fills. All measures to ensure that the wards were safely staffed were followed and the areas continued mutually supporting one another.
Registered On Nights (Trust Total 100%)
Four wards (12.8%), an increase of three, has fallen below the 80% threshold. These were Ashdale and Elmdale within the C&K BDU, Beamshaw in Barnsley as well as Sandal within the Forensic BDU. Similar reasons as above were sighted for this. The number of wards who are achieving 100% and above fill rate on nights reduced by 1 ward to 17 (54.4%) this month.
Barnsley BDU and Specialist Services remained consistent on 115% and 117% respectively. Calderdale and Kirklees BDU decreased by 2% to 110%. Forensic BDU were 108% a decrease of 1%. Wakefield BDU increased by 7% to 141%. Overall fill rate for the trust remained consistent on 116%.
Significant pressures remain on inpatient wards due various influences including demands arising from acuity of service user population, vacancies and sickness. This is also a high annual leave period for all substantive, bank and agency staff. We are expecting an improvement in the RN figures with September being a month where traditionally a significant number of newly qualified staff join the trust.

Information Governance

During August 19, there has been an increase in the number of confidentiality information governance breaches reported compared to the decreased number reported in July. 11 breaches during the month - 5 counts of information disclosed in error, 3 lost or stolen paperwork, 2 patient healthcare record issues and 1 uploaded to website in error.

Work continues in the Trust to support services to reduce the number of IG incidents occurring. Letters are sent to teams with breaches asking for completion of action plans and regular communications continues.

None of these incidents required reporting to the information commissioner's office.

Commissioning for Quality and Innovation (CQUIN)

Q1 CQUIN has been approved for Wakefield, Kirklees and Calderdale CCGs which means full achievement of available funding for Q1. Full achievement for the HSE and Barnsley CCG Q1 CQUIN indicators has now been confirmed.

The Trust is currently working on the 19/20 CQUIN requirements with preparations taking place for the Q2 submissions which sees a number of additional requirements. Overall value of the scheme has reduced to 1.25% of contract value. The indicators have been identified as follows:

- Staff flu vaccinations (Barnsley, Calderdale, Kirklees, Wakefield)
- 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 and monitor action plans to ensure maximum achievement for the year. Forecast for year end at end of August was 87% achievement with the following indicators being identified as areas of potential risk:.

- 72hr follow up post discharge - forecast some underachievement in Q3 and full achievement in Q4. Indicator takes effect from Q3. Workshop has taken place to raise awareness. Regular reporting being established to monitor. A communication strategy has been devised. Work has been taking place within BDU localities informing clinicians of the CQUIN and the rational for the change as well as asking teams to agree how best to implement the practice. Changes to the standard operating procedure for 7 day discharge to be amended to reflect the CQUIN.
- Mental Health Data Quality - focussed work taking place to concentrate on hotspot areas. Initial July performance was forecast to be 87% which falls short of payment threshold (>90%). July refresh position is now forecast at 96.1% - the improvement is related to a focussed piece of work to ensure all relevant data items were flowing and were mapped to the valid national codes. Regular reporting to monitor data quality being established. Work is now to commence on part b of the indicator which looks at the recording of interventions with reporting commencing from Q3.
- Three high impact actions to prevent Hospital Falls - internal risk identified with April and May due to late implementation following contract negotiation and clarification of requirements. This has been mitigated by proposal to submit only June data. Plans in place to ensure this is achieved from Q2 onwards. Q1 was confirmed as fully achieved, therefore reducing the financial risk.

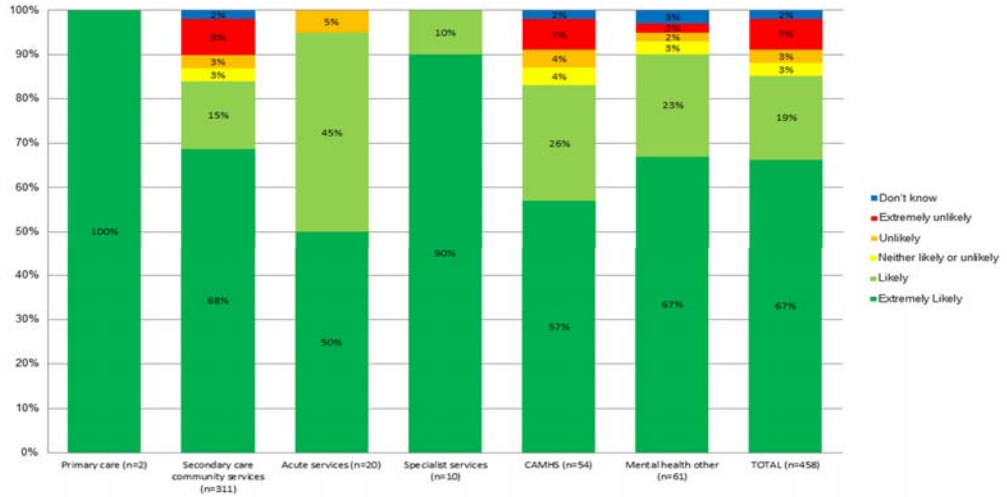
A further update on the forecast year end position will be available at the end of the month and it is anticipated that this will show an improvement on 87% achievement.

Patient Experience

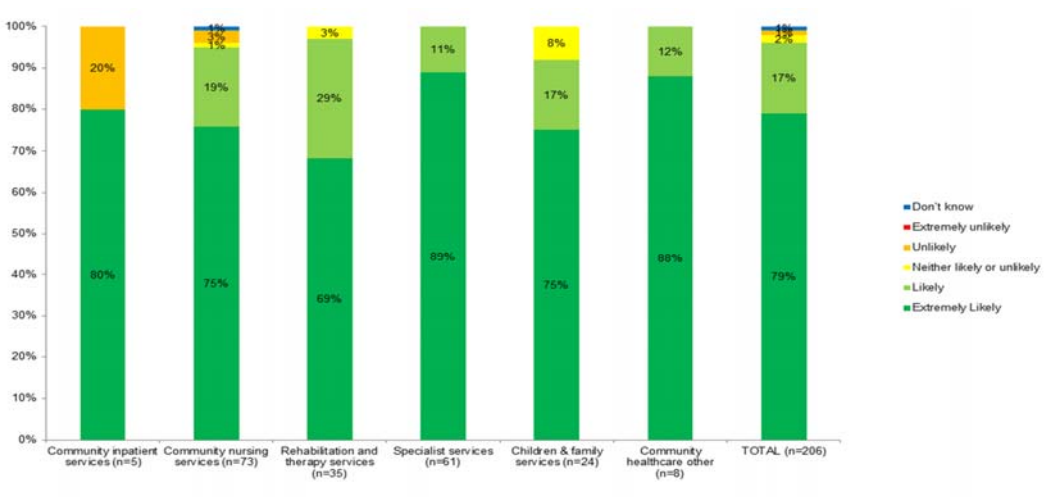
Friends and family test shows

- 86% of respondents would recommend Trust mental health services
- 96% of respondents would recommend Trust community health services
- The results show a decline in a number of people that would recommend both mental health and community services. On review of the results and the comments of those who would not recommend, we have not identified any trends or issues within the comments.

Mental Health Services



Community Services



Friends and family test feedback is viewed by business delivery units either via the live dashboard or in bespoke reports. Data is used to inform trends and to focus on areas of good practice and areas for improvement. The Trust asks 2 open ended questions:

What was good about your experience?
What would have made your experience better?

Free text responses are used to demonstrate specific positives and improvements that could be made.

Care Quality Commission (CQC)

The Care Quality Commission (CQC) inspected 4 of our core services in May and June 2019
• They also carried out a well-led review
• We received the draft report for factual accuracy checking
• The final version of the reports were published on Friday 23 August
• We're a learning organisation and we welcome their independent view of our services
The overall rating for the organisation is now GOOD. We have a number of MUST Do actions in CAMHS and Acute & PICU Core services and SHOULD do actions across the core services. We are in the process of collating a quality improvement plan that the CQC will use to monitor our progress against via our engagement arrangements.
Key findings
Their findings highlight our areas of strength and improvement:
• Our clear vision, values and strategy that are person-centred and respected throughout the Trust
• That staff felt respected, valued and supported
• That staff are kind and caring, building positive relationships with service users
• Our commitment to a holistic and preventative approach to care
• Our open culture with good reporting of incidents, and the way we learn from and act on what happens
• Our occupational health support for staff which provides help for #allofus
• Our strong relationships with partners
• Our progress from requires improvement to good for responsiveness
• The improvements seen in our community adult mental health services
The CQC have also provided a fair representation of the areas where we're facing significant challenges:
• Our services are still under pressure. Our child and adolescent mental health services (CAMHS) waiting lists are too high in some areas, particularly around ASD.
• We need to improve service user and carer engagement and speed up our responses to complaints from stakeholders
• We need to address specific issues, such as:
o Risk assessments
o Pharmacy and medicine management
o Timeliness of our cost improvement plans (CIPs)

Safeguarding

Safeguarding Adults
• The Safeguarding adults advisor is now in post
• The safeguarding team delivered the West Yorkshire Quality Mark (WYQM) domestic abuse training to the psychiatric liaison team as part of an action plan for a domestic homicide review
• The Safeguarding team co -developed a briefing paper for care homes on pressure ulcer care, this was shared with SWYPFT practitioners
• The Safeguarding Team supported the Kirklees older people service team to place the agreed plan between regarding 'information sharing' between teams

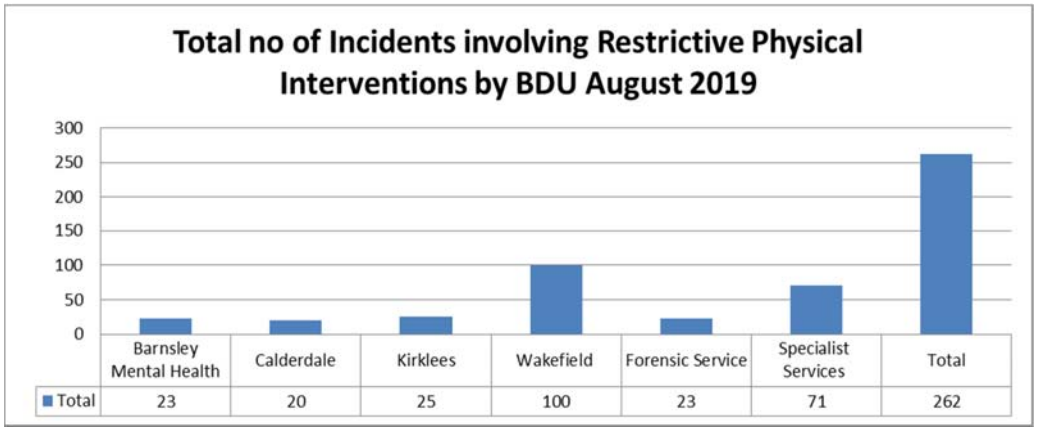
Safeguarding Children
• Named nurse safeguarding children has been supporting a BDU to develop a business plan for a representative at the daily risk assessment management meeting for domestic abuse.
• Named nurse safeguarding children has supported the BDU to agree guidelines for recording and sharing of domestic abuse information.
• Safeguarding childrens nurse advisor has begun the development of "safe to go home initiative" expected to be launched in September.
• A deep dive of PREVENT compliance has been carried out and highlighted hotspots in several teams, the managers have been contacted and extra sessions are being facilitated by the safeguarding children's team to achieve the expected mandatory percentage.

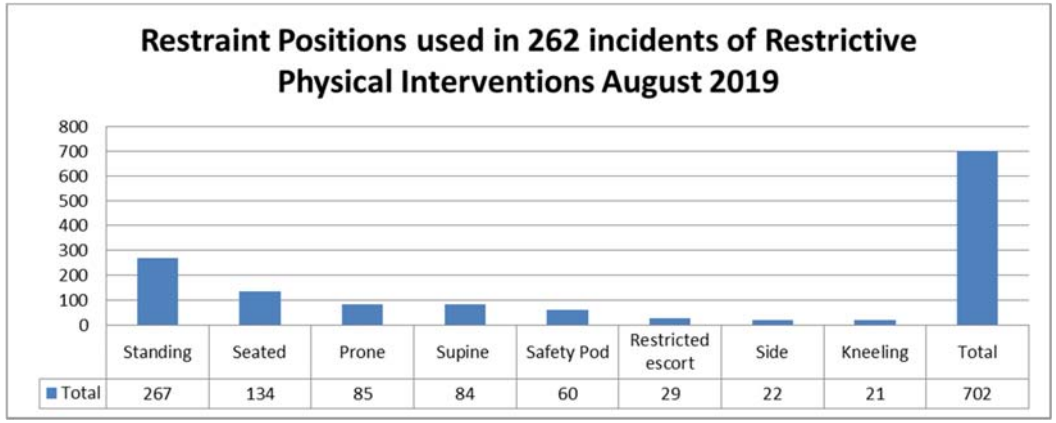
Infection Prevention Control (IPC)

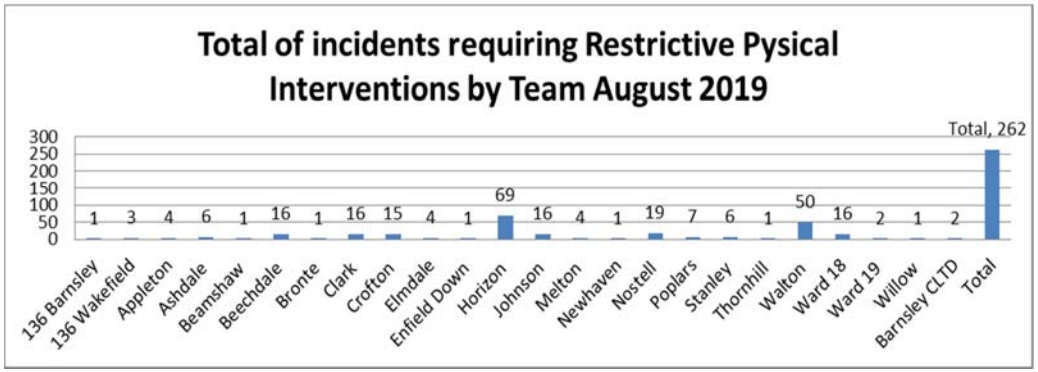
• Annual infection prevention plan 2019-20 (including quality improvement progress) is progressing well. No area at risk of non-completion.
• Surveillance: there has been no cases of MRSA Bacteraemia, MSSA bacteraemia, or clostridium difficile. There has been 1 ecoli bacteraemia case (SRU- date of case September 2019) up to date for 2019-20 data set which has been presented at PIR panel (no set trajectory for these cases).
• Q2 incidents - Wakefield - 5, Barnsley (mental health and community) – 2, Forensics - 2, Calderdale/Kirklees – 1, Specialist Services - 0 and Corporate Support Services - 0.
• Incident breakdown – 2 bite/scratch/spit, 2 incontinent of urine, 2 contact with needlestick injury (1 dirty needle / 1 clean needle), 2 faeces, 1 pathogen (infestation) and 1 ward /unit cleanliness.
• Severity rating – 8 incidents were risk rated green and 2 yellow.
• Mandatory training figures are healthy - hand hygiene-Trust wide total – 94%; Infection Prevention and Control- Trust wide total – 91%;
• Policies and procedures are up to date.

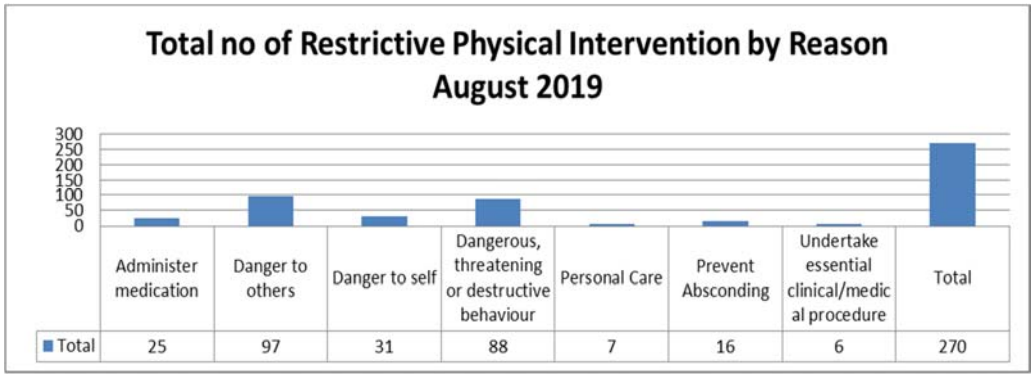
Reducing Restrictive Physical Intervention

There were 262 reported incidents of restrictive physical interventions use in August this being a 38% increase on the July figures that stood at 190. This is mainly comprised from incidents in 2 areas having a marked increase in incidents, Walton PICU and Horizon, 3 service users in these 2 areas accounted for around 84 of the incidents in August. The highest proportion of all restraints again was in the standing position 267 which equates to 38% of all positions used (702). Seated restraints stood at 134 that equates to 19% of all positions used (702). In relation to incidents of that would be deemed prone restraint, there was a 2.5% increase of prone restraint use in August (40) as opposed to July (39). Wakefield BDU had the highest number of Prone Restraints (27) Calderdale had the lowest 1. It must be noted that Calderdale has only 1 acute inpatient area.









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 table below lists the metrics that will be monitored and identifies baseline data where available and identifies performance against threshold. This table has been revised to reflect the changes to the framework introduced during 2017/18.
• Mental Health Five Year Forward View programme – a number of metrics were identified by the Mental Health Taskforce to assist in the monitoring of the achievement of the recommendations of the national strategy. The following table outlines the Trust's performance against these metrics that are not already included elsewhere in the report.
• NHS Standard Contract against which the Trust is monitored by its commissioners. Metrics from these categories may already exist in other sections of the report.
The frequency of the monitoring against these KPIs will be monthly and quarterly depending on the measure. The Trust will continue to monitor performance against all KPIs on a monthly basis where possible and will flag up any areas of risk to the board.

NHS Improvement - Single Oversight Metrics - Operational Performance

KPI	Objective	CQC Domain	Owner	Target	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Year End Forecast	Data quality rating [8]	Trend
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Improving Care	Responsive	CH	92%	97.2%	97.2%	99.3%	97.2%	99.2%	98.7%	98.7%	98.9%	98.7%	4		
Maximum 6-week wait for diagnostic procedures	Improving Care	Responsive	CH	99%	100%	100%	97.9%	100%	98.7%	100%	100%	96.3%	95.4%	4	⚠	
% Admissions Gate kept by CRS Teams	Improving Care	Responsive	CH	95%	97.6%	97.9%	98.9%	96.8%	99.2%	100%	100%	99.2%	100%	4		
% SU on CPA Followed up Within 7 Days of Discharge	Improving Care	Safe	CH	95%	97.7%	97.1%	97.1%	99.2%	96.2%	97.2%	100%	97.7%		4		
Data Quality Maturity Index [4]	Improving Health	Responsive	CH	95%	98.2%	96.8%	98.1%	98.0%	96.8%	96.9%	100.0%	*96.1%*	*94.9%*	4		
Out of area bed days [5]	Improving Care	Responsive	CH	19/20 - Q1 576, Q2 494, Q3 411, Q4 329	1181	1450	899	616	207	303	193	151	146	2		
IAPT - proportion of people completing treatment who move to recovery [1]	Improving Health	Responsive	CH	50%	54.4%	51.1%	52.4%	55.4%	54.4%	55.4%	51.9%	52.2%	*52.5%*	3		
IAPT - Treatment within 6 Weeks of referral [1]	Improving Health	Responsive	CH	75%	91.3%	94.3%	94.4%	88.7%	83.1%	86.3%	81.4%	78.2%	*74.5%*	4		
IAPT - Treatment within 18 weeks of referral [1]	Improving Health	Responsive	CH	95%	99.4%	99.6%	99.6%	99.2%	98.6%	99.1%	98.4%	98.3%	*98.0%*	4		
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Improving Care	Responsive	CH	56%	81.7%	90.3%	92.6%	*80.5%*	92.0%	72.7%	88.0%	92.0%	85.7%	4		
% clients in settled accommodation	Improving Health	Responsive	CH	*60%*	79.1%	78.8%	78.2%	78.2%	87.3%	88.0%	88.3%	88.8%	89.3%	4	⚠	
% clients in employment [6]	Improving Health	Responsive	CH	*10%*	8.6%	8.8%	9.3%	9.2%	11.3%	11.4%	11.5%	11.7%	11.7%	4	⚠	
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		Inpatient 88% Community - 78% EIP - 94.4%				Due June 20					2		

Mental Health Five Year Forward View	Objective	CQC Domain	Owner	Target	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Year End Forecast	Data quality rating [8]	Trend
Total bed days of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	*TBC*	16	45	39	23	5	29	56	7	21	2		
Total number of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	*TBC*	4	6	6	3	1	5	3	1	1	2		
Number of detentions under the Mental Health Act	Improving Care	Safe	CH	*Trend Monitor*	212	192	184	199	214			Due Oct 19		N/A		
Proportion of people detained under the MHA who are BAME [2]	Improving Care	Safe	CH	*Trend Monitor*	15.1%	14.1%	13.0%	16.6%	14.5%					N/A		

NHS Standard Contract	Objective	CQC Domain	Owner	Target	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Year End Forecast	Data quality rating [8]	Trend
Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users, as defined in Contract Technical Guidance [1]	Improving Health	Responsive	CH	90%	97.8%	98.8%	98.1%	98.9%	98.7%	99.4%	99.0%	*99.9%*		4		
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	Improving Health	Responsive	CH	99%	99.9%	99.9%	99.9%	99.9%	99.7%	99.8%	99.8%	99.8%	*99.8%*	4		
Completion of Mental Health Services Data Set ethnicity coding for all Service Users, as defined in Contract Technical Guidance	Improving Health	Responsive	CH	90%	90.8%	91.1%	90.9%	89.6%	84.1%	90.7%	89.5%	*98.5%*	*98.4%*	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
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 reported figures are in line with 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.
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'
8 - Data quality rating - added for reporting from August 19. This indicates where data quality issues may be affecting the reporting indicators. A warning triangle idenfiies any issues and detailed response provided below in the data quality rating section.

Areas of concern/to note:

- A couple of metrics have not been finalised at the time of the report. Whilst an improving picture, this is in part related to the impact of transition to SystmOne for mental health. At this point in time additional data quality checking is required for some measures.
- The Trust continues to perform well against the majority of NHS Improvement metrics
- Maximum 6-week wait for diagnostic procedures - current data identifies a number of individuals that have exceeded the 6 week wait for a paediatric audiology diagnostic procedure. Work is taking place to review the data in conjunction with the reporting definitions. This therefore has been flagged as a potential data quality issue. Further update to be provided in next months report, to confirm whether this is the case.
- During August 2019, the number of service users aged under 18 years placed in an adult inpatient ward was one 17 year old - who was admitted in August and who turned 18 year old at the end of August. 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 146 days in August which is a further decrease compared to 151 days reported in July.
- % 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. A South Yorkshire & Bassetlaw partnership bid for individual placement support wave 2 funding has been successful which will see the creation of additional employment workers to support secondary care mental health services in Barnsley.
- The IAPT 18 week wait figure for August has dropped below threshold, though this figure is provisional and will be revised in October.
- The scope of DQMI has changed in July 2019 as part of a national CQUIN, though the target has remained the same. The July and August figures are provisional, with July being published in October and August being published in November.

Data quality:

An additional column has been added to the above table to identify where there are any known data quaity issues that may be impacting on the reported performance. This is identified by a warning triangle and where this occurs, further detail will be included in the narrative section.

For the month of August, the following data quality issues have been identified in the August reporting:

- Maximum 6-week wait for diagnostic procedures indicator has been identified as being impacted by data quality issues. The detail of this can be seen above against the areas of note impacting on reported performance. Work is taking place to review the data and reporting and to ensure alignment to national reporting definitions, further update to be included in next months report.
- The reporting for employment and accomodation for august is provisional so has been flagged as a potential data quality issue.

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

• Neighbourhood team specification signed off and agreed by Barnsley clinical commissioning group governing body. Work continues to understand the full impact of the re specification of 21 individual service lines in phases 1 & 2; delivery of phase 1 by 1st April 2020 and phase two by March 2021. This will require a significant change programme for the BDU and Task and Finish Groups to commence on key work streams.
• Barnsley Yorkshire Smoke Free (YSF) mobilisation underway.
• Neighbourhood teams – professionally we are looking at first contact physiotherapists
• Long term conditions (LTC)- Level of increased demand causing pressures within the system

Strengths

• Neighbourhood team specification - moves Barnsley in the right direction of the NHS long term plan ask to have closer integration of primary and community services, which will enable an enhanced and improved service offer at a neighbourhood level.
This will also provide opportunity for AHPs to demonstrate the extended scope provision to GP practice and secondary care to improve care for patients
• Consistently positive friends and family test feedback for all services.
• All health and wellbeing services are providing excellent services, with very high performance levels.

Challenges

• Neighbourhood team specification - mobilisation of a new model of working involving 500 plus staff, changes regarding integrated leadership and management, changes of agile bases for some staff, formation of new teams and new ways of working.
• Implementation of SystmOne into childrens audiology services and correct classification of breaches.
• Management of predicated staffing shortages in children's speech and language therapy (SALT) in autumn due to multiple maternity leave/staff changes which will have an impact on service delivery.
• Recruitment: very few applications for extended scope physiotherapist
• LTC workforce issues – maternity leave, vacancy and recruitment processes
• Neighbourhood nursing service paper for investment prepared.
• Epilepsy business case in development regarding increasing demands

Areas of Focus

• To commence formal consultation (Sept 2019) with Yorkshire smoke free Barnsley team members on proposed model and structure as part of the mobilisation plan.
• Stroke Services – independent review of proposed early supported discharge model by CCG now arranged for 26 September 2019
• Neuro rehab unit – standard operating procedure for out of area placements patient transfers now developed in place and being piloted. Financial profile positively changing.

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 including intensive home based treatment team continues to experience high demand, staffing pressures and acuity leading to pressures on the wards and on-going 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, in particular the work around criteria led discharge.
• 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, with additional out of hours clinics having been held in the core pathway to meet demand.
• We are working with the CCG and primary care partners to scope and plan integrated services at neighbourhood and primary care network level.

Strengths
• As part of mobilisation plan recruitment into all age liaison psychiatry posts is proceeding well
• Continued success in recruitment to medical posts has meant currently no agency medical staff in the BDU
• Ongoing management of patient flow despite growing pressures
• Willow ward has a recovery tree on the wall and a treatment rainbow done in collaboration with staff and service users.

Challenges
• Demand and capacity in community services continues to be a challenge.
• The improving access to psychological therapies service is pursuing a range of measures to ensure concordance with its year-end access target of 19% quarters 1-3 and 22% quarter 4, including promoting internet access, the use of stresspac and running additional groups. It is challenged by vacancies in psychological wellbeing workers and access to training places, its workforce plan is currently optimising capacity.
• The action plan and training around care programme approach reviews and SystmOne is leading to some positive impact, and is being closely monitored and supported at trio level.
• 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 manager 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, including safer staffing, in community services.
• Sickness management.

Calderdale & Kirklees BDU:

Key Issues
• Older adult wards remain under pressure with very high acuity and need levels particular end of life care which increases the need for additional staff. The number of delayed transfer of care cases has increased as it was more difficult to identify suitable specialist long term accommodation. We are monitoring this in order to see if the capacity in the community is generally sufficient, before we enter the winter period. Discussions are underway with commissioners.
• On 13th September we reached had a day with no out of area patients.
• A series of improvements, the introduction of 3 advanced practitioners and positive changes to Kirklees memory service has seen the team drastically reduce waiting times for diagnostic appointments from around 12 weeks to just three.

Strengths
• High performance on mandatory training continues.
• Improving access to psychological therapy performance continues to improve now workforce has been stabilised. We had a positive meeting with the NHSE intensive support team on 12th August where we were able to show the very positive over performance in the first 4.5 months of new financial year.
• Delayed transfer of care cases remain well managed in Kirklees with some slippage due to low placement capacity in Calderdale.

Challenges
• Adult occupancy levels remain high in inpatients but has improved in IHBTs and on community caseloads.
• Calderdale psychological therapies remain under pressure with support from the CCG, moving forward to recruit additional therapists.

Areas of focus
• See above

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. Detailed 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. Regular liaison with NHSE to monitor the plan.
• Occupancy for medium secure above 90%.
• Work with the West Yorkshire provider collaborative continues. Integrated care system providing monies to support the work.
• Bid for a forensic community service has been re submitted to NHSE, with improved partner engagement and involvement.
• Forensic outreach service for learning disabilities (FOLs) is offering a consultancy and advisory service across the core week. Recruitment continues and we have successfully appointed to several key posts.
• Work on the recovery plan for Forensic child and adolescent mental health services (secure estate) continues with good progress being made. Results of the health needs analysis have been shared. Plan for service to be placed in specialist services BDU with other childrens services. Quality impact assessment planned.
• Programme of organisational development in place across the BDU looking at culture, well-being, reducing sickness, improving engagement and communication.
• Improving our volunteer opportunities to be a focus.

Strengths
• Strong performance on mandatory training.
• Good track record delivering CQUINs.
• Progress being made on CQC action plans. Only action waiting to be addressed is the call system which is waiting a Trust wide response.
• Service review of psychology service has led to improved performance.
• Excellent service user engagement at service and regional level.

Challenges
• Delivering the recovery plan for the secure estate working towards removal of performance notice.
• Recruitment of registered staff in all disciplines. A significant resource is being utilised to optimise recruitment activity.
• High turnover.
• Reducing sickness.

Areas of Focus
• Forensic child and adolescent mental health service performance notice.
• The BDU will undertake a large piece of work supported by human resource 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.
• Concentrated effort to reach appraisal targets.

Specialist BDU:

Key Issues
• There is likely to be a re-procurement of CAMHS in Barnsley in readiness to have a new service model implemented from 1 April 2020
• Waiting times from referral to treatment in Wakefield and Barnsley CAMHS remain a concern. However, the number waiting in Wakefield has reduced. Further investment has been secured in Wakefield and Barnsley (ADHD specific) to implement waiting list initiatives.
• Vacancy levels in learning disability services are adversely impacting on the ability to complete assessments/care planning within 18 weeks of referral. A Quality Impact Assessment (QIA) is being undertaken with specific regard to vacancy levels.

Strengths
• A non- medical nurse prescriber has now commenced in post in Wakefield community learning disability services. This will support the medical team in the more responsive and targeted management of current caseload.
• Three substantive CAMHS consultants have been recruited and commenced in post.

Areas for focus
• Robust action plans are being developed with regard to CAMHS waiting time. within an improvement programme support/governance framework.
• Development of robust service response to Barnsley CAMHS
• Proactively addressing vacancy levels in learning disability services (specifically consultant posts).

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

Wakefield and acute inpatients trustwide

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. Support for staff wellbeing is a priority.
• Ward 18 continues to experience particular challenges with staffing levels and retention. Action and improvement plans are in place with safer staffing and professions support. Bespoke recruitment has commenced and a new leadership team is in place.
• 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, drawing on the work around criteria lead discharge.

Strengths
• Wakefield has secured a place as a field tester pilot site as part of the national urgent and emergency mental health clinical review of standards programme lead by NHS England.
• Wakefield working age adults wards to begin editions training as part of national study in reducing restrictive practice during Q3.
• Ward 18 has successfully become part of a national programme sexual safety collaborative through the royal college of psychology.
• Management of patient flow and for Wakefield nil out of area acute bed usage, and no inappropriate psychiatric intensive care unit out of area placements.
• Official opening of unity centre to be held 10th October - to be opened by a BBC journalist with lived experience.
• Nostell ward are piloting new reducing restrictive practice idea - coloured lanyards to show staff who are free and available to undertake 1-1 interactions with patients.

Challenges
• Adult acute occupancy and acuity levels remain high.
• Medicines omissions require improvement and are particularly high across Calderdale and Kirklees wards and Melton ward Barnsley, collaborative work with pharmacy is underway and action plan is in place.
• E-discharge performance is inconsistent and an improvement action plan in place lead by the matrons across the wards.
• 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.
• Care programme approach reviews performance is still subject to action planning lead by the quality and governance lead.
• Mandatory training figures have reduced in certain areas – action plans are in place for each team and are being tracked by general managers. These include specific plans relating to fire training and inpatient areas.

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.
• Improvements to staffing levels and support for staff wellbeing on Ward 18.
• Continue to improve performance in service area hotspots through focussed action planning.
• Support for staff wellbeing across the BDU and in particular the wellbeing of staff in the acute service line.

Communications, Engagement and Involvement

• CQC publication comms. Staff briefings, infographic, press release, intranet and web content and social media all produced. Posters produced and distributed across the Trust, including an infographic poster and a quote poster.
• Project plan being developed for the Unity Centre opening in October.
• Wellbeing marketing campaign plan has been developed, focused on staff wellbeing offer on stress, anxiety and mental wellbeing. The plan is for this to be delivered in phases throughout the autumn, with staff engagement starting this week
• Internal anit-bullying and harassment campaign in development.
• Developing 'transfer talk' campaign to promote new internal job transfer market
• Meeting with regional communications colleagues to plan for Brexit
• Entered Sarah Armer (specialist dietitian) into Our Health Heroes awards and she was successfully shortlisted. Now encouraging people to vote for her
• Supported flu campaign, including developing materials and communication plan
• Plans in place to adapt and use the national mental health campaign for mental health awareness day.
• Suicide prevention communications to coincide with international awareness day.
• Continued support to Barnsley BDU regarding integrated care.
• EyUp! comms plan produced – to be shared and discussed at the next operational group. Christmas campaign and merchandising in development.
• Our Year drafted and awaiting sign off and Trust Prospectus developed and printed.
• SystmOne for mental health – comms support for phase 2 – optimisation.
• Creative Minds comms principles drafted – aim to share through the charitable funds committee and then to be actioned
• Developing comms and engagement approach for integrated care in Kirklees, developing a comms and engagement strategy for the group and case studies.
• Meeting of the West Yorkshire and Harrogate mental health and learning disability collaborative took place.
• #Allofusimprove –case studies continue to be developed and rolled out.
• Excellence awards 2019 judged and shortlists publicised. 220+ applications have been received. Two promo films produced and promoted internally and externally. Plans now under way for the evening celebration event.
• The staff app has been downloaded over 350 times and we're looking at the improvements that can be made including some work on our wellbeing offer
• Support for all staff networks, including the BAME and LGBT+ network.
• Stakeholder engagement analysis being carried out, which will then be developed into a stakeholder strategy and action plan.
• Renewal of volunteering accreditation and assessment has been submitted. Visit will take place in December.

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

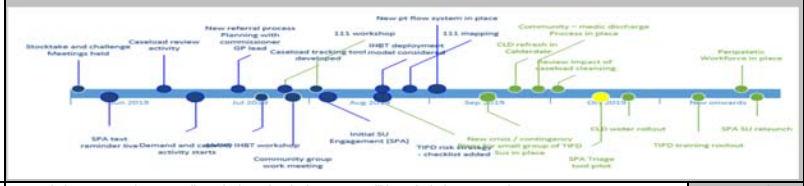
- Wakefield Projects
- Barnsley Projects
- West Yorkshire Projects
- Clinical Record System
- Embed #allofusimprove to enhance quality
- Provide all care as close to home as possible (Out of Area)

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 2019/20. 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	
IMPROVE HEALTH									
Work with our partners to join up care in Wakefield	1. To develop and deliver partnership structures and relationships that underpin integrated working 2. To deliver integrated networks in the neighbourhoods of Wakefield which meet the requirements of primary care home objectives whilst fully engaging the communities 3. To develop population health management so that decisions are underpinned by a sound understanding of what the information tells us 4. To deliver improvement programmes in key areas as identified by the partnership groups. These include: • Elderly and Frailty • Mental Health (via the MH Alliance) • Dementia (via the MH Alliance) 5. SWYPFT to take a lead partnership role in the development and delivery a MH Alliance for Wakefield that oversees • the delivery of new work streams: - Crisis pathway - Personality Disorder - Suicide prevention • the delivery of the 8 projects that make up the Dementia Programme • the delivery of legacy commitments for the following: - Peri-natal mental health investment - Psychiatric Liaison Core 24 - CYP Eating Disorders - IAPT-LTC (in partnership with Turning Point).	Sean Rayner	Sharon Carter	Transformation Board	By 31/03/20• All primary care home neighbourhoods will have: - an established integrated leadership team - co-produced priority areas of focus - population health data pack available to underpin decisions - produced stories that demonstrate impact for the people in their area • Each programme area will have delivered on key improvement aims as set out at the beginning of the year.	Monthly on IPR	The Wakefield partnership has continued to progress the integration agenda through the Integrated Care Partnership (ICP). The ICP has approved a new governance framework for drawing together all the work currently being undertaken in respect of creating and developing sustainable places and communities for Wakefield District. The November ICP meeting will largely focus on further organisational development work. The Mental Health Alliance has worked together to agree the priorities for 2019/20 in line with the mental health investment standard. The detailed proposals to support the priorities (including proposals approved against the WY&H ICS bid for transformation funding for community crisis care) were approved at the ICP Board and the Wakefield CCG Governing Body meetings in July. All the approved priorities are now being mobilised. Following a national recruitment process, the Alliance has appointed to the post of Mental Health Transformation Lead. This post, funded by Wakefield CCG, will be employed by the Trust, and accountable to the Alliance Chair. Wakefield Primary Care Networks - The Trust's director of provider development is the senior responsible officer for this programme (on behalf of the ICP Board). There are seven Primary Care Homes (PCHs), the local version of primary care networks, in Wakefield, which went '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. All seven PCHs have supported and implemented the approach whereby their social prescribing link workers are employed through Live Well Wakefield, via a memorandum of understanding.	Progress Against Plan	
							Risks are managed by each programme of work, led by Transformation Manager, reporting to MH Alliance Board on a monthly basis. Areas of risk to report include: individual schemes in the plan will not be measured effectively in terms of their respective impact. The Alliance is working on an outcomes and benefits framework as part of risk mitigation.	Management of Risk	
							By 31/03/20 Each scheme in the plan will have delivered on key improvement aims as set out at the beginning of the programme.		

Work with our partners to join up care in Barnsley	1. To develop and deliver partnership structures and relationships that underpin integrated working 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 3. To develop population health management so that decisions are underpinned by a sound understanding of what the information tells us 4. To deliver improvement programmes in key areas as identified by the partnership groups. These include: a. Frailty b. CVD c. Stroke 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. To underpin this work with a clear plan for SWYPFT in via the Barnsley and SY internal integration group.	Salma Yasmeen	Sue Barton	Transformation Board	By 31/03/20 All six neighbourhoods will have • an established integrated leadership team • co-produced priority areas of focus • population health data pack available to underpin decisions • produced stories that demonstrate impact for the people in their area • The integrated care outcomes framework will be used by partners to begin to demonstrate impact of the different pieces of work • Each programme area will have delivered on key improvement aims as set out at the beginning of the year	Monthly on IPR	Individual Placement and Support (IPS) - Following a successful procurement process, the Trust as a key partner in this ICS programme will benefit from additional funding to deliver a new service in Barnsley. Mental Health Liaison and Crisis Care - The Trust in partnership with Barnsley CCG, recently submitted two bids to NHS England for additional transformational funding as part of the SYB ICS Bids. One bid (circa £500,000) was to enable the all-age mental health liaison service to achieve 'Core 24' status and the second bid (circa £231,000) was to enable Barnsley to develop a Crisis Assessment Unit, based on the model successfully implemented by TEWV (Tees, Esk and Wear Valleys NHS Foundation Trust). The Crisis Assessment Unit should provide an alternative to ED as a place of safety and reduce usage of the S136 suite at Kendray hospital. Both bids have been successful. The Barnsley Clinical Commissioning Group (CCG) continues to work with partners, including the Trust, to develop joined up integrated care. Partners across Barnsley continue to work together to develop integrated models of care including Primary Care Networks (PCNs), integrated primary and community care as part of the neighbourhood model, and developing an integrated model of care for Stroke and Frailty. Stroke: The aim to secure final agreement to progress implementation of a new Stroke pathway including an Early Supported Discharge model. This is currently on hold pending external review, once this has been undertaken there will be a further senior/exec level meeting. Single specification for neighbourhood teams: As part of the move towards integrated and joined up care in Barnsley, the CCG are planning to issue a single service specification that will cover our general community services and memory services. Engagement events have been held throughout August for staff to learn more about the proposed changes and have their say in how services might look in the future.The mobilisation of an agreed neighbourhood team model is proposed to commence end September 2019, with implementation of new way of working for phase one from April 2020 and phase 2 by March 2021.	Progress Against Plan	
							Risks remain as follows for **Stroke services**: Recruitment and retention Finances/contracting arrangements including financial modelling particularly for early supported discharge pathway Timescale of 1 October to go live – consultation period leading up to this could delay start depending when model is agreed. Without a decision the 1st October start date is under significant risk with impact not just on ESD but also effective patient flow for the hyper-acute stroke units. Transition period to new model being fully running Double running costs during implementation. Single s**pecification for neighbourhood teams** - Identified risks so far: Inadequate resources to deliver core hours beyond current service offers and resource envelope Mobilisation of a 24/7 single point of accrss admin and clinical triage , not currently resourced Out of Hours Merger of SystmOne units will be required as a rapid programme Delivering management of change in a short period of time Estates challenges to move to a hub model in the 6 neighbourhood networks Possibility of memory assessment service being aligned away from core mental health. Impact on staff owing to changes in working arrangements . SWYPFT have collectively provided a response to the service specification and should hear the outcome by mid-September. Staff have been involved in making these comments and we are keeping our staff informed with regular briefing sessions and information updates.	Management of Risk	
							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, ICOF populated and shared, Programme areas have delivered on key improvement aims.		

Working with our partners to join up care in West Yorkshire	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&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: • Forensic services including adult, children and LD projects • LD transforming care partnerships • Children and Adolescent Mental Health services whole system pathway development • Suicide Prevention • Autism and ADHD We aim to underpin this work with a clear plan for SWYPFT via the WY internal integration group.	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.	Monthly on IPR	West Yorkshire Mental Health, Learning Disability and Autism Services Collaborative update: • Transformation funding (Wave 1) for community mental health: a WY&H ICS bid was made by the deadline of 21 June 2019. This comprised two components: Specialist community rehabilitation service (to be tested in Kirklees, Calderdale and Leeds); Young person offer focussing on early intervention for vulnerable people in defined populations (to be tested in Wakefield, Bradford and Leeds). A feedback conference call took place on 31 July 2019 related to the outcome of this bid. A further feedback session with the national team is being arranged, to help inform the learning for further submissions.(update: 12/09/19, NHSE have since agreed to fund a proportion of the bid that we submitted for 2019/20, further details to follow) • Transformation funding for community crisis care a WY&H ICS bid was made by the deadline of 24 June 2019. This bid comprised some elements that were West Yorkshire-wide and most elements were place-based. Confirmation was received on 12 July 2019 that all the WY&H ICS proposals would be funded. The place based proposals in respect of the Trust's services are being mobilised. • NHS England specialised commissioning – The intention is that by 2022/23, there will be 100% Provider Collaborative coverage nationally across all specialised mental health, learning disability and autism services. NHSE invited 'Applications' from the ICS in July 2019 and, if successful, this would result in four year contracts being awarded to the provider collaborative to lead on the delivery of these services. This builds on the new care model pilots that have been running for 12 months. The Trust has been working with our partners in the West Yorkshire Mental Health, Learning Disability and Autism collaborative to develop applications, on behalf of WY&H ICS, for CAMHS tier 4, adult eating disorder and adult secure forensic services. The Trust submitted a Lead Provider collaborative application for forensic adult secure in July 2019. The Trust received confirmation on 16 August 2019 that the application had been considered as a Further Development Track submission i.e. on track to become a Lead Provider from April 2021. Should the work be able to be completed in a shorter timeframe, the Trust will be able to re-submit the Application in the Fast Track or Development Track timeframe (November 2019 or April 2020). The West Yorkshire Forensic Provider Collaborative has begun to take this work forward and has secured £96,000 from the WY&H ICS to fund clinical and project support to undertake the next phase of the work. The Leeds York Partnership Foundation Trust, Lead Provider Application for the West Yorkshire Adult Eating Disorder Provider Collaborative, was considered to be a Fast Track submission i.e. on track to become a Lead Provider from April 2020. The LCH Lead Provider Application for the West Yorkshire CAMHS Provider Collaborative was considered to be a Development Track submission i.e. on track to become a Lead Provider from October 2020. • Specialist Community Forensic Team Pilot Wave 2 Selection The Trust submitted a bid on behalf of the West Yorkshire Forensic Provider Collaborative for Wave 2 selection. Following feedback on the bid, further work has been undertaken with partners to add more detail to the bid, particularly in respect of details on the patient cohort that the service will focus on and how the service will work innovatively with different agencies (for example, housing providers). This revised bid was submitted on 6 September 2019.	Progress Against Plan	
							Risks are managed by each programme of work. Areas of risk to report include: Failure to deliver timely response to bids and proposals due to lack of resource, other work priorities and skills. There is a risk that the timescales are too ambitious and do not allow for sufficient time to engage with all partners. Stakeholder engagement remains a challenge to progression for the majority of the programmes. West Yorkshire Forensic Lead Provider Business Case: whether a NMOC for forensics is achievable owing to financial challenges.	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.		

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	• Progress on implementing new patient flow system, with new sitrep report now in place, 'silver command style' team calls on high pressure days. More ongoing challenge around admissions to be put into the system around alternatives to admissions and joint working with IHBT over the coming months. • There are some existing challenges across the inpatient strand of work, with a drop in the number of discharges in August and an increasing number of current patients that have long stays (over 60 days). Action is being taken to proactively discharge more of the longer stays, if appropriate, and refresh activity around the criteria led discharge process is now scheduled for September (previously scheduled for August). • There is evidence of the community strand now having an impact, with reductions in numbers of people waiting to be stepped down from IHBT to community teams across Calderdale and Kirklees. This should help enable new ways of working in IHBT, in particular establishing more joint out of hours mental health act assessments with AMHPs. • The PD pathway activity continues to make good progress and teams are now establishing collaborative care plans and aiming to implement new ways of working. A pathway launch event is scheduled for 17 Sep and we're aiming to get good attendance from across the professional groups. • In SPA, a learning visit to Avon and Wiltshire has taken place (to learn from a recent similar transformation) and the learning from is being reviewed and factored into the plan. • Dashboards will be published for all strands in early September and work is taking place to ensure that the right level of information is available across all levels of management and governance in the organisation. • SSG further round of challenge is scheduled to happen in September (19th). Whilst the overall numbers of out of area bed days has remained lower than out long term averages (acute placements likely to be in line with July numbers and PICU numbers lower), there are still severe pressures on beds. Barnsley, Calderdale and Kirklees are using more beds than commissioned (30% plus based on July data). Current pressures do suggest that we going to continue to see ongoing variation in the numbers of people out of area until the change programme enables a more sustainable system.	Progress Against Plan	
							Key risks identified on programme risk register are set out below. There are plans in place to mitigate and track activity against these risks and more detail is provided in the highlight report to EMT: •Failure to deliver timely improvement due to lack of resource, other work priorities and skills - this has been flagged to steering group given some slippage - although plans are being rebased and progress is being made across all strands. •Lack of relevant information and poor data quality could lead to poor decision making and / or poor assessment of changes, leading to: - being unable to quantify impact of some changes - changes having a negative impact - changes leading to other unintended consequences (this risk is reducing). •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 #allofusimprove 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 #allofusimprove Champions and Facilitators will be in place across the Trust to support continuous improvement. The #allofusimprove 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	Trust priority conversation 'Spending wisely and reducing waste' will launch during September 2019. 246 staff across the Trust currently completing the IHI Certificate of Quality & Safety. 61 staff completed IHI Certificate and are now Trust Improvement Facilitators 4 members of staff have completed quality, service improvement and redesign (QSIR) practitioner training with advancing change and transformation (ACT) Academy. Trust Board commenced 'Leading for Improvement Board Development Programme' with first session on measurement. SPC measurement for improvement tools used in Care Closer to Home programme. Case studies published on intranet demonstrating impact. Learning Library established to share learning from experience. Knowledge Café on Change and Innovation scheduled for 30th October.	Progress Against Plan	
							no key risks identified	Management of Risk	
							By 1/05/19 I Hub Relaunched. By 31/08/19#allofusimprove toolkit updated and in place. By 31/03/20: 250 people to complete quality improvement training 24improvement case studies developed and shared 4 x QI Silver Training sessions held 20 x Improvement Coaching & Mentoring sessions held.		

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	The high level optimisation plan was signed off by EMT in July 19. Following a period of stabilisation after completion of Phase 1 (implementation and transition from RiO to SystmOne), Phase 2 (SystmOne Optimisation) commenced as a project in August 2019. The project management team has been pulled together with a project governance process, which follows the model of project delivery approved at EMT.The project continues to follow the principles of co-create, co-design and co-deliver. Key activities covered in August: • Change Reference Groups have all met recently and are currently transitioning to SystmOne Improvement Groups. Updates on optimisation have been made through these groups, with local implementation and improvement activities discussed. • An update on optimisation and a call for support in testing the new care plans went out through The Brief and on the intranet. • Codesign event on SystmOne Optimisation was held 9th August for MH, LD and CAMHS services. Other events planned for engagement with General Community services and with Medics to shape the optimisation programme plan. • A plan for implementing the new Care Plans has been developed and volunteers have been recruited from across the organisation and from different clinical backgrounds for final testing prior to roll-out. This includes testing of the training materials for the new care plans. • SystmOne programme workstreams have been reconvened, including the clinical safety design group. • Preliminary engagement and co-design of Event Templates to support improvement in data quality in SPA and IHBT services commenced • Based on user feedback, some configured lists have been made shorter and easier to use while not impacting on data reporting.	Progress Against Plan	
							Optimisation Risk assessment will be undertaken as part of workstream planning, coordinated by workstream leads meeting. Preliminary risks have been identified as: There is a risk insufficient time/resources being made available by external stakeholders, or lack of commitment to the changes from external stakeholders impacting on the success of pilots or on wider roll-out of major optimisation activities such as tasks Insufficient resources to be able to configure the clinical system as required. Insufficient resources to be able to be able to train and support clinicians External pressures such as changes to the Barnsley Community Services specification might place pressure to divert resources. In the event of end-user staff not engaging in optimisation there will be a risk of not capturing all processes/ways of working which will result in configuration of SystmOne having not made any improvement or being unsafe. There is a risk that without sufficient resources, and a consistent approach and guidance that clinicians will continue to record data incorrectly or use their own individual 'work-around' Inadequate number of staff attending the training and demonstrating competency will result in the organisation not getting the best use out of the clinical records system and no improvements identified Due to the volume of optimisation activities required there is a risk that significant optimisation opportunities might be overlooked.	Management of Risk	
							The High Level Optimisation plan signed off by EMT in July 2019 suggested preliminary milestones for the project. Owing to extending the period of stabilisation, sign off of the plan being delayed until July, CQC inspection and project management not commencing until August, the initial phase of engagement and prioritising has been rescheduled. A robust plan for ongoing engagement and involvement throughout further stages of the project is in development, and delivery of the project remains on target as 31st May 2020. Owing to the above, Optimisation programme plan rescheduled and to be in place by end of October 2019 (following sign off by PSG) As agreed by EMT in July, Post implementation Review rescheduled to be completed by October 2020. Secondary changes made by the supplier to the new Care Plan design based on initial feedback delayed roll out of the care plans for testing. Roll out (subject to sign-off by CSDG) has been rescheduled to commence from end of September.		
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		

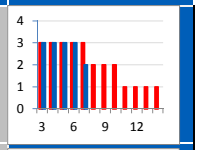
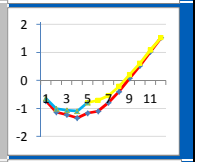
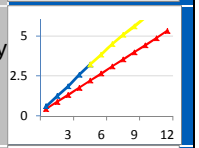
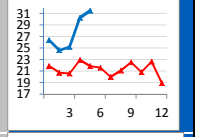
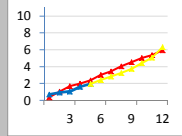
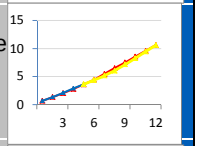
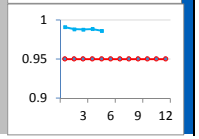
Progress against plan rating	
	On target to deliver within agreed timescales / project tolerances
	ability/confidence to deliver actions within agreed timescales / project tolerances
	ability/capacity to deliver actions within agreed timescales / project tolerances
	Actions will not be delivered within agreed timescales / project tolerances
	Action complete

Risk Rating	Likelihood			
Consequence	1 Rare	2 Unlikely	3 Possible	5 Almost certain
5 Catastrophic	5	10	15	25
4 Major	4	8	12	20
3 Moderate	3	6	9	15
2 Minor	2	4	6	10
1 Negligible	1	2	3	5

Green	1 – 3	Low risk
Yellow	4 – 6	Moderate risk
Amber	8 – 12	High risk
Red	15 – 25	Extreme / SUI risk

Overall Financial Performance 2019/20

Executive Summary / Key Performance Indicators

	Performance Indicator	Year to date	Forecast	Narrative	Trend
1	NHS Improvement Finance Rating	2	2	The NHS Improvement risk rating has improved from 3 to 2 in August 2019. This is due to the improved I & E margin position. The biggest risk to this rating is the agency performance against capped levels.	
2	Normalised Deficit (excl PSF)	(£1.3m)	(£0.2m)	August financial performance is a surplus of £188k excluding Provider Sustainability Fund (PSF). This is the first monthly surplus in 2019/20. This reduces the year to date cumulative deficit to £1.3m. The year end deficit of £0.2m is still considered achievable through continued financial control and increased cost improvements.	
3	Agency Cap	£3.2m	£7.3m	Agency expenditure is higher than plan with £0.6m spent in August, £0.2m above the agency cap set by NHS Improvement. Current year-end projection is to exceed our agency cap by £2m.	
4	Cash	£31.5m	£28.5m	The cash position continues to be healthy and higher than planned. Work will continue to ensure this is maintained for the remainder of the year.	
5	Capital	£2m	£6.4m	Following further national guidance the capital forecast has been revised again to £6.4m. This is £0.6m less than the original base £7.0m plan.	
6	Delivery of CIP	£3.6m	£10.6m	Year to date £3.6m cost reductions have been secured. Any unidentified CIPs will need to be managed within the overall financial position, currently £1.1m is rated as red with a high risk on delivery.	
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%
Amber	Variance from plan ranging from 5% to 15%
Green	In line, or greater than plan

Plan
Actual
Forecast

Contracting - Trust Board

Contracting Issues - General

A South Yorkshire & Bassetlaw partnership bid for individual placement support wave 2 funding has been successful which will see the creation of additional employment workers to support secondary care mental health services in Barnsley.

CQUIN

Q1 CQUIN approved for Barnsley and the specialist commissioner.

Contracting Issues - Barnsley

Work continues in relation to the implementation of the 2019/20 mental health investment plan including 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. Implementation of work related to children's therapies expansion and waiting list reduction is ongoing. Mobilisation continues for implementation of the new Barnsley smoke free service model for commencement 1 November 2019.

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. Work is ongoing to implement Individual Placement Support and to implement additional crisis investment gained through bids to NHSE.

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. Work is ongoing to implement additional crisis investment gained through bids to NHSE.

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 in implementation of the additional mental health investment streams related to increasing capacity within the intensive home based treatment team, expanding capacity for police liaison and providing new capacity to offer dialectic behavioural therapy within community mental health teams.

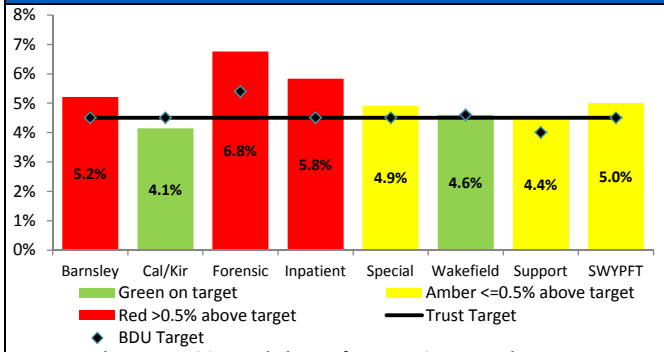
Contracting Issues - Forensics

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. In July 2019, working with our partners in the West Yorkshire & Harrogate ICS the Trust responded to a call for applications from NHSE to be a NHS lead provider collaborative for adult secure care. Following evaluation by NHSE, the application has been placed on the "further development track" to become lead provider from April 2021.

Workforce

Human Resources Performance Dashboard - August 2019

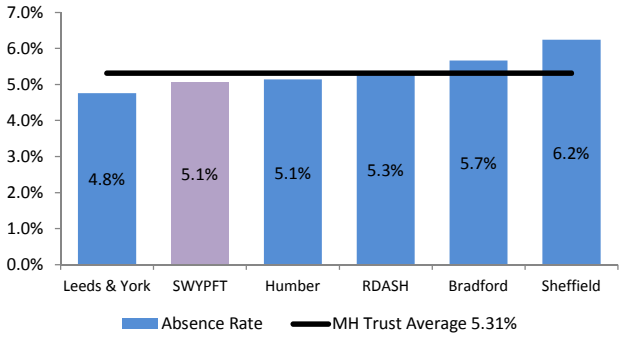
Sickness Absence



Current Absence Position and Change from Previous Month - August 2019

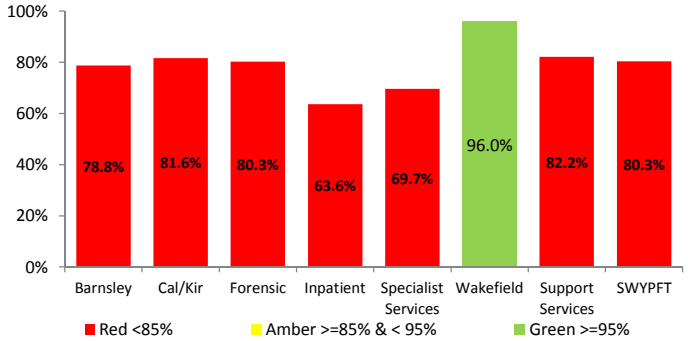
	Barn	Cal/Kir	Fore	Inpat	Spec	Wake	Supp	SWYPFT
Rate	5.2%	4.1%	6.8%	5.8%	4.9%	4.6%	4.4%	5.0%
Change	↓	↑	↓	↑	↑	↑	↑	↑

The Trust YTD absence levels in July 2019 (chart above) were above the target at 5%.
The YTD cost of sickness absence is £2,524,912. If the Trust had met its target this would have been £2,272,421, saving £252,491.



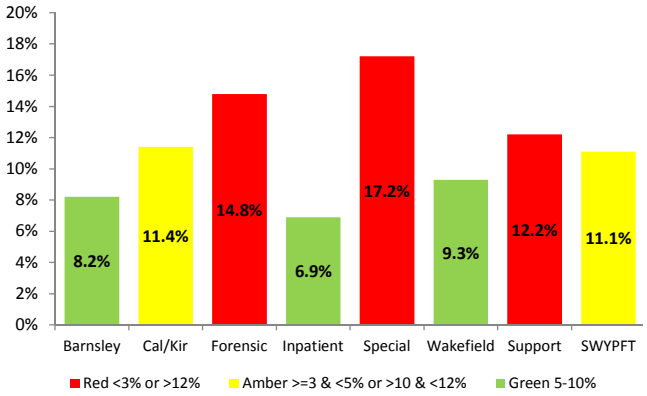
The above chart shows the YTD absence levels in MH/LD Trusts in our region for 2018-19 financial year.
During this time the Trust's absence rate was 5.05% which is below the regional average of 5.31%.

Appraisals Band 6 & Above

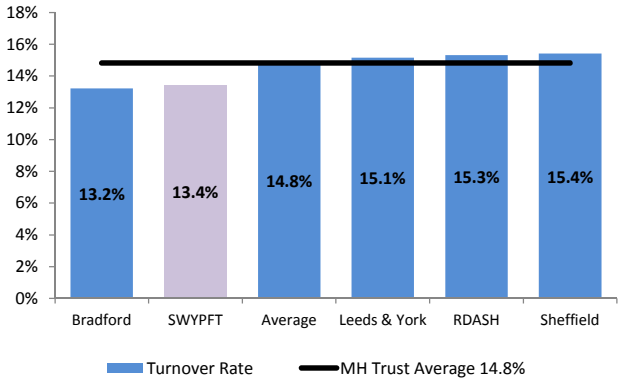


The above chart shows the appraisal rates for the Trust to the end of August 2019.
From June to August, the figures will only include staff on Band 6 and above. From September's report onwards, they will include all staff.
The Trust target for appraisals for staff on Band 6 and above is to reach 95% by the end of June each year.

Turnover and Stability Rate Benchmark

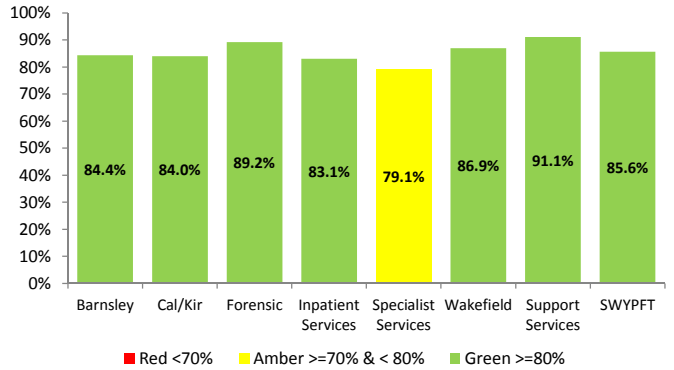


This chart shows the YTD turnover levels up to the end of August 2019.
The turnover data excludes decommissioned services



This chart shows turnover rates in MH Trusts in the region 2018-19.
This is calculated as: leavers/average headcount
These figures include temporary staff who are usually excluded from the Trust's local reports and so these figures are higher than ours.
Decommissioned services are included in this benchmark data.

Fire Training Attendance



The chart shows the 12 month rolling year figure for fire lectures to the end of August 2019. Specialist Services are still slightly below the target but all other areas and the Trust continue to achieve the 80% target.

Workforce - Performance Wall

Trust Performance Wall

Month	Objective	CQC Domain	Owner	Threshold	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Sickness (YTD)	Improving Resources	Well Led	AD	<=4.5%	4.5%	4.6%	4.8%	4.9%	5.0%	5.1%	5.1%	5.0%	4.7%	4.7%	4.9%	5.0%	5.0%
Sickness (Monthly)	Improving Resources	Well Led	AD	<=4.4%	4.8%	5.1%	5.7%	5.8%	5.7%	5.8%	5.1%	4.6%	4.7%	4.7%	5.2%	5.3%	5.0%
Appraisals (Band 6 and above) 1	Improving Resources	Well Led	AD	>=95%	92.8%	95.0%	95.8%	98.1%	98.2%	99.1%	99.1%	99.1%	6.3%	19.8%	66.2%	76.2%	80.3%
Appraisals (Band 5 and below)	Improving Resources	Well Led	AD	>=95%	48.1%	78.6%	87.2%	94.3%	95.0%	96.5%	97.5%	97.5%	0.2%	1.5%	7.8%	26.4%	39.1%
Aggression Management	Improving Care	Well Led	AD	>=80%	83.0%	82.2%	81.3%	81.4%	82.5%	83.1%	82.9%	81.7%	81.6%	82.8%	84.0%	84.3%	84.0%
Cardiopulmonary Resuscitation	Improving Care	Well Led	AD	>=80% by 31/3/17	83.3%	81.6%	80.1%	80.2%	81.2%	82.1%	81.4%	80.7%	80.2%	80.1%	81.3%	81.3%	82.8%
Clinical Risk	Improving Care	Well Led	AD	>=80% by 31/3/17	86.0%	85.8%	85.8%	86.1%	87.4%	87.8%	88.7%	88.4%	87.9%	88.7%	88.3%	86.8%	87.8%
Equality and Diversity	Improving Health	Well Led	AD	>=80%	90.1%	89.8%	90.2%	90.7%	91.3%	90.9%	91.0%	90.3%	89.6%	89.8%	90.3%	91.2%	91.2%
Fire Safety	Improving Care	Well Led	AD	>=80%	87.4%	86.3%	86.8%	86.7%	88.1%	85.2%	84.9%	84.6%	84.6%	84.6%	85.7%	86.1%	85.5%
Food Safety	Improving Care	Well Led	AD	>=80%	81.9%	81.7%	81.9%	84.1%	82.2%	82.3%	83.7%	83.4%	83.6%	83.6%	83.3%	83.8%	83.0%
Infection Control and Hand Hygiene	Improving Care	Well Led	AD	>=80%	88.5%	89.1%	89.3%	89.1%	89.7%	89.5%	90.4%	89.9%	90.5%	90.8%	91.1%	91.7&	91.7&
Information Governance	Improving Care	Well Led	AD	>=95%	92.2%	92.1%	92.3%	90.2%	90.8%	96.1%	97.6%	98.5%	97.2%	94.3%	94.5%	94.5%	94.0%
Moving and Handling	Improving Resources	Well Led	AD	>=80%	86.1%	87.2%	87.3%	88.6%	89.0%	87.8%	88.9%	90.5%	90.4%	91.4%	91.8%	92.0%	91.9%
Mental Capacity Act/DOLS	Improving Care	Well Led	AD	>=80% by 31/3/17	91.7%	90.9%	91.4%	92.6%	92.3%	92.7%	92.5%	91.7%	91.2%	91.7%	91.6%	92.4%	92.7%
Mental Health Act	Improving Care	Well Led	AD	>=80% by 31/3/17	87.3%	85.9%	85.8%	87.7%	86.7%	86.7%	86.4%	84.5%	84.2%	85.2%	86.8%	88.2%	88.6%
No of staff receiving supervision within policy guidance	Quality & Experience	Well Led	AD	>=80%	83.8%		82.6%			86.7%			69.9%			Due Oct 19	
Prevent	Improving Care	Well Led	AD	>=80%												80.8%	81.5%
Safeguarding Adults	Improving Care	Well Led	AD	>=80%	91.7%	91.5%	92.1%	93.0%	93.7%	93.2%	93.4%	92.9%	92.4%	92.5%	93.2%	93.5%	93.8%
Safeguarding Children	Improving Care	Well Led	AD	>=80%	90.4%	90.0%	90.4%	89.4%	91.4%	91.3%	90.9%	91.1%	89.6%	91.0%	91.7%	92.2%	92.3%
Sainsbury's clinical risk assessment tool	Improving Care	Well Led	AD	>=80%	95.2%	94.6%	94.6%	94.1%	94.5%	93.9%	94.5%	94.9%	94.0%	94.8%	95.1%	95.2%	95.9%
Bank Cost	Improving Resources	Well Led	AD	-	£730k	£845k	£615k	£674k	£678k	£752k	£1048k	£772k	£625k	£844k	£695k	£708k	£889k
Agency Cost	Improving Resources	Effective	AD	-	£566k	£522k	£537k	£536k	£530k	£596k	£545k	£634k	£613k	£641k	£619k	£772k	£629k
Sickness Cost (Monthly)	Improving Resources	Effective	AD	-	£471k	£507k	£586k	£571k	£572k	£602k	£476k	£482k	£479k	£494k	£521k	£541k	£507k
Business Miles	Improving Resources	Effective	AD	-	269k	279k	267k	299k	279k	286k	270k	289k	274k	240k	293k	281k	245k
Health & Safety																	
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	Improving Resources	Effective	AD	-	Reporting commenced 19/20								7			Due Oct 19	

1 - this does not include data for medical staffing.

Workforce - Performance Wall cont…

Mandatory Training
• The Trust is above 80% compliance for all 14 mandatory training programmes with 7 being above 90%. Information Governance training has a target of 95% and is currently slightly below this.

Appraisals
• Appraisal completion rate for band 6 and above has increased to 80.3% however performance to end of August is below expected levels and is below the level achieved for the same time last year. There is a time lag in terms of recording appraisals so an increase is expected by the end of September.

Sickness Absence
• Sickness absence at the end of August is 5% which is higher than the same period last year (4.5%). Compared to prior year forensic and inpatient BDUs have lower absence, whilst Barnsley is 1.49% higher.

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.
• August staff turnover was 11.1% which is a decrease compared to previous month, with particular hotspots in Forensic, Specialist and Support services BDUs.
• The year to date turnover rate for registered nursing staff is 10.6%

Health & Safety
• Q2 data for RIDDOR incidents due to be reported in October.

Publication Summary

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

NHS England and NHS Improvement

NHS oversight framework 2019/20

This guidance outlines the joint approach NHS England and NHS Improvement will take to oversee organisational performance and identify where commissioners and providers may need support. It replaces the provider Single Oversight Framework and the clinical commissioning group CCG Improvement and Assessment Framework (IAF) and will inform the assessment of providers in 2019/20. It is intended as a focal point for joint work, support and dialogue between NHS England and NHS Improvement, CCGs, providers and sustainability and transformation partnerships, and integrated care systems.

Cllick 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: 28 August 2019:
• NHS Oversight Framework for 2019/20
• WebEx: Equality, diversity and inclusion workforce planning
• Health and Care Innovation Expo 2019
• Audit and finance forum

NHS Improvement provider bulletin: 4 September 2019:
• £210 million funding boost for frontline NHS staff announced
• Identifying overseas visitors — guidance on using the message exchange for social care and health
• Enabling staff movement between NHS organisations
• Improving outcomes for people with eating disorders
• Nominate your organisation for a national retention award
• Develop your senior leadership skills with the Aspiring Chief Executive programme
• Listen to the first NHS Assembly podcast

NHS Improvement provider bulletin: 11 September 2019:
• Revised friends and family test guidance
• Unsung Hero Awards — just a few weeks left to nominate your colleagues
• Temporary Staffing Conference 2019
• The importance of evaluation in NHS engagement and communications
• National demand and capacity summit

Provisional monthly Hospital Episode Statistics for admitted patient care, outpatient and accident and emergency data: April 2019 - July 2019

Out of area placements in mental health services: June 2019

Psychological therapies: reports on the use of IAPT services, England June 2019 final including reports on the IAPT pilots and Q1 2019-20 data

Mental health services monthly statistics: final June, provisional July 2019

Delayed transfers of care: July 2019

Diagnostics waiting times and activity: July 2019

Mixed sex accommodation breaches: July 2019

Quarterly hospital activity data: Q1 2019/20

South West Yorkshire Partnership NHS Foundation Trust

Finance Report

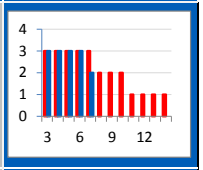
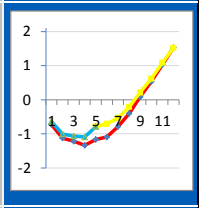
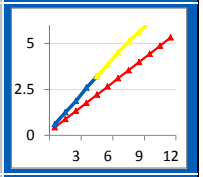
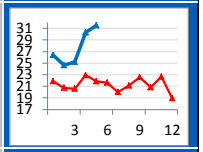
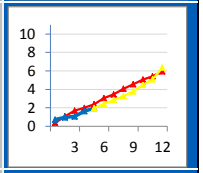
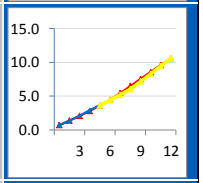
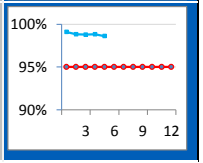
Month 5
(2019 / 20)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

Contents

1.0 Executive Summary / Key Performance Indicators

Performance Indicator		Year To Date	Forecast	Narrative	Trend
1	NHS Improvement Finance Rating	2	2	The NHS Improvement risk rating has improved from 3 to 2 in August 2019. This is due to the improved I & E margin position. The biggest risk to this rating is the agency performance against capped levels.	
2	Normalised Deficit (excl PSF)	(£1.3m)	(£0.2m)	August financial performance is a surplus of £188k excluding Provider Sustainability Fund (PSF). This is the first monthly surplus in 2019/20. This reduces the year to date cumulative deficit to £1.3m. The year end deficit of £0.2m is still considered achievable through continued financial control and increased cost improvements.	
3	Agency Cap	£3.2m	£7.3m	Agency expenditure is higher than plan with £0.6m spent in August, £0.2m above the agency cap set by NHS Improvement. Current year-end projection is to exceed our agency cap by £2m.	
4	Cash	£31.5m	£28.5m	The cash position continues to be healthy and higher than planned. Work will continue to ensure this is maintained for the remainder of the year.	
5	Capital	£2m	£6.4m	Following further national guidance the capital forecast has been revised again to £6.4m. This is £0.6m less than the original base £7.0m plan.	
6	Delivery of CIP	£3.6m	£10.6m	Year to date £3.6m cost reductions have been secured. Any unidentified CIPs will need to be managed within the overall financial position, currently £1.1m is rated as red with a high risk on delivery.	
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%, exceptional downward trend requiring immediate action, outside Trust objective levels	Plan
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels	Actual
Green	In line, or greater than plan	Forecast

1.1 NHS Improvement Finance Rating

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

			Actual Performance		Plan - Month 5	
Area	Weight	Metric	Score	Risk Rating	Score	Risk Rating
Financial Sustainability	20%	Capital Service Capacity	2.3	2	1.9	3
	20%	Liquidity (Days)	23.4	1	17.6	1
Financial Efficiency	20%	I & E Margin	-0.8%	3	-1.2%	4
Financial Controls	20%	Distance from Financial Plan	0.4%	1	0.0%	1
	20%	Agency Spend	46%	3	18%	2
Weighted Average - Financial Sustainability Risk Rating				2		3

Impact

Given the surplus in month 5 the I & E margin rating has improved from 4 to 3. This means that we no longer have any individual rating at 4 which would have capped the overall score. Therefore the overall rating has improved to 2. It is forecast to maintain this level for the remainder of the year.

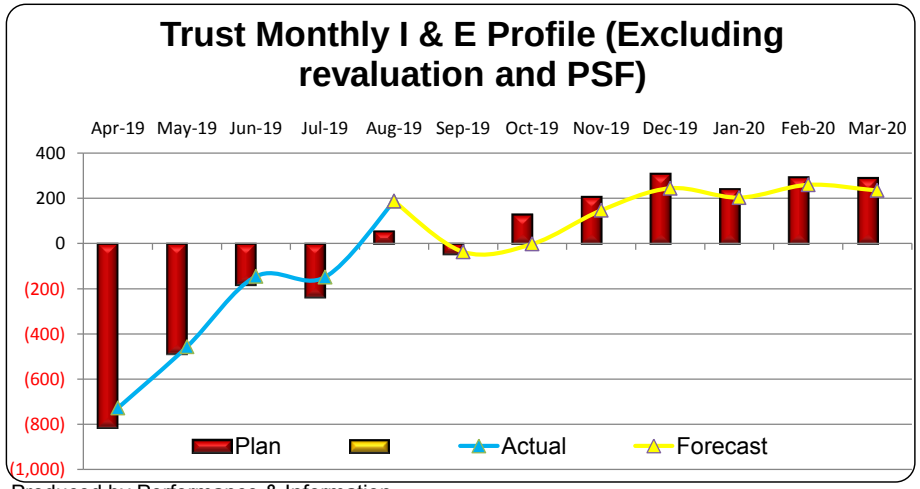
The agency rating is the only metric which is lower than planned.

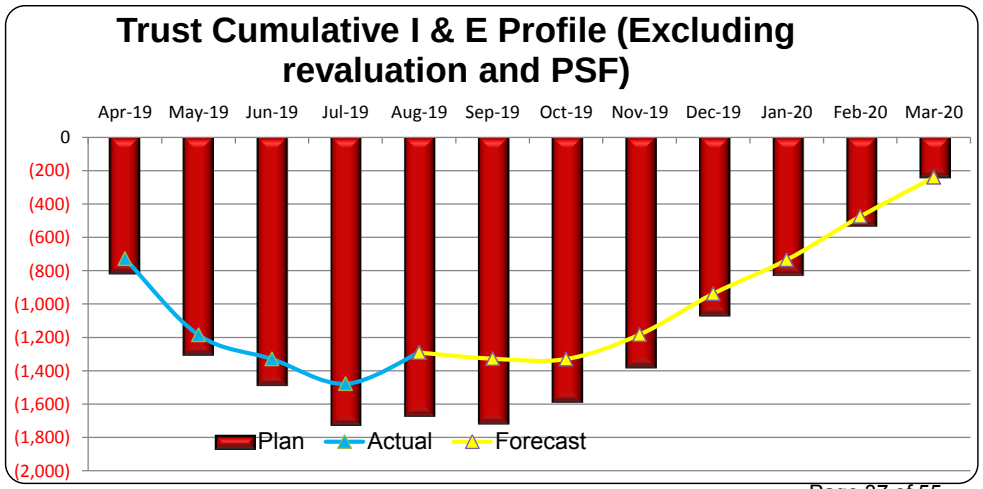
Definitions

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.

2.0 Income & Expenditure Position 2019 / 2020

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**
				17,845	17,765	(80)	Clinical Revenue	88,366	87,795	(571)	212,686	212,384	(302)
				17,845	**17,765**	**(80)**	**Total Clinical Revenue**	**88,366**	**87,795**	**(571)**	**212,686**	**212,384**	**(302)**
				1,307	1,252	(55)	Other Operating Revenue	5,812	5,982	170	13,541	13,899	358
				19,152	**19,017**	**(135)**	**Total Revenue**	**94,178**	**93,777**	**(401)**	**226,227**	**226,282**	**56**
4,221	4,057	(164)	3.9%	(15,508)	(14,522)	986	Pay Costs	(74,674)	(72,507)	2,167	(179,341)	(175,872)	3,470
				(3,572)	(3,295)	277	Non Pay Costs	(17,548)	(16,695)	853	(42,860)	(42,851)	8
				644	(340)	(984)	Provisions	(319)	(2,495)	(2,176)	3,662	370	(3,292)
				0	0	0	Gain / (loss) on disposal	0	0	0	0	0	0
4,221	**4,057**	**(164)**	**3.9%**	**(18,437)**	**(18,157)**	**280**	**Total Operating Expenses**	**(92,541)**	**(91,697)**	**844**	**(218,539)**	**(218,353)**	**186**
4,221	**4,057**	**(164)**	**3.9%**	**716**	**861**	**145**	**EBITDA**	**1,637**	**2,080**	**443**	**7,688**	**7,929**	**241**
				(442)	(467)	(25)	Depreciation	(2,209)	(2,322)	(113)	(5,302)	(5,586)	(284)
				(227)	(227)	0	PDC Paid	(1,136)	(1,136)	0	(2,726)	(2,726)	0
				8	21	12	Interest Received	42	87	45	100	143	43
4,221	**4,057**	**(164)**	**3.9%**	**55**	**188**	**133**	**Normalised Surplus / (Deficit) Excl PSF**	**(1,666)**	**(1,291)**	**375**	**(240)**	**(240)**	**0**
				118	118	0	PSF (Provider Sustainability Fund)	501	501	0	1,765	1,765	0
4,221	**4,057**	**(164)**	**3.9%**	**173**	**306**	**133**	**Normalised Surplus / (Deficit) Incl PSF**	**(1,165)**	**(790)**	**375**	**1,525**	**1,525**	**0**
				0	0	0	Revaluation of Assets	0	0	0	0	0	0
4,221	**4,057**	**(164)**	**3.9%**	**173**	**306**	**133**	**Surplus / (Deficit)**	**(1,165)**	**(790)**	**375**	**1,525**	**1,525**	**0**





Income & Expenditure Position 2019 / 20

Reduced out of area placement costs and continued expenditure control have facilitated a surplus run rate in August 2019. Actions continue to maintain this.

Month 5

The August position is a pre PSF surplus of £188k and a post PSF surplus of £306k, this is £133k ahead of plan. The key headlines are below. This is the first month in 2019/20 where a surplus has been reported and is largely due to continued reductions in out of area placement costs and expenditure control.
Both pay and non pay categories have continued to underspend, however this has been offset by income being lower than plan and some income risks being recognised.

Income

The year to date clinical revenue position recognises risk around CQUIN delivery and other known risks. Additional income risks are recognised within the provisions position.

Pay Expenditure

Pay shows an underspend of £986k. The scale of variance is very much impacted by an increased in budget to recognise changes in inpatient safer staffing. The underlying variance is actually a £450k underspend. 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.

Additional information is also highlighted within the report on agency spend. The NHSI maximum agency cap for 2019/20 has been set at £5.3m. In August agency costs are £629k. This is £186k (46%) higher than cap.

Non Pay Expenditure

Non pay is underspent by £277k in August and cumulatively is £1.3m less than the same period last year. The report highlights expenditure on out of area placements which, whilst still a major area of focus, is £1m lower than last year. More details are included within the out of area focus page.

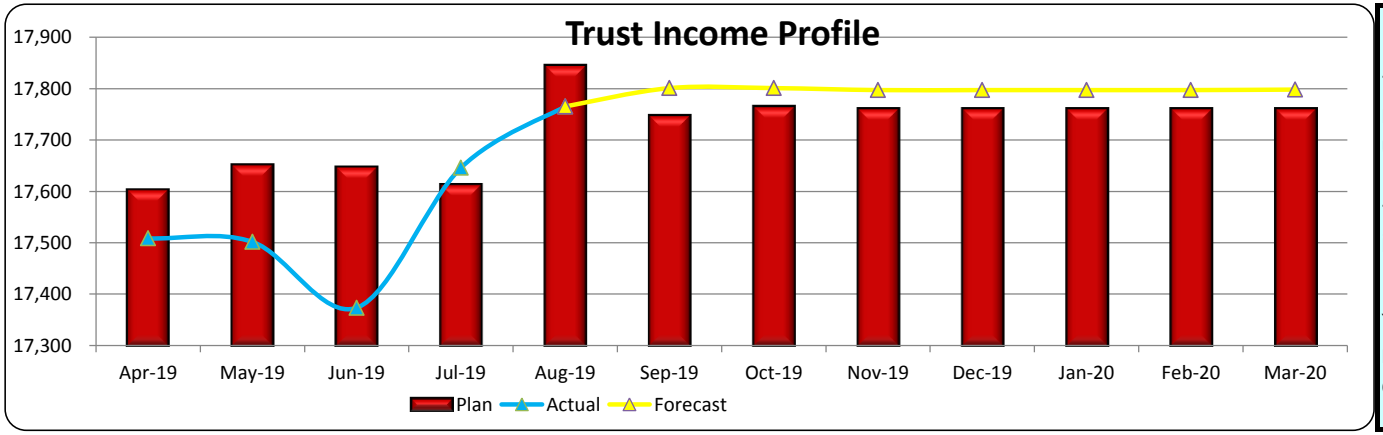
Forecast

The Trust is still forecasting to achieve its year-end control total of £240k deficit. Given a number of unidentified CIPs and other risks, particularly on income achievement, this is not assured at this point in time.

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 £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	Total 18/19 £k
CCG	12,398	12,398	12,242	12,429	12,367	12,532	12,532	12,532	12,532	12,532	12,532	12,532	**149,557**	**146,036**
Specialist Commissioner	2,025	2,025	2,025	2,025	2,025	2,025	2,025	2,025	2,025	2,025	2,025	2,025	**24,297**	**23,356**
Alliance	1,295	1,295	1,295	1,295	1,295	1,295	1,295	1,295	1,295	1,295	1,295	1,295	**15,540**	**14,596**
Local Authority	441	441	460	446	446	446	446	442	442	442	442	442	**5,334**	**5,074**
Partnerships	614	614	670	631	633	656	656	656	656	656	656	656	**7,751**	**7,172**
Other	737	730	681	821	1,001	848	848	848	848	848	848	849	**9,905**	**6,708**
Total	**17,509**	**17,502**	**17,373**	**17,646**	**17,765**	**17,801**	**17,801**	**17,797**	**17,797**	**17,797**	**17,797**	**17,798**	**212,384**	**202,942**
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	**202,942**	



Income plan, and actual, have increased in August due to :
* Additional activity and recharges for use of Trust beds by non local commissioners. This includes additional bed utilisation for the Barnsley neuro rehab beds.

* Additional income planned relating to mental health investment within Barnsley.

Year to date a CQUIN delivery risk of £125k has been recognised across all commissioners. The forecast continues to assume that this will be achieved in full.

2.1 Pay Information

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

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.

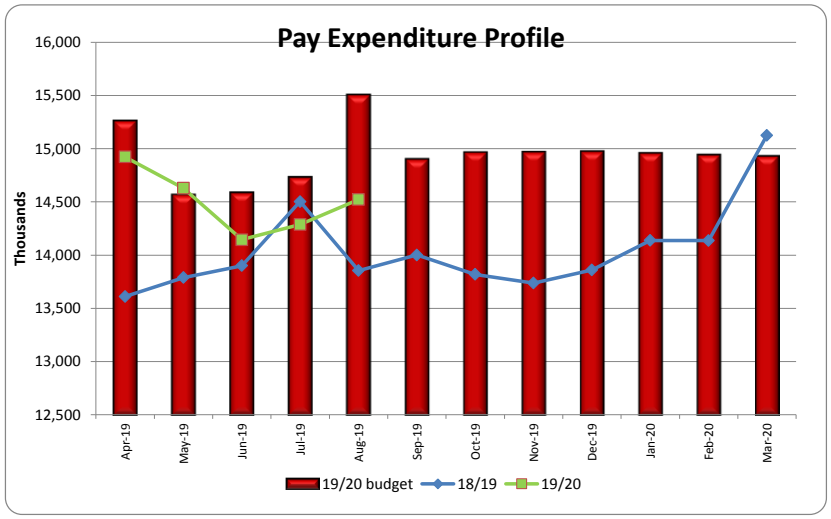
	Apr-19 £k	May-19 £k	Jun-19 £k	Jul-19 £k	Aug-19 £k	Sep-19 £k	Oct-19 £k	Nov-19 £k	Dec-19 £k	Jan-20 £k	Feb-20 £k	Mar-20 £k	Total £k
Substantive	13,647	13,082	12,768	12,819	12,959								**65,276**
Bank & Locum	663	906	752	747	934								**4,003**
Agency	613	641	624	722	628								**3,228**
Total	**14,923**	**14,629**	**14,145**	**14,288**	**14,522**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**72,507**
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	**168,476**
Bank as %	4.4%	6.2%	5.3%	5.2%	6.4%								5.5%
Agency as %	4.1%	4.4%	4.4%	5.0%	4.3%								4.5%

Year to Date Budget v Actuals - by staff group

	Budget £k	Substantive £k	Bank £k	Agency £k	Total £k	Variance £k
Medical	9,814	7,642	228	1,729	9,599	216
Nursing Registered	27,157	22,223	1,402	229	23,854	3,303
Nursing Unregistered	7,992	7,201	1,902	731	9,834	(1,842)
Other	18,187	17,653	183	519	18,355	(168)
Corporate Admin	4,945	4,651	85	8	4,744	201
BDU Admin	6,579	5,905	203	13	6,121	458
Total	**74,674**	**65,276**	**4,003**	**3,228**	**72,507**	**2,167**

Year to date Budget v Actuals - by service

	Budget £k	Substantive £k	Bank £k	Agency £k	Total £k	Variance £k
MH Community	32,402	27,589	726	2,054	30,369	2,033
Inpatient	19,151	15,564	2,857	1,049	19,471	(320)
BDU Support	3,059	2,950	88	10	3,048	11
Community	8,968	8,605	136	66	8,807	160
Corporate	11,095	10,567	195	50	10,812	283
Total	**74,674**	**65,276**	**4,003**	**3,228**	**72,507**	**2,167**



Key Messages

Overall pay expenditure is higher in 2019/20 than previous years. This is largely a result of the national pay awards and pay increments under Agenda For Change. In addition the Trust has also been successful in securing new services such as Liaison and Diversion (from April 2019) with further investment forecast throughout the course of the year (IAPT, additional bids).

In August pay underspent by £986k however this is impacted by the increased budget allocated against adult acute inpatient safer staffing. This was backdated to April 2019. Without this the underlying positon would have been c. £450k underspent. Year to date the underspend is £2.2m. Temporary staffing provided by both agency and bank staff totals £7.2m to date (10% 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 strategy for inpatient, particularly adult acute, has been agreed by EMT which enables substantive recruitment to be undertaken. This plan replaces existing temportary staff with permenant employees and resets the rota's being utilised.

2.1 Agency Expenditure Focus

The NHS Improvement agency cap is £5.3m

Spend, for the year to date, is £1.0m more than cap.

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

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

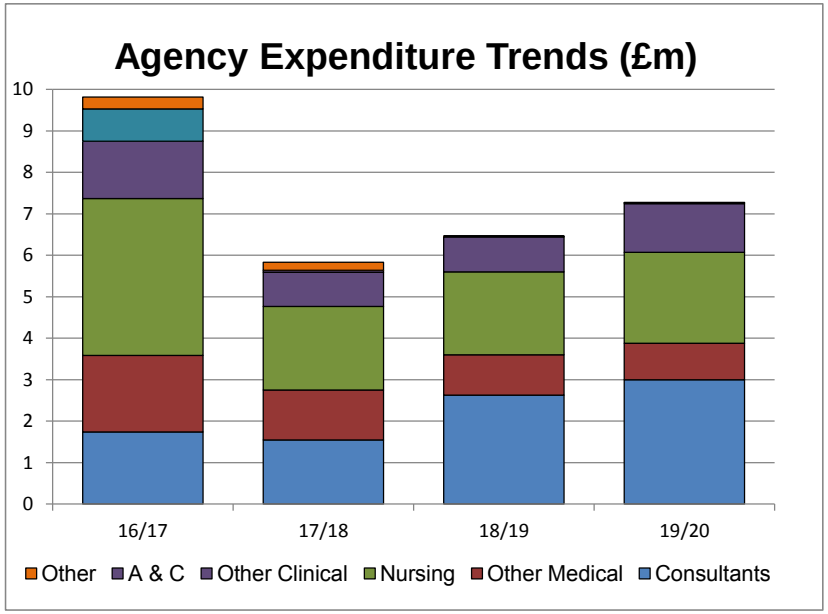
The maximum agency cap established by NHSI for 2019/20 is £5.3m which is £0.1m higher than the 2018/19 cap. In 2018/19 spend was £6.5m which breached the cap by £1.3m (24%). The NHSI agency cap has been profiled equally across the year with a maximum spend of £443k a month. The Trust plan assumed spend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

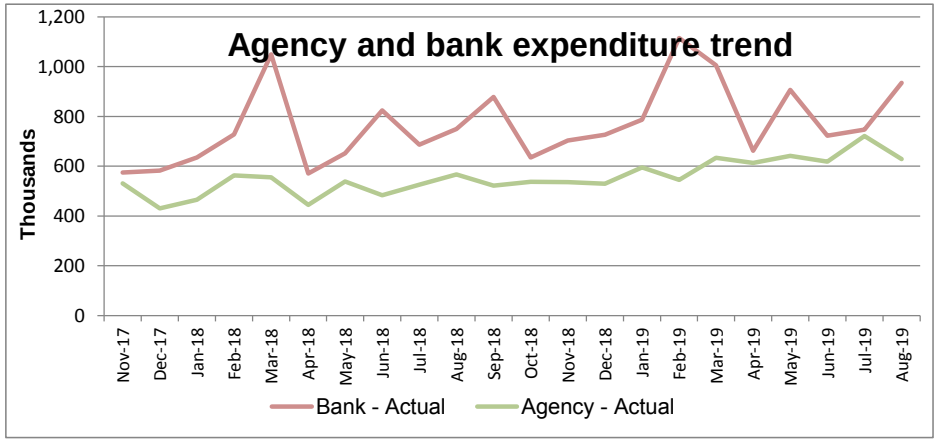
Actual agency usage continues to be reported to NHS Improvement on a weekly basis.

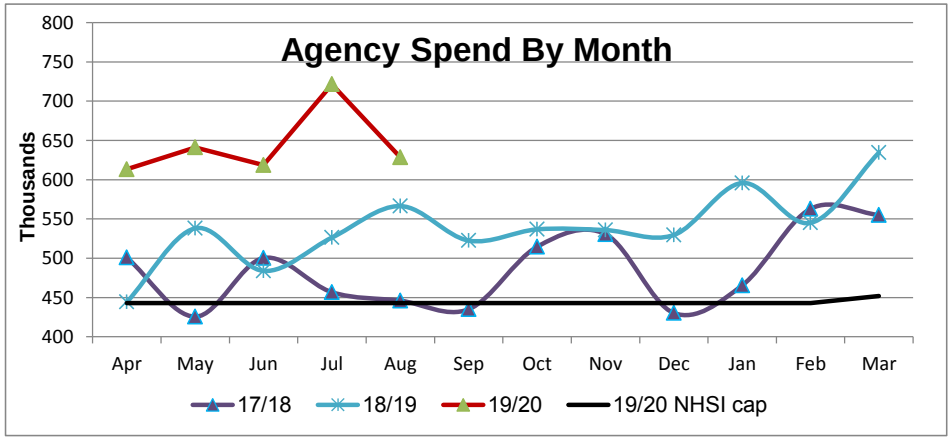
Month 5 agency spend is £629k, 42% above cap. This continues to be a higher rate than incurred in 2018/19. The Trust agency action group continues to progress actions to reduce this level of spend. Cumulatively agency spend is £3.2m which is 46% above cap and 26% higher than the same period last year.

The current forecast, based upon plans in place, is £7.3m. The impact of the Trust direct engagement process is yet to be finalised and factored into this position. Due to the timing in year savings are likely to be less than £100k.

Bank expenditure has continued to increase in cost, despite the removal of enhancement payments for unregistered staff from April 2019, with spend of £889k in month.





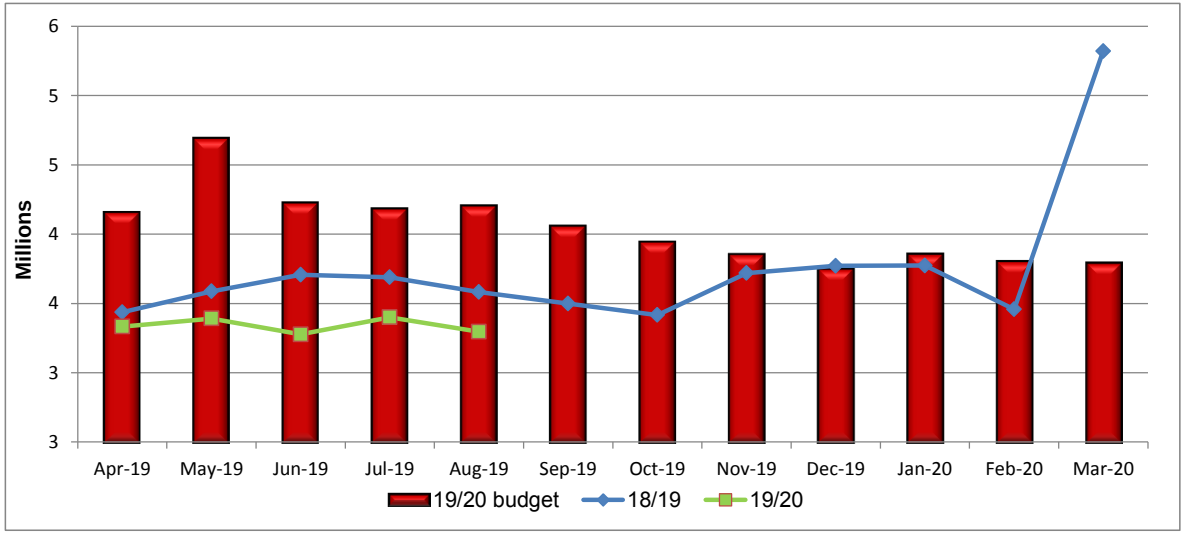


2.1 Non Pay Expenditure

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
2019/20	3,333	3,391	3,276	3,400	3,295								**16,695**
2018/19	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**

	Budget Year to date	Actual Year to date	Variance
Non Pay Category	**£k**	**£k**	**£k**
Clinical Supplies	1,145	1,146	(1)
Drugs	1,512	1,423	88
Healthcare subcontracting	2,200	2,011	189
Hotel Services	765	652	113
Office Supplies	1,916	1,871	45
Other Costs	2,096	1,789	306
Property Costs	2,720	2,849	(129)
Service Level Agreements	2,584	2,553	32
Training & Education	162	191	(30)
Travel & Subsistence	1,456	1,176	280
Utilities	441	517	(77)
Vehicle Costs	553	516	36
Total	**17,548**	**16,695**	**853**
Total Excl OOA and Drugs	**13,837**	**13,261**	**576**



Key Messages

Budgets and plans were reset during the 2019/20 annual planning round. The plan included resetting those categories which have historically overspent such as healthcare subcontracting (use of out of area placements) and drugs. Overall most categories are underspent against these reset budgets with the exception of Estates related lines (property costs, utilities). These have been subject to a detailed deep dive review and reported back to the Trust non pay expenditure group.

As illustrated by the graph, year to date non pay expenditure is £1.3m lower than in the previous year. Of this £1.0m is due to lower out of area placement costs.

The largest single underspend is within other costs (£306k). This encompasses a range of varied spend areas not covered by the other headings. The second largest is in the travel and subsistence costs category which is currently £280k under plan. These are being reviewed for areas of recurrent CIP saving.

The non pay review group continues to focus on areas of wastage and ineffeciency to ensure that all non pay expenditure offers 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 (£)

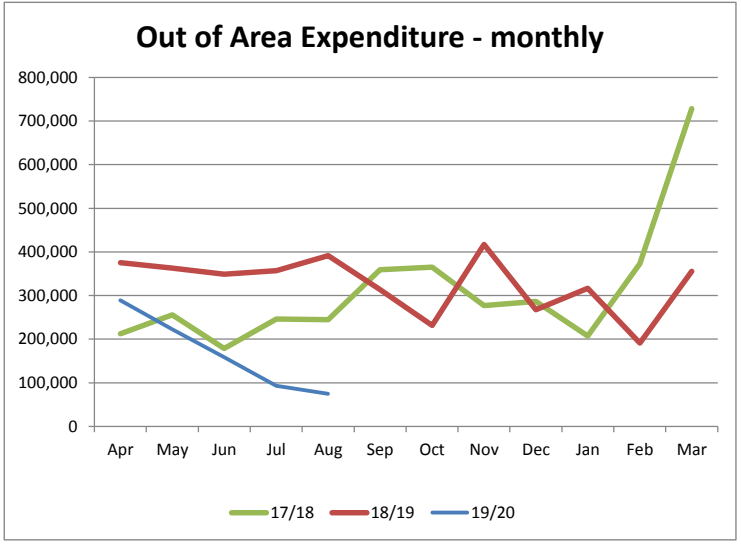
	Apr £000	May £000	Jun £000	Jul £000	Aug £000	Sep £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	Mar £000	Total £000
17/18	212	255	178	246	245	359	365	277	286	208	373	729	**3,733**
18/19	376	363	349	357	392	314	232	417	268	317	191	355	**3,929**
19/20	289	222	158	93	75								**837**

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	354	238	206	156								**1,236**

Bed Day Information 2019 / 2020 (by category)

PICU	32	26	30	26	0								**114**
Acute	160	277	178	150	141								**906**
Appropriate	90	51	30	30	15								**216**
Total	282	354	238	206	156	0	0	0	0	0	0	0	**1,236**



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 2019 reducing to 5 placements by March 2020.

Demand for placements has reduced again in August 2019 with PICU placements at zero in month. Overall the number of placements required has reduced compared to the same period last year, a year to date reduction of 1,338 days (52%).

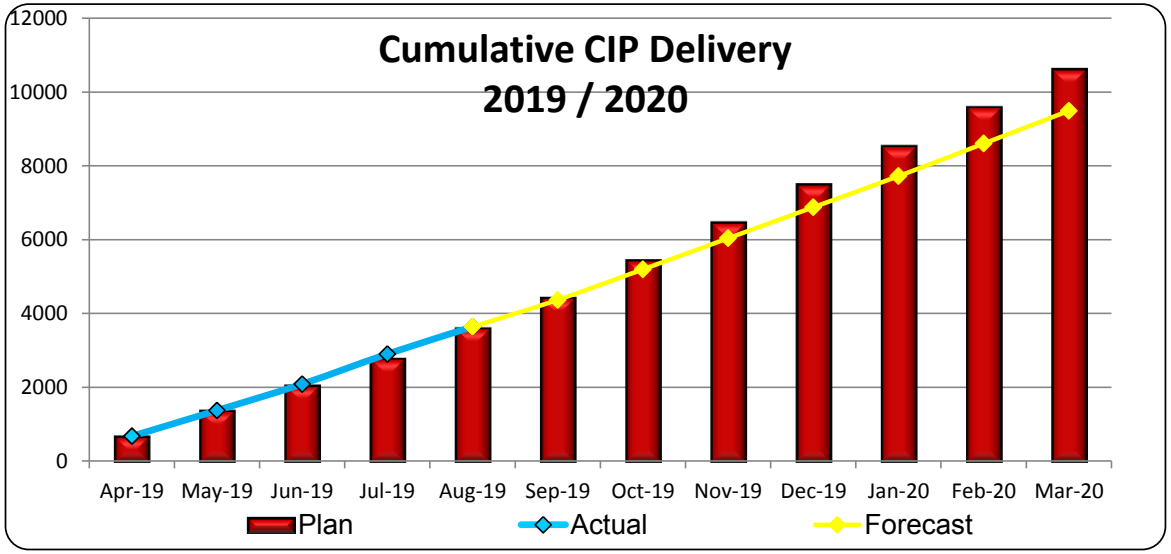
Expenditure has reduced from £1,836k to £837k for the April to August period. This is a combination of reduced usage and reduced costs for specialist nursing and transport.

These are early indications that the planned changes to reduce the number of hospital admissions and provide care as close to home as possible are having a positive impact. Work streams continue to ensure that this level of activity is maintained, or reduced further, and to assess the impact each work stream is having.

There continues to be huge focus on this issue acdross the Trust and the results achieved have been through significant effort by a large number of staff.

2.1 Cost Improvement Programme 2019 / 2020

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
TOTAL - CUMULATIVE	£	£	£	£	£	£	£	£	£	£	£	£	£
Target	688	1,376	2,066	2,790	3,615	4,439	5,455	6,481	7,507	8,542	9,596	10,624	3,615
Achieved - plan	669	1,353	2,018	2,788	3,487	4,186	4,912	5,655	6,399	7,142	7,928	8,716	3,487
Achieved - mitigation	4	19	69	113	151	181	283	381	480	578	676	774	151
Mitigations - Upside schemes									283	566	849	1,134	0
Shortfall / Unidentified	**15**	**4**	**(21)**	**(111)**	**(23)**	**72**	**260**	**444**	**345**	**257**	**143**	**0**	**(23)**



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. We are £23k ahead of the planned profile at month 5; with non recurrent mitigations offsetting shortfalls in recurrent schemes. The majority (97%) has been delivered as planned. These mitigations have reduced the unidentified value to £1.1m (£1.6m last month).

Actions plans, linked to the Trust financial sustainability agenda, continue to be developed with savings planned from drugs cost reductions, non pay savings and the implementation of a consolidated temporary staffing solution.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
RECURRENT - CUMULATIVE	£	£	£	£	£	£	£	£	£	£	£	£	£
Target	418	838	1,258	1,720	2,282	2,844	3,598	4,352	5,106	5,870	6,632	7,368	2,282
Achieved - plan	378	772	1,186	1,693	2,127	2,561	3,024	3,494	3,965	4,441	4,939	5,440	2,127
Achieved - mitigation	3	17	66	86	109	130	152	174	195	217	239	260	109
Shortfall / Unidentified	**38**	**50**	**7**	**(59)**	**47**	**153**	**423**	**684**	**946**	**1,212**	**1,454**	**1,668**	**47**

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
NON RECURRENT - CUMULATIVE	£	£	£	£	£	£	£	£	£	£	£	£	£
Target	269	538	808	1,070	1,332	1,595	1,857	2,129	2,400	2,672	2,964	3,256	1,332
Achieved - plan	291	582	832	1,095	1,360	1,625	1,888	2,161	2,434	2,701	2,989	3,276	1,360
Achieved - mitigation	1	2	3	27	42	51	131	208	284	361	437	514	42
Shortfall / Unidentified	**(23)**	**(46)**	**(28)**	**(52)**	**(70)**	**(81)**	**(162)**	**(240)**	**(317)**	**(390)**	**(462)**	**(534)**	**(70)**

3.0 Balance Sheet 2019 / 2020

	2018 / 2019 £k	Plan (YTD) £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	100,005	100,236	99,647	1
Current Assets				
Inventories & Work in Progress	259	232	259	
NHS Trade Receivables (Debtors)	3,019	4,294	2,258	2
Non NHS Trade Receivables (Debtors)	1,007	493	934	3
Prepayments, Bad Debt, VAT	1,559	2,864	2,492	
Accrued Income	5,138	3,106	2,744	4
Cash and Cash Equivalents	27,823	21,884	31,514	5
Total Current Assets	**38,806**	**32,873**	**40,200**	
Current Liabilities				
Trade Payables (Creditors)	(4,663)	(3,153)	(3,313)	6
Capital Payables (Creditors)	(1,070)	(459)	(417)	
Tax, NI, Pension Payables, PDC	(6,002)	(7,136)	(6,516)	
Accruals	(8,020)	(7,896)	(11,132)	7
Deferred Income	(276)	(372)	(630)	
Total Current Liabilities	**(20,031)**	**(19,016)**	**(22,007)**	
Net Current Assets/Liabilities	**18,775**	**13,857**	**18,192**	
Total Assets less Current Liabilities	**118,780**	**114,093**	**117,839**	
Provisions for Liabilities	(7,221)	(6,232)	(7,069)	
Total Net Assets/(Liabilities)	**111,560**	**107,861**	**110,770**	
Taxpayers' Equity				
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	48,575	51,876	8
Total Taxpayers' Equity	**111,560**	**107,861**	**110,770**	

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. This has been revised to £6.35m in line with national requests.

2. NHS trade debtors have reduced in month and are now lower than plan. The age profile of debts continue to be monitored and any issues are appropriately escalated.

3. Non NHS debtors are higher than plan, all debts over 30 days are actively chased to identify issues early.

4. Accrued income remains lower than plan, all accrued income is reviewed monthly to ensure that all invoices are raised in a timely and appropriate manner.

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

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

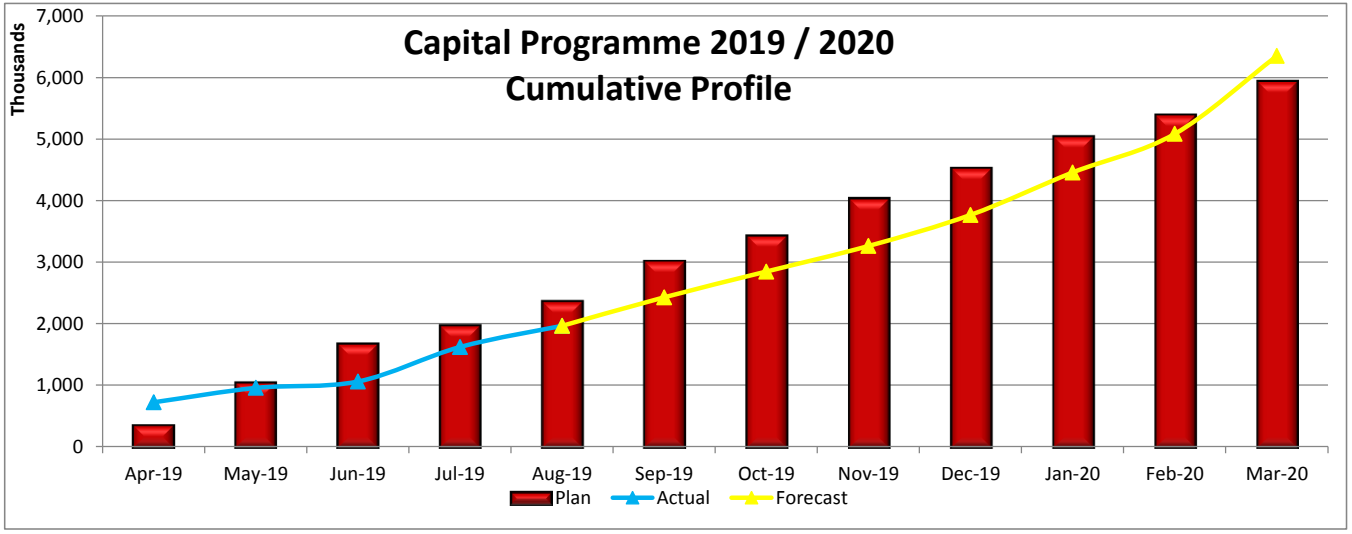
7. Accruals are higher than plan as the Trust awaits invoices for goods and services received.

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

3.1 Capital Programme 2019 / 2020

	REVISED Annual Budget £k	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Forecast Actual £k	Forecast Variance £k	Note
Maintenance (Minor) Capital							
Facilities & Small Schemes	2,074	281	174	(107)	2,484	410	
Equipment Replacement	93	20	27	7	90	(3)	
IM&T	2,158	756	652	(104)	2,429	271	
Major Capital Schemes							
Fieldhead Non Secure	805	805	936	131	936	131	2
Nurse Call system	600	300	0	(300)	200	(400)	3
Clinical Record System	220	220	175	(45)	211	(9)	
VAT Refunds	0	0	0	0	0	0	4
TOTALS	**5,950**	**2,382**	**1,964**	**(418)**	**6,350**	**400**	

The Trust capital programme has been reduced from £7m to £6m.



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.

Following various re-iterations given national guidance the capital plan for the year is now £6.35m. The revised plan here will be updated to reflect this in due course.

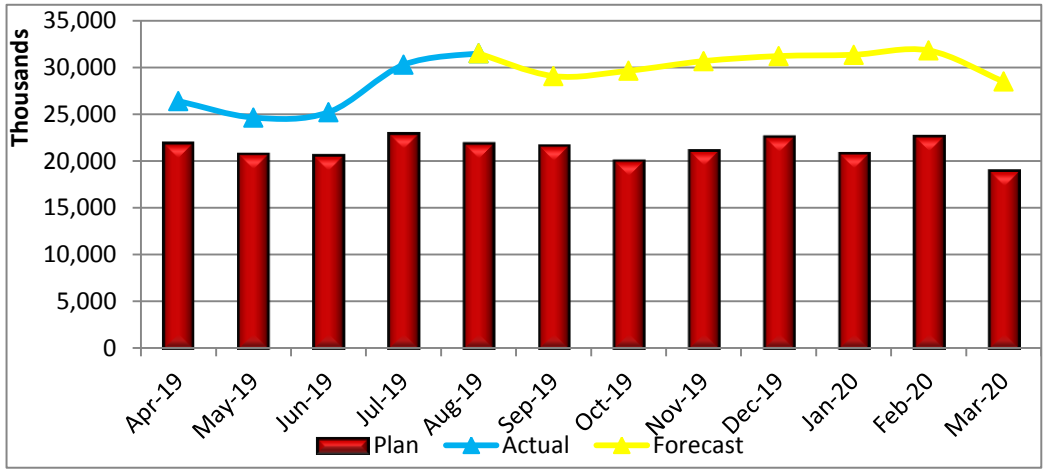
This will continue to be closely monitored through Estates TAG.

2. The final costs for the Fieldhead Non Secure are currently being agreed.

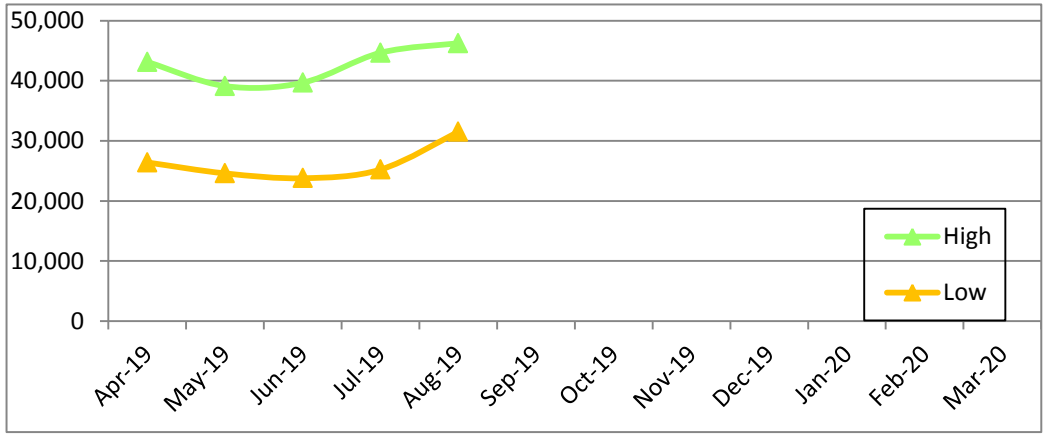
3. The nurse call system is forecast to be complete by December 2019. The value will be less than originally forecast.

4. HMRC have confirmed a number of VAT refunds from previous schemes. The adjustment will be calculated and included in future forecasts.

3.2 Cash Flow & Cash Flow Forecast 2019 / 2020



	Plan £k	Actual £k	Variance £k
Opening Balance	22,617	27,823	
Closing Balance	21,884	31,514	9,630



The Trust cash position remains healthy, it is expected to reduce in September following payment of PDC.

Cash continues to be a priority focus area mainly through the timely recovery of income.

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

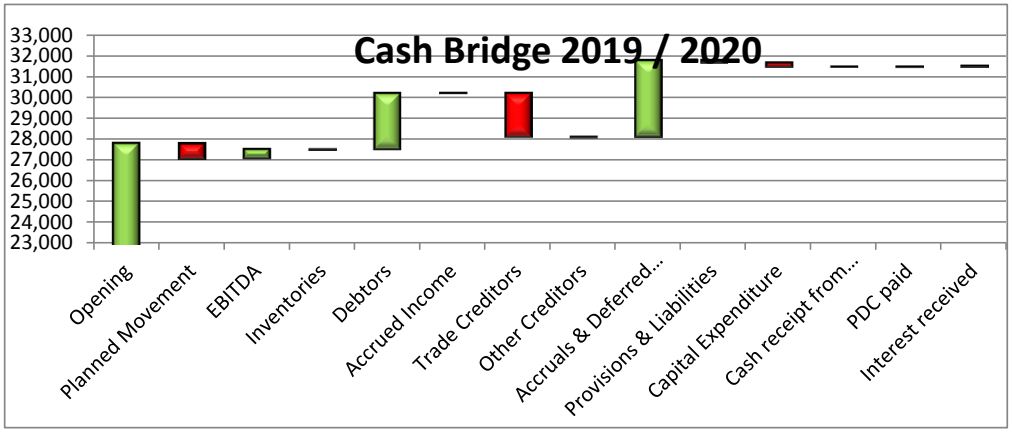
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £46.2m
The lowest balance is: £31.5m

This reflects cash balances built up from historical surpluses.

3.3 Reconciliation of Cashflow to Cashflow Plan

	Plan £k	Actual £k	Variance £k	Note
Opening Balances	**22,617**	**27,823**	5,206	1
Surplus / Deficit (Exc. non-cash items & revaluation)	2,135	2,581	446	2
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	(383)	2,296	2,679	3
Trade Payables (Creditors)	116	(1,972)	(2,088)	5
Other Payables (Creditors)	0	0	0	
Accruals & Deferred income	(187)	3,466	3,653	4
Provisions & Liabilities	(43)	(151)	(108)	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(2,411)	(2,617)	(205)	
Cash receipts from asset sales	0	0	0	
PDC Dividends paid	0	0	0	
PDC Dividends received			0	
Interest (paid)/ received	40	87	47	
Closing Balances	**21,884**	**31,514**	**9,630**	



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

Factors which increase the cash positon 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. Debtors, including accrued income,continue to be better than plan, active management of these is ongoing with an emphasis on clearing the oldest debt.

4. Accruals are higher than plan whilst we await invoices. This improves cash as we have not yet paid for goods and services received. This is normal as we await the issuing of the end of quarter 2 invoices.

Factors which decrease the cash position against plan:

5. 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.

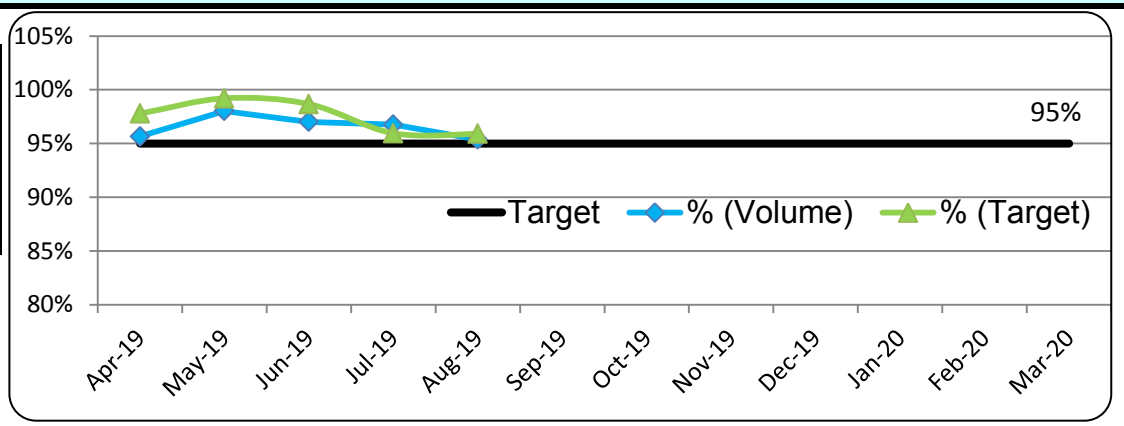
The cash bridge to the left depicts, by heading, the positive and negative impacts on the cash position as compared to plan.

4.0 Better Payment Practice Code

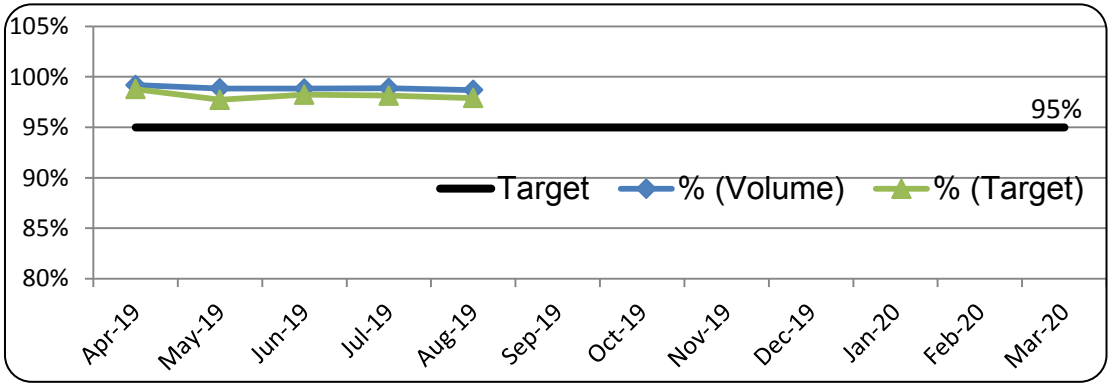
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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 July 2019	97%	96%
Year to August 2019	95%	96%



Non NHS	Number %	Value %
Year to July 2019	99%	98%
Year to August 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 (£)
20-Aug-19	Property Rental	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	3115368	226,501
31-Jul-19	Drugs	Trustwide	Bradford Teaching Hospitals NHS FT	3113411	127,030
07-Aug-19	IT Services	Trustwide	Daisy Corporate Services Trading Ltd	3114422	93,125
19-Aug-19	CNST contributions	Trustwide	NHS Litigation Authority	3115359	64,044
04-Jul-19	Staff Recharge	Wakefield	Wakefield MDC	3111027	60,870
28-Aug-19	Property Rental	Barnsley	Apollo Court	3116095	48,578
12-Aug-19	Drugs	Trustwide	Lloyds Pharmacy Ltd	3114715	45,654
25-Jul-19	Drugs	Trustwide	NHSBSA Prescription Pricing Division	3113041	42,963
11-Jul-19	Drugs	Trustwide	Lloyds Pharmacy Ltd	3111819	42,177
28-Jun-19	IT Services	Trustwide	Servelec Healthcare Limited	3110506	42,134
28-Aug-19	Drugs	Trustwide	NHSBSA Prescription Pricing Division	3115982	38,495
14-Aug-19	Purchase of Healthcare	Forensics	Sheffield Children´s NHS Foundation Trust	3114908	37,087
08-Aug-19	Purchase of Healthcare	Trustwide	Cygnet Health Care Ltd	3114493	33,881
14-Aug-19	Purchase of Healthcare	Trustwide	Cygnet Health Care Ltd	3114898	33,633
06-Aug-19	Staff Recharge	Trustwide	Leeds and York Partnership NHS FT	3114065	33,545
30-Aug-19	Property Rental	Barnsley	Community Health Partnerships	3116273	31,925
07-Aug-19	Property Rental	Barnsley	Community Health Partnerships	3114409	31,925
12-Aug-19	Drugs	Trustwide	Lloyds Pharmacy Ltd	3114715	27,127
23-Jul-19	Property Rental	Barnsley	SJM Developments Limited	3113580	27,000
18-Jul-19	Staff Recharge	Forensics	Leeds Community Healthcare NHS Trust	3112463	26,892
16-Aug-19	Communications	Trustwide	Vodafone Corporate Ltd	3115177	26,108
11-Jul-19	Drugs	Trustwide	Lloyds Pharmacy Ltd	3111819	25,721
07-Aug-19	Property Rental	Barnsley	Community Health Partnerships	3114409	25,624
30-Aug-19	Property Rental	Barnsley	Community Health Partnerships	3116273	25,624
06-Aug-19	Electricity	Trustwide	EDF Energy	3114046	25,575
09-Aug-19	Electricity	Trustwide	EDF Energy	3114636	25,113

4.2 Glossary

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

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

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

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

* Surplus - Trust income is greater than costs

* Deficit - Trust costs are greater than income

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

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

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

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

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

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

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

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

Appendix 2 - Workforce - Performance Wall

Barnsley District

Month	Objective	CQC Domain	Owner	Threshold	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	5.2%	4.8%	4.9%	5.2%	5.4%	5.2%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	5.4%	4.8%	4.9%	6.0%	6.0%	4.6%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	98.7%	8.1%	22.1%	68.2%	73.1%	78.8%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	95.7%	0.4%	2.7%	13.7%	30.9%	44.9%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	82.2%	77.8%	77.9%	81.0%	81.6%	80.5%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	82.7%	83.5%	82.4%	82.7%	81.3%	83.4%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	84.6%	78.0%	81.9%	80.3%	80.3%	79.3%
Equality and Diversity	Resources	Well Led	AD	>=80%	89.6%	88.9%	89.7%	90.5%	91.7%	91.5%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	80.9%	81.6%	81.7%	83.7%	84.4%	84.4%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	81.7%	82.4%	81.3%	79.3%	79.4%	77.4%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	90.0%	89.9%	90.9%	91.9%	92.4%	92.6%
Information Governance	Resources	Well Led	AD	>=95%	97.6%	96.8%	92.6%	92.9%	93.5%	92.9%
Moving and Handling	Resources	Well Led	AD	>=80%	87.6%	87.0%	87.5%	87.0%	87.9%	89.5%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	87.4%	88.5%	88.3%	89.3%	89.8%	90.5%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	78.8%	75.6%	78.6%	81.4%	84.1%	84.6%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	89.2%	87.5%	88.3%	90.0%	90.5%	91.9%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	89.1%	89.6%	87.3%	89.8%	89.8%	90.4%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	94.2%	93.5%	91.7%	91.9%	94.1%	95.9%
Agency Cost	Resources	Effective	AD		£37k	£28k	£57k	£46k	£56k	£53k
Overtime Costs	Resources	Effective	AD		£2k	£3k	£1k	£0k	£1k	
Additional Hours Costs	Resources	Effective	AD		£10k	£17k	£14k	£15k	£15k	
Sickness Cost (Monthly)	Resources	Effective	AD		£165k	£125k	£132k	£160k	£167K	£127k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		79.37	84.36	80.88	78.97	89.98	100.58
Business Miles	Resources	Effective	AD		97k	97k	99k	109k	104k	94k

Calderdale and Kirklees District

Month	Objective	CQC Domain	Owner	Threshold	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.5%	4.1%	4.0%	4.0%	4.0%	4.1%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	4.2%	4.1%	4.0%	3.8%	4.1%	4.3%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	100.0%	9.7%	25.1%	66.9%	77.3%	81.6%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	98.5%	0.2%	1.7%	5.3%	18.0%	29.8%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	81.4%	81.9%	82.3%	83.3%	84.0%	83.6%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	77.3%	76.3%	75.1%	75.9%	75.5%	79.2%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	89.8%	91.2%	91.2%	90.4%	87.8%	87.1%
Equality and Diversity	Resources	Well Led	AD	>=80%	90.9%	90.2%	90.2%	90.8%	91.1%	91.3%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	84.5%	84.2%	84.2%	85.0%	85.0%	84.8%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	83.4%	82.5%	81.5%	78.9%	79.5%	78.2%
Infection Control and Hand Hygiene	Quality & Experience	Well Led		>=80%	88.4%	90.1%	90.0%	89.5%	91.5%	90.7%
Information Governance	Resources	Well Led	AD	>=95%	98.8%	97.8%	96.1%	96.8%	96.7%	96.0%
Moving and Handling	Resources	Well Led	AD	>=80%	89.6%	90.5%	91.3%	92.0%	92.5%	92.3%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	91.6%	91.3%	91.6%	92.4%	92.7%	93.2%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	86.4%	86.9%	87.3%	89.6%	91.0%	90.9%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	91.4%	91.7%	92.3%	92.9%	93.0%	92.6%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	88.6%	89.5%	90.8%	90.8%	91.1%	91.0%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	95.9%	96.6%	96.4%	97.0%	96.8%	96.4%
Agency Cost	Resources	Effective	AD		£135k	£146k	£157k	£120k	£159k	£125k
Overtime Costs	Resources	Effective	AD		£1k	£2k	£7k	£2k	£2k	
Additional Hours Costs	Resources	Effective	AD		£4k	£5k	£4k	£1k	£1k	
Sickness Cost (Monthly)	Resources	Effective	AD		£109k	£92k	£94k	£84k	£84k	£90k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		68.72	75.61	80.5	71.04	95.92	101.97
Business Miles	Resources	Effective	AD		82k	66k	45k	65k	£67k	53k

Appendix - 2 - Workforce - Performance Wall cont….

Forensic Services

Month	Objective	CQC Domain	Owner	Threshold	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Sickness (YTD)	Resources	Well Led	AD	<=5.4%	7.5%	5.6%	5.9%	6.3%	6.5%	6.8%
Sickness (Monthly)	Resources	Well Led	AD	<=5.4%	5.6%	5.6%	6.2%	7.1%	6.9%	7.5%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	94.4%	3.5%	15.5%	58.8%	80.3%	80.3%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	96.3%	0.7%	0.7%	3.6%	35.2%	53.4%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	97.5%	93.1%	93.9%	97.7%	98.2%	97.8%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	95.8%	93.1%	96.1%	99.1%	99.2%	99.1%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	99.9%	99.3%	99.2%	99.3%	91.7%	99.5%
Equality and Diversity	Resources	Well Led	AD	>=80%	94.4%	91.1%	91.4%	91.4%	91.2%	91.3%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	97.7%	96.8%	96.3%	96.5%	99.0%	99.1%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	93.6%	94.3%	92.1%	92.4%	93.9%	93.8%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	99.4%	99.1%	99.4%	91.9%	91.7%	91.6%
Information Governance	Resources	Well Led	AD	>=95%	96.5%	97.0%	95.3%	95.7%	93.9%	94.9%
Moving and Handling	Resources	Well Led	AD	>=80%	94.6%	95.3%	95.3%	95.0%	94.9%	93.6%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	93.0%	93.2%	91.9%	91.4%	93.3%	93.6%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	91.8%	93.9%	93.7%	91.3%	93.0%	92.8%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	95.1%	95.1%	94.6%	94.5%	94.9%	95.1%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	93.6%	89.4%	89.6%	89.7%	91.7%	91.3%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	97.9%	90.3%	90.3%	96.8%	94.1%	93.3%
Agency Cost	Resources	Effective	AD		£69k	£50k	£59k	£65k	£65k	£75k
Overtime Costs	Resources	Effective	AD		£0k	£1k	£0k	£0k	£1k	
Additional Hours Costs	Resources	Effective	AD		£1k	£1k	£2k	£3k	£1k	
Sickness Cost (Monthly)	Resources	Effective	AD		£55k	£52k	£59k	£67k	£69k	£74k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		64.52	78.25	84.96	88.64	86.39	90.11
Business Miles	Resources	Effective	AD		9k	5k	6k	8k	10k	5k

Specialist Services

Month	Objective	CQC Domain	Owner	Threshold	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.9%	4.4%	4.8%	4.9%	5.2%	4.9%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	3.6%	4.4%	5.1%	4.9%	6.0%	4.3%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	89.5%	2.8%	10.9%	53.7%	64.7%	69.7%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	92.7%	0.0%	2.4%	9.4%	26.1%	37.4%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	89.9%	82.9%	81.6%	82.0%	81.0%	81.2%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	76.7%	78.6%	79.0%	78.1%	80.1%	80.7%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	93.6%	94.4%	96.6%	96.3%	93.7%	96.1%
Equality and Diversity	Resources	Well Led	AD	>=80%	88.3%	87.5%	88.3%	85.7%	87.4%	88.1%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	93.7%	81.6%	82.4%	79.8%	7.8%	79.1%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	71.0%	73.3%	70.0%	73.3%	71.0%	72.4%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	90.7%	90.9%	89.4%	90.6%	89.9%	90.3%
Information Governance	Resources	Well Led	AD	>=95%	96.7%	96.2%	96.2%	96.1%	94.3%	94.3%
Moving and Handling	Resources	Well Led	AD	>=80%	90.2%	89.7%	91.3%	91.9%	91.4%	90.3%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	93.4%	93.4%	91.1%	89.9%	89.2%	89.1%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	86.9%	87.3%	84.9%	85.2%	86.5%	87.3%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	93.2%	93.1%	91.3%	92.1%	91.6%	92.1%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	91.2%	90.7%	90.6%	92.1%	91.1%	91.6%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	92.3%	92.6%	94.4%	93.2%	92.4%	94.5%
Agency Cost	Resources	Effective	AD		£275k	£283k	£268k	£258k	£296k	£229k
Overtime Costs	Resources	Effective	AD		£0k	£1k	£2k	£2k	£1k	
Additional Hours Costs	Resources	Effective	AD		£3k	£10k	£5k	£5k	£3k	
Sickness Cost (Monthly)	Resources	Effective	AD		£32k	£48k	£59k	£53k	£64k	£49k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		61.42	55.85	63.99	0	81.8	81.77
Business Miles	Resources	Effective	AD		35k	34k	34k	45k	36k	37k

Appendix 2 - Workforce - Performance Wall cont….

Support Services

Month	Objective	CQC Domain	Owner	Threshold	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Sickness (YTD)	Resources	Well Led	AD	<=4.0%	4.30%	4.70%	4.50%	4.60%	4.40%	4.40%
Sickness (Monthly)	Resources	Well Led	AD	<=4.0%	4.30%	4.60%	4.40%	4.70%	4.00%	4.40%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	92.50%	3.30%	12.90%	66.70%	77.00%	82.20%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	99.20%	0.00%	0.20%	2.50%	19.80%	29.80%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	68.00%	72.10%	80.10%	79.30%	79.70%	81.00%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	64.60%	76.90%	86.00%	83.30%	87.50%	87.50%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Equality and Diversity	Resources	Well Led	AD	>=80%	88.50%	90.00%	89.70%	90.60%	92.00%	90.80%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	90.00%	89.10%	89.20%	90.20%	92.30%	91.10%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	97.90%	98.60%	97.10%	96.40%	97.10%	97.10%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	90.30%	92.00%	92.10%	92.00%	92.90%	92.70%
Information Governance	Resources	Well Led	AD	>=95%	89.20%	95.70%	94.20%	94.30%	95.30%	92.80%
Moving and Handling	Resources	Well Led	AD	>=80%	92.90%	92.40%	94.60%	95.70%	98.70%	95.20%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	99.20%	98.80%	99.00%	99.10%	99.70%	99.70%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	95.20%	90.50%	90.00%	94.10%	89.90%	89.20%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	97.50%	97.60%	97.80%	98.30%	98.70%	98.30%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	98.80%	98.50%	97.60%	97.90%	98.40%	98.00%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Agency Cost	Resources	Effective	AD		£12k	£14k	£15k	£6k	£5k	£5k
Overtime Costs	Resources	Effective	AD		£45k	£5k	£16k	£29k	£15k	
Additional Hours Costs	Resources	Effective	AD		£17k	£10k	£8k	£11k	£10K	
Sickness Cost (Monthly)	Resources	Effective	AD		£63k	£64k	£64k	£68k	£61k	£66k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		49.57	45.38	37.6	43.44	41.67	36.42
Business Miles	Resources	Effective	AD		29k	35k	22k	27k	29k	22k

Wakefield District

Month	Objective	CQC Domain	Owner	Threshold	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Sickness (YTD)	Resources	Well Led	AD	<=4.6%	4.8%	5.7%	5.2%	4.8%	4.8%	4.8%
Sickness (Monthly)	Resources	Well Led	AD	<=4.6%	4.7%	5.6%	4.7%	3.9%	4.9%	3.9%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	99.5%	4.3%	23.8%	80.7%	95.5%	95.0%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	99.8%	0.0%	0.8%	13.9%	27.0%	42.9%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	86.2%	86.8%	87.6%	87.3%	87.1%	85.9%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	80.8%	79.0%	79.6%	81.8%	82.3%	82.5%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	83.8%	83.4%	82.8%	79.5%	78.9%	84.1%
Equality and Diversity	Resources	Well Led	AD	>=80%	91.3%	89.8%	90.7%	90.8%	91.2%	91.5%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	86.8%	87.0%	84.5%	85.3%	86.0%	86.9%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	74.0%	72.7%	79.3%	90.2%	88.3%	88.3%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	90.5%	90.2%	91.6%	91.8%	92.6%	92.3%
Information Governance	Resources	Well Led	AD	>=95%	98.9%	98.3%	98.5%	98.4%	98.3%	98.3%
Moving and Handling	Resources	Well Led	AD	>=80%	93.6%	92.2%	93.0%	92.9%	92.0%	92.3%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	91.8%	90.6%	89.7%	91.3%	92.6%	92.6%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	85.6%	84.5%	83.5%	88.9%	88.2%	88.3%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	98.3%	94.6%	98.1%	98.7%	95.0%	94.6%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	90.1%	89.6%	92.4%	94.6%	94.2%	93.2%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	94.1%	93.8%	93.4%	94.3%	94.6%	95.6%
Agency Cost	Resources	Effective	AD		£107k	£92k	£84k	£24k	£34k	£31k
Overtime Costs	Resources	Effective	AD		£0k	£1k	£2k	£1k	£2k	
Additional Hours Costs	Resources	Effective	AD		£3k	£4k	£5k	£3k	£3k	
Sickness Cost (Monthly)	Resources	Effective	AD		£58k	£58k	£48k	£40k	£48k	£36k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		39.69	39.49	37.44	31.39	32.68	38.98
Business Miles	Resources	Effective	AD		37k	38k	34k	39k	34k	32k

Glossary

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

HEE	Health Education England
HONOS	Health of the Nation Outcome Scales
HR	Human Resources
HSJ	Health Service Journal
HSCIC	Health and Social Care Information Centre
HV	Health Visiting
IAPT	Improving Access to Psychological Therapies
IBCF	Improved Better Care Fund
ICD10	International Statistical Classification of Diseases and Related Health Problems
ICO	Information Commissioner's Office
IG	Information Governance
IHBT	Intensive Home Based Treatment
IM&T	Information Management & Technology
Inf Prevent	Infection Prevention
IPC	Infection Prevention Control
IWMS	Integrated Weight Management Service
JAPS	Joint academic psychiatric seminar
KPIs	Key Performance Indicators
LA	Local Authority
LD	Learning Disability
MARAC	Multi Agency Risk Assessment Conference
Mgt	Management
MAV	Management of Aggression and Violence
MBC	Metropolitan Borough Council
MH	Mental Health
MHCT	Mental Health Clustering Tool
MRSA	Methicillin-resistant Staphylococcus Aureus
MSK	Musculoskeletal
MT	Mandatory Training
NCI	National Confidential Inquiries
NHS TDA	National Health Service Trust Development Authority
NHSE	National Health Service England
NHSI	NHS Improvement

NICE	National Institute for Clinical Excellence
NK	North Kirklees
NMoC	New Models of Care
OOA	Out of Area
OPS	Older People's Services
ORCHA	Preparatory website (Organisation for the review of care and health applications) for health related applications
PbR	Payment by Results
PCT	Primary Care Trust
PICU	Psychiatric Intensive Care Unit
PREM	Patient Reported Experience Measures
PROM	Patient Reported Outcome Measures
PSA	Public Service Agreement
PTS	Post Traumatic Stress
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
QTD	Quarter to Date
RAG	Red, Amber, Green
RiO	Trusts Mental Health Clinical Information System
SIs	Serious Incidents
S BDU	Specialist Services Business Delivery Unit
SK	South Kirklees
SMU	Substance Misuse Unit
SRO	Senior Responsible Officer
STP	Sustainability and Transformation Plans
SU	Service Users
SWYFT	South West Yorkshire Foundation Trust
SYBAT	South Yorkshire and Bassetlaw local area team
TB	Tuberculosis
TBD	To Be Decided/Determined
WTE	Whole Time Equivalent
Y&H	Yorkshire & Humber
YHAHSN	Yorkshire and Humber Academic Health Science
YTD	Year to Date

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

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

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

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 24 September 2019
Agenda item 6.2

Title:	**Serious incident report Quarter 1 2019/20**
Paper prepared by:	Director of Nursing and Quality
Purpose:	This report provides information in relation to incidents in Quarter 1 and more detailed information in relation to serious incidents. Also to provide assurance that learning from healthcare deaths arrangements are in place.
Mission/values:	➢ We are respectful, honest, open and transparent ➢ We put the person first and in the centre ➢ We are always improving
Any background papers/ previously considered by:	Previous quarterly reports which have been submitted to Clinical Governance & Clinical Safety Committee (CG&CSC), along with annual incident reports, Our Learning Journey reports. CGCSC has also received papers about the introduction of the national requirement for learning from healthcare deaths and the Policy.
Executive summary:	➢ This report is produced by the patient safety support team and shows the data for incidents. Detailed Quarterly reports have been produced and shared with each BDU. All managers have access to Datix dashboards to interrogate data further. ➢ There have been no 'Never Events' reported in the Trust during Q1; the last Never Event reported was in 2010/11. ➢ The total number of serious incidents reported through Strategic Executive Information System (STEIS) in Quarter 1 was 14; this accounts for 0.4% of all incidents. ➢ There have been 2 homicides reported in Quarter 1. ➢ In quarter 1, the highest category of serious incident is 'Death' (including suspected suicide) totalling 8; 5 by apparent suicide and 3 deaths caused by unknown/ unexplained/ awaiting confirmation. ➢ The rolling Quarter 4 data shows that the Trust is below the expected number of suicides (apparent suicides reported in the last 12 months based on the National Confidential Inquiry figures for the population of the Trust and patient suicide rate (28%). ➢ 11 serious incident investigations have been submitted to the Commissioner during the quarter and 7 previous serious incidents have been closed by Commissioners. ➢ A total of 28 investigations remain under investigation and 7 of these investigations are outside the 60 working day target; these have agreed extensions with Commissioners. The complexity of investigations has contributed to delays. ➢ 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.

	➢ Within the report are some examples of learning from specialist advisors and work stream for the highest reported incidents. ➢ The Trust has developed a Datix reporting system to ensure that learning from health care deaths information is available. The policy continues to meet current national requirements and training to review records has been provided. ➢ Learning from incidents occurs at many different levels in the organisation, below are a few examples:- • Individual reflections following an incident - when an incident takes place, clinicians reflect on their practice, this is supported through supervision and appraisal. • Team reflection and action – teams can run reports from the Datix system to look at trends or new types of incidents and put team plans in place to increase the safety of practice. • Learning events – Learning events following a Serious Incident allows all members involved to have the findings presented and assist in turning the recommendations into actions that will make a difference. • BDU – Quarterly incident reports are produced for BDUs which provide data to look at trends and performance information. BDUs have held learning events within the BDUs where data and cases have been discussed. • Dashboards - The Datixweb Dashboards module has been successfully rolled out to all Datix users across the Trust. The module displays a live stream of incident data displayed in various report formats available to all Datix users depending on their area of responsibility. • Trust level – learning from incidents is reported through Executive Management Team (EMT), Operational Management Group (OMG), BDUs and Trust groups. • Specialist Advisors - receive individual incident notification to enable them to provide support if necessary. Many undertake production of quarterly reports for TAGs and wider learning. **This report was scrutinised by the Clinical Governance and Clinical Safety Committee meeting held on the 10 September 2019.** The Committee reviewed the report and commented as follows:- ➢ This report remains of high quality and well structured ➢ The Committee was assured that robust systems and processes for the reporting and investigation of incidents remain in place. ➢ The Committee took assurance from the positive comments made in the recent Care Quality Commission (CQC) Well Led Review and the work described in the “Our Learning Journey” report received at agenda item 10. ➢ The Committee noted that the report did not highlight any areas for further investigation. The importance of reviewing trend information continues to be significant in determining areas that require further interrogation or action. ➢ The improvement work described in the Patient Safety Strategy is informed by the quarterly and annual incident reports, with particular focus on suicide prevention. **Risk appetite** ➢ Risk identified – the Trust continues to have a good governance system of

	reporting and investigating incidents including serious incidents and of reporting, analysing and investigating healthcare deaths. ➢ The incident management process supports the drive to reduce harm and learn from incidents to reduce risk and prevent recurrence in the future. ➢ This report covers assurance for compliance risk for health and safety legislation and compliance with CQC standards for incident reporting. This meets the risk appetite –low and the risk target 1-6. ➢ The clinical risk – risk to service user/public safety and risk to staff safety which is again low risk appetite and a risk target of 1-6.
Recommendation:	**The Trust Board is asked to RECEIVE the Incident Management Quarter 1 Report for 2019/2020 and NOTE the assurance from the Clinical Governance and Clinical Safety Committee.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust wide Incident Management Report

Quarter 1 2019/20

Incorporating Serious Incidents and Learning from Healthcare Deaths reporting for the period 01/04/2019-30/06/2019

Report prepared by Patient Safety Support Team

July 2019

Contents

Executive Summary

This report provides information in relation to incidents reported in Quarter 1 2019/20 and more detailed information in relation to serious incidents. A brief analysis of actions arising from completed Serious Incident investigations submitted to commissioners for the period of 1 April 2019 to 30 June 2019 is included. The report also includes Learning from Healthcare Deaths data to provide assurance that arrangements are in place and to provide cumulative data for the period 01/04/2019 – 30/06/2019. The Learning from Healthcare Deaths report will be available separately on the Trust website.

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

Quarter 1 2019/20 Headlines

- **3496** incidents reported
- **89%** of incidents resulted in no/low harm
- **14** Serious incidents reported
- Serious Incidents account for **0.4%** of all incidents reported
- 2 homicides
- No Never Events

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

- This report is produced by the patient safety support team and shows the data for incidents. Detailed Quarterly reports have been produced and shared with each Business Delivery Unit. Data is also available at service line level. All managers have access to Datix dashboards to interrogate data further.
- This report has overall figures for incident reporting. Q1 had 3496 incidents; slightly higher than the previous quarter (3244).
- 89% of incidents are graded as “low” or “no harm” showing a positive culture of risk management (the more green incidents reported mean action taken proactively at an early stage before harm occurs).
- “Physical aggression/threat (no physical contact): by patient” 379 incidents (10%) remains as the most reported category.
- “Violence and Aggression” continues to be the highest reported incident type (32% (1151) of all incidents reported in the quarter, consistent with the previous quarter) [fig 4]. Staff have reported that this can be linked to individual service users but also say some incidents are linked to the trust’s current smoking policy.
- There have been no ‘Never Events’ reported in the Trust during Q1; the last Never Event reported was in 2010/11.

- The total number of serious incidents reported through Strategic Executive Information System (STEIS) in Quarter 1 was 14; a slight decrease on Quarter 4 (18). The range of serious incidents reported this quarter has included deaths (8), Self harm (2), Pressure ulcer grade 3 (1) and Violence and aggression (3) including 2 homicides.
- Homicides involving people with a serious mental illness usually require an external investigation and/or a domestic homicide review. The decision as to whether a homicide requires an external investigation rests with NHS England and will depend on the circumstances of the incident.
- In the interim, the Trust always conduct an immediate fact find and local investigation to see if any action is required to prevent reoccurrence, to offer support to those involved and to check if there are any early lessons we can learn. In these two cases, no immediate care or service delivery problems were identified, although a full comprehensive SI investigation is underway.
- The Trust will sometimes appoint an external investigator to lead our internal investigation, if this is felt appropriate following liaison with commissioners. For the two homicides reported in Quarter1, an external investigator has been appointed to lead the adult services investigation while the homicide involving a CAMHS service user is currently being reviewed by the young person's local authority in collaboration with all agencies involved, including SWYPT.
- In quarter 1, the highest category of serious incident is "Suicide (including apparent suicide) community team care – current episode" (4). This is lower than the previous quarter (12).
- The category of apparent suicide (those reported as serious incidents) for the last 4 quarters is 4, 5, 14 and 5 totalling 28. This is lower than the estimated level based on National Confidential Inquiry numbers and our population - 34/35. It is too soon to say if this has been influenced by our approach to zero suicide.
- All incidents that are graded red or amber are extracted from Datix for inclusion in a report that is reviewed at the weekly risk panel.
- All deaths are reviewed in line with the learning from healthcare deaths policy.
- We are implementing our Trust wide suicide prevention strategy, which includes conducting a deep dive analysis on hotspot areas and targeting clinical teams and service user groups where there is concern.
- We have taken the lead on the West Yorkshire and Harrogate Health Care Partnership 5-year suicide prevention strategy, which has adopted an evidence-based approach to suicide prevention and zero suicide philosophy for targeted areas and hotspots.
- 11 serious incident investigations have been submitted to the Commissioner during the quarter and 7 previous serious incidents have been closed by Commissioners.
- The actions from incidents are managed at Business Delivery Unit level. The patient safety support team produces information on completion of action plans from serious incidents and these are monitored through the operational management group.
- A number of investigations are outside the 60 working day target; these have agreed extensions with Commissioners. The complexity of investigations has contributed to delays. Ensuring full family involvement, bereavement work and the complexity of investigations has contributed to some delays in addition to temporary reduced capacity within the team. The Patient Safety Team has provided additional training to further expand the capacity within our workforce to undertake serious incident investigations and the team is currently recruiting to an investigator post. It is likely we will see a gradual reduction in the number of investigations outside of the 60 working day target by between now and end of March 2020.
- Within the report are some examples of learning from specialist advisors and work streams for the highest reported incidents.

Learning from healthcare deaths

- Our report provides figures on deaths and the number that have been reviewed.
- From April 2017 the Trust started reviewing all deaths reported on Datix using an incremental approach.
- The new policy on learning from deaths came into effect from 1 October 2017, which.
- The Trust has adopted the three levels of scrutiny suggested in the National Quality Board guidance:
  - Death Certification
  - Case record review, including Structured Judgment Record Reviews. 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.
- Total number of deaths reported on Datix by staff between 1/4/2019 – 30/6/2019 (by reported date, not date of death) = 63, all of which have been reviewed.
- Total in scope as described in report = 58
- Learning from Structured Judgement Reviews and Investigations completed to date is included in the report.

1. Introduction

This report has been prepared by the Patient Safety Support Team to bring together Trust wide information on incident activity during Quarter 1 19/20 (1 April 2019 to 30 June 2019) including reported serious incidents and Learning from Healthcare Deaths for the period 1 April 2019 to 30 June 2019.

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

2. Updates from the Patient Safety Support Team

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

- Continuing to develop our processes for learning from healthcare deaths
- Reducing the back log of incidents awaiting final approval
- Data flows for severe harm and death incidents to the CQC
- Supporting data requests for the Trust's CQC visits
- Annual reporting of incidents and apparent suicides

The Patient Safety Support Team has responded to 4 Freedom of information Requests received between 1 April 2019 to 30 June 2019 including information related to absconded/AWOL patients, homicides, and restraint which has been extracted from Datix.

3. Incident Reporting Analysis

This report has overall figures for incident reporting. Q1 had 3496 incidents which is an increase compared to the levels in the previous two quarters.

89% of incidents are graded as "low" or "no harm" showing a positive culture of risk management (the more green incidents reported mean action taken proactively at an early stage before harm occurs).

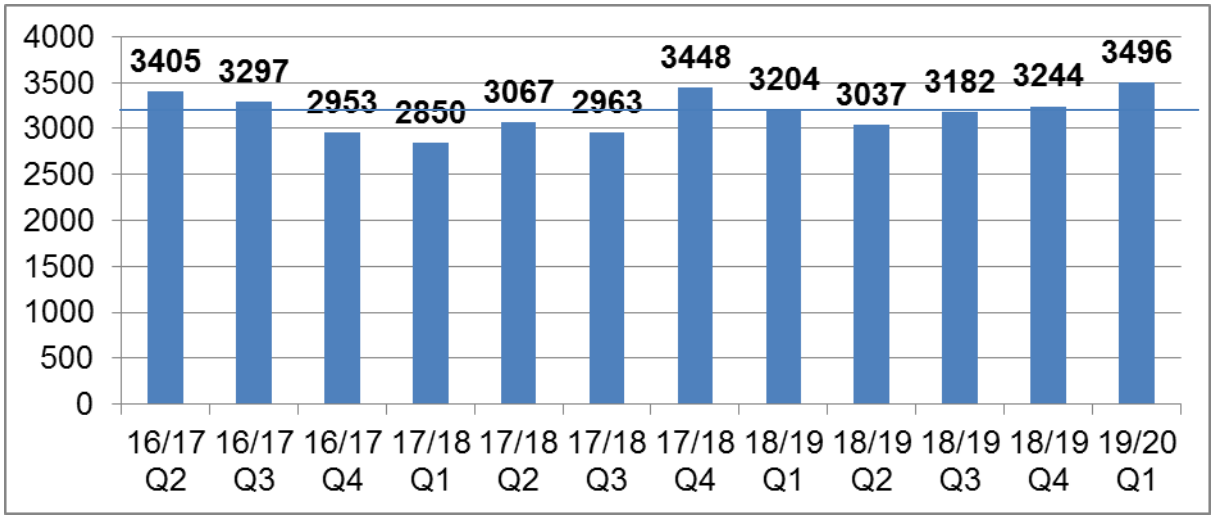
Headlines

Quarter 1 2019/20 Headlines

- **3496** incidents reported
- Increase on reporting compared with Q4 (3244)
- **89%** of incidents remain **no/low harm**
- High reporting rate with high proportion of no/low harm is indicative of a positive safety culture

Figure 1 below shows the pattern and number of incidents reported by quarter in the Trust from Q2 16/17 to Q1 19/20. The rate fluctuates as would be expected. Quarter 1 19/20 was above the average for a quarter. However with the Trust changing profile of services, direct comparisons should be viewed with caution.

Figure 1 Comparative number of incidents reported by financial quarter Q2 2016/17 to Q1 2019/20



Severity

In Figure 2 there have been 28 red incidents reported. This data is live data at the point of producing the report. The incident may be initially graded red for a number of reasons. An example would be a death (for healthcare deaths we have been encouraging staff to report on Datix) but we later find out this is natural causes or where the individual has not been involved with Trust services for over six months so this may be re-graded and not reported on STEIS, this can take some time to get this information. Not all red incidents will meet the criteria for a serious incident (see page 18).

Figure 2 All incidents reported Trust wide between 01/04/2018 - 30/06/2019 by severity and financial quarter

	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4	19/20 Q1
Green (no harm)	1990	1837	1922	1846	2058
Green	868	861	896	973	1055
Yellow	262	248	247	296	262
Amber	64	70	89	97	93
Red	20	21	28	32	28
Total Incidents Reported	**3204**	**3037**	**3182**	**3244**	**3496**

Figure 3 All incidents reported Trust wide between 01/04/2019- 30/06/2098 by severity and BDU

	Barnsley Mental Health	Barnsley General Community Services	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Trust wide (Corporate)	**Total**
Green (no harm)	135	248	186	283	354	515	317	20	**2058**
Green	70	239	132	138	214	147	105	10	**1055**
Yellow	33	7	29	37	102	37	14	3	**262**
Amber	7	44	7	11	14	4	6	0	**93**
Red	1	2	6	7	9	0	3	0	**28**
Total	**246**	**540**	**360**	**476**	**693**	**703**	**445**	**33**	**3496**

Type and Category of incidents

Figure 4 shows the overarching type of incidents reported in the Trust. All incidents are coded using a three tier method to enable detailed analysis. Type is the broadest grouping, with type breaking into categories, and then onwards into subcategories. This report provides details of the number for type (Figure 4) and the top 10 categories in the quarter (Figure 5).

Figure 4 Type of incident reported in Quarter 1 by BDU

	Barnsley Mental Health	Barnsley General Community Services	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Trust wide (Corporate support services)	Total
Violence and Aggression	96	14	56	150	246	389	198	2	1151
Care Pathway, Clinical and Pressure Ulcer Incidents	7	398	7	26	43	8	19	0	508
Self Harm	8	2	64	40	86	14	99	0	313
Medication	23	28	38	52	74	53	9	2	279
Legislation and Policy	11	1	53	45	32	67	2	1	212
Health and Safety (including fire)	16	11	27	26	42	44	29	7	202
All Other Incidents	17	10	25	24	31	53	12	2	174
Slips, Trips and Falls	13	29	24	26	55	7	2	4	160
Missing/absent service users	14	0	29	29	21	8	3	0	104
Security Breaches	11	5	3	14	15	34	4	7	93
Safeguarding Adults	7	13	8	11	13	10	13	1	76
Information Governance Incidents	7	12	2	8	9	4	19	6	67
Death (including suspected suicide)	8	3	12	14	16	0	10	0	63
IT Related Issues	5	11	4	8	5	8	12	1	54
Safeguarding Children	2	1	7	1	1	1	11	0	24
Infection Prevention/Control	1	2	1	2	4	3	3	0	16
Total	246	540	360	476	693	703	445	33	3496

Figure 5 Trust-wide Top 10 most frequently reported incident categories in rolling 5 quarters (1/4/18 – 30/6/19)

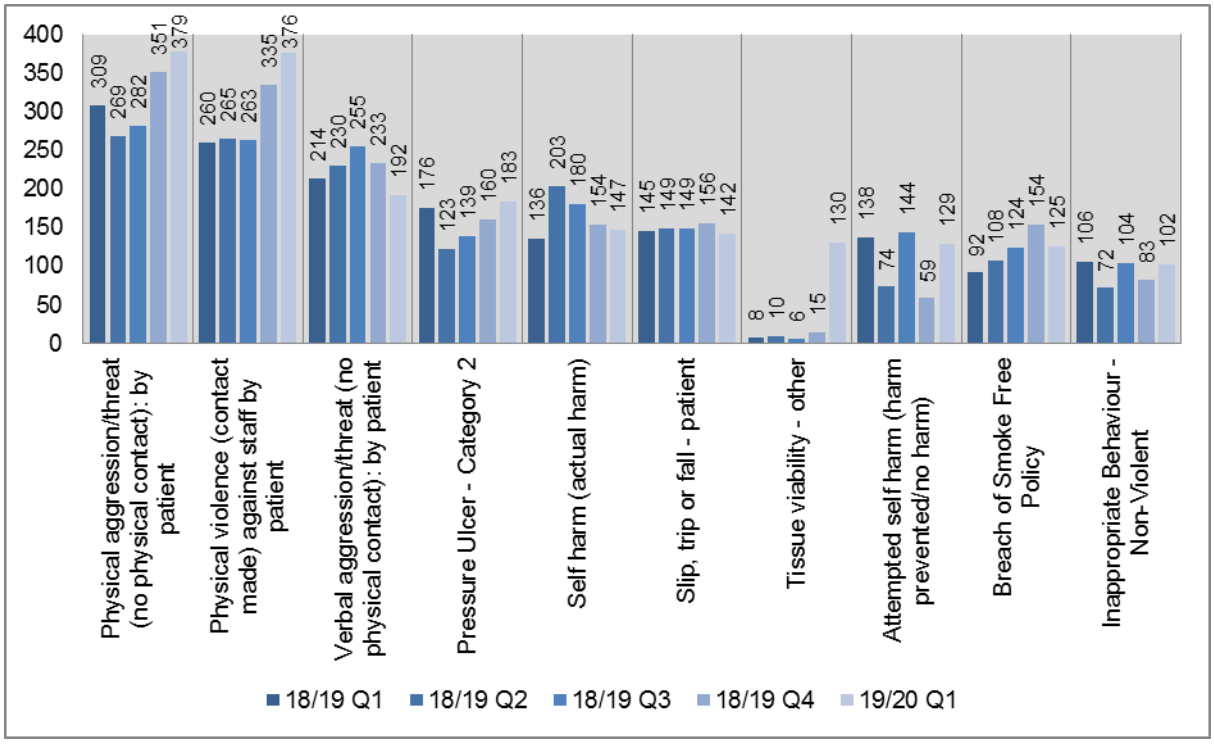


Figure 5 shows that in Quarter 1 2019/20 physical aggression/threat (no physical contact) by patient was the highest reported category of incident. Figures for previous quarters are included for comparison.

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

There has been a significant increase in the number of incidents that have been reported under the category Tissue viability – other. Of the 130 incidents, 118 were reported as Moisture Associated Skin Damage (MASD). The MASD pathway was released on 23 January 2019, all nurses have received training in the new pathway and the importance of reporting all MASD, which has resulted in the increase of incidents reported.

4. Learning from incidents

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

Safeguarding

Example 1

Service user under the care of the EIP team was reported to be accessing and distributing child pornographic material on line. The police had decided not to pursue the matter after the service user was detained in hospital under the mental health act. They informed practitioners that the matter would remain on file, however, they would not be informing service user about the allegation.

Professional contacted safeguarding team for support advised that the service user needed to know about the police involvement and the fact that this is a serious allegation.

Safeguarding concerns are that he is a risk and at risk, for the children being viewed, also concerns that he could be targeted by paedophile hunters.

Advised practitioners to contact the police to express this concern's and then arrange a professional's meeting. A professional's meeting was held, representation from social care, SWYPFT safeguarding, SWYPFT legal service and other practitioner's.

The outcome of the professional's meeting was positive, a referral is to be made into MAPPA and the advanced practitioner from social care, will take the concern through the safeguarding process.

This approach has prevented silo working, and brought all agencies together to ensure the appropriate response to a serious concern and safeguard children and the service user.

Reporting reminders for staff:

• Importance of arranging professional's meetings to ensure wider consideration of risk

• Multi-agency to ensure all options to deal with a concerns are considered

• Sharing risk will result in better outcomes for the service user and supports all practitioners involved in the case.

Example 2

The safeguarding team were contacted regarding a complex case where a service user who has learning disabilities, mobility issues, physical health concerns, confined to one room upstairs. There were concerns regarding personal cares, frequent urinary tract infections, risk of urinary retention and sepsis. The service user has also had episodes of shaking and requires urology and neurology outpatient appointments.

There were issues regarding safeguarding children concerns as there were children in the home and the impact upon them was recognised and a concern was raised. There are concerns regarding the family's ability to provide adequate care for the service user and concerns regarding potential neglect.
The priority was identified to be the service user's physical health. The family and multi-agency were in agreement that he required the urology and neurology appointments. The Best Interests decisions were discussed virtually. The service user is deemed not to have capacity regarding care and treatment.

The Safeguarding team: advised that an advocate was required to support the service user. That the appointments need planning regarding: how to reduce distress for the service user, to decide what form of transport would be used, who would travel with, how to maintain levels of distress during escort, ensuring staff at appointment aware of level of need and plan B if service user was to refuse to be escorted.

The safeguarding team advised that other professionals; Reducing Restrictive Interventions team, the SWYPFT Legal services, Intensive Support team and District Nurses should be involved with the planning.

The safeguarding team discussed of there were any potential physical concerns that may be exacerbated during the escort that may need first aid planning and or monitoring.

The safeguarding team asked that a Datix be completed to ensure there would be oversight and support from a wider audience of managers and advisers. The theme was of the documentation of decision making and clear capacity assessments.

The following learning has also been provided by the safeguarding team following the notification or completion of an external investigation. An SBAR has been produced and shared via the learning library:

External investigations where domestic abuse has been a feature K:\#allofusimprove Learning Library\By date\April 2019\Learning - Domestic Abuse.docx

Safeguarding Children

The following learning has been provided by the safeguarding team following the notification or completion of an external investigation. An SBAR has been produced and shared via the learning library:

Learning lessons review for a child in Barnsley (child S) K:\#allofusimprove Learning Library\By date\April 2019\Learning - Resolving Multi Agency Professional Disagreements and Escalation.docx

SBAR summaries of learning from serious incidents and deaths are routinely shared with SWYPT's Operational Management Group and via BDU governance groups.

Greenlight alerts

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

Greenlight alerts are available on the intranet:

- Greenlight on fluoroquinolone antibiotics
- Greenlight on adrenaline availability and use in community teams
- Greenlight on flu vaccines 2018/19
- Greenlight to take care with when required (PRN) medicines
- Greenlight on prescribing and administering liquid medicines
- Greenlight on valproate and haloperidol
- Greenlight on Buccolam (midazolam)
- Greenlight on paraffin
- Greenlight on clozapine

Bluelight Alerts

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

The Bluelight alerts that have already been circulated in Quarter 1 are available on the intranet and below:

Bluelight alert 19 - 9 July 2019 - Keeping equipment and information safe

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

Learning from Serious Incidents

Section 7 is the Serious Incident report. Further information on this is available in the incident management annual report.

5. Incident reporting processes

Resources

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

Previous quarterly and annual reports on incidents and learning are available on the Patient Safety intranet pages.

Key messages regarding incident reporting processes:

Being open and learning from healthcare deaths policy

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

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

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

Manager's Investigation – outcome

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

6. Update on some improvement work

#allofusimprove includes Patient Safety as one of its key areas. A number of case studies have been developed to share good practice and improvement work.

Learning library – this is part of #allofusimprove and is our name for our repository of information from a range of sources of learning from experience. A standard template that can be completed by any member of staff using the Situation, Background, Assessment/Analysis, Recommendation (SBAR) headings has been developed. This helps us to share information in a concise way. These will be shared through the Headlines with

links to a shared network drive. Further details are available here http://nww.swyt.nhs.uk/learning-from-experiences/Pages/Learning-library.aspx

Safety Huddles – the implementation of safety huddles sits under the patient safety strategy. There are currently 9 teams actively involved with safety huddles. The focus of huddles is broad, with some teams looking at reducing violence and aggression, falls, seclusion. Achievements of targets continue to be made.

Human Factors – Bronze level on-line training is available to all staff through the Improvement Academy. Silver training is available from the Improvement Academy and several staff have now attended. Human Factors has been incorporated into the Systems Analysis training delivered by the Serious Incident Investigators. Further details are available here. http://nww.swyt.nhs.uk/incident-reporting/Pages/Human-factors-patient-safety-training.aspx

Significant event analysis (SEA) – This tool, which has been developed in the Trust, which incorporates Human Factors, is now available. Specialist Advisors have been trained and they can support teams with its use. http://nww.swyt.nhs.uk/incident-reporting/Pages/Human-factors-patient-safety-training.aspx

7. Trust wide Serious Incident (SI) Report[1] for Quarter 1 2019/20 (Data as at 4 July 2019)

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." [2]

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*[3].

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

Investigations

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

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

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

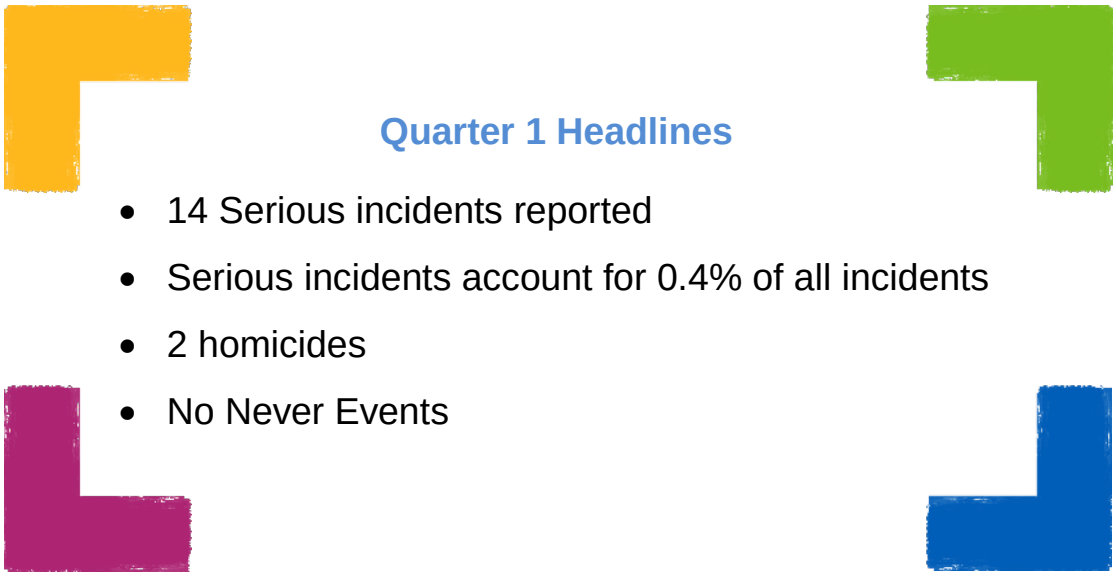
[3] NHS Improvement. Never Event policy and framework 2018

and later de-logged from StEIS following additional information. Conversely, some incidents are reported as Serious Incidents on StEIS after local investigation.

Headlines

During Quarter 1 2018/19, there were **14 Serious Incidents reported** to the relevant Clinical Commissioning Group (CCG) via the NHS England Strategic Executive Information System (StEIS).

Never Events[4] are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There were **no 'never event'** incidents reported by SWYPFT in Quarter 1 2019/20. 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.



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

Serious Incident Reporting Analysis

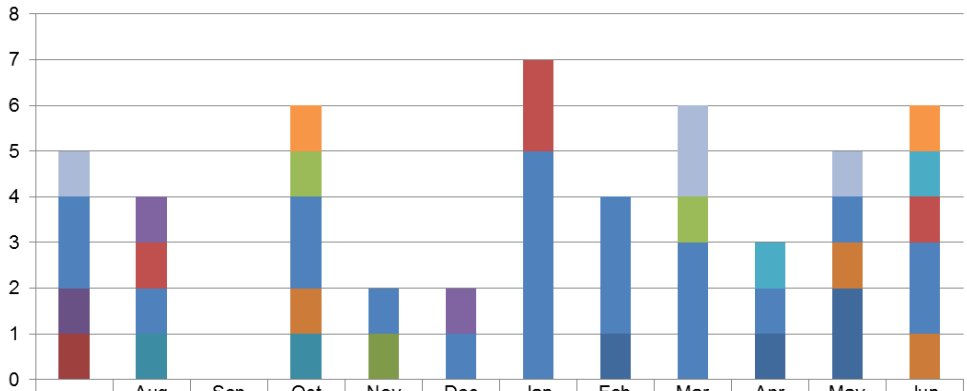
During Quarter 1 2019/20 there have been 14 serious incidents reported on STEIS, as shown in Figure 6 by financial quarter, with comparative data for previous years.

Figure 6 Serious Incidents reported to the Commissioner by financial year and quarter up to 30/06/2019 (2015/16 - 2019/20)

Financial Quarter	15/16	16/17	17/18	18/19	19/20
Quarter 1	18	13	15	8	14
Quarter 2	23	13	18	9	
Quarter 3	15	15	26	10	
Quarter 4	20	24	12	17	
Totals	76	65	71	44	14

Figure 7 shows a breakdown of the 50 serious incidents in a rolling 12 month period (1/7/2018-30/06/2019) by the type of incident and the month reported. The number of SIs reported in any given period of time can vary, and given the relatively small numbers involved and the wide definition of an SI, it can be difficult to identify and understand the reasons for this. However it is important that any underlying trends or concerns are identified through analysis.

Figure 7 Types of All Serious Incidents reported on STEIS in the 12 month period (01/07/2018 – 30/06/2019)



	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019
Pressure Ulcer - Category 3	1	0	0	0	0	0	0	0	2	0	1	0
Physical violence (contact made) against staff by patient	0	0	0	1	0	0	0	0	0	0	0	1
Homicide by patient	0	0	0	0	0	0	0	0	0	1	0	1
Unwell/Illness	0	1	0	0	0	1	0	0	0	0	0	0
Suicide (incl apparent) - inpatient care - current episode	0	0	0	1	0	0	0	0	1	0	0	0
Suicide (incl apparent) - community team care - discharged	0	1	0	0	0	0	2	0	0	0	0	1
Suicide (incl apparent) - community team care - current episode	2	1	0	2	1	1	5	3	3	1	1	2
Self harm (actual harm) with suicidal intent	0	0	0	1	0	0	0	0	0	0	1	1
Lost or stolen paperwork	0	1	0	1	0	0	0	0	0	0	0	0
Lost or stolen hardware	1	0	0	0	0	0	0	0	0	0	0	0
Information disclosed in error	0	0	0	0	1	0	0	0	0	0	0	0
Informal patient absent without leave	1	0	0	0	0	0	0	0	0	0	0	0
Death - cause of death unknown/ unexplained/ awaiting confirmation	0	0	0	0	0	0	0	1	0	1	2	0

As with previous quarters, the highest Type of serious incident is 'Death (including suspected suicide) totalling 8; 5 by apparent suicide and 3 death where cause of death unknown/ unexplained/ awaiting confirmation. Further breakdown is available later in this section.

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

Figures 8 and 9 show the SI reported in the quarter (14) by the team type and BDU and incident category.

Figure 8 Serious Incidents reported by team and BDU during Q1 2019/20

Team/BDU	Barnsley Mental Health	Barnsley General Community Services	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Total
Acute Inpatients (Adult)	0	0	0	0	1	0	0	1
Child and Adolescent Mental Health Services	0	0	0	0	0	0	1	1
Core pathway	0	0	0	0	1	0	0	1
Crisis/IHBTT (Adult)	0	0	2	1	0	0	0	3
District Nursing	0	1	0	0	0	0	0	1
Early Intervention Services	0	0	0	1	0	0	0	1
Enhanced Pathway	2	0	0	1	0	0	0	3
Single Point of Access (SPA)	0	0	0	0	2	0	0	2
Learning Disability Inpatient units [Appleton, Chippendale]	0	0	0	0	0	1	0	1
Total	2	1	2	3	4	1	1	14

Figure 9 Serious Incidents reported by incident category and BDU during Q1 2019/20

Category/BDU	Barnsley Mental Health	Barnsley General Community Services	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Total
Death - cause of death unknown/ unexplained/ awaiting confirmation	0	0	0	1	1	1	0	3
Self harm (actual harm) with suicidal intent	1	0	1	0	0	0	0	2
Suicide (incl apparent) - community team care - current episode	1	0	1	1	1	0	0	4
Suicide (incl apparent) - community team care - discharged	0	0	0	0	1	0	0	1
Homicide by patient	0	0	0	1	0	0	1	2
Physical violence (contact made) against staff by patient	0	0	0	0	1	0	0	1
Pressure Ulcer - Category 3	0	1	0	0	0	0	0	1
Total	2	1	2	3	4	1	1	14

Apparent Suicides

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

Figure 10 Apparent suicides by method reported on STEIS between 01/04/19 – 30/06/19

	Barnsley Mental Health	Calderdale	Kirklees	Wakefield	Total
Hanging - self injury	0	0	1	0	1
Jumping from height	0	1	0	2	3
Prescription medication - self poisoning	1	0	0	0	1
Total	1	1	1	2	5

The most common method of suicide in England[5] is hanging/strangulation (44%), self-poisoning (23%) and jumping/multiple injuries (16%), accounting for 83% of all apparent suicides. The Trust data for quarter 1 is small in number but includes some of these methods.

National and local demographic comparison of apparent suicides

The National Confidential Inquiry (NCI)[5] figures **October 2018** indicate that over the period of 2006-2016 there was an average of 4514 deaths in the general population (England only) that were registered as suicide or 'undetermined'.

Using this data, the NCI stated that the rate of suicide per 100,000 general population for our regions should be approximately 10 in the West Yorkshire STP footprint, and 10.0 within South Yorkshire and Bassetlaw.

This information must be viewed with caution, because the Trust does not have access to the actual local suicide numbers in general population data. The data from the National Confidential Inquiry may not reflect trends until two years later.

The NCI report states that on average during 2006-2016, patient suicides accounted for 28% of the general population suicide figures (13,698 deaths i.e. the individual had been in contact with mental health services in the 12 months prior to death). This represents an average of 1,245 patient suicides per year, though the number has fallen each year since 2012.

Analysis using population size[6] and NCI data[5] shows that a Trust covering Barnsley, Calderdale, Kirklees and Wakefield would expect to see between 34-35 patient deaths by apparent suicide per year. Figure 1 provides an indication of the number of patient suicides by district against predicted levels using the NCI statistics.

[5] National Confidential Inquiry into Suicide and Homicide 2018
[6] Office of National Statistics

Figure 11 Populations of the Trust's Districts and Average Suicide Rates

	Population ONS[6] – population estimates Mid 2017	General population suicide rate (NCI) 10.0 (West Yorkshire STP) & 10.0 (South Yorkshire and Bassetlaw) per 100,000 population	Patient suicide rate (28% general pop) (NCI)[6]
Barnsley	241,341	24.3	6-7
Calderdale	209,454	20.9	5-6
Kirklees	437,145	43.7	12-13
Wakefield*	340,790	34.0	9-10
Trust wide	1,230,730	123.07	34-35

Figure 12 All Apparent Suicides reported as SI's between the last 12 months 01/07/18 – 30/06/19 by Quarter and BDU.

	18/19 Q2	18/19 Q3	18/19 Q4	19/20 Q1	Total
Barnsley Mental Health	1	1	2	1	5
Calderdale	1	0	3	1	5
Kirklees	2	4	6	1	13
Wakefield	0	0	2	2	4
Specialist Services	0	0	1	0	1
Total	4	5	14	5	28

The rolling 4 quarter data (Figure 12) shows that the Trust is below the expected number of suicides (apparent suicides reported in the last 12 months) based on the National Confidential Inquiry figures (Figure 10) for a population the size of the Trust and patient suicide rate (28%). This figure (28) includes apparent suicide occurring in specialist services (CAMHS). The specialist services death is not allocated to a geographical area, but did occur in Wakefield district. Calderdale is as expected the number for their respective geographical areas as well as Kirklees, Wakefield is below the expected number. Barnsley is slightly below the expected level. Caution is advised with these comparisons due to the sensitivity of the figures if just one or two more incidents occur, and because the figures are not weighted by characteristics such as age, gender or socio-economic status.

It must be noted that the figures above are apparent suicides and not confirmed by the Coroner. All apparent suicides are reviewed by teams, and in line with the learning from healthcare deaths policy. Deaths will either be serious incident investigations, service level investigations, Mortality Structured Judgement Reviews or considered through safeguarding processes.

The data from the National Confidential Inquiry may not reflect trends until two years later. The Trust looks at apparent suicides on an annual basis and reports any difference between the national data and that of the Trust. The Trust may on occasions report and investigate deaths that are later removed from the numbers as the death was not found to be due to

suicide. However, when we have compared apparent suicides with results from the Coroner there is minimal data change.

Serious Incident Investigations completed during Quarter 1 2019/20

This section of the report focusses on the 11 serious incident investigation reports that were completed and submitted to the relevant commissioner during Quarter 1 2019/20. Please note this is not the same data as those reported in this period as investigations take a number of months to complete. The term 'completed' is used in this section to describe this.

Headlines

Quarter 1 Serious incident investigation headlines

- **11** SI Investigation Reports have been completed
- **7** SI investigations closed by the Commissioners
- **28** SI investigations remain under investigation (as at 04/07/19)
- Top recommendations are:
  Staff education training and supervision
  Other
  Risk assessment
  Record keeping

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

Of the 28 investigations that are underway, they are at different stages of progress. 7 are over the 60 working day timeframe (Figure 13).

Figure 13 Breakdown of SI investigations over 60 working day timescale in each quarter 01/07/18 to 30/06/19 compared with the total number of investigations underway at that time (at 04/07/19)

	Quarter 2 2018/19	Quarter 3 2018/19	Quarter 4 2018/19	Quarter 1 2019/20
Serious Incident investigations over 60 working days timeframe	4 (25%)	6 (30%)	5 (22%)	7 (25%)
Total number of ongoing SI investigations	16	20	23	28

Figure 14 Breakdown of SI investigations that are over 60 working day timeframe (at 04/07/19)

Commissioner extension (extension is usually for a further 20 working days)		Barnsley General Community	Barnsley Mental Health	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services - CAMHS	Total
Red	Investigation has required two or more extensions from commissioners beyond 60 working days.	0	0	0	2	1	0	1	4
Red	Investigation has required one extension from commissioners beyond 60 working days.	0	1	1	1	0	0	0	3
Total		0	1	1	3	1	0	1	7

The length of time an investigation is over the 60 working days is graded. Figure 14 shows a breakdown by BDU of the 7 investigations that are over 60 working days since the incident was reported on the Strategic Executive Information system (StEIS). Serious Incident Investigation progress is monitored through the weekly patient safety support team investigators meeting, and reported through the weekly clinical risk panel. The reasons for delays varying but relate to issues such as complexity, staff availability to conduct interviews and investigation allocation delays due to capacity because of absence. Bank investigators and external investigators have been used to manage some of this pressure.

SI Action Plans

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

Serious Incident learning and themes

During Quarter 1, the number of investigations completed and sent to the commissioners was 11. Of these investigations sent to commissioners, all 11 had an action plan. There were 48 separate actions made to improve the system or process to prevent recurrence**.**

Categorisation of recommendations

In analysing the actions, it isn't always straightforward to identify which category an action should be included in - some don't easily fit into any category, and some could be included

under more than one. The analysis undertaken has included each action under the issue/theme that seemed the best match. In an attempt to gain consistency, the theming of actions is undertaken by the Lead Serious Incident Investigators.

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

A standard recommendation to share learning is in common use. This is to support learning being shared across the teams, service, BDU, Trust and wider health economy. These recommendations have been removed from the analysis below.

Figure 15 shows the action themes arising from the 11 serious incidents completed and sent to commissioners during Quarter 1.

Figure 15 Quarter 1 2019/20 completed SI investigation by action themes

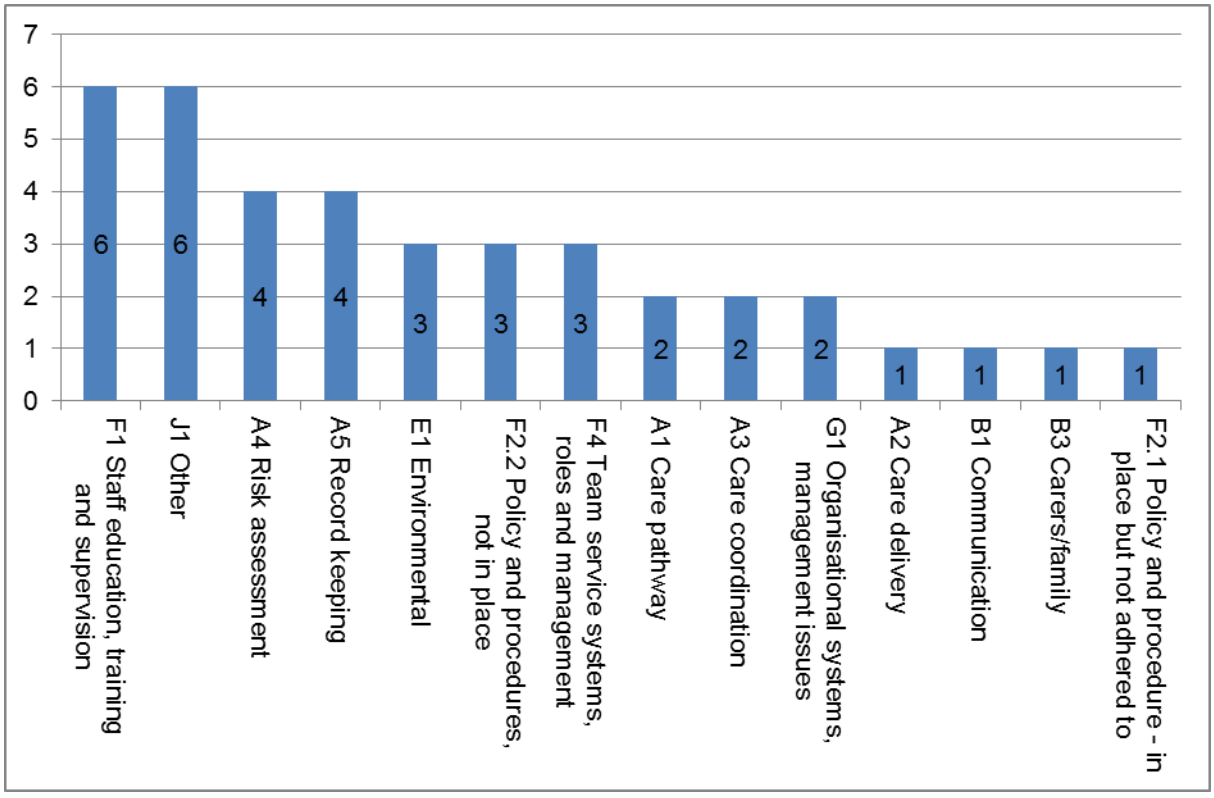
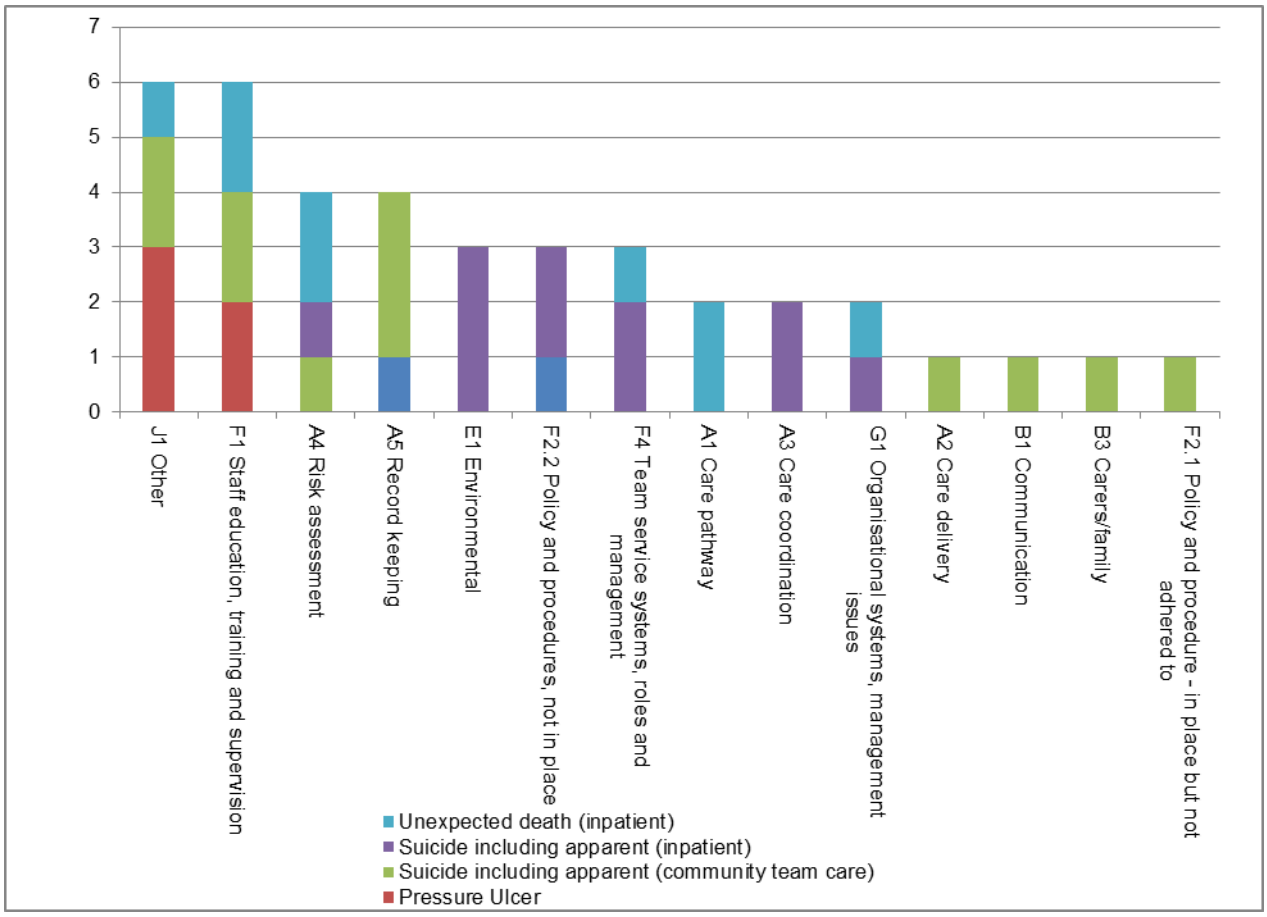


Figure 16 Comparison of action themes by incident type in Quarter 1 2019/20



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

In Quarter 1, 2019/20 the most frequent[7] action themes were Staff education training and supervision (6), Other (6) and Risk assessment (4) and Record keeping (4).

A majority of the actions from serious incident investigations apply directly to the team or BDU involved. Each BDU lead investigator works closely working with the practice governance coaches and BDUs to present learning from recommendations which is included in 'Our learning journey' reports. The SBAR learning template is now completed at the end of the investigation process to summarise the learning from an SI investigation. This is shared through Operational Management group and added to the learning library.

Learning within this quarter:-

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

Areas for improvement from the top 4 themes are as follows:

[7] Excludes recommendation to share learning

Staff education training and supervision:

- Team managers to remind all staff of the requirements of CPA when transferring service users care emphasising the importance of ensuring all relevant individuals are involved in the handover.

- All new service users to the enhanced teams must be reviewed by medical staff as part of the multi-disciplinary assessment/review

- Staff should receive training in the recognition of the link between aspiration pneumonia and coughing when eating and drinking.

- Embed the moisture lesion pathway within the Neighbourhood Nursing Service by providing further training and support.

Other

- Care plans and crisis care plans must be in place, adhered to and reviewed regularly to ensure they are relevant to the individual's personal needs.

- Where partnership working is identified across other organisations, all efforts should be made to approach investigations jointly to optimise information sharing and learning.

Risk assessment:

- Team managers to reinforce the importance of updating risk assessments when any new information and that this is shared at the team meeting.

- The Trust considers how it could be assured through audit or other means, that risk assessment and management plans are effectively communicated and implemented when patient care is transferred.

- The Trust considers through audit or other means how comprehensive, up to date and accurate risk assessment and management plans are with regard to physical or environmental problems, and whether these are fully implemented.

- The system of having risk assessment forms prepopulated with the last risk information should be reviewed in order to ensure the risk of inaccurate information being perpetuated is minimised and to ensure that there is a robust assessment of current risk.

Record keeping:

- Team managers to reinforce the importance of recording all discussions and pertinent information.

- Individual's mental state to be recorded following each visit to clozapine clinic.

- Ensure that the Department of Health consensus statement (2014) on the sharing of information to prevent suicide is disseminated across all front line services to reinforce the understanding of staff on the sharing of information to prevent harm.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 24 September 2019
Agenda item 6.3

Title:	**Update on Contingency Planning for Brexit**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates
Purpose:	This paper updates the Board on progress on the progress to date in respect of planning for the possibility that the United Kingdom (UK) leaves the European Union (EU) with no deal in place.
Mission/values:	This work stream is in place to ensure that the Trust can operate safely in a period of uncertainty and looks at key areas which could be affected. The work is part of wider planning at national level.
Any background papers/ previously considered by:	Executive Management Team (EMT) and Operational Management Group (OMG) are receiving updates from the Brexit group along with formal reports to Board.
Executive summary:	The Trust has a group considering the impact of a no deal Brexit from a contingency planning point of view. Members of this group report on progress in key areas of their responsibility as well as attending wider contingency planning groups operating at regional and national level. The Trust has a risk assessment and action plan which has been externally scrutinised and found to be in line with national guidance. The Brexit group has undertaken table top scrutiny exercises on pharmacy supply and continues to undertake tests on the key areas contained in the report. **Risk Appetite** This plan is in line with the Trust's risk appetite for both clinical services and emergency planning.
Recommendation:	**Trust Board is asked to NOTE and comment on the content of the report.**
Private session:	Not applicable

South West Yorkshire Partnership NHS Foundation Trust

Trust Board: 24 September 2019

Brexit - Contingency Planning

Introduction

This paper is intended to further update the Board on the preparations being made should there be a no deal when the UK is due to leave the European Union on the 31 October 2019.

As previously stated the possibility of a no deal exit will have consequences in a number of key areas and the Trust, along with the NHS as a whole, needs to examine what it can do to mitigate any risks. The Department of Health and Social Care continues to update its advice on actions the NHS should take to prepare for a "no deal" Brexit scenario.

The government advice remains broadly the same in all key areas. The Brexit group continues to meet fortnightly and the risk assessment and action plan contained in the appendices to this paper have been assessed by that group and have been prepared in line with that guidance.

Advice continues to be that supply chains will be maintained in key areas and that Trusts should not stockpile goods especially pharmaceuticals. The Trust continues to update its internal risk assessments and participate in all regional activities.

The recent increased publicity relating to the process around operation Yellowhammer has resulted in more enquiries on the how the Trust is preparing.

Process

The key departments listed below continue to monitor developments in their specific areas of responsibility and update the EPRR (Emergency Planning & Resilience Response) lead who is managing the risk assessments and action plan for the group which has been revised during the process into the following people.

- Pharmacy – Kate Dewhirst
- General Procurement – Tony Cooper
- Workforce – Richard Butterfield
- Food supplies – Karen Whittam
- Information Technology – Paul Foster
- Estates and Facilities lead – Nick Phillips
- General EPRR issues arising from the centre – Martin Brandon
- Communications – Jude Tipper
- Medical devices and professions – Emma Cox

The group provides updates to the Operational Management Group (OMG) for noting and appropriate action as well as escalation to EMT.

The essences of the updates for each key area have not changed from the initial reports and for completeness are as follows:

Internal Issues

Pharmacy

Advice remains that centrally purchased drugs should not be stockpiled. The few lines not from this supply chain have got assurances in place around continuing supply. The pharmacy plan has been tested by the Brexit group as a table top exercise where resilience against disruption of supplies for two key drugs not supplied by NHS supply chain was examined.

Some Trusts in the area are experiencing pressure on drugs supply due to higher levels of usage, this is being monitored.

Procurement

The Trust again purchases most items through NHS supply chain and is working to their guidance. Where we do not purchase through NHS supply chain, key suppliers have given assurance around continuity of supply. This assurance includes continuity of supply of foodstuffs.

Workforce

The situation for workforce remains that EU nationals will still be able to work in the UK after 31 October and the registration process will be free of charge to the individual. Whilst outside of the immediate work of the No Deal Brexit Group, nationally there are concerns in the short to medium term of loss of the social care workforce due to Brexit. There are already plans in place for the NHS to meet the potential shortfall in EU workers through increased training places in Nursing and Medicine, development of new roles and international recruitment, however, such plans have not been developed for the social care workforce. Emphasis from central Government is focussing on the care home sector as this is expected to be more volatile than the NHS due to pay and conditions in the sector. The Trust is not experiencing retention issues as a result of this.

Food Supplies

The main concern here remains the supply of fresh foods, which means that menus may be revised, but the advice remains that food will generally be available with some unknown restrictions, especially around fruit. This will have to be managed at the time and alternatives will be available.

Plans are in place for the Hull port to be used to relieve pressure on channel ports a planning exercise has this putting extreme pressure on the M62 corridor which could impact on deliveries. Plans for alternative menus will mitigate this again fresh food would be most at risk.

Information Technology

At present no major issues are anticipated.

External Issues

- Initial SITREP reporting has been undertaken to regional EPRR teams, with regular SITREPs expected to commence on 12 October (TBC);
- Alan Davis as Trust lead attends the Yorkshire and Humber LHRP meetings to provide assurances for the Trust relating to EPRR and EU Exit;
- Nick Phillips through work on the national council of HEFMA (Hospital Estates and Facilities Management Association) has arranged for the NHSi estates lead to brief the regional estates teams on 26 September SWYPFT personnel will be at this meeting
- Head of Security and Resilience (Martin Brandon) attends West Yorkshire CIAG (Community Impact Assessment Group) to provide assurances;
- Trust emergency planning lead (Emma Hilton) attends regional and national conference calls with NHSE and NHSI to both provide assurances and obtain up to date information on EU Exit, along with providing assurances to CCG and local health partners at local meetings;
- Community Care and Care Homes confirmed to be managed and monitored via LA and CCG's who would liaise and report to LHRP/LRF's accordingly in the event of care home issues

Recommendation

Board is recommended to

- Note the content of this report
- Note the Action plan and risk assessment at appendix 1

Nick Phillips
Head of Estates and Facilities

BREXIT No deal Risk Assessment – ***Reviewed 07 August 2019***

What are the risks?	Potential impact?	What are you already doing?	Do you need to do anything else to control this risk?	Risk owner	Completion Date	Status	RAG rating (Low/Medium /High Risk)
Medicines	Patients – lack of suitable provision due to stock shortages, leaving patients potentially unwell	National instruction in place not to stockpile medicines or write longer scripts. DHSC NHSE are monitoring stock levels nationally and locally. Goods bought direct (unlicensed goods), such as from Germany can be stockpiled. All goods being reviewed and any items that can be stockpiled will be ordered accordingly – space for storage identified. Guidance on medicines due out before the end of January	Monitor stock levels. Maximise stocks of pharmaceuticals. Purchase unlicensed medicines. Complete weekly SITREP requirements.	Kate Dewhirst	January 2019		Risk rating L = 2 C = 2 RR = 4
Medical Devices and Clinical Consumables	Patients and Staff – risk of injury if incorrect devices in use Risk of inability to undertake clinical procedures if correct devices are not available	Standard levels of stock at BICES Asset register details location of all medical devices to enable transfer where necessary. 20 packs of defibrillator pads ordered to store to replace old stock. – complete. Audit of defib pads complete and stock levels identified. MD's and subsequent repairs to be monitored at Medical Devices Trust Action Group pre/post EU Exit.		Emma Cox	March 2019		Risk rating L = 1 C = 2 RR = 2
Non clinical Consumables, Goods and Services i.e. Food & Laundry	Patients Lack of suitable food provision and/or laundry service	Number of suppliers already contacted by Procurement as they are on the national supply chain (see Procurement) Local suppliers of fresh goods and suppliers of catering equipment identified and contacted Guidance re non-medical goods and consumables due out end of February.	07.03.19 – response not yet received from ISS April 2019 – Assurances Received. *07.08.19 – **risk reduced***	Karen Whittam	March 2019		L = 2 C = 2 RR = 4

Workforce	Patients due to loss of clinical staffing; Trust reputation due to loss of workforce	14 employees have come forward to date. 3 of these staff members are Irish and therefore no action is needed due to protected rights to work and live in the UK. No plans to look at international recruitment at the moment.	All staff communicated with via Payslips in January to identify any additional staff that need to apply for settled/ pre-settled status. Workshops/1-2-1 assistance to be put in place to help staff apply for settlement status when the application window opens in March. All staff provided with details on how to access Settlement Scheme application and provided with contact details/support if needed. COMPLETE	Richard Butterfield/ Sandy Stones	March 2019		LOW Risk rating L = 1 C = 2 RR = 2
Reciprocal Healthcare	Impact on the provision of services due to an increase in demand due to the return of British Citizens from abroad.	Each BDU assessing potential impact ensuring Business Continuity plans would still be fit for purpose in the event of an increase in demand. Feedback noting that services will manage the demand increase via the implementation of OPEL levels – no noted concerns regarding impacts. System in place to liaise with Overseas Management Team in partner Trusts is transfer of care places patient in the care of SWYPFT.		EPRR Team	Ongoing		Risk rating L = 2 C = 2 RR = 4
Research and Clinical Trials	Access to devices/pharmaceuticals to undertake/finalise any trials the Trust are involved in.	One clinical trial underway in the Trust. Sponsor contacted and confirmed that no impact will be had as a result of a no deal Brexit	No action	Rachel Moser	January 2019		Risk rating L = 1 C = 2 RR - 2
Data Sharing, Processing and Access	Transfer and storage of clinical data	All suppliers of IM&T services are UK based. When tendering for any new services it is stipulated that hosting/processing of Trust data by carried out in the UK.	No further action required.	Paul Foster	January 2019		Risk Rating L = 1 C = 3 RR = 3
Procurement of Goods	Patients, Staff, Trust Inability to obtain suitable/sufficient stock to maintain patient care and back room functions	Undertaken self-assessment as instructed by Department of Health & Social Care. Response provided following cross reference of companies on assessment document.	Contact those companies not on the national framework to identify contingency arrangements. All companies contacted and contingencies confirmed.	Tony Cooper	31st January 2019		Risk Rating L = 1 C = 3 RR = 3

Diesel Access	Back Up Generators for clinical areas	In the event of power failure 25k litres of fuel will keep generators running (at full operation) for 4 days.	Fill all generators and order spare barrel of fuel for storage at the end of February. Plans to test generators and refill all generators and order spare goods by the end of March. Fuel tank ordered which will be situated in the gardeners compound at Fieldhead – holds 1200 litres of white diesel (equate to 20 tanks of fuel) which will be utilized to run Trust vehicles to deliver food and linen in the event of a fuel crisis.	Tony Tipton	May 2019		Risk Rating L = 1 C = 2 RR = 2
Fuel Crisis	Staff access to fuel limited in the event of a national fuel crisis. Patients – staff unable to attend appointments in the community or get to work on inpatient wards	Fuel plan drafted for implementation. Liaison with Community lead in Barnsley BDU to update BCPs to encompass loss of fuel	Finalise and implement Fuel Crisis BCP Cascade to all teams Request teams to update BCP's in line with Trust plan and processes. Plan in draft format and out for comment 07.03.19 March 2019 – Trust Fuel Crisis Plan implemented – all BCP owners asked to review BCP's in line with new plan, adding appropriate action card.	Emma Hilton	March 2019		Risk Rating L = 1 C = 3 RR = 3
Registration Process for Smart Card Issue	There may be instances where staff cannot provide the required documentation for accessing NHS systems (such as NI numbers for access to smartcards)	Contingency is to provide a temporary username and password access to SystmOne. This temporary username/password SystmOne access is time-limited and will be only be invoked in such instances where appropriate to do so. Any such requests will need approval by Senior IM&T Management and confirmation from HR.	Continue to monitor *07.08.19 – risk and control measure remain the same – to continue to monitor*	Paul Foster	Ongoing		Risk Rating L = 1 C = 2 RR = 2

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 24 September 2019
Agenda item 7.1

Title:	**South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYB ICS)**
Paper prepared by:	Director of Human Resources, organisational development and estates / Director of strategy
Purpose:	The purpose of this paper is to update the Trust Board on the developments within the South Yorkshire and Bassetlaw Integrated Care System (SYBICS), and Barnsley integrated care developments.
Mission/values:	The Trust's mission to **enable people to reach their potential and live well in their communities** will require strong partnership working across the different health economies. It is therefore important that the Trust plays an active role in the SYBICS.
Any background papers/ previously considered by:	The Trust Board have received regular updates on the progress and developments in the SYBICS (formerly Sustainability and Transformation Partnership), including Barnsley Integrated Care Developments. Further information on the SYBICS can be found at: https://www.healthandcaretogethersyb.co.uk/
Executive summary:	**1. South Yorkshire and Bassetlaw Integrated Care System Update** **Meeting with SYB ICS Chief Executive** The Trust Chair and Director of Human Resources, Organisational Development and Estates met with Sir Andrew Cash Chief Executive and Will Cleary-Smith, Chief Operating Officer to discuss the role of the South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) in the South Yorkshire Integrated Care System (ICS), the interim governance arrangements and the development of the final governance arrangements. The meeting was very positive with SWYPFT being recognised as a key partner organisation within the ICS and an important player in the Mental Health Alliance. **Place Reviews** The Quarter One reviews to better understand the breadth of work and innovation in services of each of the five Accountable Care Partnerships in South Yorkshire and Bassetlaw ICS are now complete. In the first round, each Partnership focused on good practice and issues where additional support would be helpful. The Barnsley Place Review was held on the 22nd May 2019. The review focused on the strong overall performance across services in the town, strong integration working and included a presentation from Tom Jackson, Clinical Lead on Learning Disability Services and a joint presentation from the Local Authority, SWYPFT, Barnsley Hospital and the Clinical Commissioning Group

(CCG) on the integrated approach to service delivery in the Dearne Valley.

South Yorkshire and Bassetlaw ICS Review

In the last three years the ICS has evolved from a Sustainability and Transformation Partnership in to an Accountable Care System and now one of the first and most advanced Integrated Care Systems in England. Throughout this time the ICS has built on our excellent foundation of working together and started to deliver real and tangible improvements for the population. Whilst there has been a lot to celebrate, the work across the System is now being captured in a formal review of work between 2016 and 2019. This review will give a solid foundation for us to build on as the ICS sets out the next phase of its ambition including delivering the commitments of the NHS Long Term Plan.

Work has been progressing over the summer in pulling together our next ICS Health and Care Strategy, coordinated by our cross-system task and finish group and with wide engagement. The aim is to publish the plan at the end of November.

New Capital Funding

South Yorkshire and Bassetlaw Integrated Care System was one of the beneficiaries in the Prime Minister's £850 million NHS capital spending pledge announcement in August, with **primary care** across our region awarded £57.5 million of new funding to improve facilities. The £57.5m for South Yorkshire and Bassetlaw is funding for which the South Yorkshire and Bassetlaw Integrated Care System submitted a bid in 2018. Work will now be undertaken, at pace, through the primary care work-stream to update the business case.

The successful funding bid included our plans to:

- Create integrated services hubs bringing together primary care, community care and social care under one roof in purpose built settings, offering the ability to deal with a wide range of issues affecting local communities in one location.
- Improve GP practice facilities so that they are able to meet the minimum requirements needed to become a 'training practice', which means we will be able to train more primary care staff in South Yorkshire and Bassetlaw.
- Undertake significant refurbishment and extension of existing primary care facilities so they are flexible and adaptive spaces which allow a wider range of health and wellbeing services to patients.
- Join up local services and therefore improve the use of digital in primary care.

In addition there is a further increase in the national capital limit of £1 billion which will allow NHS organisations to revert to their original capital plans if they were funded from the Trust's own income or reserves or where a business case or programme funding has been approved by Department for Health and social Care.

Performance Scorecard

The collective performance against national targets position over June/July has seen a slight decline, which is consistent with other areas in the North of England and also with the other nine advanced ICSs in the country and reflects service pressures. However, there is expectation that performance against national targets will improve in the short term.

NHS Constitutional Standards on Improving Access to Psychological Therapies (IAPT) access and recovery and Early Intervention in Psychosis (EIP) have continued to exceed national targets. The performance dashboard is attached.

Commissioning Development

The Long Term Plan states that by April 2021 Integrated Care Systems (ICS) will cover the whole country, and that each ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level. Typically this will involve a single CCG per ICS area with an expectation that CCGs need to be leaner, more strategic organisations that support local partnerships. It is understood that national policy is currently being developed to drive forward changes in commissioning from 2020/21 to meet the requirements of the LTP.

Across South Yorkshire and Bassetlaw the five CCG Accountable Officers and Chairs are currently discussing the future of commissioning in an integrated care system and are collectively developing an approach to change the traditional model of commissioning from 2020/21 and where some non-statutory commissioning functions could be delegated to providers in the ICS. An outline of this will be shared with organisations for discussion later in the year.

Mental Health Provider Alliance

To enhance closer collaboration and joint working between the four mental health providers that deliver services to the population of South Yorkshire and Bassetlaw, a system wide Mental Health Provider Alliance model is being established.

The Alliance will aim to improve integration across specialised and non-specialised care pathways, create opportunities to re-invest resources into local community services that best meet the needs of individuals and complement 'right-sized' specialised inpatient provision.

The providers involved are; Nottinghamshire Healthcare NHS Foundation Trust, Rotherham, Doncaster and South Humber NHS Foundation Trust, Sheffield Health and Social Care NHS Foundation Trust and the South West Yorkshire Partnership NHS Foundation Trust.

Acute Providers

Advertisements for the Hosted Network clinical leadership and manager posts have closed, with sifting and interviewing taking place over the next six weeks. Trusts have produced first outlines of the work programmes and

governance for the Networks, with the final versions being signed off once the new clinical leads are in place.
A paper laying out the final recommendations from the Hospital Services Review is being discussed by each CCG Governing Body during August and September. The recommendations focus on building the Hosted Networks for all the Hospital Service Review services, and taking forward further discussions on the potential reconfiguration of services.

ICS Guiding Coalition and the Long Term Plan
The ICS Guiding Coalition met on the 9th July to build on the work set in motion three years ago when the Sustainability and Transformation Plan was being developed. The event offered partners an opportunity to hear updates on progress against our plans and to consider the key themes within the NHS Long Term Plan, published earlier this year, to inform our refreshed vision and ambition for the South Yorkshire and Bassetlaw Integrated Care System Five Year Plan.

Partners' contributions in shaping the refreshed plan and feedback from the session is being analysed alongside feedback from the many conversations had this year with the public, staff and partners. The findings are being used by the team developing the SYB ICS refreshed Five Year Plan.

The next Guiding Coalition is scheduled for the morning of Tuesday 8th October where the findings from the final engagement report and our draft refreshed vision in our Five Year Plan will be shared. All feedback will inform the final submission of the Plan on 15th November 2019.

2. SYB ICS Mental Health, Learning Disabilities and Autism programme
The ICS Mental Health Executive steering group has a number of programmes of work that have been prioritised, below is an update on some of these programmes.

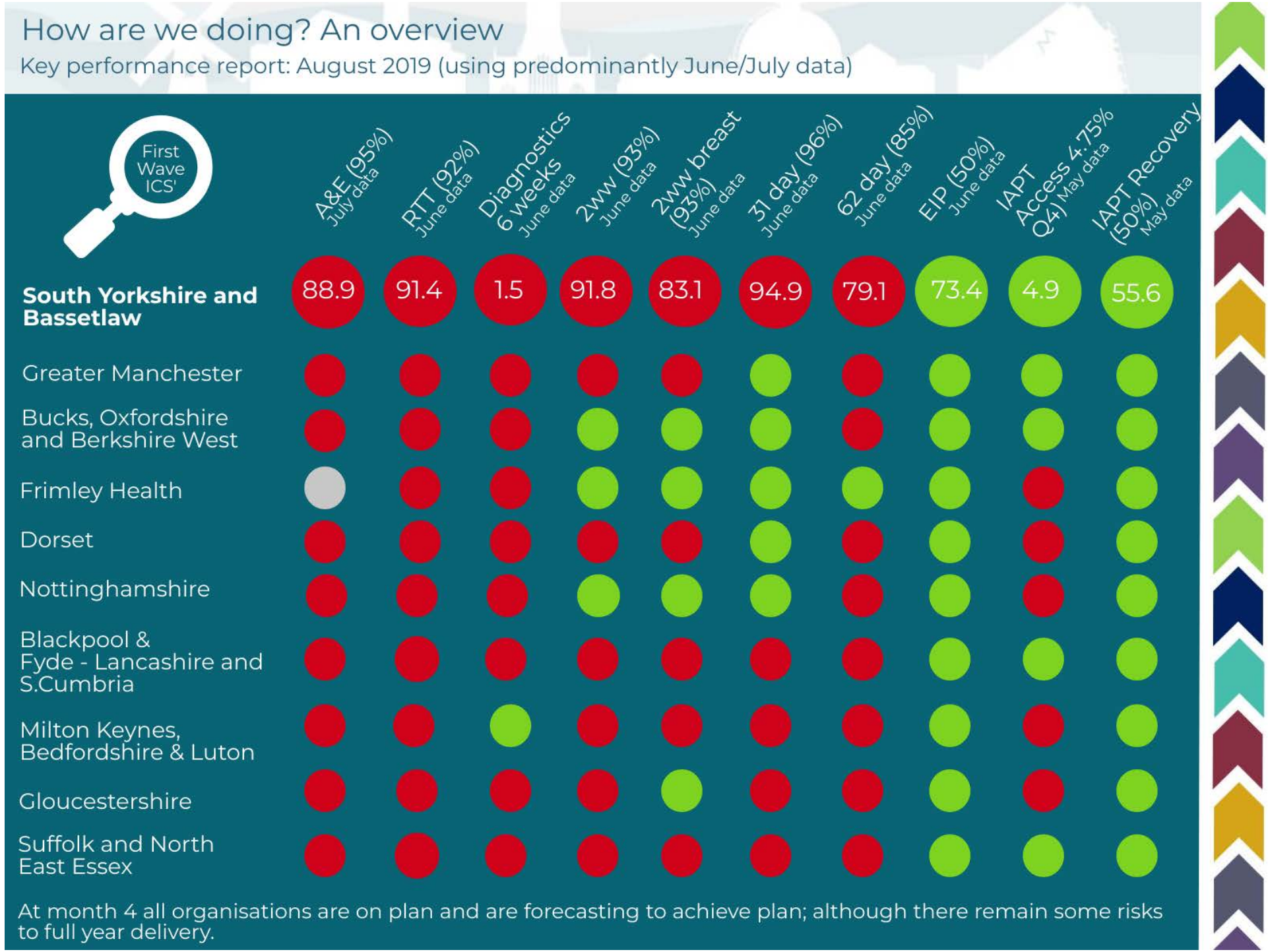
Individual Placement and Support (IPS) - Provision of IPS services is variable across the ICS and the bid submitted as part of the wave two funding to ensure that IPS services are available across the ICS has been successful. Following a successful procurement process, the Trust as a key partner in this programme will benefit from additional funding to deliver a new service in Barnsley.

Mental Health Liaison and Crisis Care - The Trust in partnership with Barnsley CCG, recently submitted two bids to NHS England (NHSE) for additional transformational funding as part of the SYB ICS Bids. One bid (circa £500,000) was to enable the all-age mental health liaison service to achieve 'Core 24' status and the second bid (circa £231,000) was to enable Barnsley to develop a Crisis Assessment Unit, based on the model successfully implemented by TEWV (Tees, Esk and Wear Valleys NHS Foundation Trust). The Crisis Assessment Unit should provide an alternative to ED as a place of safety and reduce usage of the S136 suite at Kendray hospital. Both bids have been successful.
NHS England specialised commissioning New Models of Care - The

	Specialist Forensic providers across the ICS are working together to develop a Lead provider model for Forensic services. The bid submitted to NHSE by the partners is on the development track with a gateway review / sign off by April 2020, with the intention of going live from October 2020. The Trust is not a partner in the delivery of the model in South Yorkshire (we are lead for the equivalent model in the West Yorkshire and Harrogate Health and Care Partnership) however we will continue to work with providers in South Yorkshire to ensure that pathways in to care and the impact on community services is considered as part of the development phase. **3. ICS place review - Barnsley** The ICS CEO Lead and members of the ICS Core team together with representatives from NHSI held the second quarterly place reviews in Barnsley this month. The review focused on performance, integration and joined up care and service developments including the development of Primary Care Networks (PCN). **4. Barnsley Integrated Care update** The Barnsley Clinical Commissioning Group (CCG) continues to work with provider partners including the Trust to develop joined up integrated care. Partners across Barnsley continue to work together to develop integrated models of care including Primary Care Networks (PCNs), integrated primary and community care as part of the neighbourhood model, frailty, and developing an integrated model of care for stroke and frailty. **Risk Appetite** This update supports the risk appetite identified in the Trust's organisational risk register.
Recommendation:	**Trust Board is asked to NOTE the update from the SYBICS and Barnsley integrated care developments.**
Private session:	Not applicable.

How are we doing? An overview

Key performance report: August 2019 (using predominantly June/July data)



At month 4 all organisations are on plan and are forecasting to achieve plan; although there remain some risks to full year delivery.

How are we doing? An overview

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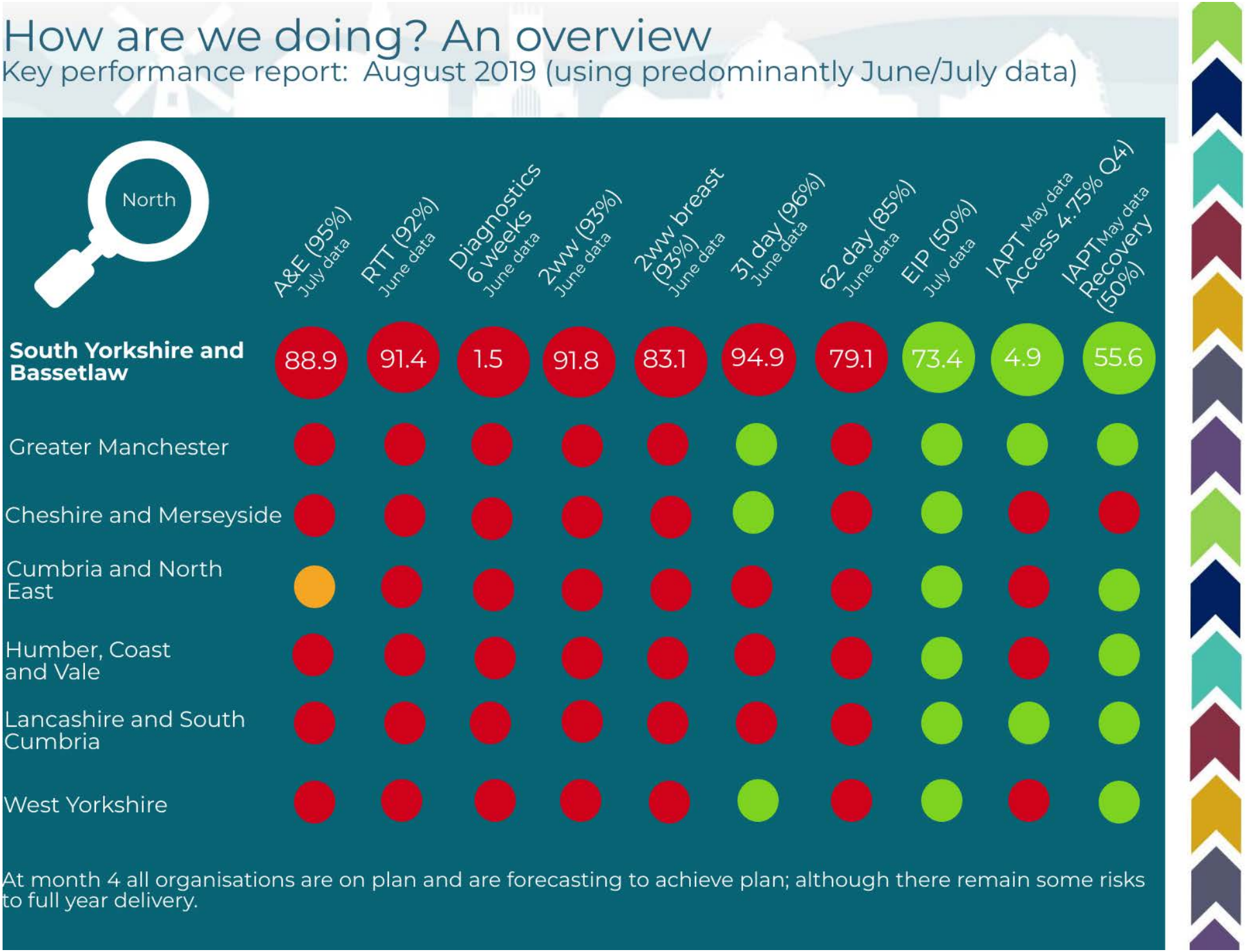


At month 4 all organisations are on plan and are forecasting to achieve plan; although there remain some risks to full year delivery.


Place*
A&E (95%) July 2019 data
RTT (92%) June 2019 data
Diagnostics 6 weeks June 2019 data
2ww (93%) June 2019 data
2ww breast (93%) June 2019 data
31 day (96%) June 2019 data
62 day (85%) June 2019 data
EIP (50%) June 2019 data
IAPT Access 4.75% Q4) Mar 2019 data
IAPT Recovery (50%)
Barnsley CCG
Barnsley Hospital
Bassetlaw CCG
Doncaster CCG
DBH
Rotherham CCG
Rotherham Hospital
Sheffield CCG
Sheffield Children's
STH
*Data based on CCG and Acute Trust performance

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 24 September 2019
Agenda item 7.2

Title:	**West Yorkshire & Harrogate Health and Care Partnership and Local Integrated Care Partnerships update**
Paper prepared by:	Director of strategy Director provider development
Purpose:	The purpose of this paper is to provide the Trust Board 1. With an update on the development of the West Yorkshire and Harrogate Health and Care Partnership and 2. Local Integrated Care Partnership developments.
Mission/values:	The development of joined up care through place-based plans is central to the **Trust's strategy**. As such it is supportive of our mission, particularly to **help people to live well in their communities.** **The way in which the Trust approaches strategy and strategic developments must be in accordance with our values**. The approach is in line with our values - **being relevant today and ready for tomorrow**. This report aims to assist the Trust Board in shaping and agreeing the strategic direction and support for collaborative developments that support the Trusts strategic ambitions.
Any background papers/ previously considered by:	Strategic discussions and updates on place based plans have taken place regularly at Trust Board including an update to July Trust Board.
Executive summary:	The Trust Strategy refresh outlines the importance of the Trust's role in each place it provides services, including the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP): ➢ WY&H HCP has evolved in to a mature Integrated Care System (ICS) that is now playing a stronger role in system performance and transformation including developing the 5 year plan in response to the NHS Long Term Plan. The plan builds on the programmes and work initiated and developed over the last few years across each of the places that make up the ICS. Engagement with partners has shaped the draft plan that is being further developed. ➢ Significant Transformation funding has been made available through the ICS to support key programmes and initiatives including the mental health, learning disabilities and autism programme. The paper will provide an update on transformation funding that will enable services developments in each of the places that we provide services. We continue to work with partners to develop and deliver joined up care and transform services and support. The paper provides an

	update that includes notable developments in the following places: • Kirklees • Calderdale • Wakefield **Risk Appetite** The development of strategic partnerships and the development and delivery of place-based plans is in line with the Trust's risk appetite supporting the development of integrated, joined up care and services that are sustainable. Risks to the Trust services in each place will need to be reviewed and managed as the partnerships develop to ensure that they do not have a negative impact upon services, clinical and financial flows.
Recommendation:	**Trust Board is asked to RECEIVE and NOTE the updates on the development of Integrated Care Partnerships and collaborations including:** ➢ **West Yorkshire and Harrogate Health and Care Partnership** ➢ **Wakefield** ➢ **Calderdale** ➢ **Kirklees**
Private session:	Not applicable.

West Yorkshire & Harrogate Health and Care Partnership and Local Integrated Care Partnerships - update

Trust Board 24 September 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.

WY&H HCP is a trailblazer and one of the earliest Integrated Care Systems (ICS) that is supported by the ICS development programme. Since May 2018 the ICS has received national recognition for the way the 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 chaired by Councillor Tim Swift, met for the second time on Tuesday 3 September 2019. The Partnership Board forms a key element of the Partnership's leadership and governance arrangements, bringing together all partners to provide formal leadership for the Partnership. The Board is responsible for setting strategic direction and providing oversight of all Partnership business and is a key forum for partners to make decisions together, in public. Key areas of focus at the partnership included the following:

- **Flexible Transformation Funding 2019/20**

The prioritisation of the £8.5m transformation funding was approved by the Partnership Board. Subsequently the specific plans for the allocation and use of the funding has been further prioritised by the programme Boards. Each of the programme Boards will oversee the delivery of the detailed plans. **The Trust is a partner in the Mental Health Programme and has contributed to the more detailed plans linked to the use of transformation funding.**

- **ICS Five Year Strategy and plan**

A first draft of the strategic narrative document was shared for comments and discussion. (The full draft document is available for Board members to review and is included in the papers in the partnership section). The document incorporates the updated priorities from each programme and builds on the existing work of the partnership. The process for further developing the plan was outlined to enable an agreed initial submission to NHSE/I in November 2019. The engagement at place level will continue through Health and Wellbeing Boards and related partnership arrangements. **The Trust is working with partners in place and contributing to the development of the ICS plan as a key partner**. **There is a separate agenda item that will provide a more detailed update on the developments of the Trust's 5 year plan**. **The Trust is referenced in the case studies section in several areas of the draft report.**

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 August meeting include the following:

- Contingency planning for EU Exit preparations continues at pace and it is likely that daily reporting will commence shortly. The partnership benefited from Robin Tuddenham and Tom Riordan's key regional leadership roles on this issue, supporting an integrated health and social care response. **The Director of Human Resources, organisational development and estates is the Trust's lead director contributing to regional and local planning forums**.
- The Strategic Outline Case for the reconfiguration of services in Calderdale and Huddersfield has now completed regional assurance and been recommended to progress through the national approval processes. **The Trust is partner in developing integrated joined up care in both Kirklees and Calderdale to support care as close to home as possible as part of the plans.**

3.2.1 Key updates from the ICS - received at the August SOAG meeting, **updates particularly of note for the Trust Board include**:

Programme updates - Unpaid carers

- New leadership arrangements are in place: Richard Parry and Karen Jackson are joint Senior Responsible Officers (SROs); Dr Andy Withers is the Clinical lead.
- Following the check and confirm discussion, a mental health strand of the programme has been added. Further work progressing to develop mental health indicators.
- Series of events focusing on young people who are carers has begun in Calderdale and Kirklees. Further events will be carried out across WY&H during the year. **The Trust is a key partner in this programme and remains committed to ensuring that we continue to improve the support provided to carers including young carers and working carers including our staff.**

3.2.2 Review of System Performance and Delivery

Finance

- The overall financial position at month four showed that the ICS was in a positive position, with several providers who formed part of the single control total reporting being ahead of plan. All NHS organisations were forecasting full delivery of their plans. However, a number of risks continued to be managed, including in two financially challenged systems: Bradford and Airedale, and Harrogate. It was noted that external

support had now been secured to help develop plans for longer term financial sustainability in Harrogate.
- Conversations with Local Authority finance colleagues continued, and it was hoped that joint reporting would commence from Quarter 2.

3.2.3 Performance Dashboard

- Key headlines on system performance were noted (the dashboard is included as part of the papers included in the partnership section for board members to review in full)
- Since the introduction of the system dashboard there have been numerous discussions in terms of how Local Authorities could input into the dashboard so that there is a true reflection of health and social care measures. Conversations have been taking place across the West Yorkshire Local Authority network and it was agreed that measures reported at Health and Wellbeing Board (HWB) level could be fed into this process, especially for those relating to homelessness and life skills and how this manifested into demand on mental health services. Conversations will continue to develop an agreed set of metrics to obtain consistency across the six HWBs.
- CAMHS waiting times will also be included in the dashboard**.**

3.3 Moving towards integrated, whole system assurance

- In 2020/21 the CCG Improvement and Assessment Framework and the Single Oversight Framework for NHS Trusts and NHSFTs will be replaced by a new **NHS Oversight Framework.**
- SOAG discussed proposals for a transition from routine assurance processes which focus on individual organisations to an approach which focuses on whole places, involving NHSE/I and the partnership working more closely together. It is anticipated that this change will be underpinned by the new NHS single oversight framework.
- The approach will include the proposed move to whole-place quarterly review meetings with the ICS and NHSE/I, incorporating a broader view of progress with place plans and a focus on long term sustainability as well as in-year delivery. A more detailed plan will be brought to the October meeting.
- **Trust Boards and CCG governing bodies retain full statutory duties and responsibilities for their own plans and performance**.

3.8 WY MHLD&ASC Committees in Common

The committee continues to meet and drive forward the agreed transformation areas across the system in line with the national improvements set out in the NHS Long Term Plan. The approved minutes from these meetings are included in the Partnership meetings section for member boards.

3.8.1 West Yorkshire Mental Health, Learning Disability and Autism Services Collaborative update

Progress is being made against all programmes as reported through the Trust Integrated Performance Report and through the Committees in Common for mental health, learning disability and autism providers. Key developments to note include:

- ***Transformation funding (Wave 1) for community mental health:*** a WY&H ICS bid was made by the deadline of 21 June 2019. This comprised two components: Specialist community rehabilitation service (to be tested in Kirklees, Calderdale and Leeds); Young person offer focussing on early intervention for vulnerable people in defined populations (to be tested in Wakefield, Bradford and Leeds). A feedback conference call took place on 31 July 2019 related to the outcome of this bid. A further feedback session with the national team has taken place, to help inform the learning for further submissions. Following on from this, it is understood that NSHE have

revisited the original decision and is likely to fund a proportion of the bid that we submitted for 2019/20. However they are unlikely to be in a position to offer any funding for 2020/21. If this goes ahead, this will allow opportunity therefore to pump prime these priorities. The original bid was for £3m for this year, and NHSE is potentially allocating £2.5m to take account of the delayed start. Work is underway to agree priorities for each place and programme to best utilise the funding should it be confirmed shortly by NHSE.

- ***Transformation funding for community crisis care*** a WY&H ICS bid was made by the deadline of 24 June 2019. This bid comprised some elements that were West Yorkshire-wide and most elements were place-based. Confirmation was received on 12 July 2019 that all the WY&H ICS proposals would be funded. This includes the following amounts of funding over a two year period to support crisis support including enhancing intensive home based treatment services and development of West Yorkshire wide mental health crisis helpline:
    - Calderdale £140,246 in 19/20 and 191,358 in 20/21
    - Kirklees £322,842 for 19/20 and £425,697 for 20/21
    - Wakefield £268,729 for 19/20 and £355,906 for 20/21

- **WY&H Mental Health, Learning Disability & Autism Programme Board –** The next meeting of the Board takes place on Friday, 20 September 2019. A verbal update will be provided to the Trust Board on the key points discussed at this Programme Board meeting.

- ***NHS England specialised commissioning –*** The intention is that by 2022/23, there will be 100% Provider Collaborative coverage nationally across all specialised mental health, learning disability and autism services. A Provider Collaborative is a collective of providers led by a Lead Provider working in partnership to provide specialised mental health, learning disability and autism services for a given population, to improve and standardise services. The nature of the system responsibilities being transferred to Provider Collaboratives and the complexity of the services delivered mean that Lead Providers will be NHS organisations who deliver specialised mental health and / or learning disability services.

  NHSE invited 'Applications' from the ICS in July 2019 and, if successful, this would result in four year contracts being awarded to the provider collaborative to lead on the delivery of these services. This builds on the new care model pilots that have been running for 12 months. The Trust has been working with our partners in the West Yorkshire Mental Health, Learning Disability and Autism collaborative to develop applications on behalf of WY&H ICS, for CAMHS tier 4, adult eating disorder and adult secure forensic services.

  The Trust submitted a Lead Provider collaborative application for forensic adult secure services in July 2019. The Trust received confirmation on 16 August 2019 that the application had been considered as a *Further Development Track* submission i.e. on track to become a Lead Provider from April 2021. Should the work be able to be completed in a shorter timeframe, the Trust will be able to re-submit the Application in the *Fast Track or Development Track* timeframe (November 2019 or April 2020). The West Yorkshire Forensic Provider Collaborative has begun to take this work forward and has secured £96,000 from the WY&H ICS to fund clinical and project support to undertake the next phase of the work.

The Leeds York Partnership Foundation Trust, Lead Provider Application for the West Yorkshire Adult Eating Disorder Provider Collaborative, was considered to be a *Fast Track* submission i.e. on track to become a Lead Provider from April 2020. The Leeds Community Healthcare Trust Lead Provider Application for the West Yorkshire CAMHS Provider Collaborative was considered to be a *Development Track* submission i.e. on track to become a Lead Provider from October 2020.

- ***Specialist Community Forensic Team Pilot Wave 2 Selection***
  The Trust submitted a bid on behalf of the West Yorkshire Forensic Provider Collaborative for Wave 2 selection. Following feedback on the bid, further work has been undertaken with partners to add more detail to the bid, particularly in respect of details on the patient cohort that the service will focus on and how the service will work innovatively with different agencies (for example, housing providers). This revised bid was submitted on 6 September 2019.

4. Local Integrated Care Partnerships - key developments

A number of the places in which the Trust provides services are part of the WY&H HCP. These include Kirklees, Calderdale and Wakefield. Barnsley is part of the South Yorkshire and 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 five Locality Networks (PCNs) have been established across Calderdale. The Trust has been working with partners to enhance the cultural, arts, health and wellbeing offer in Calderdale. A partnership report that sets out current best practice as well as what more needs to be done to become an exemplar in this area has been developed and will be discussed and shared at a forthcoming Health and Wellbeing Board. The refreshed Health and Wellbeing strategy was adopted by the Health and Wellbeing Board in August. **There is a separate paper that includes the full Health and Wellbeing strategy for Board members to consider. The Trust continues to be a partner in the Calderdale Active programme that is led by the Local Authority, funding has been received to support additional peer support workers placed in the Recovery Colleges (RC) as part of this programme, with the aim of building on the work that the RC already do to support peoples wellbeing.**

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). The ICP has approved a new governance framework for drawing together all the work currently being undertaken in respect of creating and developing sustainable places and communities for Wakefield District. The November ICP meeting will largely focus on further organisational development work.

The Mental Health Alliance has worked together to agree the priorities for 2019/20 in line with the national mental health investment standard. The detailed proposals to support the priorities (including proposals approved against the WY&H ICS bid for transformation funding for community crisis care highlighted above) were approved at the ICP Board and the Wakefield CCG Governing Body meetings in July. All the approved priorities are now being mobilised. Following a national recruitment process, the Alliance has appointed to the post of Mental Health Transformation Lead. **This post, funded by Wakefield CCG, will be employed by the Trust, and accountable to the Alliance Chair.**

Wakefield Primary Care Networks - The Trust's director of provider development is the SRO for this programme (on behalf of the ICP Board). There are seven Primary Care Homes (PCHs), the local version of primary care networks, in Wakefield, which went '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**. All seven PCHs have supported and implemented the approach whereby their social prescribing link workers are employed through Live Well Wakefield, via a memorandum of understanding.

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 through the development of an Alliance. Further engagement continues to take place with key strategic leads across the system to clarify and develop the engagement plan, governance arrangements and scope. A wider partnership engagement event is planned for this month to engage partners in shaping the development of a mental health alliance. This should include a focus on prevention and links to the nine Kirklees Primary Care Networks as they develop, as well as develop more seamless services and pathways. 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.

Kirklees IAPT services have made significant progress in improving performance. The team have also developed a comprehensive offer in Kirklees that has the potential to be replicated in each of the places that we provide IAPT services. This includes the following:

- Developed a strong offer to primary care networks that includes a dedicated therapists linked to GP practices and GP's will be able to book directly into IAPT clinics in primary care. This will allow a closer relationship between IAPT and GP's improving access and referral pathways.
- Long Term Conditions pathways – IAPT is working with the local acute Trust and with community providers to deliver Diabetes and MSK pathway's to support the psychological wellbeing of people with a long term health condition.
- Working in conjunction with Locala to provide IAPT to older adults over 65 years.
- Continued work and focus on increasing BAME access, working with Sheffield University to create a culturally sensitive Cognitive Behavioural Therapy offer.
- Exceeding locally agreed access target, recovery and access wait times.

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**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 24 September 2019
Agenda item 7.2.1

Title:	**Calderdale Health and Wellbeing plan**
Paper prepared by:	Director of strategy
Purpose:	The purpose of this paper is to seek the Trust Boards support for the refreshed Calderdale Health and Wellbeing Plan that was discussed and endorsed at the Calderdale Health and Wellbeing Board in August 2019. This place based plan contributes to the local delivery of the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP).
Mission/values: **07584331757**	The Calderdale Health and Wellbeing Plan is set firmly within the context of Calderdale Vision 2024 and the key themes of distinctiveness, kind and resilient, enterprising and talented. This is consistent with the Trust's mission to ***help people reach their potential and live well in their communities*****,** and also consistent with our strategic objectives ***to improve people's health and wellbeing, to improve the quality and experience of all that we do, and improve our use of resources*** **as well as make the Trust a great place to work.** The way in which the Calderdale plan is developed and delivered is through partnership, drawn together around the health and wellbeing board. This approach supports our values.
Any background papers previously considered by:	Updates and focused strategic discussions on placed-based plans including the WY&H HCP and Calderdale have formed part of most recent Trust Board meetings.
Executive summary:	The Calderdale Health and Wellbeing Plan sets out the strategic direction and priorities for the delivery of improvements to health and wellbeing of the population. The covering paper summarises the Calderdale Health and Well Being Plan and highlights the key areas of alignment with the Trust strategy, priorities and service developments, as well as potential risks. **Risk Appetite** Supporting the development of strategic partnerships and place-based plans that promote the development of integrated and joined up care and services is within the Trust's risk appetite. Risks to the Trust services in Calderdale will need to be reviewed and managed as the implementation plans develop to assess the impact upon services, clinical and financial flows.
Recommendation:	**Trust Board is asked to:** ➢ **DISCUSS and COMMENT on the Calderdale Health and Wellbeing Plan; and** ➢ **ENDORSE and SUPPORT the Calderdale Health and Wellbeing Plan.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust
Trust Board – 24 September 2019

Calderdale Health and Wellbeing Plan (2019-2024)

1. Introduction

The purpose of this paper is to seek the Trust Board's support for:

- The Calderdale Health and Wellbeing Plan (2019-2024). The plan was discussed and endorsed at the Calderdale Health and Wellbeing Board in August 2019. This place based plan contributes to the local delivery of the West Yorkshire and Harrogate Health and Care Partnership priorities. The plan is attached in full for Trust Board members to review.

2. Background

The refresh and development of the Calderdale Health and Wellbeing Plan sets out the strategic direction and priorities for the delivery of improvements to health and wellbeing of the population. The Wellbeing Strategy is set firmly within the context of Vision 2024 and the key themes of distinctive, kind and resilient, enterprising and talented.

Partners have been working together to develop joined up care and support in Calderdale through 'Calderdale Cares' which will remain the underpinning implementation approach. The Trust is a full partner in Calderdale and regular updates have been provided to Trust Board.

3. Calderdale Health and Wellbeing Plan Priorities

The Health and Wellbeing plan aims to address the social determinants of health, education and employment opportunities, good housing, income, social networks, including where we live and the extent to which it facilitates physical activity, good food and social connections. The overall ambition of the Strategy is to increase years of healthy life and to reduce health inequalities through a population health approach. The Council has declared a climate emergency and the Wellbeing Strategy identifies the clear links between climate and health.

The Wellbeing Strategy sets out high level objectives across the following four stages of the life course.

- Starting Well (0-15)
- Developing Well (6-25)
- Living and Working Well
- Ageing Well

The Strategy is underpinned by the following key principles,

- A new relationship with communities
- A shift to prevention and health outcomes
- Support integrated care services
- Health in all policies

4. What it means for South West Yorkshire Partnership NHS Foundation Trust

By supporting the Calderdale Health and Wellbeing plan we will commit to continue to play our full role as a member of the Calderdale Health and Care Partnership. The priorities set out in the plan are aligned to the Trust strategy and priorities. The plan enables the Trust to strengthen its role as the Mental Health and Learning Disability service provider in the area. The significant focus on prevention and the development of sustainable communities creates opportunities to strengthen the role of recovery colleges and Creative Minds within Calderdale. We are already working with partners to accelerate the development of arts, creativity and wellbeing offer in Calderdale including access to community, cultural activities and access to green spaces. We are also partners in the Active Calderdale programme that seeks to increase physical activity amongst residents of Calderdale; we are the sponsors for the mental health work stream and have successfully received funding to develop innovations in this area.

We are working with partners in localities to develop joined up care and support as close to home as possible; this includes testing and developing new ways of working in primary care settings. Our psychiatric liaison services support secondary care and ensure that physical and mental health care is better joined up.

We will continue to develop services and support for people with learning disabilities building on the work that we have done with partners through the Transforming Care partnership plan. A shared ambition is to ensure that all children and young people receive the best start in life, and timely access to support when they need it most. We are already providing perinatal services for mothers and babies across Calderdale; we have piloted the use of digital apps to support families and young people through our child and adolescent mental health services (CAMHS) and will continue to develop innovative ways of support and care with our partners, young people and families.

The recent funding received through the West Yorkshire and Harrogate Health and Care Partnership to support the development of enhanced community services and crisis support, including a crisis helpline, will enhance and improve the offer in Calderdale for people in crisis. Work continues with commissioners and partners to develop a new model of care for older adults, to develop a more comprehensive offer for children and young people with a greater focus on prevention and early support.

The Trust is working with partners as part of an emerging alliance that is currently being led by the CCG. It will be important to continue to work with partners to deliver integrated care as part of 'calderdale cares' while recognising emerging risks as the approach, scope and phasing of the alliance becomes clearer.

5. Recommendations

a) To discuss and comment on the Calderdale Health and Wellbeing plan.

b) To endorse and support the plan.

WELLBEING STRATEGY

Living a Larger Life - Calderdale 2019 - 2024

#VISIONCDALE2024

CALDERDALE CARES

VISION 2024

OUR VISION FOR CALDERDALE

The Wellbeing Strategy is set within the context of Vision 2024. Our vision for Calderdale in 2024 is for a place where you can realise your potential whoever you are, whether your voice has been heard or unheard in the past.

- We aspire to be a place where talent and enterprise can thrive.
- A place defined by our innate kindness and resilience, by how our people care for each other, are able to recover from setbacks and are full of hope.
- Calderdale will stand out, be known, and be distinctive. A great place to visit, but most importantly, a place to live a larger life.

The Wellbeing Strategy and the Inclusive Economy Strategy describe a clear and challenging strategic aspiration for Calderdale.

Our ambition is to ensure that people of Calderdale enjoy more years of healthy life; that the gaps in healthy life expectancy between different communities are reduced; and that everyone whatever their health or disability is supported and enabled to lead the fullest life possible.

Good physical and mental health has a significant influence on overall wellbeing. It allows people to participate in family life, the community and the workplace. It has value in its own right and it also creates value. Put simply, health should be viewed as an asset that is worth investing in for our society to prosper. Indeed people generally place more value on being healthy than on factors like income, careers or education.

The ways to improve health are well known: investment in early years development; lifelong learning; provision of good-quality, affordable housing; availability of high-quality jobs; public transport systems; and a food system that supports healthy options.

Calderdale is a great place to live. Most of us are fit and healthy, and generally the quality of life here is good. However, like everywhere, the picture in Calderdale is not perfect. The health and wellbeing of people in some of our communities is not improving at the same rate as others. Every year, far too many people suffer avoidable ill health or die earlier than they should – this is known as health inequality. These inequalities need to be tackled to make life better for everyone living in Calderdale.

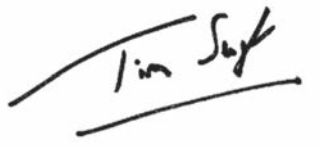
We also have a growing number of people living into old age. Whilst it is good news that people are living longer, it is important that the quality of our life remains high too.

The things that affect our health and wellbeing vary over the course of our lifetime. Therefore, the strategy has been developed using four significant stages of the life course.

- **Starting well (0-5)**
- **Developing Well (6-25)**
- **Living & working well**
- **Ageing well**

This strategy sets our high level priorities, based on these four life stages,with an overall priority of impacting on the wider determinants of health.

The success of the strategy will be measured against the outcomes we have included, which will also be used to shape commissioning across



Tim Swift
Chair, Calderdale Health and Wellbeing Board

the health and care system and to develop more detailed action plans to improve the health and wellbeing of people who live and work in Calderdale. Average is not good enough for Calderdale people. We will aim to be in the top 25% nationally for all of the measures we have identified in this strategy. A small number of measures will be common to both the Wellbeing and Inclusive Economy Strategies and align with the outcomes set out in Vision 2024. These outcome measures and action plans will be developed with Calderdale citizens and stakeholders and will be reviewed regularly by the Health and Wellbeing Board.

This strategy does not list everything that all organisations will be undertaking to improve health and wellbeing; instead it focuses on setting out our vision and priorities for integrated working over the next five years to 2024. The strategy will further evolve. For example Calderdale has recently declared a climate emergency, the actions needed to support our environment will very clearly link to protecting and promoting our health.

A wide range of partners, including those from health, local government, voluntary and community sectors will contribute towards the delivery of this overarching strategy through their own strategic aims. Above all, we will work with local people to deliver this strategy

This strategy is fundamentally concerned with people being all they can be, people should be able to “lead a larger life”. This includes being creative, being able to express ourselves fully and engage in quality relationships.

Doing things differently - Our principles

We have identified four key principles that will inform the way we all work together, what we do and how we report our progress on improving health and wellbeing:

A new relationship with communities

We believe the relationship between organisations and communities needs to change. We will listen so people feel heard and we will demonstrate - with evidence - that people have been heard. We will involve our communities in the work we do, and co-design our plans for change with them. People are empowered to take greater control over their lives and outcomes - with improved health, so they are happier and better connected. As organisations we need to focus our limited staff time and money on the things that only we can offer, and support communities to use their valuable skills and time to do more for themselves and each other. We need to work together to create stronger communities that can cope with and recover from problems well. We need to develop 'kindness by design' to ensure our offers best meet the needs of our diverse populations. We will establish methods to ensure a transfer of resources to support community action.

A shift to prevention and health outcomes

Our systems need to shift towards prevention, which will require us to change the ways our organisations and our staff work. As organisations we need to make sure it is easier for people to have healthier options and we need to have a relentless focus on health outcomes and not just on service delivery. These outcomes will be agreed with the people we serve. Our focus will be on reducing the unjust health inequalities that prevail in Calderdale and we will seek to ensure our resources are used in the most effective and efficient way to reduce inequality. We will change the nature of the relationship between people and services, and the relationship between people and their own health, changing the way our staff see their roles, their day job and constant improvement in the work they do.

Support integrated care services

A stronger focus on joining up health and care services - moving more services from hospitals to community settings, only having to tell your story once, and making it easy to find out what support is there to help you and how to access it. Calderdale Cares articulates a vision of integrated commissioning and integrated delivery with organisations coalescing around a single set of outcomes.

Health in all policies

A commitment to ensure that all policies consider and promote the health and wellbeing of citizens, and address the climate change emergency. Resources and assets will be used to address the wider determinants of health and support wellbeing.

Improving health and wellbeing throughout people's lives

Our goal is to optimise the health and wellbeing of people in Calderdale throughout the course of their lives. For this reason, our strategy is divided into four sections, each relating to one of the major life stages:

Starting Well

The first section focuses on babies and very young children, and covers ages 0-5 years (including pregnancy).

Developing Well

Childhood and young adulthood (6-25)

Living & Working Well

Working age adults.

Ageing Well

With a focus on older people, covering people 65 and older.

Being Well

A healthy person is someone with; meaningful work or purpose in life, secure housing, stable relationships, high self-esteem, and healthy behaviours.

Health is not just in the gift of our health and social care services. A healthy society, in turn, is not one that waits for people to become ill, but one that sees how health is shaped by social, cultural, political, economic, commercial and environmental factors, and takes action on these for current and future generations.

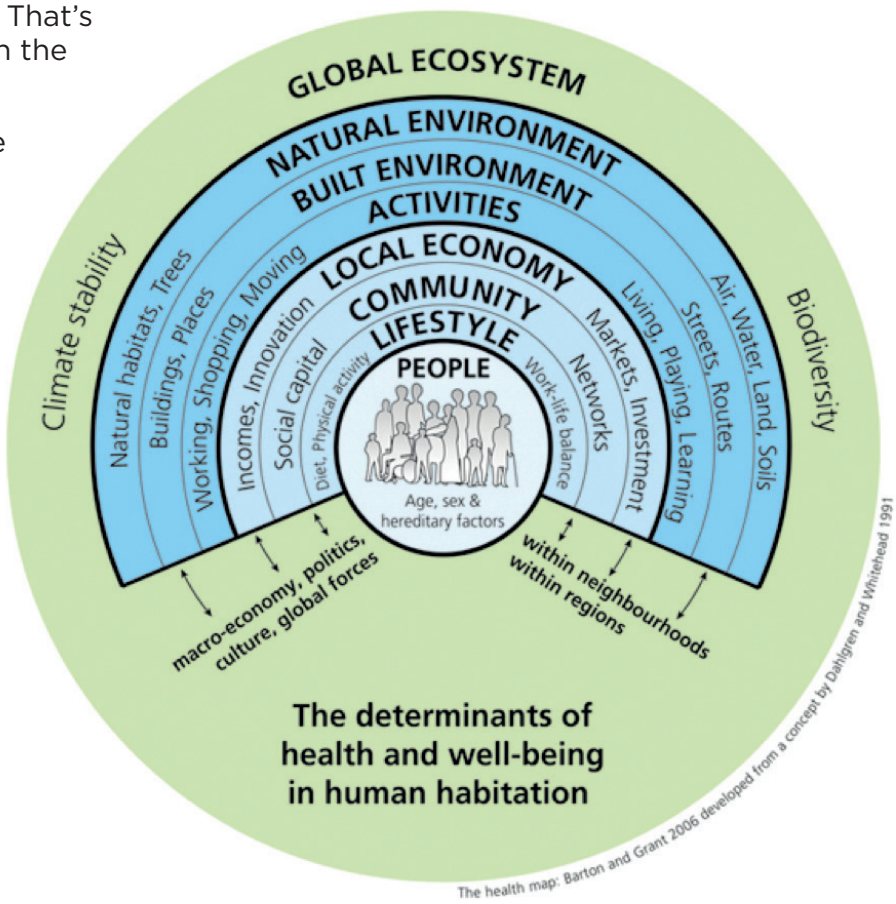
The Strategy will monitor and accelerate actions to improve the conditions and environments in which people in Calderdale live.

Some key social determinants of health are: our education and employment opportunities; our housing; our income; our social networks; and where we live and the extent it facilitates physical activity, good food and social connection. These factors shape the conditions in which people are born, grow, live, work and age (our key life courses)

Addressing these determinants is crucial in reducing health inequality and improving health.

Calderdale has declared a climate emergency. The dramatic consequences of climate change are already being seen in our borough, with presumed once in a life time floods occurring at much more regular intervals. Our climate and environment have clear impacts on our health, whether it is the mental health impact of flooding or the impact on future generations

People's health is affected by where they live, how well-off they are, their gender, and whether they have a disability. In England, a girl born in the least deprived 10% of local areas can expect to live 70.4 years in good health, but she would live only 52.0 years in good health if born in the most deprived 10% of local areas – an 18.4-year gap. That's a difference of almost two-decades in the years of life spent in good health.



Underpinning the work across the life stages will be our commitment to ensure that the wider determinants of health are considered and addressed. Some of these determinants are addressed in other strategies e.g. employment and income measures are monitored through the inclusive Economy Strategy. The Wellbeing Strategy will focus on improving air quality, access to green space, poverty and housing.

There are two key outcomes that will describe the effectiveness of the strategy in making change:

- Life expectancy
- Healthy life expectancy

	indicator	Year	Rate	Calderdale	England
Poverty	Fuel poverty	2016	%	12.2	11.1
	Income deprivation IMD	2015	%	16.4	14.6
Environment	Proportion of residents using parks and green spaces	2018	%	81.7	N/A
Employment	Employment Rate	2018-19	%	75.7	75.6
Attainment	Inequality gap in Level 2 qualification achievement rate by age 19	2018-19	%	28.9	21.9
Attainment	Inequality gap in Level 3 qualification achievement rate by age 19	2018-19	%	27.1	25.1

	Year	Calderdale	England
Life expectancy at birth - males	2015-17	78.6	79.76
Life expectancy at birth - females	2015-17	82.1	83.1
Healthy life expectancy at birth - males	2015-17	61.6	63.4
Healthy life expectancy at birth - females	2015-17	64.4	63.8

There are significant inequalities in life expectancy in Calderdale, with the least deprived men expected to live seven and a half years longer than the most deprived For women, the gap is even wider: the least deprived are expected to live just over 8 years longer than the most deprived.

Starting Well

What happens in pregnancy and early childhood impacts on physical and emotional health all the way throughout our lives.

Supporting good maternal health is important for safe delivery and good birth weight to give babies the best start. The prevention of adverse health factors in pregnancy is vital. Premature and small babies are more likely to have poorer outcomes.

The earliest experiences, starting in the womb, shape a baby's brain development. During the first 2 years of life the brain displays a remarkable capacity to absorb information and adapt to its surroundings. Positive early experience is therefore vital to ensure children are ready to learn, ready for school and have good life chances.

It is shaped by a number of factors such as:

- Sensitive attuned parenting.
- Effects of socio-economic status.
- The impact of high-quality early education and care.

Healthy mothers and healthy babies.

Support parents to take care of their own health and the health of their babies.

- More support to help women look after their mental health in the period immediately before and after the birth of their child.
- Improve outcomes for mothers and babies by reducing domestic abuse.
- Reduce the proportion of women who smoke during pregnancy.

Parenting for a bright future: All young children given a strong foundation.

- Work with parents of young children to help them develop well and give them a healthy start in life.
- Reduce the variation across Calderdale in young children's school readiness.
- Reduce the proportion of 4-5 year old children who are overweight or obese.

	indicator	Year	Rate	Calderdale	England
Infant Mortality	4.01 Infant Mortality	2015-17	Rate per 1000	5.1	3.9
Expected development aged 2-2 ½	Percentage of children at or above expected level of development in all five areas of development at 2-2½ years	2017-18	%	Not currently available	83.3
Children achieving a good level of development at the end of reception	School Readiness: the percentage of children achieving a good level of development at the end of reception	2017 -18	%	70.0	71.5
Healthy weight reception	Reception: Prevalence of healthy weight	2015-17	%	73.8	76.6

Developing Well

The well-being of our children and young people is vital if they are to become active participants in society, their communities and their families.

Evidence shows that well-being in children and young people has a wide range of social and personal benefits. These include; positive mental health, social connection, and a reduction in the likelihood of victimisation and involvement in risky behaviours. Increasing the level of well-being will ensure that young people growing up in Calderdale have a good childhood, and positive life chances.

Good mental health and wellbeing for children and young people.

We will:

- Address the wider causes of poor mental health in children and young people, including domestic abuse, and support those who are experiencing mental health problems.
- Address commonly experienced issues, such as bullying, which have a negative impact on children and young people's mental wellbeing.

Parenting for a bright future: Children and young people equipped to become healthy and successful adults.

We will:

- Support parents to help children and young people develop well and give them a healthy start in life.
- Improve life chances for our most disadvantaged children and young people, especially those looked after by the Council.

  Help children and young people to adopt healthy lifestyles (including developing an understanding of healthy and safe relationships, and improving levels of physical activity), which will reduce their risks of experiencing health problems in later life.
- Reduce the proportion of 10-11 year olds who are overweight or obese.

	Indicator	Year	% or Rate	Calderdale	England
Healthy weight year 6	Year 6: Prevalence of healthy weight	2017-18	%	63.1	64.3
Emotional wellbeing	Year 7 and 10 pupils with high life satisfaction	2018	%	65	N/A
	Year 7 and 10 pupils with low self esteem	2018	%	19	N/A

Living and Working Well

Good health and well-being for people of working age, and enabling people to work longer in good health are important.

Exercise and an active and healthy lifestyle can work wonders for both physical and emotional wellbeing, whatever your age, health status, ability or gender. An individual's health is shaped by their workplace cultures and values, and the increase in mental health conditions is taking place in the context of increasing stress within the workplace and life in general. The negative effects of unemployment on health and mortality are well documented. The effects of a positive working-life, and supporting people to return to work are important, and link closely to the aspiration in our Inclusive Economy Strategy.

Good mental health and wellbeing for working age adults.

We will:

- Address the wider causes of poor mental health and support people who are experiencing mental health problems to recover or manage their condition.
- Tackle homelessness and housing issues and their underlying causes.

Healthy lifestyles for working age adults.

We will:

- Reduce avoidable disability and premature deaths by designing our environment to help people adopt more healthy lifestyles.
- Increase the proportion of working age adults who achieve recommended levels of physical activity and reduce levels of overweight and obesity.
- Reduce the harm caused to health by smoking, alcohol and drug use among working age adults.
- Assist people with learning disabilities to live a fulfilling life as citizens in their own local community.

	indicator	Year	% or Rate	Calderdale	England
Levels of physical activity	Percentage of physically active adults	2017-18	%	68.4	66.3
Smoking prevalence	Smoking prevalence in adults (18+) – current smokers	2018	%	15.5	14.4
Alcohol-specific mortality	Alcohol-specific mortality (persons)	2015-17	Rate per 100,000	13.8	10.6
Wellbeing	Overall, how satisfied are you with your life nowadays?	2017-18	Mean score on a scale of 1 to 10 with 10 being "completely satisfied"	7.59	7.69

Ageing Well

Health as we age is fundamental to our quality of life, allowing us to remain independent, to work or be involved in our local community and maintain social connections.

While people are living longer, the number of years lived in poor health and with disability are increasing. Aging does not necessarily decrease a person's ability to contribute to society: older people can and do make valuable and important contributions to society, and enjoy a high quality of life. Retirement is an increasingly active phase of life where people have opportunities to continue contributing to society by working longer or volunteering in their communities, enabling them to take personal responsibility for their own wellbeing by working, and looking after their health.

Older people remaining physically active and independent

We will:

- Enable people over 65 to remain physically active and we will reduce levels of frailty.
- Reduce hip fractures and injuries due to falls by people over 65.
- Support older people to regain their independence following a stay in hospital.

Good support in older age and end of life

We will:

- Enable people to live in their own homes for as long as possible and reduce social isolation in people aged over 65, ensuring good support and access to services for the rest of their lives.
- Work together to develop different kinds of accommodation for older people who need support to be as independent as possible.
- Improve the quality of our care homes and ensure people who live in care homes can access all the health services they need.
- Reduce preventable winter deaths of older people.
- Improve the support, care and quality of life of people with dementia and their family carers.
- Increase the number of people who die in their preferred place of death.

	indicator	Year	% or Rate	Calderdale	England
Life expectancy at 65	Male	2015-17	Years	17.8	18.8
	Female	2015-17	Years	20.6	21.1
Social isolation indicator	Social Isolation: percentage of adult social care users who have as much social contact as they would like	2017-18	%	53.7	46.0
Hip fractures	Hip fractures in people aged 65 and over	2017-18	Per 100,000	535	578
Excess winter mortality	Excess winter mortality deaths index (3 years, aged 85+)	Aug 2014 – July 17	%	29.3	29.3

Our distinctive Communities

Calderdale is made up of distinctive and different towns and communities. We will work with the people of our distinctive communities to keep them well and to develop and improve services with them in five localities through the Calderdale Cares programme.

We will take an asset-based approach, starting from people's strengths, not their deficits. And we will develop the assets in communities, rather than assuming formal health and care services as the first option.

Our distinctive localities are where we will plan the services for people when they need support. Council staff, NHS staff and third sector organisations will work together with local people to design services that will mean:

- Easier and faster access to a wider range of joined-up care options where people only have to tell their story once.
- Better outcomes based on what is important to people.
- Fewer trips to hospital as more services will be available in the community.
- More advice and guidance to help people make the right choices and manage their own health.
- Better access to local voluntary, cultural and community groups.
- More involvement in the design of care services.

We will identify the resources our organisations use in each locality, so that those resources can be moved around to get the best outcomes. And we will tackle health inequalities by moving resources to those areas that need them most.

A Kinder Service

All of the Wellbeing Strategy applies to all Calderdale people and seeks to maintain and improve their wellbeing. But, too often, addressing people's physical wellbeing has taken precedence over their mental wellbeing. We will seek to put that right by giving mental wellbeing parity with physical wellbeing. This will mean moving some resources to help prevent mental ill health and to provide more and different services for people with mental ill health.

Our Enterprising and Talented Staff

The Calderdale health and care system has fantastic staff who provide efficient and effective services to many people, whether they work in the NHS, for the Council or for third sector organisations.

We will continue to support our staff deliver efficient and effective services. Sometimes this will mean integrating services across different sectors and staff doing their jobs in different ways. We will develop an organisational development programme and training schemes that will support staff to do this and help ensure a supply of professional staff in areas where there are sometimes national shortages.

A resilient health and care system

The foundations of this Wellbeing Strategy are addressing the wider determinants of health and helping people make good choices. But services to help people when they are less well are also very important. The resources available to us as a system have reduced over the last ten years, meaning that we have to operate as efficiently as possible.

We will:

- Arrange Care Closer to Home services through an Alliance approach ensuring that the system works together towards achieving shared agreed outcomes.
- Develop digital solutions that allow the efficient sharing of information across organisations, but, just as importantly, allow service users and patients easy access to their own information, advice, support and to services.
- Some direct service provision will be delivered digitally.
- Develop an estates strategy that will allow the most efficient use of our land and buildings, including co-locating services wherever it is of benefit to patients and is more efficient.
- A Population Health approach will make sure that our system reduces health inequalities and make the most impact.
- It is our ambition through the Wellbeing Strategy to reduce the number of people who need care in hospital. When people do need care in hospital we will improve the quality of those services, including urgent care, through our Right Care, Right Time, Right Place programme.
- Details of the full range of activities being undertaken to deliver our Calderdale Cares Programme can be found on the CCG and Calderdale MBC websites. This includes a set of key enabling activities including; digitisation and workforce.

Who will do all this?

Services will be planned and delivered through Calderdale's five localities wherever possible. Only if that is not possible will they be arranged Calderdale wide or, exceptionally, at a sub-regional level, working on the principle of 'do it once' where possible.

- Our five Calderdale Cares localities will be the place where the needs of the local population and local services are planned and delivered.
- The Integrated Commissioning Executive, informed by the individual needs of our five localities, will produce and implement a strategic commissioning strategy, focussing on delivering better outcomes for Calderdale people.
- The Health and Wellbeing Board will be the place where this strategy is overseen in public and partner organisations are held to collective account for its delivery.
- The West Yorkshire and Harrogate Health and Care Partnership will maximise opportunities for services are planned when a sub-regional approach is better for Calderdale people than more local arrangements.

Role of Primary Care Networks

Primary Care Networks (PCNs) have a critical role in delivering the Wellbeing Strategy - building on the early successes of Calderdale Cares and the evolution of the five Calderdale localities.

The Health & Well-being Board believe that the following principles will support the continued strengthening of the work we do in our localities:

- Recognising the Well-being Strategy and Inclusive Economy Strategies as the health and wellbeing system's strategic vision.
- Fostering system support for the new PCNs, building on the approach set out in Calderdale Cares, and ensuring their success as a key part of our system architecture.
- Recognising the mutual dependency between PCNs and the broadest range of local partners and communities in improving the lives of local people.
- Ensuring we build on the specific expertise and skills which already exist within the broad range of organisations and communities across the health and wellbeing system.

CALDERDALE CARES

VISION 2024

#VISIONCDALE2024

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 24 September 2019
Agenda item 8.1

Title:	**Medical Appraisal / Revalidation Annual Report 2018/19**
Paper prepared by:	Responsible Officer
Purpose:	The purpose of this paper is to inform the Trust Board of progress in achieving satisfactory medical appraisal and revalidation and to support the signing of the NHSE Designated Body Annual Board Report Statement of Compliance (appendix 5), as required by NHS England.
Mission/values:	Ensuring that all medical staff are fit to practice and up to date supports the Trust's mission to enable people to reach their potential and live well in the community and demonstrates the Trust's commitment to delivering safe and effective services.
Any background papers/ previously considered by:	Not applicable.
Executive summary:	➢ 127 doctors had a prescribed connection with the Trust as at 31st March 2019. o 92% successfully completed the appraisal process during 2018/19, a slight drop on 2017/18 which was 93%. o 8% had an agreed postponement in line with the Medical Appraisal Policy. These were approved by either the Associate Medical Director (AMD) for Revalidation or Responsible Officer (RO) as appropriate. This is an increase of 1% 2017/18. ➢ 25 revalidation recommendations made between 1st April 2018 and 31st March 2019. o 24 doctors had positive recommendations made. o 1 doctor had a recommendation of deferral. The deferral was recommended after the RO had consulted with the General Medical Council (GMC) Liaison Employment Advisor. o All recommendations made were upheld by the GMC. ➢ The Trust continues to strengthen its appraisal and revalidation processes. **Next steps** ➢ Consolidation of the Revalidation Oversight Group. ➢ Ensuring the quality of appraiser training is maintained with the introduction of new trainers. ➢ Review process for patient feedback in light of GMC consultation/updated guidance.

	Risk appetite Risk identified –the trust continues to have a good governance system of reporting and investigating incidents including serious incidents. The following are areas of potential difficulty for the Trust: ➢ The voluntary status of the appraisers and their importance to the system is noted annually. It remains a concern that, if under pressure from other areas of work, doctors could withdraw from this role, thus threatening the appraisal process. ➢ There is a continuing expectation that there will be further development demands on the revalidation process which will place increasing demands on resources. If it transpired that additional resources are required, the RO will present this to the appropriate forum in the Trust.
Recommendation:	**Trust Board is asked to:** ➢ **RECEIVE this report, noting that it will be shared, along with the Annual Organisational Audit, with the Tier 2 Responsible Officer at NHS England.** ➢ **RECOGNISE that the resource implications of medical revalidation are likely to continue to increase year on year.; and** ➢ **APPROVE the NHSE Designated Body Annual Board Report Statement of Compliance, attached as appendix 5 of this report confirming that the Trust, as a Designated Body, is in compliance with the regulations.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

MEDICAL APPRAISAL / REVALIDATION ANNUAL BOARD REPORT 2018-19

1. Executive Summary

1.1 127 doctors had a prescribed connection with the Trust as at 31st March 2019.
- 92% successfully completed the appraisal process during 2018/19, a slight drop on 2017/18 which was 93%.
- 8% had an agreed postponement in line with the Medical Appraisal Policy. These were approved by either the Associate Medical Director (AMD) for Revalidation or Responsible Officer (RO) as appropriate. This is an increase of 1% 2017/18.

1.2 25 revalidation recommendations made between 1st April 2018 and 31st March 2019.
- 24 doctors had positive recommendations made.
- 1 doctor had a recommendation of deferral. The deferral was recommended after the RO had consulted with the General Medical Council (GMC) Liaison Employment Advisor.
- All recommendations made were upheld by the GMC.

1.3 The Trust continues to strengthen its appraisal and revalidation processes.

2. Purpose of Paper

This report is presented to the Board:

2.1 For assurance that the statutory functions of the RO role are being appropriately and adequately discharged.

2.2 To inform of progress in medical appraisal and revalidation during 2018/19.

2.3 To support the signing of the Statement of Compliance (see Appendix 5).

3. Background

3.1 2018/19 was the seventh year of medical revalidation. Launched in 2012 to strengthen the way that doctors are regulated, the aim is to improve the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical profession. As this is the seventh year, a number of doctors in the Trust are now in their second 5 year revalidation cycle.

3.2 L2P, the e-appraisal web based system that the Trust utilises is based on NHSE medical appraisal guide (MAG) model appraisal form.

3.3 Each doctor much have a RO who must oversee a range of processes including annual appraisal, and who will at five yearly intervals make a recommendation to the GMC in respect of the doctor's revalidation.

3.4 The RO is appointed by the Board of the organisation, termed a Designated Body, to which the doctor is linked by a Prescribed Connection.

3.5 Provider organisations have a statutory duty to support their RO in discharging their duties under the Responsible Officer Regulations and it is expected that provider boards / executive teams will oversee compliance by:

3.5.1 Monitoring the frequency and quality of medical appraisals in their organisation.

3.5.2 Checking there are effective systems in place for monitoring the conduct and performance of their doctors.

3.5.3 Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors.

3.5.4 Ensuring that appropriate pre-employment background checks (including pre-employment for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

3.5 Compliance with the Responsible Officer Regulations forms part of the Care Quality Commission inspection.

4. Governance

4.1 Trust's Revalidation Team

- Responsible Officer – Dr Adrian Berry
- Associate Medical Director for Revalidation – Dr Gerard Roney
- Business Manager, Medical Directorate – Julie Hickling
- Medical Directorate Administrator – Charlotte Lyons
- HR Business Partner with responsibility to support Revalidation – Andrea Horton (up until July 2018)

4.2 Policy and Guidance (New and Updates)

- Non engagement definition – January 2019
- Updated multi-source feedback guidance - January 2019

4.3 Main Tools Utilised Centrally

- L2P (web based) – e-appraisal system
- Datix (Trust system) – provision of incident, complaints and compliments data
- HR Online (Trust system) – provision of sickness data and mandatory training
- GMC Connect (web based) – designated body list

4.4 Designated Body List

The Business Manager and Administrator ensure that the designated body list of doctors is accurate. The formal list of the Trust's prescribed

connections is recorded on the GMC Connect portal. As individual doctors are able to add themselves to this list, it is regularly checked to ensure that all the prescribed connections are appropriate. To facilitate this, a regular starters and leavers report is run from Electronic Staff Record.

4.5 External Oversight

The Trust is subject to the oversight of the NHS England Revalidation Team. During 2018/19, due to the Trust's continuing successful record in attaining satisfactory engagement in appraisal, an email response from the RO was the only quarterly reporting requirement. This confirms that the Trust is still on target to achieve the planned appraisal trajectory for the quarter and the year as a whole. The final year Annual Organisational Audit was still a requirement and was completed and submitted April 2019.

4.6 Internal Oversight

4.6.1 The AMD and Business Manager meet fortnightly to oversee the day-to-day running of the appraisal and revalidation processes.

4.6.2 The RO, AMD and Business Manager meet monthly to ensure that there is regular communication with the RO and that any issues are highlighted and acted upon. Where a meeting is not possible, email and telephone conversations take place to ensure matters are dealt with in a timely manner.

4.6.3 The Revalidation Team have Revalidation Review meetings to formally consider those doctors with a revalidation recommendation required within the following 12 months.

4.6.4 The Revalidation Oversight Group, which had its first meeting on 24th January 2019 has the aims of:

- To advise the Responsible Officer of delivery of appraisal and revalidation processes and overall direction in terms of strategic, policy and performance.
- To advise the Responsible Officer of delivery of the improvements to revalidation based on the recommendations from Sir Keith Pearson's Taking Revalidation Forward [TRF] report.

The group has a lay member to provide independent scrutiny.

4.7 Independent Verification

4.7.1 Independent verification is required to be undertaken every 5 years. In November 2017 a Revalidation Peer to Peer Review was undertaken with Leeds and York Partnerships NHS Foundation Trust and the resulting report shared with NHSE.

5. Medical Appraisal

5.1 Appraisal and Revalidation Data

	Consultant	SAS* & Trust Grade	Fixed Term
Number of	72	45	10

doctors as at 31st March 2019 who have a prescribed connection to the Trust						
Number of completed appraisals during 2018/19:	69 consultants completed 72 appraisals	96%	43 SAS doctors completed 43 appraisals	95.5%	5 fixed term doctors completed 5 appraisals	50%
Number of missed/ incomplete appraisals during 2018/19:	3	4%	2	4.5%	5	50%
Number of doctors in remediation:	0	0%	0	0%	0	0%
Number of doctors in disciplinary processes	0	0%	0	0%	0	0%

**SAS* - Staff Grade, Specialty and Associate Specialist doctors
See Appendix 1; Audit of missed/incomplete appraisals

5.2 Appraisers as at 31st March 2019

5.2.1 Number of appraisers – 24 (19 consultants, 5 SAS doctors)

- One appraiser left the Trust during 2018/19;
- Three new appraisers were recruited.

5.2.2 Support activities undertaken:

- A half day refresher training session was provided on 19.09.18 for 13 appraisers, which included 2 appraisers from other regional healthcare organisations
- Training sessions are facilitated by at least 2 of appraiser trainers, who are experienced Trust appraisers – Dr Mark Radcliffe, Dr Ruth Stockill, Dr Isaura Gairin and Dr Sara Davies.
- Two new appraiser trainers were recruited from the appraiser body as it is known that 2 of the existing trainers will be retiring during 2020. The new trainers will shadow the existing trainers during 2019/20.

- Appraisers Forums were held on 04.07.18 and 07.11.18. The Forums continue to provide an opportunity for appraisers to share good practice and discuss areas of concern/difficulty. Continuous improvement of the appraisal process in the Trust is also an important topic for discussion in the Forums.

5.3 Quality Assurance Processes

5.3.1 There is a portfolio minimum data set required for appraisal and the appraisers are required to check that this is uploaded or an adequate reason provided for non-inclusion.

5.3.2 The Trust utilises the multisource feedback tool embedded within L2P. This automatically flags with the doctors when they are required to undertake the colleague and patient feedbacks (required to be undertaken every 3 years, unless new to the Trust then required within first year). The reports are then not released to the doctor unless they have gained the minimum number of responses (and undertaken their self-assessments) or their request for release to the Revalidation Team is upheld.

5.3.3 The Revalidation Team inform the doctor if they are required to change their appraiser for their next appraisal (required to change after every third consecutive appraisal with same appraiser).

5.3.4 The AMD reviews all submitted appraisals (excluding those where he was the appraiser). Checks are made on appraisal inputs (appraisal portfolio), appraisal outputs (Personal Development Plan (PDP), appraisal summary and sign-off) and where appropriate, the AMD will request further work be undertaken prior to him recommending to the RO that annual appraisal is satisfactory. Those appraisals where the AMD was appraiser, the RO reviews and checks inputs and outputs.

5.3.5 The RO also reviews the appraisals on receiving the AMD's recommendation and either concurs or requests further clarification.

5.3.6 Each doctor is asked to provide feedback about the system and appraiser after their appraisal has been submitted (see section 5.6). This is a system that is embedded in the overall L2P system. This feedback is combined with other objective measures and subject to impression of the AMD who aspires to feed back in writing on an annual basis. If any issues arise in the course of the year, the AMD will liaise with individual appraisers.

5.3.7 There is on-going feedback to the doctors being appraised and appraisers, at the time that appraisal submissions are being reviewed. This takes the form of email correspondence or telephone conferences with the relevant doctors. The aim of this is to improve the quality of the appraisal submissions and to ensure there is satisfactory engagement.

5.3.8 The reviews undertaken by the AMD and RO also often raise agenda items for the Appraiser Forums, where for example inconsistencies are identified.

5.3.9 The appraisers receive further group feedback during Appraiser Forum meetings.

5.3.10 Issues also discussed at the refresher training that appraisers are required to attend every 2 years.

5.4 Access, security and confidentiality

5.4.1 The e-appraisal system (L2P) is required to be used by all doctors. No breaches to the system or individual portfolios were recorded during 2018/19.

5.4.2 Access to individual appraisals on L2P is restricted by login to the doctor, their appraiser, RO, Medical Director (MD), AMD and the Revalidation Team and any other person the doctor provides access to (via their own login).

5.4.3 Doctors are made aware via the L2P system that patient identifiable information should not be included in their appraisals. This is also stated in the Trust's Medical Appraisal Policy.

5.5 Clinical Governance

5.5.1 All doctors are provided with a PDF formatted record (including a nil response if appropriate) of their Incidents, Complaints and Sickness for their appraisal year from the Revalidation Team. This data is directly uploaded to the doctor's appraisal record on L2P. Doctors are required to reflect on their involvement in incidents and complaints, both those included in the reports and any others that they are aware of but may not have been linked to them via Datix.

5.5.2 The minimum requirement for their appraisal portfolio is provided in a Portfolio Minimum Data Set which is reviewed every year.

5.5.3 The doctor is required to complete a checklist prior to submitting their appraisal to their appraiser and where key information (predominately the minimum data set) is missing, they are required to provide a reason for its absence.

5.6 Appraisal feedback

Of the 130 feedback questionnaires completed by doctors after their appraisal, the following is a selection of the feedback given:

Was your appraisal useful for:	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Your personal development	52%	24%	6%	0%	0%
Your professional development	59%	37%	4%	0%	0%
Your preparation for revalidation	62%	37%	2%	0%	0%
Promoting quality improvements in your work	48%	47%	5%	1%	0%
Improving patient	48%	43%	8%	1%	0%

care					

Number of hours	**<1**	**1-2**	**2-3**	**3-4**	**>4**
Duration of appraisal discussion	3%	60%	27%	6%	4%

	Strongly agree	**Agree**	**Neutral**	**Disagree**	**Strongly disagree**
The appraisal was satisfactory	69%	30%	1%	0%	0%
I was able to collect all the necessary supporting information from the organisation	61%	35%	5%	0%	0%

99% of the doctors either agreed or strongly agreed that they would be happy to have the same appraiser again. 1% were neutral on this.

6. Revalidation Recommendations (1.4.18 to 31.3.19)

Number of recommendations	25
Recommendations completed on time	25
Positive recommendations	24
Deferral requests	1
Non engagement notifications	0

6.1 The Revalidation Review Group meet monthly and consider those revalidation recommendations due to be made in the following 12 months. This allows time for any further requirements to be actioned to enable a positive revalidation recommendation to be made.

6.2 As an outcome of this process, 100% of recommendations due in 2018/19 were submitted on time.

6.3 Of these, all but 1 was positive recommendation. The remaining one was for deferral.

6.4 All positive recommendations were approved by the GMC and the doctors subsequently revalidated. In the case of the deferral, the proposed new recommendation date was accepted by the GMC.

6.5 No recommendations were made late (within GMC category of late 7 days and under).

See Appendix 3; Audit of revalidation recommendations

7. Recruitment and engagement background checks

7.1 Substantive and Fixed Term appointments

During 2018/19, 7 substantive doctors were employed and 10 doctors were employed on temporary contracts.

7.1.1 During the application and interview process, doctors are assessed to ensure they have the qualifications and experience in order to fulfil the duties of the post.

7.1.2 For consultants, all interviewees are required to complete a 16PF (16 personality factors) questionnaire and the resulting assessment report is considered by the Advisory Appointment Committee.

7.1.3 For consultants, an assessment centre is held if more than 1 candidate for the role is to be interviewed.

7.1.4 Where appropriate, Medical HR checks the national database for Approved Clinician and Section 12 status. GMC registration is also checked.

7.1.5 Reference checks from the previous 3 years of employment are undertaken by Medical HR and the Appointing Officer confirms that they are satisfied with the references. The references will be checked for the correct dates and that the person giving them is the relevant person to provide.

7.1.6 Medical HR will meet with the doctor to verify their ID using the acceptable documents list. They request the original documents which are copied and used to process the Disclosure and Barring Service (DBS) check.

7.1.7 The Medical Directorate request information from the doctor's current/last RO, where the doctor has had one. This includes information about the doctor's last appraisal date, whether there are any concerns about the doctor's practice, conduct or health and if there are any outstanding investigations. The information received is checked by the Trust's RO, prior to final offer being made. Where this information is not received prior to the final offer being made*, the offer remains subject to satisfactory RO information or satisfactory Annual Review of Competence Progression (ARCP) outcome for those doctors joining the Trust straight from a training programme.

7.1.8 The MD checks and approves the final offer letter prior to sending.

7.1.9 If a doctor is recruited with GMC conditions, further information from the GMC is requested.

* if requests for RO information have not been responded to after 4 weeks, the Trust's RO will contact the GMC Employment Liaison Advisor to flag but recruitment will continue to ensure posts are filled as soon as possible.

7.2 Agency Locum appointments

7.2.1 Agency locum doctors do not have a prescribed connection to the Trust. Their connection is with their locum agency. It is the agency's responsibility to ensure their doctors are appraised and revalidated however the Trust's processes to engage locums, does include appraisal and revalidation checks.

7.2.2 During 2018/19 the Trust changed its primary supplier agreement from Athona Recruitment to ID Medical, whilst encouraging direct engagement via Brooksons as the umbrella company.

7.2.3 The Medical Clinical Lead/Medical Manager usually leads on the securing of locum doctors for their areas.

7.2.4 Athona and subsequently ID Medical, or via Brooksons as appropriate, provides suitable CVs and references through an online portal.

7.2.5 If a locum doctor's appraisal is over 24 months overdue, then it is recommended the doctor is not engaged.

7.2.6 If a booking is taken forward, a checklist is sent via email confirming the doctor has a DBS, Occupational Health clearance, Right To Work etc.

7.2.7 In line with the Trust guidance on booking locum doctors, the internal lead is then required to undertake a telephone interview prior to commencement.

7.2.8 In line with Trust guidance on booking locum doctors, on their first day a locum doctor's identification should be verified through the checking of their passport or photo-card driving licence.

7.2.9 Athona and subsequently ID Medical, provide a regular list of the locum doctors working within the Trust. This includes the doctor's appraisal status. This is then checked by the Business Manager and if an appraisal is overdue, the agency is connected for further information.

8. Monitoring Performance

8.1 Doctors are generally monitored through their team management structures.

8.2 In addition, a doctor's performance is monitored via the appraisal system which includes a requirement for feedback from service users and 360° feedback from colleagues on a three yearly basis.

8.3 Information in relation to whether a doctor is involved in serious untoward incidents or subject to complaint is also included in the appraisal system.

8.4 Serious untoward incidents are investigated using the Trust investigation procedures carried out by the trained investigators.

8.5 In the event that any concerns are raised, these are referred to the MD who can instigate various levels of investigation and take to the Responding to Concerns Advisory Group as appropriate.

9. Responding to Concerns and Remediation

9.1. The Trust has a Responding to Concerns and Remediation Policy which was approved in June 2018.

9.2. As at 31.3.19 the Trust had 2 trained Case Managers and 3 trained Case Investigators, all of whom are medical consultants.

9.3. A Responding to Concerns Advisory Group meets monthly wherever possible/required. It is chaired by the RO and is also attended by the

Medical Director, Director of Human Resources, Organisational Development and Estates, the AMD for Revalidation, Director of Nursing and Quality, Medical Directorate Business Manager and HR Business Partner with responsibility to support Revalidation. Relevant general management representatives attend as and when required. This approach ensures there is a consistent and open approach taken across the Trust in the investigation of concerns in relation to doctors. The group's terms of reference are included in the Responding to Concerns and Remediation Policy.

9.4. Remediation, when identified, is carried out on an individual basis, being tailored to the individual's needs.

10. Risk and Issues

The following are areas of potential difficulty for the Trust:

10.1 The voluntary status of the appraisers and their importance to our system is noted annually. It remains a concern that, if under pressure from other areas of work, doctors could withdraw from this role, thus threatening the appraisal process.

Mitigating factors:

- Appraisers have time allocated in their job plans for the role.
- The workload of appraisers is regularly reviewed in the Appraiser Forum and the Revalidation Oversight Group.
- Ensuring the Trust has enough appraisers to enable the maximum number of 7 appraisals for each appraiser per year to be maintained.

10.2 There is a continuing expectation that there will be further development demands on the revalidation process which will place increasing demands on resources. If it transpired that additional resources are required, the RO will present this to the appropriate forum in the Trust.

Mitigating factor:

Continuing to work with the system provider (L2P) to ensure administrative demands are met, as far as possible, through the system.

11. Actions, Improvements and Next Steps

An action plan for medical appraisal/revalidation is regularly reviewed and updated by the AMD and Business Manager and periodically reviewed with the RO.

11.1 2017-18 Actions

11.1.1 A further outcome of the peer review was to consider if invalid detentions data would be appropriate to include in the appraisal minimum data set. This is being considered in collaboration with the Trust's Legal Services Department.

Update: The Trust's Mental Health Act Office confirmed that any invalid detention would be raised on DATIX and thus picked up in the incident reports.

11.1.2 To review the current process for requesting RO to RO information and consider if it can be included in the standard online reference request process (excluding those joining the Trust straight from a training programme).

Update: There is a statutory requirement for a Responsible Officer (RO) to RO transfer of information when a doctor moves place of work i.e. after they have taken up new employment. It is currently not felt to be a particularly robust process and the Trust's RO has raised it at the GMC RO Reference Group. It is recognised nationally as an issue, particularly where the move is not NHS to NHS. Doctors moving from Health Education England used to be an issue but it has now been agreed that a doctor's ARCP (Annual review of competence progression) is sufficient.

It was agreed to consider the RO information being part of the pre-employment references however an issue is that a national website is used for recruitment. This is continuing to be explored.

11.1.3 To implement a Revalidation Oversight Group to meet on a 4 monthly basis. Role will include reviewing the NHSE Annual Organisation Audit, review appraisal/revalidation performance, provide input into the annual report, assist in the development of strategy and policy, assist in responding to national guidance/regulation and ensure continuous improvement of the appraisal and revalidation processes. Membership would include RO, MD, AMD, Business Manager, and representation from medical appraisers, non-appraiser doctors and lay representative.

Update: The group's inaugural meeting took place on 24th January 2019. At the meeting the terms of reference were agreed; the appraiser forum meeting was reviewed; the appraisers' workload was reviewed; the 2017/18 Annual Board Report actions were reviewed; and a review of overall performance to date was undertaken.

11.3 Additional Improvements Implemented 2017-18

11.3.1 An area of concern raised during 2018-19 was around the definition of non-engagement. The existing definition, within the Appraisal Policy, was only around timescales i.e. late appraisals and late submissions. As a result a locally agreed approach to engagement was developed. This is structured around the different aspects of the appraisal process and although is of a much lower level than the GMC's requirements for non-engagement, it does provide a local framework for defining satisfactory engagement in the appraisal process. The document was received positively by the appraisers and subsequently circulated to all doctors for comment and then published.

11.3.2 An area highlighted for checking by the RO during 2018-19 was around colleague multi-source feedback (MSF) and how recent the contact with colleagues requested was. This has an impact on the respondent's knowledge of the day to day practice of the doctor. The

RO undertook an audit of 40-50 MSFs, looking at the demographics of respondents. The results showed that the vast majority of doctors were choosing respondents who had had recent contact with them. The findings of the audit were circulated and the appraisers agreed with adopting the standard of 90% of respondents having recent (within two years) and regular (at least monthly) contact with the doctor requesting feedback. Of those MSFs the RO had audited, 2-3 would not have met the standard. The multi-source feedback guidance was updated to include the new standards.

11.4 Next Steps (2018-19 Actions)

11.4.1 Consolidation of the Revalidation Oversight Group.

11.4.2 Ensuring the quality of appraiser training is maintained with the introduction of new trainers.

11.4.3 Review process for patient feedback in light of GMC consultation/updated guidance.

12. Recommendations

12.1 The Board is asked to receive this report noting that it will be shared, along with the Annual Organisational Audit, with the Tier 2 Responsible Officer at NHS England.

12.2 The Board is further asked to recognise that the resource implications of medical revalidation are likely to continue to increase year on year.

12.3 The Board is finally asked to approve the Statement of Compliance attached as Appendix 5 of this report confirming that the Trust, as a Designated Body, is in compliance with the regulations.

APPENDIX 1
AUDIT OF MISSED / INCOMPLETE APPRAISALS DURING 2018/19

DOCTOR FACTORS	**CONSULTANT**	**SAS/TRUST GRADE**
Maternity Leave during the majority of the appraisal period	0	0
Sickness Absence during the majority of the appraisal period	0	2
Prolonged Leave during the majority of the appraisal period	0	0
Suspension during the majority of the appraisal period	0	0
New starter	1	4
Postponed due to incomplete portfolio / insufficient supporting information	0	0
Lack of time of doctor	0	0
Lack of engagement of doctor	0	0
Other doctor factor (describe)	2*	0
APPRAISER FACTORS	**NUMBER**	
Unplanned absence of appraiser	0	0
Lack of time of appraiser	0	0
Other appraiser factor (describe)	0	0
ORGANISATION FACTORS	**NUMBER**	
Administration or management factors	1**	0
Failure of electronic information systems	0	0
Insufficient numbers of trained appraisers	0	0
Other organisational factors (describe)	0	0

*Two doctors undertook their appraisal prior to April 2018 (both undertaken in March 2018) which has resulted in them being recorded as missing 2018/19 appraisal.

**One doctor had their appraisal month amended to align with their revalidation month as per Trust policy and this resulted in them not undertaking an appraisal during 2018/19.

4 **APPENDIX 2**

QUALITY ASSURANCE AUDIT OF APPRAISAL INPUTS AND OUTPUTS

TOTAL NUMBER OF APPRAISALS COMPLETED - 120		
	NUMBER OF APPRAISAL PORTFOLIOS AUDITED (1.4.18-31.3.19)	**NUMBER OF APPRAISAL PORTFOLIOS DEEMED TO BE ACCEPTABLE AGAINST THE STANDARDS**
APPRAISAL INPUTS		
Scope of work	120	118
Is continuing professional development compliant with GMC requirements?	120	120
Is quality improvement activity compliant with GMC requirements?	120	120
Has a patient feedback exercise been completed?	120	119
Has a colleague feedback exercise been completed?	120	119
Have all complaints been included and appropriately reflected on?	120	120
Have all significant events been included and appropriately reflected on?	120	118
Is there sufficient supporting information from all the doctor's roles and places of work?	120	119
Is the portfolio sufficiently complete for the stage of the revalidation cycle?	120	120
Other reason	120	120
APPRAISAL OUTPUTS		
Appraisal summary	120	120
Appraiser statement	120	120
PDP	120	120

All deficits were either addressed satisfactorily after the appraisal had been referred back, or agreement given that it would be addressed in the doctor's next appraisal.

APPENDIX 3
AUDIT OF REVALIDATION RECOMMENDATIONS (1st April 2018 to 31 March 2019)

Recommendations completed on time (within GMC recommendation window)	25
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	25
PRIMARY REASON FOR LATE/MISSED RECOMMENDATIONS	
No Responsible Officer in post	0
New starter / new prescribed connection established within 2 weeks of revalidation due date	0
New starter / new prescribed connection established more than 2 weeks of revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible Officer error	0
Inadequate resources or support for the Responsible Officer role	0
Other (describe)	0
TOTAL (sum of late and missed)	0

APPENDIX 4
AUDIT OF CONCERNS ABOUT A DOCTOR'S PRACTICE

CONCERNS	HIGH LEVEL	MEDIUM LEVEL	LOW LEVEL	TOTAL
NUMBER OF DOCTORS WITH CONCERNS ABOUT THEIR PRACTICE IN THE LAST 12 MONTHS				
Capability concerns (as primary category)	0	0	0	0
Conduct concerns (as primary category)	0	0	0	0
Health concerns (as primary category)	0	0	0	0
REMEDIATION/RESKILLING/RETRAINING/REHABILITATION				
Number of doctors who have undergone formal remediation				0
Consultants (permanent, employed staff)				0
Staff grade, associate specialist, specialty doctor (permanent, employed staff)				0
Temporary or short term contract holders				0
OTHER ACTIONS / INTERVENTIONS				
LOCAL ACTIONS				
Number of doctors who were suspended/ excluded (commenced or completed between 1.4.18 and 31.3.19)				0
Number of doctors who have had local restrictions placed on their practice in the last 12 months				0
GMC ACTIONS				
Number of doctors referred to the GMC between 1.4.18 and 31.3.19				0
Number of doctors who underwent or undergoing GMC Fitness to Practice procedures between 1.4.18 and 31.3.19				1
Number of doctors who had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1.4.18 and 31.3.19				0
Number of doctors who had their registration / licence suspended by the GMC between 1.4.18 and 31.3.19				0
Number of doctors who were erased from the GMC register between 1.4.18 and 31.3.19				0
NATIONAL CLINICAL ASSESSMENT SERVICES (NCAS) ACTIONS				
Number of doctors about whom NCAS has been contacted between 1.4.18 and 31.3.19				0
Reason for contacts:				
For advice				
For investigation				
For assessment				
Number of NCAS investigations performed				
Number of NCAS assessments performed				

Where 5 or more doctors have concerns about their practice in the year, a breakdown of appropriate protected characteristics will be provided.

APPENDIX 5

NHSE Designated Body Annual Board Report

Section 1 – General:

The board of South West Yorkshire Partnership NHS FT can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: 26th April 2019 Action from last year: N/A Comments: Nil Action for next year: N/A

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: N/A Comments: Dr Adrian Berry is the appointed RO. Action for next year: N/A

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: N/A Comments: There is a continuing expectation that there will be further development demands on the revalidation process which will place increasing demands on resources. If it transpires that additional resources are required, the RO will present this to the appropriate forum in the Trust. Action for next year: Monitor demand on current resources

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: N/A Comments: The Revalidation Team ensure that the designated body list of doctors is accurate. The formal list of the Trust's prescribed connections is recorded on the GMC Connect portal. As individual doctors are able to add themselves to this list, it is regularly checked to ensure that all the prescribed connections are appropriate. To facilitate this, a regular starters and leavers report is run from Electronic Staff Record. Action for next year: N/A

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: N/A Comments: Medical Appraisal Policy approved May 2018 and Responding to Concerns & Remediation Policy approved Jun 18. These policies will be routinely reviewed in 2021 unless local or national changes need addressing earlier. Action for next year: N/A

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: Peer review required. Comments: In November 2017 a Revalidation Peer to Peer Review was undertaken with Leeds and York Partnerships NHS Foundation Trust and the resulting report shared with NHSE. Action for next year: N/A

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: N/A Comments: All doctors working in the Trust, work under the Trust's governance processes. The Trust's processes to engage agency locums includes appraisal and revalidation checks and once an agency locum has been working within the Trust for 6 months, they are offered the opportunity to undertake their appraisal within the Trust's processes, with the agreement of their RO. Doctors on short-term contracts within the Trust undertake appraisal within the Trust's processes and have access to study leave as per substantive doctors. Action for next year: N/A

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: N/A

Comments: All doctors are provided with a PDF formatted record (including a nil response if appropriate) of their Incidents, Complaints and Sickness for their appraisal year from the Revalidation Team. This data is directly uploaded to the doctor's electronic appraisal record. Those doctors who also undertake work outside of the Trust are required to provide supporting information from their other places of work.

Action for next year: N/A

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: N/A

Comments: Where this supporting information is missing, this is picked up in the review process (all appraisals are reviewed by the AMD for revalidation and the RO) and the doctor would be asked to provide the information or explain the reason for its absence.

Action for next year: N/A

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: N/A

Comments: Approved by Executive Management Team, May 2018.

Action for next year: N/A

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Undertake appraiser recruitment process

Comments: In anticipation of some appraisers retiring, a recruitment round was undertaken to ensure the Trust has the appropriate number of appraisers to undertake a maximum of 7 appraisals per year each. The figures are regularly monitored.

Action for next year: Further appraiser recruitment to be undertaken.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action from last year: N/A

Comments: Appraiser forums are held 3 times a year. All appraisers have to undergo refresher training every 2 years. The AMD for revalidation provides individual annual feedback to each appraiser.

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of

Action for next year: N/A

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: N/A

Comments: A comprehensive annual appraisal/revalidation report is submitted to Board. The report details the QA processes in place. Additionally this year a revalidation oversight group was established, with lay representation, to monitor performance and quality.

Action for next year: Include appraisal, revalidation, responding to concerns data in Integrated Performance Report for Board

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: N/A

Comments: A process is in place within the Revalidation Team to ensure timely recommendations are made. No late recommendations were made in 2018/19.

Action for next year: N/A

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: N/A

Comments: The RO confirms with the doctor if a deferral is to be recommended, providing the reasons for this decision – in most cases discussions will have already been taking place with the doctor around a possible deferral. The same would occur if a non-engagement recommendation was required.

Action for next year: Implement a process to directly inform doctors when their recommendation has been undertaken by the RO.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: N/A

Comments: Clinical governance for doctors is overseen by the Trust's Clinical Governance and Safety Committee. Its remit is to provide assurance to Trust Board that appropriate and effective clinical governance arrangements are in place throughout the organisation through receipt of exception reports from relevant Directors to demonstrate that they have discharge their accountability for parts of their portfolios relating to clinical governance. This covers the areas of practice effectiveness, drugs and therapeutics, infection prevention and control, diversity, information governance and clinical documentation, managing violence and aggression, medical education, safeguarding children, research and development, compliance, and health and safety.

Action for next year: N/A

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: N/A

Comments: The medical directorate collate information from reporting systems for complaints and significant incidents relating to doctors. This together with sickness data is uploaded to the doctor's appraisal document. Other relevant information, such as involvement with Coroners inquests, is also noted on the document. Doctors are also required to upload their mandatory training matrix to their appraisal document. Job planning is now completed on the same electronic system to allow easier sharing of information across the two processes. Colleague feedback occurs at least every 3 years and is automatically uploaded to the appraisal form. Triangulation of all above data and review of content of appraisal occurs before sign off by the RO.

Action for next year: N/A

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: N/A

Comments: The Trust has a Responding to Concerns and Remediation Policy which was approved in June 2018. A Responding to Concerns Advisory Group meets monthly wherever possible/required. It is chaired by the RO and is also attended by the Medical Director, Director of Human Resources, Organisational Development and Estates, the AMD for Revalidation, Director of Nursing and Quality and Medical Directorate Business Manager. Relevant general management representatives attend as and when required. This approach ensures there is a consistent and open approach taken across the Trust in the investigation of concerns in relation to doctors. The group's terms of reference are included in the Responding to Concerns and Remediation.

Action for next year: N/A

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[2].

Action from last year: N/A Comments: There were no formal concerns in 2018/19. There is a pathway to receive concerns which includes the Medical Director and RO. The Responding to Concerns Advisory Group ensures there is consistency in the investigations and management of concerns across the Trust. The annual appraisal/revalidation report is submitted to Board includes a table detailing numbers, types and outcomes of concerns Action for next year: To explore if protected characteristics could be included in annual report due to small number and potential for identification. Include data of number of doctors within the MHPS process in Integrated Performance Report for Board.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[3].

Action from last year: Consider the transfer of information process. Comments: A new form has been developed for the transfer of information and this would be used where concerns needed to be transferred. Action for next year: N/A

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: N/A Comments: Equality Impact Assessment was undertaken in developing the Responding to Concerns & Remediation Policy. The Responding to Concerns Group monitors all processes relating to concerns about doctors' practice however the low numbers involved precludes meaningful analysis Action for next year: N/A

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation
http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: N/A Comments: Medical staffing undertake pre-employment checks for all employed doctors in line with Trust agreed procedures. CVs and references are required for agency locum staff, together with a telephone interview. Action for next year: N/A

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of last year's actions; N/A**
- **Actions still outstanding: N/A**
- **Current Issues**
- **New Actions:**
  - **Monitor resource demand on resources**
  - **Undertake appraiser recruitment**
  - **Include appraisal, revalidation, responding to concerns data in Integrated Performance Report for Board**
  - **Implement a process to directly inform doctors when their recommendation has been undertaken by the RO.**
  - **To explore if protected characteristics could be included in annual report due to small number and potential for identification.**

Overall conclusion: This has been a very positive year both in terms of performance of the appraisal and revalidation system and the incremental development of the process. Appraisee feedback continues to remain positive and as does the Associate Medical Directors feedback to appraisers. Anticipated changes to the guidance for patient feedback may play a significant role in future improvements to the appraisal process and personal development of the medical workforce.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of South West Yorkshire Partnership NHS FT has reviewed the content of this report and can confirm the organisation is

compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 24 September 2019
Agenda item 8.2

Title:	**Sustainability Report 2018/19**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates
Purpose:	The purpose of this paper is to provide the Board with an overview on performance on sustainability based mainly on the impact the Trust is having in reducing its environmental impact. It covers how we buy, use and dispose of resources and the impact this has on our carbon footprint. It also looks at how people within the organisation travel and the impact of new ways of working and technology which can assist in reducing energy usage.
Mission/values:	This report is in line with the Trusts ambition to be a positive contributor to society overall and to allow people to live their life to the full.
Any background papers/ previously considered by:	Sustainability Strategy 2015/16 – 2019/20 and associated policy.
Executive summary:	The report evidences the excellent performance of the Trust in driving down energy consumption and carbon emissions through a combination of estate rationalisation, Investment in energy saving processes and equipment and good housekeeping. The report also addresses actions in key areas as follows: ➢ Reducing the use of vehicles. ➢ Promoting the use of technology ➢ Responsible procurement ➢ Waste and recycling ➢ Promotion of agile working and hot desking ➢ Green travel plans ➢ Sustainable building ➢ Future strategic direction **Risk Appetite** This report forms part of the annual information process for Board for the sustainability agenda.
Recommendation:	**Trust Board is asked to NOTE the content of this report.**
Private session:	Not applicable.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Sustainability

Summary report

2018/19

September 2019

With **all of us** in mind.

Introduction

The Trust defines sustainability in its broadest terms as being a good corporate citizen. In order to help meet its goal to help people to reach their potential and live in the community the Trust needs to operate in a sustainable manner both in how it uses valuable resources and how it purchases its goods.

Furthermore, the Trust is seeking to expand its ethical use of resources by reducing its use of single use items wherever possible by either substitution or ceasing to use these products.

Sustainability Strategy

The national strategy for sustainable development for the health and social care system includes goals to aim for by 2020 including:

- A healthier environment – including reducing pollution and carbon emissions
- Resilience – for changing times and climates.
- Responsible sourcing of goods and services.

The Trust is in the final year of a sustainability strategy covering the period 2015/16 - 2019/20. The strategy provides the framework to ensure the integration of resource sustainability into Trust operations and in engagement with staff, service users and other parties we work with.

The sustainability strategy covers the national goals and delivers on our energy and carbon management and designing the built environment including adaptations.

Staff who focus on specific areas of the agenda continue to deliver good results across the areas described above. There is work to do to re-energise broader staff connection to the sustainability agenda. Sustainable issues have been highlighted through I hub with an emphasis on changing behaviours. This initiative is being used to reenergise staff participation in this important agenda.

Sustainable Development and Carbon Management

Trusts Carbon Management Plan:

The Trust carbon emissions for 2018-19 have been updated and the comparisons of both the base year 2010-11 and last year 2017-18 are detailed below:

DEFINITION: The definitions used in the plan are as follows:-

- Stationary refers to fixed installations for heating power and lighting etc.
- Transport refers to all vehicles used in Trust business but excludes the supply chain.
- Further Sources refers to other smaller items such as generators etc.

The Carbon Management Tool covers **Stationary** (Electricity and Gas Consumption) **Transport** (Business Transport) and **Further Sources** (Water and Waste) with all these inputs converted into CO2 emissions

Carbon Emissions – Data Analysis

Data

		Carbon Emissions		
	CO2 (tonnes) 2010-11 Baseline Emissions	**CO2 (tonnes) 2017-18**	**CO2 (tonnes) 2018-19**	**Overall %Reduction**
Stationary	11,515	7,367	6,672	**-42.1**
Transport	1,404	1,133	1,133	**-19.3**
Further Sources	452	43	43	**-90.5**
	13,373	**8,543**	**7,848**	**-41.3**

Sustainability Strategy

The Trust set an original carbon reduction target of 18% (2,407 Tonnes (CO2) based on its carbon emissions in 2010-11 of **13,373** tonnes (CO2). This ambitious reduction in stationary, transport and further sources committed the Trust to actively pursue areas of specific improvements. Through a targeted operational and energy efficiency investment plan, coupled with the Trust's Estate Strategy that recognises service change with agile working and estates rationalisation, has resulted in the planned reduction being exceeded in each reporting year

Existing Carbon Reduction Target of 34% by 2020

The focus and challenge of reducing the Trust's carbon emissions has resulted in a significant improvement in our carbon footprint and therefore the original planned 5-year target has been extended to 2020, with a target reduction of 34% against the 2010/11 baseline that in total will require the Trust to reduce its carbon emissions by 4,547 Tonnes CO2.

This target has been exceeded in this year and the Trust should consider resetting the target to a 43% reduction from the baseline

Trust's Carbon Management Plan: 2018-19 Update

Source - ERIC Data for 2018-19

- Baseline Analysis – 2010-11 to 2018-19 Carbon Reduction 5,525 Tonnes (CO2)
- Actual Reduction in period 2017-18 to 2018-19 is 695 Tonnes (CO2)
- Trust CO2 reduction target over achieved
- The Trust should consider setting a new target of 43% reduction

It should be noted that due to changes in ERIC collection mileage is no longer submitted so for this report we have used last year's figures. This information will be updated as part of the revised sustainability plan which is about to be revised ahead of its existing expiry date of 2021 to reflect changes in thinking in the field nationally

Sustainable Development and Carbon Management Plan

The Trust's ongoing commitment to reducing carbon emissions is crucial to delivering the Sustainable Development and Carbon Management Plan with targeted investment in energy efficiency improvements. A robust approach to monitoring and the contribution made through the implementation of the Trust's Estate Strategy by the rationalisation of the property portfolio, supported by agile working, have contributed to an impressive overall reduction of **5,525** Tonnes (CO2) **41.3%** from the base year **2010-11** and therefore the targeted reduction of has been achieved. The significance of continually striving to reduce the Trust's carbon footprint, linked to both consumption/cost reduction, is becoming increasingly more important as the commodity prices are increasing with market volatility, alongside additional (non commodity) government tax rises. Transport and distribution costs are also increasing the cost of electricity, gas and water and so we are and will be seeing significant price increases over the coming years. Therefore, it is essential that every opportunity to ensure energy and water is been effectively purchased, used and utilised has become business critical.

Procurement

We continue to build on the work of previous plans to procure our services using the whole life costing model. We monitor the use of local SME (Small, Medium Enterprises) suppliers and work proactively to maintain and increase engagement with these organisations. Any contracts which are tendered are conducted via the Trust's e-Tendering portal and are advertised on *"Contracts Finder",* the recommended website for advertising public sector contract opportunities to local community suppliers. In addition, all tenders include a section on sustainability, which requests the submission of a statement from the bidder on their organisation's position linked to the Good Corporate Citizen concept.

The main procurement challenges for the coming months include:

- To monitor environmental and sustainability in all goods and service tenders
- To work with suppliers who are environmentally aware and hold the relevant accreditations. This being achieved through including environmental sustainability in the list of requirements to become a supplier to the Trust
- To undertake contracting exercises to reduce the vehicular carbon footprint of deliveries through use of single suppliers for multiple items
- To reduce the use of single use plastics wherever possible
- To develop skills in the procurement team to enable positive change
- To examine where reductions in packaging as well as the use of recycled packaging can be promoted

Sustainable Travel & Agile Working

The Trust recognises its responsibilities to contribute to a cleaner environment and is committed to sustainable transport. We are working to reduce the need for staff to bring their personal vehicle to work, to reduce the need to use their vehicle for business purposes and to promote awareness of the benefits of sustainable travel choices and reducing reliance on car travel.

Green Travel

To support further reduction in business mileage the Trust has a green travel plan to minimise the impact of travel on the environment within the context of running an efficient business. The plan includes a range of measures aimed at promoting sustainable travel choices and reducing reliance on car travel. If effective, this will bring environmental, social and health benefits to both staff and to our communities. In addition the Trust is actively looking at the benefits of ZEV (zero emission vehicles) in its white fleet (vehicles leased or owned by the Trust such as estates department and delivery vehicles and the installation of charging points to promote ZEV use in its grey fleet (wider vehicles such as leased vehicles used by staff in the course of their duties

The travel plan has the main aims of:

- A positive corporate social responsibility message, demonstrating good environmental and transport practice. By the promotion of alternative transport to single occupancy private cars
- A commitment to reduce greenhouse gas emissions, contributing to environmental targets both corporately, locally and nationally
- Healthier and more motivated staff by reducing reliance on private transport such as cars
- Improved access to sites for staff, visitors and patients by improving information on the use of public transport
- Economic and environmental sustainability over time
- Cost/energy savings.

For staff

- Increased travel choices
- Contribute to improved health and reduced stress
- Travel cost savings through cheaper alternatives and car-sharing
- Reduce parking pressure
- Support staff who, out of necessity or choice, do not use a car
- Slow down the growth in car use, especially drivers travelling alone

For local communities, green travel can enhance the local environment through:

- Reduced congestion and pollution
- Reduced greenhouse gas emissions that contribute to climate change
- A healthier, more attractive environment in which to live and work
- Support for the use of public transport and the development of safe cycling and walking routes will enhance opportunities for all.

As stated due to changes in central reporting the measurement of Co2 emissions the Trust is seeking guidance on the reporting of these going forward as they will continue to contribute to our overall plans .

Baseline assessment

To assist the continuing development of the green travel plan, a detailed understanding of the current position is required. Travel surveys at Fieldhead and Kendray will be repeated in 2020 with a view to looking at longer term trends. Also we are working closely with our Mid Yorkshire Hospitals Trust as Fieldhead and Pinderfields are very close geographically, so a combined approach should benefit both Trusts. Further initiatives across the whole Trust area will form part of the revisions to the plan which is currently underway.

We know that staff use cars for convenience and to undertake other activities on the way to and from work. Time and cost savings are also major factors.

The following is included in the current Green Travel Plan:

- Providing public transport information on the intranet and the Trust's website, ensuring this is regularly updated
- Bike to Work and staff cycle incentive schemes, with reminders about safe cycle storage
- Staff invited to join task and finish groups for specific pieces of work, providing a forum to consult staff on the implementation of the Travel Plan and to develop ideas for further improvement
- Survey of staff travel to work choices
- Re-launch of the car sharing schemes with Liftshare
- Work with local bus companies to provide better public transport links, for example, to community hubs.
- Publicise that staff can access the Mid Yorkshire bus services to Pinderfields and Pontefract Hospitals, following recent negotiations

Positive practice in agile working and use of technology:

The Trust continues to promote the adoption of agile working and locations where this is possible outside the Trust estate are:

- Barnsley Hospital NHS Foundation Trust
- Huddersfield Royal Infirmary
- Calderdale Royal Hospital
- Broad Lea House, Bradley
- Batley Health Centre
- Beckside Court, First Floor
- Cleckheaton Health Centre
- Dewsbury Health Centre
- Eddercliffe Health Centre
- Fartown Health Centre
- White Rose House, Wakefield
- Mill Hill Health Centre
- Holme Valley Memorial Hospital

- Skype for Business Audio Conferencing Facilities available at:
  - Fieldhead Hospital
  - Kendray Hospital
  - Folly Hall
  - Laura Mitchell Health & Wellbeing Centre
  - Drury Lane Health & Wellbeing Centre
  - Baghill House Health & Wellbeing Centre
  - Priestley Unit Dewsbury

- Skype for Business Video Conferencing Facilities available at:
  - Folly Hall
  - Laura Mitchell Health & Wellbeing Centre
  - Priestley Unit Dewsbury

- Skype for Business Video Conferencing Facilities will soon be available at:
  - Fieldhead Hospital
  - Kendray Hospital
  - Beckside Court
  - Ravensleigh Resource Centre

- There are significant numbers of staff using mobile broadband which supports working in community settings and in people's homes
- There are more than 1900 agile workers with VPN enabling home working and other otherwise unsecured Wi-Fi connections
- There are over 1900 Skype for Business users, having access to both audio and video conferencing facilities via laptop/desktop computers regardless of location (provided there is network connection)

- Hot desking is available at the following locations to support staff in reducing travel:

Barnsley	Calderdale	Kirklees	Wakefield
Kendray Hospital	Laura Mitchell	Folly Hall	Baghill House
Worsbrough LIFT	The Dales	Beckside Court	Drury Lane
Apollo Court MC	Hope Street Resource Centre	Priestley Unit	Fieldhead
Cudworth LIFT	Hebden Bridge HC	Ravensleigh Resource Centre	
Goldthorpe LIFT			
Hoyland LIFT			
Athersley Roundhouse			
Mount Vernon Hospital			

Recycling furniture

The Trust has continued to recycle furniture before purchasing new and the stocks resulting from estate rationalisation have almost been expended which has avoided them going to waste even though they would have been recycled.

Waste Management Procedure Policy

The Trust's Waste Management Policy is subject to update in line with developments in environmental and waste legislation.

All employees generating waste are responsible for the correct segregation of waste. Where staff treats or cares for a person in their own home, any waste produced is considered to be produced by that care professional. Part of the Duty of Care is to ensure that the waste is dealt with appropriately, from point of production to final disposal. The Trust has a waste contract which sends zero waste to landfill and promotes recycling by segregating waste at a recycling facility for reuse before sending any residual waste to be used in the generation of heating and power in a local waste to heat plant.

Designing the Built Environment and Adaptation

The Trust's Estate Strategy, approved by Trust Board and monitored through the Estates Trust Action Group, is to move from smaller properties, which do not offer a functional space, to purpose built hubs, which offer an optimal environment from which to deliver healthcare. This includes improving high quality green space and biodiversity on our estate, promoting physical health and wellbeing. This strategy is nearing the end of life and a new strategy is currently being developed. At the centre of the new policy will be a need to have a safe, secure, sustainable estate.

Integrating health and sustainable development considerations in our built environment is part of all new build projects and adaptations, with continued investment in energy reduction technologies, renewable energy and future proofing. The Trust's Estate Strategy is shared with partner organisations and there is joint work to ensure that adaptation (the ability to respond in extreme circumstances) is a key part of local planning processes across the wider footprints of our integrated care systems (ICSs).

The Trust works to the national Climate Change Mitigation and Adaptation Plan and Trust business delivery units (BDUs) are supported to embed resilience activity into their operations. The Trust aims to be a leading exemplar in the management of major and extreme events and has incorporated the impacts of climate change into the scenarios utilised for testing our plans. Currently this is in table top exercises on how we would deal with flooding, heatwaves etc. This is done both internally as an organisation and participation in wider regional events.

In addition, the Trust has invested in the redevelopment of the Fieldhead site for non-secure services with the completed development being occupied in May 2019. This building incorporates high levels of insulation together with photo voltaic electricity panels and natural stack ventilation to reduce the consumption of fossil fuels. This is reflected in our ongoing reduction in the use of fossil fuels and carbon reduction.

Summary / Next Steps

Work continues to deliver the Trust's Sustainability Strategy and to monitor performance.

The next major change is to review and refresh the Trust's Sustainability Strategy, which has commenced. Key themes in this will include:

- The continued commitment to reduce CO2 emissions
- To examine the Trust's use of single use materials
- To recognise how behaviours affect environmental performance
- To improve the use of technology in meetings to reduce travel
- To use technology to communicate on environmental issues
- To have an open approach to this field which includes all aspects of environmental management.

The revision to the sustainability strategy will be an inclusive exercise involving as many interested parties as possible with initial engagement meetings scheduled in September 2019.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 24 September 2019
Agenda item 8.3

Title:	**Workforce Race Equality Standard (WRES) Summary Report and action plan and Workforce Disability Equality Standard (WDES) action plan**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates
Purpose:	WRES Summary Report and action plan and WDES action plan require the Equality and Inclusion (E&I) Committee and Trust Board sign off prior to submission and publication
Mission/values:	The Trust serves a diverse population across a large geographical area and it is important we strive for a workforce that reflects the local population. A diverse workforce is vital to enable all parts of the communities served by the Trust to reach their potential. Equality and Diversity is core to the Trust's values and is an important part of its service and workforce objectives.
Any background papers/ previously considered by:	The E&I Committee have approved the WRES and WDES summary report and action plan prior to them being submitted to Trust Board for final sign off. The issues within the WRES action plan have been central to a number of discussions at the E&I Committee and key background papers include the Trust Equality Workforce Monitoring Annual Report 2019. The Workforce Disability Equality Standard (WDES) was introduced this year and has been discussed at the E&I Committee. The first WDES action plan has been submitted for consideration by the E&I Committee prior to going to Trust Board for final sign off. Both the WRES and the WDES will be published at the end of September 2019.
Executive summary:	The Trust recognises the importance in delivering culturally sensitive services that meet the needs of the communities we serve and a diverse workforce is critical to achieving this aim. The WRES, which is a requirement for NHS Trusts and has been included in the NHS standard contracts since 2015, provides a framework which will support the embedding of workforce equality. The WDES is also now included in the NHS standard contract and this is the first year NHS Trusts have been required to report on it. The main purpose of the WRES and the WDES is to help local and national NHS organisations to review their workforce data against the associated indicators (nine for WRES and currently ten for the WDES). This review should then enable organisations to produce action plans to close any gaps in workplace experience between White and Black, Asian and Ethnic minority (BAME) staff, and disabled and non-disabled staff, and to improve representation at a senior level of the organisation. The WRES and WDES are believed to be the best means of helping the NHS as a whole to improve its equality performance. There is considerable evidence across the NHS that suggests BAME and disabled staff experience less favourable treatment than white and non-disabled staff which then has a significant impact on the efficient and effective running of services. The Trust has a key leadership role to play in shaping a collective and inclusive culture across all protected characteristics and many of the actions can be equally applied across the organisation and to all protected characteristics.

	The Trust's WRES action plan integrates with the EDS2 to ensure a consistent approach and to reflect the commitment to moving this agenda forward. The WDES action plan is currently a stand-alone document for the first year but integration into a combined workforce equality action plan is planned for next year. There is no standard format this year for the WDES action plan. In 2018 the NHS staff survey generated a 40% return rate (4% lower than the previous year). The results of the survey found that BAME staff in general were more positive than White in the key areas of staff engagement, workplace health and wellbeing and quality of appraisal. However, BAME staff were more negative than white staff regarding their experience of bullying and harassment. Disabled staff reported a more negative experience in all 4 areas. In summary key areas of positive development since 2018 in terms of WRES/WDES are: ➢ The Board and Directors are more diverse in terms of both ethnicity and gender. ➢ The percentage of BAME staff experiencing harassment, bullying and abuse from patients, relatives or the public in the last 12 months has improved. ➢ The percentage of BAME staff experiencing discrimination at work from manager/team leader has improved. ➢ The Moving Forward programme to support BAME staff development is in place with very positive feedback ➢ The BAME Staff Network continues to play an active role in promoting equality in the Trust. ➢ The Disability staff network has established a steering group and is in the process of agreeing a work plan for the forthcoming year. The key areas for improvement and focus for 2019 in terms of WRES/WDES are: ➢ Tackling harassment and bullying by service users and carers ➢ Implementing new framework for Bullying and Harassment which will include the development of specialist harassment advisors with a focus on racially motivated incidents. ➢ Widening access to Clinical Excellence Awards ➢ Rolling out of the Reciprocal Mentoring scheme ➢ Continue to support the BAME network, the New Horizons project and the Stepping Up, Ready Now and Moving Forward programmes ➢ Development of a Disability Policy ➢ Continue to develop the Staff Disability Network The integrated WRES and EDS2 action plan consists of standing objectives based on national requirements which the Trust will continue to promote and monitor every year. The intention is to incorporate the WDES action plan. In addition to the rolling action plan there are then specific actions in response to 2019 data and feedback from staff. **Risk Appetite** The WRES and WDES data are outside of the risk appetite and this has been recognised in the action plan and on the risk register.
Recommendation:	**The Trust Board is asked to APPROVE the WRES summary report and action plan and WDES action plan.**
Private session:	Not applicable.

Integrated EDS2 and WRES workforce action plan progress update July 2019

AIMS (based on EDS2 Goal 3 outcomes)		OBJECTIVES (those based on WRES indicators are numbered)		AGREED ACTION	UPDATE
3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	1	To increase the % of BME staff in each of the AfC bands 1-9 and VSM (inc Executive Board members) to reflect the % in the local population	<u>Increase applications from BAME population</u> • Continuing with the 'New Horizons' project, working with schools and colleges in North & South Kirklees. Project includes engaging with the local BME community on the areas of mental health awareness, employability skills and promoting the Trust and wider NHS as an employer of choice	Project evaluation from both students and teachers continues to be very positive and we are progressing with the recommendation to build on this success in the future. A fourth programme of work is scheduled for September/October 2019
		2	To ensure that the relative likelihood of BME staff being appointed from shortlisting across all posts is the same as that of white staff	• Updated recruitment information continues to include use of social media showing a diverse workforce • Continue and enhance the work with Universities to increase the number of students from BME communities on health related degree courses	Recruitment and retention group currently looking at the recruitment marketing and onboarding. Use of appropriate platforms for all recruitment including medical and Director level, as well as bank staff recruitment
		9	To have a Trust Board whose BME voting membership reflects its overall BME workforce	• Include representative workforce focus in annual workforce planning discussions with BDU's and services	The Trust has appointed 2 BME Board members since April 18
				<u>Positive action to support development of BAME Staff</u> • The Trust continues to sponsor BME staff onto the NHS Leadership Academy 'Stepping Up' and 'Ready Now' programmes. These offers are incorporated in the Trust's Leaders and Managers development pathway and access to 360 feedback is included within these programmes	Trust continues to sponsor a number of candidates on the national leadership programme. In addition, access to the regional 'RADAR' programme is now available
				• 'Moving Forward' is being progressed in partnership with Bradford Care Trust and L&Y Partnership. The crucial conversations training/coaching is offered to Trust participants on the Moving Forward Programme	The Trust's in house 'Moving Forward' programme is being delivered between October 19 and April 2020 and includes BME staff from 2 of our MH alliance partners along with our Wakefield Continue Care alliance partners

				• Introduction of Reciprocal Mentoring pilot programme <u>Ensuring our recruitment processes are fair and transparent</u> • Centralised exit interviews for all staff has been approved and the process is now in operation. The feedback will be collated 6 monthly and reviewed by the EMT and Workforce and Remuneration Committee • Staff wellbeing survey now includes questions for both EDS2 and WRES audit. The next survey is due Spring 2020. • Audit of acting arrangements to take place in September 2019	The Trust has created a development opportunity for an individual to play a key role in the introduction and evaluation of a Reciprocal Mentoring programme for BME staff. The Trust's gender pay gap report and action plan has been extended to include ethnicity Actions to be included in the overall staff wellbeing action plan
3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations		To undertake local audits by gender, ethnicity and disability	• Annual pay audit undertaken and submitted to the Workforce and Remuneration Committee. Next submission date March 20	Gender pay gap action plan update to go to Workforce and Remuneration Committee
3.3	Training and development opportunities are taken up and positively evaluated by all staff	4	To ensure that the relative likelihood of BME staff accessing non-mandatory training and CPD is the same as that of white staff	• Ensure all training is recorded and monitored and study leave forms completed across the Trust. • There is an appeals process that staff can access if they believe training requests have been unfairly rejected.	Training outcomes are identified though formal learning needs analyses with services to inform a training delivery plan with associated resources and costs included
3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source	5	To reduce the numbers of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	• The RACE Forward network was established to review support and actions required regarding harassment and bullying from service users, carers and visitors • The Trust has held 'engage and listen' events looking at next steps in 4 key priority areas for improving staff and service user experience:	The network has formed a cross organisational group with similar NHS organisations in the Region to look at developing shared pieces of work to progress this agenda The Trust is developing a revised framework for the prevention of harassment and bullying. This will

		6	To reduce the numbers of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months	➢ Increasing staff engagement ➢ Preventing harassment & bullying ➢ Workplace wellbeing ➢ Improving the quality of appraisals • Middleground, a 2 day forum for senior leaders, is being refreshed and will focus on the Trust's 4 key priorities	include looking at rights and responsibilities and relaunching the H&B advisor roles The Middleground programme's main emphasis will be on leadership actions and behaviours that will support us in developing the Trust to be 'a great place to work'
3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives		To ensure all staff have equal access to request flexible working opportunities	• Appeals against flexible working decisions are rare. No evidence of any WRES issues. • The staff survey results show that BME staff are equally as positive as white staff regarding flexible working opportunities • Flexible working guidance will be reviewed.	Any issues arising will be addressed as required. Review as part of Staff surveys A further review will be discussed at the Safer Staffing meeting Autumn 19 Retire and return guidance is being revised and updated.
3.6	Staff report positive experiences of their membership of the workforce		To improve the experience of staff while working for the Trust	• Staff wellbeing and engagement survey • EDS2 survey undertaken again 2019 • Friends and Family test	Results discussed with staff networks and relevant action plan developed …… " …… …… " ……
		3	To ensure that the relative likelihood of BME staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation is the same as that of white staff	• Review disciplinary cases and lessons learned. • Disciplinary procedure currently being reviewed	The Trust will engage with the BAME network to support this process. Review to take place in late 19/early 20 Procedure will include 'just culture' and decision tree
		7	To increase the numbers of BME staff believing the Trust provides equal opportunities for career progression or promotion	• Continue to evaluate experiences of staff attending 'Stepping-Up' & Moving Forward programmes. • Continue with 'Moving Forward' programme and monitor progression of participants. • Continue to deliver aspiring directors (Shadow Board) programme and executive coaching/ mentoring for senior leaders/managers.	The Trust is working with the BAME network supporting colleagues into 'Ready Now', 'Stepping Up' and 'RADAR' the NHS Leadership Academy programmes. Partnering with BD, LYPTF and WCC Alliance to deliver 'Moving Forward' and 'Shadow Board' programmes

					Medical leaders development programmes launched in Spring 2019 with additions agreed for Autumn 2019
		8	To reduce the numbers of BME staff who have personally experienced discrimination at work from manager/ team leader or other colleagues in the last 12 months	• Preventing Harassment and Bullying Framework will be launched summer 19.	This year the Trust held 'engage and listen' events which focussed on 4 key areas including harassment and bullying. The framework will include rights and responsibilities and relaunching the H&B advisor roles

South West Yorkshire Partnership NHS Foundation Trust
Workforce Disability Equality Standard (WDES) Action Plan 2019/20

Objective & WDES indicator		**Action**	**Responsibility**
1	Improve the declaration rates on ESR to reduce the number of null/not known categories	• Take positive action and in partnership with the chair of the staff disability network contact all employees whose status is recorded as null/not known and invite them to update their personal details. • Work with trust communications to remind staff of the ESR self-service portal and encourage updating of personal data.	HR/Network Chair HR/ Communications
2	Increase the relative likelihood of disabled staff being appointed from shortlisting across all posts compared to non-disabled staff	• Review recruitment and selection policy and identify if any additional work/inclusion of positive messages are required in relation to disabled staff. • Review information for disabled applicants on NHS jobs to identify if any additional positive messages are required to promote the trust as a disability friendly employer.	HR/Staff Side/Staff Network/E & E Managers HR/Staff Network/ Communications
4	Reduce the numbers of disabled staff experiencing harassment, bullying or abuse from: i. Patients/service users, their relatives or other members of the public. ii. Managers iii. Other colleagues	• Develop and implement a framework for the management and prevention of bullying and harassment • In partnership with the staff disability network, identify any targeted actions to support disabled staff e.g. produce and publish advice regarding the appropriate use of language and	HR HR/Staff Network/E&I managers

		providing input to equality training.	
5	Increase the numbers of disabled staff believing the trust provides equal opportunities for career progression and promotion	• Ensure access to talent development & leadership development framework and processes via trust-wide, localised and Positive Action programmes & interventions • In partnership with the staff network, promote key messages in relation to the trust being a disability friendly employer.	L&D/HR/Workforce/ Managers HR/Staff Network/ Communications
6	Presenteeism	• Engage with the staff disability network regarding the roll out of trustwide wellbeing action plans. • Support the development of a staff disability policy and disability passport in collaboration with the staff disability network.	HR/Staff Network HR/Staff Network/Staff Side
7	Ensure disabled staff feel satisfied with the extent to which the trust values their work. Improve the experience of disabled staff while working for the trust	• Continue to support the ongoing development of the staff disability network and agree priorities and workplans. • Ensure results from various data sources are discussed with the staff disability network. • Once fully established, actively engage with disabled staff though the staff disability network to identify learning and actions arising from lived experience	HR/Staff Network HR/Staff Network HR/Staff Network
8	Ensure that adequate and reasonable adjustments are made to enable disabled staff to carry out their work	• In collaboration with the staff disability network, Occupational Health department and Communications: i. develop intranet page(s) dedicated to	HR/OH/Staff Network/ Communications

		disability issues (provision of basic advice, signposting etc.) ii. Produce a guide to reasonable adjustments and signpost to other support available e.g. Access to Work iii. Develop and implement a staff disability policy and consider incorporating a 'disability passport'	
9	Ensure that disabled staff feel engaged and have a voice within the organisation	• Continue to support the ongoing development of the staff disability network • Continue to identify and utilise opportunities to engage with disabled staff and involve them in any associated action plans.	HR/Staff Network HR/Staff Network

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 24 September 2019
Agenda item 8.4

Title:	**Care Quality Commission (CQC) inspection 2019**
Paper prepared by:	Director of Nursing and Quality
Purpose:	To provide an update to Trust Board in relation to the outcome of the Care Quality Commission 2019 inspection and next steps
Mission/values:	All areas of the CQC revisit and report are aimed at identifying how we provide a safe and effective service, reflect areas that we need to improve upon and celebrate our successes. All of the key lines of enquiry are in line with our mission and values.
Any background papers/ previously considered by:	Previous CQC briefing papers and updates on action plans
Executive summary:	The Trust was subject to a well-led inspection by the Care Quality Commission (CQC) in May & June 2019. As a learning organisation, the Trust's values are at the heart of everything it does, and the CQC visit and its independent view of services was welcomed. Draft reports were provided to the Trust for factual accuracy checking which was undertaken collaboratively by corporate support and operational teams. The Trusts final reports (CQC staff briefing attached at Appendix B) were published on 23rd August 2019 and the headlines are as follows:- ➢ Our Well led Review considered the senior leadership and governance arrangements and rated them as Good ➢ 12 of our 14 core services are rated Good, with over 87% of our individual domains rated Good or Outstanding. ➢ 4 core services were visited. Of the services visited one improved to Good and three stayed the same, showing real improvements in several areas. ➢ Our community mental health services for people of working age have improved and is now rated Good ➢ Our acute mental health / psychiatric intensive care wards have improved with the removal of a single inadequate rating but remain Requires Improvement overall ➢ CAMHS has remained Requires Improvement ➢ Our services for Older Adults have remained Good We have submitted a report of actions to the CQC outlining what activity we will undertake to improve quality against the 12 MUST DO requirements.

This report was scrutinised by the Clinical Governance and Clinical Safety Committee meeting held on the 10 September 2019.

The Committee commented that;

- The recent achievement of a "Good" rating is to be celebrated and acknowledged that significant work has been undertaken to achieve this position.
- The reduction in the number of must and should do actions is positive.
- The CQC action plan submission target date will be met.
- The adoption of a quality improvement approach to address areas requiring action is a positive move and fully supported. It was acknowledged that this approach will ensure sustainable improvement is embedded.
- The detail behind the quality improvement approach against the identified domains is required for the next meeting
- The quality improvement approach should be set in the context of our aspiration to be outstanding, and acknowledged the need to ensure that existing improvement activity is sustained.

The CQC will monitor our progress against the plan through ongoing engagement arrangements.

Internally we have a number of mechanisms in place to assure the quality of our care. These include high level strategies, (with implementation plans), systems and processes to monitor quality improvement and assurance. Our structures facilitate ward to board connectivity and meaningful activity to improve the safety, effectiveness and experience of care.

Through a workshop approach we collaboratively developed a quality improvement plan to address all MUST DO actions and are using the same approach to develop Should Do (37) actions, where this is required.

In addition we utilised a session at Extended EMT to critically appraise how we should use the findings from the CQC report to ensure we achieve sustainable change to quality and validated the use of quality improvement methodology, i.e. The Model for Improvement. The focus will be on incorporating teams from across the trust to participate in work streams as opposed to Core Services developing their plans in isolation.

In addition we will enhance our learning library (system of 'share and spread') to promote learning from quality improvements.

Appendix A is a first draft of the Quality Improvement Plan with MUST DO activity. This remains work in progress.

Key work streams have already started to address areas identified as

	‘safety’ concerns in the CQC report. **Risk appetite** The Trust continues to have a good governance system of monitoring and reporting against the actions that are required following the re-inspection of services. This report covers assurance for compliance risk legislation and compliance with CQC standards. This meets the risk appetite –low and the risk target 1-6.
Recommendation:	**The Trust Board is asked to RECEIVE the CQC report and NOTE the assurance from the Clinical Governance and Clinical Safety Committee.**
Private session:	Not applicable.

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Yorkshire Partnership
NHS Foundation Trust

CQC Inspection 2019

Next steps

Next steps

NHS
South West Yorkshire Partnership
NHS Foundation Trust

- Report published 23rd August 2019
- Overall rating of **GOOD**
- We have submitted a report of actions outlining what activity we will undertake to improve quality against the **12 MUST DO** requirements
- We have collaboratively developed a quality improvement plan to address all MUST DO actions and in the process of adding **Should Do (37)** actions
- Utilised a session at Extended EMT to critically appraise how we use the findings from the CQC report to ensure we achieve sustainable change to quality

With **all of us** in mind.

Key themes from feedback

South West Yorkshire Partnership NHS Foundation Trust

3 main themes from the action plan

These areas account for 9 out of 12 **must do** actions and 8 of the **should do** actions and feature in the Well Led, Acute, OPS and CAMHS reports.

1. **Risk assessment:**
   - Senior leadership oversight
   - Completion, review and update of risk assessments
   - Risk assessments reflected in care plans

2. **Medications**
   - Administration and recording of medicines
   - Adherence to medicines policies

3. **Care planning and record keeping**
   - Accurate, complete and contemporaneous care records
   - Person centred care
   - Accurate recording of seclusion, restraint, MHA/MCA
   - Physical health monitoring after rapid tranquilisation

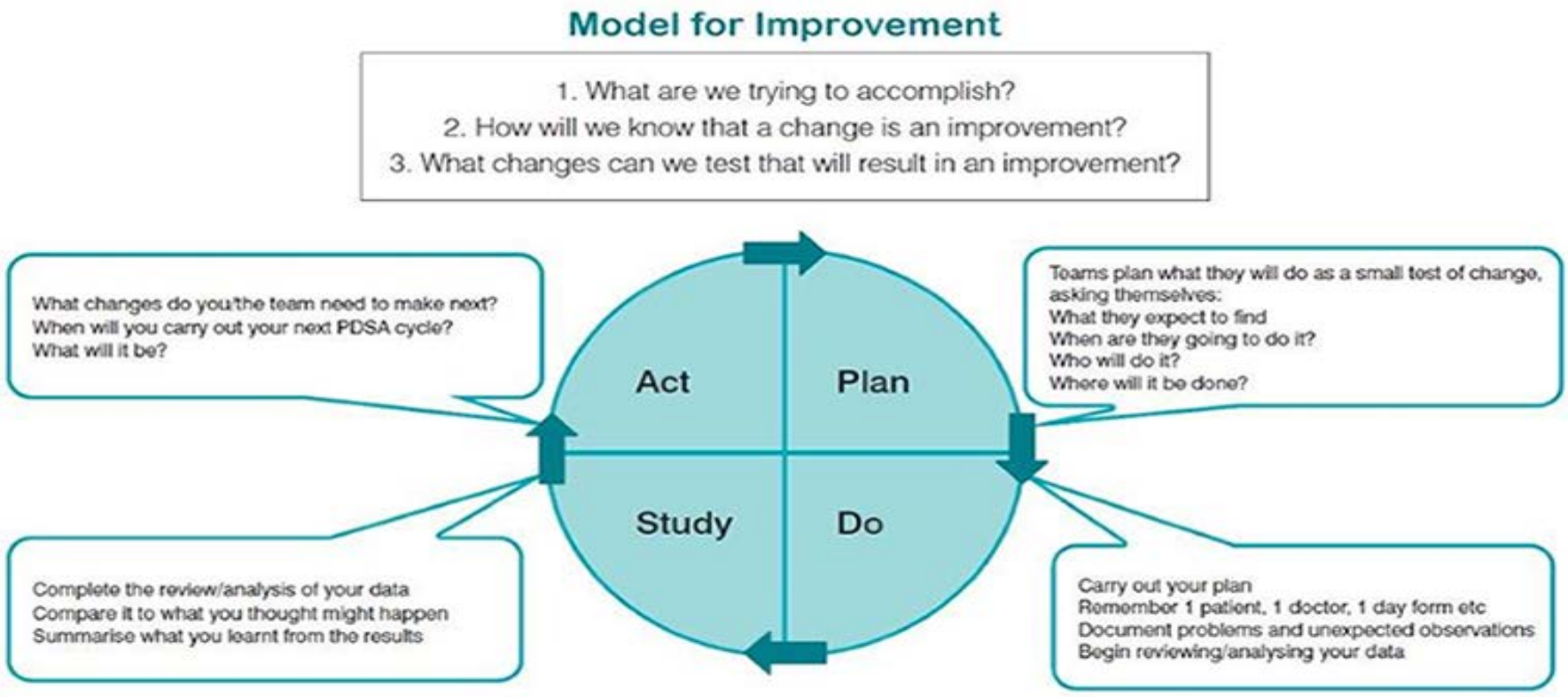
With **all of us** in mind.

Approach to address key themes

South West Yorkshire Partnership NHS Foundation Trust

Use a **quality improvement approach**

Establish a quality improvement group for each key theme



Other areas for quality improvement :

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DIGNITY & RESPECT

- Respectful engagement with patients - ‘always event’

SAFETY

- Monitoring of emergency equipment
- Rapid tranquilisation

WELL-LED

- Implementation of actions from clinical audits

With **all of us** in mind.

Governance process

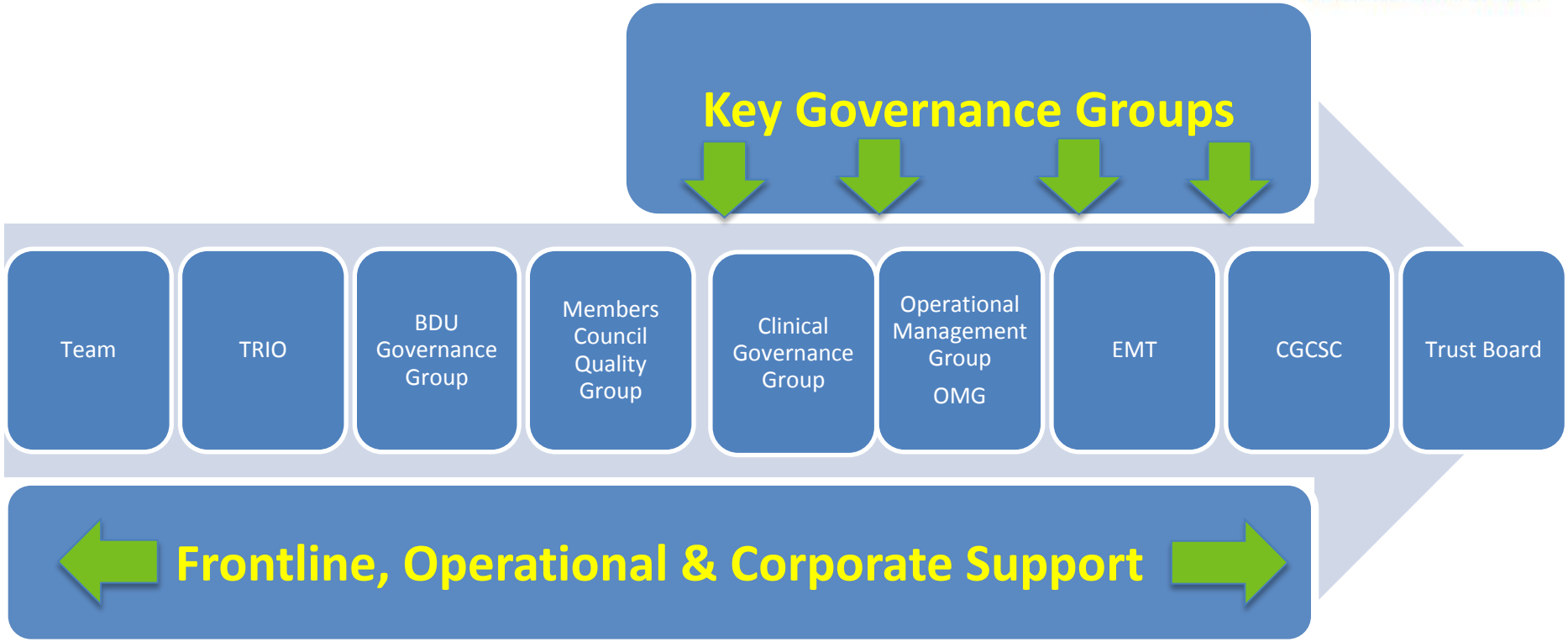
South West Yorkshire Partnership NHS Foundation Trust

- ✓ Trust wide and core services will be required to develop a ***quality improvement plan***
- ✓ Identified individual will oversee their section of the improvement plan and will act as the ***key contact person***, providing updates
- ✓ BDU ***Governance Groups*** will monitor their actions as a standing agenda item on a monthly basis
- ✓ Each BDU will be asked to provide an assurance update to the monthly ***Clinical Governance Group***
- ✓ The CGG will review progress and achievements, RAG rate the level of assurance and ***escalate any concerns*** to OMG
- ✓ Regular reports to ***Clinical Governance & Clinical Safety Committee***
- ✓ OMG will receive ***hotspot reports*** as part of monthly clinical risk report
- ✓ A progress report about the implementation of the CQC action plan will be provided by the QIAT ***to the CQC on a monthly basis***
- ✓ Improvement plan outcomes will be evaluated through our ***existing quality monitoring processes***

With **all of us** in mind.

Governance framework

South West Yorkshire Partnership NHS Foundation Trust



With all of us in mind.

Learning Lessons from our experience going forward...

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NHS Foundation Trust

- ✓ Using a Quality Improvement approach
- ✓ Strengthening early warning signs to identify risk
- ✓ Digitalisation for quality control
- ✓ Visibility of senior staff in services
- ✓ Closing the loop on plans and ensuring sustainability
- ✓ Staff and service user engagement in QI
- ✓ Sharing lessons across services

With **all of us** in mind.

South West Yorkshire Partnership NHS Foundation Trust

SWYPFT CQC Inspection 2019: Quality Improvement Plan

September 2019

APPENDIX A

CQC Re inspection MUST/SHOULD do action plan – progress report January 2019

Following the May-June 2019 core service visits and well-led review, the CQC issued the Trust with **12 MUST do and 37 SHOULD** do actions. These included 1 MUST do and 8 SHOULD do Trust wide actions.

CQC action plan headlines

Following our recent CQC inspection, 12 of our 14 core services are rated as 'good.' Our overall rating changed to 'Good.'
Our aim is to keep on improving and to work towards being outstanding
Our response

- We put safety first, always, and so our first priority is to address the safety issues highlighted and immediate action was taken where necessary.
- We're responding in line with our values, being open, honest and transparent and aiming to improve and be outstanding.
- We're working collaboratively to finalise our action plan, which will be published on our website via our Trust Board papers in due course.
- Our response will involve having more emphasis on having a quality improvement plan to address our areas for improvement rather than an action plan.

Monitoring of actions against our CQC action plan

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

APPENDIX A

Must Do Actions

MUST do	Actions to be taken	Date actions will be completed	Person(s) responsible	Improvement progress
RISK ASSESSMENTS TWMD1: The Trust MUST ensure that systems and processes are established and operated so they effectively ensure senior leaders have oversight of compliance with risk assessment documentation across services AMD2: 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 OMD1: The Trust MUST ensure that risk assessments are comprehensive and reviewed in a timely manner CAMHSMD1: The Trust MUST ensure they assess the risks to the health and safety of service users receiving care and treatment and do all that is practicable to mitigate any such risks. All risks must be assessed, identified and documented in risk management plans including children and young people on the waiting list. Crisis plans must be individualised to the child or young person using the service	Action we are going to take: We have established a quality improvement group to review our practice in relation to risk assessment and management. Inaugural meeting 23.9.19. • Review clinical risk assessment and management training for staff, to include: o The principles underpinning clinical risk assessment and management (why, who, what, when, where and how) o Review mode of delivery – e-learning vs face to face o As part of the optimisation of SystmOne we will provide staff with training on how to access and complete the risk assessment documentation. • Develop/revise clinical and practice standards on clinical risk assessment, including policy	31st May 2020	Director of Operations	

APPENDIX A

MUST do	Actions to be taken	Date actions will be completed	Person(s) responsible	Improvement progress
	review • Review local induction packages and Preceptorship package to ensure practice expectations in relation to risk assessment and management are clear and assessed during Preceptorship period • Review availability of business intelligence tool to support management oversight of risk assessments and management plans • Clinical risk assessment information will be reported into Operational Management Group and in our Integrated Performance Report • Flowcharts have been developed and disseminated to provide guidance to staff on the process for completing the Sainsbury's Level 1 and Level 2 risk assessments Outcomes: • All people who access SWYPFT mental health services will have a risk assessment appropriate to their needs • Increase workforce capability to complete an effective risk			

APPENDIX A

MUST do	Actions to be taken	Date actions will be completed	Person(s) responsible	Improvement progress
	assessment • Increase workforce competence in navigating SystmOne to access and record risk assessments • Increase workforce knowledge on general principles of risk assessment and why this is important in keeping people safe • Provide clarity on practice standards related to risk assessment across the care pathway, i.e. who updates the risk assessment, when etc. • Ensure staff understand the importance of reviewing risk assessments at appropriate times and immediately after a significant event.			
AMD1: The Trust MUST ensure they effectively assess, monitor and mitigate risks relating to the safety of patients and staff and work to reduce the incidents of aggression and violence towards staff	• One of our wards has recently participated in a quality improvement (QI) initiative on reducing restrictive physical interventions, and has reduced their restrictive interventions by 85% for restraints, 44% reduction in the use of seclusion and 76% in the use of rapid tranquilisation. We plan to disseminate and share the learning and outcomes from this QI plan and implement them on the other acute wards.	31st March 2020	Director of Operations	

APPENDIX A

MUST do	Actions to be taken	Date actions will be completed	Person(s) responsible	Improvement progress
	• We will introduce pilots around the trust and work with wards through quality improvement initiatives to review safety huddles, positive behavior plans, the use of the 'Broset Violence checklist' and the introduction of the significant event analysis tool during post incident debriefs. The aim of piloting these initiatives on the wards is to measure which initiative has the best outcome and adds the most value on the wards in reducing aggression and violence. Learning from these quality improvement initiatives will be shared across the trust. • We will strengthen and further promote the Occupational Health service offer to staff. This will offer them help and support with regards to their wellbeing. • We plan to build strong partnerships with the local police in each BDU / area. In Wakefield we have a named police officer who is contacted when there is any violence towards staff. The named officer deals with the incident quickly and efficiently and also speaks to the service			

APPENDIX A

MUST do	Actions to be taken	Date actions will be completed	Person(s) responsible	Improvement progress
	user who was involved in the assault. This gives staff assurance that we will not tolerate violence or aggression towards them. By implementing these initiatives on the wards we aim to effectively assess, monitor and mitigate risks relating to the safety of patients and staff and to reduce the incidents of aggression and violence on the acute wards.			
MEDICATIONS MANAGEMENT AMD3.1: The Trust MUST ensure that staff assess and review 'as required' medication in line with guidance AMD3.2: That medicine with a short shelf life has a date of opening listed. AMD3.3: The Trust must ensure staff undertake the required physical health monitoring following the administration of rapid tranquilisation and that all episodes of rapid tranquilisation are documented correctly	**1. Staff assess and review 'as required' medication in line with guidance** • Medical staff , with Pharmacy support, to review our existing standards (located in the medicine code) and adhere to these when reviewing as required medication (PRN) • A task 'review as required medication' to be added to MDT agenda • System for monitoring compliance against standards to be introduced. **2. Medicine with a short shelf life has a date of opening listed** • Pharmacy will introduce labels with a use by date when items are dispensed • Nursing staff will check label	31st December 2019	Medical Director and Director of Operations	

MUST do	Actions to be taken	Date actions will be completed	Person(s) responsible	Improvement progress
	when administering medication • Pharmacy will check the label as part of their ward checks **3. The required physical health monitoring following the administration of rapid tranquilisation and that all episodes of rapid tranquilisation are documented correctly** • We have provided clarity for staff on what is and what is not rapid tranquilisation • We have developed a rapid tranquilisation flowchart • We have introduced a system where ward managers monitor performance against this practice on a daily basis and a back- up system where Matrons dip sample the records for compliance on a monthly basis. • We will explore how the expectations of practice when someone has been subject to rapid tranquilisation can be incorporated into existing training • We will standardise practice across our inpatient wards • Documentation to support			

MUST do	Actions to be taken	Date actions will be completed	Person(s) responsible	Improvement progress
	physical health monitoring rapid tranquilisation is to be added to SystmOne. This will allow easier oversight of performance against this practice			
AMD4: The Trust MUST ensure that staff monitor and record checks of emergency equipment in line with Trust policy	• We will ensure all emergency bags are tagged and expiry dates of the equipment stored in the bag is documented on the tags. The equipment will be regularly checked. Once equipment is used it will be replaced and retagged. • We will ensure that it is standard practice, that all emergency medications are stored in the emergency bag and tagged. • We will ensure all wards are using the new and up to date record sheet when completing record checks of equipment. • We will review our policy in line with other organisations in regards to the frequency of the checks. We plan to achieve standardisation across all wards in the trust regarding what is kept in the emergency bags and where they are stored. This will make it easier for staff covering other	31st December 2019	Medical Director and Director of Operations	

MUST do	Actions to be taken	Date actions will be completed	Person(s) responsible	Improvement progress
	wards to find and check the emergency equipment. It will also ensure that staff are monitoring and recording checks of emergency equipment in line with the Trust policy.			
AMD5: The Trust MUST ensure that staff maintain an accurate, complete and contemporaneous care record in respect of each service user, including evidence of patient involvement and a holistic approach to their needs within their care plans	• Matron's within our acute mental health services for working age adults have developed a checklist. As part of this checklist they are dip sampling a number of care records to look at a number of areas, including whether the care plans are person centred and holistic. • The dip sampling process above is being used to identify where examples of good practice exist so these can be shared within and across teams. Likewise areas for improvement will also be identified. • We will work with our SystmOne team to look at whether the new care planning information within the electronic system can pull through a service user section as a mandatory field to make sure the service user's voice is fully captured within their care	31st May 2020	Director of Operations	

MUST do	Actions to be taken	Date actions will be completed	Person(s) responsible	Improvement progress
	plan. • We will be holding discussions with our SystmOne team to see if mandatory fields can be developed within the system to enable the service user's views and comments from MDT meetings to be pulled through into the care plans. • To re-introduce training around record keeping. • To review Trust wide standards around record keeping. • We will organise cross service sharing events to help staff better understand what practices are taking place within other services across the Trust We will develop templates of good practice.			
AMD6: The Trust MUST ensure that patients are always treated with dignity and respect and staff are not abrupt in their approach	• We will develop a template for managerial supervision including a section on dignity and respect, enabling performance in this area to be discussed formally on a regular basis • We will deliver focussed Equality and Inclusion training within the core service • We will 'recruit' Dignity and	31st January 2020	Director of Operations	

MUST do	Actions to be taken	Date actions will be completed	Person(s) responsible	Improvement progress
	Respect Champions within each ward. The champions will promote the Trusts values and act as liaison to service users if they feel they have not been treated appropriately • We will use the 'Always Event' methodology to coproduce an agreement between staff and service users on what to expect from each other whilst staying on an inpatient ward We will include 'Dignity and Respect' on the agenda at ward based community meetings so that it is discussed on a regular basis			
AMD7: The Trust MUST ensure that patient documentation, including records relating to seclusion, restraint, Mental Health Act and Mental Capacity Act and physical health monitoring are completed and recorded consistently and accurately	• The ward managers are now undertaking a weekly checklist. This includes checks of the documentation listed above. • The matron's have also developed a checklist, including oversight of the documentation checks so any shortfalls can be quickly addressed. • The Mental Health Act office conduct weekly checks of a dashboard that enables them to have oversight of when a service user has been given their S132 rights and when	31st December 2020	Director of Operations	

APPENDIX A

MUST do	Actions to be taken	Date actions will be completed	Person(s) responsible	Improvement progress
	reminders are needed. The plan is that band 7 staff will take on this piece of work in the near future. • A flowchart has been developed to act as an aide memoir for staff on physical health monitoring requirements following the use of rapid tranquilisation. • Teams have organised away days which include reminders of policies and procedures. • We will explore the possibility of adding debriefing following incidents as a mandatory field within Datix to ensure consistent practice. A food and fluid chart will be included within the seclusion paperwork.			
AMD8: The Trust MUST ensure that the systems and processes including auditing procedures are robust and evidence improvements following action plans	• We will ensure audit results are disseminated across all BDU's to ensure learning is shared, improvement is sustained and variation reduced. We will communicate and share this information through BDU governance meetings, I-hub (the Trust's QI platform) and infographic posters disseminated around the Trust	31st May 2020	Director of Operations and Director of Nursing and Quality	

MUST do	Actions to be taken	Date actions will be completed	Person(s) responsible	Improvement progress
	• We will implement an assurance plan to ensure wards are effectively undertaking local audits and implementing change • We will up skill the workforce around audit and quality improvement, encouraging staff to undertake local audits and use QI methodologies to improve practice The Quality Improvement and Assurance Team will monitor the above and if necessary escalate issues to Operational Management Group for guidance and support			
CAMHSMD2: The Trust MUST continue to take action to reduce waiting times and access to treatment times for services that exceed 18 weeks.	Barnsley CAMHS have undertaken a number of initiatives to try to reduce the waiting times; • A summer workshop in conjunction with Mindspace the school based mental health service targeting those long waits on the specialist pathways • A telephone initiative contacting those longest waits who were unable to attend the summer workshops to review the reasons for the wait, update risk assessments and	Identifying the need will be completed by November 2019 and then staff recruitment will take place based on funding available. Waiting list to be reduced by August 2020	Director of Operations	

APPENDIX A

MUST do	Actions to be taken	Date actions will be completed	Person(s) responsible	Improvement progress
	provide information on other appropriate support services • The development of a "drop in" group specifically aimed at those young people awaiting an intervention on the specialist pathways. This group will be psychoeducational and led by clinicians with the aim of appropriately signposting any inappropriate waits • A "drop in" group specifically aimed at parent/carers of young people awaiting intervention to provide support and coping strategies/skills • Skill mix has been strengthened with a further 2 support worker roles now in the service; these roles will focus on supporting qualified clinicians and providing more group work to the long waits • A non-recurrent ADHD business case was successful and the service has received additional monies for this; recruitment is live for an additional specialty Doctor and additional clinical support to target the long waits for ADHD assessment and treatment medication)			

MUST do	Actions to be taken	Date actions will be completed	Person(s) responsible	Improvement progress
	• The CCG have also provided additional monies to target the long waits over the next 6 month during the time the service is out for procurement. The service is currently reviewing CV's and interviewing agency/bank staff to ensure the correct staff members will partake in this waiting list initiative • Pathways and interventions are being reviewed in line with the Thrive model now that a new service specification has been produced which highlights this as the preferred model • Capacity and demand work is ongoing to review the way the service is currently working and to support with aligning this to the new ways of working required to work under a Thrive model Linking with wider services (such as 0-19 service) to ensure appropriate support is also available from alternative sources Wakefield CAMHS have undertaken several initiatives to address the waiting times within the service.			

MUST do	Actions to be taken	Date actions will be completed	Person(s) responsible	Improvement progress
	These include: 1) A waiting list risk management initiative, whereby the young people who have been waiting the longest have been contacted and offered a telephone review of risk and to update on their current circumstances, where appropriate and needs based face to face reviews have been offered. If the risks have changed then the risks assessments have been updated and alternative treatments offered. Up to date safety plans have been made and support services have been shared with young people and their families. 2) Funding requests have been made to strengthen the offer of early help in the community, 2 new posts have been secured to deliver MDT consultation and treatment within a school environment, and 2 new posts have been secured to deliver group work and brief intervention. In addition to this 2 support worker posts have been secured to support health promotion and to support the delivery of group work and			

MUST do	Actions to be taken	Date actions will be completed	Person(s) responsible	Improvement progress
	whole school interventions such as assemblies and class based activities. This should support the reduction in numbers of young people being referred to core CAMHS and ensure young people get help in an accessible and timely way. 3) All pathways are being reviewed again and demand and capacity work is being undertaken to understand the impact of new ways of working. This will be shared with commissioners. 4) Through contracting discussions are taking place about the resources required to reduce the waiting lists to meet the 18 week wait 5) Additional resources have been provided by the CCG to support the long waits for ASD assessment and assessments have increased from 4 per month to 12 per month to allow us to meet the 26 week wait by January 2020.			

APPENDIX B

NHS
South West Yorkshire Partnership
NHS Foundation Trust

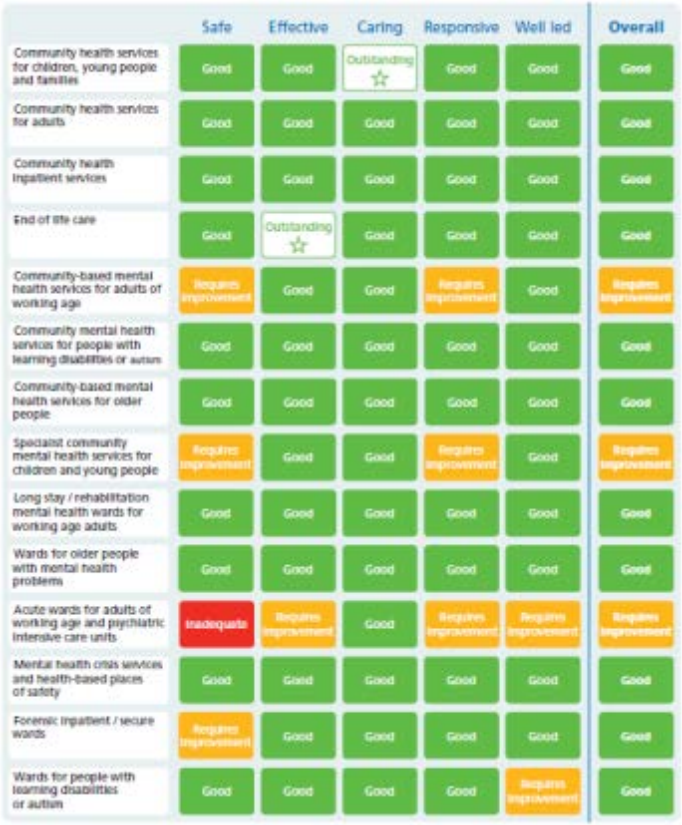
CQC inspection findings

2019

With **all of us** in mind.

Background

- The Care Quality Commission (CQC) inspected 4 of our core services in May and June 2019
- They also carried out a well-led review
- We received the draft report for factual accuracy checking
- The final version of the report will be published on Friday 23 August
- We're a learning organisation and we welcome their independent view of our services



	Safe	Effective	Caring	Responsive	Well led	Overall
Community health services for children, young people and families	Good	Good	Outstanding ☆	Good	Good	Good
Community health services for adults	Good	Good	Good	Good	Good	Good
Community health inpatient services	Good	Good	Good	Good	Good	Good
End of life care	Good	Outstanding ☆	Good	Good	Good	Good
Community-based mental health services for adults of working age	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Community mental health services for people with learning disabilities or autism	Good	Good	Good	Good	Good	Good
Community-based mental health services for older people	Good	Good	Good	Good	Good	Good
Specialist community mental health services for children and young people	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Long stay / rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Good	Good	Good	Good	Good	Good
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Mental health crisis services and health-based places of safety	Good	Good	Good	Good	Good	Good
Forensic inpatient / secure wards	Requires improvement	Good	Good	Good	Good	Good
Wards for people with learning disabilities or autism	Good	Good	Good	Good	Requires improvement	Good

2018 ratings grid

With **all of us** in mind.

Our approach

- We welcomed the revisit and their independent view
- It’s an opportunity to continue improving our services for local people
- We’ve worked hard over the last year to improve
- We’ve delivered on the majority of actions from the last report
- We want to improve further.

With **all of us** in mind.

What did the CQC tell us?

South West Yorkshire Partnership NHS Foundation Trust

We are now rated

G O O D

With **all of us** in mind.

What did the CQC tell us?

- We have improved overall
- 4 of our 5 Trust domains are rated Good
- 12 of 14 service lines rated Good
- Over 87% of our domains are Good or Outstanding

And its all thanks to you…

2018

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Community health services for children, young people and families	Good	Good	Outstanding ☆	Good	Good	Good
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2019

With **all of us** in mind.

Key findings

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Their findings highlight our areas of strength and improvement:

- Our clear vision, values and strategy that are person-centred and respected throughout the Trust
- That staff felt respected, valued and supported
- That staff are kind and caring, building positive relationships with service users
- Our commitment to a holistic and preventative approach to care
- Our open culture with good reporting of incidents, and the way we learn from and act on what happens
- Our occupational health support for staff which provides help for #allofus
- Our strong relationships with partners
- Our progress from requires improvement to good for responsiveness
- The improvements seen in our community adult mental health services

With **all of us** in mind.

Key findings cont.

The CQC have also provided a fair representation of the areas where we're facing significant challenges:

- Our services are still under pressure. Our child and adolescent mental health services (CAMHS) waiting lists are too high in some areas, particularly around ASD.
- We need to improve how we measure service user and carer experience and speed up our responses to complaints from stakeholders
- We need to improve our services for older people with mental health
- We need to address specific issues, such as:
  - Risk assessments
  - Pharmacy and medicine management
  - Timeliness of our cost improvement plans (CIPs)

Overall Headlines

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Our Well led Review considered the senior leadership and governance arrangements and is Good

12 of our 14 core services are rated Good, with over 87% of our individual domains rated Good or Outstanding.

4 core services were visited. Of the services visited one improved to Good and three stayed the same, showing real improvements in several areas.

- Our community mental health services for people of working age have **improved** and is now rated **Good**
- Our acute mental health / psychiatric intensive care wards have **improved** with the removal of a single inadequate rating but remain **Requires Improvement** overall
- CAMHS has remained **Requires Improvement**
- Our services for Older Adults have remained **Good**

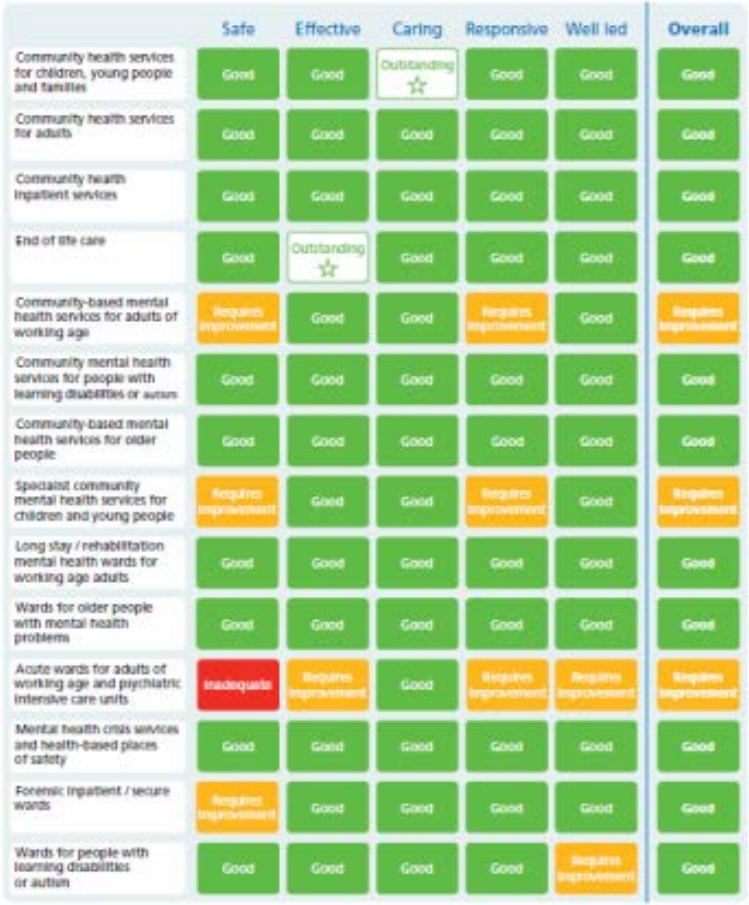
Our Well Led review is rated **Good**

93% of our services are rated as Caring and Responsive

With **all of us** in mind.

Clear service improvement

South West Yorkshire Partnership NHS Foundation Trust



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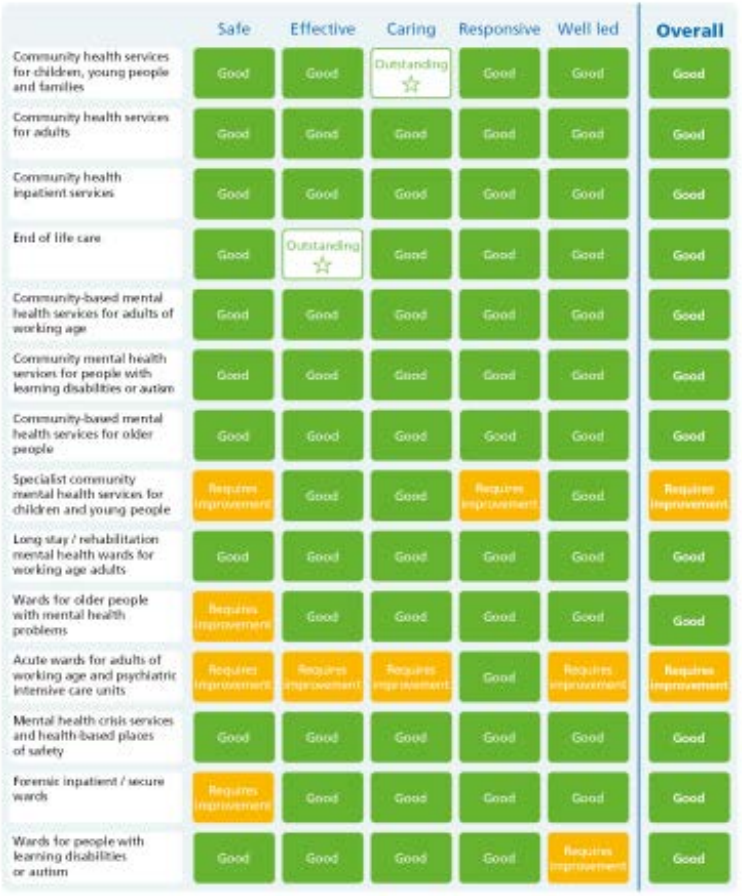
2018 ratings grid



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Wards for people with learning disabilities or autism	Good	Good	Good	Good	Requires improvement	Good

2019 ratings grid

Overall ratings

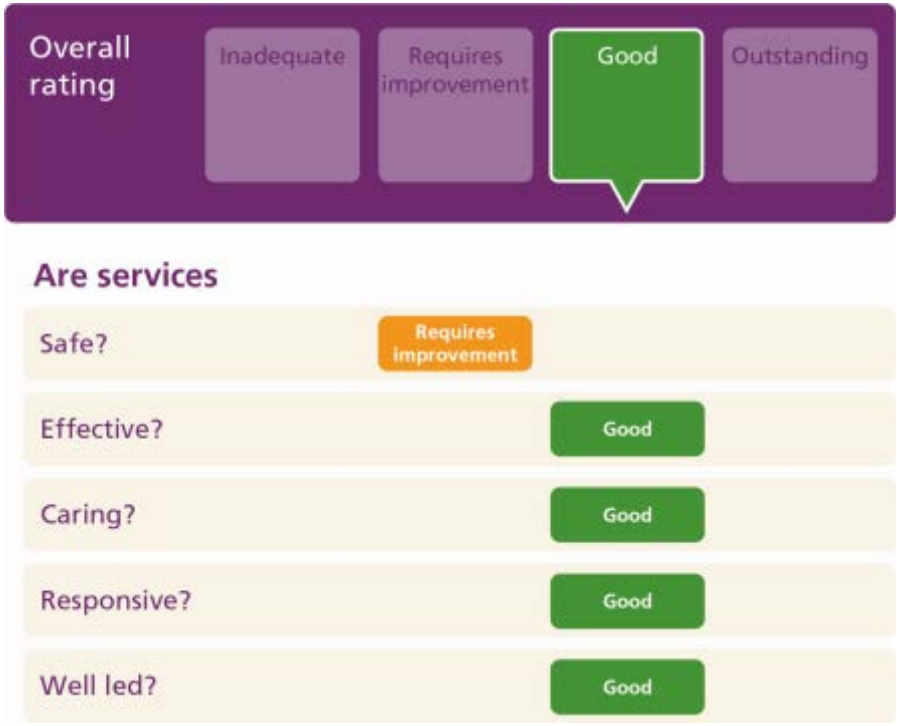
Overall, we have been rated **Good** for:

- Responsive
- Caring
- Effective
- Well led

We have been rated **Requires Improvement** for:

- Safe

This means that we have been rated Good as a Trust.



2019 overall rating

With **all of us** in mind.

Our response and next steps

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

As a learning organisation that is values led we will focus on what we need to do to make further improvements.

We will continue to do whatever we can to make sure that service users, carers and families are supported and receive the best care and experience possible.

Read the report on our website / intranet or at www.cqc.org.uk/provider/RXG

With **all of us** in mind.

Key messages

NHS
South West Yorkshire Partnership
NHS Foundation Trust

We are now rated as Good, and that's down to you

Thank you - You were found to be kind, caring and compassionate

We are now rated as Good for being Responsive

We have improved in many of our service line ratings since the last inspection

87% of domains within service lines are rated 'Good' or 'Outstanding'

We're a learning organisation and committed to improvement - we welcomed the CQC's insights

We look forward to building on the work that's been done and aim to be outstanding

With **all of us** in mind.

Thanks to each of you

NHS
South West Yorkshire Partnership
NHS Foundation Trust

We’re grateful for the continuing effort and hard work of all our staff right across the organisation.

Thank you for your continued support.

With **all of us** in mind.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 24 September 2019
Agenda item 8.5

Title:	**Five Year Strategic Plan**
Paper prepared by:	Director of Finance and Resources
Purpose:	To provide board members with an update of the Integrated Care System (ICS) 5 year plan and associated processes.
Mission/values:	All Trust values.
Any background papers/ previously considered by:	The Trust Board has received regular updates on the development of the annual plan, and received information on the ICS 5 year planning process at the Trust Board strategy session on 3 September 2019.
Executive summary:	In response to the NHS Long Term Plan, published in January 2019, ICSs have been asked to create their five year strategic plans by November 2019 covering the period of 2019/20 to 2023/24. Each ICS area is required to submit a: ➢ **System strategic plan narrative** ➢ **System delivery plan** In doing this, systems are expected to ensure that their plans align with the following principles: ➢ Clinically-led. ➢ Locally owned. ➢ Realistic workforce planning. ➢ Financially balanced. ➢ Delivery of all commitments in the Long Term Plan and national access standards. ➢ Action that is phased over 5 years and based on local need. ➢ Using allocated funding to reduce local health inequalities and unwarranted variation. ➢ Focussed on prevention and how to prevent ill health. ➢ Driving innovation. The Trust is part of two ICSs - South Yorkshire and Bassetlaw (SYB) and West Yorkshire and Harrogate (WYH). For the purpose of the 5 year plans, we are included in the WYH 5 year plan, but are contributing to narrative for both systems. In addition, each organisation is required to complete a **5-year e-workforce tool.** **West Yorkshire & Harrogate Health & Care Partnership (WYHHCP)** For West Yorkshire and Harrogate, the Trust has contributed to the system-wide strategic plan narrative, a draft of which was included in the WYHHCP Board papers on 3 September 2019. This aligns closely with our own Trust plans.

	The full draft is available at: https://www.wyhpartnership.co.uk/meetings/partnershipboard/papers/partnership-board-meeting-3-September-2019. The plan is being built up by each place in the ICS. Financial and workforce numbers will be aggregated following individual trust and Clinical Commissioning Group (CCG) submissions. A draft of the Trust's element of the system delivery plan (including the Trust's finance and workforce assumptions) was submitted on 6 September 2019 to the WYHHCP in line with agreed timescales. The WYHHCP have amalgamated delivery plans from each contributing CCG and provider and carried out a high level trend analysis. Following on from place-based feedback on the strategic planning tool submissions expected week commencing 16 September 2019, CCGs and trusts will submit a second draft of the strategic planning tool by 20 September 2019, with the initial WYH system plan national submission due 27 September 2019. Final versions of ICS plans must be submitted by 15 November 2019. **South Yorkshire and Bassetlaw Integrated Care System (SYBICS)** For, South Yorkshire and Bassetlaw the Trust has contributed to the system narrative through the Barnsley place response. A draft strategic plan narrative has not yet been circulated.
Recommendation:	**Trust Board is asked to:** ➢ **NOTE the contribution of the Trust and process undertaken in developing the draft 5 year ICS plans; and** ➢ **COMMENT on the WYHHCP ICS draft 5 year plan narrative.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 24 September 2019
Agenda item 8.6

Title:	**Finance, Investment & Performance Committee**
Paper prepared by:	Director of Finance and Resources
Purpose:	To provide the Trust Board with the proposed Terms of Reference for the new Finance, Investment & Performance Committee with the aim of gaining agreement on the final Terms of Reference for this Committee.
Mission/values:	All Trust values and objectives apply.
Any background papers/ previously considered by:	Paper outlining potential approaches and scope previously shared and discussed with Trust Board members. Draft reviewed at Finance Oversight Group (FOG) on 19 September 2019. Draft reviewed at Executive Management Team (EMT) meeting on 19 September 2019.
Executive summary:	➢ Following agreement to create a Finance, Investment & Performance Committee, draft Terms of Reference have been developed which have been reviewed by both the FOG and EMT with comments taken into account. ➢ The attached document identifies the proposed Terms of Reference. ➢ Specific responsibilities are outlined in relation to each constituent part of the meeting. ➢ It is proposed the FOG arrangements continue until the end of October 2019 and the Finance, Investment and Performance Committee become effective from November 2019. ➢ Scheduling of Committee meetings is still under consideration. ➢ Thought has been given as to whether the Committee membership should only include Non-Executive Directors, but given the fact the remit also includes investment and performance it is considered more appropriate to include executive directors as members as well. **Risk appetite** 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. .
Recommendation:	**Trust Board is asked to REVIEW the proposed Terms of Reference for the Finance, Investment & performance Committee and APPROVE them, subject to any amendments agreed at the Trust Board meeting.**

Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

FINANCE, INVESTMENT & PERFORMANCE COMMITTEE
Terms of Reference
To be approved by Trust Board 24 September 2019

All Trust Board Committees are responsible for the scrutiny, monitoring and provision of assurance to Trust Board on key issues set out in their terms of reference and/or allocated to them by the Board. Agendas are set to enable Trust Board to receive assurance that scrutiny and monitoring processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Finance, Investment & Performance Committee is being established in 2019. The Terms of Reference of the Committee will be reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role, any changes to other committees and revised membership. The Finance, Investment & Performance Committee is a committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by Trust Board. Committees 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.

Purpose
The Finance, Investment & Performance Committee's prime purpose is to provide oversight and challenge of the Trust's financial performance and financial plans to ensure the Trust and the services it provides remain financially sustainable. It will also review capital plans with particular focus on the scrutiny of major investments, including post evaluation reviews. The committee will also review the overall performance metrics of the Trust to identify key trends and issues. This may result in direction being given to other committees of the Board to carry out more detailed review and determine where corrective action needs to be taken. On behalf of the Trust Board, it will have an oversight of related risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.

Membership
The Committee is always chaired by a Non-Executive Director of the Trust and the membership consists of a minimum of two other Non-Executive Directors and three executive Directors.

Membership as at 24 September 2019
Chair – Non-Executive Director – Chris Jones;
Non-Executive Director – Sam Young;
Non-Executive Director – Kate Quail.

Lead Director – Director of Finance & Resources – Mark Brooks;
Chief Executive – Rob Webster;
Director of Nursing & Quality / Deputy Chief Executive – Tim Breedon

Attendee as at 24 September 2019
Director of Operations – Carol Harris

Attendance

The Director of Finance and Resources is in attendance (as lead Director) at meetings. The Chair of the Trust, other Directors, and relevant officers attend the Finance, Investment and Performance Committee by invitation. Administrative support is provided by the Personal Assistant to the Lead Director.

Quorum

The quorum will be two Non-Executive Director members and the lead Director (or nominated Director) plus one other Director. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee 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.

Frequency of meetings

For the first twelve months of its existence the Committee will meet on a monthly basis given the focus on the ongoing development and implementation of the financial sustainability plan.

It is the responsibility of the Chair to work with the Lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation.

Authority

The Committee 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 Committee.

Sub-committees

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-committees.

Duties

<u>Finance</u>

The Committee will focus on the following in respect of the financial affairs of the Trust:

- Oversee and evaluate financial strategy;
- Seek assurance on delivery of financial and operational targets (through the integrated performance report);
- Consider forecasts for financial and operational information;
- Assess risks and seek assurance on mitigating action;
- Review proposed annual financial plan;
- Review proposed three and five year financial plans;
- Seek assurance on delivery of the cost improvement programmes (CIPs);
- Oversee delivery of the financial sustainability plan;
- Review Trust's service line financial reporting; and
- Consider the Trust's performance using benchmarking information including that included in the model hospital.

Investment
The Committee will focus on the following in respect of Trust investments:

- Approve business cases as required by Trust Standard Financial Instructions (SFIs) and oversee the post implementation review process for these; and
- Review the annual, three year and five year capital plans for the Trust.

Performance
The Committee will focus on the following in respect of Trust performance:

- Review the integrated performance report and identify key trends and issues across the Trust;
- Provide information to other Trust committees on these key trends and issues which may require corrective action to be taken; and
- Receive and review NHS benchmarking reports.

In carrying out its work, the Committee will primarily utilise internal expertise. Where required it will seek reports and assurances from Directors and managers concentrating on the delivery of financial plans, investment criteria and over-arching Trust performance.

Relationship with the Members' Council

At the discretion of the Chair of the Committee and/or the Chair of the Trust, governors may be invited to attend meetings of the Committee to support the Members' Council in meeting its duty to hold Non-Executive Directors to account for the performance of the Board.

Monitoring

The Committee 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 an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to Trust Board.

Reporting to Trust Board

Trust Board will receive the minutes of Committee at the Trust Board meeting following the Committee meeting. The Committee will also report to the Board annually on its work and include commentary on its support of the Annual Governance Statement, the effectiveness of assurance systems, the work of internal and external audit and the annual accounting process.

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees and Trust Board. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups.

To be approved by Trust Board: 24 September 2019
Next review due: April 2020

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 24 September 2019

Agenda item 9 – Receipt of public minutes of partnership boards

Barnsley Health and Wellbeing Board

Date	Next meeting scheduled for 8 October 2019 (last update from meeting 4 June 2019)
Member	Chief Executive / Director of Strategy
Items discussed	➢ To be confirmed.
Minutes	Papers and draft minutes (when available): http://barnsleymbc.moderngov.co.uk/mgCommitteeDetails.aspx?ID=143

Calderdale Health and Wellbeing Board

Date	8 August 2019
Non-Voting Member	Medical Director / Director of Nursing & Quality
Items discussed	➢ Calderdale Health and Wellbeing Strategy ➢ Developing the West Yorkshire and Harrogate 5 Year Strategy – Consideration of the draft priorities ➢ Calderdale Cares Update
Minutes	Papers and draft minutes (when available): https://www.calderdale.gov.uk/council/councillors/councilmeetings/agendas-detail.jsp?meeting=27436

Kirklees Health and Wellbeing Board

Date	Next meeting scheduled for 26 September 2019 (last update from meeting 25 July 2019)
Invited Observer	Chief Executive / Director of Nursing & Quality
Items discussed	➢ To be confirmed.
Minutes	Papers and draft minutes (when available): https://democracy.kirklees.gov.uk/ieListMeetings.aspx?CId=159&Year=0

Wakefield Health and Wellbeing Board

Date	19 September 2019
Member	Chief Executive / Director of Provider Development
Items discussed	➢ West Yorkshire and Harrogate Health and Care Partnership 5 Year Strategy ➢ Better Care Fund ➢ Focussed Discussion - Building Sustainable Communities
Minutes	Papers and draft minutes are available at: http://www.wakefield.gov.uk/health-care-and-advice/public-

	health/what-is-public-health/health-wellbeing-board

South Yorkshire & Bassetlaw Integrated Care System Collaborative Partnership Board

Date	14 September 2019
Member	Chief Executive
Items discussed	➢ To be confirmed.
Minutes	Approved Minutes of previous meetings are available at: https://www.healthandcaretogethersyb.co.uk/about-us/minutes-and-meetings

West Yorkshire & Harrogate Health & Care Partnership Board

Date	3 September 2019
Member	Chief Executive
Items discussed	➢ WY&H Five Year Strategy ➢ West Yorkshire & Harrogate Workforce Strategy
Further information:	Further information about the work of the Partnership Board is available at: https://www.wyhpartnership.co.uk/meetings/partnershipboard

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 24 September 2019

Agenda item 10 – Assurance from Trust Board committees

Clinical Governance & Clinical Safety Committee

Date	10 September 2019
Presented by	Charlotte Dyson, Deputy Chair (Chair of Committee)
Key items to raise at Trust Board	➢ Care Quality Commission (CQC) action plan ➢ Clinical Records System Optimisation Phase One ➢ Waiting list improvement plan ➢ Child & Adolescent Mental Health Services (CAMHS) ➢ Forensic CAMHS ➢ Received reports on Safeguarding, Learning Lessons, Mandatory training, and Patient Experience
Approved Minutes of previous meeting/s for receiving	➢ Minutes of the Committee meeting held on 11 June 2019 (attached).

Equality & Inclusion Committee

Date	10 September 2019
Presented by	Angela Monaghan, Chair (Chair of Committee)
Key items to raise at Trust Board	➢ Mental Act Committee – MHAC data noted ➢ Equality Impact Assessment (EIA) focus ➢ Performance Dashboard ➢ Feedback staff networks & BDU groups ➢ Workforce Race Equality Standards (WRES) report ➢ Workforce Disability Equality Standards (WDES) data
Approved Minutes of previous meeting/s for receiving	➢ Minutes of the Committee meeting held on 4 June 2019 (attached)

Mental Health Act Committee

Date	29 August 2019
Presented by	Kate Quail, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	➢ Care Quality Commission (CQC) action plan – elements that relate specifically to the Mental Health Act to be reported into Committee ➢ Mental Capacity Act work streams being done ➢ Code of Practice group ➢ Improvement on outstanding actions
Approved Minutes of previous meeting/s for receiving	➢ Minutes of the Committee meeting held on 14 May 2019 (attached).

West Yorkshire Mental Health Collaborative Committees in Common

Date	Next meeting scheduled for 3 October 2019
Presented by	Angela Monaghan, Chair (Chair of Committee)
Key items to raise at Trust Board	➢ To be confirmed.
Approved Minutes of previous meeting/s for receiving	➢ To follow.

Workforce & Remuneration Committee

Date	Next meeting scheduled for 7 November 2019
Presented by	Sam Young, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	➢ To be confirmed.
Approved Minutes of previous meeting/s for receiving	➢ To follow.

Note, assurance from the Charitable Funds Committee is provided to the Corporate Trustee for charitable funds.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Clinical Governance and Clinical Safety Committee held on 11 June 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)
	Dr Subha Thiyagesh (SThi)	Medical Director
	Kate Quail (KQ)	Non- Executive Director
Apologies:	Committee	
	Alan Davis (AGD)	Director of Human Resources, Organisational Development and Estates
	Others	
In attendance:	Mike Doyle (MD)	Deputy Director of Nursing & Quality
	Sarah Millar (SM)	PA to Medical Director (author)
	Dave Ramsay (DR)	Deputy Director of Operations (Item 17.1)
	Carol Harris (CH)	Director of Operations
	Sue Threadgold (ST)	Deputy Director of Forensic Services (for item 17.2)
	Karen Batty (KB)	Associate Director of Nursing
	Tabitha Arulampalam	Insight Programme (observer)
	Nick Phillips	Head of Estates and Facilities (covering Alan Davies)
	Yvonne French	Assistant Director, Legal Services

CG/19/60 Welcome, introductions and apologies (agenda item 1)

The Chair Charlotte Dyson (CD) welcomed everyone to the meeting. The apologies, as above, were noted and Tabitha Arulampalam, Insight Programme Participant was welcomed in attendance. It was noted that there were several people attending to cover items on the agenda, as noted above.

CG/19/61 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/19/62 Minutes of previous meetings held on 2 April 2019 and 14 May 2019 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the meetings held on 2 April 2019 and 14 May 2019.

CG/19/63 Matters Arising (agenda item 4)

Actions from the meeting held on 2 April 2019 were noted and the action log was updated as appropriate.

CG/19/64 Consideration of items from the organisational risk register relevant to the remit of the Clinical Governance & Clinical Safety Committee (agenda item 5)

Tim Breedon (TB) reported that the risk register had been reviewed and all risks updated. It was noted that a new risk had been added in relation to patient safety and Angela Monaghan (AM) suggested that changes or new additions should be highlighted in red so Committee can see updates at a glance. TB agreed to speak with Emma Jones about incorporating this.

Action: Tim Breedon

- 1362 – relating to the delay in implementation of the falsified medicines directive. AM queried whether Committee could be assured of compliance. Subha Thiyagesh (SThi) reported that computers and scanners are in place so we are compliant with the legislation. This risk was on the organisational Risk Register and was then stepped down. It remains as a lower risk due to factors outside of our control. There was also a potential future cost risk in relation to acquiring further computers. AM queried the sustainability of having a single terminal in use and SThi agreed to liaise with Pharmacy.

  Action: Subha Thiyagesh

- 1370 – relating to the waste management contract. This risk was agreed at Trust Board on 30 April 2019 for closure and acknowledged here for completeness.

It was RESOLVED to NOTE the current Trust-wide Corporate/organisation level risk register and be ASSURED that the current risk level, although above the Trust risk appetite, given the current environment is appropriate.

CG/19/65 Quality Accounts, 18/19 final report and external audit report (agenda item 6)

TB reported that the Clinical Governance and Clinical Safety Committee (CGCSC) meeting to consider the Quality Accounts and Quality Strategy progress had taken place in May. The final report had gone to May Trust Board and the auditor report had been received. The report would go before parliament in the near future.

It was RESOLVED to NOTE progress on the Quality Account report.

CG/19/66 Learning Lessons Report (agenda item 7)

TB reported a decision to defer this report to September. This was due to capacity & sickness issues. It was acknowledged that all learning lessons events were still occurring and records being kept, however the quarterly report to provide assurance to the CGCSC was unavailable.

It was RESOLVED to AGREE to defer this item until 10 September 2019. (Assuming that the capacity position has improved)

CG/19/67 Apparent Suicide Report (agenda item 8)

Mike Doyle (MD) gave a summary of the main findings from the 2018/19 apparent suicide report:

- Number of suicides reduced by 28% to 43 from 60 in 2017/18.
- Four year average rate of 45.75 apparent suicides per 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.
    - Deaths of those under 25 have continued to reduce to 5 (12%).
    - Compared with recent years, there has been a reduction in deaths of those 55 and over in 2018/19 (5).
    - There has been a significant decrease in the number of apparent suicide of males under 35 years with 12 deaths.
- 40% of deaths were by females (17).
- 72% of deaths by suicide were from those in the white - British ethnic group.

It was noted that there had been some improvement overall and work is ongoing to align our work with the West Yorkshire and Harrogate ICS. MD reported that £300k funding had been awarded to the ICS and would be utilised for various initiatives including a targeted pathway for males via sporting clubs, gyms, etc and a publicity campaign for military veterans.

MD referred to planned stakeholder events and the development of a specific improvement plan. Kate Quail (KQ) queried the plan for engagement with young people and MD reported on proactive work with schools so that everyone understands their respective roles. This had led on from the thematic review last year on suicides in young people and how we engage with local authorities.

AM queried how the ethnicity figures break down and TB advised that this data was not available but would be included in future reports and any concerns monitored through the Equality and Inclusion Committee.

AM referred to the suicide prevention plan and queried whether suicide prevention training was now mandatory. MD confirmed that risk assessment and management training was mandatory and there were plans to further develop a specific suicide prevention training plan.

AM queried whether only detained patients have access to advocacy services. Yvonne French (YF) advised that these are funded by local authorities and only people who are subject to the Mental Health Act or Mental Capacity Act can access them. Committee noted the unequal access to advocacy for our service users in the community.

AM acknowledged the strong focus on embedding and promoting our trust wide commitment to carers, which was being reported on through the Equality & Inclusion Committee.

CD referred to the apparent suicide rates for under 25's and queried whether the Trust was an outlier. TB would check the National Confidential Inquiry figures to compare.

Action: Tim Breedon

It was queried how the action plan would be monitored and MD advised that it had been submitted to NHS England and we were awaiting feedback. There would also be an impact

plan with details developed with stakeholders and monitored through the Patient Safety Strategy Group.

AM concluded by indicating that governors had asked for a focus on suicide prevention at their next meeting. This will be published on the 2/8/19.

It was RESOLVED to NOTE the annual report on apparent suicides and the planned next steps.

CG/19/68 Clinical Audit and Practice Effectiveness (CAPE) Annual Plan (agenda Item 9)

During 2018/19 the Clinical Audit and Practice Evaluation (CAPE) prioritised plan had a total of 69 clinical audit projects registered, 15 national audits and 54 annual audits. There were 39 audits completed, 6 audits are still in progress and 24 projects have been deferred into 2019/20.

Karen Batty (KB) reported that the main reasons for deferral were the implementation of a new clinical records system or for re-audits where planned improvement work had not yet happened. AM queried how Committee could be assured that services were taking steps to improve and not simply deferring re-audit without making changes. KB indicated that there were usually factors that had prevented improvements occurring in the timeframe and the re-audits would still be undertaken.

The following was noted:

- Record keeping – there continues to be a number of areas of concern and these are being addressed through the Improving Clinical Information Group, as part of the inpatient strategy, through patient centred care planning care and setting standards for training and engaging staff. This would be re-audited and KB added that in future data would be taken straight from SystmOne rather than by manually auditing.
- Prescriptions – it was reported that a bid for an e-prescribing system had been put in and we were awaiting a response although there had been a huge response nationally. OMG were also developing a business case which would allow for more flexibility.
- Environment – re-audit of inpatient areas. It remained concerning that the cleaning audit scores were 72%. It was noted that this did not refer to housekeeping but Infection Prevention Control.
- Cleaning of environment – 72% - not housekeeping IPC

It was queried where the outcomes were being picked up, monitored and addressed. Carol Harris (CH) advised that individual BDUs have action plans and it was suggested that it would be useful to benchmark in order to track progress. CH agreed to pick this up through OMG.

Action: Carol Harris

It was RESOLVED to NOTE the update on clinical audit.

CG/19/69 BDU Governance Group Annual Report (agenda item 10)

Committee received the BDU Governance Group Annual Report and the following priorities were noted:

- To standardise clinical processes where possible to achieve consistency across all wards within all BDU's led by the Matron's Charter. The CQC had highlighted the function of the Matron was to get things right first time.
- Collaborative working with Primary Care Networks and neighbourhoods to improve service offer.
- Development of integrated care pathways within neighbourhood teams.
- Working with SSG regarding care closer to home and service demand.
- Further developing of an Older Peoples' Service crisis team for Calderdale older people to improve service offer.
- Retention – Forensic services have one of the highest turnover rates in the Trust. The service will be focussing on this.
- Reduction in reported peer bullying and harassment – a key piece of work being undertaken by the BDU supported by HR.
- Proactively work through recruitment challenges.
- Reduction in waiting lists through transformation of early offer (strengthened Single Point of Access, brief interventions) and focus on job planning. CH reported on additional support resource to work through waiting lists in CAMHS.

The challenges were noted as:

- Managing capacity and demand and new service specifications.
- Recruitment and retention, especially registered nurses and medical staff.
- SystmOne transition.
- Record keeping.

CD queried how people are taking responsibility for the priorities and TB referred to the Quarter 1 methodology being embedding in change.

AM queried how and where improvements were being recognised and celebrated. CH advised that the executive trio had a programme of visits to services planned and good work is being personally acknowledged.

It was RESOLVED to RECEIVE the BDU Governance Group Annual Report.

CG/19/70 Transformation & Priority Programmes Update (agenda item 11)

11.1 Transformation Review update

In line with the Trust strategy, the Trust Board have agreed 4 strategic objectives. These are: improving health, improving care, improving use of resources, and improving our workforce. Some of the work under these areas for 2019/20 is strategic and emergent; others are priority programmes of change.

It was RESOLVED to RECEIVE the Priority Programmes Update.

11.2 Clinical Records System Implementation Plan

Committee noted that 100% of Trust staff have completed SystmOne training and the focus would now be on optimisation.

It was RESOLVED to NOTE the update.

CG/19/71 Care Quality Commission Action Plan (agenda item 12)

MD reported that the report had been received and a more detailed report would be taken to the next Trust Board.

It was RESOLVED to note progress on the CQC action plan and NOTE the areas of risk.

CG/19/72 Trust achievements (agenda item 13)

The Committee noted the significant number of Trust achievements across all areas of the organisation and also the importance of sharing our achievements externally.

It was RESOLVED to NOTE the update.

CG/19/73 Patient Experience report (agenda item 14)

KB reported that work is continuing to improve our customer services process to make sure that the Trust always responds in ways that ensure learning and becomes more responsive where service issues arise. This will mean services will see the issues first, with a robust process in place to support them.

KB referred to the recovery plan for the customer services team and advised that there have been improvements but at a slower pace than anticipated which has impacted on the 40 day KPI. Further KPIs have been identified for this year so Committee would get a broader perspective of what is happening in the service.

KB reported that an internal audit had highlighted inconsistent data and different standards and Datix was being considered for future reporting purposes.

KB added that work is ongoing in relation to training for completing the toolkits as there were sometimes quality issues with responses from services not being up to standard.

AM referred to the 40 day and it was noted that this is set by the Trust and the statutory response time is 6 months. AM queried if we communicate with people so they are not disappointed and KB confirmed that the team do manage expectations and keep people informed.

CD commented that the Friends and Family feedback only referred to Quarter 4 data and queried how it is compare to previous quarters. TB advised that there is a trend on the Integrated Performance Report.

It was RESOLVED to RECEIVE the report and to NOTE the feedback received in Quarter 4.

CG/19/74 Issues arising from Performance report (agenda item 15)

TB reported that there had been a query around whether sickness and turnover were linked and this is being picked up under the staff survey action plan through BDUs.

It was RESOLVED to NOTE the update.

CG/19/75 Update on topical, legal and regulatory risks (agenda item 16)

TB briefed the Committee on the following:-

- Long Term Plan
- The LeDer Stakeholder Briefing
- CQC Interim Restraint Report

It was noted that a summary would be taken to Trust Board to provide assurances that as an organisation we meet the reported requirements. CH and Rob Webster also spoke to individuals who are subject to long term segregation on Horizon.

It was RESOLVED to NOTE the update.

CG/19/76 Child and adolescent mental health services - update (agenda item 17.1)

Dave Ramsay (DR) attended to provide an update on clinical governance/risk issues and development plans in Barnsley, Calderdale, Kirklees and Wakefield CAMHS.

The CQC inspection in May had concentrated on the Barnsley and Wakefield teams and the following areas of focus were noted:

- Waiting times from referral to treatment.
- Ligature environment risk assessment.
- Gaps in the rotas in Barnsley in relation to psychiatry cover.
- The extent to which risk is assessed or identified for current service users.

DR reported that a Barnsley Children and Young People Mental Health Review had been undertaken at the request of the CCG, by the Mental Health Intensive Support Team (IST) which are part of NHS England/NHS Improvement. The report had been produced in draft form and was being taken to the CCG governing body this week and then to the Barnsley executive commissioning group. It was noted that the report was quite critical of the CAMHS system in Barnsley and our services were a key part of that. Areas for development included:

- Assurance via service specifications which were currently not available. AM queried whose responsibility this was and it was noted to be the Commissioner's and had been raised with them.
- Establishment of a system wide forum.
- Reduction of waiting times and a joined up plan to manage this.
- The extent to which we understand the demand and capacity challenge to the CAMHS service.
- Improvement of data – the implementation of SystmOne will help with this.
- Managing the clinical risk in relation to children and young people who are waiting for treatment.
- Review and develop a neuro-developmental pathway. DR reported that an ADHD waiting list initiative would be implemented in 2019/20 to include additional medication review capacity.

DR advised that it had been agreed with the CCG that if the report is shared wider it would be accompanied by a plan.

AM queried who would be involved in a system wide forum which it was noted would focus more on investments into prevention rather than development of the CAMHS offer. It was noted that our key partners would be the CCG, Mindspace (Tier 2 provider), schools and

Social Services (for children in care). AM suggested involvement of the Hospitals Trust as a key part of the crisis work and primary care to develop the discharge pathway, etc. AM also suggested that there may be opportunity to involve the Integrated Care Partnership group for a more collaborative approach and a move away from a blame culture.

It was queried what had been done to reduce waiting lists and DR reported on a short term action plan whereby funding was available to assist between now and December. Going forward reduced waiting times would form part of the wider agenda.

DR advised that once feedback had been received from the governance group, a clear action plan would be developed and this would be brought to a future CGCSC meeting.

Action: Dave Ramsay

DR referred to a scheduled joint Ofsted/CQC SEND (special educational needs and/or disabilities) inspection in Wakefield. It was noted that there had been a lot of positive work over the last two years to reduce waiting times for under 14's although a consequence of this was less resource going into over 14's and had resulted in a two tier system.

It was RESOLVED to NOTE the update paper.

Item 17.2 Forensic CAMHS Wetherby YOI Independent Report update

Sue Threadgold (ST) gave an overview of the report submitted to the Committee:

- There is a dedicated Harmful Sexual Behaviour (HSB) service into HMYOI Wetherby and Adel Beck secure children's home.
- Leeds Community Health (LCH) has commissioned a health needs assessment.
- The recovery plan has been signed off by NHS England.
- The Secure Stairs programme has been approved.
- Partnership working with the prison service and Local Authority.
- Operational development work planned with LCH – delivered as one within the care system. Also doing our own development work.
- Extensive recruitment taking place to fill vacancies and Secure Stairs.
- Early verbal feedback from the HMIP/CQC visit was very positive.
- Issues with LCH's SystmOne which is less developed than ours so mental health data is difficult to get from the system.
- LCH has had their performance note lifted but SWYPFT's is still in place. LCH are insisting that our service is moved into a CAMHS service and we are working towards that despite reservations that it should remain as a Forensic service. AM queried if we are an outlier in that respect and what is LCH's evidence base for insisting that it is moved. SThi explained how the change would work in relation to clinical leadership and that SWYPFT would be making a commitment to improve the service which would assist in the removal of the performance notice. AM indicated that the move to CAMHS needed to be monitored and potentially escalated to the organisational Risk Register if necessary.

CGCSC acknowledged all the positive work and effort in the Forensic CAMHS service.

KQ referred to a recent instance where a young person was accommodated in a 136 suite and the difficulties with staffing whereby adult staff were trained in the use of holds, etc but not in the care of a young person and CAMHS staff were not confident in caring for someone in an inpatient environment given that SWYPFT do not have an inpatient CAMHS service. CGCSC acknowledged that this was an isolated occurrence.

It was agreed that a Forensic CAMHS update should be brought to the next CGCSC meeting.

Action: Sue Threadgold

It was RESOLVED to RECEIVE the update report and to NOTE the next steps.

CG/19/77 Quality Impact Assessment review (agenda item 18)

KB gave an update on the 2018/19 Quality Impact Assessments report and an interim position for 2019/20.

The next steps were noted as:

- Quality impact challenge panels to be established and would continue as new CIPs are received by QIAT.
- The Operational Management Group to monitoring progress in achieving CIPs and overseeing CIPS that have been rated as 'red' and 'amber'.
- Cost improvement plans to be discussed monthly at extended management team (EMT).
- Continue to undertake service change quality impact assessments when requested.

It was RESOLVED to RECEIVE and NOTE the update and the areas of risk.

CG/19/78 Serious Incident Q4 Report and Annual Report (agenda Item 19)

MD reported that there was a slight increase of reported incidents on the previous year with a total of 12,640. There were 45 serious incidents reported during the year although not all were subject to investigation.

MD updated the Committee on the Quarter 4 Serious Incident report:

- All deaths are now considered with three levels of grading; expected, for review and serious untoward incident.
- There had been an audit in relation to the healthcare deaths policy.
- The CQC inspectors had been assured by how the Trust reports, monitors and responds to incidents.
- Medicines omissions are showing as high, partly because it represents a snapshot so if people go on leave or refuse, these are classed as medicines omissions. The system has recently been improved.
- Frequent incidents of violence and aggression were noted. SThi indicated that there is a lot of work around Reducing Restrictive Physical Intervention but that the Trust support staff to take the necessary action.
- The number of RIDDORS was down including the number of people off work for more than 7 days after injury.

MD also reported that those involved in incidents were being invited to attend or ring in to Risk Panel to get immediate feedback which was appreciated. CD acknowledged this as a positive development.

AM queried the plans for implementing the key actions and areas for development in 2019/20 and MD advised that this would be part of the Inpatient Improvement Strategy.

It was RESOLVED to RECEIVE and NOTE the Serious Incident Q4 Report and Annual Report.

CG/19/79 Internal Audit (agenda item 20)

Nil

CG/19/80 Health & Safety Annual report, Objectives & Action Plan (agenda item 21)

Nick Phillips (NP) presented the report which had been to EMT. It was noted to include general health and safety, security, fire and emergency planning.

The following key points were highlighted:

- For the third year running, Health & Safety management across the Trust has improved following analysis from 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), Clinical Commissioning Groups (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.

It was RESOLVED to RECEIVE the annual report on safety services.

CG/19/81 Reducing Restrictive Physical Interventions Annual Report (agenda item 22)

MD presented the report and the following was noted:

- Reports of Violence and Aggression on Datix **increased** by 543 (13.2%) from the financial year 2017/18.
- Physical violence by patient on staff (contact made) **increased** by 90 (8.86%) from the financial year 2017/18.
- Physical violence by patient on patient (contact made) **reduced** by 2 (0.73%) from the financial year 2017/18.
- Training figures Trust wide had **improved** and **remained** above the mandatory target of 80%.
- Physical Intervention (restraint) training on inpatient units **increased** to 86.59% of staff trained and in date from the financial year 2017/18.
- The number of restraints **increased** by 263 (12.8%) from the financial year 2017/18.
- The number prone restraints **reduced** by 24 (6%) from the financial year 2017/18.
- The number of seclusions **reduced** by 23 (4.65%) from the financial year 2017/18.

AM queried the increase of violence and aggression reports. MD advised that this was attributable to a small number of individuals and multiple incidents. Also, in LD services the figures show high because of the low number of beds. TB indicated that in future new software will be utilised for safer staffing which will improve the recording of incidents.

MD reported that the Managing Aggression and Violence team had been renamed Reducing Restrictive Physical Intervention team and were under the management of the safeguarding team. Immediate life support was included as part of the training and there was more of a skills based approach to deescalating anger, etc. SThi indicated that there was a reducing restrictive practice pilot taking place on Nostell ward as part of the quality improvement work. SThi and Julie Warren-Sykes visited Nostell last week to hear about the very positive improvements on the ward. It was noted that Healthcare Assistants and service users are being encouraged to get involved alongside the project team.

CD queried a timescale for trust wide roll out and it was noted that the executive trio were liaising with inpatient areas and receiving support from a life coach from the Royal College of Psychiatrists.

It was RESOLVED to RECEIVE the annual report on Reducing Restrictive Physical Interventions.

CG/19/82 IPC Annual Report (agenda item 23)

TB presented the report and noted that it had been a good year in relation to achieving the work programme despite the resource challenges and small team. There was a clear link with the Patient Safety Strategy and the Trust is fully compliant with quality standards in relation to Infection Prevention and Control.

CD queried why there was no RAG rating and TB advised that exception reports are provided on a bi-monthly basis.

The next steps were noted:

- The Trust has responsibility to ensure that the services it provides have adequate arrangements in place for infection prevention and control, comply with the relevant legislation and national targets.
- SWYPFT is now expected to report via the Trust board to local commissioners on plans and progress on the implementation of national initiatives for its directly provided services.
- SWYPFT has ensured that there are robust governance arrangements in place with delegated responsibility and accountability to ensure that the infection prevention and control programme is implemented.
- 2018-2019 has been a challenging and busy year for Infection Prevention and Control. It is acknowledged that the Trust will continue to achieve Health Care Associated Infection (HCAI) set targets.
- IPC is a crucial component of safe systems for the provision of healthcare. The profile of IPC continues to be significantly high, linked to the growing public awareness of infections and also registration of organisations with the Care Quality Commission.
- Moving forward, focus remains on eliminating all avoidable HCAI, to sustain improvements in best practice in infection prevention and control and to embrace antimicrobial reduction strategies/action plans.

It was RESOLVED to RECEIVE the annual report on Infection Prevention and Control and to APPROVE the next steps.

CG/19/83 Freedom to Speak Up Guardian Action Plan (agenda item 24)

NP reported that the Vision and Strategy for Freedom to Speak Up has been launched and meetings with teams have started. 0.5 wholetime equivalent has been allocated for a lead guardian and interviews are scheduled for next week. CD queried how the action plan would be monitored and NP would clarify with Alan Davis (AD).

Action: Nick Phillips

AM reported that newly elected staff governors have the option to become a Freedom to Speak Up Guardian and this should be added to the action plan.

Action: Nick Phillips

It was RESOLVED to NOTE the update.

CG/19/84 Sub-groups – exception reporting (agenda item 25)

Drug & Therapeutic (agenda item 25.1)

It was RESOLVED to NOTE the report.

Safety & Resilience (agenda item 25.2)

It was RESOLVED to NOTE the report.

Infection Prevention and Control (agenda item 25.3)
It was RESOLVED to NOTE the report.

Safeguarding adults & children (agenda item 25.4)
I
It was RESOLVED to NOTE the report.

Reducing Restrictive Physical Interventions (agenda item 25.5)

It was RESOLVED to NOTE the report.

Improving Clinical Information Governance Group (agenda item 25.6)
TB raised that we needed to be clear where updates on the data quality work and impact of the changes to data quality were being reported. TB would check and report back to CGCSC.

Action: Tim Breedon

It was RESOLVED to NOTE the update

CG/19/85 Serious Incident Update (agenda item 26)

TB updated the Committee on recent serious incidents:

- There was a meeting set in relation to an incident that had received interest from a local MP.
- In relation to the homicide in community forensic services, SANCUS had notified the Trust of a new line of enquiry relating to safeguarding concerns. TB would update Committee when details are clearer.

Action: Tim Breedon

- Report completed for the incident where the individual got over the roof.

CG/19/86 Issues and items to bring to the attention of Trust Board and other Committees (agenda item 27)

Issues were identified as:

- The following annual reports were received by CGCSC;
  - Quality Accounts
  - Apparent Suicide
  - Serious Incidents
  - Reducing Restrictive Physical Interventions
  - BDU Governance - positive and clarity on priorities
  - Health and Safety
  - Infection Prevention and Control
- CAMHS
- Forensic CAMHS
- Briefings on the LD issues – alert to Trust Board to take further assurance.

CG/19/87 Consideration of any changes from the organisational risk register relevant to the remit of the Clinical Governance & Clinical Safety Committee (agenda item 28)

CGCSC agreed to monitor the following for possible inclusion in the organisational Risk Register:

- CAMHS service at HMYOI Wetherby
- CAMHS IST report.

CG/19/88 Work Programme (agenda item 29)

It was agreed to review the work programme at the next agenda setting meeting.

CG/19/89 Any Other Business (agenda item 30)

NP assured Committee that the recently reported deaths of NHS patients due to consuming sandwiches provided by an external company did not affect SWYPFT. A quick but thorough review indicated that the Trust does not have any dealings with that particular sandwich company and there is therefore no impact on our service users.

CG/19/90 Date of next meeting (agenda item 31)

The next meeting will be held at 14.00 on 10 September 2019 in Meeting room 1, Fieldhead Hospital, Ouchthorpe Lane, Wakefield WF1 3SP.

South West Yorkshire Partnership NHS Foundation Trust

Equality and Inclusion Committee held on 4 June 2019

Present:	Angela Monaghan (AM)	Chair of the Trust (Chair)
	Tim Breedon (TB)	Director of Nursing and Quality (lead Director)
	Alan Davis (AGD)	Director of Human Resources, Organisational Development & Estates
	Erfana Mahmood (EM)	Non-Executive Director
	Sam Young (SYo)	Non-Executive Director
In attendance:	Emma Jones (EJ)	Company Secretary (notes - items 1-6.5)
	Claire Hartland (CH)	Human Resources Business Manager
	Elaine Shelton (ES)	Staff Side Chair – Equality Lead and Chair of the Disability Network
Apologies:	Members	
	Sean Rayner (SR)	Director of Provider Development
	Rob Webster (RW)	Chief Executive
	Attendees	
	Aboo Bhana (AB)	Equality & Engagement Development Manager
	Nasim Hasnie (NH)	Public Governor, Members' Council
	Zahida Mallard (ZM)	Equality & Engagement Development Manager
	Dr Subha Thiyagesh (SThi)	Medical Director

EIC/19/14 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.

EIC/19/15 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 2019 and Members' Council in May 2019 or subsequently.

EIC/19/16 Minutes from the meeting held on 5 March 2019 (agenda item 3)

It was RESOLVED to APPROVE the Minutes of the meeting held 5 March 2019 as a true and accurate record.

EIC/19/17 Matters arising (agenda item 4)

Action log from the meeting held on 5 March 2019 (attached - Chair)

The following matters arising were discussed:

- EIF/19/04 Matters arising (EIF/18/37 Lesbian, gay, bisexual and transgender (LGBT) Plus staff network) - Alan Davis (AGD) advised that discussion was taking place in relation to the membership of the staff forum.
- EIF/19/05 Consideration of items from the corporate / organisational risk register aligned to the Forum - updates to be discussed under agenda item 5.
- EIF/19/06a Draft equality and inclusion dashboard (ethnicity reporting) - Claire Hartland (CH) commented that the main information available was the stonewall "what's it go to do with you" leaflet which is aimed to support staff with requesting information from the service user. This has been provided to Tim Breedon (TB) for

information. TB commented that the aim was to put something in place to support staff in starting the conversation.

- EIF/19/06c Equality Impact Assessments (EIA) update - TB commented that this had been discussed by the trios and they are looking at updating the clinical risk report to include the performance management of EIAs. Monthly routine reports go into the Operational Management Group. The Extended EMT session needs to be rescheduled.
- EIF/19/06f Forum annual report 2018/19 (strategic session) - potential update to the work programme in relation to a strategic session to be discussed under agenda item 12.
- EIF/18/50 Work programme (LGBT update in Calderdale) - Calderdale Council conducted a needs assessment in August/September 2018 with 84 who identified at LGBT+. Calderdale Council wanted to share the results with the Trust and work was needed on how the Trust can ensure that data is received from partners and was work taking place the community.
- EIF/18/25 Equality Impact Assessments (EIA) update (policies) - Emma Jones (EJ) confirmed that the policy approval proforma had been updated to have a specific item confirming that the EIA had been reviewed with Equality & Engagement leads.

Updated Terms of Reference

AM reported that the updated Terms of Reference were formally approved by the Trust Board on 30 April 2019. One of the areas for further review is the governor attendee and a paper will be prepared for the Members' Council meeting on 2 August 2019 to reconfirm the attendee given the change in form from a Forum to a Committee.

Sam Young (SYo) commented that under duties section the risk element was not explicit since changing from a Forum to a Committee. AM commented that review of the risks aligned to the Committee was included as a standing agenda item and can be considered for updating in the next review of the Terms of Reference.

Action: Angela Monaghan / Emma Jones

EIC/19/18 Consideration of items from the corporate/organisational risk register aligned to the Committee (agenda item 5)

AM commented that the risks need to be updated in line with the actions from previous meetings. EJ commented that the Executive Management Team (EMT) were reviewing the risk register this week as part of the cyclic review.

It was RESOLVED to:

- **DISCUSS the current Trust-wide Corporate / organisation level risks, relevant to this Committee, as provided above; and**
- **Satisfy themselves that they are ASSURED that the current risk level, although above the Trust risk appetite, given the current environment is appropriate.**

EIC/19/19 Performance reports (agenda item 6)

Draft equality and inclusion dashboard (agenda item 6.1)

TB reported that the draft included indicators under three headings: Workforce Recruitment Data, Service User data, and Corporate Processes with a number of areas picked that might serve as useful progress indicators. CH commented that this would reflect what is included in WRES data. AGD commented that currently the WRES data used a proforma that included pre-populated formulas and the Trust would need to develop its own.

TB commented that in relation to patient experience, service audits and evaluations was removed as the data was not available. Ethnicity breakdown was also not currently available however it was felt it should remain as an aspiration.

AGD commented that the workforce dashboard showed areas where there is need to take positive action. WRES data has been used to assist and it needs to be clear what is being measured and what action will be taken as a result.

SYo commented that one of the Trusts ambitions was to treat carers in the same way as someone with a protected characteristic. CH commented that the data was not currently available. SYo acknowledged that while the data wasn't currently being collected it may be good to include some narrative to show that is a recognised area. AM commented that the number of people we support as service users who are carers could be used as a proxy around commitment to carers. TB commented that the carers assessments may be able to be reported on however it would need to be checked as this data was received from local authorities.

Action: Tim Breedon

AM asked for an update on how the Trust was progressing in relation to carers champions on all inpatient wards as part of our commitment to carers. SYo commented that updates in relation to this might be an area to include on the work programme. Elaine Shelton (ES) asked if this included staff carers or only service users. AM commented that the commitment to carers was across the board and should include staff. CH commented that this was an area that cannot be reported on currently.

ES asked if anything could be included in relation to retention data. AGD commented that it should be possible under the current turnover reporting in the Workforce & Remuneration Committee and a new breakdown could be by protected characteristics.

SYo asked how the links to performance and embedding could be made clear. TB commented that when people were asked for suggestions one of the backdrops was how it would assist with reporting performance around the equality strategy. There needs to be a clear link back to the key outcomes in the strategy.

AM asked when it was anticipated that data could be populated in the dashboard. CH commented that work will take place towards completing for next meeting. AM requested that the dashboard be populated with the available data for the next Committee meeting, understanding that there may be some gaps due to timing. TB commented that the most recent data will be included for Quarter 1.

Action: Tim Breedon

Erfana Mahmood (EM) asked where the dashboard would be reviewed. TB commented that it would be reviewed by the Committee and some areas included in the Integrated Performance Report (IPR) to Trust Board.

It was RESOLVED to REVIEW and COMMENT on the draft dashboard.

Equality standard updates (agenda item 6.2)

- Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)

CH reported that a link to last years' report was included in the paper and a newsletter provided under agenda item 8. The timetable for this years' process was roughly the same as last year with the template due soon for WRES and no indication yet for WDES. The WRES report would come to the next Committee meeting in September 2019 prior to going to Trust Board for approval to publish. WDES has 10 metrics with one metric voluntary for

year one. Most organisations may not do the voluntary metric and it was an area to keep in view as it may undergo some changes.

AM asked if a decision was needed on whether the voluntary metric would be included. CH commented that a lot of organisations had indicated through the regional meeting they would not include it due to the current differences in processes and recording of data. AGD commented that a decision was not needed at this stage and the metric would be completed internally but may not be included in the published version. AM asked if it related to staff who declare that they have disability. CH commented that it was staff who considered themselves as having a disability and had registered this. Currently the Trust had approximately 6% of staff who had registered which was which was higher than similar organisations and shows a positive recording culture. Staff are routinely encouraged to review their details and update if needed. AGD commented that the staff survey results show that they are one of the most negative groups in relation to employment. When pay audits were conducted in terms of spread it was similar across the grades however it can hide how people feel they are being treated. This was one of the reasons why the Trust was trying to encourage staff to establishment a Disability Staff Network.

CH commented in that the publication date for WDES had been changed to 30 September 2019 which ties in well with WRES. AM asked if there were any issues producing the data to comply with the requirements. CH commented that there was a data monitoring spreadsheets due in June 2019 which will be checked against the Trusts reporting and sent back. After this work will start on summary reports when the templates are received.

EM asked if information from governors could be included as they were an large and engaged group of members who could effect collective engagement. CH commented that the data would not be included as it related to staff and the staff survey. EJ commented that when people join as members of the Trust they are asked if they want to provide some equality data, however it was not mandatory. Where possible, how the Trusts membership is representative of the community it serves is reported each year at the Annual Members' Meeting.

AGD commented that there was still a lot of work to do in relation to the WRES. The Trust had improved on three areas which is good progress, however BAME staff still felt that there were less opportunities.

It was RESOLVED to NOTE the updates provided.

Equality Impact Assessments (EIA) update (agenda item 6.3)

TB commented that with the two Equality & Engagement leads away the update had not been finalised which highlighted the fragile nature of some of our systems. There was a small team in place which supported this work and when away could cause difficulties in the system. A further discussion with Salma Yasmeen, Director of Strategy may be needed on how to improve this in the future. The EIA update would be circulated to the Committee when available.

Action: Tim Breedon

Equality Delivery System (EDS2) update (agenda item 6.4)

TB commented that again as the two Equality & Engagement leads were away the update had not been finalised. The EDS2 update would be circulated to the Committee when available.

Action: Tim Breedon

AM asked for an update on the status of EDS3. TB commented that he would seek confirmation with the introduction of EDS3 originally indicated for September/October 2019.

Action: Tim Breedon

Equality strategy - annual update on action plan (agenda item 6.5)

TB reported that as the leads had not been available some further enhancements may be able to be provided following their return. Progress is described mainly in qualitative terms rather than quantitative and it was important to link the dashboard to the outcomes of this Strategy and the reporting. Key headlines included:

- Continue to successfully involve and engage communities and staff, hosting a number of workshops, events to support Transformation of service including Community Mental Health Services/Older peoples services.
- Revised the commitment to Family, Friends and Carers and developed a Carers' charter. This was done involving our staff and carers. need to ensure we deliver and a conversation will take place on the plans for 2019/20.
- Actively reaching communities who don't engage through traditional approaches – Deaf community with regard to accessing mental health services, learning disabilities and the uptake of annual health checks.
- Promoting Trans awareness across the Trust
- We review satisfaction with services through analysis of feedback through customer services and patient experience processes
- Established four staff networks, BAME, Disability, LGBT+ and a Staff Carers Network
- We achieved 12.5% above our 80% mandatory training compliance target which Between1 April 2018 and 31 March 2019.
- We continue to successfully meet reporting requirements and delivered EDS2 with involvement of stakeholders.
- Working towards establishing a Reciprocal mentoring programme

EM commented that the report showed that really good progress was being made. A area that stood out for 2019/29 was in relation to staff who had a disability background feeling they had poorer management. AM commented that as mentioned by AGD, this was an area for action that had been identified through the staff survey.

The Committee made the following suggestions for future reporting:

- That figures should be included to back up the findings where they were available, rather than anecdotal findings.
- In relation to the Friends & Family Test that it would assist if the number of people who responded to the survey were included.
- When comparing to other organisations it would assist to make comparisons to the best organisations rather than averages.

Action: Tim Breedon

TB commented that when original strategy produced the format was more narrative. Future versions would include measurable targets linked to the dashboard which will assist.

AM asked in relation to complaints where discrimination were a factor whether nil received was correct. TB confirmed this was correct.

TB commented that one of the areas still missing from the report was suggested areas of focus from the ground up. Some suggestions have been included as high level actions, however extra information is needed from people within the system. Conversations are taking place with Salma Yasmeen, Director of Strategy regarding some possible changes within the structure to assist.

AM commented in relation to learning disabilities and the engagement of service users, families and carers, that she had attended a conference about preventing deaths where there was a and focus on engagement with evidence about how that improves outcomes. It would be interesting to hear how staff feel improvements could be made, such as introducing learning disability champions and promoting inclusion and engagement across all services.

AM commented that other area could be the recent LGBT+ survey that took place in Calderdale. It would be good to recognise the opportunities in working in collaboration to make sure we are aligned and doing things more efficiently for the benefit of our service users and our carers.

EM asked if the staff networks had input into the plan. AGD commented that the BAME staff network had been asked to set some aspirational targets and it was important that the networks set targets to assist with being part of the solution. EM commented that the update to the strategy could provide an opportunity for the staff network to come together to influence future plans. ES asked if the draft plan for 2019/20 could be shared with the staff networks.

Action: Tim Breedon

AM commented that the focus areas for 2019/20 needed to be clear along with the process for reviewing the equality strategy. SYo requested that the update be circulated as soon as possible rather than waiting for the next Committee meeting in September 2019.

Action: Tim Breedon

It was RESOLVED to NOTE the progress report and COMMENT upon its contents.

EIC/19/20 Feedback from staff networks and development programmes (agenda item 7)

EIC/19/20a Feedback from staff equality networks (agenda item 7.1)

- **BAME**

AD reported that the Trust had gone out to recruit a project manager for the reciprocal mentoring project. This would be a 1-day a week secondment and was being promoted as a development opportunity for a BAME member of staff. The project would run for 12 months and then be embedded in the normal coaching and mentoring processes.

AD reported that the 'Moving Forward' programme will potentially be running again, either across the West Yorkshire and Harrogate Mental Health Services Collaborative or just in Wakefield.

- **Disability**

Elaine Shelton (ES) reported that only one person, in addition to the core group, had attended the disability network day which suggested that the communications were not yet right, so the group will be revising these. The intention is to use the disability policy and equality strategy to encourage involvement. It was noted that there had been lots of energy raised in the first network meeting which had led to improvements. The next meeting is planned for September with steering group meetings taking place in between.

AD commented that the HR team want to engage with the disability network as part of the 'Making SWYPFT a Great Place to Work' engagement exercise. It would be good to identify and report positive responses to issues raised, in line with 'you said, we did'.

The network secretary, Andrew Alcock, will be invited to attend the Equality and Inclusion Committee.

ACTION: Emma Jones

AD will also invite the network to appoint a Freedom to Speak Up Guardian and to support the upcoming Non-Executive recruitment process.

Managers will be reminded of Trust guidance regarding allowing attendance at staff networks.

ACTION: Alan Davis

- **LGBT+** - including draft work programme (action from 5 March 2019)

AD reported that there was lots of energy at the most recent meeting but it was still not agreed who should be on the steering group. Paul Brown and Kate are currently acting as coordinators, to maintain progress.

- **Carers**

There is still lots of enthusiasm for the working carers' network, which is still developing, and this requires nurturing.

It was RESOLVED to note the updates provided.

EIC/19/20b Inclusive leadership and development programme updates (agenda item 7.2)

- The Insight Programme

The Trust continues to support this regional talent development programme and is currently hosting one Insight candidate, Tabitha Arulampalam, who is being mentored by the Chair.

- Shadow Board

AD reported that a decision is yet to be taken about whether or not this programme will run again and, if it does, what the selection criteria will be for participants. In the previous programme, SWYPFT wanted it to be open access, whereas our partners, Leeds & York Partnership Trust and Bradford Care Trust, regarded it as succession planning for staff already at a senior level.

- Middle Ground 5 (MG5)

No update

- Building leadership for inclusion

No update

It was RESOLVED to note the updates provided.

EIC/19/21 National issues and impact locally (agenda item 8)

- NHS England WRES newsletter

The committee noted the latest NHS England WRES newsletter. It was also noted that the NHS Long Term Plan has a strong focus on health inequalities.

It was RESOLVED to note the updates provided.

EIC/19/22 Any other business (agenda item 9)

None

EIC/19/23 Consideration of any changes to the corporate/organisational risk register relevant to the remit of the Committee (agenda item 10)

The Committee agreed there were no further changes to recommend to the risk register.

EIC/19/24 Items to bring to the attention of Trust Board / committees (agenda item 11)

The Committee agreed to bring the following items to the attention of the Board and committees:

- **Board**
  - Performance dashboard
  - WRES/WDES equality standard updates
  - Equality strategy action plan update
  - Development of staff equality networks

- **Workforce and Remuneration Committee**
  - Recruitment and retention data

- **Audit Committee**
  - Consider adding audit of equality impact assessments to internal audit programme

EIC/19/25 Work programme 2019/20 (agenda item 12)

It was agreed to add Commitment to Carers to the work programme for December.

ACTION: Emma Jones

It was RESOLVED to note the work programme.

EIC/19/26 Date of next meeting (agenda item 13)

The next meeting of the Committee will be held on Tuesday 10 September 2019 at 10.30am to 1.00pm, Meeting room 1, Block 7, Fieldhead, Wakefield.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Minutes of the Mental Health Act Committee Meeting held on 14 May 2019

Present:	Dr Subha Thiyagesh	Medical Director (lead Director)
	Kate Quail	Non-Executive Director (Chair)
	Tim Breedon	Director of Nursing and Quality
	Erfana Mahmood	Non-Executive Director
	Laurence Campbell	Non-Executive Director
Apologies:	Members	
	Salma Yasmeen	Director of Strategy
	Attendees	
	Julie Carr	Clinical Legislation Manager
	Anne Howgate	AMHP Team Leader (Kirklees) – local authority representative
	Deborah Longmore	Adult Safeguarding Named Nurse, Barnsley – acute trust
	Stephen Thomas	MCA/MHA Team Manager (Wakefield) – local authority representative
In attendance:	Shirley Atkinson	Professional Development Support Manager (Barnsley) – local authority representative
	Danielle Benn	Staff Nurse, Newton Lodge (item 2)
	Yvonne French	Assistant Director, Legal Services
	Gary Haigh	Independent Associate Hospital Manager
	Carol Harris	Director of Operations
	Terry Hevicon-Nixon	Operations Manager - Working Age Mental Health (Calderdale) – local authority representative (to item 7)
	Jennifer Howes	Ward Manager, Newton Lodge (item 2)
	David Longstaff	Independent Associate Hospital Manager
	Sarah Millar	PA to Medical Director (author)
	Graham Quinn	CQC Inspector (observing)
	Victoria Thersby	Head of Safeguarding (Calderdale and Kirklees) – acute trust representative (to item 7)
	Carly Thimm	Mental Health Act / Mental Capacity Act Manager

MHAC/19/15 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/19/16 The Act in Practice (agenda item 2)

MHAC/19/16a Mental Capacity Act – Restrictive practice in clinical settings (blanket restrictions) (agenda item 2.1)

Presentation from Jennifer Howes (JH) and Danielle Benn (DB) from Newton Lodge Medium Secure Forensic Unit on the use of restrictive practice in clinical settings.

JH advised that service users were involved in developing the training which would be rolled out to other Business Development Units (BDUs) to adapt for their own needs. It was also hoped that service users would deliver the training themselves in future.

The Committee thanked JH and DB for their excellent presentation and agreed that it was positive that this had come from the highest secure area in the Trust which may be considered the most restrictive. It was also agreed that the involvement of service users in this work had been particularly important.

MHAC/19/17 Legal updates (agenda item 3)

MHAC/19/17a Mental Capacity (Amendment) Bill (agenda item 3.1)

Yvonne French (YF) reported that the progress of the amendment bill was being tracked and it was anticipated that implementation would occur between April and July 2020. YF gave an overview of the potential significant changes.

Committee noted that there were a number of significant workstreams identified such as:

- Workforce – all staff would require training
- Policies – would need to be reviewed
- Partnership working

Erfana Mahmood (EM) raised the potential risks involved in the relatively major changes to the Mental Capacity and Mental Health Acts. YF advised that the Mental Capacity Act changes were being monitored as above and a paper would be taken to Executive Management Team (EMT) in relation to the Mental Health Act (expected December 2020) and what support would be needed to ensure preparedness.

Victoria Thersby (VT) advised that local partners had already talked about potential risks and KQ added that Committee was assured by the regular updates.

It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.

MHAC/19/17b Independent Review of the MHA 1983 Modernising the MHA (agenda item 3.2)

YF provided an update and it was noted that the government were aiming for a response by December 2019. Julie Carr (JC) had been approached to sit on the national group and the Trust had supported this involvement.

David Longstaff (DL) added that the role of the Hospital Manager may change fundamentally and there were also potential budget implications to the changes.

It was RESOLVED to RECEIVE the briefing and to NOTE the next steps identified.

MHAC/19/17c CQC Report, Monitoring the MHA in 2017/18 (agenda item 3.3)

YF reported that the CQC had published an annual report highlighting the findings of their work during the period 2017/18. It was noted that the report had been received at Trust Board and a summary taken to Operational Management Group (OMG). YF had also reviewed the report and significant items had been added into a grid and shared with Carol Harris (CH) and Tim Breedon (TB), who had used it on service visits. Key areas identified in the report were being included in ongoing workstreams to address them. CH reported that the Acute Care Forum had had the opportunity for input and TB advised that a section would be added to the Clinical Safety Strategy.

Gary Haigh (GH) raised a point about the provision of information about legal rights to patients and relatives continuing to be the most frequent issue raised at CQC visits. It was noted that this report related to national findings and referred to both reports from patients and carers and record checks.

YF advised that an update would come to Mental Health Act Committee (MHAC) in August.

Action: Yvonne French

It was RESOLVED to RECEIVE the briefing and to NOTE the progress.

MHAC/19/18 Local Authority and Acute Trusts (agenda item 4)

The following updates were noted:

Shirley Atkinson (SA) - Barnsley Local Authority

- The situation with Yorkshire Ambulance Service (YAS) conveyance delays had improved over the last six months.
- There were a high number of 136 admissions but a low percentage of these had converted to a Section 2/3.
- SA queried if SWYPFT had a Section 140 (bed management) protocol and TB added that this had been a national issue raised by the Coroner. YF advised that one does exist and is available on the intranet. YF added that from a legal perspective the CCG were responsible for providing a list of emergency beds.

Terry Hevicon-Nixon (TH-N) – Calderdale Local Authority

- Calderdale had seen a similar big improvement in YAS response times.
- There had been issues with the police not turning up/poor response times – this was being raised at the multi-agency s136 meetings.
- Partnership working with SWYPFT was going really well with more positive working relationships.
- There had been a situation over the Bank Holiday when a young person had been admitted to a 136 Suite for several days. TB advised that a debrief had found that those involved had provided the least worst option for a person in significant distress and their family. It was also noted that at this time no bed was available nationally.

Victoria Thersby – Calderdale and Kirklees Acute Trust

- The safeguarding annual report was available and would be shared as the mental health part sits within safeguarding. VT reported that there had been really good partnership working with SWYPFT over the last 12 months and good attendance at meetings and forums.
- New section packs have been developed to support staff.

Yvonne French – Feedback from police meeting

- Decision from West Yorkshire police to not respond to reports of individuals not returning from leave until organisations had carried out a number of steps. This did not apply in the case of absconsion. YF advised that there was a summit meeting planned for next week with of all the partner agencies and West Yorkshire police to understand their position. YF to report back to next MHAC meeting in August.

Action: Yvonne French

MHAC/19/19 Minutes of previous meeting held on the 12 March 2019 (agenda item 5)

VT raised an amendment to item MHAC/19/10a – Visits and summary reports received in Quarter 3. The sentence should read "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".

It was RESOLVED to APPROVE the notes of the meeting held on 12 March 2019 as a true and accurate record of the meeting once the above amendment had been made.

MHAC/19/20 Matters arising (agenda item 6)

MHAC/19/20a Action points (agenda item 6.1)

The action points were noted and the following items raised:

- MHAC/19/4 – TB reported that recent Child and Adolescent Mental Health Service (CAMHS) difficulties had been discussed in a joint meeting chaired by David Black, Regional Medical Director and reported into the SWYPFT Trust Board. TB would forward the minutes of that meeting to Anne Howgate for information.

Action: Tim Breedon

- MHAC/19/6/a – Update from NICE Steering Overview Group – YF reported that a full clinical meeting had identified that we were generally compliant with NICE guidance. A recommendation for a small working party would go to OMG.
- MHAC/19/6/a – 5 key areas identified – Subha Thiyagesh (ST) had taken the recommendation to EMT and the next step was for YF to look at key areas of risk identified and control measures/mitigating factors and consider for inclusion in the organisational Risk Register.

Action: Yvonne French

- MHAC/19/7/a – Inclusion of data had been clarified in the performance section and did relate only to formal admissions into hospital.
- MHAC/18/49a – The single Trust wide checklist that had been developed for use in all the Trust Mental Health Act offices had been shared with ST to consider its use by medics.

MHAC/19/20b 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/19/21 Statistical information use of the Mental Health Act (MHA) 1983 and Mental Capacity Act (MCA) 2005 (agenda item 7)

MHAC/19/21a Performance report – Monitoring information Trust wide January-March 2019 (agenda item 7.1)

CH advised that Mike Garnham had helped to produce a more focused report for MHAC highlighting clear key areas for consideration. A more finished product would be brought to the next meeting.

The report was considered and the following noted:

- Ethnicity recording continued to represent a significant data quality issue. MHAC noted that the move to SystmOne had been fairly recent and time would be needed to work on processes and practice changes. KQ queried what specific action was being taken and

it was noted that this would be part of the June SystmOne optimisation work and an update would come to the next MHAC meeting.

- The delay to SOAD related to the certificate being returned rather than the authorisation itself.
- S49 activity continued to present a pressure. The requests continue to be logged and submitted to the Royal College of Psychiatry. The issue had also been discussed at the National Mental Health and Learning Disability Nursing Directors' forum.
- It was further clarified that the graph showing admissions to the Trust related only to those people who were formally detained. TB noted that he was aware of Trusts where patients could not be admitted unless they were detained under the Mental Health Act.
- Internal transfer activity between the Priestley Unit and The Dales had increased. ST indicated that this had been looked into and the majority of cases were for Electroconvulsive Therapy (ECT) or gender reasons. This was being picked up as part of the Care Closer to Home work and continued to be monitored.
- There were four exception reports in Quarter 4 and Duty of Candour had been completed in each case.
- CTO activity increased in Quarter 4. DL indicated that the Hospital Managers' view is that the least restrictive option is a CTO which can enable people to live in the community for a better quality of life.
- The predominant reason for Tribunals not being heard was cancellation. It was suggested that this related to patients being taken off section by being reviewed regularly and discharged appropriately.
- Section 136 activity remained unpredictable with only 28% of assessments resulting in admission. YF advised that this was being raised in relevant multiagency 136 meetings. TB added that the increase in young people being admitted to 136 Suites was worrying and would be discussed as part of the New Model of Care (NMC) Clinical Governance Group for CAMHS in West Yorkshire and Harrogate Integrated Care System (ICS).
- One complaint was received in Quarter 4 which had been resolved. YF routinely receives a report from Customer Services which includes a lot of feedback from service users and specifically in relation to the Mental Health Act. This is now included in the quarterly Performance Report rather than being separately reported into Committee. KQ had asked YF to do a 'deep dive' into service user feedback because 'nil' returns for complaints / feedback had been received in previous quarters. YF worked with Customer Services to refine the search and confirmed that Q2 and Q3 data was accurate and no complaints or issues relating to MH Act had been received in those quarters. KQ commented that service user feedback is essential to triangulate information and for Committee to receive assurance.

It was RESOLVED to RECEIVE and NOTE the contents of the monitoring report.

MHAC/19/21b Draft proposal – reduction in appeals (agenda item 7.2)

MHAC had noted a steady decline in the number of applications for appeals by patients against their detention to the Hospital Managers and Tribunal. At the November 2018 meeting, MHAC requested a paper considering the reasons for this change in activity.

YF reported that she had contacted services to get feedback and the following was noted:

- There were no concrete reasons for reduction in activity.
- Length of stay was generally shorter than in the past.
- Clinicians were discharging from sections (although people remained in hospital).
- The acuity of illness at admission meant that patients were less likely to have capacity to make a decision to appeal.
- Responsible Clinicians were keeping people under review, which was positive.

The services had agreed to look at the number of people eligible to appeal. Promotional material had been sourced to explain the rights of appeal to service users, along with a form that they can complete. Posters would also be put up on ward areas. Information regarding the Hospital Mangers would also be included.

It was RESOLVED to RECEIVE the paper and AGREE the actions.

MHAC/19/21c Local Authority Information (agenda item 7.3)
YF reported that no data had been received for the meeting, however going forward it may be possible to access some data on SystmOne to take some pressure off Local Authority colleagues.

MHAC/19/22 CQC compliance actions (agenda item 8)

MHAC/19/22a 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 the West Yorkshire 136 policy remained in draft and the lack of progress had been raised at the multiagency meeting on 7 May. It was suggested to remove things from the document that were preventing agreement. YF assured Committee that SWYPFT have Standard Operating Procedures in relation to 136 use.

It was RESOLVED to RECEIVE the update.

MHAC/19/22b MHA/MCA/DoLS mandatory training update (agenda item 8.2)
YF reported the current position as:

- Mental Capacity Act/DoLS training – 91.68% compliant
- Mental Health Act training – 84.54% compliant

against an 80% target. Committee noted this positive progress and achievement.

YF advised that people were starting to need refresher training and e-learning packs had been approved and were available for use. This would be promoted and it was noted that Learning and Development were now issuing reminders for refresher training a lot earlier which gave people more time to arrange their training before it expired. YF added that face to face training was still available but there had been fewer sessions in March due to staff 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/19/23 Audit and Compliance Reports (agenda item 9)

MHAC/19/23a Section 17 – cancelled escorted leave (agenda item 9.1)
YF reported that the CQC MHA visits had identified concerns from patients that they have, at times, been unable to access their authorised Section 17 leave. A 'snapshot' audit was carried out which achieved a 100% rate. The main conclusions were:

- On the day of the audit 140 patients were granted escorted leave.
- 85% of all patients whose only access to leave was escorted leave were able to access their leave.

- Of those patients who did not access their full leave, only 2 patients were not able to do so as a consequence of staff not being available to provide the escort due to short staffing or sickness issues.

KQ indicated that it was important to distinguish what became problematic for the service user and it was noted that when a patient cannot take leave because of us, the circumstances are investigated/recorded on Datix.

There was general discussion on patient-centred needs and individual circumstances such as a service user who remained in bed until after the ward had met and allocated leave for the day and what could be put in place to ensure that leave was not missed because of this.

The following recommendations were noted:
- For the matrons /Practice Governance Coaches (PGC's) to reinforce good practice and determine training needs for staff to support the patient to access their s.17 leave rather than expect the patient to hold responsibility. This responsibility has particular significance in those services where the patient lacks capacity to make their care and treatment decisions.
- For the PGC's to reinforce good practice and determine training needs for staff to develop care plans to support s.17 leave.
- For the s.17 cancellation audit to remain on the MHAC annual work plan.

It was RESOLVED to RECEIVE the briefing and AGREE the recommendations.

MHAC/19/23b Assessment of capacity and consent to treatment (agenda item 9.2)
YF reported that the CQC had identified issues Trust wide relating to Consent to Treatment activity during their ward visits. An audit was undertaken in April 2019 across inpatient areas to determine compliance with the Act and Code of Practice.

YF advised that a group of medics had reviewed formal consent forms against medicine cards and found that when there was a discrepancy in records (with the electronic record or certificate held by the MHA office), the version attached to the card was the most up-to-date.

EM queried if Committee could be assured that the issues lay with data gathering rather than capacity assessments not being carried out. YF advised that it was possible in some cases, however this would be explored as part of the SystmOne optimisation work.

YF added that the audit had been circulated to BDUs for review and development of action plans and MHAC were asked to consider establishment of a Consent to Treatment Working Group. It was agreed that input from Pharmacy would be valuable and they would be approached to be involved.

It was RESOLVED to RECEIVE the briefing, NOTE the next steps and AGREE the establishment of a Consent to Treatment Working Group.

MHAC/19/24 Care Quality Commission visits (agenda item 10)

MHAC/19/24a Visits and summary reports received in Quarter 4 (agenda item 10.1)
YF reported that there were 4 CQC Mental Health Act visits in Quarter 4.

Within the quarter, 3 MHA monitoring summary reports were received relating to ward visits made to; Melton Suite, Chantry and Stanley Ward.

5 responses were submitted to the CQC; Ward 19 (female), Ryburn, Melton Suite, Chantry and Stanley Ward.

The Committee received detailed information about the outstanding issues.

Access to WiFi had been noted as both positive practice and requiring action. YF advised that WiFi was now available in all areas, however there had been an issue using it.

It was noted that the Defacto Detention related to a voluntary patient who should have been allowed to leave or the legal framework considered to keep that individual safe.

YF concluded that progress was being made although some areas required changes to practice.

It was RESOLVED to RECEIVE the report and to NOTE the update.

MHAC/19/24b Update on CQC MHA action plans (agenda item 10.2)
YF presented a much shorter report than previously which, along with the added table, represented a useful summary of progress from action plans.

It was RESOLVED to RECEIVE the report and to NOTE the update.

MHAC/19/25 Mental Health Act Code of Practice Policy (agenda item 11)

MHAC/19/25a Reducing restrictive practice (blanket restrictions) (agenda item 11.1)
YF reported that in January 2019 the Trust EMT had approved the Mental Health Act Code of Practice Policy on the use of global restrictive practice, otherwise known as blanket restrictions. Monitoring the use of blanket restrictions would be through MHAC on a quarterly basis and Committee received the first report.

It was noted that during the reporting period there were 81 applications of restrictive practice, the majority of which were recorded due to the 'smoking restriction' or the removal of alcohol from service users. Committee noted that these would not ordinarily be reported as blanket restrictions as they were supported by Trust policy, however the working group were also considering the impact of restrictions.

YF added that whilst the working group would continue, there would also be an Implementation of Reducing Restrictive Practice group to embed practice across the Trust.

It was RESOLVED to RECEIVE the report and to NOTE the quarterly reporting requirement.

MHAC/19/26 Independent Hospital Managers (agenda item 12)

MHAC/19/26a Hospital Managers' Forum Notes 9 April 2019 (agenda item 12.1)
The Committee received the notes of the last Forum. DL reported an excellent training session from two consultants on risk assessment and management.

DL advised that despite some soundproofing work, the Tribunal Room in the Unity Centre remained extremely noisy. Carly Thimm (CT) indicated that she had a meeting scheduled with the Capital Planning Manager to address this.

It was RESOLVED to NOTE the update.

MHAC/19/27 Key Messages to Trust Board (and Clinical Governance and Clinical Safety Committee as necessary) (agenda item 13)

The key issues to report to Trust Board were agreed as:

- Amendment to Mental Capacity Act, review of Mental Health Act – two significant pieces of work representing organisational change, ie training, assurance, clinical impact.
- Taking forward the findings from the CQC annual report.
- Task and finish approach to dealing with some of the issues in the annual plan.
- Update on Reducing Restrictive Practice – the presentation being a good example.
- Positive feedback from partners.

The key issues to report to Clinical Governance:

- First two as above.
- Increased use of 136 Suites by under 18's to be flagged.

MHAC/19/28 Date of next meeting (agenda item 14)

The next Committee meeting will be held on 29 August 2019 in Meeting Room 1, Block 7, Fieldhead Hospital, Wakefield from 1.30-4.00 pm.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 24 September 2019
Agenda item 11

Title:	**Use of Trust Seal**
Paper prepared by:	Company Secretary on behalf of the Chief Executive
Purpose:	The Trust's Standing Orders, which are part of the Trust's Constitution, require a report to be made to Trust Board on the use of the Trust's seal every quarter. The Trust's Constitution and its Standing Orders are pivotal for the governance of the Trust, providing the framework within which the Trust and its officers conduct its business. Effective and relevant Standing Orders provide a framework that assists the identification and management of risk. This report also enables the Trust to comply with its own Standing Orders.
Mission/values:	The paper ensures that the Trust meets its governance and regulatory requirements.
Any background papers/ previously considered by:	Quarterly reports to Trust Board.
Executive summary:	The Trust's Standing Orders require that the Seal of the Trust is not fixed to any documents unless the sealing has been authorised by a resolution of Trust Board, or a committee thereof, or where Trust Board had delegated its powers. The Trust's Scheme of Delegation implied by Standing Orders delegates such powers to the Chair, Chief Executive and Director of Finance of the Trust. The Chief Executive is required to report all sealing to Trust Board, taken from the Register of Sealing maintained by the Chief Executive. The seal has been used two times since the report to Trust Board in June 2019 in respect of the following: ➢ Lease for Pontefract Health Centre, Trinity Street, Wakefield between NHS Property Services Limited and the Trust. ➢ Contract of Sale and Transfer of Registered Title for the Ossett Health Centre, New Street, Ossett between the Trust and McCarthy Stone Retirement Lifestyle Limited.
Recommendation:	**Trust Board is asked to NOTE use of the Trust's seal since the last report in June 2019.**
Private session:	Not applicable.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board annual work programme 2019-20

Agenda item/issue	Apr	June	July	Sept	Oct	Nov	Jan	Mar
Standing items								
Declaration of interest	✘	✘	✘	✘	✘	✘	✘	✘
Minutes of previous meeting	✘	✘	✘	✘	✘	✘	✘	✘
Chair and Chief Executive's report	✘	✘	✘	✘	✘	✘	✘	✘
Business developments	✘	✘	✘	✘	✘	✘	✘	✘
STP / ICS developments	✘	✘	✘	✘	✘	✘	✘	✘
Integrated performance report (IPR)	✘	✘	✘	✘	✘	✘	✘	✘
Serious Incidents (private session)	✘	✘	✘	✘	✘	✘	✘	✘
Assurance from Trust Board committees	✘	✘	✘	✘	✘	✘	✘	✘
Receipt of minutes of partnership boards	✘	✘	✘	✘	✘	✘	✘	✘
Question from the public	✘	✘	✘	✘	✘	✘	✘	✘
Quarterly items								
Corporate/organisational risk register	✘		✘		✘		✘	
Board assurance framework	✘		✘		✘		✘	
Serious incidents quarterly report		✘		✘		✘		✘
Use of Trust Seal		✘		✘		✘		✘
Corporate Trustees for Charitable Funds# (annual accounts presented in July)	✘		✘		✘		✘	
Half yearly items								
Strategic overview of business and associated risks	✘				✘			
Investment appraisal framework (private session)	✘				✘			
Safer staffing report	✘				✘			
Digital strategy (including IMT) update	✘				✘			
Estates strategy update			✘				✘	
Annual items								
Draft Annual Governance Statement	✘							
Audit Committee annual report including committee annual reports	✘							

Agenda item/issue	Apr	June	July	Sept	Oct	Nov	Jan	Mar
Compliance with NHS provider licence conditions and code of governance - self-certifications *(date to be confirmed by NHS Improvement)*	✘	✘						
Guardian of safe work hours	✘							
Risk assessment of performance targets, CQUINs and Single Oversight Framework and agreement of KPIs	✘							
Review of Risk Appetite Statement	✘							
Annual report, accounts and quality accounts - update on submission		✘						
Health and safety annual report		✘						
Patient experience annual report		✘						
Serious incidents annual report		✘						
Equality and diversity annual report			✘					
Medical appraisal/revalidation annual report			✘					
Sustainability annual report				✘				
Workforce Equality Standards				✘				
Assessment against NHS Constitution						✘		
Eliminating mixed sex accommodation (EMSA) declaration								✘
Data Security and Protection toolkit								✘
Strategic objectives								✘
Trust Board annual work programme								✘
Operational plan	✘					✘ (draft / private)	✘ (draft / private)	✘ (draft / private)
Five year plan				✘				
Policies and strategies								
Constitution (including Standing Orders) and Scheme of Delegation					✘			
Communication, Engagement and Involvement strategy		✘ (update)					✘	
Organisational Development Strategy						✘		
Risk Management Strategy	✘							
Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies)							✘	
Treasury Management Policy							✘	
Workforce Strategy								✘

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 December 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.	