With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board (business and risk)
Thursday 28 April 2016 at 12:30
Small conference room, Learning and Development Centre, Fieldhead, Wakefield, WF1 3SP

AGENDA

1. **Welcome, introduction and apologies, and service user story** (verbal item)

2. **Declaration of interests** (verbal item)

3. **Minutes and matters arising from previous Trust Board meeting held on 29 March 2016** (attached)

4. **Assurance from Trust Board committees** (attached)
   - 4.1 Audit Committee 5 April 2016 (verbal item)
   - 4.2 Clinical Governance and Clinical Safety Committee 18 April 2016 (verbal item)
   - 4.3 Information Management and Technology Forum 18 April 2016 (verbal item)
   - 4.4 Mental Health Act Committee 2 March 2016 (attached for information only)

5. **Chair and Chief Executive's remarks** (verbal item)

6. **Strategic overview of business and associated risks** (to follow)

7. **Audit Committee annual report 2015/16** (attached)

8. **Performance reports month 12 2015/16**
   - 8.1 Quality performance report month 12 2015/16 (to follow)
   - 8.2 Finance report month 12 2015/16 (attached)
   - 8.3 Customer services report quarter 4 2015/16 (attached)

8.4 Exception reporting and action plans

(i) Risk assessment of performance targets, CQUINs and NHS Improvement risk assessment framework (to follow)

(ii) Planned visits annual report 2015/16 (attached)

(iii) Volunteer accreditation (attached)

(iv) Well-led review action plan (attached)

(v) Trust Board self-certification – compliance with Licence conditions (attached)

(vi) Trust visual identity (attached)

9. Items for approval

9.1 Information Management and Technology (attached)

10. Board self-assessment of operational, clinical and quality risks (attached)

11. Assurance framework and risk register (attached)

12. Date and time of next meeting

The next meeting of Trust Board will be held on Tuesday 28 June 2016 in rooms 3 and 4, Laura Mitchell House, Great Albion Street, Halifax, HX1 1YR.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

TRUST BOARD
28 APRIL 2016

AGENDA ITEM 3
Minutes and matters arising from the meeting held on 29 March 2016

For Trust Board to APPROVE

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Minutes of Trust Board meeting held on 29 March 2016

Present:	Ian Black	Chair
	Laurence Campbell	Non-Executive Director
	Rachel Court	Non-Executive Director
	Charlotte Dyson	Non-Executive Director
	Julie Fox	Deputy Chair
	Chris Jones	Non-Executive Director
	Jonathan Jones	Non-Executive Director
	Steven Michael	Chief Executive
	Adrian Berry	Medical Director
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Jon Cooke	Interim Director of Finance
	Alan Davis	Director of Human Resources and Workforce Development
	Alex Farrell	Deputy Chief Executive
Apologies:	None	
In attendance:	James Drury	Deputy Director, Strategic Planning (to item 7.1)
	Kate Henry	Interim Director, Marketing, Engagement and Commercial Development
	Dawn Stephenson	Director of Corporate Development (Company Secretary)
	Bernie Cherriman-Sykes	Board Secretary (author)
Guests:	Daniel Redmond	Publicly elected governor (Calderdale), Members' Council

TB/16/12 Welcome, introduction and apologies (agenda item 1)

The Chair (IB) welcomed everyone to the meeting, in particular, Daniel Redmond from the Trust's Members' Council. There were no apologies. He invited Julie Fox (JF) to tell the story of Mr. D, previously an in-patient on Chantry, Fieldhead, Wakefield. JF explained that Mr. D had not wanted to attend the meeting personally but he did want Trust Board to hear his story and specifically requested a response from the Board.

Tim Breedon (TB) responded that the issues set out were recognised, particularly around the balance of domesticity and formality, and he commented that there has been much work undertaken on Chantry recently. Adrian Berry (ABe) added that the challenge for the Trust and its staff is to introduce uniformity when service user views differ so much on matters such as these. TB also commented that the experience also reflects that acuity and challenging behaviour found on wards has increased. As the Trust reduces its bed-base and provides more services in the community, separation of service users in terms of gender and acuity of illness or support becomes more difficult. This supports the decision taken by Trust Board to invest in non-secure estate on the Fieldhead site.

In response, it was agreed to:

- send an extract of Trust Board minutes to Mr. D;
- provide (or send an extract of) the Care Quality Commission (CQC) inspection report on Chantry (although it was noted that reference may only be by service not by specific unit);
- hold another Trust Board meeting in Newton Lodge or an alternative secure facility, which would include sampling the food;
- provide an outline of the investment the Trust has made in the service since July 2015.

IB thanked Mr. D for bringing these issues to the attention of Trust Board, which Directors found helpful. In relation to the difficulties Mr. D experienced in making his complaint, Trust

Board asked that the Trust examines how it promotes customer services, how to raise complaints, concerns or compliments, and reviews the information included in the welcome pack for service users.

TB/16/13 Declaration of interests (agenda item 2)

The following declarations were considered by Trust Board.

Name	Declaration
CHAIR	
Ian Black	Independent Non-Executive Director, Benenden Healthcare Society Chair, Benenden Wellbeing Chair, Keegan and Pennykidd Non-Executive Director, Seedrs (with small shareholding) Trustee and Director, NHS Providers Chair, Family Fund (UK charity) Member, Whiteknights, a charity delivering blood and samples on behalf of hospitals in West and North Yorkshire Private shareholding in Lloyds Banking Group PLC (retired member of staff)
NON-EXECUTIVE DIRECTORS	
Laurence Campbell	Director, Trustee and Treasurer, Kirklees Citizens' Advice Bureau and Law Centre, includes NHS complaints advocacy for Kirklees Council
Rachel Court	Director, Leek United Building Society Director, Invesco Perpetual Life Ltd. Director, Leek United Financial Services Ltd. (from 27 April 2016) Chair, PRISM Governor, Calderdale College Magistrate Chair, NHS Pension Board
Charlotte Dyson	Independent marketing consultant, Beyondmc (marketing consultancy work for Royal College of Surgeons, Edinburgh) Lay Chair, Leeds Teaching Hospitals NHS Trust Advisory Appointments Committee for consultants (occasional) Lay member, Leeds Teaching Hospitals NHS Trust Clinical Excellence Awards Committee Lay member, Advisory Committee Clinical Excellence Awards, Yorkshire and Humber Sub-Committee Lay member, Royal College of Surgeons of Edinburgh, MRSC Part B OSCE
Julie Fox	Trustee and Advisory Board member, Peer Power (social justice organisation supporting young people) Employed by HM Inspectorate of Probation (to 30 June 2016) Daughter appointed as Independent Hospital Manager
Chris Jones	Director and part owner, Chris Jones Consultancy Ltd. Trustee, Children's Food Trust
Jonathan Jones	Member, Squire Patton Boggs (UK) LLP Member, Squire Patton Boggs (MENA) LLP Trustee, Hollybank Trust Spouse, Company Secretary, Zenith Leasedrive Holdings Limited and its subsidiaries Spouse, shareholder, Zenith Leasedrive Holdings Limited
CHIEF EXECUTIVE	
Steven Michael	Trustee and Treasurer, Spectrum People Chair, NHS Confederation Mental Health Network Trustee, NHS Confederation

Name	Declaration
	Chair, Huddersfield University Business School Advisory Board Partner, NHS Interim Management and Support (to 31 March 2016) Health and Wellbeing Boards, Wakefield and Barnsley (to 31 March 2016) Involvement in Care Quality Commission mental health inspection arrangements (to 31 March 2016) Partner is employed by Mid-Yorkshire Hospitals NHS Trust
EXECUTIVE DIRECTORS	
Adrian Berry	No interests declared
Tim Breedon	No interests declared
Jon Cooke	No interests declared (although on secondment as Chief Finance Officer, Yorkshire and Humber Commissioning Support Unit)
Alan Davis	No interests declared
Alex Farrell	No interests declared
COMPANY SECRETARY	
Dawn Stephenson	Chair and Voluntary Trustee, Kirklees Active Leisure Governor, Membership Council, Calderdale and Huddersfield NHS Foundation Trust (and member of Remuneration and Terms of Service sub-committee)
OTHER DIRECTORS	
Carol Harris	No interests declared
Kate Henry	No interests declared
Sean Rayner	Member, Independent Monitoring Board for HMP Wealstun Trustee, Barnsley Premier Leisure
Diane Smith	No interests declared
Karen Taylor	No interests declared

There were no comments or remarks made on the Declarations, therefore, **it was RESOLVED to formally NOTE the Declarations of Interest by the Chair and Directors of the Trust.** It was noted that the Chair had reviewed the declarations made and concluded that none present a risk to the Trust in terms of conflict of interests. It was also noted that all Non-Executive Directors had signed the declaration of independence and all Directors had made a declaration that they meet the fit and proper person requirement.

TB/16/14 Minutes of and matters arising from the Trust Board meeting held on 29 January 2016 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held on 29 January 2016 as a true and accurate record of the meeting. There were no matters arising.

TB/16/15 Assurance from Trust Board committees (agenda item 4)

TB/16/15a Audit Committee 2 February 2016 (agenda item 4.1)

The following areas were raised.

- Following the concerns expressed by the Committee in relation to an internal audit of patients' property, the Committee received a presentation from Karen Taylor on the action taken within services to address the recommendations. KPMG will undertake a re-audit, the outcome of which will be reported to the Committee.
- The internal audits receiving partial assurance for service level agreements and job planning will be formally presented to the Committee at its April 2016 meeting.

- The Committee received and supported the work plan from the Trust's external auditors, Deloitte.
- As part of this report, the Committee was advised of a number of concerns in relation to the Quality Accounts local indicator on care planning. TB advised that this had been a matter of definition and that the issues have been resolved.

TB/16/15b Clinical Governance and Clinical Safety Committee 23 February 2016 (agenda item 4.2)
The following areas were raised.

- The Committee received the Trust's Suicide Prevention Strategy, which includes a section on how the Trust will work with partners in respect of suicides in the wider system where individuals are not in contact with Trust services.
- The Committee received a useful report on psychological therapies, which provided a good understanding of the current position across the Trust.
- The Committee also received an update on quality impact assessments of proposed cost savings. There had been good progress with 70% complete and no obvious concerns arising.

TB/16/15c Mental Health Act Committee 2 March 2016 (agenda item 4.3)
The Committee received a presentation on the positive outcome of a review of Mental Health Act audits undertaken between 2012 and 2015, which demonstrated a number of areas of improvement.

TB/16/15d Remuneration and Terms of Service Committee 9 February 2016 (agenda item 4.4)
IB commented on the Committee's support for the 1% pay award for all staff on Agenda for Change and the Executive Management Team (EMT). The Committee also reviewed Director performance in relation to the performance related pay scheme for 2015/16 and re-endorsed the condition that no award would be made unless the Trust achieved at least 'good' for its CQC inspection.

JF commented that she noted from the minutes that the Committee is proposing that the sickness absence target returns to 4%. Alan Davis (AGD) responded that increasing the sickness absence target has had unforeseen consequences. The lower target provided a focus and was at an aspirational level. The increase has acted as a disincentive to the continued drive to reduce absence. The Committee was, therefore, supportive of a return to a target of 4% in 2016. The Trust will target the highest areas of concern through a wellbeing and engagement process and focus on areas, such as forensic services, to provide targeted support for managers to reduce absence through health coaching and performance management of their management of individual members of staff as part of a wider performance dashboard for trios within BDUs.

TB/16/15e Estates Forum 26 February 2016 (agenda item 4.5)
Jonathan Jones (JJ) highlighted in particular the excellent performance against the capital plan for 2015/16. Chris Jones (CJ) asked what the Trust does in terms of post-implementation reviews of capital schemes. JJ responded that the Forum has asked for a review of what the Trust said it would do in the Estates Strategy and what has been achieved at the next meeting. AGD added that all capital schemes are subject to a twelve-month post-implementation evaluation, which would consider the business benefits and whether these were as anticipated. These are considered through the Estates TAG and the EMT. JJ commented that it might be useful for the Forum to receive these as well.

TB/16/15f Equality and Inclusion Forum 8 March 2016 (agenda item 4.6)
JJ asked how the Trust will know if it is making a difference and how this translates into Trust Board level objectives. IB responded that the last recruitment exercise for Non-Executive Directors did attract many BME candidates into the pool; however, not necessarily with suitable experience. The next recruitment exercise will focus on and recognise this area. In terms of staff, the organisation is serious about understanding issues and putting action in place to address themes.

Trust Board noted that an independent report on the roll-out of the upgrade to the Trust's clinical information system, RiO, will come to a future meeting.

IB also confirmed that he will be looking to review membership of Trust Board Committees with a view to ensuring Non-Executive Directors have as much experience as possible on different Committees. This will be undertaken after all appraisals are complete for this financial year anticipated at the end of April 2016.

TB/16/15g Proposed changes to Trust Board Committees' terms of reference (agenda item 4.7)
It was RESOLVED to APPROVE the proposed changes to Committee terms of reference as set out in the paper.

TB/16/16 Chair and Chief Executive's remarks (agenda item 5)

Taking the context of the plan for 2016/17, IB commented that the focus at national level is the coming year only and the fact that this is not a longer-term view is of concern. The Trust has been given a 'control total' by Monitor and this will be considered as part of the next item.

IB went on to confirm that Rob Webster (RW), the Trust's new Chief Executive, will start on 16 May 2016. Interviews for the Director of Finance post took place last week with RW chairing the panel. Mark Brooks has been appointed and it is expected that he will join the Trust in June 2016. IB also advised that RW will lead development of the Sustainability and Transformation Plan (STP) in West Yorkshire (health and care organisations within geographic footprints will work together to narrow the gaps in the quality of care, their population's health and wellbeing, and in NHS finances).

He ended by formally recording that this is a well performing Trust and that it is so is due significantly to the contribution of Steven Michael (SM). This Trust would not be in this position without him.

In his farewell remarks, the Chief Executive commented that fundamental to his tenure has been to ensure the organisation operates on its value base. He thanked people who use Trust services and the communities the Trust serves for their support. He commended Trust staff for the feedback from the Care Quality Commission (CQC) that they found staff to be caring often under difficult circumstances, and this was without exception. He added his own thanks to staff for their commitment and efforts. He thanked Trust Board colleagues who he found to be open, honest and values-based and thanked other colleagues in the EMT. He ended these remarks by thanking the Chair who has been a great Chair and enabled him to be a better Chief Executive.

SM also covered the following.

- The outcome of the CQC visit is not yet known. He thanked staff for all their hard work in making the visit a success.

- Although the consultation regarding accident and emergency services in Calderdale and Greater Huddersfield does not directly affect this Trust, the concern is to ensure any change at Calderdale and Huddersfield Trust (CHFT) does not have an impact on the Trust's ability to deliver services on the Dales site in Halifax. The position is similar for Mid-Yorkshire Hospital NHS Trust in that any plans it has do not impact on delivery of Trust services in the Priestley Unit in Dewsbury.

AF commented on the contracting position and advised that there were a number of outstanding issues remaining with NHS commissioners, mainly relating to safer staffing. A return was submitted to Monitor to advise the Trust's position, which is that negotiations continue with commissioners. Wakefield health and wellbeing and Barnsley substance misuse services are both areas where the Trust's contract has been extended with a view to commissioners tendering for services. The position for 0-19 services (Barnsley Healthy Child Programme) is subject to further discussion in the private session of the meeting.

The Chair invited JF to comment on the Shadow Board programme. This is a pilot and the Trust is one of only three taking part. It is a short, modular and practical programme providing senior managers and clinicians with an insight into the working of a foundation trust board, directorship and good corporate/clinical governance. It is supported by the NHS Leadership Academy and will enable up to ten staff to undertake a programme of learning, which includes the formation of a 'shadow board, which JF will chair.

IB ended his remarks by confirming that SM will remain as Chief Executive and Accounting Officer until 31 March 2016. AF will act as interim Chief Executive and Accounting Officer until 15 May 2016. AGD will act as interim Deputy Chief Executive from 1 April 2016 to the end of August 2016. Jon Cooke (JC) will remain as interim Director of Finance until the substantive appointment begins (anticipated as early June 2016).

TB/16/17 Annual plan and budgets 2016/17 and annual plan submission to Monitor (agenda item 6)

Following an introduction from IB, AF took Trust Board through a tabled paper on the operational plan for 2016/17 and outlined the action required to complete the plan. JC went on to summarise the financial plan.

- Development of the plan has been an inclusive process, including the involvement of the full Trust Board.
- Monitor has set the Trust a 'control total' of £1.2 million surplus. The Trust's plan recognises a £500,000 surplus due to a more prudent approach adopted to safety and quality of clinical services in the light of the March 2016 CQC inspection. This reflects a realistic position for this Trust although it does not equate to the 'control total' set by Monitor.
- The £10 million cost improvement programme is subject to a quality impact assessment process, has been robustly challenged by the finance team and by the EMT, and has been externally reviewed by Deloitte.
- The programme represents 4.7% of the Trust's income and contains an element as yet unidentified, which does present a risk to the Trust.
- There is an additional investment of £4.4 million in Trust services, which has also been the subject of robust challenge by the EMT and will be subject to the quality impact assessment process.
- The capital plan includes the start of a £16 million investment in non-secure services on the Wakefield site.
- The Trust is forecasting a financial risk rating of 4 (out of 4); however, the impact of not setting a budget that reflects the 'control total' is not known.

- The report from Deloitte will be presented to the Board in April 2016 although assurance will be sought prior to the submission to Monitor on 11 April 2016. The report in April 2016 will include the management response to recommendations.

IB and JJ were both of the view that the small group to whom the Board was being asked to delegate authority will need some assurance from Deloitte before the operational plan is sent to Monitor to derive some comfort. JJ added that he would want to see the report in advance of submission. CJ commented that he was surprised that Deloitte was involved as he would see this as an operational/management response and, therefore, he felt he had sufficient assurance from today. The challenge remains in achieving the level of cost savings. Laurence Campbell (LC) and Rachel Court (RC) concurred. In response, JJ explained why the review had originally been commissioned. SM added that it had formed a particular worry for Trust Board and also demonstrated openness and transparency. There is a fine line between assurance and reassurance but he still saw the value in an external review. IB commented that he derived assurance from the EMT process, which has improved year-on-year, the track record on delivery of the plan and the external review by Deloitte. He would find assurance from an external review particularly useful given that Trust Board may set a budget that differs from the 'control total'.

RC asked if Deloitte would look at opportunities for realising more cost savings than currently identified. She also asked if Trust Board needed this assurance to approve the plan. It would provide additional value and comfort but would not be a prime factor in informing the decision. IB added that the review also provides an external view of the 'market place' and the environment in which the Trust operates. AF commented that, as part of the scope, Deloitte will look at the reliability of the Trust's risk ratings, the appropriateness of Trust processes (that is, best practice) and comparison with others. A clear view would be available from Deloitte by 8 April 2016 with the detail and management response presented to Trust Board on 28 April 2016. IB asked that Trust Board considers whether a review should be commissioned for the 2017/18 plan earlier in the process next year.

JF commented that she would prefer for all members of Trust Board to see the report from Deloitte before any decision is made to delegate authority to a small group. CJ commented that he was not sure Trust Board should delegate authority if the report was not positive or was less than positive. He was also not sure what action the group would, could or should take if this resulted in any change to the budget. JC responded that he was not sure that anything arising from the review would change the bottom-line of the plan. The Trust would use provisions, mitigation and contingencies to maintain the position approved by Trust Board. SM added that the role of Trust Board at this meeting is to approve the plan and budget and there would be no changes to the bottom-line. He would also suggest seeking the advice of Deloitte prior to submission of the operational plan to Monitor on the proposed financial outcome. AF also clarified that changes in the operational plan outlined in the paper to Trust Board refer to action required to complete the plan. The delegated authority requested is for this purpose and not to seek to change the budget approved by Trust Board today.

It was RESOLVED to APPROVE the proposal to delegate authority to the Chair, Deputy Chair, interim Chief Executive and interim Director of Finance to approve and submit the final version of the operational plan and the budget (as approved today) to NHS Improvement by 11 April 2016.

JF commented that the process seems to have been a 'scramble' this year. Charlotte Dyson (CD) agreed but commented that she did derive more assurance than through the previous process. IB commented that it had seemed rushed and he will consider the timing of Trust Board to reflect the submission to NHS Improvement for 2017/18. JC responded that this had been a measured, full and thorough process with the detail robustly considered by the

EMT prior to the review by Deloitte. He did, however, acknowledge the delay in commissioning this review. SM added that these had been exceptional circumstances with the change in Director of Finance mid-stream, the timing of the CQC inspection and the late imposition of a 'control total' by Monitor.

IB summarised that Trust Board:

- supports the submission of a budget which provides for a £500,000 surplus;
- acknowledges the 'control total'; however, as a result of the CQC inspection, Trust Board has agreed to take a more prudent approach to the safety and quality of its clinical services, which reflects a realistic position for this Trust although it does not equate to the 'control total' set;
- supports the capital programme for 2016/17 noting the reduction in cash balances;
- would seek significant assurance from the review of the rating of cost savings;
- supports the contingencies proposed;
- is supportive that the potential for a receipt from the sale of the St. Luke's Hospital site is not included in the budget for 2016/17 but the receipt for the sale of Aberford Field is included in 2015/16;
- will review the budget and forecast for 2016/17 at the meeting in July 2016 when quarter 1 is complete and the CQC report has been received.

It was RESOLVED to:

- **APPROVE the draft operational plan and budget for 2016/17, subject to the completion of the actions detailed in the covering paper, which are not expected to require material alteration to the content and direction of the plan;**
- **APPROVE delegated authority as set out in the above resolution;**
- **COMPLETE the review of strategic objectives linked to the four-tier service model for presentation to Trust Board in April 2016.**

TB/16/18 Performance reports month 11 2015/16 (agenda item 7)

TB/16/18a Performance report (agenda item 7.1)

The performance report for month 11 was noted. RC asked if safer staffing would be included in future reporting and whether this would identify 'hotspots'. TB responded that more detailed reports are presented to the Clinical Governance and Clinical Safety Committee. He agreed that future reports would include more detail by BDU and identify areas that are not meeting required levels, the reasons for this and mitigating action. IB commented that the Trust will pick up any differences in the Trust's assessment and that of the CQC of its services when the inspection report is received.

TB/16/18b Finance report (agenda item 7.2)

JC commented that the delay in completion of the sale of Aberford Field has reduced the Trust's risk rating to 3 (out of 4) as it has impacted on the Trust's cash profile causing a significant variation to the plan in February 2016. If the sale is completed by the end of March 2016, the risk rating will return to 4 in quarter 4.

CD asked for assurance that processes are in place to ensure the capital spend allocated to information management and technology is realised. JC responded that he was confident that the level of spend at the year-end will be as planned. Spend against agile working has also been accelerated for 2015/16.

In relation to Aberford Field, AGD commented that he was confident that exchange and completion and transfer of monies would be completed by 31 March 2016 or, at the very least, legal exchange will have taken place.

TB/16/18c Exception reports and action plans – Safer staffing (agenda item 7.3(i))
TB took Trust Board through the paper. LC asked why there was an 80% threshold for nurses but 90% for other staff. TB responded that the Trust's approach is based on guidance issued for the acute care system and it would look to review following the CQC inspection visit report. It was agreed to take the full rates through the Clinical Governance and Clinical Safety Committee.

In terms of comparison with other Trusts, local benchmarking shows the Trust is slightly higher or similar in terms of ratios. The CQC expressed a degree of concern but this was mainly due to recruitment and retention rather than a concern due to staffing levels. The CQC will consider the Trust's rationale for its position and will make its own judgement on whether this is adequate.

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

TB/16/18d Exception reports and action plans – Information Governance toolkit (agenda item 7.3(ii))
It was RESOLVED to NOTE the current position regarding information governance and to APPROVE the Trust's information governance toolkit submission.

TB/16/18e Exception reports and action plans – Eliminating mixed sex accommodation (agenda item 7.3(iii))
IB asked if the Trust has a policy on transgender accommodation. TB responded that assessment is currently undertaken on an individual needs basis. The Trust is currently working on a set of policies and enhanced guidance for staff.

It was RESOLVED to APPROVE the declaration.

TB/16/19 Governance matters (agenda item 8)

TB/16/19a Annual Governance Statement (agenda item 8.1)
It was RESOLVED to APPROVE the first draft of the Annual Governance Statement for 2015/16. Trust Board noted that the Statement would be subject to change following review by Deloitte as part of the audit of the Trust's annual report and accounts. As a consequence, **Trust Board APPROVED the proposal to delegate authority to the Audit Committee to approve a final version of the Statement as part of its approval of the annual report and accounts on 24 May 2016.** The final version of the statement will be brought back to Trust Board in June 2016 as part of Trust Board's consideration of the annual report and accounts.

SM commented that he was nervous of any significant changes made following his departure as this was his statement on 2015/16 as Accounting Officer and he would very much wish it to remain, as far as possible, in its current form. This was noted by Trust Board.

IB reminded Trust Board of the open invitation to attend both the Audit Committee to approve the annual report and accounts on 24 May 2016 and the Clinical Governance and Clinical Safety Committee to approve the Quality Accounts on 17 May 2016.

TB/16/19b Decision-making framework (agenda item 8.2)
It was RESOLVED to NOTE the report and the work undertaken to date, and to APPROVE the proposal to retain the current financial limits for Trust Board approval.

TB/16/19c Calderdale Vanguard partnership agreement (agenda item 8.3)

AF explained the background to the paper and the changes proposed by the Trust. CJ asked whether there were any implications relating to the first clause on resources. AF responded that this will become clear when the scope of services included is known, particularly commitments to specific projects and contribution to the project management support arrangements.

AF also commented that the success of the Vanguards will rely on local leadership and demonstration of how they add value.

IB commented that the first point of contact is likely to be child and adolescent mental health services. He asked whether the health economy was prepared for this. AF responded that Trust Board should not be unduly concerned. The Trust is in a position to influence the agenda, this builds on existing arrangements and the summits held during 2015, and it is an area of national concern and perceived gap.

JF asked about the fit of Vanguards with Sustainability and Transformation Plans. SM responded that he was not sure they did fit but Vanguards will form a mechanism for delivery with the plans.

It was RESOLVED to NOTE the Trust's engagement with the Calderdale Vanguard and APPROVE the Calderdale Vanguard Partnership Agreement, including associated delegated authority to act, subject to the changes the Trust has proposed to the draft document.

TB/16/20 Use of Trust seal (agenda item 9)

It was RESOLVED to NOTE use of the Trust's seal since the last report in December 2015.

TB/16/21 Date and time of next meeting (agenda item 10)

The next meeting of Trust Board will be held on Thursday 28 April 2016 in the small conference room, Learning and Development Centre, Fieldhead, Wakefield.

Signed …… Date ……

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 28 April 2016
Agenda item 4 – assurance from Trust Board Committees

Audit Committee

Date	5 April 2016
Presented by	Laurence Campbell
Key items to raise at Trust Board	➢ Risk assessment undertaken to assess implications of recent corporate manslaughter case. ➢ As part of future Committee annual reporting process, greater emphasis on the difference Committees make and evaluation of their work. ➢ Internal audit reports on medicines management and job planning. ➢ Care programme approach local indicator for Quality Accounts and how this is reported. ➢ Decision taken by the Committee to receive the ISA 700 (enhanced auditor reporting) without disclosure of detailed findings until it is mandatory for NHS trusts to do so.

Clinical Governance and Clinical Safety Committee

Date	18 April 2016
Presented by	Julie Fox
Key items to raise at Trust Board	➢ Development of the Trust's Suicide Prevention Strategy. ➢ Supporting service users into employment. ➢ Feedback from sub-groups. ➢ Friends and Family Test for service users and staff.

Information Management and Technology Forum

Date	18 April 2016
Presented by	Ian Black
Key items to raise at Trust Board	➢ RiO V7 upgrade implementation and action taken by the Trust. ➢ Information Management and Technology Strategy. ➢ Options appraisal for clinical information system re-provisioning ➢ As standing items, the Forum also reviewed progress against plan and against capital spend. ➢ Key achievements against priorities in 2015/16.

Mental Health Act Committee – 2 March 2016 – minutes included for information

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Minutes of the Mental Health Act Committee Meeting held on 2 March 2016

Present:	Julie Fox	Deputy Chair (Chair)
	Chris Jones	Non-Executive Director
	Adrian Berry	Medical Director
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Dawn Stephenson	Director of Corporate Development
Apologies:	**Members**	
	Jonathan Jones	Non-Executive Director
	Attendees	
	Anne Howgate	AMHP Team Leader (Kirklees) – local authority representative
	Ian Priddey	Professional Lead and Development Co-ordinator (Mental Health) (Calderdale) – local authority representative
In attendance:	Shirley Atkinson	Professional Development Support Manager (Barnsley) – local authority representative
	Julie Carr	Clinical Legislation Manager
	Bernie Cherriman-Sykes	Board Secretary (author)
	Alwyn Davies	Lead Professional, Safeguarding Adults, Barnsley Hospital NHS Foundation Trust – acute trust representative
	Yvonne French	Assistant Director, Legal Services
	Mike Garnham	Health Intelligence Analyst (item 10.1)
	Lorraine Jeffrey	Independent Associate Hospital Manager
	Stephen Thomas	MCA/MHA Team Manager (Wakefield) – local authority representative

MHAC/16/01 Welcome, introduction and apologies (agenda item 1)

Julie Fox (JF) welcomed everyone to the meeting. The apologies, as above, were noted.

MHAC/16/02 The Act in practice (agenda item 2)

Audits: Consent to treatment, Community Treatment Orders, patients' rights, Section 17 leave, cancellation of leave (agenda item 2.1)

Julie Carr (JC) presented the outcome of a review of audits conducted between 2012 and 2015 for Mental Health Act Section 17 leave, consent to treatment and Community Treatment Orders and the impact of activity undertaken by Mental Health Administrators within BDUs.

Section 17 leave

It was agreed there was sufficient progress to undertake an audit annually and this would be scheduled for November 2016.

Consent to treatment

JF asked for further information on incomplete returns and asked for data, particularly on T2 in Barnsley, to be checked and any explanation included in the report. As a principle, the Committee asked that an explanation of why forms are not returned or are incomplete to be included in audit reports.

Action: Julie Carr

The Committee asked Yvonne French (YF)/JC to review the timing of the audit in 2016, currently scheduled for May, to ensure a spread of audits across the year.

Action: Yvonne French/Julie Carr

Community Treatment Orders
JF commented that the response rate was very poor. Adrian Berry (ABe) questioned whether teams contacted actually have Community Treatment Orders (CTOs) and whether this had an impact on the response rate. JF suggested either undertaking a re-audit or asking internal audit to undertake an independent audit, which would then be received by the Audit Committee. ABe and JC were asked to review the audit and agree action by the end of March 2016 for JF to report into the Audit Committee in April 2016.

Action: Adrian Berry/Julie Carr

August 2016 was suggested as the timing for a re-audit given the work already underway in services.

The recommendations (below) for all audits were noted by the Committee.

- The outcome of all audits will be shared with BDUs.
- Materials to support clinicians' practice will continue to be enhanced.
- Community Treatment Orders, Section 17 leave and consent to treatment audits will be retained on the Committee's annual work plan.
- The Committee considered the focus of each audit to be appropriate.

MHAC/16/03 Legal update/horizon scanning (agenda item 3)

Deprivation of Liberty Standards and 16/17 year olds
The Committee noted the ruling regarding the individual when fifteen years old and then at sixteen, and the standing of parental consent. Trust arrangements for young people under the age of sixteen have been reviewed and the impact is likely to be minimal on mental health services; however, the ruling will have implications for local authorities and for the Trust's children's services.

Care Quality Commission Mental Health Act briefing 2015
The themes and expectations were noted and the Committee also noted that the areas highlighted by the Care Quality Commission (CQC) were already areas the Trust is reviewing and developing.

Deaths of detained patients summary (report by Equality and Human Rights Commission)
JF asked if the Trust could be more proactive with prisons to offer support and training. ABe and Tim Breedon (TB) agreed to consider.

Action: Adrian Berry/Tim Breedon

She also commented that she would like the Trust to have a response to the report. TB suggested mapping the conclusions back to other reports and activities, such as managing aggression and violence, and identify any further action the Trust should take. It was agreed YF would consult the Deputy Director of Nursing and provide a response to the next meeting.

Action: Yvonne French (with Mike Doyle)

Department of Health response to Law Commission consultation on Mental Capacity Act/Deprivation of Liberty Standards
The Law Commission will provide a response to all responses, including the Department's, later in 2016, which will come to the Committee.

Action: Yvonne French

Deprivation of Liberty Standards and guardianship
The outcome of the Upper Tribunal consideration of the Cheshire West decision was noted.

Transfer of prisoners from prisons to hospital briefing note – clarification of procedure under the Mental Health Act 1983
ABe commented that most instances are straightforward although there are occasions when timescales are breached, such as the level of detention between high and medium secure services, which the Ministry of Justice deems to be unacceptable.

MHAC/16/04 Minutes from the previous meeting held on 10 November 2015 (agenda item 4)

It was RESOLVED to APPROVE the minutes from the meeting held on 10 November 2015.

MHAC/16/05 Matters arising from previous meeting (agenda item 5)

The updates contained in the action point list were noted. There were two matters arising.

MHAC/15/37 Physical health monitoring
The paper was noted.

MHAC/15/51 Patient-led assessments of the care environment (PLACE)
The paper was noted. Chris Jones (CJ) suggested a further analysis of the range of 'scores' for privacy, dignity and wellbeing would be useful.

Action: Tim Breedon

MHAC/16/06 Compliance and assurance (agenda item 6)

Mental Health Act Committee annual report to Trust Board (agenda item 6.1)
Annual report 2015/16
It was agreed to include reference to the Committee's awareness of the position with seclusion in the Horizon Centre.

Action: Tim Breedon

CJ commented that he would like to see reference to the impact and evaluation of the work of the Committee and it was agreed to review and accommodate this in the workplan for 2016.

Action: Chair/Dawn Stephenson

It was RESOLVED to APPROVE the draft annual report for 2015/16.

Terms of reference
It was agreed to include reference to measuring impact and evaluation and that this should also be extended to the Clinical Governance and Clinical Safety Committee to demonstrate how the Committees raise issues and where this has improved performance.

Action: Dawn Stephenson

Work programme
The work programme was supported with the amendments to the timing of Mental Health Act audit work agreed under item 2.

Action: Dawn Stephenson

The Chair asked whether there were any other areas it would be useful to include in the work programme. It was suggested that, as 2016/17 is focused on a 'year of delivery', the Committee should receive a summary at each meeting of the four transformation

workstreams (one at each meeting) and the implications for the use of the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Standards using examples.

Action: Tim Breedon/Yvonne French

Alwyn Davies (AD) suggested that another area could be the understanding of doctors of the application of the Mental Health Act in acute Trusts. YF commented that the Trust administers the Mental Health Act in acute Trusts. This could be used as a forum for support and the Trust could also look at provision of training to doctors within acute Trusts. She will discuss this further with AD and the possibility of a presentation to the Committee on the application of the Mental Health Act within acute Trusts with particular reference to psychiatric liaison. YF to provide an update to the next meeting.

Action: Yvonne French

Stephen Thomas (ST) commented on the operational group in Wakefield, which provides a forum to address issues and clarify arrangements/practice in relation to the Mental Health Act. This works well and the Committee suggested this could be replicated elsewhere.

MHAC/16/07 Transformation update (agenda item 7)

TB highlighted the following, which, although they have a minimal impact on the Trust's application of the Mental Health Act, are of interest to the Committee.

- Vanguards – TB will circulate a briefing on the development of Vanguards and the Trust's involvement.

  Action: Tim Breedon
- Suicide Prevention Strategy – to be circulated to the Committee for information.

  Action: Tim Breedon
- Apprenticeships – the paper was noted.
- Mental Health Task Force report – publication was noted.

MHAC/16/08 Audit and compliance reports (agenda item 8)

Consent to Treatment, Section 17 escorted leave and Section 132A Community Treatment Orders were presented under agenda item 1.

Section 136 place of safety

The report was found to be helpful; however, the statistics presented produced a number of questions, which require further analysis, interpretation and benchmarking. It was agreed this should be an annual audit with trend analysis. Specific information related to:

- Wakefield rates and outcomes;
- Kirklees analysis of lower rates;
- impact of street triage;
- whether full information on individuals presenting in crisis are included and an analysis of why Section 136 suites are not used.

The Committee asked that further information comes to the Committee's next meeting.

Action: Julie Carr/Yvonne French

ST asked if the Trust could discuss increasing Section 136 provision with commissioners. TB responded that this was a reasonable request; however, the Trust would need to be able to evidence the increase in demand to support any proposal. TB and ABe were asked to consider the suggestion and an approach, and provide an update to the next meeting.

Action: Tim Breedon/Adrian Berry

MHAC/16/09 Care Quality Commission visits (agenda item 9)

Recent visits (agenda item 9.1)

The three monitoring visits to Chippendale, Newton Lodge, Fieldhead, Wakefield (30 October 2015), Poplars, Pontefract (8 December 2015) and Elmdale, The Dales, Halifax (14 December 2015) were noted. Of interest to the CQC was internet access for patients. Application of this would be challenging for the Trust; however, the principle behind the CQC's interest is understood.

In relation to observation panels in doors on Chippendale, ABe confirmed that observation panels are in place to maintain patient safety. Services have trialled different models and these have been found not to be safe. There is, therefore, a possibility that the Trust will explain to the CQC that the organisation cannot meet this recommendation. ABe was asked to bring an update/progress report to the next meeting with a proposal regarding a way forward.

Action: Adrian Berry

Outstanding actions/progress report (agenda item 9.2)

Clinical issues

Following a detailed review at Clinical Governance and Clinical Safety Committee, it was agreed that Sean Rayner and Karen Taylor would review the responses from services to ensure there is evidence in place to demonstrate that action has been taken and provide assurance to both Committees, that this is included in the report and the RAG rating represents the current position.

Action: Yvonne French (via District Directors)

YF commented that, from quarter 1 2016/17, issues will be reported by BDU with clear responsibility for action within services and with corporate actions remaining the responsibility of the Nursing Directorate. It was agreed that 'green' actions could be removed.

Action: Yvonne French

Environmental issues

It was also agreed at the Clinical Governance and Clinical Safety Committee that, where there is a recommendation relating to wider estate development, this is noted and the recommendation removed from the report.

MHAC/16/10 Monitoring information (agenda item 10)

New format for Mental Health Act statistics (agenda item 10.1)

Mike Garnham (MG) outlined progress to develop Mental Health Act reporting since his presentation to the Committee in November 2015. Further work is needed to ensure there is correlation of information extracted from the Trust's clinical information system, RiO, and that held by performance and information. Development of SharePoint as a platform within the Trust currently may provide a solution, which would also enable external access by colleagues in local authorities. A core development group has been established, involving performance and information, MG and JC and will involve other people as necessary. JF asked for another presentation to the Committee at its next meeting to update on progress.

Action: Julie Carr/Mike Garnham

Monitoring information Trust-wide October to December 2015 (agenda item 10.1a)

The Committee noted that non-disclosure of ethnicity is reducing; however, it remains a concern. Dawn Stephenson (DS) commented that she was unclear what the monitoring information is telling the Committee. JF added that revised reporting arrangements should inform more analysis and annual reporting on ethnicity would be more likely to identify trends

and areas of concern given the small numbers involved. This would then allow the Committee to address the 'so what' factor and agree further action/analysis required.

Tim Breedon left the meeting.

Summary of uses of Section parts 2 and 3 reflects an upward trend of use of the Mental Health Act, which was noted in the CQC annual report.

For Sections 5(2), 5(4) and 4, the Trust is required to monitor the period to complete an assessment between sections. YF and JC will work with MG to review how this can be reported.

Action: Yvonne French/Julie Carr

The Committee also asked that YF identifies areas of the Mental Health Act the Trust is required to report on and provide feedback to the Committee at its next meeting.

Action: Yvonne French

Tim Breedon re-joined the meeting.

Local authority information (agenda item 10.2)

Barnsley

There appears to be an underreporting of assessments and the Committee asked that this is resolved to ensure accurate reporting.

Action: Shirley Atkinson

Wakefield

Better collection rates were reported from Approved Mental Health Professionals (AMHPs). Issues with conveyancing are low due to an agreement with West Yorkshire Police, which is working quite well, work undertaken with Yorkshire Ambulance Service and better bed availability.

Kirklees

JC raised an issue in relation to a ward in Kirklees where there have been instances where the interpretation by staff has meant that patients were not admitted to Trust services under the Mental Capacity Act until an assessment is complete and the individual is detained. The Mental Health Act Code of Practice advises that practice must be in the best interests of patients and guidance will be issued to staff.

Hospital Managers' Forum 23 November 2015 (agenda item 10.3)

The Forum notes from November 2015 were noted. Lorraine Jeffrey (LJ) advised that Gary Haigh and David Knight had both offered to act as the alternative Hospital Manager attendee at the Committee if LJ cannot attend. It was suggested both should be invited to a future meeting.

Action: Chair

LJ also advised that the CQC, as part of its inspection, has asked to meet Hospital Managers on 8 March 2016 and, so far, six people have volunteered.

Compliments/complaints/concerns in relation to the Mental Health Act October to December 2015 (agenda item 10.4)

The report was noted. In relation to the smoking ban, it was noted that, if an individual consents to admission and is not prepared to adhere to the Trust's policy regarding smoking, the Trust would consider this not to be an informal admission

Hospital Managers' concerns (agenda item 10.5)
YF agreed to follow up the concern in relation to the absence of a plan for the eventuality of the patient being discharged (page 3) and LJ asked that this is also escalated within services.

Action: Yvonne French

MHAC/16/11 Partner agency update (agenda item 11)

Local authority (agenda item 11.1)
No further items were raised.

Acute health care (agenda item 11.2)
No further items were raised.

AD advised that this was his last meeting and he would ensure another acute Trust representative was identified.

Action: Alwyn Davies

MHAC/16/12 Key messages for Trust Board (agenda item 12)

The key issues to report to Trust Board were agreed as:

- the positive audit reports and areas to be followed up;
- the CQC annual mental health briefing, which highlights a number of areas already in train for the Trust;
- the inclusion of transformation in the workplan for 2016.

MHAC/16/13 Date of next meeting (agenda item 13)

The next meeting will be held on Tuesday 17 May 2016 at 14:00 in the Boardroom, Kendray, Barnsley.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Strategic overview of business and associated risks

Trust Board 28 April 2016

Key issues

External Environment

- National picture
- Local Commissioners
- Local Providers

Internal Environment

- Performance
- Delivery of Annual Plan
- Transformation
- RiO
- CQC

External Environment

- National and regional
- National financial position Provider Sector out turn - keep within the £1.8 billion deficit forecast for 2015-16
- Issuing of control totals and share of transformation funding follow up from 8 Feb submission
- No additional transformation funding for mental health and community trusts .
- Similar approach from number of local MH Trusts to agreement of control totals
- 25 April national deadline set for contracts to be agreed otherwise default into arbitration.
- Early call with NHS Improvement re plan submission indicates more control exerted for example on capital spend.
- Vanguard allocations for 2016-17 – reduced funding available

Local Commissioners

- CCG contracts agreed additional investment in CAMHS , IHBTT in Calderdale ; police liaison and Early Intervention in Psychosis . Some unfunded cost pressures in CAMHS
- Wakefield Vanguards – MCP vanguard allocated 75 % of funding – includes Mental health Liaison workers in integrated hubs and Telehealth offer . Care Home Vanguard £300k funding includes Portrait of a life training in care homes
- Calderdale CCG Value proposition funding allocation for 2016-17 significantly reduced – working through impact on bid proposal and how the joint venture between community provider (CHFT) and GP federation will impact on commissioning of integrated service model
- Urgent care Vanguard West Yorks – Workstreams progressing need to integrate approach into Sustainability and Transformation Plan . Allocation received again lower than original bid.
- 0-19 Barnsley local authority discussions progressing
- Barnsley creation of Accountable Care System Board

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South West Yorkshire Partnership NHS
NHS Foundation Trust

Sustainability and Transformation Plans (STP)

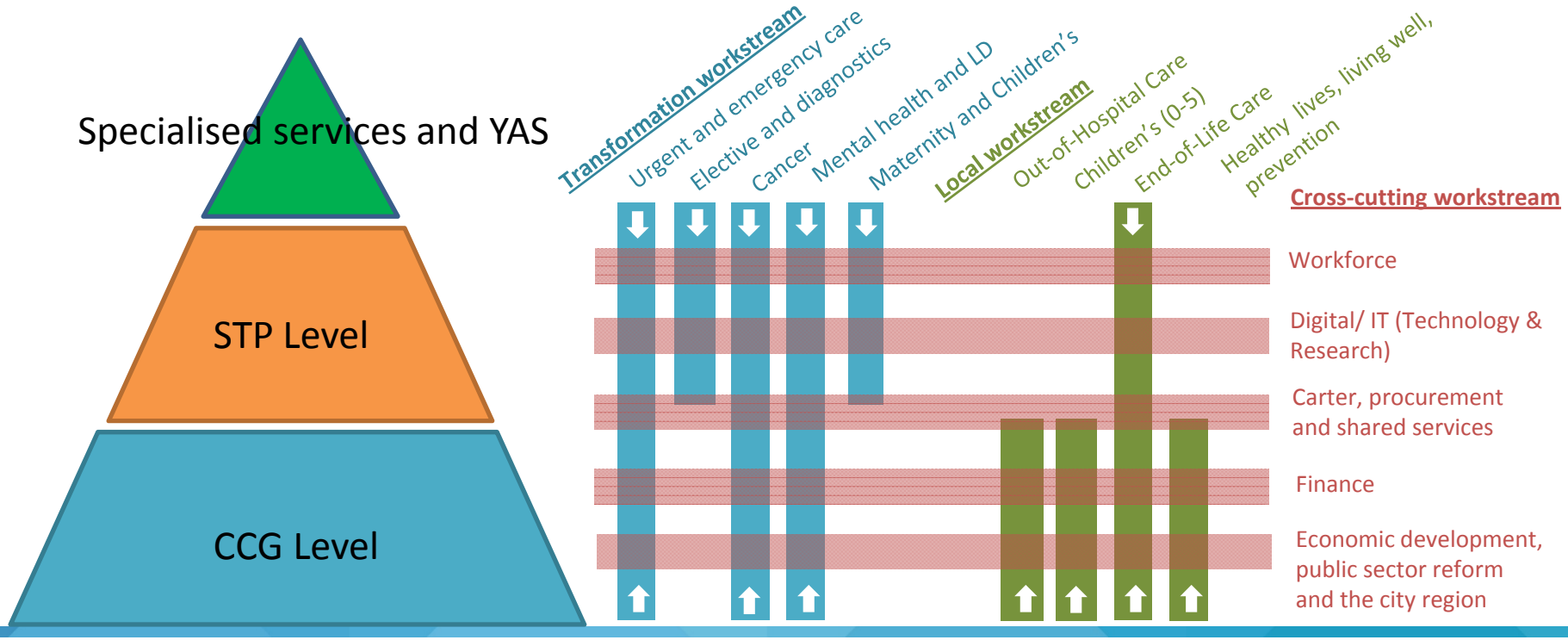
- Geographical coverage – West Yorkshire and South Yorkshire
- Similar approaches – Place based plans for Primary care and out of hospital care ; Key service and cross cutting themes.
- West Yorkshire key themes :include Mental Health ; Urgent Care , Cancer
- South Yorkshire key themes – Urgent Care; Elective and Diagnostics; Cancer ; Mental health and LD; Maternity and Childrens.
- Common cross cutting themes workforce ; digitisation ; finance
- Governance submission 15th April
- Final submission 30 June – needs appropriate sign of through governance of each contributor organisation

NHS

Workstream structure South Yorkshire

- Cross-cutting workstreams will cut across both local and transformation workstreams and there will be coordination between STP and CCG level planning, to ensure that synergies are exploited and to reduce duplication
- These workstreams will enable us to respond to priorities across the footprint and the STP's triple aims

Workstream type*	Definition
Transformation workstreams	Primarily 'top down' from an STP level, with some contribution from 'bottom-up' CCG-level planning
Local workstreams	Primarily 'bottom up' from a CCG-level, with some contribution from 'top-down' STP level planning
Cross-cutting workstreams	Workstreams primarily focused on enablers which 'cross-cut' intersect with local and transformation workstreams



Local Providers

- Barnsley hospital no longer in turnaround – impact of the STP for South Yorkshire .
- CHFT - consultation on hospital configeration with Calderdale as site of acute and emergency care
- Mid Yorks changes in senior staff – CEO and Director of Finance
- Continued development of GP federations – developing proposal for MCP in Barnsley in accountable care organisation model
- Continued work with third sector in Wakefield on H& WB model and local authority on integrated MH teams

Impact on risk

- Overall financial position is deteriorating nationally and heightened response and control from centre
- 2016-17 awaiting outcome of arbitration and impact on local commissioners . Additional investment linked to improved delivery in particular CAMHS.
- Strategic Transformation Plan – Mental health a priority in both regions .
- Local Authority financial position and impact on integrated teams
- Impact of national drive for “accountable care organisations “ re locality focus and potential to influence and reduced funding available locally for Vanguards.

Internal Environment

Performance in year

- Waiting times IAPT and Early Intervention in psychosis
- Management of Information Governance issues

Implementation of Annual Plan

- Monitoring CIP delivery
- Control of cost pressures – agency , out of area
- Management of run rate
- Implementation of red rated CIP schemes
- Management of acute bed base – pressures on recruitment
- CAMHS – improvement on access - external review by Children's society and Healthwatch Wakefield

Internal Environment

Transformation

- Implementation of Learning Disabilities model
- Consultation for acute and community mental health model
- Review of older peoples workstream including Meridian recommendations
- General Community – incorporate new model into Accountable care work in Barnsley
- Pricing strategy needs to underpin this and provide some transparency and stability in levels of funding
- Workforce plans also key in supporting new service models

Internal Environment

RiO Upgrade

- Classed as serious incident
- Key remaining issue is intermittent loss of access by users which leads to work not being saved
- Internal investigation to be completed by end of April
- External investigation underway to report in May
- Continued dialogue with supplier
- Additional training resource commissioned
- Reviewing impact on data collection and central submissions
- Relaunch plan post external review to refocus on benefits and ensuring functionality

Internal Environment

Key Internal risks

- Sustainability of CIP delivery .
- Achieving CQUIN income linked to achievement of KPIs linked to mental health currency
- Alignment of transformation work with requirements of annual plan and STP e.g. testing sustainability of model ; deliverability of model and pace of change required ;financial impact ; engagement of workforce in developing new roles and new ways of working.
- Ensuring appropriate focus and participation in multiple transformation activities across system
- Managing Impact of bid activity and mobilisation on day to day services particularly on CAMHS and forensics

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South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 28 April 2016
Agenda item 7

Title:	**Audit Committee annual report to Trust Board 2015/16**
Paper prepared by:	Chair of Audit Committee
Purpose:	The purpose of this paper is to provide assurance to Trust Board that its Committees operate effectively and meet the requirements of the terms of reference.
Mission/values:	A strong and effective Board and Committee structure enables the Trust to achieve its vision and goals, and maintain a sustainable and viable organisation.
Any background papers/ previously considered by:	The Audit Committee received annual reports from Trust Board Committees as well as considering its own report at its meeting on 5 April 2016.
Executive summary:	The Audit Committee is required under its terms of reference to review other risk Committees' effectiveness and integration to provide assurance to Trust Board that: - risk is effectively managed and mitigated within the organisation; - Committees are fulfilling their terms of reference; and - integration between Committees avoids duplication. The Committee agreed to combine this process with the production of the Annual Governance Statement (AGS). Trust Board Committees are responsible for scrutiny and providing assurance to Trust Board on key issues within their terms of reference. Agendas are set to enable Trust Board to be assured that scrutiny processes are in place to allow the Trust's strategic objectives to be met, and to address and mitigate risk. As part of this process of assurance to Trust Board and as part of development of the AGS annually, Trust Board Committees are required to produce an annual report and an annual workplan, undertake an annual self-assessment, and review their terms of reference for relevance and appropriateness. The Audit Committee received the annual report and work programme from each Committee at its meeting on 5 April 2016, supported by a short presentation from each Committee Chair and Lead Director to provide assurance to the Committee on the assurance each Committee has provided to Trust Board in terms of meeting its terms of reference, in identifying and mitigating risk, and in integrating with other Committees. A summary is contained in the Audit Committee annual report. The individual Committee annual reports and work programmes have been approved by the relevant Committee and were presented to the Audit Committee. These are available for Trust Board if required. Overall the review of the documents and presentation of the work of the Committees was sufficient to enable the Chair of the Audit Committee to

	support an assurance to Trust Board that the integrated governance arrangements in the Trust were operating effectively and that Committees: ➢ had met the requirements of the Terms of Reference; ➢ had followed a workplan aligned to the risks and objectives of the organisation, within the scope of its remit; and ➢ could demonstrate added value to the organisation. Trust Board approved changes to the terms of reference for the four risk Committees of the Board at its meeting on 29 March 2016.
Recommendation:	**Trust Board is asked to RECEIVE the annual report from the Audit Committee and to SUPPORT the view that the Committee can provide assurance that, in terms of the effectiveness and integration of risk Committees, risk is effectively managed and mitigated through assurance that:** - **Committees meet the requirements of their Terms of Reference;** - **Committee workplans are aligned to the risks and objectives of the organisation within the scope of their remit; and** - **Committees can demonstrate added value to the organisation.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Audit Committee Annual Report 2015/16
Presented to Trust Board 28 April 2016

1. Purpose of report

The purpose of the report is to provide a summary of the Committee's activities during the financial year 2015/16 to provide assurance and evidence to Trust Board of its effectiveness and impact through compliance with its Terms of Reference.

2. Terms of reference and Committee duties

The Audit Committee is a formal Committee of Trust Board, which provides the Board with assurance that the Trust is discharging its responsibilities in relation to the following.

- The establishment and maintenance of effective systems and processes that provide internal control within the organisation, particularly, review of all risk and control related disclosure statements, such as the Annual Governance Statement and value for money audit opinion.
- The effectiveness of the governance arrangements that cover evidence of achievement of corporate objectives and the adequacy of the assurance framework.
- The effectiveness of policies and processes to ensure compliance with regulatory frameworks, including Monitor's risk assessment framework.
- The effectiveness of systems of internal control for the management of risk including the risk strategy, risk management systems and the risk register.
- The effectiveness of policies and procedures to prevent and manage fraud and compliance with regulatory requirements monitored through the Counter Fraud and Security Management Service.
- Overview of the work of other Committees to provide Trust Board with assurance in relation to the overall effectiveness of governance arrangements through the committee structure.

<u>Changes to Committee terms of reference</u>

In January 2015 at the request of the Committee, it received a presentation from Deloitte on Audit Committee effectiveness and best practice. There were a number of minor points of best practice in relation to the Committee terms of reference.

1. Stronger narrative around scrutiny of the effectiveness of control arrangements and arrangements for staff to confidentially raise concerns.
2. Statement on the responsibility to develop and implement a policy on the provision of non-audit services.
3. Clarifying the Committee's role and relationship with the Members' Council, as articulated in Monitor's Code of Governance.

The changes were supported by Trust Board in September 2015 and approved by the Committee in February 2016. Formal approval of the changes was given by Trust Board in March 2016.

<u>Reporting to Trust Board</u>

Under its terms of reference, the Audit Committee is required to produce a brief annual report on its activities, which is presented formally to Trust Board. The Committee's minutes are presented to the Trust Board following each meeting.

Membership

The Committee is made up of Non-Executive Directors and members from April 2015 to March 2016 were Peter Aspinall (April 2015), Laurence Campbell (Chair), Chris Jones (from October 2015) and Jonathan Jones. In agreement with the Chair of the Trust, there were two members of the Committee for the period May to October 2015 due to the timing of Non-Executive Director appointments.

3. Review of Committee activities

The Committee's activities during the year have been cross referenced to its Terms of Reference.

3.1 Governance, risk management and internal control

The Committee shall review the establishment and maintenance of effective systems and processes that provide internal control within the organization.

Review all risk and control related disclosures, in particular, the Annual Governance Statement and declarations of compliance with value for money assessments together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances. Review underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of management of principle risks and the appropriateness of the disclosure statements (above), including the fitness for purpose of the assurance framework.	**Progress** As part of its consideration of the annual report, accounts and Quality Accounts, the Committee received and approved the Chief Executive's Annual Governance Statement for 204/15. The Committee also received the statement from external audit for those with responsibility for governance in relation to 2014/15 and the Head of Internal Audit opinion. The Committee was presented with the external audit plan in February 2016. Significant audit risks were outlined as follows. - Revenue recognition in respect of Commissioning for Quality and Innovation (CQUIN) income. - Property revaluation. - Laura Mitchell House and New Street brought into use. - Management override of controls (it was noted that the Interim Director of Finance was content that this was highlighted as a risk; however, the Trust will retain a prudent approach to its accounting practice). - Agresso software upgrade (following the issues with the implementation of the upgrade to the Trust's clinical information system, RiO, the upgrade has been deferred to June 2016. It will not, therefore, be identified as a risk in 2015/16; however, Deloitte will review the risk posed by the issues encountered during the implementation of RiO V7 and the potential impact on the Agresso upgrade). These were noted by the Committee and the Trust's annual report will specifically outline the management action to address these risks, explaining the mitigating action in place to address the risks or, where appropriate, an explanation as to why the Trust does not consider these to be risks, and explaining its tolerance of any residual risk. Three areas of potential risk were identified in

	Progress
	relation to value for money in terms of the contractual relationships in respect of interim senior staff, the outcome of the forthcoming Care Quality Commission inspection and delivery of the transformation programme (Deloitte will review the outcome of the internal audit work on the transformation programme to inform its opinion). The Committee receives an annual report on the process to develop the Assurance Framework, which is presented quarterly to Trust Board.
Review policies and processes for ensuring compliance with relevant regulatory, legal or code of conduct requirements, including the Monitor risk assessment framework.	The Committee reviews the processes to meet the external agencies policy. This has been scheduled into the Committee's work plan in July 2016 following a review of the policy by the Director of Nursing.
Review the systems for internal control, including the risk management strategy, risk management systems and the risk register.	*Consideration and approval of the Trust's risk management strategy is a matter reserved for Trust Board and the organisational risk register is reviewed quarterly by Trust Board.* The Committee receives a report at each meeting on the triangulation of risk, performance and governance, which provides assurance that all key strategic risks are captured by the risk management process, that risks are appropriately highlighted and managed through governance committees and operational meetings, and there is a clear link between risk management and identifying areas of poor performance by the cross-reference of performance reporting to the risk register. The Committee finds this report particularly helpful in supporting scrutiny of performance and risk through Trust Board.
Review the policies and procedures for all work related to fraud and corruption as set out in the Secretary of State's directions and as required by the Counter Fraud and Security Management Service.	See section 3.3.
Review the work of other Committees whose work can provide relevant assurance regarding the effectiveness of controls and governance arrangements.	See section 4.2.
Review the arrangements that allow Trust staff to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety and other matters.	The Committee received a presentation from the Director lead for 'whistleblowing' arrangements in October 2015. The Committee took assurance on the arrangements in place within the Trust to enable staff to raise issues and concerns and that the variety of ways for staff to do this reflects the Trust's desire to be open and transparent encouraging staff to raise issues and concerns in a timely and effective way through a variety of methods they are comfortable with and confident in. The Director lead was invited to return to the Committee in October 2016 with an update, including any monitoring information.

3.2 Internal Audit

The Committee shall consider the appointment of the internal auditor (for approval by Trust Board) and ensure that there is an effective internal audit function, established by

management, that meets NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chair, Chief Executive and Trust Board.

	Progress
Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.	The Committee agreed an extension to the contract for KPMG as the Trust's internal auditors for one year (to 30 June 2016) and has considered its approach to internal audit and counter fraud services beyond this date. In February 2016, the Committee approved a further extension to KPMG's contract to 30 June 2017 given the changes within the organisation at a senior level and the desire to minimise unnecessary risk to the Trust. Under the Public Sector Internal Audit Standards, all internal audit service providers are required to develop an internal audit charter, which is a formal document that defines the activities, purpose, authority and responsibilities of internal audit at the Trust. It also ensures the internal audit service provided to the Trust meets the requirements of both Professional Internal Auditing Standards and KPMG's own Internal Audit Manual. This was approved by the Committee in July 2015.
Review and approval of the Internal Audit strategy, programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.	The Internal Audit Annual Plan for 2015/16 was presented to and approved by the Committee in April 2015. The plan provides a risk-based analysis of the Trust's operations, utilising the Trust Board assurance framework, reflecting the Trust's corporate objectives, priorities and areas identified for improvement. Progress against the plan is reviewed at every meeting and this includes reports on the Trust's progress against actions identified to address recommendations made by internal audit. Regular meetings are held with the Director of Finance to monitor progress against the work plan.
Consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources.	The Committee receives audit reports and audit findings in line with the audit plan. The recommendations are followed up to ensure actions are taken in line with the action plans agreed. From April 2015 to February 2016, thirteen internal audit reports were presented to the Committee. Of these, there were: - two significant assurance opinions; - six significant assurance with minor improvement opportunities; - four partial assurance reports (management of service level agreements, information governance toolkit (phase I), patients' property follow up and bed management); and - no 'no' assurance opinion. An opinion for the audit of quality improvement was taken in two parts. The Quality Improvement Strategy received an opinion of significant assurance with minor improvement opportunities and data quality received a partial assurance opinion.

	Progress Management action has been agreed for all recommendations. These are reported to the Committee and, where appropriate, progressed by KPMG. In the main, there are no significant outstanding actions; however, the Committee has an ongoing concern regarding data quality within the Trust. At its request, the Committee received a presentation from the Deputy Director of Nursing in October 2015 to seek assurance that the Trust has taken sufficient and adequate management action to improve the quality of clinical information. A further update was provided to the Committee in February 2016. The Committee was assured by both presentations but this will remain as an item on the Committee's agenda. The Committee also asked the Executive Management Team to review the findings of the patients' property audit to ensure ownership and improvement given the concerns raised by the Chair of the Committee at the meeting in October 2015. An update on progress to implement the recommendations was provided to the Committee in February 2016. The Committee appreciated the positive response and noted there were a few additional areas still to address. It was suggested a return visit by internal audit in three months. The Audit Committee reviewed and received the Head of Internal Audit Opinion as part of the final accounts process for 2014/15. This provided significant assurance with minor improvement opportunities.
Ensure the Internal Audit function is adequately resourced and has appropriate standing in the organisation.	The ongoing adequacy of resources is assessed as part of the review of the internal audit plan and monitoring progress. No significant issues have been raised in-year although there are some residual issues raised by the Director of Finance in relation to the scoping and planning of audit work.
An annual review of the effectiveness of internal audit.	KPMG has identified a number of performance areas against which the Committee can assess its performance. Performance against these is reported to the Committee through the internal audit progress report at each meeting and a summary included in the internal audit annual report, received in May 2015.

3.3 Counter Fraud

The Committee shall review the policies and procedures for all work related to fraud and corruption as set out in the Secretary of State's directions and as required by the Counter Fraud and Security Management Service. The Committee shall also review the work and findings of the Local Counter Fraud Specialist as set out in the NHS Protect Standards for Providers and as required by NHS Protect.

	Progress
Consideration of the appointment of the Trust's Local Counter Fraud Specialist, the fee and any	See 3.2 above. The Trust's contract for internal audit services with KPMG includes provision of

	Progress
questions of resignation or dismissal.	counter fraud services.
Review the proposed work plan of the Local Counter Fraud Specialist ensuring that it promotes a pro-active approach to counter fraud measures.	KPMG presented a programme of work to the Committee in April 2015, which was approved. The Committee receives a Counter Fraud update report at each meeting to identify progress and any significant issues for action. The Trust undertook a self-assessment against NHS Protect's Standards for Providers, the outcome of which was reported to the Committee in July 2015. The Trust achieved an amber rating, which demonstrates that the Trust meets the standards and had no red ratings. The review had been cross-referenced with the external assessment reported in October 2013 and there was only one area of potential mis-match in relation to proactive liaison with other organisations and agencies. The Trust will raise with NHS Protect the question of whether it could be included in NHS Protect protocols with other organisations. The outcome against the standards has also been used as a baseline to prioritise counter fraud activity supported by responses to the staff counter fraud awareness survey, which will be built into the counter fraud annual plan. In February 2016, the Committee received a further update following a review by KPMG. In the main, the ratings remain as in July 2015 with no red ratings. An action plan is in place, which will be monitored by the Committee during 2016.
Receive and review the annual report prepared by the Local Counter Fraud Specialist.	The Committee received an annual report for 2014/15 in July 2015.
Receive update reports on any investigations that are being undertaken.	These are included in the progress reports to the Committee.

3.4 External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Members' Council and consider the implications and management's responses to their work.

	Progress
Consideration of the appointment and performance of the External Auditor, as far as Monitor's rules permit.	Following a re-procurement exercise during 2015, the Members' Council approved a proposal to re-appoint Deloitte as the Trust's external auditor from 1 October 2015 for a period of three years. The Lead Governor for the Members' Council was involved in the tender process.
Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Audit Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy.	The Audit Committee has received and approved the Annual Audit Plan (February 2016). Progress against the plan is monitored at each meeting.
Discussion with the External Auditors of its local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.	The fee for Deloitte was approved as part of the re-appointment process in 2015. A formal audit plan was presented to and approved by the Committee in February 2016. This included an evaluation of risk, which is summarised under section 3.1 above.
Review of External Audit reports, including agreement of the annual audit letter before	The Audit Committee received and approved: - the statement for those with responsibility for

submission to Trust Board and any work carried on outside of the annual audit plan, together with the appropriateness of management responses. Develop and implement a policy on the provision of non-audit services by the External Auditor.	**Progress** governance in relation to 2014/15 accounts; - final reports and recommendations as scheduled in the annual plan. This is scheduled for development and presentation to the Committee in July 2016.

3.5 Financial reporting

The Committee has responsibility for approving accounting policies.	**Progress** The Committee considered and approved minor changes to accounting policies at its meeting in February 2016. These changes were supported by the Trust's external auditor.
The Committee has delegated authority from Trust Board to review the annual report and financial statements, both for the Trust and charitable Funds, and the Quality Accounts/Report and to make a recommendation to the Chair, Chief Executive and Director of Finance on the signing of the accounts and associated documents prior to submission.	The Committee approved the annual report, accounts and Quality Accounts at its meeting on 22 May 2015 prior to submission to Monitor. This included the Trust's charitable funds. The Committee also approved the stand-alone annual report and accounts for charitable funds in October 2015. As part of the consideration of the auditor's report, the Committee received and reviewed the Use of Resources Assessment for 2014/15. The Committee also reviewed the external audit report on the production of Quality Accounts for 2014/15. *(It should be noted that the scrutiny of the preparation, development and final content of the Quality Accounts is the responsibility of the Clinical Governance and Clinical Safety Committee.)*
The Committee also ensures that the systems for, and content of, financial reporting to Trust Board are subject to review so as to be assured of the completeness and accuracy of the information provided.	The internal audit programme includes routine testing of the Trust's financial reporting systems; however, financial reporting and scrutiny remains with Trust Board, including any review of the adequacy of reporting. The Committee receives a regular report on treasury management and reviews the Treasury Management Strategy and Policy on an annual basis (February 2016). The Committee also receives a detailed report on procurement activity, which monitors non-pay spend and progress on tenders, and progress against the Procurement Strategy and associated cost improvement programme. The Committee's agenda includes a standing item to review progress towards implementation of service line reporting and currency development. This has included assurance on operational implementation and use from BDU Directors as well as, in October 2015, a review of the Trust's approach to pricing, which was supported by the Committee. The Committee is also required, on behalf of Trust Board, to approve the methodology for determining the Trust's reference cost submission. This was considered at its meeting in April 2015. The Committee asked for further assurance regarding the data used to compute the costs and was assured regarding the principles and standards. A further report on the

	Progress work to improve the quality of clinical data was received in October 2015. Although the Committee has residual concerns regarding data quality, it has been reassured with regard to the management action in place. The Committee received and reviewed the Use of Resources Assessment for 2014/15.
The Committee also: - reviews proposed changes to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation;	The Committee received a proposal relating to the Scheme of Delegation following a concern that levels of approval and escalation in relation to procurement and tendering appear to be low in value in comparison with other NHS organisations. The Committee supported the conclusion form the Interim Director of finance that there will not be any recommendation to change the current position as it does not cause major difficulties in terms of Trust processes. The Committee will receive a formal paper to endorse this approach in April 2016. There is an ongoing review of the overarching Scheme of Delegation, which will be presented to Trust Board in April 2016 for approval. Any resultant impact on the Trust's Standing Orders, Standing Financial Instructions and Constitution will be presented to Trust Board for approval.
- examines circumstances associated with each occasion Standing Orders are waived;	There were no occasions when Standing Orders were waived in 2015/16.
- reviews the schedules of losses and compensations on behalf of Trust Board.	The losses and special payments report is received by the Committee at each meeting.

4. Governance Assurance

4.1 Review of Audit Committee effectiveness

Each Committee has Terms of Reference and is required to produce an annual report outlining achievements against objectives and compliance with Terms of Reference. The Committee reviewed a first draft of its own annual report, work programme and terms of reference at its meeting in February 2016. The work programme was approved and changes to the Committee terms of reference recommended to Trust Board for formal approval.

4.2 Audit Committee review of the effectiveness of Trust Board Committees

In April 2010, the Audit Committee agreed an approach and process to fulfilling its role to provide oversight and assurance to Trust Board on the effectiveness of the other sub-committees of the Board.

The Committees assumed within scope of the Audit Committee review are:

- Clinical Governance and Clinical Safety Committee;
- Mental Health Act Committee; and
- Remuneration and Terms of Service Committee.

The Audit Committee reviewed Committee annual reports, annual work programmes and the outcome of self-assessments on 5 April 2016 for 2015/16. The purpose of the review is for the Audit Committee to provide assurance to Trust Board that:

- each Committee meets the requirements of its Terms of Reference;
- each Committee's workplan is aligned to the risks and objectives of the organisation, which are in the scope of its remit;
- each Committee can demonstrate added value to the organisation.

The review was undertaken as part of formal Audit Committee business with Committee Chairs and key Committee members invited to present to provide assurance to the Audit Committee on the assurance each Committee has provided to Trust Board in terms of meeting its terms of reference, in identifying and mitigating risk, and in integrating with other Committees.

Audit Committee

Chair – Laurence Campbell; Lead Director – Alex Farrell (to 4 January 2016)/Jon Cooke (from 4 January 2016)

- The Committee met its Terms of Reference and developed a work plan to reflect the risks and objectives of the organisation.
- A small number of changes to the Committee's terms of reference were approved by Trust Board in March 2016.
- In his role as Audit Committee Chair, Laurence Campbell has attended meetings of all Committees during the year to facilitate integration and to receive assurance.
- The Committee led the tender process for the appointment of the Trust's auditor, which resulted in the re-appointment of Deloitte from 1 October 2015. The Committee also approved an extension to the contract for internal audit, provided by KPMG, for a further year.
- Training is a recurring theme from the annual self-assessment and the Committee will take the opportunity in the coming year to consider the form this should take with support from internal and external audit.

Clinical Governance and Clinical Safety Committee

Chair – Julie Fox *(NB Helen Wollaston was Chair of the Committee to 1 August 2015)*; Lead Director – Tim Breedon

- There has been a focus during the year on quality improvement.
- Directors sitting on the Committee have continued to bring regulatory issues and national developments and reports to the Committee setting out the implications and risks.
- Key service issues scrutinised by the Committee during the year included improving access to psychological therapies, transformation, child and adolescent mental health services, a review of services at the Horizon Centre and the Care Quality Commission inspection visit.
- The self-assessment identified two areas for focus relating to induction for new members and facilitating links with the Audit Committee. This will be supported by the availability of Committee papers to all members of Trust Board following the move to a paperless system.
- A clear plan of work is in place for 2016/17.
- Further work will be considered to assess the cost of and resources available to Committees.

Mental Health Act Committee

Chair – Julie Fox; Lead Director – Tim Breedon

The Committee's agenda is informed by two main areas.

- The Act in practice ensures the Committee is aware of matters, mostly external, that impact on the Trust.
- Compliance and assurance provides a focus on the application of the Act within the Trust and improvements have been seen in some areas. There are also some areas where the Committee has asked for re-audits to be undertaken within six months.

Other highlights were reported as follows.

- The gap in ethnicity recording remains a concern and the Committee has asked for further work to be undertaken in this area.
- Development of data reporting and its presentation to the Committee has continued through the year with the support of the Health Intelligence and Innovation Team. The coming year will see further developments to include analysis of Mental Health Act statistics.
- Good relationships continue with Associate Hospital Managers and the Chair of the Hospital Managers' Forum attends the Committee on a regular basis. The Chair of the Mental Health Act Committee is also invited to and attends Forum meetings.

In terms of the Care Quality Commission inspection visit, the following were noted.

- The connectivity between the Clinical Governance and Clinical Safety, and Mental Health Act Committees was noted.
- Although there are instances of overlap in items considered by both Committees, there is a clear difference in remit and approach, which provides a different viewpoint of areas such as Care Quality Commission Mental Health Act visits.
- The Care Quality Commission understood how Committees operate and appreciated the significant benefits of ensuring that all members of Committees understand the context, for example, through presentations from clinicians on the application of the Mental Health Act.

Remuneration and Terms of Service Committee
Chair – Ian Black; Lead Director – Alan Davis
Six key areas were highlighted for 2015/16.

- Directors' remuneration arrangements and performance related pay. A high bar was set for 2015/16 and included a requirement to achieve a rating of 'good' or above from the Care Quality Commission inspection before any payment can be made.
- Two major executive director appointments (Chief Executive and Director of Finance) were overseen by the Committee as well as interim arrangements for both posts.
- Cost savings realisable from Quality Academy synergies and the administration and management review.
- Oversight of the Clinical Excellence Awards, which are set against local criteria with the emphasis that any award must be for performance over and above the expectations of a competent doctor.
- Workforce issues, in particular, staff engagement and leadership and management strategies, staff wellbeing survey, and performance and exception reports, particularly in relation to sickness absence.
- Review of Directors' contracts in relation to the Fit and Proper Persons' Test.

As part of the review of terms of reference, both the Clinical Governance and Clinical Safety, and Mental Health Act Committees have included a requirement to assess, measure and evaluate their impact, both quantitatively and qualitatively, and include the outcome of this in the annual report to the Audit Committee and to Trust Board. This was approved by Trust Board in March 2016. It was also suggested this should be replicated for the Audit and Remuneration and Terms of Service Committees.

Overall the review of the documents and presentation on the work of the Committees was sufficient to enable the Chair of the Audit Committee to support an assurance to Trust Board that the integrated governance arrangements in the Trust were operating effectively and that Committees:

- had met the requirements of their Terms of Reference;
- had followed a workplan aligned to the risks and objectives of the organisation, within the scope of each Committee's remit; and
- could demonstrate added value to the organisation.

4.3 Independent review of the Trust's governance arrangements

In 2014, Monitor stated its expectation that all foundation trust boards would carry out an external review of their governance arrangements every three years given that:

- good governance is essential in addressing the challenges the sector faces;
- oversight of the Trust's governance arrangements is the responsibility of Trust Board;
- governance issues are increasing across the sector; and
- regular reviews can provide assurance that governance arrangements are fit for purpose.

As a result, Monitor issued guidance to support Trusts in ensuring they are 'well-led'. The framework supports the NHS response to the Francis Report and is aligned with the assessment the Care Quality Commission makes on whether a foundation trust is well-led as part of its revised inspection regime. The framework has four domains, ten high-level questions and a description of 'good practice' that can be used to assess governance. The four domains cover:

- strategy and planning – how well the Board sets the direction for the organisation;
- capability and culture – whether the Board takes steps to ensure it has the appropriate experience and ability, now and into the future, and whether it positively shapes the organisation's culture to deliver care in a safe and sustainable way;
- process and structures – whether reporting lines and accountabilities support the effective oversight of the organisation; and
- measurement – whether the Board receives appropriate, robust and timely information and that this supports the leadership of the Trust.

Following a decision by Trust Board to undertake an independent review of the Trust's governance arrangements in line with Monitor's well-led framework for governance reviews, Deloitte was appointed to undertake the review in April 2015. Trust Board's decision to undertake an independent review at this time is part of the developmental approach the Board takes to its governance arrangements and will ensure fitness for purpose in the move to the next challenging phase.

Following a robust and thorough review and scrutiny of the Trust's governance arrangements, which included interviews and focus groups with Trust Board, key stakeholders, the Members' Council and staff, the review concluded with presentation of the key findings to Trust Board on 21 July 2015. This was followed by a workshop with the Members' Council on 21 September 2015.

There were no 'material governance concerns' arising from the review. Out of the ten areas assessed, two areas were rated as green (in relation to Board engagement with patients, staff, governors and other stakeholders, and the Board having the skills and capability to lead the organisation) and eight as amber/green. There are a number of developmental areas where Deloitte has recommended further work and these form the basis of an action plan with timescales, which Trust Board will take forward. It is anticipated that all actions will be complete by April 2016 and internal audit will undertake a review of implementation as part of its audit work for corporate governance arrangements in 2016.

The process and outcome reflect the developmental approach taken and Trust Board is satisfied with the outcome. The Deloitte report very much reflects Trust Board's own

assessment of the Trust's arrangements and the report provides a series of helpful and constructive recommendations. As required, the Chair formally wrote to Monitor with the outcome of the review on 3 September 2015.

5. Review of Committee administrative arrangements

The Committee meets the minimum requirement for the number of meetings in the year and has been quorate at each meeting. The requirement to send papers out six clear days in advance of the meeting has been met throughout the year. There have been some instances where individual papers have, with agreement, been sent out after this requirement.

6. Self-assessment

In line with the Terms of Reference, the Committee has an agreed self-assessment process. The proforma used is that recommended by the Audit Committee Handbook. The self-assessment has eight sections:

- composition, establishment and duties;
- compliance with the law and regulations governing the NHS;
- internal control and risk management;
- Internal Audit;
- External Audit;
- Annual Accounts;
- administrative arrangements
- other issues

From the feedback received the majority of areas were assessed as compliant. The key comments/findings were as follows. The responses will be considered by the Committee later in the year and any action agreed as a result.

<u>Composition, establishment and duties</u>

Has the Committee been provided with sufficient membership, authority and resources to perform its role effectively and independently?

Short-term reduction in members now addressed (see above under section 2).

Are members, particularly those new to the Committee, provided with training?

No specific training received.

The Trust could do more on this through external and internal auditors.

<u>Compliance with the law and regulations governing the NHS</u>

Has the Committee formally assessed whether there is a need for the support of a 'Company Secretary' role or its equivalent?

This was questioned by a new member to the Committee.

The Company Secretary role sits within the portfolio of the Director of Corporate Development. It should be noted that Trust Board considered this as part of its application for Foundation Trust status and during a review of its arrangements as a result of the transfer of services under Transforming Community Services.

<u>Internal audit</u>

Are any scope restrictions placed on internal audit and, if so, what are they and who establishes them?

Comment made that the scope is agreed with the Chair of the Committee at the beginning of each year.

Are the key principles of the terms of reference set out in the Standing Financial Instructions?

This was questioned by one member.

The role of internal and external audit is set out in the Trust's Standing Financial Instructions; however, as part of the ongoing review, this will be reviewed to ensure it reflects the current scope of the auditors' remit and Committee terms of reference.

7. Conclusion

In summary, the Annual Report of the Audit Committee can evidence the Committee has discharged its responsibilities in relation to its statutory obligations and Terms of Reference. This includes providing the Board with assurance on the effectiveness of other Committees which is part of the Audit Committee role in supporting Integrated Governance.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Quality Performance Report

Strategic Overview

March 2016

Table of Contents

	Page No
Introduction	4
Quality Headlines	5 - 6
Compliance	7 - 8
Strategic Overview Dashboard	9 - 10
Finance - Overall Financial Position	11
Contracts - Trust - BDU	12
MH Currencies Development	13 - 14
Workforce	15 - 17
Publication Summary	18 - 19
Glossary	20

Introduction

Dear Board Member/Reader

Welcome to the Trust's Integrated Performance Report: Strategic Overview for March 2016 information unless stated. 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.

The Trust continues to improve its performance framework to deliver the Trust IM&T strategy of right information in the right format at the right time. Performance reports are now available as electronic documents that allow the reader to look at performance from different perspectives and at different levels within the organisation.

Performance is reported through a number of key performance indicators (KPIs) using the Trust's balanced score card to enable performance to be discussed and assessed with respect to

- Business Strategic Performance – Impact & Delivery
- Customer Focus
- Operational Effectiveness – Process Effectiveness
- Fit for the Future - Workforce

KPIs provide a high level view of actual performance against target and assurance to the Board about the delivery of the strategic objectives and adhere to the following principles:

- Makes a difference to measure each month
- Focus on change areas
- Focus on risk
- Key to organisational reputation
- Variation matters

Quality Headlines

1. Feedback from managers following incident reviews/investigation

Patient safety support team have developed and tested the facility on Datix to provide feedback to staff who reported an incident. This will be live before the end of April. Staff who report incidents will be able to choose to receive feedback following the review by the manager when the incident is finally approved. If an investigation is still ongoing staff will be informed of this and given the managers name to contact for further update.

2. Infection, prevention and control

The annual plan 2015-16 has progressed well. Positive work has been undertaken throughout the year. There were 71 objectives, 68 have been completed 3 are in progress. All 3 are audits that have been undertaken; the data has been collated, awaiting reports and subsequent action plans.

- 2016-17 Annual Plan has been approved at IPC TAG.
- Barnsley BDU has a locally agreed C difficile Toxin Positive Target of 6. End of year total 3 cases, all scrutinised through the Post Infection Review (PIR) group and deemed unavoidable.
- Mandatory training- Hand Hygiene training - trust total- 90%
- Infection Prevention and Control- trust total – 88%
- Participating in PLACE audits throughout the trust.
- Save Lives: Clean your hands- WHO's global annual call to action for health workers, will be on the 5th May 2016.

3. NMC assurance visit

The NMC recently visited a number of clinical areas/practice placements within SWYPFT as part of their Quality Assurance monitoring of the undergraduate nursing courses at University of Huddersfield. Reviewers commented on strong partnerships, good risk management strategies, good service user and carer involvement and considerable investment in the support of nursing mentors. They concluded that effective Quality Assurance processes were in place, supported by Practice Learning Facilitators and consequently all outcomes were met.

4. Revalidation

We have developed a presentation and workshop to train staff and their managers/confirmers in revalidation and the requirements, to date over 300 people have attended. We have also developed a website on the trust intranet with all resources required. We have worked closely with colleagues in workforce to ensure systems support (e.g. alerts are sent to registrants to remind them) and have met with colleagues in Learning and Development to look at how appraisal might support and we are working on some potential options. There are 2 people seconded until June 2016 to lead the process and they have managed to steer first 20 nurses through in April 2016 using a case managed cohort approach.

Lots of lessons learned and even with very clear systems, training, reminders and intensive support of project leads, some people appear to struggle to engage with the process. Colleagues in workforce reported that this was not unusual and every month, under current (much simpler) system of re-registration, we usually have a couple of registrants who either fail to reregister or leave till very last minute.

5. Safer staffing

There remains a concern about staffing on the acute wards in Wakefield. Work is ongoing, led by the BDU in partnership with the nursing, AHPs and Clinical Governance Directorate to address and resolve the issues. This includes shift planning and support from the Safer Staffing Project Manager. Additionally the acute wards have been provided with the first four peripatetic HCSW's.

Recruitment – there is an ongoing Trust wide Band 5 recruitment Drive. Currently we have held 3 assessment centres resulting in 37 successful candidates being offered posts. The recruitment drive continues and we are actively engaging in university careers fairs and planning an open day.

6. Innovation factsheets

As part of the preparation for the CQC inspection we produced a number of factsheets and innovation briefings, these are bite size pieces of information that give an overview of what we have done to improve the quality of care. Briefings can be found on the trust intranet. We have received very positive feedback on the factsheets .

7. Physical health care in mental health and learning disability services

46% of people with mental health problems or learning disabilities also have long term physical health problems (King's Fund, 2012). It's vital we look after the whole person. We have established a programme of work to address this need.

Achievements to date

- We have audited the physical health examination undertaken by medical staff during the admissions process and found some good results.
- We have audited the physical health monitoring of people who have been prescribed antipsychotic medications looking for baseline measurements and ongoing monitoring again found good areas of practice. .
- The guideline document on physical health care is in use trust wide and has received positive feedback from services and clinicians.
- A pilot is in situ on the Fieldhead site looking at the use of the Bradford Physical health model with particular emphasis on ECG measurements using state of the art equipment .
- RAMPPS training is being actively pursued with the creation of the Physical Health Training facitlity in L&D FHH.
- Proposed future work involves developing a Physical Health Policy and rolling out of the Bradford Physical Health Model across the trust.

8. Information Governance

82 IG incidents were recorded across the Trust during the quarter, which represents a 32.3% increase on the previous quarter. This increase in incidents remains a concern and a plan to mitigate the risks is in place.

An IG SIRI was notified to regulators in January when sensitive information about a child was disclosed in error to the birth mother of a fostered child and allegedly later posted on social media. The investigation into the employee responsible for the error has now been completed and the first draft report will be available shortly.

9. Enfield Down

Recent visit by CQC has triggered an action plan to develop the following improvements

1. Medical time enhanced and evenly spread across the week
2. Psychological Therapies enhanced with future position identified
3. Physical Health interventions improved – a no of options to pursue
4. Clinical Leadership structure redesign
5. Band 6 focus on the pillars of governance

All actions to improve access to Mental Health, Physical Health and Psychological Services to enhance individual well -being which supports their rehab programme for step down, step up.
Clinical leadership will focus on clinical outcomes, ensuring the workforce is fit for purpose to deliver the rehab and recovery service.

10. Health of Children in Care

A number of areas have been worked on this year in partnership with our local authority partners and the CCG. Actions were identified from CQC inspections and lessons learned from a serious case review.
What difference have these actions made?

- Better use of the Strengths and Difficulties (SDQ) both within individual health assessments and data collection to identify themes and trends.
- Health professionals that undertake LAC health assessments have received training to support competency requirements recommended in the Looked after Children: Knowledge, skills and competences of health care staff. INTERCOLLEGIATE ROLE FRAMEWORK March 2015
- Young people's right to consent or dissent is supported and upheld.
- Information from a wider range of health provision is used to inform health assessments.
- There is closer timely monitoring of health assessments and any concerns are escalated including to the CCG when appropriate.
- Children and young people placed out of Barnsley are not disadvantaged in terms of their health needs.
- The Service Specification for Children in Care and Care Leavers has been reviewed by the CCG, to ensure it remains appropriate in light of new statutory guidance. They have also liaised with Public health to ensure LAC provision is considered within the new commissioning arrangements for 0-19 children's community services.

11. MHA/MCA action plan

As part of the CQC inspection we submitter our action plan for the MHA code of Practice. The outstanding amber actions are placed within the relevant BDU's and TAG's. The action plan is on the agenda for the MHA committee in May 2016

12. Junior Doctor industrial action

To date the industrial action taken by junior doctors has had a minimal impact to our planned services. This is expected position for future action.

13. RIO

We continue to experience ongoing issues with RiO. The team continue to work with Servalec to address the problems and resolve issues as quickly as possible.

14. Risk panel goes live

We have enhanced our weekly risk scan and commenced a risk panel attended by the Medical and Nursing Directors to assess and make recommendations in response to clinical risks impacting on the Trust arising from serious incidents reported on datix.
The panel will fulfil a number of functions including

- Review of red and amber serious incidents (Sis) reported on DATIX in previous week and
- Contributing to the terms of reference for SI reviews
- Commission reviews and/or advise on objectives for reviews of amber incidents and/or clinical reviews as required
- Identify where themes or trends emerge following the reviewing of incidents
- Advise on remedial actions if required
- Review intelligence from within and outside the Trust

15. Children's services exit strategy and risk

SWYPFT are working to ensure a smooth transfer of staff following the decision by SWYPFT to withdraw from the provision of Barnsley's 0-19 healthy child programme commissioned by Barnsley MBC
What have we done?

- Following months of negotiation with BMBC, SWYPFT's Board took the difficult decision to withdraw from this contract as no clinically safe model could be agreed upon within the resources available.
- Briefings have been held with staff affected and Staffside colleagues kept informed.
- HR currently working on TUPE
- Internal Transformation team formed to undertake actions prior to and during transfer to new provider. Meetings held on a weekly basis regarding transfer and continuity of service provision.
- Director level weekly programme dial in meeting held with Senior colleagues at BMBC, to raise actions/issues etc.

16. Horizon action plan

Following a number of concerns relating to practice at the Horizon Centre in 2006, 2013 and 2014, SWYPT commissioned an independent review in order for the concerns to be explored in detail and to seek assurance relating to practice and culture in accordance with its vision, values and national standards. In response a number of concerns were highlighted and a comprehensive and detailed action plan has now been put in place supported by senior managers in the Trust and the service commissioners.

17. Management of aggression and violence

The trust took part in NHS Benchmarking Network's national exercise and our performance overall in relation to patient to patient violence and violence against staff is better than sector average as is use of restraint overall. Some individual areas were above the average for their sectors in that month. We are aware that overall our figures for violence against staff and patient on patient have increased this year but we are still below average for both areas when weighted.

Compliance

1. CQC Inspection

The Trust received a formal CQC inspection under the new framework in March 2016. Initial verbal feedback from the visit has been received by the trust, with the final report being expected early May 2016. When we are awarded our rating from the CQC we are required to display them in each and every premise where regulated activity is delivered, in our main place of business and on our website. The CQC guideline also encourages Trusts to raise awareness of ratings when communicating with people who use our services, by letter, email or other means.

2. CQC regulation fees

As the CQC is required to reduce the funds it receives from central finances the costs are being recouped from the services it regulates. Throughout 2015/16 the CQC have made

3. CQC Strategy 2016-2021

In March 2016 the CQC published a consultation document: Shaping the future (CQC's strategy 2016 to 2021). This document sets out how they propose to deliver their vision by becoming a more efficient and effective regulator. There are 6 themes to the review which may collectively have potential risks we need to consider and mitigate against. The themes are:

- improving use of data and information;
- implementing a single shared view of quality
- targeting and tailoring inspection activity
- developing a flexible approach to registration
- assessing how well hospitals use resources
- developing methods to assess quality for populations and across local areas

Should these proposals be accepted early identifiable potential risks may include:

- the increased importance of correct and complete clinical information
- increase in whistleblowing alerts and subsequent investigations
- contribution to a new data set in a move away from intelligent monitoring to 'CQC insight'
- all quality reporting to be aligned to the CQC 5 key domains framework (both at national and local level)
- increased regulatory scrutiny of services that receive ratings of either requires improvement or inadequate in any of their core services/ teams.

4 CQC Intelligent Monitoring

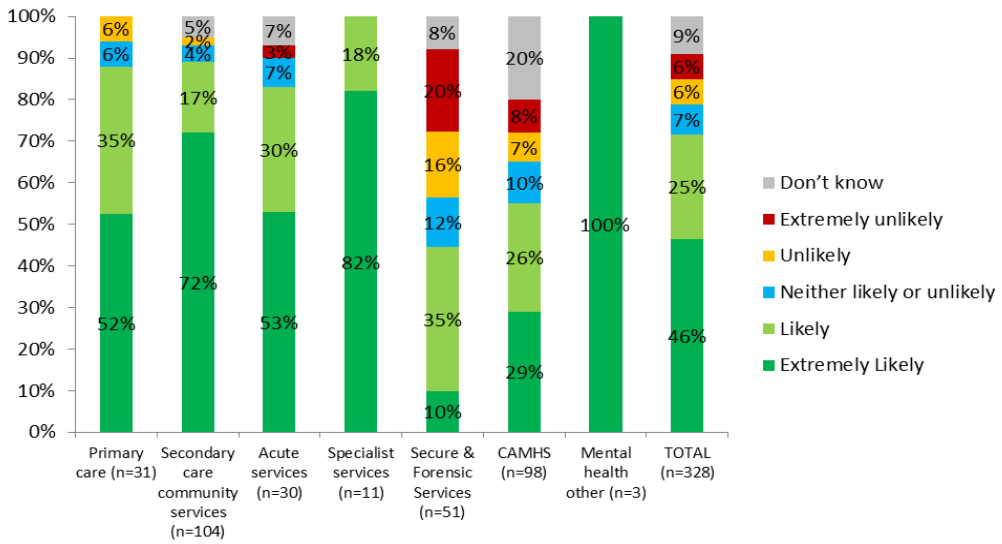
In February 2016 the Trust received the latest CQC Intelligent Monitoring report, which is a report the CQC has developed for monitoring a range of key indicators about Trusts that

Patient experience – Trust FFT scores (heading)

The trust has adopted the FFT as its quality measure for patient experience as this is the one consistent question that is asked across all services. March results can be seen on the chart 's below:

Mental Health

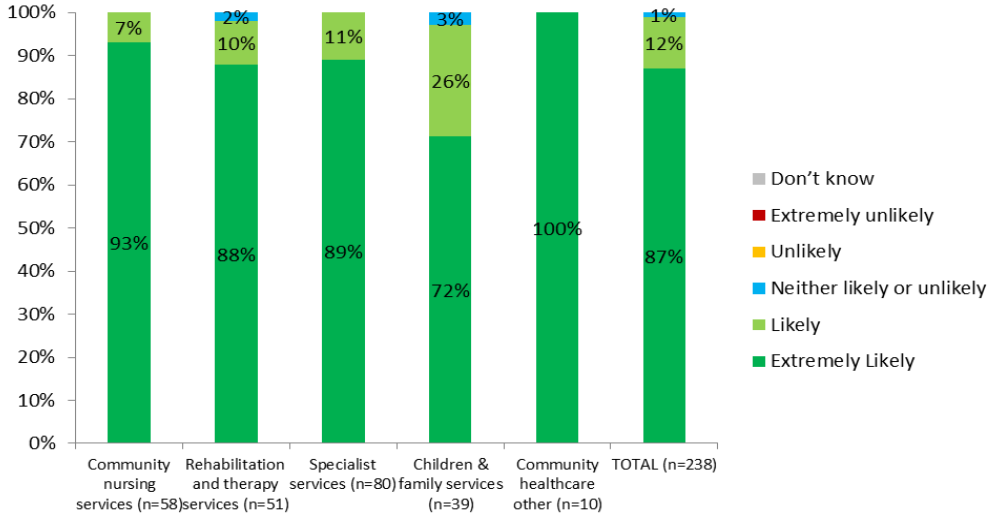
Number of unique patients accessing services during the month: 13735



71% would recommend mental health services, 12% would not.

Community Services

Number of unique patients accessing services during the month: 19919



99% would recommend community services, 0% would not.

Strategic Overview Dashboard

Business Strategic Performance Impact & Delivery

1	Section	KPI	Source	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Q1	Q2	Q3	Q4	National Average	Year End Forecast Position
2	Monitor Compliance	Monitor Governance Risk Rating (FT)	M	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		4
3		Monitor Finance Risk Rating (FT)	M	4	4	4	4	4	4	4	4	4	4	4	3	4	4	4	4	4		4
4	CQC	CQC Quality Regulations (compliance breach)	CQC	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		4
5	CQUIN	CQUIN Barnsley	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	*Amber/G*	Amber/G	Amber/G	*Amber/G*	Amber/G	Amber/G	Amber/G	*Amber/G*		3
6		CQUIN Calderdale	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	*Amber/G*	Amber/G	Amber/G	Amber/G	Amber/G		3
7		CQUIN Kirklees	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	*Amber/G*	Amber/G	Amber/G	Amber/G	Amber/G		3
8		CQUIN Wakefield	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	*Amber/G*	Amber/G	Amber/G	Amber/G	Amber/G		3
9		CQUIN Forensic	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	*Green*	Amber/G	Amber/G	Green	Amber/G	Amber/G	*Amber/G*	*Green*	*Green*	*Green*	*Amber/G*		3
10	Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	C	6	0	0	0	2	1	0	0	0	0	0	0	0	0	3	0	0		4
11	C-Diff	C Diff avoidable cases	C	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		4
12	Outcomes	% SU on CPA in Employment	L	10%	6.55%	7.34%	7.18%	6.97%	7.38%	7.55%	7.68%	7.32%	7.37%	7.17%	7.25%	7.05%	7.18%	7.55%	7.37%	7.25%		
13		% SU on CPA in Settled Accommodation	L	60%	60.27%	65.26%	64.44%	57.79%	60.34%	62.81%	64.46%	63.39%	64.09%	63.56%	62.26%	61.34%	64.44%	62.81%	64.09%	62.26%		

Customer Focus

14	Section	KPI	Source	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Q1	Q2	Q3	Q4	National Average	Year End Forecast Position
15	Complaints	% Complaints with Staff Attitude as an Issue	L	< 25%	12% 8/66	14% 6/44	13% 9/69	12% 9/73	12% 5/42	15% 6/41	12% 5/42	16% 9/58	15% 6/40	7% 4/57	13% 10/74	21% 17/80	14% 23/179	13% 20/156	14% 20/140	15% 31/211		4
16	Service User Experience	Friends and Family Test	L	TBC	89.00%	92.00%	87.00%	93.00%	89.00%	91.00%	88.00%	85.79%	93.51%	89%	88.00%	83.00%	89.00%	91.00%	88.83%	87.20%		
17	MAV	Physical Violence - Against Patient by Patient	L	14-20	Above ER	Above ER	Above ER	Within ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER		4
18		Physical Violence - Against Staff by Patient	L	50-64	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER		4
19	FOI	% of Requests for Information Under the Act Processed in 20 Working Days	L	100%	100% 24/24	100% 17/17	100% 24/24	100% 28/28	100% 20/20	100% 25/25	100% 19/19	100% 13/13	100% 19/19	100% 23/23	100% 23/23	100% 29/29	100% 65/65	100%73/73	100% (51/51)	100% 75/75		4
20	Media	% of Positive Media Coverage Relating to the Trust and its Services	L	60%	92.00%	92.00%	92.00%	80.00%	75.00%	50.00%	40.00%	50.00%	Data avail month end	Data avail month end	Data avail month end	Data avail month end	92.00%	68.00%	Data avail month end	Data avail month end		4
21	Befriending services	% of Service users allocated a befriender or volunteer led group support (gardening/music/social) within 16 weeks	L	70%	50.00%	50.00%	50.00%	20.00%	20.00%	100%	100%	100%	100%	100%	100%	100%	50.00%	20.00%	100%	100%		4
22		% of Service Users Requesting a Befriender Assessed Within 20 Working Days	L	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		4
23		% of Potential Volunteer Befriender Applications Processed in 20 Working Days	L	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		4

Operational Effectiveness: Process Effectiveness

24	Section	KPI	Source	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Q1	Q2	Q3	Q4	National Average	Year End Forecast Position
25	Monitor Risk Assessment Framework	Max time of 18 weeks from point of referral to treatment - non-admitted	M	95%	99.11%	100%	99.86%	100%	99.32%	98.60%	99.86%	97.64%	100%	97.91%	95.43%	97.41%	99.70%	99.28%	99.18%	96.90%		4
26		Max time of 18 weeks from point of referral to treatment - incomplete pathway	M	92%	98.06%	97%	99.82%	100%	97.31%	99.16%	98.92%	97.58%	100%	100.00%	97.86%	95.81%	98.35%	98.76%	98.80%	98.11%	93.10%	4
27		Delayed Transfers Of Care	M	7.50%	2.69%	1.64%	2.06%	1.96%	1.70%	1.80%	3.49%	2.89%	2.42%	2.31%	2.23%	2.46%	2.12%	1.83%	2.73%	Data avail month End		4
28		% Admissions Gatekept by CRS Teams	M	95%	93.28%	96.30%	97.20%	100%	95.90%	96.12%	95.49%	95.90%	96.77%	99.06%	95.88%	100.00%	95.51%	97.29%	95.69%	98.32%		4
29		% SU on CPA Followed up Within 7 Days of Discharge	M	95%	98.21%	100%	97.86%	97.70%	95.35%	100%	95.39%	95.60%	95.95%	97.73%	97.52%	97.33%	98.66%	97.97%	95.50%	97.44%	96.90%	4
30		% SU on CPA Having Formal Review Within 12 Months	M	95%	96.37%	95.18%	97.92%	96%	86.57%	98.44%	86.88%	97.52%	98.56%	98.32%	96.72%	96.60%	97.92%	98.44%	98.56%	96.60%	97.67%	4
31		Meeting commitment to serve new psychosis cases by early intervention teams QTD	M	95%	108.97%	102%	104.60%	147.59%	108.97%	113.25%	83.42%	99.48%	102.51%	96.15%	83.85%	94.14%	104.60%	113.25%	102.51%	94.14%		4
32		Data completeness: comm services - Referral to treatment information	M	50%	100%	100%	100%	100%	100%	100%	100%	100%	100.00%	100.00%	100%	100%	100%	100.00%	100.00%	100%		4
33		Data completeness: comm services - Referral information	M	50%	94.00%	94%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%		4
34		Data completeness: comm services - Treatment activity information	M	50%	94.00%	94%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%		4
35		Data completeness: Identifiers (mental health)	M	97%	99.70%	100%	99.62%	100%	99.62%	99.54%	99.65%	99.55%	99.45%	99.25%	99.82%	98.48%	99.62%	99.54%	99.45%	98.48%		4
36		Data completeness: Outcomes for patients on CPA	M	50%	78.83%	79.07%	77.63%	78.67%	77.64%	76.97%	78.40%	77.94%	78.58%	78.13%	76.84%	75.58%	77.63%	76.97%	78.58%	75.58%		4
37		Compliance with access to health care for people with a learning disability	M	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant		Compliant
38		IAPT - Treatment within 6 Weeks of referral	M	75%	81.46%	76.52%	75.72%	73.70%	75.83%	77.98%	75.31%	72.28%	65.66%	70.06%	70.04%	71.42%	77.84%	75.91%	71.62%	70.51%		
39		IAPT - Treatment within 18 weeks of referral	M	95%	98.60%	98.90%	99.74%	99.09%	98.89%	99.38%	99.38%	99.67%	99.10%	98.15%	97.47%	97.50%	99.09%	99.15%	99.37%	98.09%		
40		Early Intervention in Psychosis - 2 weeks (NICE approved care package)	M	50%	40.00%	81.82%	58.33%	56.25%	55.56%	80.00%	66.67%	84.60%	See below for new criteria.									
		Early Intervention in Psychosis - 2 weeks (NICE approved care package) - Clock Stops		50%	National reporting commenced Q3.								85.19%	90.91%	88.24%	73.33%	National reporting commenced Q3		85.19%			
		Early Intervention in Psychosis - 2 weeks (NICE approved care package) - Waiting at month end		50%	National reporting commenced Q3.								25.00%	93.75%	60%	60%	National reporting commenced Q3		25.00%			
43	Data Quality	% Valid NHS Number	C (FP)	99%	99.87%	100%	99.88%	99.71%	99.58%	99.76%	99.58%	99.30%	94.11%	99.58%	99.65%	Avail Next Month	99.88%	99.68%	97.66%	Avail Next Month		4
44		% Valid Ethnic Coding	C (FP)	90%	99.05%	95%	94.86%	94.88%	94.90%	94.83%	94.73%	94.12%	99.31%	99.62%	94.59%	Avail Next Month	96.28%	94.87%	96.05%	Avail Next Month		4

Strategic Overview Dashboard

Fit for the future Workforce

45	Section	KPI	Source	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Q1	Q2	Q3	Q4	National Average	Year End Forecast Position
46	Sickness	Sickness Absence Rate (YTD)	L	4.4%	4.80%	5.10%	5.00%	4.80%	4.80%	4.90%	4.90%	4.90%	5.00%	5.00%	5.00%	5.00%	5.00%	4.90%	5.00%	5.00%		1
47	Appraisal	Appraisal Rate Band 6 and above	L	95%	Avail M3	Avail M3	56.80%	72.90%	80.30%	87.30%	89.50%	91.60%	92.90%	94.50%	97.33%	97.50%	58.80%	87.30%	92.90%	97.50%		4
48		Appraisal Rate Band 5 and below	L	95%	Avail M6	Avail M6	Avail M6	Avail M6	Avail M6	66.30%	75.80%	80.30%	83.60%	89.20%	96.59%	96.90%	Avail M6	66.30%	83.60%	96.90%		4
50	Mandatory Training	Aggression Management	L	80%	73.70%	73.65%	75.83%	77.04%	78.89%	78.85%	80.38%	80.78%	83.12%	82.53%	83.18%	83.20%	75.83%	78.85%	83.12%	83.20%		1
51		Equality, Diversity & Inclusion	L	80%	82.30%	84.55%	84.87%	85.76%	87.17%	88.28%	88.81%	89.37%	90.31%	90.58%	91.39%	92.21%	84.87%	88.28%	90.31%	92.21%		4
52		Fire Safety	L	80%	86.50%	86.24%	86.31%	86.55%	86.44%	85.33%	84.60%	84.83%	85.56%	83.78%	86.66%	86.69%	86.31%	85.33%	85.56%	86.69%		4
57		Food Safety	L	80%	65.20%	66.89%	69.00%	70.67%	71.80%	73.06%	74.30%	74.10%	75.79%	75.36%	76.99%	78.41%	69.00%	73.06%	75.79%	78.41%		1
54		Infection, Prevention & Control & Hand Hygiene	L	80%	80.60%	82.09%	82.82%	83.69%	85.25%	85.55%	85.58%	84.86%	85.84%	86.52%	88.24%	87.60%	82.82%	85.55%	85.84%	87.60%		4
55		Information Governance	L	95%	91.90%	92.55%	92.67%	92.76%	92.73%	91.96%	91.56%	90.58%	89.06%	82.42%	95.12%	95.98%	92.67%	91.96%	89.06%	95.98%		4
56		Safeguarding Adults	L	80%	82.80%	82.60%	84.14%	84.95%	86.16%	86.94%	87.74%	87.34%	88.34%	88.65%	89.40%	90.19%	84.14%	86.94%	88.34%	90.19%		4
57		Safeguarding Children	L	80%	84.70%	85.22%	86.00%	86.39%	87.12%	87.93%	86.12%	85.54%	87.68%	88.22%	89.21%	89.95%	86.00%	87.93%	87.68%	89.95%		4
58		Moving & Handling	L	80%	71.80%	73.66%	75.31%	77.40%	79.32%	80.37%	82.11%	83.03%	83.83%	84.57%	85.89%	85.64%	75.31%	80.37%	83.83%	85.64%		1
59	Safer Staffing	Safer Staffing - Fill Rate (Nurses)	L	90%	91.80%	94.20%	96.30%	94.40%	91.10%	92.80%	95.90%	97.60%	93.90%	93.70%	95.90%	94.10%	96.30%	92.80%	93.90%	94.10%		4
60		Safer Staffing - Fill Rate (HCA's)	L	90%	117.60%	118.60%	115.40%	112.90%	112.90%	111.90%	116.10%	113.60%	114.30%	116.00%	116.10%	117.40%	115.40%	111.90%	114.30%	117.40%		4

KEY	
4	Forecast met, no plan required/plan in place likely to deliver
3	Forecast risk not met, plan in place but unlikely to deliver
2	Forecast high risk not met, plan in place but vey unlikely to deliver
1	Forecast Not met, no plan / plan will not deliver
CQC	Care Quality Commission
M	Monitor
C	Contract
C (FP)	Contract (Financial Penalty)
L	Local (Internal Target)
ER	Expected Range
N/A	Not Applicable

Impact and Delivery

• Performance for Quality indicators (CQUINs) is monitored by BDU's on a monthly basis. The Quarter 4 performance is currently being collated. The risk assessment on achievement of all indicators for 2015/16 is predicting an overall potential shortfall in income of £1.273M, which equates to 73% achievement and the overall rating for the year end position remains at Amber/Green.

• Under performance issues related to CQUINS to date are linked to MH Clustering in all BDU's, Care Planning in Calderdale, Kirklees and Wakefield and High Performing Teams in Barnsley - detailed action plans have been drawn to improve performance however, some underperformance is forecast to continue to end of Q4.

Operational Effectiveness

• Issues in performance associated with waiting times for IAPT continue in March 16 and this can be linked in part to psychological wellbeing practitioner vacancies within IAPT teams. Mitigating actions have been put in place, however, the indicator reports against clients that have completed treatment and this is therefore taking time to be evidenced in the performance.

There is an underperformance related to the number of new cases of psychosis at end of March 16. This indicator is being removed from the Monitor Risk Assessment Framework in 16/17 and replaced with the Early Intervention access indicator where the focus will be on timely access to services.

Workforce

• Sickness continues to remain above trajectory at end of March 16 and has been static for the last four months. Work continues to focus on reducing sickness related absence within the Trust with specific target being placed on long term sickness.

• Food Safety training is now the only area not achieving threshold but has shown an incremental increase month on month since April 15.

Overall Financial Performance 2015 / 2016

Performance Indicator		Month 12 Performance	Annual Forecas	Trend from last month	Last 3 Months - Most recent		
Trust Targets					11	10	9
1	Monitor Risk Rating	●	●	↑	●	●	●
2	REVISED £0.10m Surplus on Income & Expenditure	●	●	↑	●	●	●
3	Cash Position	●	●	↑	●	●	●
4	Capital Expenditure	●	●	⇔	●	●	●
5	Delivery of CIP	●	●	⇔	●	●	●
6	Better Payment Practice Code	●	●	↑	●	●	●

Key

●	In line, or greater than plan
●	Variance from plan ranging from 5% to 15%
●	Variance from plan greater than 15%

Summary Financial Performance

These Key Performance Indicators (KPI's) help the Trust to monitor progress against each element of our financial strategy.

1. The year end Trust Financial Risk Rating is 4 against a plan level of 4. (A score of 4 is the highest possible).

2. The year end position is a surplus of £207k which is £107k better than planned. This has been possible through the use of Trust reserves to offset in year pressures arising from healthcare contract income and non pay expenditure within the BDU's.

3. At March 2016 the cash position is £27.11m which is £2.84m ahead of plan.

4. Capital spend to March 2016 is £11.29m which is £0.71m (6%) behind the original Trust capital plan. The main variance relates to IM & T expenditure where schemes have been delivered at a cost less than planned.

5. At March 2016 the Cost Improvement Programme is £1350k behind plan. (14%).In year delivery has also included £2454k of non recurrent schemes.

6. As at March 2016 91% of NHS and 96% of non NHS invoices have achieved the 30 day payment target (95%). This continues to be a small improvement from previous months.

Contracting

Trust Summary by BDU - Current Contract Performance - Position at month 11

Contract Variations	In progress	Completed	TOTAL
B BDU	£0.0	£1,013.0	£1,013.0
W BDU	£0.0	£62.2	£62.2
C BDU	£3.7	£0.0	£3.7
K BDU	£0.0	£0.0	£0.0
S DBU	£277.1	£94.0	£371.1
F BDU	£0.0	£0.0	£0.0
TOTAL CVs	£280.8	£1,169.2	£1,450.0

CQUIN Performance **Q4 Forecast based on**

Quarter	Quarter 3 £000s	Achieved	Variance	M11 Performance	Variance
Barnsley	£426.6	£378.6	-£48.0	£489.8	-£92.8
Wakefield	£136.1	£70.7	-£65.4	£115.8	-£177.2
Kirklees	£150.3	£76.6	-£73.7	£127.3	-£194.2
Calderdale	£67.4	£34.4	-£33.1	£57.1	-£87.2
Specialised	£75.4	£75.4	£0.0	£56.5	-£18.9
Forensics	£22.5	£22.5	£0.0	£397.4	£0.0
Trust Total	£878.4	£658.2	-£220.1	£1,244.0	-£570.3

CQUIN Performance Year-end Forecast

Quarter	Annual £000s	Forecast Achievement	Variance
Barnsley	£1,790.1	£1,441.3	-£348.8
Wakefield	£793.9	£465.6	-£328.4
Kirklees	£878.2	£495.0	-£383.3
Calderdale	£394.1	£200.1	-£194.0
Specialised	£301.7	£282.8	-£18.9
Forensics	£562.3	£562.3	£0.0
Trust Total	£4,720.4	£3,447.1	-£1,273.3

Key Contract Issues - Specialist

CAMHS - RiO Issues - Trust wide data potentially 20% under what should be. Main area for CAMHS is unoutcomed appointments
C&K: Still awaiting DoV from Commissioners. 2016/17 new contract being issued for 1yr period.
Both C & K services will go out to tender for new contract in 17/18.
Barnsley: Task & Finish Group dissolved. Future contracting issues to be picked up within main BCCG meetings
Wakefield: WCCG focussing on service delivery and make up. Potential in year review.

Learning Disability
W - constraints on the number of patients able to be admitted against contract plan due to intake of complex client
C - SWYPFT team delivering on timescales. Positive feedback and service being recognised as good practice

Key Contract Issues - Barnsley

Wakefield MDC - SWYPFT is agreeing to an extension to 30/09/16 and a 3% reduction in value
Rotherham & Doncaster MBCs PH - SWYPFT is agreeing a contract reduction against the Drugs which is a pass through
Substance Misuse Services - SWYPFT is agreeing the new model & transition costs with PF service. SWYPFT has done so with a model costing £558k, current contract value is £1,079k

QIPP Targets & Delivery for 2015/16

CCG	Target £000s	Planned £000s	Remainder £000s	RAG
Wakefield*	£1,790.0	£1,843.3	£53.3	***
Kirklees**	£1,000.0	£595.6	-£404.4	
Calderdale	£0.0	£0.0	£0.0	
TOTAL £000s	£2,790.0	£2,438.8	-£351.2	

* W target is cumulative covering 2014/15 & 2015/16: ** K includes Specialist LD scheme
*** W RAG remains at R as risks identified ~ see summary below

Proposals under the QIPP scheme -

W:- £1.79m in total. OOA Bed Mgt - above plan: OPS Reconfiguration (Saville Park) - on target: MH contract reduction - delivered: OAPs for LD & CHC (CCG held budgets)- high risk: Castle Lodge (CCG budget - prevention client OOA) ~ CCG contesting this £47k : Repricing LD beds - ongoing: Risk within plan as includes £41k for use of Barnsley PICU bed & SWYPFT funded £338k from contract growth for ADHD sustainable case & backlog clearance ~tbc by CCG
C:- 15/16 Schemes to be identified by end of Q1. Potential Productivity Schemes identified, not finalised/agreed.
K:- £1m in total: 1) Reduction on OOA spend for Specialist Rehabilitation & Recovery placements £500k, 2) Reduction in OOA LD Specialist placements £500k (CCG budgets), both schemes required to generate in excess of £1m, for reinvestment in new service models. Below target

KPIs and Penalties

Commissioner	Penalty £000s	Comment
Barnsley CCG	£2.2	MSK as at Mth 11

Key Contract Issues - Kirklees

Psychology: 18 week pathway holding although there has been an increase in referrals. Waiting lists beginning to reduce.
IAPT: Remaining below target for recovery, 6 week & 18 week waits (ref to entering IAPT treatment).
Police Liaison: £150k funding for GH for 2.2 wte staff. 12hr day service with SWYPFT staff being co-located with the Police. Rapid Response pathway to operate utilising IHBT capacity to provide overall cover.

Key Contract Issues - Calderdale

Police Liaison: £150k funding for Calderdale for 2.2 wte staff. 12hr day service with SWYPFT staff being co-located with the Police. Rapid Response pathway to operate utilising IHBT capacity to provide overall cover.
R&R: CCCG clear about intentions re redesign of pathway. Joint pathway with health & social care. Move from bed based approach and moving to community rehab model.
IAPT (AQP): DoV signed by SWYPFT. Awarded tender for future provision.
ED: Agreement for a B6 Care Co-ordinator to coordinate existing ED cases Feb 16-31st Mar 17

Key Contract Issues - Forensics

National procurement identified for 2015/16/17 for Medium & Low Secure MH Services with CAMHS likely to be in first lot.

Key Contract Issues - Wakefield

Key Contract Issues - Health & Wellbeing

Negotiations are ongoing with Wakefield MDC & Rotherham & Doncaster MBS with regard to changes in their contracts for 2016/17

Currency Development

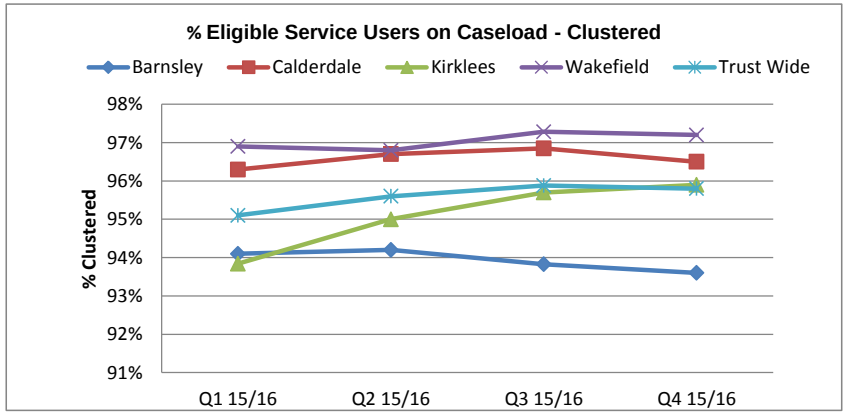
Mental Health

The currency for most mental health services for working age adults and older people has been defined as the 'clusters'. That means that service users have to be assessed and allocated to a cluster by their mental health provider, this assessment must be regularly reviewed in line with the timing and protocols. It is the intention that clusters will form the basis of the contracting arrangements between commissioners and providers, the commencement of this is not yet clear.

The Trust have been at the forefront of developments of the mental health clustering process and have had strong links into the national project. The clustering is now embedded into operational practice and the below are key priorities within the Trust related to development of mental health currencies.

Person First and in the Centre - access to timely assessment

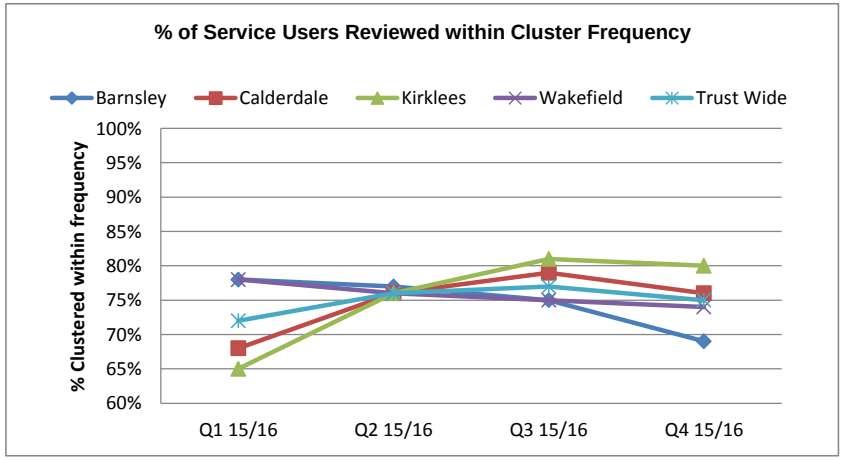
At the end March 16, the Trust have achieved 95.8% of service users clustered against a national target of 95%. There are some under performance issues within individual BDU's and each BDU has a trajectory of improvement:

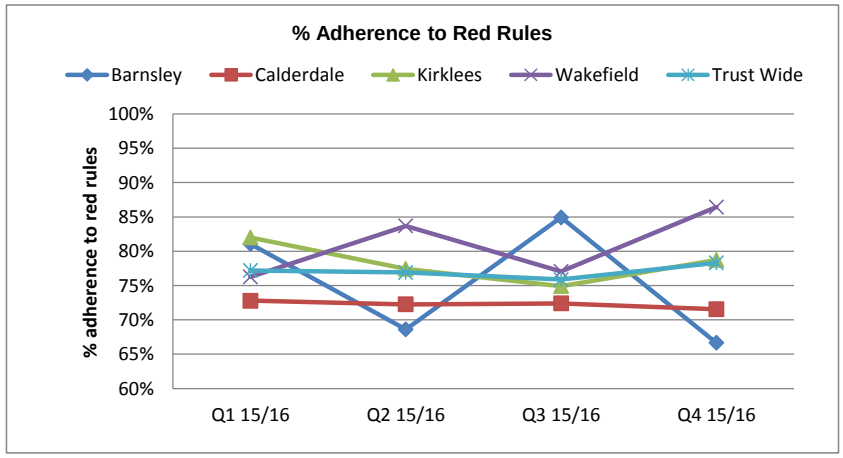


Barnsley BDU - Engaged with Transition and Development Manager- action plan to be developed over the next month as there has been a definite decline in performance overall.
Calderdale BDU - Refresher sessions taking place; Shared Governance group being developed for sustainability.
Kirklees BDU - OPS have process in place to review all medical caseloads and data cleansing-meet monthly; members of OPS staff assisting with the review of the people never clustered, 12 month out of review date; Training sessions being set up and identified staff for shared governance group ; Support identified in WAA; Support and refresher training to be undertaken with the Dual diagnosis team.
Wakefield BDU - Support identified for WAA CMHT; Shared Governance group commencing April; Caseload Reviewer in post for one year, who is also carrying out training; Concentrated efforts supporting and data cleansing OPS Medical staff; Meeting with TRIOs and attending service line meetings ; Caseload reviewer carrying out training with IHBTT staff, and all inpatient staff

Trajectory of improvement to be set for 16/17 based on 15/16 Q4.

Recovery with the use of the care pathway to facilitate recovery - promoting relationships





This KPI measures assurance that the cluster is accurate, complete and of high quality

Currency Development

The care package (Interventions) are our core business and the care we deliver supports the individual person receive the right care through shared decision- making, self management, person centred 'safety planning, consistently, through competence, listening and communication to support recovery
KPI's that are associated with this are:
* % with a MHCT on CPA/standard care
% with MHCT at discharge

This has been identified as an area for training as the Trusts new CPA policy is now in place. Reporting and monitoring for this will commence during quarter 1.

Training and refresher training across the whole Trust will commence once the national MHCT booklet V5 is published.

Outcome measures and reporting of these are being developed across the Trust, these include:
Clinician Rated Outcome Measures
Patient Rated Outcome Measures
Patient Related Experience Measures

Other developments to be considered and supported within the Trust relate to clustering for Learning Disabilities, Children & Adolescent Mental Health Services, Forensic, Improving Access to Psychological Therapies (IAPT).

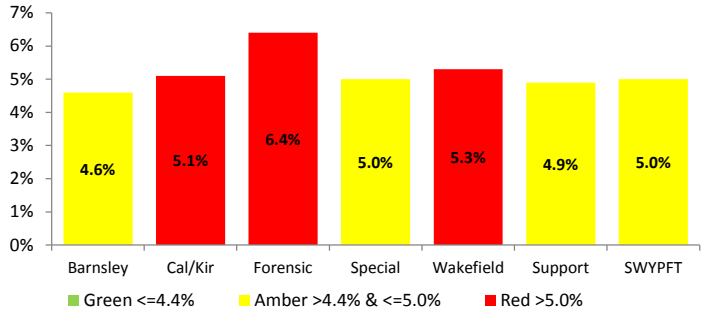
Community Services

The NHS Pricing Authority and case mix team at HSCIC are working in partnership to develop a national currency for community services. The partnership have hosted a number of national events which the Trust has been engaged in. The Trust are keen to be involved in this development and have expressed an interest in involvement of the Community Steering group who will provide governance for community dataset development which will feed into the currencies project. Nationally, organisations have been sharing local work on community currencies. These ideas and local innovations across England are being incorporated into the project. The project is keen for the currency design to resonate with the way services are developing.

Workforce

Human Resources Performance Dashboard - March 2016

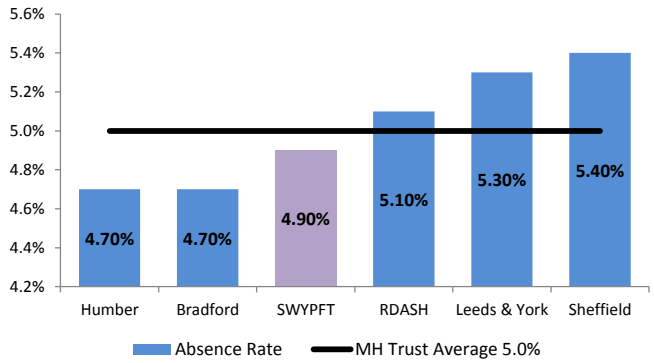
Sickness Absence



Current Absence Position - February 2016

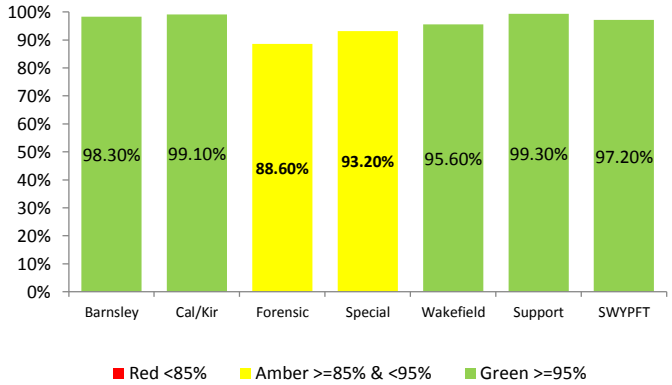
	Barn	Cal/Kir	Fore	Spec	Wake	Supp	SWYPFT
Rate	5.5%	5.6%	5.7%	6.5%	4.1%	3.7%	5.2%
Trend	↓	↑	↓	↑	↓	↑	↓

The Trust YTD absence levels in February 2016 (chart above) were above the 4.4% target at 5%.



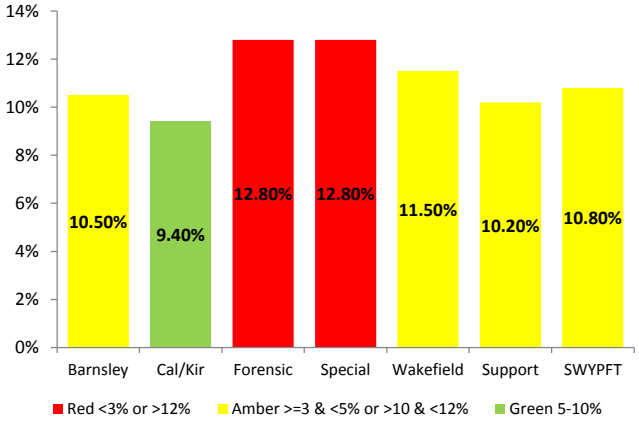
The above chart shows the YTD absence levels in MH/LD Trusts in our region to the end of September 2015. During this time the Trust's absence rate was 4.9% which is below the regional average of 5%.

Appraisals - All Staff

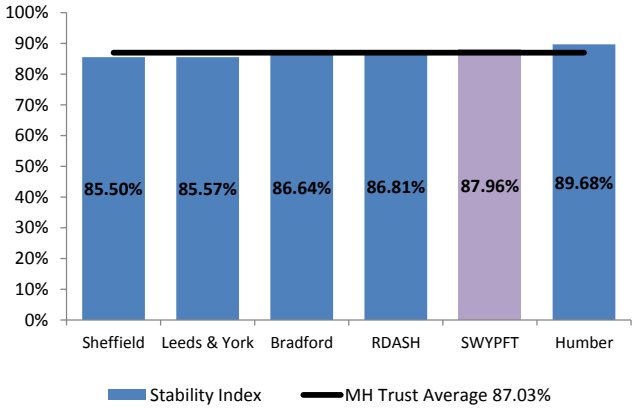


The above chart shows the YTD appraisal rates for all Trust staff to the end of March 2016.
The Trust's target for appraisals is 95% or above.
All areas have shown improvement each month since the inclusion of Bands 1 to 5 in the figures in September 2015.

Turnover and Stability Rate Benchmark

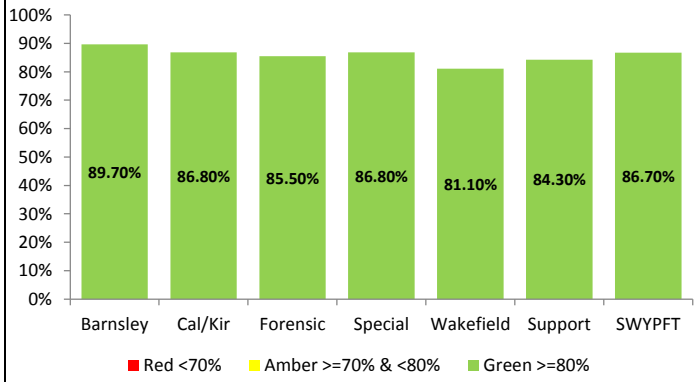


This chart shows the YTD turnover levels up to the end of March 2016.



This chart shows stability levels in MH Trusts in the region for the 12 months ending in October 2015. The stability rate shows the percentage of staff employed with over a year's service. The Trust's rate is better than the average compared with other MH/LD Trusts in our region.

Fire Lecture Attendance



The chart shows the YTD fire lecture figures to the end of March 2016. The Trust continues to achieve its 80% target for fire lecture training, with all areas having maintained their figures above target for several months.

Workforce - Performance Wall

Trust Performance Wall

Month		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Sickness (YTD)	<=4.4%	4.90%	4.90%	5.00%	5.00%	5.00%	5.00%
Sickness (Monthly)	<=4.4%	4.90%	5.30%	5.40%	5.00%	5.50%	5.20%
Appraisals (Band 6 and above)	>=95%	89.50%	91.60%	92.80%	94.50%	97.30%	97.50%
Appraisals (Band 5 and below)	>=95%	75.80%	80.10%	83.50%	89.20%	96.60%	96.90%
Aggression Management	>=80%	80.40%	80.80%	83.10%	82.50%	83.20%	83.20%
Equality and Diversity	>=80%	88.80%	89.40%	90.30%	90.60%	91.40%	92.20%
Fire Safety	>=80%	84.60%	84.80%	85.60%	83.80%	86.70%	86.70%
Food Safety	>=80%	74.30%	74.10%	75.80%	75.40%	77.00%	78.40%
Infection Control and Hand Hygiene	>=80%	85.60%	84.90%	85.80%	86.50%	88.20%	87.60%
Information Governance	>=95%	91.60%	90.60%	89.10%	82.40%	95.10%	96.00%
Moving and Handling	>=80%	82.10%	83.00%	83.80%	84.60%	85.90%	85.60%
Safeguarding Adults	>=80%	87.70%	87.30%	88.30%	88.70%	89.40%	90.20%
Safeguarding Children	>=80%	86.10%	85.50%	87.70%	88.20%	89.20%	89.90%
Bank Cost		£478k	£428k	£414k	£426k	£419k	£548k
Agency Cost		£772k	£770k	£606k	£527k	£774k	£1449k
Overtime Cost		£30k	£37k	£22k	£31k	£30k	£33k
Additional Hours Cost		£74k	£87k	£89k	£64k	£70k	£103k
Sickness Cost (Monthly)		£475k	£546k	£533k	£515k	£576k	£483k
Vacancies (Non-Medical) (WTE)		324.2	306.46	316.89	353.49	380.25	400.13
Business Miles		333k	347k	323k	327k	323k	257k

Barnsley District

Month		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Sickness (YTD)	<=4.4%	4.10%	4.20%	4.30%	4.40%	4.60%	4.60%
Sickness (Monthly)	<=4.4%	4.20%	4.50%	5.10%	5.20%	5.90%	5.50%
Appraisals (Band 6 and above)	>=95%	92.10%	94.40%	95.60%	97.20%	98.20%	98.60%
Appraisals (Band 5 and below)	>=95%	83.30%	87.50%	89.80%	92.10%	97.20%	98.20%
Aggression Management	>=80%	83.50%	82.90%	84.10%	80.80%	82.60%	87.00%
Equality and Diversity	>=80%	90.70%	91.30%	92.60%	93.00%	93.60%	94.70%
Fire Safety	>=80%	84.70%	85.80%	86.20%	85.80%	89.50%	89.70%
Food Safety	>=80%	80.10%	75.70%	74.90%	72.70%	74.20%	77.10%
Infection Control and Hand Hygiene	>=80%	86.40%	87.00%	88.10%	87.80%	90.50%	91.00%
Information Governance	>=95%	92.10%	90.90%	90.50%	86.40%	96.20%	97.40%
Moving and Handling	>=80%	84.50%	85.10%	86.10%	86.40%	88.10%	87.90%
Safeguarding Adults	>=80%	90.00%	89.20%	89.80%	90.10%	91.00%	92.90%
Safeguarding Children	>=80%	87.90%	87.40%	89.00%	89.40%	90.40%	91.70%
Bank Cost		£85k	£75k	£65k	£61k	£61k	£50k
Agency Cost		£119k	£200k	£130k	£170k	£168k	£289k
Overtime Cost		£10k	£17k	£8k	£17k	£16k	£10k
Additional Hours Cost		£35k	£40k	£36k	£33k	£33k	£60k
Sickness Cost (Monthly)		£138k	£155k	£175k	£199k	£230k	£190k
Vacancies (Non-Medical) (WTE)		92.75	85.33	87.34	108.19	124.09	130.8
Business Miles		144k	148k	126k	132k	135k	105k

Calderdale and Kirklees District

Month		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Sickness (YTD)	<=4.4%	4.80%	5.00%	5.10%	5.00%	5.10%	5.10%
Sickness (Monthly)	<=4.4%	5.10%	6.60%	5.60%	4.80%	5.90%	5.60%
Appraisals (Band 6 and above)	>=95%	98.80%	99.70%	99.10%	99.70%	100.00%	100.00%
Appraisals (Band 5 and below)	>=95%	85.00%	88.80%	91.70%	92.50%	98.40%	98.40%
Aggression Management	>=80%	83.20%	82.80%	86.10%	87.30%	87.20%	85.40%
Equality and Diversity	>=80%	90.60%	91.60%	92.00%	93.20%	92.40%	92.80%
Fire Safety	>=80%	83.00%	83.20%	85.40%	83.00%	86.10%	86.80%
Food Safety	>=80%	69.50%	70.20%	72.00%	74.50%	74.10%	72.10%
Infection Control and Hand Hygiene	>=80%	88.60%	90.00%	90.40%	91.10%	90.70%	88.60%
Information Governance	>=95%	90.40%	89.80%	87.50%	83.30%	96.30%	96.70%
Moving and Handling	>=80%	81.30%	82.70%	83.40%	84.30%	85.20%	84.80%
Safeguarding Adults	>=80%	86.60%	86.80%	88.20%	88.90%	88.50%	89.70%
Safeguarding Children	>=80%	86.20%	86.50%	89.40%	91.00%	90.40%	90.60%
Bank Cost		£117k	£124k	£114k	£123k	£147k	£161k
Agency Cost		£199k	£173k	£117k	£124k	£182k	£246k
Overtime Cost		£1k	£2k	£0k	£3k	£0k	£3k
Additional Hours Cost		£2k	£3k	£3k	£2k	£5k	£5k
Sickness Cost (Monthly)		£101k	£142k	£116k	£97k	£131k	£107k
Vacancies (Non-Medical) (WTE)		71.14	75.66	72.44	69.5	64.92	64.88
Business Miles		65k	73k	61k	63k	62k	56k

Forensic Services

Month		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Sickness (YTD)	<=4.4%	7.20%	7.00%	6.80%	6.60%	6.50%	6.40%
Sickness (Monthly)	<=4.4%	6.80%	5.80%	5.70%	5.00%	5.30%	5.70%
Appraisals (Band 6 and above)	>=95%	70.00%	74.70%	84.70%	84.10%	86.60%	87.00%
Appraisals (Band 5 and below)	>=95%	66.20%	71.50%	77.60%	83.90%	89.20%	89.10%
Aggression Management	>=80%	78.20%	80.70%	81.70%	80.60%	80.20%	79.70%
Equality and Diversity	>=80%	90.40%	92.40%	92.80%	93.00%	92.90%	93.90%
Fire Safety	>=80%	87.30%	88.60%	89.00%	83.10%	86.40%	85.40%
Food Safety	>=80%	70.60%	73.50%	79.70%	79.60%	82.70%	86.00%
Infection Control and Hand Hygiene	>=80%	85.30%	84.40%	85.40%	87.00%	88.00%	88.40%
Information Governance	>=95%	91.70%	91.90%	90.80%	80.60%	93.00%	94.30%
Moving and Handling	>=80%	85.80%	87.60%	87.90%	88.80%	89.20%	89.20%
Safeguarding Adults	>=80%	88.50%	89.90%	91.50%	91.90%	92.10%	92.10%
Safeguarding Children	>=80%	85.30%	85.90%	87.70%	85.20%	86.10%	87.30%
Bank Cost		£114k	£97k	£86k	£108k	£77k	£142k
Agency Cost		£122k	£68k	£68k	£92k	£143k	£320k
Overtime Cost		£0k	£2k	£0k	£-1k	£0k	
Additional Hours Cost		£0k	£0k	£0k	£0k	£1k	£1k
Sickness Cost (Monthly)		£58k	£56k	£50k	£40k	£44k	£41k
Vacancies (Non-Medical) (WTE)		24.94	24.54	37.11	45.11	49.62	49.57
Business Miles		9k	9k	12k	7k	4k	6k

Workforce - Performance Wall cont…

Specialist Services

Month		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Sickness (YTD)	<=4.4%	5.10%	5.00%	4.80%	4.80%	4.80%	5.00%
Sickness (Monthly)	<=4.4%	4.70%	4.60%	3.80%	4.40%	4.60%	6.50%
Appraisals (Band 6 and above)	>=95%	68.70%	73.80%	75.10%	77.90%	91.80%	92.30%
Appraisals (Band 5 and below)	>=95%	47.50%	53.60%	64.80%	71.30%	94.00%	94.70%
Aggression Management	>=80%	76.40%	77.10%	79.80%	81.20%	81.60%	80.00%
Equality and Diversity	>=80%	89.90%	90.00%	90.50%	90.10%	91.30%	92.40%
Fire Safety	>=80%	83.20%	82.10%	84.60%	85.10%	86.00%	86.80%
Food Safety	>=80%	69.00%	71.20%	73.70%	73.20%	74.50%	74.50%
Infection Control and Hand Hygiene	>=80%	84.00%	84.30%	85.90%	86.30%	87.40%	87.30%
Information Governance	>=95%	90.10%	90.20%	89.50%	85.20%	95.90%	96.40%
Moving and Handling	>=80%	82.50%	83.10%	83.10%	84.80%	85.70%	87.00%
Safeguarding Adults	>=80%	83.20%	82.00%	84.40%	84.80%	86.60%	86.80%
Safeguarding Children	>=80%	84.90%	81.30%	85.60%	87.70%	87.80%	87.30%
Bank Cost		£31k	£28k	£32k	£25k	£21k	£30k
Agency Cost		£228k	£216k	£146k	£59k	£173k	£313k
Overtime Cost		£1k	£1k	£1k	£2k	£2k	£1k
Additional Hours Cost		£5k	£7k	£11k	£4k	£9k	£6k
Sickness Cost (Monthly)		£53k	£55k	£45k	£43k	£44k	£54k
Vacancies (Non-Medical) (WTE)		45.31	44.49	40.71	39.15	49.08	55.33
Business Miles		30k	39k	40k	36k	37k	28k

Support Services

Month		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Sickness (YTD)	<=4.4%	4.70%	4.80%	5.00%	5.00%	5.00%	4.90%
Sickness (Monthly)	<=4.4%	4.80%	5.40%	6.00%	5.40%	4.90%	3.70%
Appraisals (Band 6 and above)	>=95%	95.90%	96.50%	96.90%	98.50%	99.00%	99.00%
Appraisals (Band 5 and below)	>=95%	71.10%	72.70%	74.80%	89.70%	99.60%	99.40%
Aggression Management	>=80%	72.40%	74.30%	78.60%	78.50%	78.90%	76.80%
Equality and Diversity	>=80%	78.70%	78.90%	80.40%	80.90%	84.10%	84.40%
Fire Safety	>=80%	84.60%	84.30%	83.50%	80.90%	84.20%	84.30%
Food Safety	>=80%	90.10%	89.20%	89.90%	87.30%	91.00%	90.90%
Infection Control and Hand Hygiene	>=80%	82.30%	76.80%	78.30%	79.20%	82.00%	81.20%
Information Governance	>=95%	91.70%	89.60%	86.60%	71.30%	90.90%	91.50%
Moving and Handling	>=80%	81.10%	81.50%	81.90%	82.70%	84.80%	83.90%
Safeguarding Adults	>=80%	84.90%	84.50%	85.40%	85.90%	86.90%	86.90%
Safeguarding Children	>=80%	83.70%	82.80%	84.80%	85.50%	88.60%	90.00%
Bank Cost		£60k	£14k	£39k	£38k	£42k	£57k
Agency Cost		£71k	£40k	£74k	£33k	£42k	£135k
Overtime Cost		£4k	£0k	£0k		£0k	£3k
Additional Hours Cost		£22k	£19k	£20k	£17k	£13k	£17k
Sickness Cost (Monthly)		£61k	£68k	£84k	£80k	£72k	£47k
Vacancies (Non-Medical) (WTE)		51.48	36.73	37.2	43.98	41.82	45.57
Business Miles		42k	35k	48k	45k	42k	32k

Wakefield District

Month		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Sickness (YTD)	<=4.4%	5.30%	5.40%	5.50%	5.40%	5.30%	5.30%
Sickness (Monthly)	<=4.4%	5.60%	5.90%	5.80%	4.80%	5.00%	4.10%
Appraisals (Band 6 and above)	>=95%	88.10%	90.20%	91.80%	95.10%	97.90%	97.90%
Appraisals (Band 5 and below)	>=95%	68.40%	76.70%	81.30%	87.00%	93.90%	93.90%
Aggression Management	>=80%	82.90%	82.80%	84.20%	82.10%	83.80%	85.20%
Equality and Diversity	>=80%	92.20%	92.20%	92.60%	91.50%	92.70%	93.50%
Fire Safety	>=80%	86.10%	84.70%	85.20%	82.50%	82.90%	81.10%
Food Safety	>=80%	68.60%	69.70%	69.50%	68.80%	70.40%	72.30%
Infection Control and Hand Hygiene	>=80%	83.80%	81.80%	82.00%	85.30%	86.70%	84.10%
Information Governance	>=95%	92.60%	91.50%	89.00%	84.40%	97.00%	97.90%
Moving and Handling	>=80%	74.00%	75.70%	77.60%	78.30%	79.00%	78.60%
Safeguarding Adults	>=80%	89.70%	88.90%	89.00%	88.20%	89.70%	88.80%
Safeguarding Children	>=80%	85.60%	85.30%	86.30%	86.40%	87.70%	87.20%
Bank Cost		£71k	£90k	£78k	£72k	£71k	£108k
Agency Cost		£34k	£73k	£71k	£49k	£66k	£145k
Overtime Cost		£14k	£14k	£12k	£10k	£12k	£15k
Additional Hours Cost		£9k	£13k	£12k	£7k	£9k	£8k
Sickness Cost (Monthly)		£63k	£70k	£64k	£55k	£56k	£44k
Vacancies (Non-Medical) (WTE)		36.58	34.71	40.49	45.96	48.79	51.83
Business Miles		43k	44k	37k	44k	43k	31k

Publication Summary

NHS England

Sustainability and transformation plan footprints

This document outlines the 44 footprint areas that will bring local health and care leaders, organisations and communities together to develop local blueprints for improved health, care and finances over the next five years, delivering the NHS five year forward view.
Click here for briefing

Monitor

2016/17 national tariff payment system

This guidance contains a set of prices and rules to help providers of NHS care and commissioners provide best value to their patients. This year's national tariff aims to give providers of NHS services the space to restore financial balance and support providers and commissioners to make ambitious longer term plans for their local health economies.
Click here for guidance

Care Quality Commission (CQC)

Fees scheme 2016/17

This document outlines the changes to revised fees that providers will have to pay to cover the chargable costs of CQC regulation for 2016/17. These new fees will take effect from 1 April 2016.
Click here for provider guidance

NHS England

Our 2016/17 business plan

This business plan builds on three guiding principles to shape the work of NHS England for the year ahead: constancy of purpose and priorities; coherent national support for locally-led improvement; and solving today's issues by accelerating tomorrow's solutions.
Click here for business plan

Publication Summary cont….

Department of Health

NHS outcomes framework 2016 to 2017 at-a-glance

The NHS outcomes framework will remain unchanged for 2016 to 2017. This document lists the indicators that will be used to hold NHS England to account for improvements in health outcomes.
Click here for outcomes framework

Department of Health

Multi-agency statutory guidance on female genital mutilation (FGM)

These multi-agency guidelines on FGM are aimed at those with statutory duties to safeguard children and vulnerable adults. It supersedes the previous guidance issued in 2014, 'Female genital mutilation: guidelines to protect women and children'.
Click here for guidance

NHS England

CCG improvement and assessment framework 2016/17

This new assessment framework for CCGs will include ratings published online to show patients how their local health service is performing in six important areas. From June, an initial assessment of CCG performance will be available online that will cover six crucial areas including cancer, dementia, diabetes, mental health, learning disabilities and maternity care. Each will be based on metrics in the framework that will be verified by independent panels chaired by experts in each field. This will be followed by an annual assessment in June 2017 which will incorporate additional
Click here for framework

The following section of the report identifies publications that may be of interest to the Trust and it's members.

Combined performance summary, January 2016

Hospital activity data, January 2016

Direct access audiology waiting times, January 2016

Mixed sex accommodation breaches, February 2016

Diagnostic imaging dataset, March 2016

Winter health watch summary, 17 March 2016

Winter health watch summary: 24 March 2016

NHS workforce statistics, December 2015, provisional statistics

NHS sickness absence rates, November 2015, provisional statistics

Hospital activity data, February 2016

Glossary

ADHD	Attention deficit hyperactivity disorder
AQP	Any Qualified Provider
ASD	Autism spectrum disorder
AWA	Adults of Working Age
AWOL	Absent Without Leave
B/C/K/W	Barnsley, Calderdale, Kirklees, Wakefield
BDU	Business Delivery Unit
C&K	Calderdale & Kirklees
C. Diff	Clostridium difficile
CAMHS	Child and Adolescent Mental Health Services
CAPA	Choice and Partnership Approach
CCG	Clinical Commissioning Group
CGCSC	Clinical Governance Clinical Safety Committee
CIP	Cost Improvement Programme
CPA	Care Programme Approach
CPPP	Care Packages and Pathways Project
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CROM	Clinician Rated Outcome Measure
CRS	Crisis Resolution Service
CTLD	Community Team Learning Disability
DoV	Deed of Variation
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
FT	Foundation Trust
HONOS	Health of the Nation Outcome Scales
HSCIC	Health and Social Care Information Centre
HV	Health Visiting
IAPT	Improving Access to Psychological Therapies
IG	Information Governance
IHBT	Intensive Home Based Treatment
IM&T	Information Management & Technology
Inf Prevent	Infection Prevention
IWMS	Integrated Weight Management Service
KPIs	Key Performance Indicators

LD	Learning Disability
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
NICE	National Institute for Clinical Excellence
NK	North Kirklees
OOA	Out of Area
OPS	Older People's Services
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
SU	Service Users
SWYFT	South West Yorkshire Foundation Trust
SYBAT	South Yorkshire and Bassetlaw local area team
TBD	To Be Decided/Determined
WTE	Whole Time Equivalent
Y&H	Yorkshire & Humber
YTD	Year to Date

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Finance Report

Month 12 (2015 / 2016)

Contents

1.0	Strategic Overview	1.0	Key Performance Indicators	3
		1.1	Financial - Continuity of Service Risk Rating (COSRR)	4
2.0	Statement of Comprehensive Income	2.0	Summary Statement of Income & Expenditure Position	5
		2.1	Cost Improvement Programme	7
3.0	Statement of Financial Position	3.0	Balance Sheet	8
		3.1	Capital Programme	9
		3.2	Cash and Working Capital	10
		3.3	Reconciliation of Cash Flow to Plan	11
4.0	Additional Information	4.0	Better Payment Practice Code	12
		4.1	Transparency Disclosure	13
		4.2	Glossary of Terms & Definitions	14

Overall Financial Performance 2015 / 2016

Performance Indicator		Month 12 Performance	Annual Forecast	Trend from last month	Last 3 Months - Most recent		
Trust Targets					11	10	9
1	Monitor Risk Rating	●	●	↑	●	●	●
2	REVISED £0.10m Surplus on Income & Expenditure	●	●	↑	●	●	●
3	Cash Position	●	●	↑	●	●	●
4	Capital Expenditure	●	●	⇔	●	●	●
5	Delivery of CIP	●	●	⇔	●	●	●
6	Better Payment Practice Code	●	●	↑	●	●	●

Key	
●	In line, or greater than plan
●	Variance from plan ranging from 5% to 15%
●	Variance from plan greater than 15%

Summary Financial Performance

These Key Performance Indicators (KPI's) help the Trust to monitor progress against each element of our financial strategy.

1. The year end Trust Financial Risk Rating is 4 against a plan level of 4. (A score of 4 is the highest possible).

2. The year end position is a surplus of £207k which is £107k better than planned. This has been possible through the use of Trust reserves to offset in year pressures arising from healthcare contract income and non pay expenditure within the BDU's.

3. At March 2016 the cash position is £27.11m which is £2.84m ahead of plan.

4. Capital spend to March 2016 is £11.29m which is £0.71m (6%) behind the original Trust capital plan. The main variance relates to IM & T expenditure where schemes have been delivered at a cost less than planned.

5. At March 2016 the Cost Improvement Programme is £1350k behind plan. (14%).In year delivery has also included £2454k of non recurrent schemes.

6. As at March 2016 91% of NHS and 96% of non NHS invoices have achieved the 30 day payment target (95%). This continues to be a small improvement from previous months.

Monitor Risk Rating

As per the Risk assessment Framework, updated August 2015, the financial performance of the Trust is monitored through a number of financial sustainability risk ratings.

This revision increased the number of metrics from 2 to 4. This retains the original 2 which focus on the Continuity of Services and add 2 further in relation to Financial Efficiency. A further metric in relation to capital expenditure performance against plan was proposed but has not been adopted.

				Actual Performance		Annual Plan	
	Financial Criteria	Weight	Metric	Score	Risk Rating	Score	Risk Rating
Continuity of Services	Balance Sheet Sustainability	25%	Capital Service Capacity	3.3	4	2.9	4
	Liquidity	25%	Liquidity (Days)	14.7	4	6.8	4
	Weighted Average - Continuity of Services Risk Rating				4		4
Financial Efficiency	Underlying Performance	25%	I & E Margin	0.2%	3		
	Variance from Plan	25%	Variance in I & E Margin as a % of income	0.1%	4		
	Weighted Average - Financial Sustainability Risk Rating				4		

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

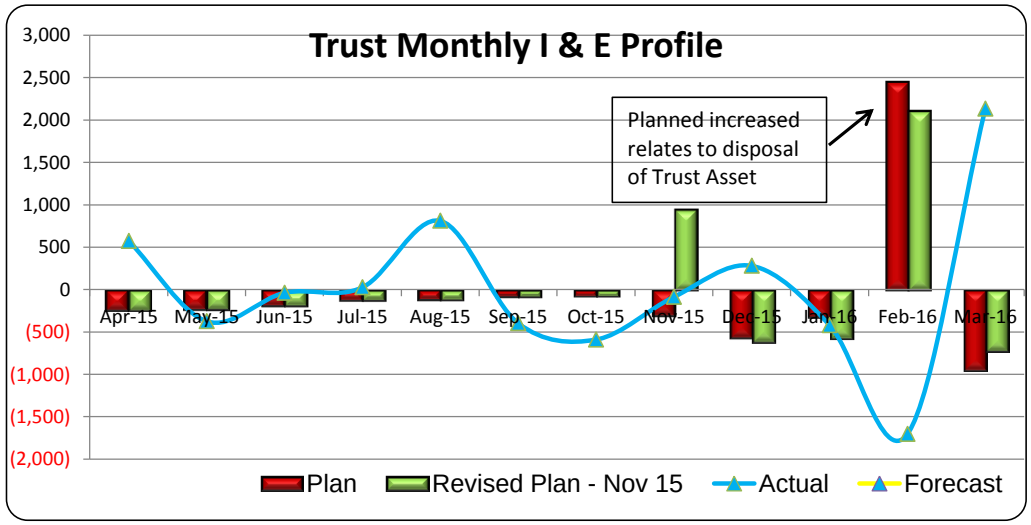
I & E Variance - variance between a foundation Trust's planned I & E margin and actual I & E margin within the year.

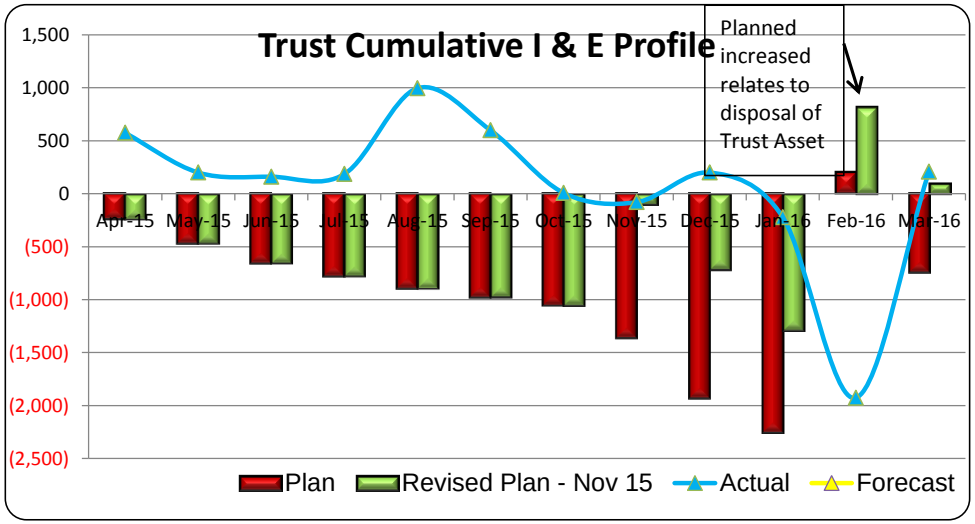
Risk Rating 4 - No evident Concerns

Risk Rating 3 - Emerging or minor concern potentially requiring scrutiny.

Income & Expenditure Position 2015 / 2016

Budget Staff in Post	Actual Staff in Post	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**
				(17,408)	(17,256)	152	Clinical Revenue	(210,774)	(209,632)	1,143	(210,774)	(209,632)	1,143
				(17,408)	**(17,256)**	**152**	**Total Clinical Revenue**	**(210,774)**	**(209,632)**	**1,143**	**(210,774)**	**(209,632)**	**1,143**
				(1,368)	(1,453)	(85)	Other Operating Revenue	(16,208)	(16,890)	(682)	(16,208)	(16,890)	(682)
				(18,776)	**(18,709)**	**67**	**Total Revenue**	**(226,982)**	**(226,521)**	**461**	**(226,982)**	**(226,521)**	**461**
4,428	4,243	(185)	4.2%	14,270	15,099	830	BDU Expenditure - Pay	171,708	171,651	(57)	171,708	171,651	(57)
				4,489	5,520	1,032	BDU Expenditure - Non Pay	46,310	46,537	228	46,310	46,537	228
				31	(2,101)	(2,132)	Provisions	3,085	1,584	(1,500)	3,085	1,584	(1,500)
4,428	**4,243**	**(185)**	**4.2%**	**18,790**	**18,519**	**(270)**	**Total Operating Expenses**	**221,102**	**219,773**	**(1,329)**	**221,102**	**219,773**	**(1,329)**
4,428	**4,243**	**(185)**	**4.2%**	**14**	**(190)**	**(204)**	**EBITDA**	**(5,880)**	**(6,748)**	**(868)**	**(5,880)**	**(6,748)**	**(868)**
				456	552	96	Depreciation	5,475	6,566	1,090	5,475	6,566	1,090
				257	267	11	PDC Paid	3,080	2,990	(90)	3,080	2,990	(90)
				(6)	(18)	(12)	Interest Received	(75)	(89)	(14)	(75)	(89)	(14)
				0	(2,745)	(2,745)	Revaluation of Assets	(2,700)	(2,926)	(226)	(2,700)	(2,926)	(226)
4,428	**4,243**	**(185)**	**4.2%**	**720**	**(2,134)**	**(2,854)**	**Deficit / (Surplus)**	**(100)**	**(207)**	**(107)**	**(100)**	**(207)**	**(107)**





Income & Expenditure Position 2015 / 2016

Month 12

Overall the Trust has delivered a surplus of £0.21m which is £0.11m higher than plan. This represents the Trust's unaudited Annual Accounts position.

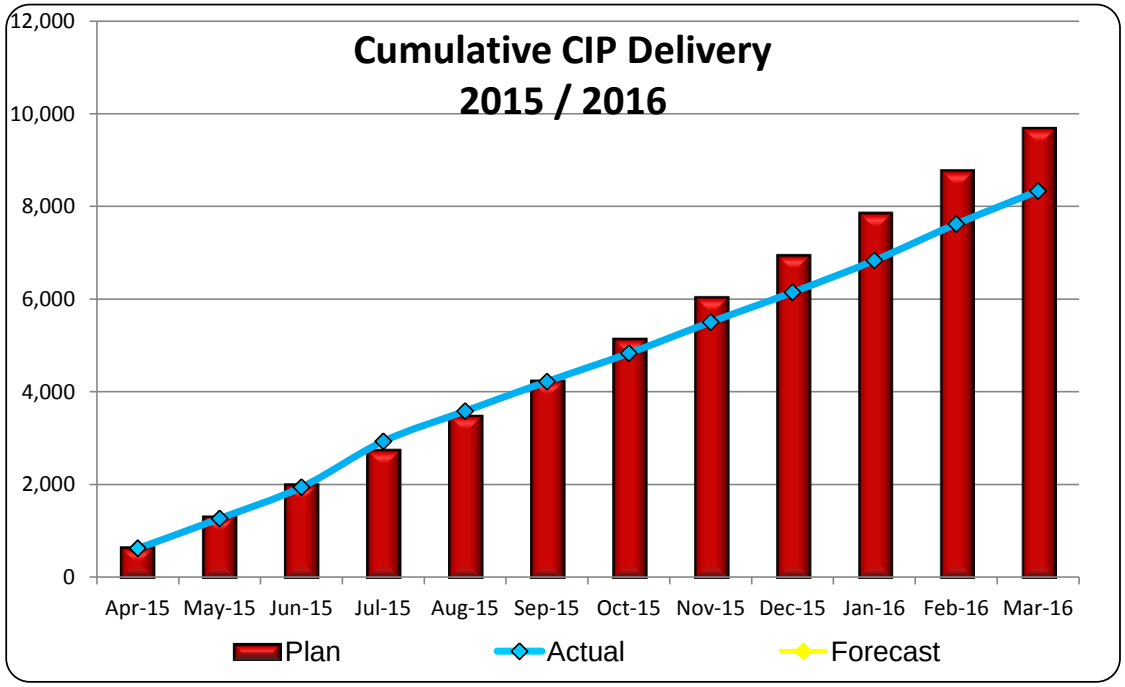
As experienced throughout the year the main factor in delivering this position has been the control and release of Trust reserve funding. This has been required to offset in year pressures experienced within Healthcare Contract Income (primarily CQUIN delivery) and accelerated depreciation charges arising from the Trust's Estates Strategy. As such this funding has not been used as originally intended.

In previous years financial pressures have been absorbed through BDU underspends within the operational budgets. This has not been the case for 2015 / 2016 and is a reflection of the financial challenges being faced across the Trust.

Examples of the financial challenge includes the increased level of agency expenditure being managed by both the financial position and the requirement to provide a quality, clinically safe service. Spend has risen from £5.1m to £8.4m; an increase of £3.3m in year. This is significantly more than the NHS Improvement Agency cap set for 2016 / 2017 and continues to present a financial risk to the Trust.

Cost Improvement Programme 2015 / 2016

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Forecast
	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k
Target - Recurrent	606	613	642	686	690	705	845	850	849	856	856	864	9,061	9,061
Target - Non Recurrent	52	52	52	52	52	52	52	52	52	52	52	52	622	622
Target - Monitor Submission	657	664	694	738	742	756	897	902	901	908	908	916	9,683	9,683
Target - Cumulative	657	1,322	2,016	2,754	3,496	4,252	5,149	6,051	6,951	7,859	8,767	9,683	9,683	9,683
Delivery as planned	400	806	1,226	1,751	2,197	2,643	3,101	3,627	4,112	4,615	5,147	5,692	5,692	5,692
Mitigations - Recurrent	11	22	32	45	61	76	92	107	127	147	167	187	187	187
Mitigations - Non Recurrent	205	436	682	1,134	1,324	1,500	1,639	1,769	1,907	2,071	2,307	2,454	2,454	2,454
Total Delivery	**616**	**1,264**	**1,940**	**2,930**	**3,582**	**4,220**	**4,831**	**5,503**	**6,147**	**6,834**	**7,621**	**8,333**	**8,333**	**8,333**
Shortfall / Unidentified	41	58	75	(176)	(86)	33	318	547	805	1,026	1,146	1,350	1,350	1,350



The profile of the Trust Cost Improvement Programme for 2015 / 2016 is outlined above. This follows a detailed bottom up process conducted as part of the Trust Annual Plan; one which was subjected to an external review.

Year End Position

Overall there has been a shortfall in CIP delivery; and whilst this has been managed within overall Financial position, this does present a risk for 2016 / 2017. This risk has been assessed and factored into the Trust Annual Plan for 2016 / 2017.

Delivery for 2015 / 2016 is made up of:

£5.69m	59%	In line with original plan
£0.19m	2%	Recurrent Mitigations
£2.45m	25%	Non Recurrent Mitigations
£1.35m	14%	In year delivery shortfall

Balance Sheet 2015 / 2016

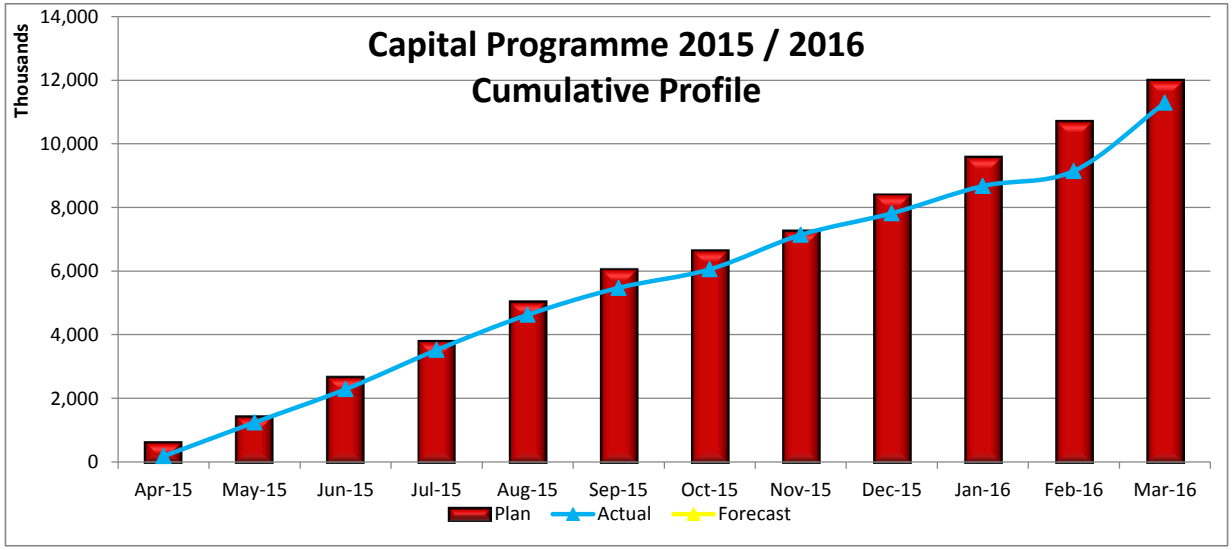
	2014 / 2015 £k	Plan (YTD) £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	106,649	113,065	114,433	1
Current Assets				
Inventories & Work in Progress	204	154	190	
NHS Trade Receivables (Debtors)	3,015	1,715	2,623	2
Other Receivables (Debtors)	4,963	5,138	7,242	2
Cash and Cash Equivalents	32,617	24,268	27,107	3
Total Current Assets	**40,799**	**31,274**	**37,162**	
Current Liabilities				
Trade Payables (Creditors)	(5,851)	(5,851)	(6,430)	4
Other Payables (Creditors)	(3,621)	(3,621)	(3,481)	4
Capital Payables (Creditors)	(770)	(2,220)	(785)	
Accruals	(10,335)	(9,335)	(9,076)	5
Deferred Income	(751)	(751)	(789)	
Total Current Liabilities	**(21,328)**	**(21,778)**	**(20,560)**	
Net Current Assets/Liabilities	**19,471**	**9,496**	**16,602**	
Total Assets less Current Liabilities	**126,120**	**122,561**	**131,035**	
Provisions for Liabilities	(8,104)	(5,288)	(9,517)	
Total Net Assets/(Liabilities)	**118,016**	**117,273**	**121,518**	
Taxpayers' Equity				
Public Dividend Capital	43,492	43,492	43,492	
Revaluation Reserve	16,780	16,780	19,579	
Other Reserves	5,220	5,220	5,220	
Income & Expenditure Reserve	52,524	51,781	53,228	6
Total Taxpayers' Equity	**118,016**	**117,273**	**121,518**	

The Balance Sheet analysis compares the current month end position to that within the Monitor Annual Plan, submitted May 2015. The previous year end position is included for information.

1. Due to the Estates revaluation exercise, actioned in February 2016, the value of fixed assets is now higher than originally planned.
2. NHS debtors have remained higher than planned at month 12. This is primarily due to Quarter 4 recharges, estimated charges for Quarter 4 CQUIN and resolution of contract income issues. Other Debtors includes £2.8m arising from the sale of a Trust Asset. This was paid on 1st April 2016.
3. 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 on page 11.
4. Creditors, at year end, are higher than planned and this mainly relates to Non NHS. No specific high value issues remain and invoices continue to be paid as soon as appropriately approved.
5. Accruals are lower than previous years as we have continued to pursue invoices being raised and resolved. (as shown within the increased debtors and creditors values). A full analysis of accruals provides a key component of the year end accounts working papers.
6. This reserve represents year to date surplus plus reserves brought forward.

Capital Programme 2015 / 2016

	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	2,200	2,200	2,387	187	2,387	187	4
IM&T	2,348	2,348	1,676	(672)	1,676	(672)	3
Total Minor Capital & IM &T	**4,548**	**4,548**	**4,063**	**(485)**	**4,063**	**(485)**	
Major Capital Schemes							
Barnsley Hub	950	950	1,214	264	1,214	264	5
Halifax Hub	4,052	4,052	4,251	199	4,251	199	5
Hub Development	1,450	1,450	1,120	(330)	1,120	(330)	6
Fieldhead Development	1,000	1,000	760	(240)	760	(240)	7
Total Major Schemes	**7,452**	**7,452**	**7,345**	**(107)**	**7,345**	**(107)**	
VAT Refunds	0	0	(119)	(119)	(119)	(119)	
TOTALS	**12,000**	**12,000**	**11,289**	**(711)**	**11,289**	**(711)**	



Capital Expenditure 2015 / 2016

1. The Trust Capital Programme for 2015 / 2016 is £12.0m and schemes are guided by the overall Trust Estates Strategy.

A revised forecast expenditure of £11.5m has been communicated to Monitor; this specifically related to reduced IM & T expenditure following reduced costs from a competitive tendering process.

2. The year end position is £0.71m under plan (6%). Total Capital Spend in year is £11.29m.

3. IM & T spend is within the overall capital allocation and all planned schemes have been delivered in year.

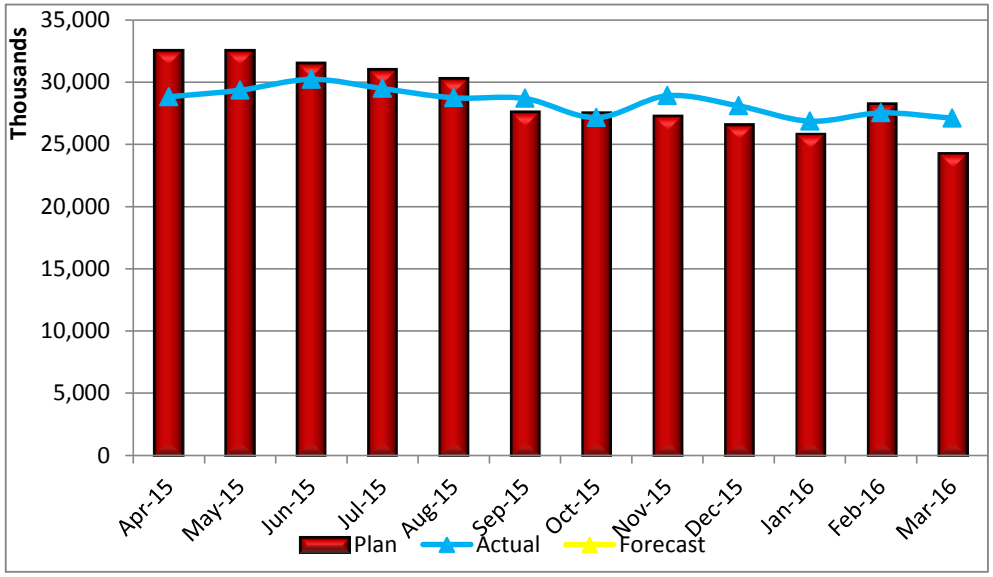
4. There have been additions in year to the Minor Capital schemes list such as improvements to the Bretton Centre entrance. As such this has exceeded planned expenditure in year.

5. Both the Barnsley and Halifax hubs have been completed in year; resulting in new modern facilities within these locations.

6. The development of hubs within Wakefield and Pontefract have commenced in 2015 / 2016 and are expected to be completed in 2016 / 2017.

7. The Trust has commenced a programme of significant capital investment on the non secure facilties at the Fieldhead site.

Cash Flow & Cash Flow Forecast 2015 / 2016



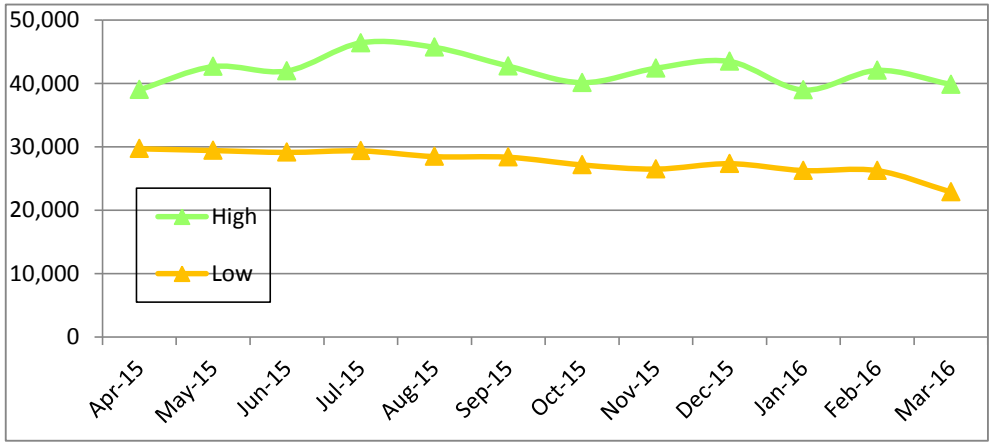
	Plan £k	Actual £k	Variance £k
Opening Balance	32,617	32,617	
Closing Balance	24,268	27,107	2,840

The Cash position provides a key element of the Continuity of Service and Financial Efficiency Risk Rating. As such this is monitored and reviewed on a daily basis.

Weekly review of actions ensures that the cash position for the Trust is maximised.

Overall the cash position is £27.11m which is £2.84m higher than planned.

A detailed reconciliation of working capital compared to plan is presented at page 11.



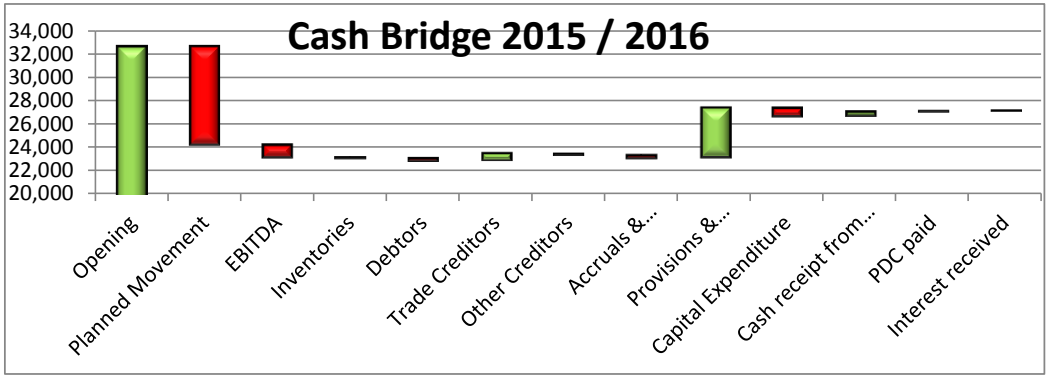
The graph to the left demonstrates the highest and lowest cash balances with each month. This is important to ensure that cash is available as required.

The highest balance is: £39.84m
The lowest balance is: £22.87m

This reflects cash balances built up from historical surpluses that are available to finance capital expenditure in the future.

Reconciliation of Cashflow to Cashflow Plan

	Plan £k	Actual £k	Variance £k	Note
Opening Balances	**32,617**	**32,617**		
Surplus (Exc. non-cash items & revaluation)	7,846	6,751	(1,096)	
Movement in working capital:				
Inventories & Work in Progress	50	14	(36)	
Receivables (Debtors)	1,125	888	(237)	
Trade Payables (Creditors)	0	580	580	2
Other Payables (Creditors)	0	(115)	(115)	
Accruals & Deferred income	(1,000)	(1,222)	(222)	
Provisions & Liabilities	(2,816)	1,413	4,229	1
Movement in LT Receivables:				
Capital expenditure & capital creditors	(10,550)	(11,274)	(724)	4
Cash receipts from asset sales	0	383	383	3
PDC Dividends paid	(3,080)	(3,016)	64	
PDC Received	0		0	
Interest (paid)/ received	75	89	14	
Closing Balances	**24,268**	**27,107**	**2,840**	



The Plan value reflects the May 2015 submission to Monitor.

Factors which increase the cash positon against plan:

1. The increase in provisions means that the Trust retains cash until this are paid. This is planned for during 2016 / 2017.

2. The Trust has higher creditors than planned and as such retains the cash within our bank.

3. The cash received from the sale of Trust assets has been higher than planned. These are smaller Trust assets sold as part of the wider Estates Strategy.

Factors which decrease the cash position against plan:

4. Capital expenditure (including the impact of capital creditors) is higher than planned. This is mainly due to invoices being received and paid prior to year end.

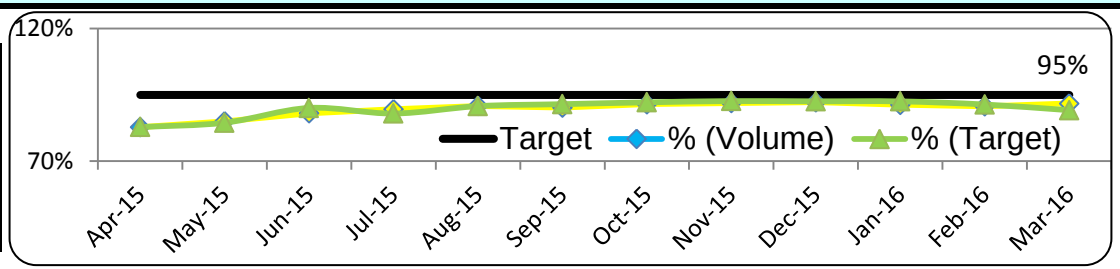
5 . Debtor levels overall are higher than planned and have increased in month 12 due to a debtor relating to the disposal of a Trust asset (£2.8m). This was paid on 1st April 2016. Without this we would have seen a reduction in the value of debtors.

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

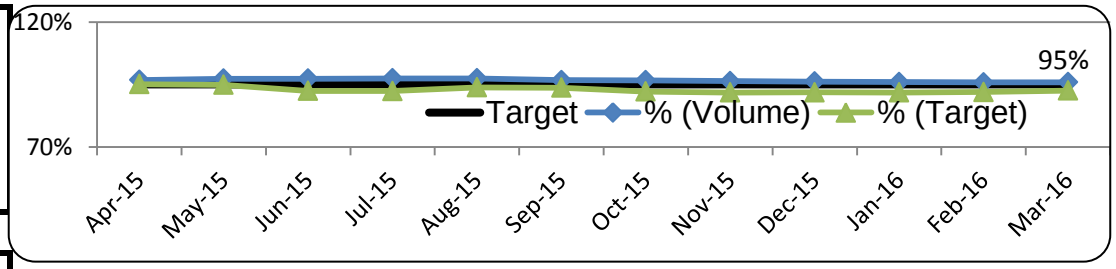
Better Payment Practice Code

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.
In November 2008 the Trust adopted a Government request for Public Sector bodies to pay local Suppliers within 10 days. This is not mandatory for the NHS.
The team continue to review reasons for non delviery of the 95% target and identify solutions to problems and bottlenecks in the process.

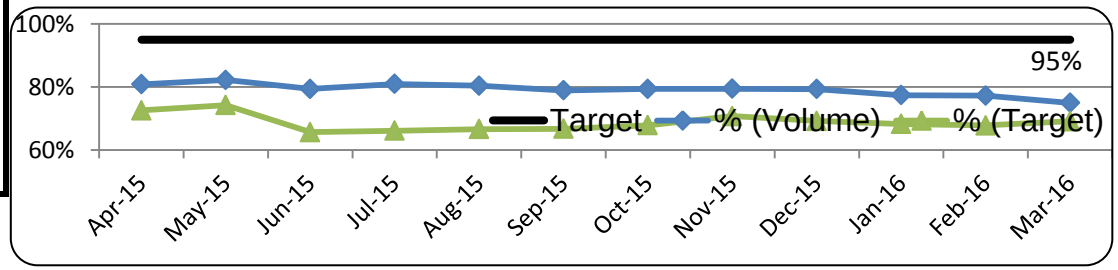
NHS	Number %	Value %
Year to February 2016	91%	93%
Year to March 2016	91%	91%



Non NHS	Number %	Value %
Year to February 2016	96%	92%
Year to March 2016	96%	92%



Local Suppliers (10 days)	Number %	Value %
Year to February 2016	77%	68%
Year to March 2016	77%	68%



Transparency Disclosure

As part of the Government's commitment to greater transparency, there is a requirement to publish online, central government expenditure over £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.

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

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

Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
09/02/2016	Service Level Agreement	Trustwide	Mid Yorkshire Hospitals NHS Trust	2197637	290,160
16/03/2016	Service Level Agreement	Calderdale	Calderdale and Huddersfield NHS Fou	8153065	208,398
09/02/2016	Estate Managment SLA	Trustwide	Mid Yorkshire Hospitals NHS Trust	2197637	179,004
09/02/2016	Domestic SLA	Trustwide	Mid Yorkshire Hospitals NHS Trust	2197637	160,596
15/01/2016	Drugs	Trustwide	Mid Yorkshire Hospitals NHS Trust	2195205	124,826
30/03/2016	Utilities SLA	Calderdale	Calderdale and Huddersfield NHS Fou	2199323	112,837
22/02/2016	Drugs	Trustwide	Mid Yorkshire Hospitals NHS Trust	2197078	102,749
26/02/2016	Drugs FP10´s	Trustwide	NHSBSA Prescription Pricing Division	2197534	98,508
09/02/2016	Maintenance Management SLA	Trustwide	Mid Yorkshire Hospitals NHS Trust	2197637	82,092
29/02/2016	Staff Recharge	Wakefield	Wakefield MDC	2197554	58,127
16/03/2016	Drugs	Trustwide	NHS Calderdale CCG	2198440	56,508
09/02/2016	Portering SLA	Trustwide	Mid Yorkshire Hospitals NHS Trust	2197637	55,836
12/02/2016	Agency Qualified Nurse	Trustwide	Talent HCM Limited	2196718	51,916
09/02/2016	Switchboard SLA	Trustwide	Mid Yorkshire Hospitals NHS Trust	2197637	48,360
03/03/2016	Specialty Registrar (CT1-3)	Trustwide	Leeds and York Partnership NHS FT	2197764	43,218
29/03/2016	Training Expenses	Trustwide	University of Huddersfield HEC	8153939	39,808
24/03/2016	Staff Recharge	Trustwide	NHS Yorkshire & the Humber CSU	2199194	36,543
29/02/2016	Staff Recharge	Wakefield	Wakefield MDC	2197552	36,021
09/02/2016	Service Level Agreement	Trustwide	Mid Yorkshire Hospitals NHS Trust	2197637	33,060
12/02/2016	Agency Unqualified Nurse	Trustwide	Talent HCM Limited	2196715	29,211

Glossary

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

* Non-Recurrent - 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

* 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 - This is the surplus we expect to make for the financial year

* Target Surplus - This is the surplus 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. Recently this has been set as part of the IBP/LTFM process. Previously we aimed to achieve breakeven.

* 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 pat of the Recurrent Underlying Surplus.

* Cost Improvement Programme (CIP) - We only agree actions which have a recurring effect, so these savings are part of our Recurrent Underlying Surplus.

* Non-Recurrent CIP - A CIP which is identified in advance, but which only has a one off financial benefit. This Trust has historically only approved recurrent CIP's. 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.

* IFRS - International Financial Reporting Standards, there are the guidance and rules by which financial accounts have to be prepared.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 28 April 2016
Agenda item 8.3

Title:	**Customer Services report – quarter 4 2015/16**
Paper prepared by:	Director of Corporate Development
Purpose:	To note the service user experience feedback received via the Trust's Customer Services function, the themes arising, learning, and action taken in response to feedback. To note also the summary Friends and Family Test results and number of requests received by the Trust under the Freedom of Information Act.
Mission/values:	A positive service user experience underpins the Trust's mission and all values. Ensuring people have access and opportunity to feedback their views and experiences of care is essential to delivering the Trust's values and is part of how we ensure people have a say in public services. The Trust is committed to responding openly and transparently to all requests for information under FOI.
Any background papers/ previously considered by:	Trust Board reviews the Customer Services policy on an annual basis; the last review was in January 2016. Most recent policy updates reflects CQC essential standards and best practice in complaints management as outlined in 'My Expectations' – a vision outlined following collaborative work by the Parliamentary and Health Service Ombudsman, the Local Government Ombudsman and Healthwatch England. Weekly Customer Services reporting to BDUs is enabling increased scrutiny of issues and themes, complaints investigation, response timeframes and action planning, to ensure service improvement in response to feedback.
Executive summary:	**Customer Services Report – Q4 2015/16** This report provides information on feedback received, the themes indicated, lessons learned and action taken in response to feedback. The report format has been revised to support summary information to BDUs to supplement weekly reporting on specific cases. In Q4, there were 112 formal complaints, 164 compliments, 372 issues were responded to and 77 requests to access information under the Freedom of Information Act. This report is distributed to commissioners and is subject to discussion at Quality Boards and through contracting processes. It is reviewed by Healthwatch across the Trust's geography. The information is also reviewed alongside other service user experience intelligence at the internal Customer Experience Group.
Recommendation:	**Trust Board is asked to REVIEW and NOTE the feedback received through Customer Services in Q4 of financial year 2015/16.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Customer Services Report - Quarter 4 2015/ 16

Introduction

This report covers all feedback received by the Trust's Customer Services Team - comments, compliments, concerns and complaints, which are managed in accordance with policy approved by Trust Board. Trust processes emphasise the importance of using insight from service user experience to influence and improve services.

The service operates as a single gateway for raising issues and enquiries, including requests under the Freedom of Information Act. Urgent issues or potential risks identified through Customer Services processes are highlighted to the relevant BDU and escalated to the Trust wide risk register / assurance framework as appropriate.

This report includes:

- The number of issues raised and the themes arising
- External scrutiny and partnering
- Equality data
- A breakdown of issues at BDU level including:
  - customer service standards
  - actions taken / changes as a consequence of service user and carer feedback
  - compliments received
  - Friends and Family Test results
- The number and type of requests processed under the Freedom of Information Act

Contact

The Customer Services Team processed 119 general enquiries in Qtr. 4, in addition to '4 Cs' management. Consistent with past reporting, signposting to Trust services was the most frequently requested advice. Other enquiries included requests for information about Trust Services, providing contact details for staff and information on how to access healthcare records. The team also responded to over 170 telephone enquiries from staff, offering support and advice in resolving concerns at local level (a significant decrease in staff contact on the previous quarter).

Feedback received

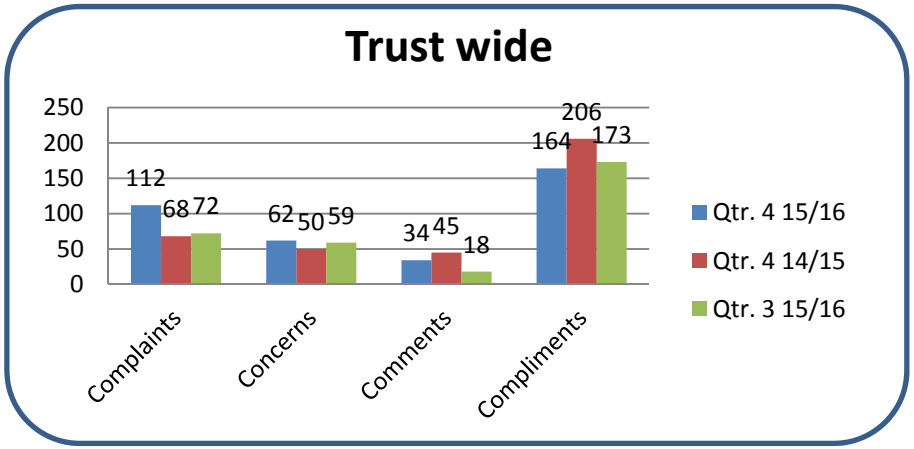
In Qtr. 4. The Customer Services Team responded to 372 issues (366 in Qtr. 3); 112 formal complaints were received (72 in Qtr. 3) and 164 compliments (173 in Qtr. 3).

Communication was identified as the most frequently raised negative issue (31). This was followed by Trust admin/ policies/ procedures (30), values and behaviours (staff) (29), patient care (28) and access to treatment and drugs (18) Most complaints contained a number of themes

In Qtr. 4 there were 24 formal complaints regarding the possible discontinuation of the art therapy component of psychological therapy services in Calderdale. Engagement with service users, staff, commissioners and local authority Overview and Scrutiny is continuing .

CQC inspectors reviewed Trust processes for complaints management as part of the inspection in March, reviewing also a sample closed cases. Service ensured promotion of the Customer Services function as part of preparation for the inspection.

In Qtr. 4, 78% of people using mental health services said they would recommend them, 98% would recommend community health services.



NHS Choices

The Trust has introduced measures to attempt to drive traffic to NHS Choices, in recognition that this site is an external source of information about the Trust. Survey materials promote NHS Choices as an additional means to offer feedback about the Trust and its services. The website is monitored to ensure timely response to feedback posted.

During Qtr. 4, 1 individual added a positive comment on NHS Choices about their experience of Trust services, which was acknowledged, and shared with staff on Trinity 2, Wakefield BDU.

PHSO (Ombudsman)

In Q4, 3 complainants asked the Parliamentary and Health Service Ombudsman to review their complaint following contact with the Trust. Such cases are subject to rigorous scrutiny by the Ombudsman, including a review of all documentation and the Trust's complaints management processes. Information requested by the Ombudsman in relation to the above was provided within the prescribed timeframe.

During the quarter, the Trust received feedback from the Ombudsman regarding 7 cases. 5 were closed with no further action required. 2 cases (Wakefield BDU) were partially upheld. Recommendations to the Trust included the preparation of action plans to reflect proposed improvements to services, and an appropriate apology to the complainant. The Trust currently has 7 cases pending with the Ombudsman.

It can take a number of months before the Ombudsman is in a position to advise the Trust on its decisions (due to the volume of referrals received by PHSO).

Mental Health Act (MHA)

7 complainants raised concerns with the Trust in Qtr. 4 regarding detention under the Mental Health Act. Five individuals chose not to specify their ethnicity - two described themselves as white British.

Information on the numbers of complaints regarding application of the Act is routinely reported to the Mental Health Act Sub Committee of the Trust Board.

CQC / ICO

1 issue referred to the Trust by the CQC in Qtr. 3 (Wakefield Older People In-patient Services) was reopened in Qtr. 4.

The Information Commissioner is currently reviewing a report prepared by the Trust regarding an information governance breach in Kirklees CAMHS.

Joint Working

National guidance emphasises the importance of organisations working together where a complaint spans more than one health and social care organisation, including providing a single point of contact and a single response.

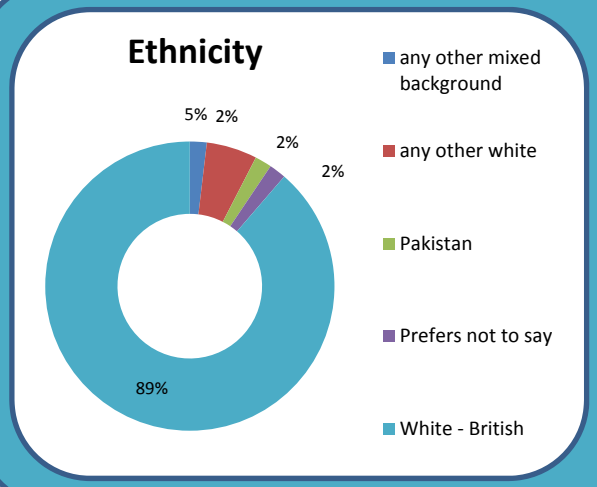
Joint working protocols are in place with each working partnership. The purpose of these is to simplify the complaints process when this involves more than one agency and improve accessibility for users of health and social care services.

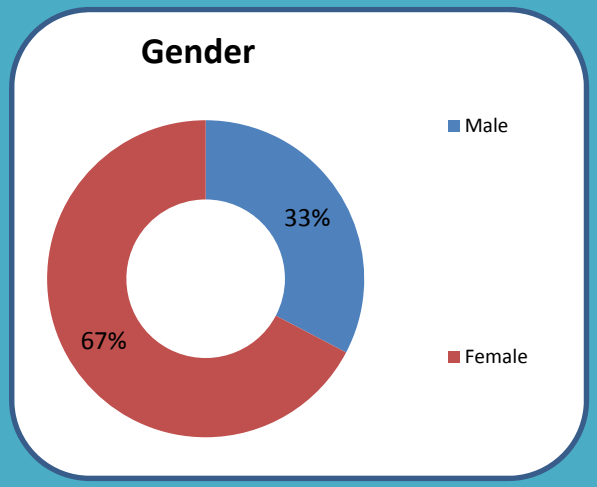
The Customer Services function also makes connection to local Healthwatch to promote positive dialogue and respond to any requests for information. Healthwatch are provided with copies of quarterly reports and request additional information from the Trust on occasion.

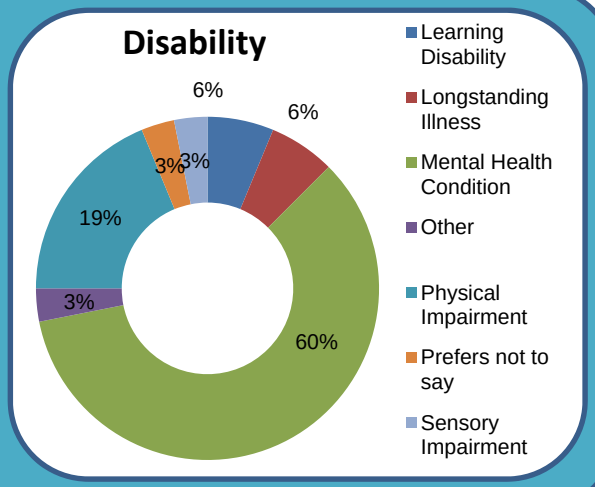
Healthwatch Calderdale attended a recent art therapy engagement event; Healthwatch Barnsley have recently reviewed CAMHS services and are liaising with the service regarding recommendations.

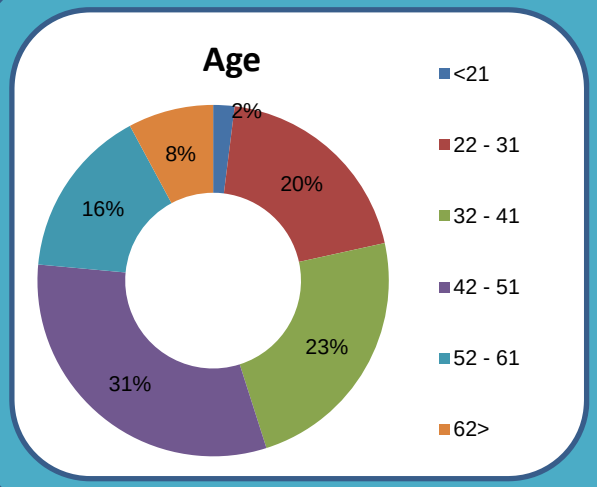
Issues spanning more than one organisation Qtr. 4	Complaint	Concern	Comment
Barnsley Metropolitan Borough Council	1	0	0
Care Quality Commission	1	0	0
Member of Parliament	7	3	10
Mid Yorkshire Hospital NHS Trust	1	0	0
NHS Calderdale CCG	1	0	0
NHS Greater Huddersfield CCG	1	0	0
NHS Wakefield CCG	0	1	0
Other Local Authority	1	1	0

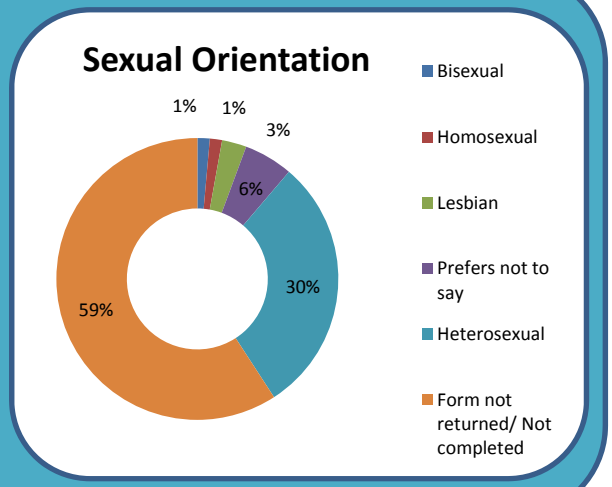
Equality and Inclusion – Formal Complaints - Protected Characteristics Data











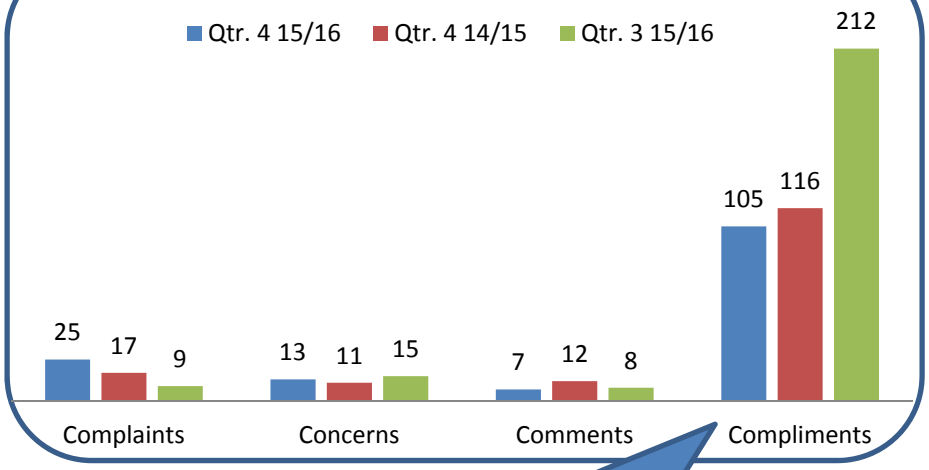
Equality data is captured, where possible, at the time a formal complaint is made. Where complaints are received by email or letter, an equality monitoring form is issued with a request to complete and return. To support improvement in the number of forms returned / completed, additional information is now also shared explaining why collection of this data is important to the Trust and that it is essential to ensure equality of access to Trust services.

The Team continues to explore best practice in data capture, both internally with teams and externally with partner organisations and networks, and incorporates any learning into routine processes.

The charts show, where information was provided, the breakdown in respect of ethnicity, gender, disability, age and sexual orientation. This is collated Trust- wide.

Barnsley Business Delivery Unit

Number of issues



Actions Taken

- Service to continue to improve communication with family/carers. – district nursing.
- Service to ensure improved and timely communication, including telephone and postal contact re appointments. Service has also done work to ensure referral criteria understood by other organisations and services - COPD team.
- Service to improve communication between service user and staff. - CMHT Central
- A further 'Opt In' letter will be issued to service user, which will not impact on the position on the waiting list - CMHT Central.
- Service to ensure that appropriate debrief and documentation on RiO is completed following restraint - Clark Ward
- Service to produce information booklet for carers, to include information on the side effects of anti-psychotic medication. – Beamshaw Ward

Everyone involved in looking after me during my time on the ward. I can't thank you enough for your time and patience in helping me recover and get back on my feet. Keep up the excellent work.
Stroke Unit

Complaints closed <25 days
60%

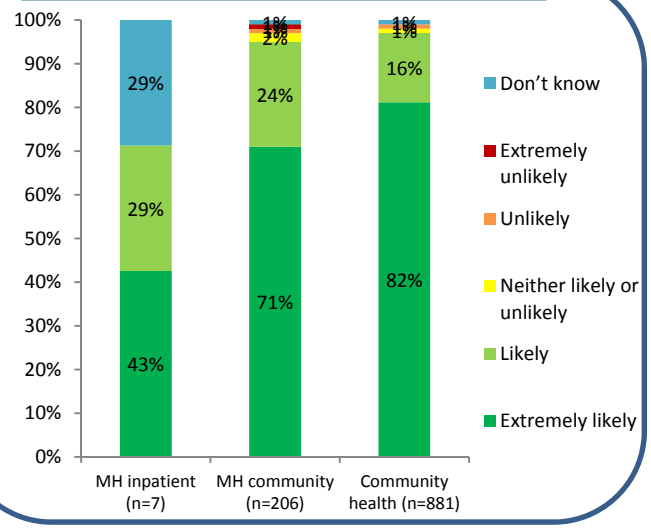
Complaints closed 26 – 40 days
27%

Complaints closed >40 days
13%

In Qtr. 4 47% of complaints (7) that were closed took over 5 days for a lead investigator to be allocated, and 3 complaints were re-opened.

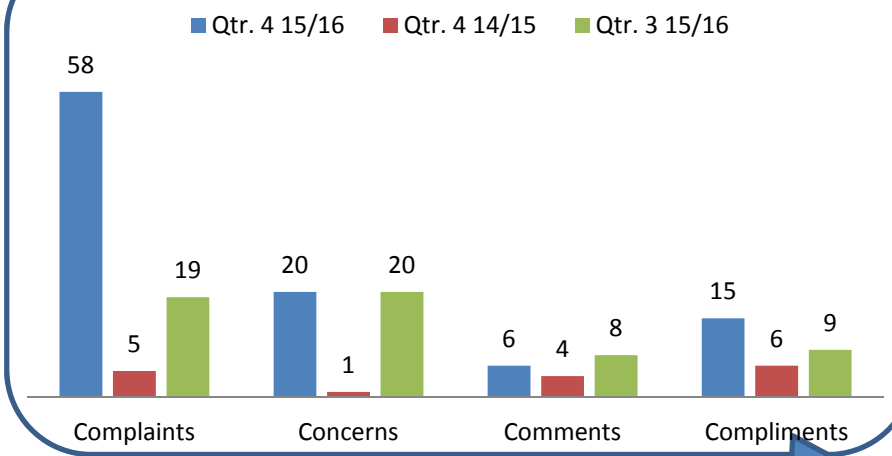
There has been an improvement in the number of complaints closed within the 25 day timeframe since last quarter. Weekly reporting to BDUs, which is shared with district directors, deputies and 'Trios', identifies areas of concerns which require action, and identify any lessons learned to inform governance processes.

Friends and Family Test



Calderdale & Kirklees Business Delivery Unit

Number of issues



Comments / Actions Taken

- Service to ensure that relative's details are noted in health care records wherever possible - CMHT Lower Valley.
- Staff to ensure that service users have information regarding how to access support outside normal working hours should they need to due to deterioration in their mental health – CMHT Kirklees.

The significant increase in complaints in the quarter relates to the possible discontinuation of the art therapy component of psychological therapy services in Calderdale.

MP Contact

5 contacts were received from MP's, on behalf of constituents:

- Craig Whittaker, Holly Lynch, and Jason McCartney all raised concerns regarding possible discontinuation of art therapy.
- Jo Cox, leave arrangements, and non-smoking issues.

A very big thank you to all for your loving care and attention. Your help and support has helped me to make a good recovery. You have a wonderful unit.
Ward 18, Priestley Unit.

Complaints closed <25 days
64%

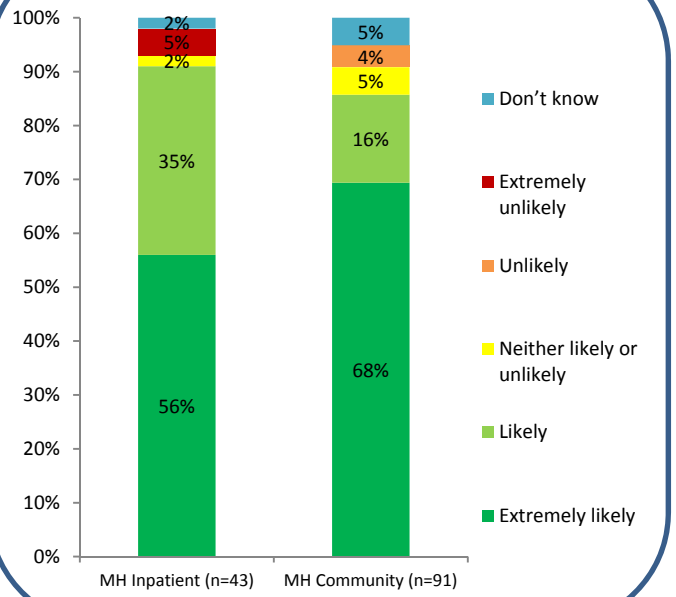
Complaints closed 26 – 40 days
18%

Complaints closed >40 days
18%

In Qtr. 4, 13% of complaints (13) took over 5 days to allocate a lead investigator and 6 complaints were re-opened.

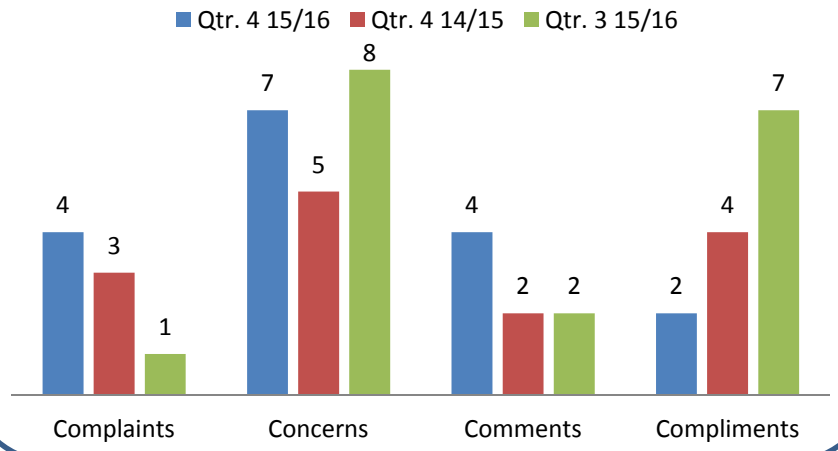
There has been an improvement in the number of complaints closed within the 25 day timeframe since last quarter. Weekly reporting to BDUs which is shared with district directors, deputies and 'Trios' identifies areas of concerns which require action, and identifies any lessons learned to inform governance processes.

Friends and Family Test



Forensics Business Delivery Unit

Number of issues



Actions Taken

- The service will ensure that service users receive all documentation prior to tribunals – Hepworth Ward
- Staff will improve communication with families / carers in respect of unescorted leave - Hepworth Ward
- The service will encourage a service user to explore his thoughts and feelings through ongoing psychology sessions, and to discuss his on-going care and experiences with staff - Newhaven
- Staff to ensure they are appraise d of actions documented on RiO prior to appointments/meetings - Ryburn Ward.

Complaints closed <25 days
50%

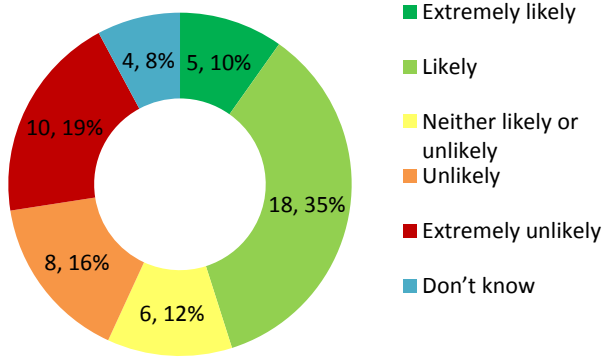
Complaints closed 26 – 40 days
25%

Complaints closed >40 days
25%

In Qtr. 4, 75% of complaints (3) took over 5 days for a lead investigator to be allocated.

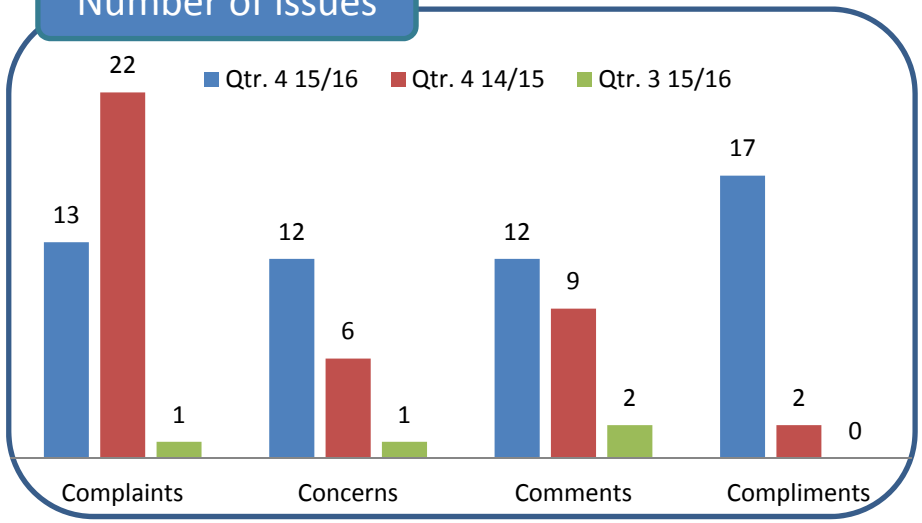
There has been an improvement on the number of complaints closed within the 25 day timeframe since last quarter. Weekly reporting to BDUs which is shared with district directors, deputies and 'Trios' identifies areas of concerns which require action, and any lessons learned to inform governance processes.

How likely are you to recommend our service to friends and family if they required similar care or treatment? (n=51)



Specialist Services Business Delivery Unit (incl. CAMHS)

Number of issues



We were made to feel very welcome and the initial meeting was so gentle and easy. The staff have a unique manner and ensure such positivity, comprehension and incredible empathy which is invaluable.
Horizon Centre Assessment and Treatment Service

MP Contact

Jason McCartney MP requested information regarding the waiting time for ADHD assessments.

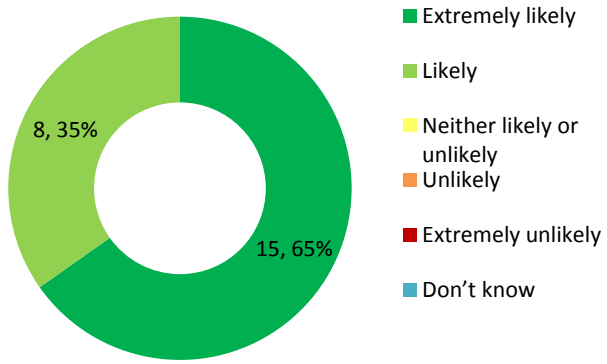
Complaints closed <25 days
100%

Complaints closed
26 – 40 days
0%

Complaints closed >40 days
0%

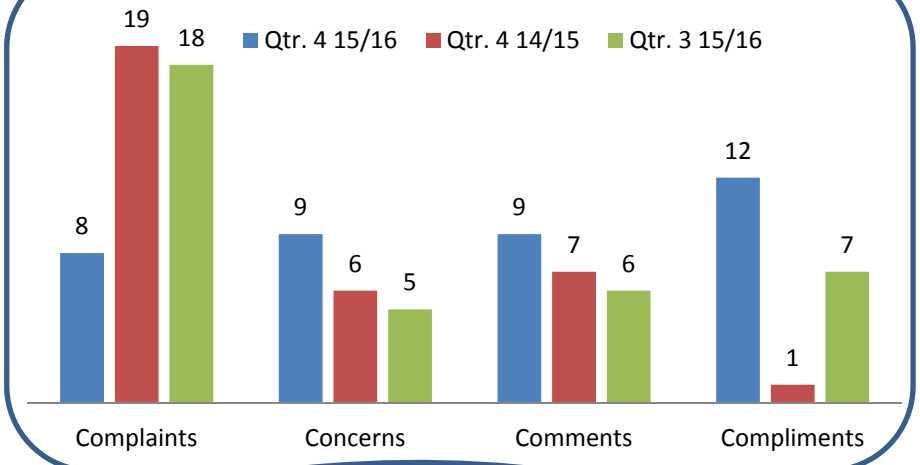
There has been an improvement on the number of complaints closed within the 25 day timeframe since last quarter. Weekly reporting to BDUs which is shared with district directors, deputies and 'Trios' identifies areas of concerns which require action, and any lessons learned to inform governance processes.

How likely are you to recommend our service to friends and family if they required similar care or treatment? (n=23)



Child and Adolescent Mental Health Services

Number of issues



Actions Taken

- Staff to ensure that cancellation of appointments is appropriately communicated.

MP contact

8 contacts were received from MP's, on behalf of constituents:

- Jason McCartney – waiting time for assessment for autism, and ASD assessments.
- Holly Lynch – waiting time for assessment for ADHD,
- Mary Creagh – requested information regarding waiting times, and referrals for assessment for autism.
- Paula Sherriff – waiting time for assessment for ASD, and chose and book options for service.
- Andrea Jenkins – waiting times for counselling
- Yvette Copper – waiting time for an appointment with service

I wanted to take this opportunity to say a huge thank you for the help and support you have given my daughter over the past year. She is now her confident, happy self again and you played a really big part in achieving this. Thank you again. the work you do is so very valuable.
CAMHS Barnsley

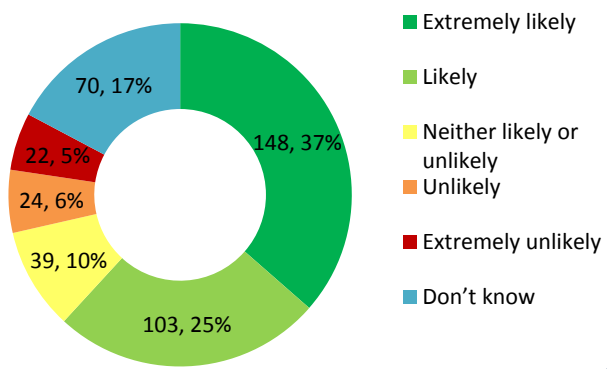
Complaints closed <25 days
64%

Complaints closed 26 – 40 days
0%

Complaints closed >40 days
36%

In Qtr. 4, 40% of complaints (4) took over 5 days for a lead investigator to be allocated, and two complaints were re-opened.

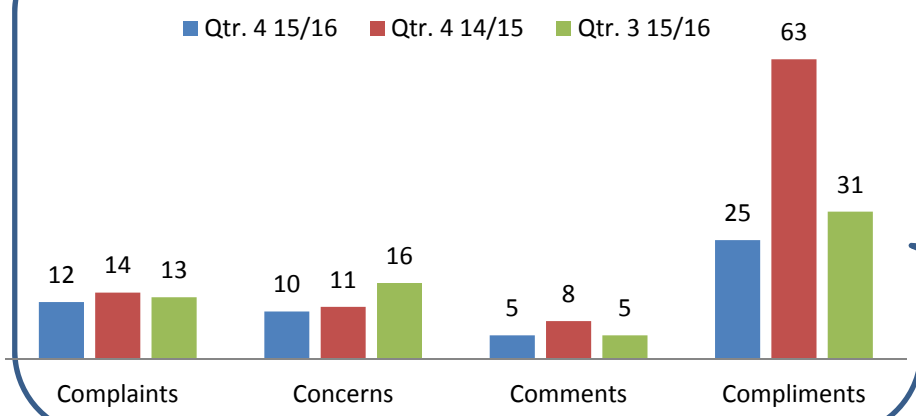
How likely are you to recommend our service to friends and family if they required similar care or treatment? (n=406)



There has been an improvement on the number of complaints closed within the 25 day timeframe since last quarter. Weekly reporting to BDUs which is shared with district directors, deputies and 'Trios' identifies areas of concerns which require action, and any lessons learned to inform governance processes.

Wakefield Business Delivery Unit

Number of issues



Actions Taken

- Service to improve communication between staff and service users – APTS, Fieldhead.
- Service to ensure that service users and carers understand response times in respect of crisis referrals – SPA.

This member of staff really understands the impact therapy can have on peoples lives and brings his own experiences to help and show how other people deal with challenges
APTS, Fieldhead

MP contact

3 contacts were received from MP's, on behalf of constituents:

- Yvette Cooper, regarding care package following discharge
- Mary Creagh, information regarding Asperger's syndrome and anxiety, and information regarding mental health services for men in Wakefield.

Complaints closed <25 days 50%

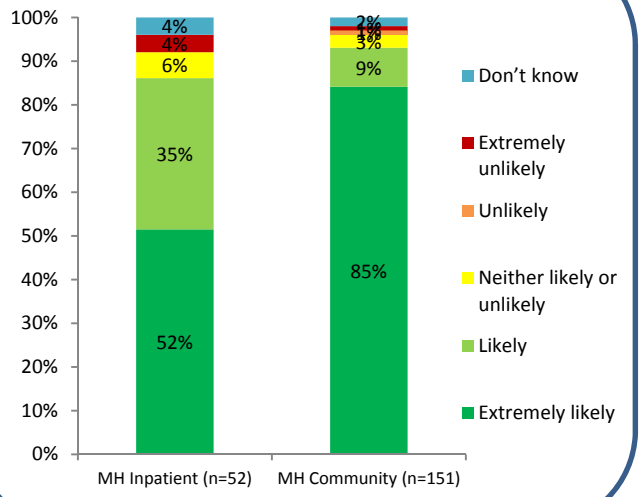
Complaints closed 26 – 40 days 30%

Complaints closed >40 days 20%

In Qtr. 4, 54% of complaints (6) took over 5 days for a lead investigator to be allocated, and two complaints were re-opened.

There has been a improvement in the number of complaints closed wit in the 25 day timeframe since last quarter. Weekly reporting to BDUs, which is shared with district directors, deputies and 'Trios' identifies areas of concerns which require action, and any lessons learned to inform governance processes.

Friends and Family Test



Freedom of Information requests

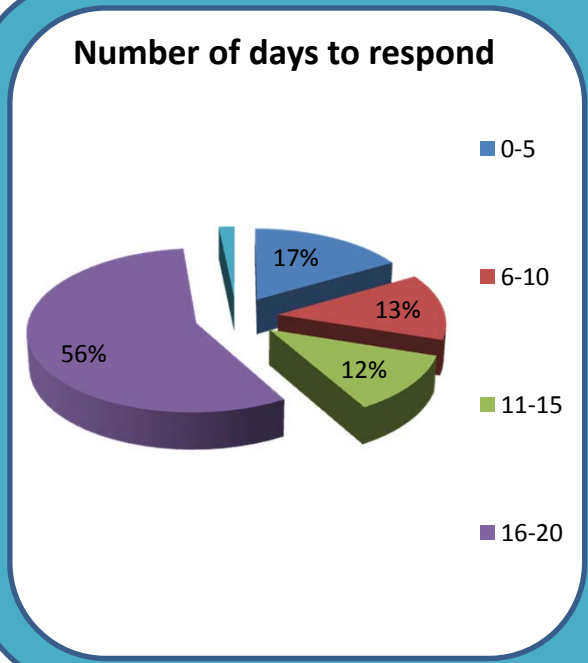
77 requests to access information under the Freedom of Information Act were processed in Qtr. 4, an increase on the previous quarter when 53 requests were processed. Most requests were detailed and complex in nature and required significant time to collate an appropriate response working with services and quality academy functions.

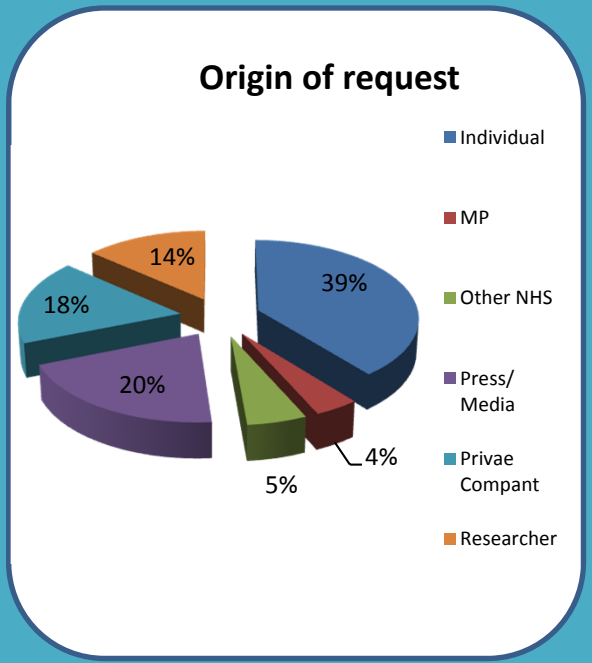
The Customer Services Team works with information owners in the Trust to respond to requests as promptly as possible, but within the 20 working day requirement.

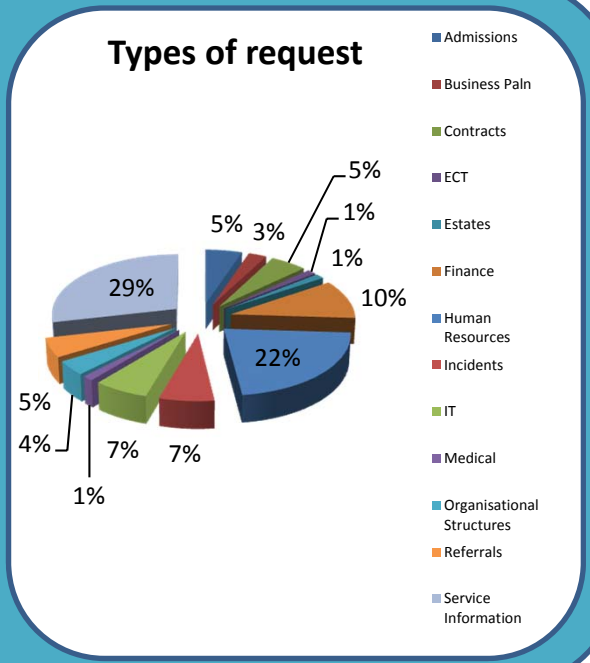
During Qtr. 4 8 exemptions were applied:

- 3 x Exemption 40, Personal information
- 3 x Exemption 43, Commercial Interests
- 1 x Exemption 21, Information reasonably accessible to the applicant by other means
- 1 x Exemption 41, Information provided in confidence

There was one appeal against a decision made in respect of management of requests under the Act during the quarter., exemption 41, Information provided in confidence , which was upheld by the Trust. Appeals are reviewed by the Deputy Director of Corporate Development.







With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 28 April 2016
Agenda item 8.4(i)

Title:	**Risk assessment of performance and compliance targets**
Paper prepared by:	Director of Finance
Purpose:	The purpose of this report is to outline to Trust Board: • the main changes to performance and compliance requirements for 2016/17; • issues with expected level of attainment; • significant risk in terms of reputation and finance; • assurance on risk mitigation.
Mission/values:	The annual review of compliance and contract arrangements supports the delivery of services which have the right quality and are efficient making the best use of resources including technology and put the person in the centre.
Any background papers/ previously considered by:	Annual report April 2012, Risk Assessment Reports 2013/14, 2014/15 and 2015/16. Monthly Performance Reporting.
Executive summary:	The report outlines the main changes to performance and compliance requirements for 2016/17. There is assessment of expected levels of attainment and risk in terms of finance and reputation with assurance given as to risk mitigation. In terms of the regulator, Monitor and the Trust Development Agency (TDA) have merged functions from 1 April 2016 and have been renamed NHS Improvement (NHSI). The legal framework under which foundation trusts are regulated has not changed. The two areas considered are: • regulators and regulations; • contractual requirements. In summary: • there are currently no major issues or risks relating to the Trust's compliance with its Provider Licence; • the Trust has a positive financial risk rating of 4 for viability as a going concern and the Operational Plan is assessed to remain at level 4 with no risks identified; • the Trust has a green governance rating and no risks to maintenance of this rating have been identified; • at March 2016, the Trust continued to carry two compliance actions under previous inspection regimes. The Trust believes these actions have been addressed. These compliance actions are expected to be removed as part of the Care Quality Commission (CQC) feedback from the recent inspection; • the Trust received a formal CQC inspection in March 2016 and the final report is expected in mid-May 2016, which will award the Trust's CQC rating. The risks and follow-up actions will be further assessed on receipt of the final report; • CQC regulation fees are due to increase in line with national plans. This will increase the costs to the Trust from £90,000 in 2016/17 to £217,000 by 2017/18. • future CQC inspection themes that are currently under consultation will

	require further consideration and risk assessment if implemented; • performance against the national access and outcomes requirements has an impact on the Trust's governance rating. Significant changes to performance are not anticipated and the forecast remains green. Overall performance risk is reduced compared to 2015/16. • CPA 7 Day Follow Up remains the target at most risk of under achievement; however, action is being taken to minimise risk; • the introduction of the legal right to choice for mental health services will be monitored by commissioners in 2016/17 through contract management processes. The level of change in patient flows during 2016/17 is expected to be minimal, but performance trends will be monitored, and actions taken to be the service user's provider of choice; • full achievement of CQUIN income remains at risk and plans are in place to improve performance/achievement. The national CQUIN for improving physical healthcare for Mental Health service users continues to be an area requiring additional focus. All risks in achieving compliance will be included on the Risk Register with mitigating action plans in place. These will be monitored through BDUs and the Delivery EMT.
Recommendation:	**Trust Board is asked to NOTE the content of the report, the assessment of risk and the actions planned to mitigate risk.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 28 April 2016
RISK ASSESSMENT:
2016-17 PERFORMANCE AND COMPLIANCE TARGETS

EXECUTIVE SUMMARY

1. PURPOSE OF REPORT

The purpose of this report is to:

- Outline the main changes to performance and compliance requirements for 2016-17
- Highlight any keys issues related to the level of attainment
- Identify any significant risk issues in terms of reputation and finance
- Provide assurance on risk mitigation

The two areas considered are:

- Regulators and regulations
- Contractual requirements

2. REGULATORS AND REGULATIONS

2.1 NHS IMPROVEMENT

NHS Improvement is responsible for overseeing Foundation Trusts and NHS Trusts, as well as independent providers that provide NHS-funded care. From 1 April 2016, NHS Improvement is the operational name for the organisation that brings together Monitor and the Trust Development Authority. Their stated priority is to offer support to providers and local health systems to help them improve. Throughout this report all references to Monitor have been replaced with 'NHS Improvement'.

Under NHS Improvement the Provider Licence remains in effect as the regulator's primary tool for overseeing NHS Foundation Trusts, incorporating requirements covering governance and financial viability.

There are no major issues or risks identified in relation to the Trust's continued compliance with its Licence. Trust Board makes a quarterly self-certification as part of the Trust's quarterly return to Monitor and annually receives a full assessment of compliance against the terms of the Trust's Licence (see also agenda item 8.4(v)).

The Risk Assessment Framework covers two parts related to Finance and Governance.

- **Continuity of Services Licence Condition 3 (Finance):**

The Trust has a rating of 4 (out of a maximum of 4) which continues to signify sufficient financial headroom and liquidity. The annual plan for 2016/17 is assessed at level 4.

This rating is based on the Trust's:

- Liquidity ratio,
- Capital servicing capacity,
- Income and expenditure surplus compared to income, and
- Ability to deliver in line with published plan.

- **NHS Foundation Trust Licence Condition 4 (Governance)**

NHS Improvement uses a governance rating, incorporating information across a number of areas, to describe their views of the governance of an NHS Foundation Trust.

The Trust continues to predict no significant impact on its current governance risk rating in 2016/17, which has been 'green' during 2015/16. However new access measures in relation to IAPT, EIP and CAMHS will require close monitoring throughout the year to ensure this remains the case.

Performance against national access and outcomes requirements forms one strand of information used by NHS Improvement in determining the overall governance rating for the Trust.

- **Risk Assessment Framework (RAF) - Performance against national access and outcomes requirements**

NHS Improvement expects NHS Foundation Trusts to establish and effectively implement systems and processes to ensure that they can meet national standards for access to health care services and outcomes objectives. These cover both community and mental health services.

Material or on-going underperformance against these access and outcomes requirements may reflect a governance concern and warrant consideration by NHS Improvement for further investigation and possible enforcement action.

Material or on-going underperformance is generally interpreted as failure to meet at least four of these requirements at any given time, or failing the same requirement for at least three quarters.

All indicators applicable to SWYPFT are subject to monitoring on a quarterly basis. Internal monitoring occurs on a monthly basis via the Strategic Overview report and individual BDU performance is monitored via the BDU Dashboards.

Indicators that are applicable to the Trust are listed in the below table. For 16/17, the indicator set is a continuation of measures used in 2015/16, which included the addition of three new access indicators from quarter 3 2015/16 onwards. These relate to Improving Access to Psychological Therapies (IAPT) and Early Intervention in Psychosis (EIP).

There has been some under performance in 2015/16 related to the new KPI – "People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral". However performance is improving and the trajectory is for this to be achieved in 2016/17. Nevertheless following two consecutive Quarters in 2015/16 where the IAPT access target was not met it is now critical that this target is achieved in Quarter 1 2016/17.

There is further national development to take place regarding the reporting against the Early Intervention access indicator and the flow of data into the Mental Health Services Dataset. However achievement to date has been met.

The forecast for achievement of the NHS Improvement access and outcome requirements is therefore green.

Indicator	Threshold *(16/17)*
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	**92%**
CPA Receiving follow-up contact within 7 days of discharge	**95%**
CPA having formal review within 12 months	**95%**
Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams	**95%**
Meeting commitment to serve new psychosis cases by early intervention teams	**95%**
EIP: People Experiencing a first case of psychosis treated within a NICE approved care package within two weeks of referral	**50%**

Indicator	Threshold *(16/17)*
IAPT: People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral	**75%**
IAPT: People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	**95%**
Minimising mental health delayed transfers of care	**≤7.5%**
Mental health data completeness: identifiers	**97%**
Mental health data completeness: outcomes for patients on CPA	**50%**
Data Completeness: Community Services - Referral to treatment information	**50%**
Data Completeness: Community Services - Referral information	**50%**
Data Completeness: Community Services - Treatment activity information	**50%**
Certification against compliance with requirements regarding access to health care for people with a learning disability	N/A

2.2 CHOICE IN MENTAL HEALTH SERVICES

In 2014/15 legal rights to choice in Mental Health services were introduced as part of the parity of esteem agenda covering both choice of mental health provider and choice of mental healthcare team. In December 2014 NHS England produced guidance and clinical scenarios on implementing choice to support consistent application of rights across the mental health sector. The requirements to adhere to offering choice are part of the contractual obligations placed on providers through the NHS standard contract and commissioners will monitor progress in implementation through contract management processes in 2016/17.

This is a key area for SWYPFT to address. Based on the previous experience of rolling out choice for physical health services nationally it is expected that the new legal right will be taken up gradually and not result in significant shifts of activity in the short term.

2.3 CARE QUALITY COMMISSION

The CQC inspection framework includes the 5 key questions being asked of services: Are they safe? Are they effective?; Are they caring?; Are they responsive?; Are they well-led?. Judgements are made against a 4 point scale – Outstanding, good, requires improvement, inadequate. Ratings are not limited to an aggregated whole but are drilled down to core services. The future frequency of inspection will relate to the judgement reached.

The Trust received a formal CQC inspection in March 2016. Initial verbal feedback from the visit has been received by the Trust, with the final report being expected early May 2016.

Prior to the inspection the Trust carried 2 compliance actions (but no enforcement actions) in regard to previous CQC visits under the former inspection regime. The Trust has taken all the necessary action required to address these compliance actions and has agreed with the CQC that these compliance actions would be reviewed as part of the Trusts formal inspection in March 2016. We consider that there is no further work outstanding and are awaiting the CQC to close the compliance actions.

As the CQC is required to reduce the funds it receives from central finances the costs are being recouped from the services it regulates. Throughout 2015/16 the CQC has made changes to the fees associated with regulation, effectively increasing our costs from approx. £90,000 per year to £217,000 by 2017/18.

In March 2016 the CQC published a consultation document: Shaping the Future (CQC's strategy 2016 to 2021). This document sets out how they propose to deliver their vision by becoming a more efficient and effective regulator. There are 6 themes in the review:

1. improving use of data and information;

2. implementing a single shared view of quality
3. targeting and tailoring inspection activity
4. developing a flexible approach to registration
5. assessing how well hospitals use resources
6. developing methods to assess quality for populations and across local areas

If adopted, these proposals should trigger a risk assessment by the Trust to consider the impact of the following factors:

- Increased importance of correct and complete clinical information
- Possible increase in whistleblowing alerts and subsequent investigations
- The new data set needed to support 'CQC Insight', which would replace the current 'intelligent monitoring' approach.
- All quality reporting to be aligned to the CQC 5 key domains framework (both at national and local level)
- Increased regulatory scrutiny of services that receive ratings of either 'requires improvement' or 'inadequate' in any of their core services/ teams.

2.4 MANDATORY DATA SETS

The Health and Social Care Information Centre (HSCIC) is increasingly becoming the main repository of health and social care data with the expectation that all information will flow to the Commissioning Support Units (CSUs) & regulators from the HSCIC rather than directly from provider organisations. The number, content & submission frequency of mandated data sets continues to increase.

Key areas of risk include:

- The requirement to collect new and additional data items
- Differences in interpretation and analysis of data between the HSCIC and or the CSUs and internally generated reports
- Ability to obtain fit-for-purpose data extracts from RiO and SystmOne. May require software upgrades.
- Increased frequency of data submissions reduces the time available between submissions for data checking/validation

Mitigation includes:

- BDU and clinical quality involvement in defining key operational practice standards so data input can be standardised and streamlined
- Pro-active management of data interpretation through our contracting meetings
- The Business Intelligence development will facilitate more pro-active use of data therefore improving data quality.

3. CONTRACTUAL REQUIREMENTS

Contractual performance requirements are broadly split into two categories covering national and local requirements. These are set out within the Quality Schedule of the contracts.

3.1 NATIONAL PERFORMANCE REQUIREMENTS

There are a range of national performance and quality standards which continue from 2015/16 and attract financial penalties if not achieved or maintained. The performance standards to which the Trust is applying a particular focus in 2016/17 are as follows;

- Care Programme Approach (CPA): The percentage of service users under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care (target 95%). The Trust-wide RAG rating is Amber/Green, which reflects a predicted continuation of the improvement trend seen in 2015/16.
- Completeness of data sets including NHS numbers, ethnicity and outcome data. Some risk has been identified in relation to the inclusion of children's services in the Mental Health Data Set from 1st January 2016. RAG rating is therefore Amber/ Green.

Overall the value of the risk associated with national performance requirements is minimal (£3,800) and decreasing year on year. The RAG rating of relevant performance requirements is set out in the table below;

National Performance Requirements	Penalty	Associated Risk - 2016/17				
		Barnsley CCG	Calderdale CCG	N Kirklees / Greater Huddersfield CCG	Wakefield CCG	Trust Wide Potential Penalty
Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	£300 in respect of each such Service User above that threshold	Green	N/A	N/A	N/A	**Green**
Percentage of Service Users waiting less than 6 weeks from Referral for a diagnostic test	£200 in respect of each excess breach above that threshold	Green	N/A	N/A	N/A	**Green**
Sleeping Accommodation Breach	£250 per day per Service User affected	Green	Green	Green	Green	**Green**
Care Programme Approach (CPA): The percentage of Service Users under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care	£200 in respect of each excess breach above that threshold	A/G Potential Annual Penalty £600	A/G Potential Penalty Forecast £1000	A/G Potential Annual Penalty £400	A/G Potential Annual Penalty £1800	**A/G** **Potential Annual Penalty £3800**
Zero tolerance MRSA	£10,000 in respect of each incidence in the relevant month	Green	Green	Green	Green	**Green**
Zero tolerance RTT waits over 52 weeks for incomplete pathways	£5,000 per Service User with an incomplete RTT pathway waiting over 52 weeks at the end of the relevant month	Green	N/A	N/A	N/A	**Green**
Duty of candour	Recovery of the cost of the episode of care, or £10,000 if the cost of the episode of care is unknown or indeterminate	Green	Green	Green	Green	**Green**
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 in respect of each excess breach above that threshold	Green	Green	Green	Green	**Green**
Completion of Mental Health Minimum Data Set ethnicity coding for all detained and informal Service Users, as defined in Contract Technical Guidance	£10 in respect of each excess breach below that threshold	A/G	A/G	A/G	A/G	A/G
Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users, as defined in Contract Technical Guidance	£10 in respect of each excess breach above that threshold	Green	Green	Green	N/A	**Green**
Early Intervention in Psychosis programmes: the percentage of Service Users experiencing a first episode of psychosis who commenced a NICE-concordant package of care within two weeks of referral	Issue of Contract Performance Notice and subsequent process in accordance with GC9	Green	Green	Green	Green	Green
Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who are treated within six weeks of referral	Issue of Contract Performance Notice and subsequent process in accordance with GC9	A/G - no financial risk.	A/G - no financial risk.	Green	N/A	No financial risk
Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who are treated within 18 weeks of referral	Issue of Contract Performance Notice and subsequent process in accordance with GC9	Green	Green	Green	N/A	N/A
Total Potential Penalty		**A/G** **Potential Annual Penalty £600**	**A/G** **Potential Annual Penalty £1000**	**A/G** **Potential Annual Penalty £400**	**A/G** **Potential Annual Penalty £1800**	**A/G** **Potential Annual Penalty £3800**

3.2 LOCAL PERFORMANCE REQUIREMENTS

Local performance requirements are set for each service area and specified within the contractual documentation. These are subject to regular monitoring through formal contract performance review processes. Where performance is highlighted as an issue through appropriate processes and the Provider fails to address the performance the Commissioner has the contractual right to invoke the requirement for the Provider to produce a remedial action plan.

BCCG has confirmed that there will be a local KPI for 2016/17 which relates to maintenance of the 15/16 CQUIN for LD related to cancer screening. This has been risk assessed at green and it is expected that the BDU will maintain the level of performance.

3.3 CQUINS

3.3.1 General

In line with the national planning guidance the value of the CQUIN scheme remains up to 2.5% of annual contract value. National indicators are worth at least 1.0% each and local schemes 1.5%.

The total contract income associated with CQUIN schemes is £4.5m. At present we are forecast to achieve around 82% of the available CQUIN income. This is not in line with the level of contingency in our Operational Plan, and there is a need to undertake further work to improve this position.

3.3.2 CQUIN focus in each BDU

- **Wakefield, Kirklees and Calderdale BDUs**

The Wakefield, Kirklees and Calderdale BDUs continue to have a single CQUIN scheme as part of the main contract with the relevant CCG's. the CQUIN's agreed are:

Local CQUINs	National CQUINs
1) Improving the Health & Wellbeing of NHS Staff *1a) Introduction of Health & Wellbeing Initiatives – Option B.* *1b) Health Food for NHS Staff, Visitors and Patients* *1c) Improving the Update of Flu Vaccinations for Frontline Clinical Staff* 2) Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (PSMI) *2a) Cardio Metabolic Assessment & Treatment for Patients with Psychoses* *2b) Communication with General Practitioners.*	3) MH Currency *3a) MH Clustering – Adherence to Red Rules* *3b) Review of Service Users & Clusters* *3c) MH Clustering – Cluster at Discharge* 4) Care Planning – Quality of Care Plans 5) NHS Safety Thermometer 6) Learning Disability Outcome Measures – Development of Risk Register 7) CAMHS – Implementation of Primary Practitioner Roles in Wakefield Community. *Wakefield Only.*

Three out of the 7 schemes are new for 2016/17:

- Improving the Health & Wellbeing of NHS Staff,
- Learning Disability (LD) Development of Risk Register and
- Implementation of Primary Practitioner Roles in Wakefield CAMHS

The key risk areas for all 3 BDUs include the continuation of the National Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness CQUIN, the locally agreed NHS Safety Thermometer; and Care Planning.

- **Barnsley BDU**

The main CQUIN scheme applicable to the Barnsley BDU is with Barnsley CCG, including Rotherham, Doncaster and Sheffield CCG's as associates. The final details of the content of the CQUIN scheme in Barnsley are being finalised but will cover the following

- Improving the Health & Wellbeing of NHS Staff
- Improving Physical Healthcare for People with Severe Mental Illness
- Community Nursing Services - Implementation of actions arising from service review
- A Falls CQUIN
- A Mental Health currency CQUIN

The key risk area is the Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness indicator.

- **Specialist Services BDU (LD/CAMHS)**

There are 4 CQUIN indicators specifically relating to Specialist Services.

- Learning Disability Services in Wakefield, Kirklees and Calderdale have a CQUIN which relates to assisting in the development of a Risk Register to meet Transforming Care guidance.
- The Wakefield CAMHS CQUIN relates to the implementation of a community delivery model integrated with partner services through primary practitioners.

- **Forensics BDU**

For 16/17 only 3 CQUINs have been attached to the Forensic Service. The following CQUINs have been agreed:

National CQUINs	Local CQUINs
1) Recovery Colleges for Medium and Low Secure Patients 2) Reducing Restrictive Practices within Adult Low and Medium Secure Services *Please note: the Improving Physical Healthcare CQUIN has not been applied by NHSE for Forensics. Work will continue as part of core business. This is contained within the Quality Schedule of the Contract*	1) Care & Treatment Reviews Task & Finish Group (CTR)

It is envisaged that the local CQUIN will be fully achieved. The RAG rating of the national indicators is amber/ green.

3.4 QIPP TARGETS

Through contract negotiations the principle has been established that cash will not be released from contracts unless agreed schemes are in place between the parties and until the point in time that the cash release can be made, where the scheme is intended to release cash directly from SWYPFT contract. At the commencement of the financial year there are no agreed QIPP schemes related to cash releasing values directly from SWYPFT contracts.

In conjunction with Wakefield CCG a number of areas are under review to identify potential system efficiencies related to CCG held budgets including mental health prescribing in primary care, Out of Area specialist placements and Learning Disability placements.

The QIPP schemes agreed with Kirklees commissioners in 2015-16 continue into 2016-17. These schemes aim to reduce spend on CCG held Out of Area budgets for management of specialist adult rehabilitation and recovery placements, and Learning Disability placements.

In Barnsley there are a number of community services under review which could drive future efficiencies. In Calderdale the CCG is aiming to deliver savings from the redesign of rehabilitation and recovery services.

Further action is required to develop and agree risk sharing arrangements across a number of schemes where co-dependencies with commissioners or other organisations are critical to deliverability.

3.6 MENTAL HEALTH CURRENCIES

For 2016/17 it has been agreed to work with commissioners to develop a tariff linked to Cluster episode building on findings of SLR analysis. Work from the costing review will require sign up of all SWYPFT commissioners to a collaborative approach that recognises the impacts of local funding differences and provides for reasonable transition periods for all.

3.7 SERVICE LINE REPORTING

Service Line Reporting has continued to be implemented during 15/16 as a tool to inform future decision making at service line level and decisions in managing financial risks. Service Line Reporting is essential in order to facilitate service redesign and efficiency and to inform BDUs future service offer and plans.

The introduction of the system will also facilitate better benchmarking and information to support service-redesign and the transformation agenda during 2016/17 including informing negotiations with commissioners

4.0 CONCLUSION

The main conclusions in regard to regulatory and contractual compliance are as follows.

- There are currently no major issues or risks relating to the Trust's compliance with its Provider License.
- The Trust has a positive financial risk rating of 4 for viability as a going concern and the Operational Plan is assessed to remain at level 4 with no risks identified;
- The Trust has a green governance rating and no risks to maintenance of this rating have been identified.
- At March 2016 the Trust continued to carry two compliance actions under previous inspection regimes. The Trust believes these actions have been addressed. These compliance actions are expected to be removed as part of the CQC feedback from the recent inspection
- The Trust received a formal CQC inspection in March 2016 and the final report is expected in May 2016 which will award the Trusts CQC rating. The risks and follow-up actions will be further assessed on receipt of the final report.
- CQC regulation fees are due to increase in line with national plans. This will increase the costs to SWYPFT from £90,000 in 2016/17 to £217,000 by 2017/18.
- Future CQC inspection themes that are currently under consultation will require further consideration and risk assessment if implemented.
- Performance against the national access and outcomes requirements has an impact on the Trust's governance rating. Significant changes to performance are not anticipated and the forecast remains green. Overall performance risk is reduced compared to 15/16.
- CPA 7 Day Follow Up remains the target at most risk of under achievement. However action is being taken to minimise risk.
- The introduction of the legal right to choice for mental health services will be monitored by commissioners in 2016/17 through contract management processes. The level fo

change in patient flows during 2016/17 is expected to be minimal, but performance trends will be monitored, and actions taken to be the service user's provider of choice.

- Full achievement of CQUIN income remains at risk and plans are in place to improve performance/ achievement. The national CQUIN for improving physical healthcare for Mental Health service users continues to be an area requiring additional focus

5.0 RECOMMENDATION

Trust Board is asked to note the content of the report, the assessment of risk and the actions planned to mitigate risk.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 28 April 2016
Agenda item 8.4(ii)

Title:	**Trust Planned Visit Programme 2015/16**
Paper prepared by:	Director of Nursing, Clinical Governance and Safety
Purpose:	The purpose of this report is inform Trust Board of the finding and actions following completion of the Trust planned visit programme for in-patient areas for 2015/16.
Mission/values:	The Trust Visit Programme report supports the governance framework by enabling objective assessment of Trust services against both the CQC essential standards and the Trusts quality priorities. Undertaking these reviews gives teams the opportunity to reflect on the care and treatment they deliver, celebrate their achievements and make required improvements. In addition it aids the strategic team to further understand the difficulties teams face on a day to day basis, identify good practice and encourages learning from across the Trusts services.
Any background papers/ previously considered by:	Regular updates are provided to the Clinical Governance and Clinical Safety Committee.
Executive summary:	The paper describes ➢ the approach taken for the trust's planned programme of visits in 2015/16; ➢ comparison with 2014/15 results; ➢ key ratings from the visits against the five key Care Quality Commission questions; ➢ comments from staff, service users and visit team members. The visits are just one element amongst several by which the Trust self-assesses compliance against Care Quality Commission (CQC) standards. To ensure they remain fit for purpose, the Trust is undertaking a full review of the process, which will be aligned to any changes the CQC recommends in its five-year strategic review (currently out for consultation). Early thinking is that potential changes may include inviting external partners, service user involvement and monitoring of action taken against the recommendations of the visit. The Trust will also consider the recommendations from the CQC inspection visit report to inform its programme for 2016/17.
Recommendation:	**Trust Board is asked to RECEIVE the paper**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

TRUST INTERNAL 'CQC' VISIT PROGRAMME 2015/16

Annual report for Trust Board
28 April 2016

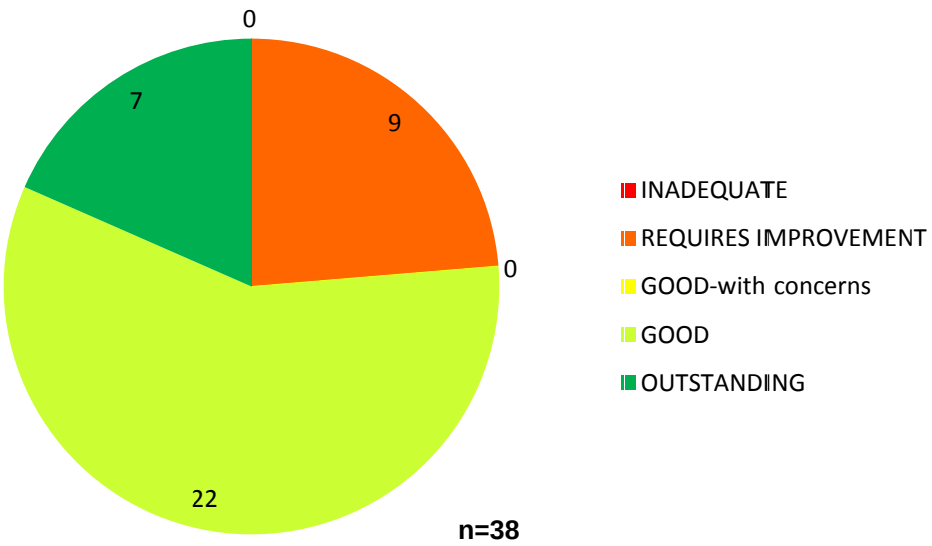
Report prepared by the Quality Improvement & Assurance Team

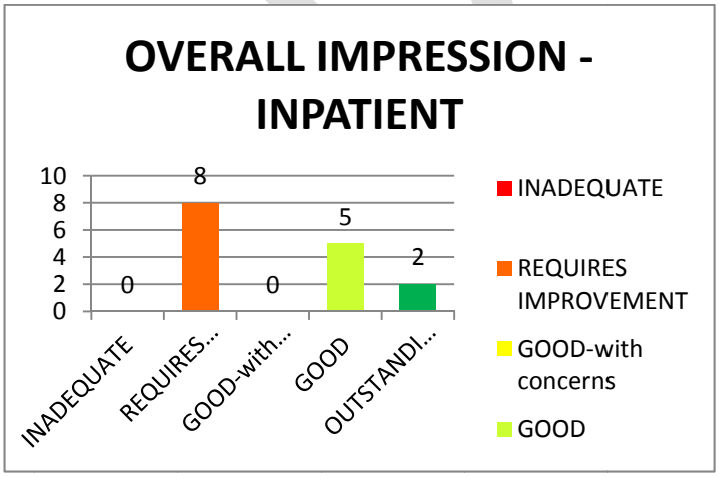
TRUST VISIT PROGRAMME 2015/16

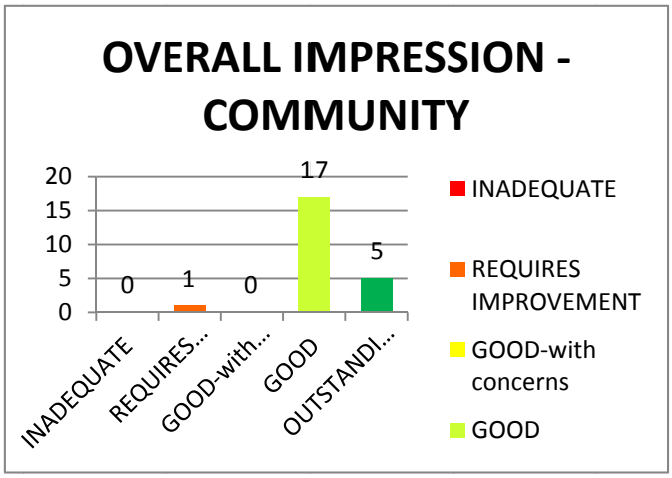
1. 2015/16 PROGRAMME

The visit programme focused on assessment against both the CQC fundamental standards and the Trust's quality priorities. A total of 39 visits were made, 24 (62%) to community teams and 15 (38%) to bedded units. (For more detail see Appendix 1). From these visits, 38 reports were completed (for one visit the report was unable to be completed) and 7 teams (18%) were given an overall rating of 'outstanding', 22 teams (58%) a rating of 'good' and 9 teams (24%) a rating of 'requires improvement'. None of the teams visited were given a rating of 'inadequate'. Commissioners (from Clinical Commissioning Groups on the West) joined a community team visit, from which they were assured of the rigour of the governance process.

Figure 1: Overall Judgement



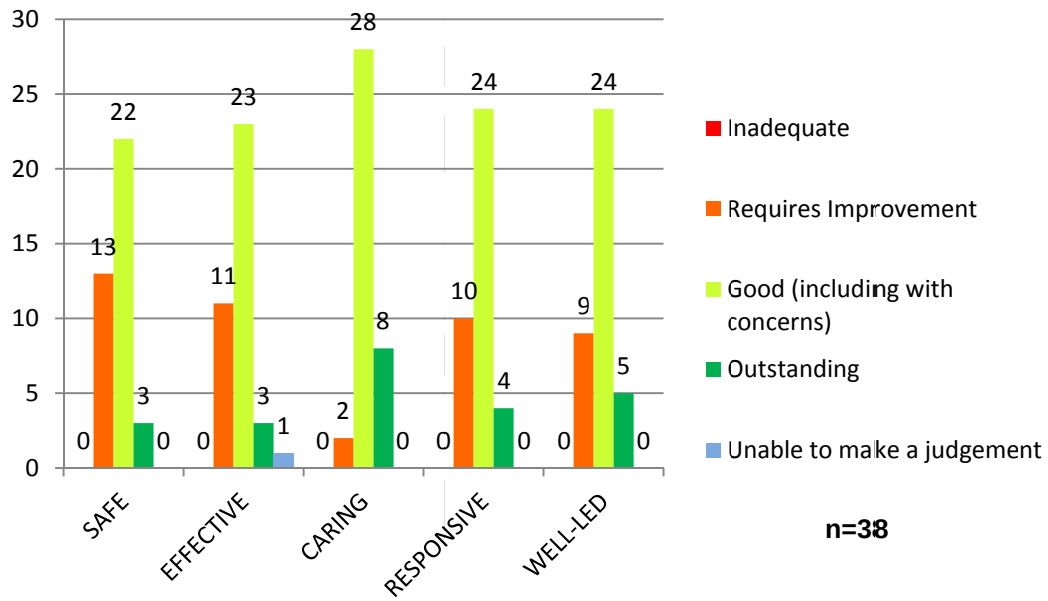




In regard to the 5 key CQC questions (safe, effective, caring, responsive, well-led):

- 25 teams (66%) were judged to be safe (assessed to be outstanding, good or good with concerns). For 13 teams (34%) there were some aspects related to safety questioned.
- 26 teams (68%) were judged to be effective (assessed to be outstanding, good or good with concerns). For 11 teams (29%) there were some aspects related to effectiveness questioned (it was not possible to judge one team).
- 36 teams (95%) were judged to be caring (assessed to be outstanding, good or good with concerns). For 2 teams (5%) there were some aspects related to caring questioned.
- 28 teams (74%) were judged as responsive (assessed to be outstanding, good or good with concerns). For 10 teams 26(%) there were some aspects related to responsiveness questioned.
- The visit team concluded that well-led factors (both at team and organisational level) applied positively for 29 teams (76%) (assessed to be outstanding, good or good with concerns). . For 9 teams (24%) there were some aspects related to the well-led category that were questioned.

Figure 2: Judgements Against the 5 Key Questions



There were a range of visit team responses covering areas of good practice and areas of concern Table 1 below summaries the areas of concern.

Table 1: Main Areas of Concern

	CONCERNS	
	COMMUNITY	**BEDDED UNITS**
SAFE	• Recording incidents on Datix • Completing mandatory training • Transferring Risk assessment info into Care Plans	• Staffing • Lessons learned • Recording incidents on Datix • Incomplete clinical Records • Mandatory training
EFFECTIVE	• Clinical supervision procedures • Effective use of outcome / performance data • Clinical audit process • Communication between services about service users	• Level of detail in clinical records • Involving S.Users in Care Planning • S.User Privacy/dignity • S.User room suitability • Breaching gendered accommodation • S.User info in user friendly format
CARING	• Incomplete clinical records • Involving Service Users in developing their Care Plans • Physical health assessments	• Complaints info/ process. • Temperature levels • Staffing levels • Adjusting care / environment to meet s.user needs • Info for s.users with reading/ visual/ cognitive impairments
RESPONSIVE	• Accommodation • Undertaking S.User experience reviews / gather S.User feedback • Waiting lists for treatment	• Application of NICE guidance • Understanding / undertaking service evaluations & audits • Monitoring outcomes
WELL-LED	• Links to quality academy, other services, to share good practice, wider services • Transformation- • Morale, communication and consultation • Agile working	• Impact of 12hr shifts • Staff levels • Staff feeling valued

APPENDIX 1: 2015/16 VISIT PROGRAMME DETAILS

TOTAL VISITS = 39

- Community = 24 (62%)
- In-Patient = 15 (38%)

Morning Visits = 16 (41%)
Afternoon Visits = 21 (54%)
Evening Visits = 2 (5%)

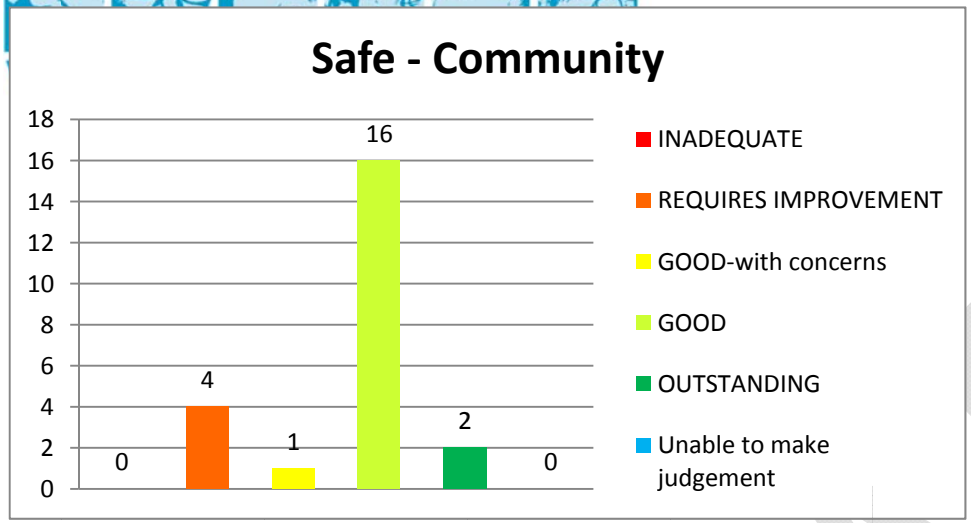
ACTIVITIES UNDERTAKEN BY VISIT TEAM	YES	NO*
OBSERVED UNIT ENVIRONMENT	35	4
OBSERVED TREATMENT/CARE	14	25
TALKED TO STAFF	38	1
TALKED TO SERVICE USERS & CARERS	29	10
EXAMINED RECORDS	38	1

*** In one visit the visit team were unable to assess and complete a full report.**

OVERALL IMPRESSION

Outstanding = 7 (18%)
Good = 22 (58%)
Requires Improvement = 9 (24%)
Inadequate = 0

5 KEY QUESTIONS	Outstanding	Good (including with concerns)	Requires improvement	Inadequate	Unable to make judgement
SAFE	3 (8%)	22 (58%)	13 (34%)	0	0
EFFECTIVE	3 (8%)	23 (61%)	11 (29%)	0	1 (3%)
CARING	8 (21%)	28 (74%)	2 (5%)	0	0
RESPONSIVE	4 (11%)	24 (63%)	10 (26%)	0	0
WELL-LED	5 (13%)	24 (63%)	9 (24%)	0	0


Safe - Community
18
16
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12
10
8
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1
16
2
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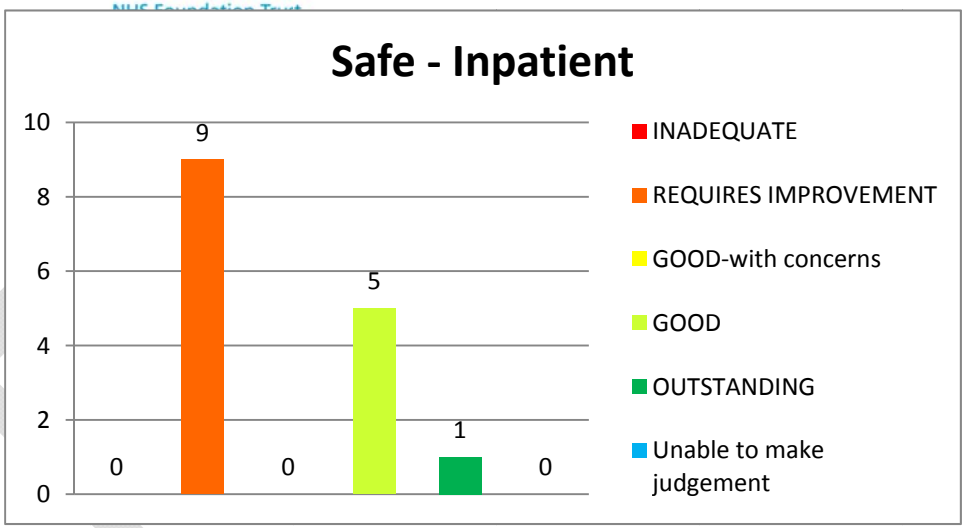
INADEQUATE
REQUIRES IMPROVEMENT
GOOD-with concerns
GOOD
OUTSTANDING
Unable to make judgement


Safe - Inpatient
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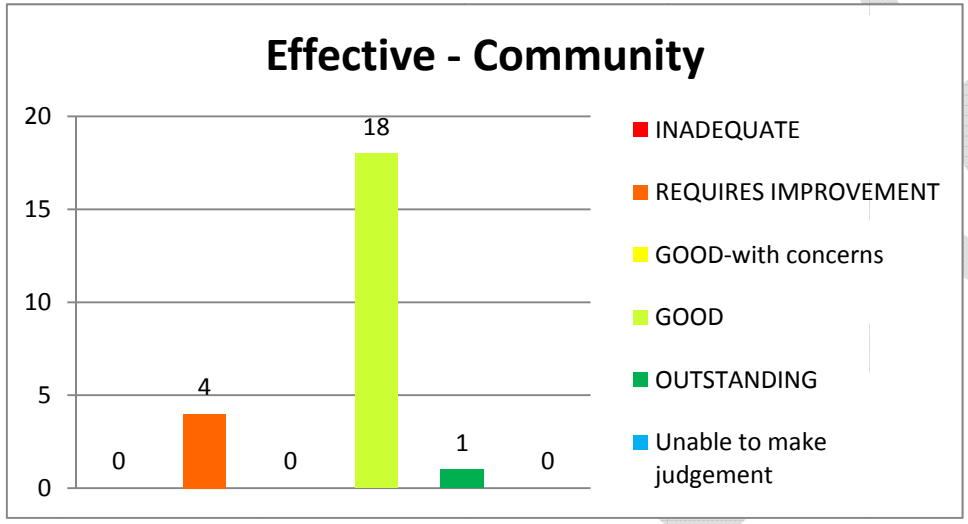
INADEQUATE
REQUIRES IMPROVEMENT
GOOD-with concerns
GOOD
OUTSTANDING
Unable to make judgement


Effective - Community
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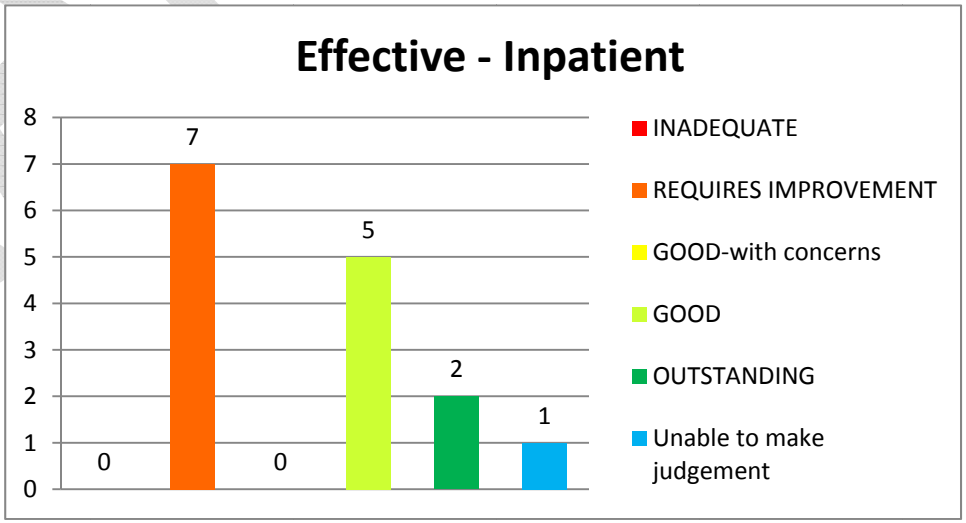
INADEQUATE
REQUIRES IMPROVEMENT
GOOD-with concerns
GOOD
OUTSTANDING
Unable to make judgement


Effective - Inpatient
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INADEQUATE
REQUIRES IMPROVEMENT
GOOD-with concerns
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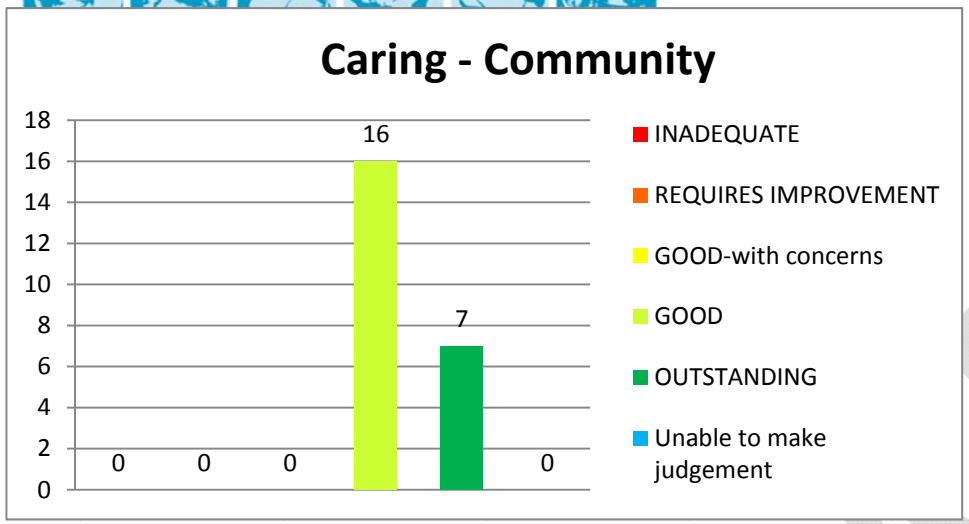
OUTSTANDING
Unable to make judgement


Caring - Community
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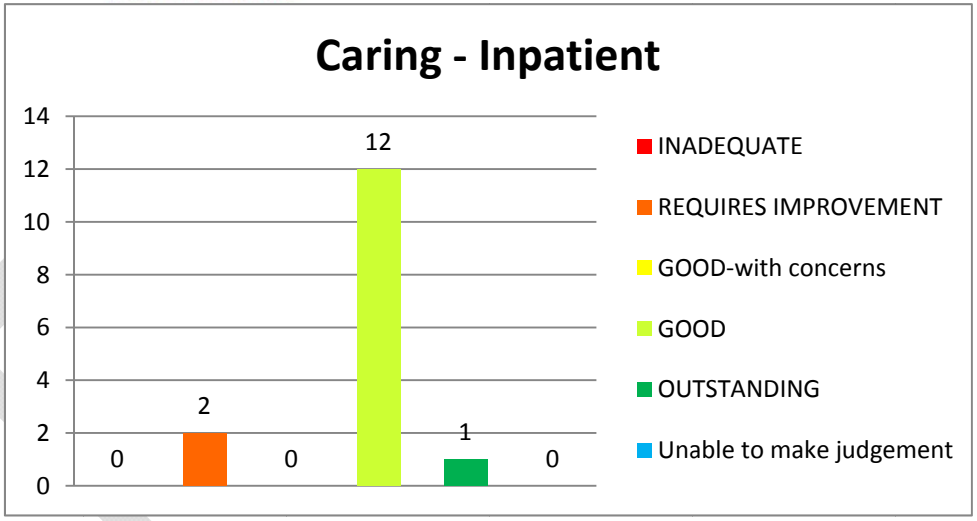
INADEQUATE
REQUIRES IMPROVEMENT
GOOD-with concerns
GOOD
OUTSTANDING
Unable to make judgement


Caring - Inpatient
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REQUIRES IMPROVEMENT
GOOD-with concerns
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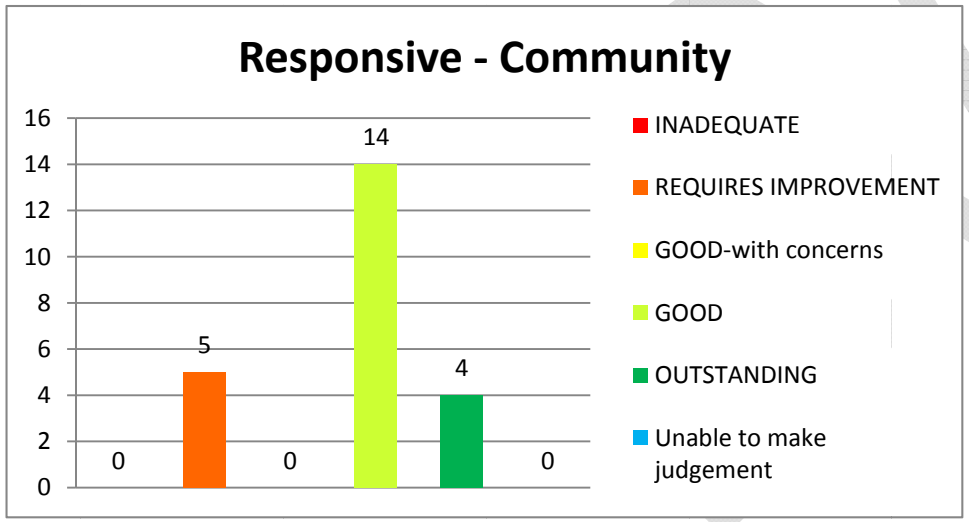
OUTSTANDING
Unable to make judgement


Responsive - Community
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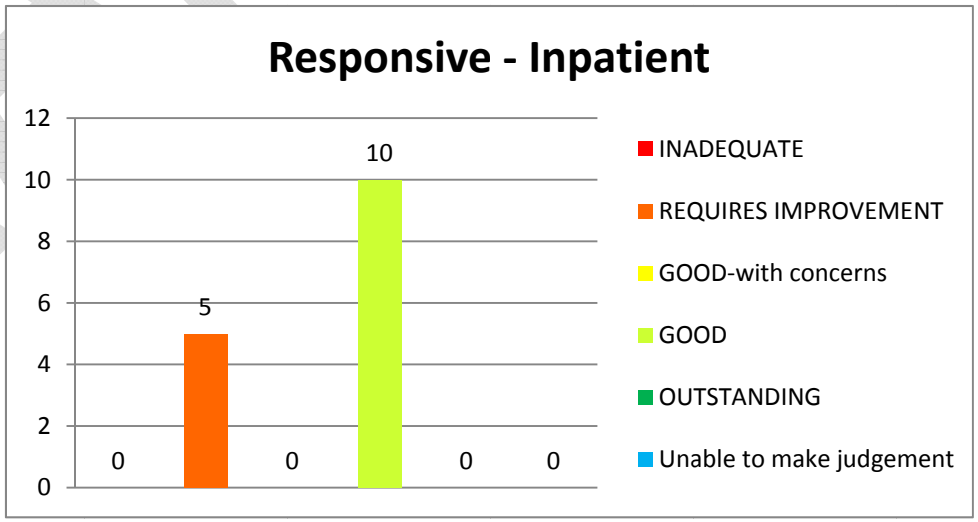
INADEQUATE
REQUIRES IMPROVEMENT
GOOD-with concerns
GOOD
OUTSTANDING
Unable to make judgement


Responsive - Inpatient
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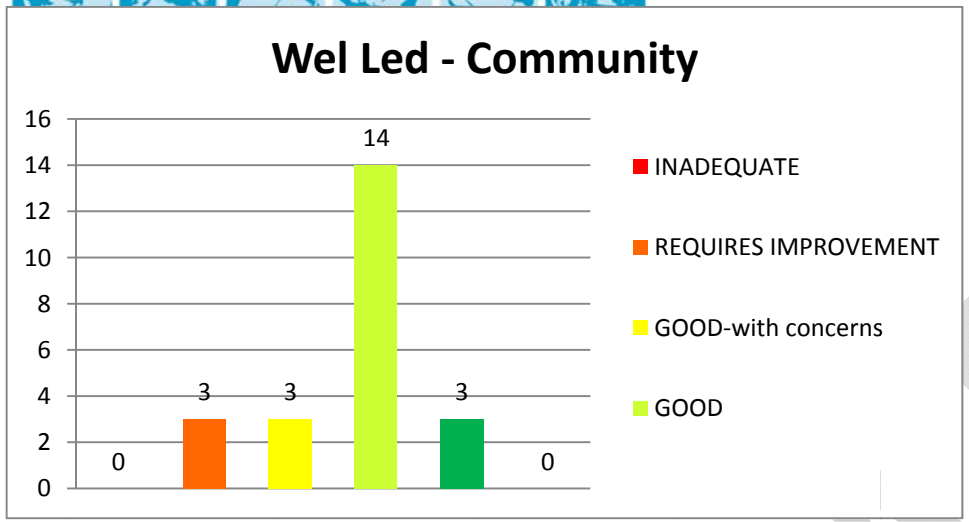
INADEQUATE
REQUIRES IMPROVEMENT
GOOD-with concerns
GOOD
OUTSTANDING
Unable to make judgement


Wel Led - Community
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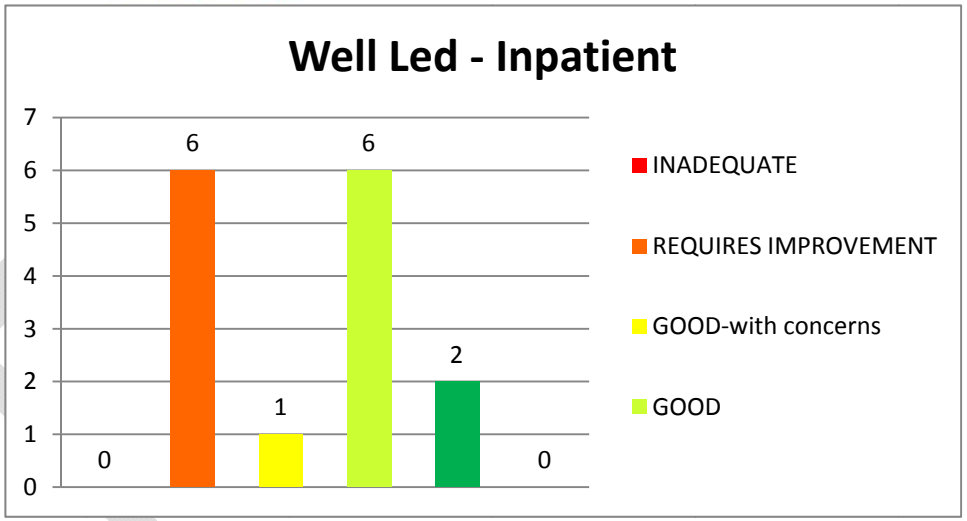
INADEQUATE
REQUIRES IMPROVEMENT
GOOD-with concerns
GOOD


Well Led - Inpatient
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INADEQUATE
REQUIRES IMPROVEMENT
GOOD-with concerns
GOOD

In-Patient Visits

BDU	Visit Time	Overall Impression	Actions identified from previous visit or MHA visit
BARNSLEY			
Willow	Evening	Good	Generally been poorly addressed, most issues outstanding
CALDERDALE & KIRKLEES			
Lyndhurst	Afternoon	Good	Generally been well addressed, minor issues outstanding
Elmdale	Afternoon	Outstanding	Satisfactorily followed up
Ward 18	Morning	Good	Generally been well addressed, minor issues outstanding
Ashdale	Afternoon	Requires Improvement	Generally been well addressed, minor issues outstanding
Beechdale	Morning	Requires Improvement	Satisfactorily followed up
Ward 19	Afternoon	Requires Improvement	Generally been poorly addressed, most issues outstanding
WAKEFIELD			
Priory 2	Afternoon	Good	Generally been poorly addressed, most issues outstanding
Chantry	Afternoon	Requires Improvement	Satisfactorily followed up
Poplars	Morning	Requires Improvement	Generally been well addressed, minor issues outstanding
FORENSIC			
Hepworth	Morning	Requires Improvement	N/A
Waterton	Morning	Outstanding	N/A
Thornhill	Evening	Good	Unable to check
Chippendale	Afternoon	Requires Improvement	Generally been poorly addressed, most issues outstanding
SPECIALIST			
Horizon	Afternoon	Requires Improvement	Generally been well addressed, minor issues outstanding

Community Visits

BDU	Visit Time	Overall Impression	Actions identified from previous visit or MHA visit
BARNSLEY			
IAPT	Afternoon	Good	N/A
North CMHT	Afternoon	Good	N/A
School Nursing-Goldthorpe	Morning	Summary only	N/A
Health Visiting-Central	Morning	Good	N/A
Diabetes	Afternoon	Good	N/A
DN-Penistone	Afternoon	Outstanding	N/A
DN-Athersley DN	Afternoon	Outstanding	N/A
HV North East-Cudworth	Afternoon	Outstanding	N/A
Early Intervention Team	Afternoon	Good	N/A
DN-Worsbrough LIFT	Afternoon	Outstanding	N/A
Community Matrons	Morning	Outstanding	N/A
CALDERDALE & KIRKLEES			
Mental Health Liaison Team	Morning	Good	N/A
Calderdale West OPS CMHT	Morning	Good	N/A
Community Therapies Team S.Kirklees	Afternoon	Good	N/A
EIP Calderdale	Morning	Good	N/A
WAKEFIELD			
Intensive Home Based Treatment Team (Crisis)	Afternoon	Good	N/A
CMHT Ossett including AOT	Morning	Good	N/A
CMHT2 Airedale	Afternoon	Good	N/A
Rapid Access including HBT function	Morning	Good	N/A
FORENSIC			
Forensic CAMHS	Morning	Good	N/A
SPECIALIST			
Barnsley CAMHS	Morning	Requires Improvement	N/A
Wakefield CAMHS Crisis Team	Morning	Good	N/A
C&K CAMHS	Afternoon	Good	N/A
Kirklees Learning Disability Team	Afternoon	Good	N/A

APPENDIX 2: STAFF FEEDBACK

COMMUNITY TEAMS	
POSITIVE	**NEGATIVE**
• good place to work • team worked well together • felt part of the team • service user needs were responded to in a timely fashion • happy in their work • strengths lie in risk assessment/management and positive risk taking • support staff were invaluable • daily briefing • links with other teams • Collaborative team. Integrated team works really well • Supportive team • enjoying their jobs • Supported and valued by the team and the organisation. • remained positive and professional in the face of the uncertainty of the future of the 0-19 service • new induction compared favourably to previous inductionsx2 • good support received from senior staffx3 • positively on the preceptorship process • recent changes to the team, led by the general manager • valued by team leader	• not all team members were fully in tune with the ** model • felt that staff morale was fairly low and that there were leadership problems • challenges to the team was the geographic area- visit someone on the border of the catchment area, return to base, assessments could take up to 3 hrs • IT/agile working infrastructure x2 • Team composition was not fully MDT. • Caseload is a bit light at the moment-. Would like more opportunity to go out more for assessment & go out with the qualified staff. • LA employees are having to use SWYPFT training • Relationship with inpatient units • Discharge paperwork not completed- -previous work not considered in inpatient care planning. • impending changes to the service and job security • Staff absence

BEDDED UNITS	
POSITIVE	**NEGATIVE**
• Some staff stated they had a brilliant ward managerx2 • Student nurses -positive about the ward philosophy x2, patient care, MDT working and the welcome • Delivered best patient care. • -team- supportive x2 • Commitment of the team. • progress on recovery journey	• appropriateness of some of the admissions • do not feel valued by the organisation • 12hr shift pattern - increase the number of violent incidents against staff. • 12 hr shift patterns were not giving service users consistent care • Felt like 'Agency staff'. • 12hr shifts –leaving as do not suit their family life. • anxieties due to impending transformation • Low moral • Only 'qualified' person on duty on a night time and on weekend day shifts- impact on taking breaks. • Fixed term posts make people feel unsettled and a lot of staff looking for other jobs' • On 'off the ward' activities. • blind eye when complaints were made about the standard of care provided by agency staff • Issues are brushed under the carpet

APPENDIX 3: SERVICE USER FEEDBACK

COMMUNITY TEAMS	
POSITIVE	**NEGATIVE**
Comments • Working with staff is fantastic • Treated with dignity and respect • showed how to do things for self • praise and admiration for the staff • welcoming, and don't fob you off • gold standard • no complaints; don't know where he would have been without them • couldn't wish for better companion, can't fault anybody and he always keeps me cheerful • professional, calm and caring and information and support was in place once accessing the service • At the beginning of my consultations saw 3 or 4 different consultants which was upsetting • Good for helping people out of depression. Everyone enjoys relaxing and the atmosphere • This service is vital to me to help my mental health condition. Without it my mental health status would vastly deteriorate • Very happy with service. Everyone is very helpful, friendly and puts you at ease • The service is vital for my needs as a service user. It has helped with my confidence and enabled me to meet new friends and attempt different projects • Good service for me • I would recommend this art group to family and friends • Don't know what I would have done without this service. They have brought me out of despair to a much better place • I would encourage people to come to the services as I myself have to push myself to come, but really enjoy it. All the staff are fantastic and understanding, plus you meet other people • cannot get the psychiatrist when you need him • Treatment they received was good. All staff were respectful and helpful. Service users felt supported by the team. The service users reported they felt they had been involved in developing their care and that their opinions had been considered • very happy with the service and how they had been supported • particularly valued the service's willingness to change their approach to his treatment and try something new that better suited his needs • If the country ran as well as this we'd be OK • We greatly appreciate the skill, professionalism, absolute reliability and loving care that you all	Comments • further information about discharge and what happens if she has a relapse • possible relapse and if re - referred would possibly not have the people that he trusts involved in his care • support and information on the service from referral until the child is seen by the service • lack of clarity about their outcome and care plan • More funds needed for art group and drop-in at Castleford run by the CMHT at Airedale • We could do with more finance for the art class as we don't have much money for materials and the art class is used by a lot of service users • unsure if they had a 'care plan' • The doctor is not always polite to carers... downright rude

showed towards her (patient), and the level of support you provided for us (carers)

- She (patient) has always been involved in decisions relating to her care and the nurses make sure that she understands her treatment and the reasons that certain decisions are made...The team always explored every avenue to try to get extra help from other agencies
- 100% satisfied with the treatment and service. I have previously received this service in my own home and had no problems, it's very good
- Absolutely brilliant and all nice
- For five years had difficulty getting the support required. However, is now "finally getting the help" she needs and is really happy with her current worker.
- 'If it weren't for this place I wouldn't be here…it has totally transformed my relationship with my family…at last they're proud of me' (service user)
- I only have positive thoughts now…very helpful over recent bereavement…fantastic
- I can't speak highly enough of them…I'm back on my feet, feel more motivated…exceptional
- Staff really listen, just let me offload
- Staff really educated me and my wife about my illness, helped us understand…sorted us out…(team member) has always been there and
- given excellent advice, told me when I needed to be in hospital…if she doesn't know the answer herself, she always knows someone who does…very helpful
- the doctor helps and listens

Comment cards

- *first impression of the service was positive*
- *treated with dignity and respect*
- *service was flexible to meet their needs*
- *satisfied with the service received and would recommend to family and friends.*
- *The staff could do with a more efficient background organisation team so they can perform their job more smoothly*
- *Not structured enough. Not been able to bring patients back in cars when they have to attend appointments*
- *Feel I was listened to. Got some answers*
- *Had injection after I complained about pain. We worked out some strategies to sort it out. Thank you*

BEDDED UNITS	
POSITIVE	**NEGATIVE**
Comments • Staff looked after him well. The member of staff who showed them the ward kept him supplied with tea and coffee by shopping for him in her own time • staff were very approachable • Staff on the ward, the food and the Occupational Therapy provision. • They felt that staff cared and that they wanted to make a difference • staff were extremely friendly and engaging and felt that nothing was too much trouble • Time to discuss any problems and mentioned that with their support progress on improving their wellbeing was been positively supported. • Complimentary about staff and team manager. • flexible to meet their needs • treated with dignity and respectx2 • They felt listened to • good level of care provided x5 and were involved in care planning • Treated with respectx3 and that they felt they were listened to. • Processes were explained upon admission • Staff respond positively when dealing with comments or concerns. • Staff are very good at conflict management between patients. • Activities are well provided and staff seek patients out to encourage participation. • 99% of the staff are wonderful • absolutely excellent care • Staff had been unresponsive to a complaint about staff behaviour whilst on an access visit and that he had been embarrassed by staff tactlessness on another occasion. Did not feel these issues had been responded to well. • Good place to come for care. • When I've got a new tablet, they explain it to me	Comments • still adjusting to a new ward he was a little troubled by some of his peers who were clearly unwell • wasn't enough to do - wanted to go the gym not possible because of staffing levels. Several staff were trained but they couldn't facilitate it at present because of staffing levels and acuity. • The foodx2 • Activities 'off the ward • Staff were kind and caring but can be occasionally patronising. • mixed ward and that some service users sometimes feel vulnerable • given my care plan without discussion… I'm just spoken to in MDT, it's quite intimidating… I've complained about this but nothing happens. • staff are rude…I rarely see the named nurse (couldn't name her)…when a patient was distressed, a nurse ignored her… I'd like to complain but I won't until I've left the ward' • I don't know if I've got a care plan • Staff are busy... seem to rush,

• very nice place' • Why am I on section 2…have I done something wrong? • The support, and the way they're working with me to get my legs back. (nurse) is fantastic... I'd like a bit more time from her. •	
Comment cards • excellent for anyone with issues/problems • we need staff and not agency ones as they cannot do access or courtyard duties because they are not radio trained	

APPENDIX 3: OTHER COMMENTS MADE BY VISIT TEAMS

- The site is not well signposted and so service users and carers struggle to identify the centrex2
- The reception displays a number of signs for Barnsley PCT, along with old SWYPFT posters which could cause confusion for service users. Also, the reception area contained empty water bottles and clinical equipment awaiting storage, which is not appropriate.
- Following the implementation of a smoke free site, the environment was reviewed and it was identified that the smoking garden still contained cigarette buts. This was discussed with the staff who reported that the buts had been removed weeks before the smoke free date and so this needs undertaking again.

  In addition to this, the garden needs updating and there were wet towels on the floor when the visiting team were walking round the unit.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 28 April 2016
Agenda item 8.4(iii)

Title:	**Volunteer services national accreditation – Investing in Volunteers.**
Paper prepared by:	Director of Corporate Development
Purpose:	To note that the Trust has achieved national accreditation against the Investing In Volunteers standard. To note the positive feedback from the assessor, volunteers and staff and the recommendations contained in the assessment report.
Mission/values:	Volunteering within the Trust supports the Trust's mission 'enabling people to reach their potential and live well in their community'. The Trust's commitment to a quality volunteer service underpins our values to ensure that people are at the centre of all we do; that families and carers matter; to improve our services by enhancing the offer supported by volunteers and to recognise the importance of the skill and experience of people who volunteer their time and energy to the Trust going forward.
Any background papers/ previously considered by:	The Trust approved the policy on volunteering in June 2015. This set out the Trust's commitment to volunteering as being important in complementing and enhancing the quality of Trust services and recognised the benefits that volunteering can bring to the volunteer and to the Trust. The Trust ultimately seeks to work in partnership with volunteers to ensure that services meet the needs of the people who use them and that they are co-developed and co-delivered wherever possible.
Executive summary:	The Trust's commitment to volunteering is underpinned by the principle of co-production, and creating opportunities to increase self-confidence, develop new skills and support a return to employment. Over the past year, Trust wide processes have been implemented to ensure that all volunteers are offered a consistent and supportive process in respect of recruitment and associated checks, training, induction and on-going supervision. Trust services currently benefit from over 175 volunteers, which equates to approximately 2,100 volunteer hours per week. A further 15 potential volunteers are currently waiting role matching. Our volunteers have a diverse range of roles, supporting staff and service users in, for example, recovery colleges, the mental health museum, befriending service, participation in research, Expert Patient Programme, Oasis Café, canteens and library services. Work is currently underway to create volunteer opportunities for three service users at Newton Lodge, who are currently completing hygiene certificates with a view to volunteering in catering services. National accreditation against the Investing in Volunteers (IiV) award was sought as a means of ensuring Trust processes in supporting volunteers are robust and mirror best practice. The assessment involved review of policy and procedures and on-site visits to meet with volunteers, supervisors and service and corporate managers. The Trust was assessed as meeting the criteria for accreditation, subject to national panel endorsement (in April). The assessor stated that "During the IiV development process and assessment days, evidence demonstrated that the Trust is committed to developing the volunteering services 'incrementally' and is committed to

	continuing to offer an 'excellent, quality' service for volunteers. It was evidenced during the IiV process and assessment days that huge steps have been taken in bringing the Trust's volunteer services 'under one umbrella' - improving consistency and quality across all services and beginning to implement the Trust's vision for volunteering; and that volunteers have played a major part in this". Volunteers who participated in the assessment said (for example) "Volunteering feels so much better now – such an improvement – all great!" "I was a newbie volunteer and have found it immensely rewarding, it's great seeing people moving forward" "Volunteering has made me feel visible again – I've found my voice" "We bring bags of life experience and bags of empathy" "We can show service users that you can recover and that you are not on your own" "The staff are all very supportive, my mental health has improved massively" "I feel flattered, the Trust makes you feel worthwhile and we know they see us as an asset. I feel so safe here and we are treated with great respect" "I give a lot to the Trust and get a hell of a lot back! It's like a two-way process – I have benefitted so much! It's what I call a 'beneficial cycle'." Staff said: "Volunteers can add quality and value to all – to everything we do in the Trust" "They can offer that 'lived experience' which is fantastic!" "Volunteers bring great value to the Trust and there's a great sense of community among volunteers" "It's great working with people who want to get involved, are enthusiastic, passionate, it's such a pleasure. We couldn't deliver what we do without volunteers." "We want to make volunteering a 'win win' for everyone" "We are increasing the numbers of volunteers incrementally. We want to offer a quality experience with quality support to everyone who volunteers with the Trust. It's so important" The assessor made two recommendations, which accord with Trust development plans in taking volunteering forward: • to ensure that, as the number of volunteers increases there is sufficient staff capacity for supervision and to maintain a quality offer to volunteers; • to continue to review the structure of services that support volunteers (recovery colleges) to ensure they understand and experience a consistent /common model of delivery.
Recommendation:	**Trust Board is asked to NOTE that accreditation has been achieved and to note that representatives from NAVSAM (National Association of Voluntary Services Managers) will present the award on 7 June at 12 noon, Fieldhead.** (This will be part of an event to celebrate and thank Trust volunteers during 'Volunteer Week' from 1 to 12 June 2016.)
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 28 April 2016
Agenda item 8.4(iv)

Title:	**Well-led governance review**
Paper prepared by:	Director of Corporate Development
Purpose:	To update Trust Board of progress against the recommendations arising from the independent review of the Trust's governance arrangements.
Mission/values:	Ensuring the Trust has good and appropriate governance arrangements in place provides the framework for the Trust to meet its mission and adhere to its values.
Any background papers/ previously considered by:	Regular updates provided to Trust Board.
Executive summary:	Following a robust and thorough review and scrutiny of the Trust's governance arrangements by Deloitte against Monitor's well-led framework for governance reviews, the report and action plan were formally presented to Trust Board in September 2015. There were no 'material governance concerns' arising from the review. Out of the ten areas assessed, two areas were rated as green (in relation to Board engagement with patients, staff, governors and other stakeholders, and the Board having the skills and capability to lead the organisation) and eight as amber/green. A number of developmental areas were identified where Deloitte has recommended further work and these form the basis of the action plan. An update on the Trust's progress is attached for information.
Recommendation:	**Trust Board is asked to NOTE the update on progress against the recommendations arising out of the independent review of the Trust's governance arrangements.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Independent review of governance arrangements – recommendations
30 July 2015
V6 Trust Board 28 April 2016

designed
implemented

Rec	Ref	Recommendation	Priority/ risk rating	Dir. Lead	Management response/action	Update	Timescales							
							S	O	N	D	J	F	M	A
1	**1A**	Ensure that the five year plan clearly articulates the strategic priorities for the Trust along with outline goals over the short, medium and longer term.	H	AF	Agreed – articulation of strategic priorities to be clearer in five-year plan with associated goals. <u>Timescales</u> - Review transformation programme Extended EMT August 2015 - Revised structure for EMT meetings to provide focus for transformation - Stocktake of strategic plan and transformation Trust Board September 2015 - EMT time out October 2015 - Trust Board strategy November 2015 and February 2016 - Trust Board in March 2016 sign-off	Process begun – EMT September 2015 Completed – revised structure implemented from August 2015 Completed – stocktake presented to Trust Board 22 September 2015 with ongoing reporting to Trust Board quarterly. EMT time out 15 October 2015 Trust Board strategy sessions 24 November 2015 and 1 March 2016 First draft of annual plan submitted to Monitor 8 February 2016 (approved by Trust Board 29 January 2016). Final version of annual plan submitted to Monitor 18 April 2016 (approved by Trust Board 29 March 2016). EMT time out 21 April 2016 to determine priorities for strategic objectives with paper to Trust Board 28 April 2016 (AF).								
2	1A	Consider further strengthening the annual	M	AF	Agreed – annual planning cycle to be reviewed and strengthened to increase	Strategic planning team will support planning events in each BDU for								

Rec	Ref	Recommendation	Priority/ risk rating	Dir. Lead	Management response/action	Update	Timescales							
							S	O	N	D	J	F	M	A
		planning cycle by providing an opportunity to increase the levels of engagement between the board and senior leaders in order to increase oversight of the key aspects of the BDU plans and to provide a further opportunity for debate.			engagement. Timescales - Review transformation programme Extended EMT August 2015 - Revised structure for EMT meetings to provide stronger focus on transformation - Stocktake of strategic plan and transformation Trust Board September 2015 - Review EMT time out October 2015 - Trust Board strategy November 2015 and February 2016 - Trust Board in March 2016 sign-off	2016/17. Process begun – EMT September 2015 Completed – revised structure implemented from August 2015 Completed – stocktake presented to Trust Board 22 September 2015. EMT time out 15 October 2015 Trust Board strategy sessions 24 November 2015 and 1 March 2016 First draft of annual plan submitted to Monitor 8 February 2016 (approved by Trust Board 29 January 2016). Final version of annual plan submitted to Monitor 18 April 2016 (approved by Trust Board 29 March 2016).								
3	**1A**	Further develop the process for monitoring progress against the strategic plan including strengthening outcome measures and collating progress into a single dashboard which is presented to the strategy board at regular intervals throughout the year.	H	AF	Agreed - How – September 2015 Trust Board through stocktake of strategic plan and transformation - What – November 2015 strategy Trust Board. - Close links with new Non-Executive Directors ('fresh pair of eyes') and utilising skills and experience.	Examples of best practice reviewed. Stocktake of 2015/16 plan at Trust Board January 2016. Agree format for review of plan for 2016/17 in March/April 2016. EMT approval of approach to development of business intelligence January 2016. Group established involving Non-Executive Directors to review dashboard reporting (stocktake and follow up meetings held November 2015 and February 2016). Timescales revised to reflect development of strategic objectives (EMT time out 21 April 2016 and Trust Board 28 April 2016). Meetings of								

Rec	Ref	Recommendation	Priority/ risk rating	Dir. Lead	Management response/action	Update	Timescales							
							S	O	N	D	J	F	M	A
						sub-group established to finalise.								
4	**1A**	Strengthen the processes for the dissemination and monitoring of the strategy both to ensure that there is greater awareness of the key objectives for the Trust, as well as increased engagement in this process. This should include: • Localised activities, such as the BDU leadership undertaking engagement events in their service areas; • greater dissemination of the message to staff using a varied of media sources; and • alignment of BDU, service and individual objectives with the strategic intentions.	H	BDU Dirs KH/AGD EMT	Agreed. - Review transformation programme Extended EMT August 2015. - Revised EMT focus and strengthened communications and engagement with report into Trust Board September 2015. - Link to staff wellbeing survey to agree metrics to review. - EMT time out October 2015. Implementation December 2015 with review of progress in February 2016.	See 1 and 2. Regular stocktake of transformation programme, and strengthened communications and engagement at EMT and Trust Board. Revised methodology for dissemination to staff developed with detailed plan and timescales. Following approval of Trust operational plan for 2016/17, EMT time out 21 April 2016 to determine priorities for strategic objectives with paper to Trust Board 28 April 2016 (AF).								
5	**1B**	As part of the planned review of the AF, the Trust should amend this to more clearly align to the strategic objectives; to align risks to Board Committees as well as an ED; and for the format to be in line with best practice taking into account the points outlined in 1B.	H	DS	Agreed. Revised version of assurance framework to Trust Board October 2015 (with quarterly reporting from December 2015 – see below).	Examples of best practice reviewed and assurance framework revised for presentation to October 2015 Trust Board. Q3 presented to Trust Board January 2016. Internal audit February 2016 (with finding of significant assurance).	**Completed**							
6	**1B**	The Trust needs to be clear how assurance over the delivery of the Transformation programme will be	H	AF/ workstre am leads	Trust Board has considered establishment of a finance Committee on a number of occasions (most recently at the Deloitte feedback									

Rec	Ref	Recommendation	Priority/ risk rating	Dir. Lead	Management response/action	Update	Timescales							
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		undertaken, especially given the risks to the Trust in this area. In particular, the Trust should consider: • implementing a Transformation forum or a Finance Committee (which could also amalgamate the work of the IM&T and Estates forums); and • strengthening the content of reports presented to the Board.			workshop on 21 July 2015) and agreed that the Trust's financial position is a matter for Trust Board and should receive full Trust Board attention (see also recommendation 7). Reporting of transformation will be strengthened from September 2015. - Re-alignment of EMT meetings from August 2015 to provide stronger scrutiny of transformation progress. - Discussion at Extended EMT regarding clarity of visions and governance for transformation August 2015. - Reviewed also at EMT to inform report to Trust Board in September 2015. - Ongoing quarterly reporting to Trust Board (at business and risk meetings) with exception and risk reporting as required.	Completed – revised structure implemented from August 2015 Process begun – EMT September 2015 and EMT time out 15 October 2015 Completed – stocktake presented to Trust Board 22 September 2015 Project Management Office developed highlight report for transformation programme for ongoing quarterly reporting to Trust Board. Review of governance arrangements and reporting at different levels moving from planning to implementation. Group established involving Non-Executive Directors to review dashboard reporting (stocktake and follow up meetings held November 2015 and February 2016). Timescales revised to reflect development of strategic objectives (EMT time out 21 April 2016 and Trust Board 28 April 2016). Meetings of sub-group established to finalise.								
7	2A	Revisit the name and content	M	IB	Agreed – establish clearer distinction	Review of quarterly cycle of Trust	Completed							

Rec	Ref	Recommendation	Priority/ risk rating	Dir. Lead	Management response/action	Update	Timescales							
							S	O	N	D	J	F	M	A
		of the business and risk board and the public board to clarify the distinction and to set agendas in the context of the key risks facing the Trust. Retain a separate focus on strategy through the strategic board.			between business and risk, and 'public' Trust Board meetings. Attendance at Trust Board reviewed and agreed by Chair and Chief Executive from September 2015. Formal terms of reference to be established for Trust Board in support. Implementation of revised Trust Board quarterly meeting cycle from October 2015 with paper to September 2015 Trust Board and Audit Committee October 2015. - Month 1 business and risk – purpose to ensure strategy and, in particular, transformation, feature more prominently, including the Trust's plans for investment, to provide a link to the Trust's financial position and sustainability (i.e. change job). Will include quarterly reporting to Monitor. - Month 2 maintain strategic sessions as protected time. - Month 3 performance and monitoring – focus on delivery, finance and performance (i.e. the day job), including the assurance framework and risk register, compliance and regulation.	Board meetings: - Business and risk - Strategy - Performance and monitoring Attendance at Trust Board reviewed and agreed.								
8	**2B**	Implement a range of engagement mechanisms to supplement the Trust newsletter. Consider especially how any additional communications can be meaningful to staff in diverse roles and locations.	M	KH/AGD	Agreed – commission full review of all internal communication approaches, including newsletter, intranet, social media and other digital approaches. - Initial presentation to EMT August 2015 with view to agree a definitive approach. - Include in presentation to Trust	- Implementation of staff engagement strategy through action plan owned at EMT level. Will form key part of Director Q4 reviews with CE. - Review of marketing, communications and engagement function and channels –								

Rec	Ref	Recommendation	Priority/ risk rating	Dir. Lead	Management response/action	Update	Timescales							
							S	O	N	D	J	F	M	A
					Board in September 2015 with implementation by December 2015.	completed by KH and revised structure in place from January 2016. - Clinical advisory role established. - Develop new approach to how the Trust engages with people using digital technology – role established within Communications Team to take the Trust's approach forward. - Revisit transformation programme visions, and communications and engagement plans. - Survey of staff for views on communication and engagement with outcome reported to EMT September 2015. - Paper presented to Trust Board in September setting out plans for a refocused marketing, communications and engagement function – implemented and in place from January 2016. - Plan in place to engage and communicate with staff on the Trust's strategic objectives – to follow April's EMT time out and Trust Board.								
9	3A	Update Committee terms of reference to clarify their expected interaction with other groups and forums and to incorporate the additional aspects of good practice.	L	DS	Agreed – to be included in Committee annual reports February 2016	Terms of reference reviewed as part of annual reporting process and amendments will be presented to Trust Board on 29 March 2016.	**Completed**							
10	3A	Consider further enhancing the Committee reporting to the Board through the use of	M	DS	Agreed – Committee minutes to be presented to the most appropriate and timely Trust Board meeting (business	Completed – Committee minutes taken at each Board meeting as appropriate.	**Completed**							

Rec	Ref	Recommendation	Priority/ risk rating	Dir. Lead	Management response/action	Update	Timescales							
							S	O	N	D	J	F	M	A
		a standard format for the Chair's action log. Revisit the frequency of Committee reporting to the Board, ensuring that there is a clear process to escalate issues as required, and ensure that Board forums are included within this process also.			and risk or performance and monitoring). From October 2015.									
11	**3A**	Clearly define the required reporting and escalation arrangements from TAGs which outlines when (and to where) TAGs should report along with the frequency and nature of reports required.	M	EMT	Agreed. - Scope TAG reporting and report to EMT in September 2015 (performance, delivery and assurance), with clear links to Trust Board Committees and sub-committees in terms of assurance. - Update to Trust Board in October 2015.	TAGs mapped as part of description of Trust governance arrangements for Care Quality Commission inspection visit. To be reviewed at EMT November 2015 and reporting clarified. TAGs mapped as part of description of Trust governance arrangements for Care Quality Commission inspection visit. To be reviewed by EMT following receipt of CQC final report and clarification with new Chief Executive around EMT meeting structures and governance (due date December 2016).								
12	**3B**	Further refine the content and purpose of BDU performance meetings by improving the structure of items to be considered across all BDUs and through the inclusion of a specific focus on the development of and progress against strategic objectives.	M	BDU Dirs	Agreed – clarify arrangements at EMT September/October 2015. Extend to include BDU governance meetings and transformation boards.	To be reviewed by EMT following receipt of CQC final report and linked to planned audit of BDU Governance Groups to be undertaken by Practice Governance Coaches (due date September 2016). *NB annual BDU governance groups report presented to Clinical Governance and Clinical Safety Committee in April each year.*								

Rec	Ref	Recommendation	Priority/ risk rating	Dir. Lead	Management response/action	Update	Timescales							
							S	O	N	D	J	F	M	A
13	**3B**	Clarify the role and purpose of ORG. Consider amending its remit to include a focus on broader performance issues on an exceptions basis where it impacts on operational delivery.	M	SM	Agreed. - Purpose for ORG reviewed early August 2015. - Clarity to be confirmed in development of ToR for ORG and EMT October/November 2015.	Purpose of operational requirement group clarified by Chief Executive August 2015 and in February 2016. *(To review, discuss and agree action in relation to operational issues and pressures, and to focus on delivery of the plan, in particular, the delivery of the cost improvement programme. It is not a replication of EMT meetings or of its role.)*	**Completed**							
14	**3B**	Introduce an Assurance and Escalation Framework that clearly describes when and how key issues and risks should be escalated.	M	DS	Agreed.	Examples of best practice reviewed and paper presented to Trust Board and approved January 2016.	**Completed**							
15	**4A**	The IPR should be updated to include: • an executive summary in order to highlight key exceptions and outline actions in place to improve performance in these areas; • greater use of graphical analysis to present data in order to aid interpretation and understanding; and • a more rounded overview of performance at BDU level against key metrics covering all aspects of the business (to include quality, performance, finance and workforce).	M	AF	Agreed. Recommendations 3 and 12 inform 15 and 16. Longer timescales to allow for development of reporting and to ensure involvement of NEDs, particularly new appointments.	Examples of best practice reviewed. Presentation and engagement to Extended EMT September 2015. Group established involving Non-Executive Directors to review dashboard reporting (stocktake and follow up meetings held November 2015 and February 2016). Timescales revised to reflect development of strategic objectives (EMT time out 21 April 2016 and Trust Board 28 April 2016). Meetings of sub-group established to finalise.								
16	**4A**	The Board would benefit from the inclusion of clear	M	AF	Agreed. Recommendations 3 and 12 inform 15	To be included in work to address recommendation 15.								

Rec	Ref	Recommendation	Priority/ risk rating	Dir. Lead	Management response/action	Update	Timescales							
							S	O	N	D	J	F	M	A
		alignment between the metrics included in the Strategic Overview Dashboard and the key strategic priorities. This should be accompanied by the inclusion of locally determined metrics aligned to the priorities.			and 16.									
17	**4A**	Review the aspects of the finance report which are currently received by the Board in private with a view to merging non-commercially sensitive elements into the main IPR finance report received in public.	M	AF	Agreed. Finance report to be discussed at agenda setting and challenged at callover, supported by review at end of each Board meeting. From September 2015.	All agenda items for Trust Board are reviewed and discussed at agenda setting and callover with Chair and Chief Executive to ensure appropriate items are reported in public and private with a clear rationale for items scheduled for both public and private meetings.	**Completed**							
18	**4A**	Introduce a more granular BDU level view of quality performance as part of the quality metrics received by the CG&CS Committee. This could take the form of a heat map or performance wall.	M	TB/AF	Agreed.	To be included in the scope of work address recommendation 15.								
19	**4B**	Introduce routine assurance reporting on data quality with clear alignment to a Board Committee. This should include periodic updates on progress in delivering the data quality action plans.	M	TB/AF	Agreed. Routine reporting for assurance on process to Audit Committee. Routine reporting for clinical assurance to Clinical Governance and Clinical Safety Committee. Continued reporting in terms of IM&T Strategy at IM&T Forum. From October 2015.	Report to Audit Committee October 2015 with ongoing reporting as appropriate. Standing item on the agenda for the Clinical Governance and Clinical Safety Committee. Issues escalated to Trust Board as appropriate (for example, IT virus and RiO V7 implementation).	**Completed**							
20	**4B**	Introduce data quality kite marks to Board performance reporting to enabling BMs to have a clear line of sight of	M	AF	Agreed.	To be included in the scope of work address recommendation 15. Further action to be aligned to the recommendations arising from the								

Rec	Ref	Recommendation	Priority/ risk rating	Dir. Lead	Management response/action	Update	Timescales							
							S	O	N	D	J	F	M	A
		the underlying data quality in each of the indicators being presented.				internal audit report (April 2016).								

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 28 April 2016
Agenda item 8.4(v)

Title:	**Trust Board self-certification – compliance with Licence conditions**
Paper prepared by:	Director of Corporate Development
Purpose:	To provide assurance to Trust Board that it is able to make the required self-certifications as part of the governance statements required to inform the submission of the annual plan to Monitor.
Mission/values:	The Trust's annual plan describes how the Trust will meet its mission and adhere to its values.
Any background papers/ previously considered by:	Trust Board received and approved the annual plan for 2016/17 on 29 March 2016. Trust reviewed compliance with NHS Constitution in September 2015.
Executive summary:	<u>Background</u> As part of the annual planning arrangements, Monitor requires the Trust to make a number of governance declarations. Trust Board is required to make self-certifications in relation to: 1. systems for compliance with licence conditions (as required by general condition 6 of the NHS Provider Licence); 2. availability of resources (as required by continuity of services condition 7 of the NHS Provider Licence); 3. Corporate Governance Statement (as required by the Risk Assessment Framework); 4. Academic Health Science Centre and governance arrangements for these (as required by appendix E of the Risk Assessment Framework); and 5. training of governors (as required by s151(5) of the Health and Social Care Act 2012). Self-certifications against item 1 is the subject of this paper. Self-certification 2 was included in the annual planning return for Monitor submitted on 18 April 2016. Items 3 and 5 are required by 30 June 2015 and will be presented to Trust Board in June 2016. Item 4 is not applicable to this Trust at the current time. <u>Trust compliance with its Licence</u> The Licence is a requirement of the Health and Social Care Act 2012 and is the mechanism by which Monitor regulates providers of NHS services, both NHS and non-NHS. The provider licence is split into six sections, which apply to different types of providers. From 1 April 2013, all Foundation Trusts were automatically issued with a licence as the Health and Social Care Act 2012 specified that Foundation Trusts were to be treated as having met all the licence criteria. In the main, the licence requires the Trust to adhere to (and provide evidence that it has done so) certain conditions, which it does as part of its existing governance and reporting arrangements. The attached appendix provides assurance to Trust Board that the Trust meets the conditions of its Licence and identifies potential areas of risk. Each quarter, the exception report to Monitor specifically refers to the Trust's compliance with the conditions of its Licence and Trust Board is alerted to any exceptions or emerging risks through the quarterly reporting process.

	Trust Board is asked to certify that “the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution” and “the board declares that the Licensee continues to meet the criteria for holding a licence”.
Recommendation:	**Trust Board is ASKED to CONFIRM that it is able to make the required self-certification in relation to compliance with the terms of its Licence.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 28 April 2016
Monitor provider licence

This paper is intended to provide assurance that the Trust complies with the terms of its Licence and sets out a broad outline of the licence conditions and any issues for Trust Board to note.

The provider licence is split into six sections, which apply to different types of providers.

1. General conditions – general requirements applying to all licensed providers.
2. Obligations about pricing – obliges providers to record pricing information, check data for accuracy and, where required, charge commissioners in line with tariff. Applies to all licensed providers who provide services covered by national tariff.
3. Obligations around choice and competition – obliges providers to help patients make the right choice of provider, where appropriate, and prohibits anti-competitive behaviour where against patients' interests. This applies to all licensed providers.
4. Obligations to enable integrated care – enables the provision of integrated services and applies to all licensed providers.
5. Conditions to support continuity of service – allows Monitor to assess whether there is a risk to services and to set out how services will be protected if a provider gets into financial difficulty. Applies to providers of commissioner requested services only.
6. Governance licence conditions for Foundation Trusts – provides obligations for Foundation Trusts around appropriate standards of governance. Applies to Foundation Trusts only.

Condition	Provision	Comments
General licence conditions (G)		
1. Provision of information	Obligation to provide Monitor with any information it requires for its licensing functions.	The Trust is currently obliged to provide Monitor with any information it requires and, within reasonable parameters, to publish any information Monitor requires it to. Formal articulation of this Condition, therefore, does not present any issues for the Trust although the Conditions are so broad the obligation could become overly burdensome.
2. Publication of information	Obligation to publish such information as Monitor may require.	
3. Payment of fees to Monitor	Gives Monitor the ability to charge fees and for licence holders to pay them.	There are currently no plans to charge a fee to Licence holders. Trust Board should note that there is, currently, no provision in the budget for additional fees and this would, therefore, become a cost pressure.

Condition	Provision	Comments
4. Fit and proper persons	Prevents licences from allowing unfit persons to become or continue as governors or directors.	The Care Quality Commission published the fit and proper person requirements to take effect from 1 October 2014. The Trust has included the requirement for members of Trust Board to make an annual declaration against the requirements on an annual basis and has robust arrangements in place for new appointments to the Board (whether non-executive or executive).
5. Monitor guidance	Requires licensees to have regard to Monitor guidance.	The Trust responds to guidance issued by Monitor. Submissions and information provided to Monitor are approved through relevant and appropriate authorisation processes.
6. Systems for compliance with licence conditions and related obligations	Requires providers to take reasonable precautions against risk of failure to comply with the licence.	The Trust has systems and processes in place to ensure it complies with its Licence and this is co-ordinated by the Director of Corporate Development. Trust Board makes a self-certification quarterly that the Trust remains compliant with its Licence.
7. Registration with the Care Quality Commission	Requires providers to be registered with the CQC and to notify Monitor is their registration is cancelled.	The Trust is registered with the Care Quality Commission.
8. Patient eligibility and selection criteria	Requires licence holders to set transparent eligibility and selection criteria for patients and apply these in a transparent manner.	Work is ongoing to formally articulate and publish patient eligibility and selection criteria employed by the Trust. The Trust will include a statement on its website linked to further work to develop service directories for each BDU.
9. Application of section 5 (which relates to continuity of services)	Sets out the conditions under which a service will be designated as a CRS	Covers all mandatory services and "any other service which the licensee has contracted with a Commissioner to provide as a Commission Requested Service (CRS)." See CoS1.
Pricing conditions (P)		
1. Recording of information	Obligation of licensees to record information, particularly about costs.	Monitor requirements in relation to pricing information are still being developed, particularly for care that currently falls outside of the national tariff.
2. Provision of information	Obligation to submit the above to Monitor.	
3. Assurance report on submissions to Monitor	Obliges licensees to submit an assurance report confirming that the information provided is accurate.	

Condition	Provision	Comments
4. Compliance with the national tariff	Obliges licensees to charge for NHS health care services in line with national tariff.	The Trust continued to work with its commissioners on the requirement to develop a local tariff within the terms of national guidance. The Trust has been using mental health currencies since 2012 and will continue to do so. Work done to date has improved baseline information and enabled a better understanding of the impact of the tariff. This is a potential area of risk for the Trust in terms of assessing the implications for the Trust's income, and data quality and recording.
5. Constructive engagement concerning local tariff modifications	Requires licence holders to engage constructively with commissioner and to reach agreement locally before applying to Monitor for a modification.	See P4 above.
Choice and competition (C)		
1. Patient choice	Protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a choice of provider.	In 2014/15, a legal right to choice in mental health services was introduced as part of the parity of esteem agenda, covering both choice of mental health provider and choice of mental healthcare team. NHS England produced guidance in December 2014 to support consistent application of the right to choice across the sector. Commissioners will monitor the Trust's compliance with the legal right of choice through contract monitoring in 2016/17 in line with NHS Standard Contract requirements. This includes the provider publishing all relevant services on Choose and Book. This is a key area for the Trust to address. Based on the previous experience of rolling out choice for physical health services nationally, it is expected that the new legal right will be taken up gradually and not result in significant shifts of activity in the short term.
2. Competition oversight	Prevents providers from entering into or maintaining agreements that have the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health	Trust Board has reviewed its position and considers that it has no arrangements that could be perceived as having the effect of preventing, restricting or distorting competition in the provision

Condition	Provision	Comments
	care users.	of health services. The Trust is aware of the requirements of competition in the health sector and would seek legal and/or specialist advice should Trust Board decide to consider any structural changes, such mergers or joint ventures. There is a risk to the Trust that challenges on competition could restrict or block service re-design or improvements.
Integrated care condition (IC)		
1. Provision of integrated care	Requires Licensee to act in the interests of people who use healthcare services by facilitating the development and maintenance of integrated services.	The Trust actively works with its partners, through formal and informal mechanisms to foster and enable integrated care and is involved in three Vanguard pilots aimed at developing new ways of working and new models of delivery.
Continuity of service (CoS)		
1. Continuing provision of commissioner requested services	Prevents licensees from ceasing to provide CRS or from changing the way in which they provide CRS without the agreement of relevant commissioners.	All mandatory services were automatically considered as CRS from 1 April 2013. CCGs were given a three-year period (i.e. to the end of the 2015/16 financial year) to review this designation. As part of the 2016/17 contracting negotiations, the Trust has agreed CRS with commissioners, with the exception of Barnsley, that all mental health services will be considered as CRS. Discussions continue with NHS Barnsley CCG. Community services in Barnsley and improving access to psychological therapies in Kirklees are no longer CRS.
2. Restriction on the disposal of assets	Licensees must keep an up-to-date register of relevant assets used in CRS and to seek Monitor's consent before disposing of these assets IF Monitor has concerns about the licensee continuing as a going concern.	As the majority of services the Trust provides are classed as CRS, all assets associated with these services are classed as restricted and these can be identified by the Trust. Any changes to estate and the asset base are discussed with commissioners in relation to the provision of services. The Trust has an asset register in place. The Trust is only required to seek Monitor's consent for disposal of assets if Monitor was

Condition	Provision	Comments
		concerned about its ability to continue as a going concern.
3. Monitor risk rating (standards of corporate governance and financial management)	Licensees are required to adopt and apply systems and standards of corporate governance and management, which would be seen as appropriate for a provider of NHS services and enable the Trust to continue as a going concern.	The Trust has robust and comprehensive corporate and financial governance arrangements in place. It reported a green risk rating for both the continuity of services and governance Licence conditions throughout 2015/16 and intends to do the same in 2016/17.
4. Undertaking from the ultimate controller	Requires licensees to put a legally enforceable agreement in place to stop the ultimate controller from taking action that would cause the licensee to breach its licensing conditions.	Does not apply to the Trust.
5. Risk pool levy	Obliges licensees to contribute to the funding of the 'risk pool' (insurance mechanism to pay for vital services if a provider fails).	Further guidance on this is awaited from Monitor. It could have the potential to bring significant further financial burden on providers.
6. Co-operation in the event of financial stress	Applies when a licensee fails a test of sound finances and obliges the licensee to co-operate with Monitor.	The Trust is aware it would need to co-operate with Monitor in such circumstances.
7. Availability of resources	Requires licenses to act in a way that secures resources to operate CRS.	The Trust has sound and robust processes and systems in place to ensure it has the resources necessary to deliver its services.
Foundation Trust conditions		
1. Information to update the register of NHS foundation trusts	Obliges foundation trusts to provide information to Monitor.	See G1. The Trust is currently obliged to provide Monitor with any information it requires, including information to update its entry on the register of NHS foundation trusts.
2. Payment to Monitor in respect of registration and related costs	The Trust would be required to pay any fees set by Monitor.	Monitor has undertaken not to levy any registration fees on foundation trusts without further consultation.
3. Provision of information to advisory panel	Monitor has established an advisory panel to consider questions brought by governors. Foundation trusts are obliged to provide information requested by the panel.	The Advisory Panel was established in April 2013 and the Trust provided a briefing on the Panel for the Members' Council. The Trust's governors understand the role and remit of the Panel and the seriousness of any reference to it, representing a breakdown of the existing communication channels between the Trust Board and the Members' Council.

Condition	Provision	Comments
4. NHS Foundation Trust governance arrangements	Gives Monitor continued oversight of the governance of foundation trusts.	The Trust has sound corporate governance processes in place and reviews of these arrangements are a core part of the internal audit annual work programme. This was also evidenced in the outcome of the well-led review of the Trust's governance arrangements.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 28 April 2016
Agenda item 8.4(vi)

Title:	**Trust visual identity**
Paper prepared by:	Director of Marketing, Engagement and Commercial Development
Purpose:	To summarise the progress towards a refreshed visual identity for the Trust.
Mission/values:	The creative concept behind our visual identity and the co-production in its development helps us keep people in the centre, respecting individuality. By developing a visual identity in line with new national policy, we not only remain relevant today but also ready for tomorrow. Acting as a national case study means we are improving but also aiming to be outstanding.
Any background papers/ previously considered by:	No
Executive summary:	The NHS logo and letters are registered trademarks owned by the Department of Health. NHS England is responsible for the brand guidelines of the NHS and is in the process of finalising a new policy, due to be launched at the end of May. This will replace the existing NHS brand guidelines, which are approximately 10 years old. All NHS organisations are required to comply with the national brand policy, with a clause on abiding by them already written in contracts. It is expected that this will be more closely monitored going forward. The policy has been developed by NHS England following extensive public and stakeholder research and engagement which found that people want to see a consistent application of the NHS identity. In response to the research, the new policy firmly limits the use of font, colour and style but it is up to each Trust to find a unique visual style which still clearly presents us as part of the NHS but gives us enough flexibility to differentiate ourselves. Our visual identity, which is in need of an update, is being refreshed so that we fully comply with the new policy and are able to differentiate ourselves in the marketplace. Following research with Trust staff (Aug 2015) we are keeping our well-known strapline 'with all of us in mind', with emphasis on the 'all of us' part. The illustrated heads are considered an alternative logo by NHS England and not allowed under the new policy. Given the restrictions in place and the extensive research and engagement already carried out nationally, we have concentrated our efforts locally on the process of co-producing our new visual identity in line with our values. Staff, service users, carers and partners have been asked to contribute to help form a collective pattern which will be a key part of our refreshed identity. Our new visual identity will be launched mid-May to coincide with refreshed communication channels. In line with national policy our services will be encouraged to phase introduction and avoid unnecessary cost; non-digital communications materials will only be updated as and when required.

Recommendation:	**Trust Board is asked to receive the presentation and note progress made.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 28 April 2016
Agenda item 9.1

Title:	**Information Management and Technology Strategy 2016/19**
Paper prepared by:	Interim Chief Executive
Purpose:	To review and note the IM&T Strategy
Vision/goals:	This paper outlines how the IM&T Strategy supports the Trust in working towards achieving the Trust's strategic vision and objectives.
Any background papers/ previously considered by:	The Strategy has been considered and supported by the Executive Management Team (EMT) and IM&T Forum.
Executive summary:	This Strategy describes the projects we will deliver to create a vibrant IT and information environment that supports staff in addressing real business needs flexibly and efficiently. The aim of the IM&T Strategy is to ensure the Trust effectively delivers the **'Right information at the Right time and in the Right format to the Right person'.** Information Management and Technology (IM&T) is a critical lynchpin for the Trust as the way in which the organisation uses technology and how information impacts on the care we provide, all the activities we undertake and the decisions we make both individually and corporately. Working in partnership with the local Commissioners, NHS Providers, Social Enterprises and Local Authorities the Trust will develop, produce and implement Local Digital Roadmaps, setting out how as a Trust and Local Health Community we will achieve the ambition of "paper-free at the point of care' by 2020. The Trust has recognised the need to transform services to improve efficiency, effectiveness and the outcomes for service users. Accurate information (not data), delivered well is critical to the whole process from identifying areas for improvement to evidencing the impact of changes made. This strategy will focus on 6 key domains: • Infrastructure • Clinical & Corporate Systems • Information Sharing • Digitisation • Business Intelligence • Training & Skills Development This strategy covers a three-year period, 2016–2019, and should, therefore, deliver the following in the next three years. • The infrastructure and evidence base to inform the Right decision. • Tools to support high quality outcomes for service users and carers from their service experiences. • Innovative use of technology and information to ensure the most effective/efficient use of available resources. • Integration of systems that remove the requirement for paper records and

	support the Trust in becoming paper free by 2020 and enable the sharing of information to support the delivery of care. • Information Sharing that supports the improvement in data and information accuracy, ensuring relevant information is shared in a timely and automated way. Achievement of these objectives will enable the Trust to make significant progress in realising the aim of the effective delivery of *'Right information at the Right time, in the Right format to the Right person'*
Recommendations:	**Trust Board is asked to APPROVE the Strategy.**
Private session:	Not applicable

South West Yorkshire Partnership NHS
NHS Foundation Trust

IM&T Strategy 2016 - 2019

Version

April 2016

Adrienne Pickering – Deputy Director of IM&T

With all of us in mind

'Effective Delivery of the Right information at the Right time and in the Right format to the Right person'.

Information Management and Technology (IM&T) is a critical lynchpin for the Trust as the way in which the organisation uses technology and how information impacts on the care we provide and the decisions we make both individually and corporately.

The Trust has recognised the need to transform services to improve efficiency, effectiveness and the outcomes for service users. Accurate information (not data), delivered well is critical to the whole process from identifying areas for improvement to evidencing the impact of changes made.

Working in partnership with the local Commissioners, NHS Providers, Social Enterprises, Local Authorities and private industry the Trust will develop, produce and implement Local Digital Roadmaps, setting out how as a Trust and Local Health Community we will achieve the ambition of 'paper-free at the point of care' by 2020.

Challenges facing the Trust

within the NHS there are disparate systems with very little interoperability which leads to very limited access to and sharing of information with partners internal and external to the NHS

The IM&T Strategy Must address

- the complexity of the systems being used
- suggest ways in which technology can be developed and deployed to ensure that information is accessible at the point of care to both staff and clients
- provide a means of actively involving clients in the development and deployment of technology

Key Deliverables

- Successful partnership working to deliver an integrated approach to the delivery and sharing of information and technology across the local health community to improve patient care.
- The infrastructure and evidence base to inform the Right decision
- Tools to support high quality outcomes for service users and carers
- Innovative use of technology and information to ensure the most effective/efficient use of available resources
- Integration of systems that remove the requirement for paper records and support the Trust in becoming paper free by 2020
- Information Sharing that supports the delivery of care, improvement in data and information accuracy, ensuring relevant information is shared in a timely and automated way.
- Use of Business Intelligence tools to deliver information in a standardised, user-friendly way & an increased use of forecasting, benchmarking and statistical techniques to deliver information rather than data.

How the Strategy Fits together

Infrastructure - *Good Connection , Good Performance*

(Access to Trust IT services and systems whenever and wherever they are needed regardless of location, be that in a Trust site, clients home or other partner premises.)

What does this cover

- *Data & Telephony networks*
- *Data storage*
- *IT support services*

Where do we want to be

Establish an IT infrastructure that is

- responsive and user friendly
- reliable and resilient
- fit for purpose,
- operating at optimum levels
- enables safe and secure access to key systems
- future proofed to support innovation & new ways of working
- facilitates data sharing
- supports access to the latest technologies

Where are we now

- successfully transitioned to a new IT Services
- network infrastructure upgraded to all Trust sites
- Wireless and mobile access is available across all Trust sites
- WiFi available in a limited number of partner sites
- Legacy / end of life systems upgraded
- new telecommunications system
- replacement of the Virtual Private Networking (VPN) solution

What will this enable us to do

- access the Trust network where ever they are working the Local Health Community
- effectively use clinical systems and share data.
- Guest wifi network access to service users and carers across
- flexibility to support future innovation
- invest in new technologies to support Trust and National agendas

Clinical & Corporate systems – *delivering key systems that are fit for purpose and user friendly*

(Harnessing the power of systems to improve service delivery, making it easy to access information held within the systems and delivering a service that is paper-free at the point of care.)

What does this cover

Clinical Systems	*Transactional Systems*
Mental Health - RiO	HR & Finance Systems
Community - SystmOne	IM&T & Estates Systems
Datix, Pharmacy	Corporate Systems
	Reporting Systems

Where are we now

- Integration of SystmOne & RiO starting to address the inability to share information
- SystmOne fully deployed clinically
- Mental Health System (RiO) upgraded to latest National Spine version
- Secure access to RiO for staff working in areas with poor or no network connection

Where do we want to be

- operate paper-free service at the point of care by 2020.
- fully exploit & develop system functionality
- User friendly, flexible, reliable & future proofed systems
- development of systems driven by the users
- Access to all systems via Trust portal
- integration between all systems becomes the norm
- strategic approach to developing & procuring systems
- Do not assume that one size fits all

What will this enable us to do

- electronic information sharing between the Trust & partner's systems
- shift from reliance on paper to use of electronic records
- improved Clinical outcomes through timely sharing of information
- Service user & staff experience improved
- Increased utilizing of technology by staff / service users
- Adoption of a strategic approach to systems development

Information sharing - *Information Governance seen as an enabler rather than barrier to sharing information*

(Safe sharing of information with other care providers, easy access for staff and service users to information held within relevant clinical systems.)

What does this cover

The sharing of information between

- Health and Social Care organisations
- professionals providing care
- service users receiving Trust services

Where are we now

- Information Governance and Policy established
- Proactive management of Information Governance processes Trust wide
- Information Governance key component of all IM&T programmes of work.
- 'THINK IG' branding established

Where do we want to be

- Service User front and centre stage with regards to information and not an afterthought.
- Work in partnership with health and social care organisations in the local health community to achieve a common vision for deployment of IM&T
- Ability for the Trust to optimise sharing of systems and information with our partners and our service usersto improve patient and public experience and health outcomes
- Change perceptions of organisational boundaries and technical constraints

What will this enable us to do

- Increased information sharing across different care settings supporting the improvement in data & information accuracy
- timely and automated sharing of relevant information at the point of care.
- Provide client portals that allow service users/carers (with service user consent) access to their own information
- Opportunity to integrate and share applications and equipment across health communities.

Business Intelligence – *Turning data into information*

(analysis, interpretation, sharing and presentation of information fundamental to the operation and transformation of the organisation.)

What does this cover

- providing *actionable* information
- Mandated statutory reporting
- Commissioning data flows (contracts.)
- Balanced scorecards
- Reports on Activity themes
- Information to support business cases & service change.

What will this enable us to do

- Provide an information hub, accessible to all, providing the gateway to all reports. With key reports "pushed" out to staff
- Development of information bank to explain each benchmarking indicator and metric
- Information quality key to any new development
- Provision of added intelligence & analysis services provide to the Trust
- data quality is understood and maintained within the Trust.

Where do we want to be

- "information savvy" workforce clear on their input & outcome to business processes.
- Provision of good quality information (not data)
- Key business intelligence available and used to drive improvement
- Forecasting of performance commonplace.
- Intelligence reports, automated, easy to use & meaningful to teams.
- partnership working with operational colleagues to influence how the Trust works & the quality of its services.

Where are we now

- Moving away from outdated technology & reliance on manual interventions
- Investment made, improving skill set of staff
- Service restructure facilitating development work
- data warehouse commenced.
- Trialling use of dashboard technology & other presentational techniques
- Benchmarking being used more widely

Digitisation - *Using technology in the care environment as we do in our everyday life.*

(Harnessing the power of technology to improve and transform how we deliver care and services.)

What does this cover

- *Communication with Service Users* – ways of improving & developing communications with service users
- *Effective Deployment of Staff* - how technology can support staff in service delivery

What will this enable us to do

- allow the Trust to change how we support, communicate and deliver care to our service users now and in the future.
- Service users able to use home technologies to receive and utilise healthcare
- clinical services able to meet the service user's expectations
- By keeping abreast of change we will ensure any new technology improves service user care and delivers efficiencies.
- review new & emerging technologies in partnership with external agencies.
- Established central scanning bureau to reduce legacy paper records & improve access to records

Where are we now

- Agile working successfully deployed
- Digital Dictation technologies being assessed for ability to improve efficiencies and reduce administration overheads..
- Skype software deployed across the Trust, (supports staff working remotely enabling them to communicate via phone, desktop video conferencing or instant messaging with colleagues at other sites and organisations)
- Use of technology to manage workflow & reporting of Subject Access Requests (SAR)
- Scanning project initiated – scanning of legacy paper records

Where do we want to be

- provide solutions that fit into the service user's lifestyle
- ability to offer staff & service user's solutions that support them in delivering and receiving a high level of care.
- invest in technological developments driven by the service users clinical service requirements

Training & Skills Development – *Skills and confidence to use systems & technology to support the role.*

(Ensuring staff have the skills & confidence to use current & future technology to meet the demands of their roles & the Trust)

What does this cover

delivery of skills and training to enable staff to use technology, access Information and exploit the functionality of systems.

Where are we now

- not all staff have the same knowledge, confidence and skills in using information and technology
- initial work as commenced on the following areas:
  - training needs assessments being undertaken for clinical systems users but this needs to be extended to cover all systems and technology.
  - Basic IT Training currently being provided in conjunction with the agile working programme of work.
  - Roles based approach to training being established within current IM&T projects, this approach needs to be adopted within all Trust projects.

Where do we want to be

- staff effectively using digital technologies to deliver services and client care and exploiting the functionality and capabilities of the current and future clinical and corporate
- strategic approach to the development and delivery of Information technology training
- role based training programme to address
  - basic IT training,
  - management of resources,
  - analytical skills
  - technical skills.
- staff equipped with the tools to enable them to use technology, interrogate and interpret the information used with in their role.

What will this enable us to do

- Staff equipped with the skills & confidence to use information and technology within the work place and in delivering care.
- opportunity to offer different ways of learning and provide IM&T training utilising innovative delivery methods.
- Provide guidance and support in using current & new technologies
- Improve accessibility to training services.

IM&T Domain Milestones

Infrastructure Domain	2015 / 16	2016 / 2017				2017 / 2018				2017 / 2018			
	Qtr 4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4
Wifi access													
on Trust Sites & Limited access on partner sites	■												
via NHS Partner sites	■	■	■	■	■								
via Local Authority sites				■	■	■	■	■					
Guest Wifi (inc service users internet access)			■	■									
Infrastructure Modernisation Programme													
phase 1 - rationalisation of legacy networks & improved network links	■												
phase2 – replacement of legacy hardware & email platform upgrading	■	■	■	■	■								
phase3 – data centre rationalisation				■	■	■	■	■	■				
Telecommunications replacement													
South Yorkshire	■												
West Yorkshire		■	■	■	■								
Microsoft Review							■	■	■	■			
Email review													
New VPN Solution	■	■											
Smartphone / Mobile phone provision & support					■								

IM&T Domain Milestones

Clinical and Corporate Systems Domain	2015 / 16	2016 / 2017				2017 / 2018				2017 / 2018			
	Qtr 4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4
Clinical portal													
phase 1													
phase 2													
Client portal													
Integration													
Integration of transactional systems													
Clinical Systems - Transformation Programme(s) Support & Alignment (e.g. clinical pathways development)													
S1 EPR Core													
Barnsley													
Trust wide													
S1 Clinical Deployment													
S1 Contract reprovisioning/finalisation													
RiO v7 upgrade													
RiO Patient Viewer													
Paperlight													
Mental Health Information Systems													
Smoking cessation													
NHS No.													
MIG													
eDischarge Messaging													
Community equipment													
Medicines Management													
e-referrals													

IM&T Domain Milestones

Digitisation Domain	2015 / 16	2016 / 2017				2017 / 2018				2017 / 2018			
	Qtr 4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4
Agile working													
phase 1	■												
phase 2		■	■	■	■								
phase 3						■	■	■	■				
Teleconsultation	■												
Skype for Business	■	■											
Digital Dictation		■	■	■	■	■							
Apps development					■								
Centralised mailing review									■	■	■	■	

Information Sharing & Business Intelligence Domains	2015 / 16	2016 / 2017				2017 / 2018				2017 / 2018			
	Qtr 4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4
Information Sharing Domain													
Vanguards	■												
Partnership working – digital road maps	■	■	■	■	■	■	■	■	■	■	■	■	■
Electronic Document Management						■	■	■	■				
Records Scanning	■	■	■	■	■	■	■						
Business Intelligence Domain													
Business Intelligence / Data warehouse - Phase 1	■	■	■										
Business Intelligence / Data warehouse (informationhub & Dashboards)				■	■	■	■	■	■	■	■	■	■

Information Management and Technology Strategy

2016 - 2019

Status: **Draft**

Version: **V0.2**

Date:

Executive Summary

The aim of the IM&T Strategy is to ensure the Trust effectively delivers the **'Right information at the Right time and in the Right format to the Right person'.**

This Strategy describes the projects we will deliver to create a vibrant IT and information environment that supports staff in addressing real business needs flexibly and efficiently.

Information Management and Technology (IM&T) is a critical lynchpin for the Trust as the way in which the organisation uses technology and information impacts on the care we provide, all the activities we undertake and the decisions we make both individually and corporately.

Working in partnership with the local Commissioners, NHS Providers, Social Enterprises and Local Authorities the Trust will develop, produce and implement Local Digital Roadmaps, setting out how as a Trust and Local Health Community we will achieve the ambition of 'paper-free at the point of care' by 2020.

These partnership arrangements are an important element in the Trust developing systems which will support and deliver a "fully interoperable electronic health record so that patient's records are paperless" and facilitate the sharing of information across health and social care providers.

The key partnerships for the Trust are:

- The 4 commissioning CCG's
- The 3 main NHS providers (CHFT, BHNFT & Mid Yorkshire)
- Social Enterprise Organisations (Locala, Spectrum)
- 4 local authorities
- IT Service Provider (Daisy)

The Trust has recognised the need to transform services to improve efficiency, effectiveness and the outcomes for service users. Accurate information (not data), delivered well is critical to the whole process from identifying areas for improvement to evidencing the impact of changes made.

This strategy will focus on 6 key domains:

- Infrastructure
- Clinical & Corporate Systems
- Information Sharing
- Digitisation
- Business Intelligence
- Training & Development

This strategy covers a 3 year period, 2016–2019 and should, therefore, deliver the following in the next 3 years:

- The infrastructure and evidence base to inform the Right decision

- Tools to support high quality outcomes for service users and carers from their service experiences

- Innovative use of technology and information to ensure the most effective/efficient use of available resources

- Integration of systems that remove the requirement for paper records and support the Trust in becoming paper free by 2020 and enable the sharing of information to support the delivery of care.

- Information Sharing that supports the improvement in data and information accuracy, ensuring relevant information is shared in a timely and automated way.

Achievement of these objectives will enable the Trust to make significant progress in realising the aim of the effective delivery of *'Right information at the Right time, in the Right format to the Right person'*

Purpose

The purpose of the report is to set out the strategy and deliverables for IM&T for the Trust in supporting internal developments and external partnerships.

The content of the strategy covers:

- How Information Management and technology relates to the business of the Trust

- What are the deliverables of IM&T and how these objectives will be achieved

- Who is responsible for delivering the strategy.

- How will the Board be assured that processes are being managed and there is adequate scrutiny and governance.

Strategic Context and Direction

The challenges within the NHS are that there are disparate systems with very little interoperability which leads to very limited access to and sharing of information with partners internal and external to the NHS.

The IM&T Strategy must address the complexity of the systems being used and suggest ways in which the Trust can develop and deploy technology to ensure that information is accessible at the point of care to both staff and clients and it must provide a means of actively involving clients in the development and deployment of technology.

The Trust recognises that IM&T is a key enabler in supporting the delivery of Trust objectives in relation to:

- Working in partnership with our commissioners and health & social care colleagues to deliver an integrated approach to the delivery and sharing of information and technology across the local health community to improve patient care.

- Supporting Trust processes and providing evidence of achievement for compliance requirements for the provision of health services, information governance, financial probity, contract performance, HR best practice and corporate governance.

This strategy is concerned with how IM&T relates to the business of the Trust and aligns with the organisation's Transformation Agenda and other key business themes.

The ambitions of the IM&T strategy are:

- Work towards the development and delivery of an integrated digital care record to support the ambition that health care professionals will operate 'paper-free at the point of care' and that all patient and care records will be digital, interoperable and real-time by 2020.

- Ensuring technology is harnessed and used as an enabler to support the Trust in redesigning services and IT solutions and technologies provided enable improved access to information in a timelier manner.

- Through the review and realignment of the IM&T support functions the needs of the Business Delivery Units are met and the provision of a more proactive IT service to enable it to effectively and efficiently support the increased reliance and dependency on technology.

- Better use of clinical information systems and exploitation of the available functionality.

- Use of Business Intelligence tools to deliver information in a standardised, user-friendly way (e.g. dashboards/graphics) and an increased use of forecasting, benchmarking and statistical techniques to deliver information rather than data.

- Improved skills within services with all staff having access to or being provided with the appropriate skills to use current and future technologies to meet the changing demands of the organisation.

There are 6 key domains which support the delivery of the IM&T Strategy:

- Infrastructure
- Clinical & Corporate Systems
- Information Sharing
- Digitisation
- Business Intelligence
- Training & Skills Development

Infrastructure - *Good Connection, Good Performance*

Access to Trust IT services and systems whenever and wherever they are needed regardless of location, be that in a Trust site, clients home or other partner premises.

In Scope

The infrastructure domain consists of the elements that form the foundations of the Trusts future IT developments, the key elements consist of

> *Data & Telephony networks* – these are the links and solutions that allow users access to the Trusts clinical and corporate systems when and where they require it. Therefore supporting how they wish to work now and in the future.
>
> *Data storage* – ensures the Trust data is accessible as and when required by users and that it is stored in resilient and secure data storage facilities.
>
> *IT support services* – ensure that services are maintained and available and that users have access to the IT expertise via a Trust IT service desk.

Vision

To enable the Trust to embrace and utilise technology and to compete with existing and emerging market providers it needs to be able to offer staff and service user's access to the latest technologies that will assist them in delivering and receiving care.

We need to enable our health and care professionals and service users with technology, not hinder them, therefore we need to use IM&T enablers to support new ways of working such as agile working, provision of video conferencing capabilities (SKYPE), service user access to wifi and enhanced telecommunications provision so that staff are not restricted in how they wish to deliver care in the future.

To achieve this the Trust will need a reliable and resilient IT infrastructure that is able to support staff, service users and partners in accessing the appropriate systems as and when required, users will not experience any variance in performance regardless of where they are accessing the network from and the infrastructure will enable safe and secure access to key systems and data sharing.

The Trusts IT Infrastructure will be fit for purpose, operating at optimum levels and future proofed to support innovation. It will be responsive and user friendly (access to services and systems will be standardised and **will not** be complex) and help will be provided as and when needed, and ultimately develop staff into confident users of the technology.

Current Position

In 2015 the Trust successfully transitioned to a new IT Services Provider to improve service provision and delivery.

The network infrastructure within the Trust and to all sites has been enhanced and work is ongoing to ensure improvement is maintained and delivered. Wireless and mobile access is available across all Trust sites and a limited number of partner sites and work as commenced to progress the sharing of network facilities at partner organisations

Legacy / end of life systems have been upgraded and replaced (for example: decommissioning of windows XP, implementation of new telecommunications system and replacement of the Virtual Private Networking (VPN) solution to enable improved access to Trust systems remotely)

Deliverables

This Domain will enable the trust to deliver the following:

Ability for staff to access the Trust network when working out of partner's premises (through wireless network connectivity) and provision of reciprocal arrangements for our partner's when working from our premises. This capability will enable staff to effectively use clinical systems and share data.

Provision of a robust, reliable and resilient network infrastructure that will allow safe and secure access to key systems and data sharing. Ability to offer Guest wifi network access to service users and carers across all Trust Sites and a network that is flexible to support future innovation, transformation and estate rationalisation.

Utilise and exploit partnership working with the IT Support Services provider to investigate and invest in new technologies, therefore providing the Trust with the capabilities deliver any technology requirements of the Trust Sustainability and Transformation Plans.

Clinical & Corporate systems – ***delivering key systems that are fit for purpose and user friendly***

Harnessing the power of systems to improve service delivery, making it easy to access information held within the systems and delivering a service that is paper-free at the point of care.

In scope

This domain consists of operational systems both clinical and non-clinical that support the Trust in the provision and delivery of effective care and support to its service users, the key systems are:

Clinical Systems -	Mental Health - RiO Community - SystmOne Datix, Pharmacy

Transactional Systems-	HR Systems (Electronic Staff Record (ESR), Expenses etc.) Finance Systems IM&T Systems (Integration solution, Desktop Software. (Microsoft)) Estates Systems Corporate Systems (SharePoint)
Reporting Systems	Business Intelligence & Benchmarking

Vision

The ambition of the Trust is to achieve the Government's commitment in Personalised Health and Care 2020 that "all patient and care records will be digital, interoperable and real-time by 2020". In practice this means all healthcare professionals will operate paper-free service at the point of care.

To achieve this we need to improve how the users access and use our systems, we need to fully exploit and develop existing and new system functionality whilst ensuring we meet the user's requirements.

The development of a Trust portal will allow users to sign on once and have access to all the systems they require, making all systems more user friendly, improving the users experience and supporting the move to a paper free environment. In developing the portal the Trust will also be able to develop its interoperability capabilities enabling systems both clinical and transactional to talk to each other to support business delivery and wider service integration both internally and in collaboration with our partners. The ongoing aim will be to ensure that integration between all systems is considered and where appropriate implemented ensuring that through integration, access to information for staff and clients is improved, data duplication is reduced and functionality is maximised.

The establishment of a strategic approach to developing and procuring systems both internally and with partners will ensure we make the best use of our investment in key systems and ensure systems are able to talk to each other but what is fundamental to achieving and delivering this vision is, the Trust must not assume that one size fits all and development of systems must be driven by the users.

To enable the Trust to fully embrace and utilise its key systems and compete with existing and emerging clinical service providers it needs to be able to offer staff and service user's systems that are sufficiently flexible, reliable and future proofed to support them in delivering and receiving a high level of care.

Current Position

Integration of the Trusts 2 clinical systems SystmOne & RiO (in pilot phase), this will start to address the current lack of interoperability between clinical systems within the Trust and also within partner organisations. The benefits of this to users will be a reduction in unnecessary data input, reduced risk of data loss and information

governance incidents and improved sharing of information with partners and service users.

The full clinical functionality of the Trust's Community System (SystmOne) has been deployed to community-based front-line clinical services such as Health Visiting and District Nursing.

Mental Health System (RiO) upgraded to latest National Spine version to facilitate improved usage of the system, reduce data input and to enable the maximisation of functionality to improve the users overall experience of using the system to record and retrieve information. Secure access to system provided to staff working in areas with poor or no network connection thereby ensuring care can be provided when and where required by the service user.

Deliverables

The developments within this domain will enable the Trust to deliver the following:

Integration between clinical, transactional and reporting systems facilitating the sharing of information between the Trust and its partners, it will drive forward the shift from existing reliance upon paper records to the use of electronic records and it will reduce duplication of clinical and corporate data input and the risks associated with staff involved in a client's care not having access to relevant clinical information.

Achieve the objective of all systems communications between all parties involved in healthcare being electronic therefore removing the requirement for paper records, becoming a paper free Trust and achieving the national digitisation agenda.

Clinical effectiveness and quality of outcomes will be improved through timely sharing of information between providers and improved operational effectiveness will be achieved by reducing data input and minimizing delays in accessing information to support clinical interventions.

Service user and staff experience will be improved by increasing convenience and access to services and by staff utilizing technology to support provision of services in multiple locations e.g. telehealth and agile working.

Adopting a strategic approach to systems development will enable the Trust to ensure systems integrate, are fit for purpose and delivery the required functionality.

Information sharing - ***Information Governance seen as an enabler rather than barrier to sharing information***

Safe sharing of information with other health & social care providers and easy access for staff and service users to information held within relevant clinical systems.

In Scope

The sharing of information between Health and Social Care organisations, professionals providing care and the service users receiving Trust services.

Vision

Information is a vital asset, both in terms of the clinical management of individual patients and the efficient management of services and resources. It plays a key part in clinical governance, service planning and performance management. To enable the Trust to safely manage and share information with each other, our partners and our service users we need to change our perceptions of organisational boundaries and technical constraints and we need to put our client's front and centre stage with regards to information and not as an afterthought.

Working in partnership with health and social care organisations in the local health community the objective is to define common vision for deployment of IM&T to achieve economies of scale and optimise sharing of systems and information to improve patient and public experience and health outcomes.

Current Position

Information Governance and Policy established which supports staff in advising on providing reliable information at the point of need; ensuring individuals understand the importance of using it correctly, sharing it lawfully and protecting it from improper use.

Proactive management of Information Governance processes that support the collection of good quality information which is stored, shared and manipulated in accordance with best practice and legal and regulatory requirements. Information Governance plays a fundamental role and is an inclusive key component of all the IM&T themes and programmes of work.

'THINK IG' branding established to raise the awareness and importance of how we look at sharing information and specialist advice and support provided to all Trust services when required.

Deliverables

The developments within this domain will enable the Trust to deliver and support:

Information sharing that supports the improvement in data and information accuracy by ensuring relevant information is shared in a timely and automated way and addresses the lack of access to relevant information at the point of care.

Support provided to staff in developing pathways of care, identifying when it is important and appropriate to share information.

Developing client portals that provide service users/carers (with service user consent) access to their own information to: understand their care needs, the opportunity and options for self-care and the ability to choose the services, support and treatment that is right for them and extend information access and sharing across all partner organisations to improve informed care delivery, where client consent has been granted

Increased information sharing across different care settings within health and more information sharing with partners outside of the NHS to improve service user care.

Opportunity to integrate and share applications and equipment across health communities.

Digitisation - *Using technology in the care environment as we do in our everyday life.*

Harnessing the power of technology to improve and transform how we deliver care and services.

In Scope

The Digitisation domain focuses on 2 distinct groups, communications with service users and effective deployment of staff

- *Communication with Service Users* – technological ways of improving and developing communications with service users and effectively delivering services. (e.g. Text messaging, Use of Apps, Telehealth, and Skype)

- *Effective Deployment of Staff* **-** how technology can support staff in service delivery and improve internal efficiencies. (e.g. Remote working and improved communications, Digital dictation, Paper Free)

Vision

The technologies and business models we need to deliver digital health have been slow to emerge, but now are much more mature and accessible.

To enable the Trust to fully embrace and utilise existing and future technologies it needs to be able to offer staff and service user's solutions that are sufficiently flexible, reliable, secure and future proofed to support them in delivering and receiving a high level of care.

The key principles in delivering and moving forward the Trusts digitisation agenda is to provide solutions that fit into the service user's lifestyle, making it easy for staff and service users to access information held within the Trust. Fundamental to the Trust achieving and delivering this vision is investing in technological developments that are driven by the service users and clinical service requirements.

Current Position

Agile working deployed successfully to support the estates strategy and transformation agenda making flexible mobile working the default for all our staff thus making better use of available office space.

Digital Dictation technologies being assessed for ability to improve efficiencies and reduce administration overheads. Project team established and working towards the

implementation of a suitable Trust wide solution within the first 12 months of this strategy.

Skype software deployed across the Trust, this system supports staff working remotely by enabling them to communicate via phone, desktop video conferencing or instant messaging with colleagues at other sites and organisations, they also have the ability to share documents and information more effectively and the potential to use Skype to communicate with service users is also available.

Improved use of technology to manage the workflow and reporting of Subject Access Requests (SAR) has been implemented and storage arrangements for paper records and scanning options have been reviewed.

The initiation of a project to scan legacy paper records either due to go into off-site storage or retrieved from off-site storage because a client has come back into service has begun. These records will be accessible electronically in a bespoke, controlled, web-based document management system available to clinical staff whenever they need it. In the longer term, these records will be accessible via the Trust's clinical portal.

Deliverables

By using technology as an enabler it will allow the Trust to change how we support and communicate with our service users, deliver services and the transformation agenda now and in the future.

Service users will be able to use home technologies to receive and utilise healthcare and the clinical services will be able to meet the service user's expectations as to how their healthcare should be provided.

The technology we already have in place such as agile working and Skype is starting to influence how we deliver services but to keep abreast of change we must ensure that any new technology improves service user care and delivers efficiencies.

The continued use of Skype technologies will allow the Trust to share relevant information and liaise with colleagues from other disciplines when providing care to service users therefore improving the overall experience for the service user and staff.

With the "paperless NHS" challenge in place, work within the central health records team will focus on achieving a reduction in the movement of paper records around the organisation. A central scanning bureau will be set up to support the reduction in legacy paper records and improved access to these records when needed.

Through partnerships with external agencies and the regular scanning and review of new/emerging technologies the Trust can ensure that it utilises the most appropriate technologies which support business objectives, enhance service delivery, improve efficiencies/effectiveness and add value to business development and future opportunities.

Business Intelligence – ***Turning data into information***

The analysis, interpretation, sharing and presentation of information is fundamental to the operation and transformation of the organisation. Knowing how we are doing is the foundation of all performance monitoring, improvement and management and goes back to the right information at the right time.

In Scope

The Business Intelligence (BI) domain encompasses all aspects of reporting including:

- Mandated statutory national datasets submitted to the Health & Social Care Information Centre (e.g. MHLDDS).
- Commissioning data flows mandated within contracts.
- Balanced scorecards showing trend performance against Key Performance Indicators (KPIs) at Trust and Business Delivery Unit (BDU) level.
- Suites of reports on themes such as activity and clustering.
- Information to support business cases and service change.
- Ad hoc requests to support teams and individual staff members.

However, the main focus will be on providing *actionable* information that teams and individuals can use on a daily basis to know how they are doing and take action to do better.

Vision

The Department of Health's information strategy, *The power of information: Putting all of us in control of the health and care information that we need*, published in May 2012, recognises the journey required to provide good quality information (not data) and support to use it effectively within an organisation.

In order to respond quickly and appropriately to the changing data flows (internally and externally), raw data from all systems needs to be accessible in a standardised format, mapped to the various organisational layers (e.g. team, business delivery unit (BDU), Trust). This will be via a data warehouse built incrementally to meet the needs of each release of reporting products. Each information product or suite of business intelligence reports will be automated, easy to use and meaningful to teams.

Our approach will be:

- Incremental – This will involve agreeing one "release" or suite of reports at a time to support a particular business process (e.g. caseload management). As a rough guide, each release is likely to take around 3 months.
- Evolutionary – Each release will build upon previous work and add new business value.
- Collaborative - The work is driven by service needs and information consumer (operational staff) requirements, with operational staff playing a vital part of

the development process. The technology is an enabler but it is the collaboration of the business in developing reports and using them that will make the difference.

- Iterative – A BI programme is not something that gets done once and "signed off"; it is always live and developing as needs and priorities change. Each iteration or update should add more value to the organisation.

The critical success factor will be the engagement of the organisation in the programme. Business Intelligence is not about technology but how the organisation uses the information it provides. This will require IM&T staff to work alongside operational colleagues (clinical and non-clinical) to develop the reports in partnership and staff to use these effectively to influence how the organisation works and the quality of its services. As not all staff have the same knowledge, confidence and skill in using information, additional support will be given to those who need it.

As the foundations fall into place, work can begin to automate the production of key routine reports. In the longer term, external data flows (such as the commissioning and nationally mandated data sets) would then be automated to ensure reliable feeds to the Health and Social Care Information Centre (HSCIC) and Commissioners.

As Business Intelligence takes hold within the organisation we would expect to see:

- An "information savvy" workforce clear on their input and outcome to business processes.
- Key business intelligence available and used to drive improvement on an on-going (daily rather than once a month or once a quarter) basis and accessed by all layers of the organisation.
- Key performance indicators that can be drilled into (from client or healthcare professional up to Trust level) on a daily basis.
- Forecasting of performance commonplace.
- Highlighting of data quality or input issues *before* rather than after performance targets are not achieved.

<u>Current Position</u>

Steps are already being taken to move away from outdated technology and the heavy reliance on manual interventions which increase the likelihood of errors.

Investment has already been made in improving the skill set of staff within Information Services to enable them to make this journey to provide a timely, flexible, user-friendly service to the organisation. The team has been restructured to allow development work to be undertaken alongside "business as usual". The technical architecture (hardware and software) is also now in place.

The first release of reporting has been agreed and engagement with the relevant services has already begun to identify requirements, map processes and begin to bring the required data flows into the fledgling data warehouse.

The use of dashboard technology and other presentational techniques are being trialled to provide performance dashboards and automated workflows. Driven by user feedback, tailored and themed dashboards will be provided to evidence performance, activity, improvement and quality of services.

Benchmarking is also starting to be used more widely to determine expected standards covering performance, quality and productivity.

Deliverables

The challenge facing the Trust is standardising and simplifying healthcare information so that it can be presented to both staff and clients in an understandable and easy to use format.

The developments within this domain will deliver the following:

- An information hub, accessible to all, providing the gateway to all reports. Data and information will be presented within the hub in a range of ways. This will include standard reports, dashboards and, in the longer term, tools with which to build your own bespoke report.
- Key information reports will also be "pushed" out to staff, accessible via their mailbox and taking them directly into the information hub.
- All information will be accessed and stored in a secure manner with appropriate access levels built in.
- An information bank that explains each benchmarking indicator and metric in an accessible way will need to be developed.

The quality of data within the clinical systems at the Trust needs to be both understood and maintained to a standard whereby it can be confidently used to assess the performance of the organisation. Information quality will be a key part of any new development, upgrade or data flow. Standardisation will be a key deliverable.

The Performance and Information and Health Intelligence teams will also provide added intelligence and analysis services to the Trust and will ensure that data quality is understood and maintained within the Trust.

Training & Skills Development – *Skills and confidence to use systems and technology to support the role.*

Ensuring staff are equipped with the skills and confidence to use current and future technology to meet the demands of their roles and the Trust.

In Scope

This domain will focus on the delivery of the skills and training to enable staff to effectively use and access Information and systems.

Vision

To enable staff to effectively use technology and information to deliver services and client care, the Trust needs to ensure its workforce is equipped with the most appropriate skills and training.

A role based training programme needs to be established to address basic IT training, management of resources, analytical and technical skills. The aim of this approach will be to provide staff with the tools to enable them to use technology and interrogate / interpret the information used within their role.

Training and development is pivotal in ensuring the optimal use of digital technologies and in exploiting the functionality and capabilities of the current and future clinical and corporate systems, it is therefore essential for the Trust to adopt a strategic approach to the development and delivery of technology skills and training for its entire staff

Current Position

It is recognised that not all staff have the same knowledge, confidence and skills in using information and technology so initial work as commenced on the following areas:

Programme of work established to undertake training needs assessments for clinical system users but this needs to be extended to cover all systems and technology.

Basic IT Training currently being provided in conjunction with the agile working programme of work.

Roles based approach to training being established within current IM&T projects but recognised that this approach needs to be adopted within all Trust projects.

Deliverables

The developments within this domain will enable staff to gain the skills and confidence to use technology within the work place and in delivering care.

Provision of a training and development service that utilises innovative ways to deliver training, provides guidance and support that helps staff to develop and maintain required skill sets.

Technology used to improve accessibility to training services, utilising a variety of learning opportunities to meet the needs of the users.

Governance & Accountability

The IM&T department should be viewed as an integral part of the Trust and will be led by the Deputy Director of IM&T who will:

- Manage the provision of a IM&T services to the Trust
- Provide professional leadership to the departments
- Provide professional advice in all aspects of IM&T

The enabling initiatives outlined earlier within the Strategy are the key drivers for improvement.

These drivers inform the objectives and therefore also provide milestones and performance indicators to prioritise action and use of resources. These key drivers will be subject to regular monitoring within the IM&T Dashboard

If there is adverse variance against corporate objectives this will be reflected within the Corporate Risk Register. The content of the Risk Register is reviewed by the Management Executive Team and the Extended EMT. This scrutiny provides assurance to the Board that risks are appropriately recoded and managed within the organisation.

Operational Accountability for Information Management and Technology

Trust Board: The Board has the ultimate responsibility for the delivery of the key Trust objectives for IM&T. The Board requires assurance that key objectives have measurable outcomes and benefits; performance against objectives is monitored; and appropriate corrective action is taken where performance deviates from plan.

Executive Management Team: The EMT provides assurance to the Board that the Trust is delivering its objectives in relation to IM&T.

Director of Finance: Trust Lead Director for IM&T supported by the Deputy Director of IT is responsible providing the organisational lead on IM&T and representing the Trust in partnership arrangements and key link for performance management.

Trust Lead Director for Information Governance and the nominated Board representative for the "senior information risk owner"

Director of Nursing: Caldicott Guardian and responsible for the safeguarding and appropriate use of patient information.

Executive & BDU Directors: Responsible for ensuring that their staff attend appropriate training; and enable their directorates to contribute to information work programmes by providing staff resource to support implementation and define information requirements.

All Trust Managers: Responsible for ensuring that staff are aware and comply with policy and legislation relating to Freedom of Information, confidentiality and security requirements which deal with sensitive information and appropriate use of IT assets and technology e.g. use of the internet.

Individual staff: Responsible for the appropriate use and safe custody of Trust assets and technology and individual compliance with Trust policies and procedures.

Appendix A – IM&T Workplan

IM&T Work Programme				
Domain	**2015 / 16**	**2016 / 2017**	**2017 / 2018**	**2018 / 2019**
Infrastructure	Wifi access on Trust Sites & Limited access on partner sites Infrastructure Modernisation Programme (rationalisation of legacy networks & improved network links) Telecommunications replacement - South Yorkshire New VPN Solution	Wifi access via NHS Partner sites Infrastructure Modernisation Programme (phase2 – replacement of legacy hardware) Telecommunications - West Yorkshire Smartphone / Mobile phone provision & support Guest Wifi (inc service users internet access)	Wifi access via Local Authority sites Infrastructure Modernisation Programme (phase3 – data centre rationalisation) Microsoft Review Email review	
Clinical & Corporate Systems	Clinical portal phase 1 S1 Clinical Deployment S1 EPR Core – Barnsley RiO v7 upgrade NHS No. Smoking cessation Community equipment	Clinical portal phase 2 Integration S1 EPR Core - Trust wide Clinical Systems - Transformation Programme(s) Support & Alignment (e.g. clinical pathways development) S1 Contract reprovisioning Mental Health Information Systems RiO Patient Viewer MIG eDischarge Messaging Medicines Management e-referrals Paperlight	Client portal Integration of transactional systems Paperlight Clinical Systems - Transformation Programme(s) Support & Alignment (e.g. clinical pathways	Paperlight
Digitisation	Agile working - Phase 1 Teleconsultation Skype for Business	Agile Working - Phase 2 Digital Dictation Apps development	Agile Working - Phase 3	Centralised mailing review
Information Sharing	Partnership working – digital road maps	Partnership working – digital road maps Vanguards Electronic Document Management Records Scanning	Partnership working – digital road maps Vanguards	Partnership working – digital road maps
Business Intelligence	Business Intelligence / Data warehouse	Business Intelligence / Data warehouse (information Hub & Dashboards)		

Black – Not Started **Blue** – Completed **Amber** – In Planning **Green** - In Progress

Appendix A – IM&T Domain Milestones

Infrastructure Domain	2015 / 16	2016 / 2017				2017 / 2018				2017 / 2018			
	Qtr 4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4
Wifi access													
on Trust Sites & Limited access on partner sites													
via NHS Partner sites													
via Local Authority sites													
Guest Wifi (inc service users internet access)													
Infrastructure Modernisation Programme													
phase 1 - rationalisation of legacy networks & improved network links													
phase2 – replacement of legacy hardware & email platform upgrading													
phase3 – data centre rationalisation													
Telecommunications replacement													
South Yorkshire													
West Yorkshire													
Microsoft Review													
Email review													
New VPN Solution													
Smartphone / Mobile phone provision & support													

Appendix A – IM&T Domain Milestones

Clinical and Corporate Systems Domain	2015 / 16	2016 / 2017				2017 / 2018				2017 / 2018			
	Qtr 4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4
Clinical portal													
phase 1													
phase 2													
Client portal													
Integration													
Integration of transactional systems													
Clinical Systems - Transformation Programme(s) Support & Alignment (e.g. clinical pathways development)													
S1 EPR Core													
Barnsley													
Trust wide													
S1 Clinical Deployment													
S1 Contract reprovisioning/finalisation													
RiO v7 upgrade													
RiO Patient Viewer													
Paperlight													
Mental Health Information Systems													
Smoking cessation													
NHS No.													
MIG													
eDischarge Messaging													
Community equipment													
Medicines Management													
e-referrals													

Appendix A – IM&T Domain Milestones

Digitisation Domain	2015 / 16	2016 / 2017				2017 / 2018				2017 / 2018			
	Qtr 4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4
Agile working													
phase 1													
phase 2													
phase 3													
Teleconsultation													
Skype for Business													
Digital Dictation													
Apps development													
Centralised mailing review													

Information Sharing & Business Intelligence Domains	2015 / 16	2016 / 2017				2017 / 2018				2017 / 2018			
	Qtr 4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4
Information Sharing Domain													
Vanguards													
Partnership working – digital road maps													
Electronic Document Management													
Records Scanning													
Business Intelligence Domain													
Business Intelligence / Data warehouse - Phase 1													
Business Intelligence / Data warehouse (informationhub & Dashboards)													

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 28 April 2016
Agenda item 10

Title:	**Board self-certification and assessment of operational, clinical and quality risks (Monitor Quarter 4 return 2015/16)**
Paper prepared by:	Director of Corporate Development
Purpose:	To enable Trust Board to be assured that sound systems of control are in place including mechanisms to identify potential risks to delivery of key objectives.
Mission/values:	Compliance with Monitor's Risk Assessment Framework supports the Trust to meet the terms of its Licence and supports governance and performance management enabling the Trust to fulfil its mission and adhere to its values.
Any background papers/ previously considered by:	The exception report to Monitor highlights issues previously reported to Trust Board through performance and compliance reports.
Executive summary:	Quarter 4 assessment Based on the evidence and assurance received by Trust Board through performance and compliance reports, the Trust is reporting a governance risk rating of **green** under Monitor's Risk Assessment Framework. Based on performance information set out in reports presented to Trust Board, the Trust is reporting a continuity of services/finance risk rating of **green** with a score of **4**. Self-certification Monitor authorises NHS foundation trusts on the basis that they are well-governed, financially robust, legally constituted and meet the required quality threshold. Monitor's Risk Assessment Framework is designed to: - show when there is a significant risk to the financial sustainability of a provider of key NHS services, which endangers the continuity of those services through the continuity of services risk rating; and/or - show where there is poor governance at an NHS Foundation Trust through the governance rating. Trust Board is required to provide board statements certifying ongoing compliance with its Licence and other legal requirements to enable Monitor to operate a compliance regime that combines the principles of self-regulation and limited information requirements. The statements are as follows. - For continuity of services, that the Trust will continue to maintain a risk rating of at least 3 over the next twelve months. - For governance, that the board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the Framework and a commitment to comply with all known targets going forward. - And that Trust Board can confirm there are no matters arising in the quarter requiring an exception report to Monitor, which have not already been reported. The Framework also uses an in-year quality governance metric, which is currently the same as that used since quarter 4 of 2013/14, of executive team

turnover as this is seen as one of the potential indicators of quality governance concerns. The Trust is required to provide information on the total number of executive (voting) posts on the Board, the number of these posts that are vacant, the number of these posts that are filled on an interim basis, and the number of resignations and appointments from and to these posts in the quarter. Given the recent changes at senior level, this could potentially be of concern to Monitor; however, the Trust has informed Monitor on an ongoing basis of progress and arrangements in place and this has not affected Monitor's view of the governance arrangements in place.

The in-year governance declaration on behalf of Trust Board will be made to confirm compliance with governance and performance targets.

The attached report is a first draft of the exception report to be submitted to Monitor in respect of Quarter 4.

Foundation Trust sector comparison

As at 16 February 2016, there were 151 Foundation Trusts authorised by Monitor. Of these, 43 are mental health trusts.

Monitor has published the Quarter 3 Performance Report for 2015/16 for the sector. This allows us to place Trust performance in a national context. The tables below show that the Trust remains in the upper quartile with a Continuity of Service Rating of 4 and a Green Governance rating. The key headlines are as follows.

- Foundation Trust deficit amounts to £2.26 billion, which is £622 million worse than planned. This is against a quarter 2 figure of £169 million. The forecast deficit is £2.37 billion against a 'control total' of £1.8 billion.
- As this is neither sustainable nor affordable, NHS Improvement wrote to all providers calling for urgent action to be taken. This identified £452 million of financial improvement opportunities (including £0.8 million for this Trust).
- The main reason continues to be pay expenditure pressures arising from the requirement to utilise agency staff to cover shortages in permanent staff and failure to deliver cost savings.

All Foundation Trusts

		Governance rating			
		No evident concerns	Issues identified	Enforcement action	Total
Continuity	4	35	2	2	39
	3	41	14	4	59
	2	8	8	8	24
	1	2	2	25	29
	Total	**86**	**26**	**39**	**151**

Mental Health Trusts

		Governance rating			
		No evident concerns	Issues identified	Enforcement action	Total
Continuity	4	21	0	1	22
	3	14	3	0	17
	2	2	1	1	4
	1	0	0	0	0
	Total	**35**	**5**	**3**	**43**

Recommendation:

Trust Board is asked to APPROVE the submission and exception report to Monitor, subject to any changes/additions arising from papers discussed at the Board meeting around performance, compliance and

	governance.
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board self-certification – Monitor Quarter 4 return 2015/16
Trust Board 28 April 2016

Compliance with the Trust's Licence
The Trust continues to comply with the conditions of its Licence.

Trust Board
As previously advised to Monitor, the process to recruit to the Chief Executive post was completed with a formal interview process on 10 and 11 February 2016. Rob Webster, Chief Executive of the NHS Confederation, was appointed and will join the Trust on 16 May 2016. The appointment was ratified by the Members' Council on 12 February 2016.

Monitor has also been advised of the interim arrangements in place following Steven Michael's retirement. Alex Farrell (formerly Deputy Chief Executive) will act as interim Chief Executive with Deputy support provided by Alan Davis (Director of Human Resources and Workforce Development).

The Trust has also appointed a substantive Director of Finance, Mark Brooks, and he will join the Trust on 1 June 2016. Mark is currently Chief Financial Officer at Southern Health NHS Foundation Trust. Jon Cooke continues as interim Director of Finance until 1 June 2016 to ensure a smooth handover. Jon will also act as Senior Information Risk Owner for the Trust in the interim.

At its meeting on 12 February 2016, the Members' Council approved a proposal from the Nominations Committee to re-appoint Jonathan Jones for a further year to provide stability and continuity in a time of change at Trust Board level within the Trust.

Members' Council
The nominations process for the Members' Council ended on 17 March 2016. The following were elected unopposed.

- Barnsley (one seat for election) – Shaun Adam
- Wakefield (two seats for election) – Peter Walker (re-elected) and Bob Clayden

An election was held for two seats in Calderdale (five candidates) and in Kirklees for three seats (five candidates) and this closed on 28 April 2016. XX and XX were elected in Calderdale and XX and XX in Kirklees.

The seat for the rest of South and West Yorkshire remains vacant.

No nominations were received for the staff seat for nursing support; however, a bi-election has been held and XX has been duly elected. The staff seat for social care staff in integrated teams remains vacant.

There are also two vacant stakeholder seats (Barnsley Hospital NHS Foundation Trust and Kirklees Council), which will be pursued with the appropriate organisations.

Care Quality Commission (CQC)
The CQC undertook an inspection of Trust services in the week beginning 7 March 2016.

Initial feedback from the CQC was that they found Trust staff to be caring, and this was without exception. The CQC was also impressed with how welcoming, helpful, open and honest they found Trust staff to be, as well as how organised. The CQC highlighted some notable areas of good practice. In general community services, this included the commitment of staff in the Barnsley 0-19 service, the telehealth and care navigation service, the epilepsy service and the end-of-life care service. In mental health and specialist services, this included the attention deficit hyperactivity disorder service, prison in-reach, community learning disability service, community child and adolescent mental health services and the older people's wards. The CQC identified some areas of concern, which the Trust is already aware of and has plans in place to address. These included safer staffing, particularly on acute wards, monitoring of care and treatment in rehabilitation services, particularly at Enfield Down, Mental Health Act and Mental Capacity Act training and recording of it taking place, waiting lists for child and adolescent mental health services and psychological therapies, and physical health monitoring. The inspection chair also commented on how impressed the inspection team was with how the Trust is responding to an extremely challenging environment in such a positive way.

Since the close of the inspection, a number of additional requests for information have been received but there have been no further visits to services. The draft report for factual accuracy should be sent to the Trust mid-May 2016 with the final report due on 7 June 2016.

- The two compliance actions from the Fieldhead inspection visit (Trinity 2, Newton Lodge and Bretton) against outcomes 7 (safeguarding) and 10 (safety and suitability of premises) remain open. As previously reported the Trust has formally notified CQC of completion of the action plan but has not received a response.
- There were two CQC Mental Health Act visits in Q4 which were made to Appleton and Hepworth wards, Newton Lodge, Wakefield.
- Within the quarter, four Mental Health Act monitoring summary reports have been received relating to visits made to The Poplars, Pontefract (Wakefield), Elmdale ward, The Dales, Halifax (Calderdale), and Appleton and Hepworth wards, Newton Lodge, Wakefield. All responses were submitted in accordance with the timeframes set by CQC.
- Most aspects of the monitoring visits were positive in terms of practice and implementation of actions identified from previous visits; however, a recurring issue relates to recording and, in particular, the recording of capacity and consent and patients' rights.

Absent without Leave (AWOL)
There were no CQC reportable cases during Q4.

Eliminating Mixed Sex Accommodation (EMSA)
NB figures relate to Q3
There have been no reported breaches in Q3. The Trust continues to monitor (via DATIX) where service users are placed in an individual room on a corridor occupied by members of the opposite sex. Trust Board approved the EMSA compliance declaration at its meeting in March 2016.

Infection prevention and control
- Barnsley BDU has been set a locally agreed Clostridium Difficile Toxin Positive Target of six. There have been no cases in Q4. To date, there have been a total of three cases of C difficile in Barnsley.

- There have been no MRSA bacteraemia cases reported in the Trust during Q4, resulting in no cases reported in 2015/16.
- In Quarter 4 there have been two outbreaks. One of norovirus in the Poplars Unit, Hemsworth, resulting in closure of the unit for nine days and one in of gastroenteritis on Ward 18, Dewsbury, where the ward was closed for five days.

Information Governance

The Trust reported an incident in Q3 to the Information Commissioner's Office (ICO) in respect of a complaint received by the Trust from a solicitor acting on behalf of the mother of a child that was a previous service user. The Trust has responded to a number of queries from the ICO and is awaiting the completion of the internal investigation.

On 14 April 2016, a level 2 incident was reported to the ICO. A batch file of letters for the National Child Measurement Programme was produced via nightly SystmOne extract. These letters report outcomes of child measurement, such as weight, to parents/guardians. Once produced, a sample check of addresses for 50 letters was cross-checked against the latest system front-end address. These were all correct and the letters released. Three batches were produced. The first two batches of @1,700 letters each were sent. Following receipt of a number of letters marked 'return to sender', the third batch of @1,900 letters was halted. Initial investigation of the process has shown that an incorrect field from the database has been used to generate the addresses. This has now been corrected and a comparison between extracts is being undertaken to determine the volume that may have been sent to old addresses.

Safeguarding Children

In Q4, there has been an increase of 15% in the number of recorded incidents relating to issues of child protection. Out of 68 reports, 57 (84%) were graded as green where staff had identified concerns during assessments, home visits and interventions. All incidents were reviewed by the Named Nurses and were assessed to have been appropriately reported and managed.

Safeguarding Vulnerable Service Users

No referrals have been made to the Disclosure and Barring Service this quarter and no red incidents reported through the Trust's reporting system, DATIX.

Serious Incidents

- During the course of Q4 there have been twenty SIs reported to commissioners, which is an increase from Q3 (fifteen). This is made up of four in Barnsley (mental health), one in Barnsley (general community services), three in Calderdale, eight in Kirklees, two in Wakefield, one specialist services and one in forensic services.
- SI investigations and reports are being completed within timeframes agreed with commissioners; however, there is continued pressure to complete reports within timescales.
- No 'Never Events' occurred in the Trust during this quarter.

The Trust reported a serious incident in Q3 in relation to the upgrade of its mental health clinical information system from RiO version 6 to RiO version 7. Following the upgrade, a serious incident was declared in December 2015 as a result of significant technical and operational issues resulting from the upgrade. The incident has been investigated through the standard investigation procedure and the Trust has commissioned an independent

review by Deloitte. This will report to the Board-level Information Management and Technology Forum in June 2016 and then Trust Board on 28 June 2016.

Although system performance has improved, this has not been to a level necessary for full operational capacity. Therefore, services continue to use workarounds and contingency plans to ensure continuity of service and management of clinical risk. The operation of the clinical information system remains a significant clinical, technical and operational risk for the Trust. In addition to the efforts to resolve all the outstanding issues, the Trust will be taking legal advice on the level of redress it can seek from the system supplier.

Duty of Candour (Q3 2015/16 figures)

The Trust aims to deliver the highest standards of healthcare to all its service users. The promotion of a culture of openness is a prerequisite to improving patient safety and the quality of healthcare systems. This communication is open, honest and occurs as soon as possible following a patient safety event. It should be noted that the severity of the incident as recorded on the Trust's Datix system is different from the National Patient Safety Agency definition of harm; therefore, this set of data is not comparable with other data.

- Total number of incidents meeting NPSA definition of moderate, severe harm or death = 57 (2014/15 Q3 – 31, Q4 – 30; 2015/16 Q1 – 45, Q2 - 53)
- Number reported on STEIS as SIs = 13 (2014/15 Q3 – 28, Q4 – 16; 2015/16 – 11, Q2 – 11)
- Other (all moderate) = 42 (2014/15 Q3 – 3, Q4 – 14; 2015/16 Q1 – 34, Q2 – 42)

Customer Services

- The Trust received a total of 112 formal complaints in Q4. The breakdown is as follows:
  - Barnsley – 25;
  - Calderdale and Kirklees – 58;
  - Wakefield – 12;
  - Specialist services – 13 (includes eight complaints relating to child and adolescent mental health services);
  - Forensic – 4.
- Across all complaints, communication was identified as the most frequently raised negative issue (31). This was followed by Trust admin/policies/procedures (30), values and behaviours (staff) (29), patient care (28), and access to treatment or drugs (eighteen). Most complaints contained a number of themes.
- During Q4, there were 24 formal complaints regarding the possible discontinuation of the art therapy component of psychological therapy services in Calderdale. Engagement with service users, staff and the local authority Overview and Scrutiny Committee continues.
- In quarter 4, three complainants asked the Parliamentary and Health Service Ombudsman to review their complaint following contact with the Trust. Such cases are subject to rigorous scrutiny by the Ombudsman, including a review of all documentation and the Trust's complaints management processes. All requested information was provided within the prescribed timeframe. During the quarter, the Trust received feedback from the Ombudsman regarding seven cases. Five were closed with no further action required. Two cases (Wakefield BDU) were partially upheld with recommendations to the Trust including the preparation of action plans to reflect proposed improvements to the service and an appropriate apology to the complainant. The Trust currently has seven cases pending with the Ombudsman.

Third party reports
Nine internal audit reports have been received in 2016 from 2015/16 internal audit programme:

- management of service level agreements – partial assurance with improvements required;
- Information Governance Toolkit (phase 1) – partial assurance with improvements required;
- Information Governance Toolkit (phase 2) – significant assurance;
- payroll – significant assurance with minor improvement opportunities;
- job planning – partial assurance with improvements required;
- financial management and reporting – significant assurance with minor improvement opportunities;
- medicines management – partial assurance with improvements required;
- risk management and board assurance framework – significant assurance.

Management action has been agreed against all recommendations and progress will be tracked through the Audit Committee.

Summary Performance Position
Based on the evidence received by Trust Board through performance reports and compliance reports, the Trust is reporting the achievement of all relevant targets. The issue reported in Q3 in relation to improving access to psychological therapies (IAPT) target has been resolved.

The Trust has completed the baseline assessment regarding the attainment of Early Intervention in Psychosis (EIP) targets including the workforce gap analysis. There is a risk due to only partial funding being obtained that the Trust will be able to comply with all requirements by 31 March 2016 due to the following issues.

- Agreement of additional funding over and above the 2015/16 baseline assessment to meet the workforce target.
- Ability to recruit and operationalise the new model in the last quarter.
- Allowing sufficient build time to ensure the clinical processes and record keeping generate the required key performance indicators.

Service issues
<u>Barnsley Healthy Child Programme (0-19 services)</u>
To be updated following Trust Board 28 April 2016 to ensure the return reflects the up-to-date position.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 28 April 2016
Agenda item 11

Title:	**Assurance framework and organisational risk register Q4 2015/16**
Paper prepared by:	Director of Corporate Development
Purpose:	For Trust Board to be assured that a sound system of control is in place with appropriate mechanisms to identify potential risks to delivery of key objectives.
Mission/values:	The assurance framework and risk register are part of the Trust's governance arrangements and integral elements of the Trust's system of internal control, supporting the Trust in meeting its mission and adhere to its values.
Any background papers/ previously considered by:	Previous quarterly reports to Trust Board.
Executive summary:	**Assurance framework 2015/16** The Board assurance framework provides Trust Board with a simple but comprehensive method for the effective and focused management of the principal risks to meeting the Trust's strategic objectives. In respect of the assurance framework for 2015/16, the principle high level risks to delivery of corporate objectives have been identified and, for each of these, the framework sets out: - key controls and/or systems the Trust has in place to support the delivery of objectives; - assurance on controls where Trust Board will obtain assurance; - positive assurances received by Trust Board, its Committees or the Executive Management Team confirming that controls are in place to manage the identified risks and these are working effectively to enable objectives to be met; - gaps in control (if the assurance is found not to be effective or in place); - gaps in assurance (if the assurance does not specifically control the specified risks or no form of assurance has yet been received or identified), which are reflected on the risk register. A schematic of the assurance framework process is set out as an attachment. The Chief Executive has used the Assurance Framework to support his quarterly review meetings with Directors to ensure Directors are delivering against agreed objectives and action plans are in place to address any areas of risk identified. The new assurance framework remains work in progress and will be further refined through discussions with individual directors and Chairs of Trust Board Committees, and reviewed through the Executive Management Team (EMT) in preparation for the first quarter of 2016/17. The assurance framework indicates a current assurance level of amber/green

	overall. Changes in Q4 relate to: - a move to amber/green (from amber/red) for S1 as contracting negotiations with commissioners are now almost complete and the operational plan and budget have been approved by Trust Board; - a move to green (from amber/green) for S3 as the capital plan for 2015/16 was achieved in support of the Estates Strategy; - a move to amber/green (from amber/red) for S6 as the Trust has successfully managed the external pressures in the health and social care economy during 2015/16; - a move to green (from amber/green) for E3 as the Trust has managed its capacity and resources to achieve its priorities and objectives; - a move to amber/red (from amber/green) for St3 given the residual issues relating to the Trust's clinical information system. **Organisational risk register** The organisational risk register records high level risks in the organisation and the controls in place to manage and mitigate the risks. The risk register is reviewed by the EMT on a monthly basis, risks are re-assessed based on current knowledge and proposals made in relation to this assessment, including the addition of any high level risks from BDUs, corporate or project specific risks and the removal of risks from the register. EMT reviewed the risk register at its meeting on 14 April 2016. It was agreed to add a new risk in relation to the impact of staffing levels on Wakefield acute services and the wider system and to remove the risk around bed occupancy (527) as the Wakefield position supersedes this particular risk. The risk register now contains the following risks: - Trust sustainability declaration; - transformational service change programme – Trust's transformation programme, its implementation and staff engagement; - transformational service change – wider health economy transformation and engagement and alignment with commissioners; - impact on services as a result of continued local authority spending cuts and changes to the benefits system in relation to local authorities in their role as commissioners; - commissioning risks – local commissioning intentions and impact of national developments; - impact on services as a result of continued local authority spending cuts and changes to the benefits system in relation to local authorities in their role as providers; - mechanisms for contracting and pricing for mental health and community services; - capture of clinical information; - inability to secure sufficient funding to support a sustainable child and adolescent mental health service; - information governance incidents; and - staffing levels in Wakefield acute services. **Internal audit board assurance framework and risk register** As part of its annual internal audit programme, KPMG reviews the board assurance framework and risk register, which informs the Head of Internal Audit Opinion. The review, reported to the Audit Committee in April 2016, provided an opinion of significant assurance with three low priority

	recommendations. 1. The Trust should ensure the content of the assurance framework is formally discussed at the Board and that these discussions are clearly minuted. *Management response* *Trust Board does discuss the content of the Board assurance framework, particularly in the context of items on the Trust Board agenda; however, it is acknowledged that there could be more specific discussion and dialogue regarding the content of the assurance framework as well as the focus on risk and during specific items on the Trust Board agenda.* This has been discussed with the Chair for implementation from this meeting. 2. The Trust should seek to use the covering sheet to the agenda item to highlight the key messages or any changes in the content of the assurance framework to support discussions by Trust Board. *Management response* *Accepted. The Trust will include key messages arising from the Board assurance framework and make specific reference to changes and updates to the assurance framework in the Trust Board front sheet.* This will be included from this quarter. 3. The Trust should ensure the rationale for the risk ratings within the assurance framework are sufficiently detailed to support the Board's understanding and effective decision making. *Management response* *Accepted. The rationale for risk assessments included in the Board assurance framework will be clearer and sufficiently detailed to enable and facilitate Trust Board discussion.* This will be included from this quarter.
Recommendation:	**Trust Board is asked to:** ➢ **NOTE the controls and assurances against corporate objectives for Q4 2015/16;** ➢ **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.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST ASSURANCE FRAMEWORK – STRUCTURE AND PROCESS

Our mission: enabling people to reach their potential and live well in their community.

The Operational Context of the BAF
Purpose: to provide a comprehensive method for the effective and focused management of the principal risks to achieving the corporate delivery objectives.
Provides direct evidence for: Annual Governance Statement and the Head of Internal Audit Opinion

Strategic direction: Ambition, values, goals, strategic objectives forming annual Plan, linked to wider health economy and regulatory requirements

Corporate delivery objectives Approved by Trust Board and reviewed regularly

Controls
- Accountability
- Regular performance measures
- Operational plans
- Policy and procedure
- Systems and structures

Assurances
- Audit (inc clinical audit) reports and opinions
- Actual performance measurement
- External and internal reports

Gaps
- Audit report, opinion and recommendations to be implemented
- Poor performance management and related actions

Principal risks linked to corporate objectives

Controls in respect of risks and corporate objectives

Assurances in respect of the controls and corporate objectives

Gaps in controls and assurances and actions required to address the gaps

Strategic level risks (15+) into organisational risk register

Risks at directorate and local level identified and scored through DATIX in line with risk management strategy and procedure. These **may** include gaps identified in the BAF

Exec Management Team

Individual director/BDU assurance arrangements

Trust Board Committees

TRUST BOARD

Closure of gaps
- Time bound responsibilities identified plus lead

Corporate review of the Assurance Framework
- Trust Board quarterly review of the BAF in terms of the adequacy of assurance processes and the effectiveness of the management of principal risks and gaps
- Audit Committee review of process for development of BAF annually

Assurance Framework 2015/16

Board governance/setting strategic direction, EMT Governance/execution Partnership working/Independent review, Performance framework/monitoring, Service Strategy, Enabling strategy

Principle Delivery Objective: - Strategy Embedded person-centred delivery system, delivering safe services, efficiently and effectively across the Trust	Lead Director(s)	Key Board or Committee	Current Assurance Level			
			Q1	Q2	Q3	Q4
	CEO	CG & CS	A/G	A/G	A/G	A/G

	Principle Strategic Risks that need to be controlled and consequence of non-controlling and current assessment	Rag Rating
S1	Continued uncertainty of strategic partnership landscape, including commissioning, acute partners and local authorities linked to the Five-Year Forward View leading to unsustainable organisational form.	A/G
S2	Failure to understand and respond to changing market forces leading to loss of market share and possible de-commissioning services.	A/G
S3	Failure to deliver the Estates Strategy and capital programme for 2015/16 leading to health and safety/compliance issues, poor service user and staff experience.	G
S4	Trust Plans for service transformation are not aligned to the multiplicity of stakeholder requirements leading to inability to create a person-centre delivery system	A/G
S5	Failure of transformation plans to realise appropriate quality improvement leading to development of a service offer that does not meet service user/carer needs and/or commissioning intentions	A/R
S6	Changing service demands and external financial pressures in local health and social care economies have an adverse impact on ability to manage within available resources	A/G

	Controls – systems and processes (what are we currently doing about the Strategic Risks?)
1	Trust Board sets the Trust vision and corporate objectives as the strategic framework within which the Trust works (S1)
2	Trust Board Strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives. (S2)
3	Production of annual plan and five-year strategic plan demonstrating ability to deliver agreed service specification and activity within contracted resource envelope or investment required to achieve service levels and mitigate risks (S1)
4	Director leads in place for revised service offer through transformation programme, work streams and resources in place, overseen by project boards and EMT, key change management projects linked to corporate and personal objectives, with resources and deliverables identified (S4, S5)
5	Executive Management Team ensures alignment of developing strategies with Trust vision and strategic objectives (S1, S3)
6	Monthly review by EMT of stakeholder and partnership position through rich picture and risk assessment (S1)
7	EMT production and review of market assessment against a number of frameworks including PESTEL/SWOT and threat of new entrants/substitution, partner/buyer power.(S2)
8	Formal contract negotiation meetings with clinical commissioning groups and specialist commissioners underpinned by legal agreements to support strategic review of services (S6)
9	Development of joint QIPP plans with commissioners to improve quality and performance, reducing risk of decommissioning. CCG/Provider performance monitoring regime of compliance with QIPP plan and CQUIN targets in place (S6)
10	SWYPFT performance management system in place with KPIs covering national and local priorities (S6)
11	IM & T strategy in place supporting delivery of strategic objectives, agile working, estates strategy, underpinned by IM&T Forum, with defined terms of reference, chaired by a NED (S3)
12	Workforce plans in place identifying staffing resources required to meet current and revised service offers and meeting statutory requirements re training, equality and diversity (S4)
13	Estates Forum in place with defined Terms of Reference chaired by a NED, Estates TAG ensuring alignment of Trust strategic direction, with estates strategy and capital plan with identification of risk and mitigating action to meet forward capital programme (S3)
14	Annual Business planning guidance in place standardising process and ensuring consistency of approach (S2)
15	New leadership and management arrangements established and embedded at BDU and service line level with key focus on clinical engagement and delivery of services (S4, S5)

Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)		Date
1	Quarterly Assurance Framework and Risk Register report to Board providing assurances on actions being taken.	Quarterly reports to Trust Board
2	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place	Triangulation of risk, performance and governance presented to each Committee
3	Assurance reports to Clinical Governance and Clinical Safety Committee covering key area of risk in the organisation seeking assurance on robustness of systems and processes in place	November 2015 – transformation, improving clinical information, creating a smoke-free environment, Horizon review (and February 2016), emergency planning review of IT virus incident, clinical audit and practice effectiveness progress report, Care Quality Commission (inspection and Mental Health Act visits), nurse re-validation, exceptional cases update, and incident management reporting. February 2016 – independent review of safeguarding arrangements, Suicide Prevention Strategy, Barnsley 0-19 services, implementation of twelve-hour shifts, improving access to psychological therapies, Mazars report on Southern Health NHS Foundation Trust Standing items – Quality Accounts, child and adolescent mental health services
4	Audit Committee review evidence for compliance with policies, process, standing orders, standing financial instructions, scheme of delegation, mitigation of risk, best use of resources	October 2015 – Internal Audit Charter, approval of Charitable Funds annual report and accounts, Trust arrangements for whistleblowing, data quality, pricing strategy, service line reporting and reference costs, currency development February 2016 – review of accounting policies, progress and approach to annual accounts, decision-making framework Standing items – triangulation of risk, performance and governance, Treasury Management, internal, external and counter fraud reports, procurement report and losses and special payments report
5	Annual plan and budget and five-year strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by Monitor	Annual plan and budget approved by Trust Board and submitted to Monitor (March and May 2015). Through 2015/16, supported by monthly financial reporting to Trust Board and Monitor and quarterly exception reports. Budget and draft operational plan approved by Trust Board March 2016. External review of plan undertaken by Deloitte undertaken March 2016 (reporting to April 2016 Trust Board).
6	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan.	Audit Committee April 2015 and Trust Board April 2015.
7	Monthly/Quarterly quality/integrated performance reports to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken	Monthly performance and finance reporting to EMT and Trust Board. Exception reporting – child and adolescent mental health services, serious incidents quarterly reporting, learning lessons from incidents, community mental health survey 2015/16, IT virus incident, assessment and treatment for people with learning disabilities, Barnsley Healthy Child Programme, safer staffing, and Information Governance Toolkit.
8	Quarterly Monitor exception report to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken, which includes confirmation that the Trust complies with the conditions of its Licence and, where it does/may not, the risk and mitigating action	Quarterly exception reporting and self-certification to Trust Board. Quarterly review meeting with Monitor supported by Monitor's formal letter in response to quarterly submission.
9	Transformation plans monitored and scrutinised through EMT ensuring co-ordination across directorates, identification of and mitigation of risks.	Bi-monthly meetings of EMT (general) provide focus for the Trust's transformation plans. Transformation update also provided to Trust Board on a quarterly basis.
10	Quarterly documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems	Quarterly reviews with Directors undertaken by the Chief Executive and key points and issues summarised following each review.
11	Business cases for expansion/change of services approved by EMT and/or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework	Bids and tenders report (standing item delivery EMT), Public Health Education Team (October 2015), Meridian productivity proposal (October 2015), resuscitation (November 2015), records management and scanning (November 2015), Fieldhead non-secure business case (EMT and Trust Board October, November and December 2015), disclosure and barring checks (November 2015), ASD adult services diagnostic (November 2015),

Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)		Date
		adult ADHD specialist services QIPP workstream (December 2015), Barnsley Healthy Child Programme (EMT and Trust Board standing item to March 2016), forensic CAMHS (March 2016), pharmacy services (March 2016). Child and adolescent mental health services (October and December 2015), Transformation update (Trust Board December 2015 and March 2016), possible Tier 4 CAMHS development services (October and December 2015, March 2016)
12	Strategic overview and analysis of partnerships by EMT, review of stakeholder and partnership position through rich picture and risk assessment	Bi-monthly meetings of EMT (general) include an assessment and analysis of Trust relationship and partnership with its stakeholders. This includes an analysis of risk and mitigation.
13	Monthly review and monitoring of performance reports through Delivery EMT deviations identified and remedial plans requested	Monthly performance and finance reporting to EMT and Trust Board.
14	Independent PLACE audits undertaken and results and actions to be taken reported to EMT, Members' Council and Trust Board	Update provided to Clinical Governance and Clinical Safety Committee (April 2016)
15	Rolling programme of staff, stakeholder and service user/carer engagement and consultation events	Staff engagement strategy approved by Trust Board with implementation plan approved by EMT. Programme of visits to services by CE during Q2. Middleground 4 (rolling programme) with involvement of CE, Executive and Non-Executive Directors. Changes instigated to approach to communications with staff. Involvement and engagement with service users/carers through Friends and Families test. Staff wellbeing and national surveys, which includes Friends and Families test for staff. Planned programme of service user/carer events, including transformation, and planned Insight events in Q4. Equality and diversity engagement events for service users/carers in Q3.

Gaps in control and what do we need to do to address these and by when	Date
Risk register no 275 and 772 impact on services as a result of continued local authority spending cuts, being mitigated through action plans as set out in the organisational risk register	Ongoing
Risk register no. 463 and 773 – transformational service change, implementation and staff engagement, being mitigated through action plans as set out in the organisational risk register	Ongoing
Risk register no. 695 – Trust sustainability declaration, being mitigated through action plans as set out in the organisational risk register	Ongoing
Risk register no. 812 – commissioning intentions, being mitigated through action plans as set out in the organisational risk register	Ongoing

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	Date
Workforce plans require on-going development as transformation standard operating procedures are being finalised to deliver the revised service offers, transformation reports to EMT setting out time lines for changing workforce plans, skills and competencies to deliver revised service offers.	Monthly EMT

Rationale for current assurance level
- Independent well-led review assessed the Trust as Green in two areas and amber/green in eight areas with action plan in place to move towards green by end of Q1 2016/17. - Governance rating green and financial rating of 4 in line with Monitor's Risk Assessment Framework. - Informal feedback from Care Quality Commission inspection in the main positive. Trust commended for caring approach of staff within services. - Clear strategic approach identified for 2016/17 and operational plan submitted to Monitor following Trust Board approval. - Contracts agreed with commissioners and clarification of approach to Barnsley 0-19 services. - Successful delivery of plans for 2015/16.

Principle Delivery Objective: - execution Well governed, legally constituted, well-led and financial sustainable Trust, clear consistent messages are articulated and communicated at all levels in the Trust	Lead Director(s)	Key Board or Committee	Current Assurance Level			
			Q1	Q2	Q3	Q4
	Direct. Corp. Dev/ Dir of Fin	Audit Co. B & R TB	A/R	A/G	A/G	A/G

	Principle Strategic Risks that need to be controlled and consequence of non-controlling and current assessment	Rag Rating
E1	Failure to deliver level of transformational change required impacting on ability to deliver resources to support delivery of the annual plan	A/R
E2	Unexplainable variation in clinical practice resulting in differential patient experience and outcomes and impact on Trust reputation	A/G
E3	Lack of capacity and resources not prioritised leading to non-delivery of key organisational priorities and objectives	G
E4	Inadequate capture of data resulting in poor data quality impacting on ability to deliver against care pathways and packages and evidence delivery against performance targets and potential failure regarding Monitor Compliance Framework	A/R

	Controls – systems and processes (what are we currently doing about the Strategic Risks?)
1	Trust Board approved strategic objectives supporting delivery of Trust mission, vision and values monitored through appraisal process down through director to team and individual team member (E1, E3)r
2	Independent "Well led" review of governance arrangements commissioned and action plan in place (E1)
3	Director leads in place for transformation programme and key change management projects linked to corporate and personal objectives, with resources and deliverables identified (E1)
4	Risk assessment and action plan for delivery of CQUIN indicators in place (E2)
5	Project Boards for transformation workstreams established, with appropriate membership skills and competencies, PIDs, Project Plans, project governance, risk registers for key projects in place (E3)
6	Risk assessment and action plan for data quality assurance in place (E4)
7	Weekly Operational Requirement Group chaired by Chief Executive providing overview of operational delivery, services/resources, identifying and mitigating pressures/risks (E1,E3)
8	Formal contract negotiation meetings with clinical commissioning groups and specialist commissioners underpinned by legal agreements to support strategic review of services (E2, E4)
9	Performance management system in place with KPIs covering national and local priorities reviewed by EMT and Trust Board (E2, E4)
10	Process in place for systematic use of benchmarking to identify areas for improvement and identifying CIP opportunities (E3)
11	Values-based appraisal process in place and monitored through KPI's (E3)
12	Workforce plans in place identifying staffing resources required to meet current and revised service offers and meeting statutory requirements re training, equality and diversity (E1, E3)
13	Complaints policy and complaints protocol covering integrated teams in place (E2)
14	Cross-BDU performance meetings established to identify performance issues and learn from good practices in other areas (E2)

	Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)	Date
1	Quarterly Monitor exception report to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken, which includes confirmation that the Trust complies with the conditions of its Licence and, where it does/may not, the risk and mitigating action	Quarterly exception reporting and self-certification to Trust Board
2	Quarterly Assurance Framework and Risk Register report to Board providing assurances on actions being taken	Quarterly reports to Trust Board
3	Assurance reports to Clinical Governance and Clinical Safety Committee covering key area of risk in the organisation seeking assurance on robustness of systems and processes in place	November 2015 – transformation, improving clinical information, creating a smoke-free environment, Horizon review (and February 2016), emergency planning review of IT virus incident, clinical audit and practice effectiveness progress report, Care Quality Commission (inspection and Mental Health Act visits), nurse re-validation, exceptional cases update, and incident management reporting. February 2016 – independent review of safeguarding arrangements, Suicide

Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)		Date
		Prevention Strategy, Barnsley 0-19 services, implementation of twelve-hour shifts, improving access to psychological therapies, Mazars report on Southern Health NHS Foundation Trust Standing items – Quality Accounts, child and adolescent mental health services
4	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place	Triangulation of risk, performance and governance presented to each Committee
5	Annual report to Trust Board to risk assess changes in compliance requirements and achievement of performance targets, in year updates as applicable	Trust Board report April 2015
6	Medical staff appraisal and revalidation in place evidenced through annual report to Trust Board and supported through Appraisers forum	Independent desk-top review of revalidation process during Q3, which found the process in place is robust, comprehensive and fit for purpose. Annual report to Trust Board June 2015. Appraisers' Forum held three times/year.
7	Quarterly documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems	Quarterly reviews with Directors undertaken by the Chief Executive and key points and issues summarised following each review.
8	Transformation plans monitored and scrutinised through EMT ensuring co-ordination across directorates, identification of and mitigation of risks.	Bi-monthly meetings of EMT (general) provide focus for the Trust's transformation plans.
9	Business cases for expansion/change of services approved by EMT and/or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework	Bids and tenders report (standing item delivery EMT), Public Health Education Team (October 2015), Meridian productivity proposal (October 2015), resuscitation (November 2015), records management and scanning (November 2015), Fieldhead non-secure business case (EMT and Trust Board October, November and December 2015), disclosure and barring checks (November 2015), ASD adult services diagnostic (November 2015), adult ADHD specialist services QIPP workstream (December 2015), Barnsley Healthy Child Programme (EMT and Trust Board standing item to March 2016), forensic CAMHS (March 2016), pharmacy services (March 2016). Child and adolescent mental health services (October and December 2015), Transformation update (Trust Board December 2015 and March 2016), possible Tier 4 CAMHS development services (October and December 2015, March 2016)
10	Monthly review and monitoring of performance reports through Delivery EMT deviations identified and remedial plans requested	Monthly performance and finance reporting to EMT and Trust Board.
11	Data quality improvement plan monitored through EMT deviations identified and remedial plans requested	Included in monthly performance reporting to EMT and Trust Board. Regular reports to CG&CS Committee and report to Audit Committee October 2015 and February 2016.
12	Serious incidents from across the organisation reviewed through the Clinical Reference Group including the undertaking of root cause analysis and dissemination of lessons learnt and good clinical practice across the organisation	Process in place with outcome reported through quarterly serious incident reporting to EMT, Clinical Governance and Clinical Safety Committee and Trust Board. Learning lessons report presented quarterly to Trust Board.
13	Quarterly quality/integrated performance reports to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken	Quarterly quality performance reporting to EMT and Trust Board with supporting, more detailed compliance report.
14	Annual appraisal, objective setting and PDPs to be completed in Q1 of financial year for staff in Bands 6 and above and in Q2 for all other staff, performance managed by EMT.	March 2016 98.6% B6+ (target 95% in Q1) and 98.2% B5- (target 95% in Q2)
15	Audit of compliance with policies and procedures in line with approved plan co-ordinated through clinical governance team in line with Trust agreed priorities	Clinical audit and practice effectiveness annual report to CG&CS September 2015 and Q2 report November 2015.
16	Sustainability action plans monitored through Sustainability TAG, deviations identified and remedial plans requested.	Sustainability TAG minutes. Sustainability Strategy update to Trust Board June 2015.
17	Rolling programme of staff, stakeholder and service user/carer engagement events to ensure we capture and respond to service user and carer needs	Staff engagement strategy approved by Trust Board with implementation plan approved by EMT. Programme of visits to services by CE during Q2. Middleground 4 (rolling programme) with involvement of CE, Executive and Non-Executive Directors. Changes instigated to approach to communications with staff. Involvement and engagement with service

Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)	Date
users/carers through Friends and Families test. Staff wellbeing and national surveys, which includes Friends and Families test for staff. Planned programme of service user/carer events, including transformation, and planned Insight events in Q4. Equality and diversity engagement events for service users/carers in Q3.	

Gaps in control and what do we need to do to address these and by when	Date
Risk register no. 267 - capture of clinical information, being mitigated through action plans as set out in the organisational risk register	Ongoing
Risk register no. 695 - Trust's financial viability and long term sustainability, being mitigated through action plans as set out in the organisational risk register	Ongoing
Risk register no. 851 – sustainability of CAMHS, being mitigated through action plans as set out in the organisational risk register	Ongoing
Risk register no. 852 – information governance incidents, being mitigated through action plans as set out in the organisational risk register	Ongoing
Risk register no. 463 – transformational change, being mitigated through action plans as set out in the organisational risk register	Ongoing
MH Act audits identified issues with recording around capacity and consent, being addressed through BDU action plans working with MH Act officers,	March 2016
Internal audit report – patient property partial assurance with improvement requirements being addressed through BDUs.	March 2016
Risk register – staffing pressures in Wakefield (new risk)	Ongoing

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	Date
Further updates to CG&CS and Audit Committees on capture of clinical information and impact on data quality	February 2016

Rationale for current assurance level

- Independent well-led review assessed the Trust as Green in two areas and amber/green in eight areas with action plan in place to move towards green by end of Q1 2016/17.
- Governance rating green and financial rating of 4 in line with Monitor's Risk Assessment Framework.
- Informal feedback from Care Quality Commission inspection in the main positive. Trust commended for caring approach of staff within services.
- Clear strategic approach identified for 2016/17 and operational plan submitted to Monitor following Trust Board approval.
- Contracts agreed with commissioners and clarification of approach to Barnsley 0-19 services.
- Successful delivery of plans for 2015/16
- Ongoing scrutiny of CAMHS through Clinical Governance and Clinical Safety Committee
- Internal audit reports – management of service level agreements – partial assurance with improvements required; Information Governance Toolkit (phase 1) – partial assurance with improvements required; Information Governance Toolkit (phase 2) – significant assurance; payroll – significant assurance with minor improvement opportunities; job planning – partial assurance with improvements required; financial management and reporting – significant assurance with minor improvement opportunities; medicines management – partial assurance with improvements required; risk management and board assurance framework – significant assurance.

Principle Delivery Objective: - Culture Embedded mission and values across the Trust, focussing not just on what we do but how we do it	Lead Director(s)	Key Board or Committee	Current Assurance Level			
			Q1	Q2	Q3	Q4
	D of N Med. Dir HR Direc.	CC & CS	A/G	A/G	A/G	A/G

	Principle Strategic Risks that need to be controlled and consequence of non-controlling and current assessment	Rag Rating
C1	Failure to create and communicate a coherent articulation of Trust Mission, Vision and Values leading to inability to identify and deliver against strategic objectives	G
C2	Failure to engage the workforce	A/G
C3	Failure to create a learning environment leading to repeat incidents impacting on service delivery and reputation	A/G
C4	Staff and other key stakeholders not fully engaged in process around redesign of service offer, leading to lack of engagement and benefits not being realised through delivery of revised models and ability to deliver best possible outcomes, through changing clinical practice	A/R
C5	Failure to motivate and engage clinical staff through culture of quality improvement, benchmarking and changing clinical practice, impacting on ability to deliver best possible outcomes	A/G

	Controls – systems and processes (what are we currently doing about the Strategic Risks?)
1	Trust Board approved strategic corporate objectives supporting delivery of Trust mission, vision and values monitored through appraisal process down through director to team and individual team member (C1)
2	Independent "Well led" review of governance arrangements commissioned and action plan in place (C1)
3	OD Framework re support objectives "the how" in place with underpinning delivery plan (C, C5)
4	Partnership Boards established with staff side organisations to manage and facilitate necessary change (C2, C4)
5	Weekly serious incident summaries (incident reporting system) to EMT supported by quarterly and annual reports to EMT, Clinical Governance and Clinical Safety Committee and Trust Board (C3, C5)
6	Values based Trust Welcome event in place covering mission, vision, values, key policies and procedures (C2, C4)
7	Creative Minds Strategy and action plan in place approved by Trust Board, promoting different ways of working and partnership approach (C4)
8	Involving People Strategy and action plan in place approved by Trust Board, promoting and developing key relationships (C4)
9	Further round of Middleground developed, delivered and evaluated linked to organisational and individual resilience to support staff, prepare for change and transition and to support new ways of working (C2)
10	Communications and Engagement Strategies and approaches in place for service users/carers, staff and stakeholders/partners (C4)
11	Risk Management Strategy in place facilitating a culture of horizon scanning, risk mitigation and learning lessons supported through appropriate training (C3)
12	Mandatory training standards set for each staff group (C3)
13	New leadership and management arrangements established and embedded at BDU and service line level with key focus on clinical engagement and delivery of services (C5)

	Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)	Date
1	Staff engagement plan approved by Trust Board, Action Plan reviewed through EMT	Staff engagement strategy (Trust Board June 2015)
2	Trust Board Strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives	Quarterly strategy sessions in place
3	Assurance reports to Clinical Governance and Clinical Safety Committee covering key area of risk in the organisation seeking assurance on robustness of systems and processes in place	November 2015 – transformation, improving clinical information, creating a smoke-free environment, Horizon review (and February 2016), emergency planning review of IT virus incident, clinical audit and practice effectiveness progress report, Care Quality Commission (inspection and Mental Health Act visits), nurse re-validation, exceptional cases update, and incident management reporting. February 2016 – independent review of safeguarding arrangements, Suicide Prevention Strategy, Barnsley 0-19 services, implementation of twelve-hour shifts, improving access to psychological therapies, Mazars report on

Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)		Date
		Southern Health NHS Foundation Trust Standing items – Quality Accounts, child and adolescent mental health services
4	Service user survey results reported annually to Trust Board and action plans produced as applicable	Community mental health survey (December 2015)
5	Quarterly documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems	Quarterly reviews with Directors undertaken by the Chief Executive and key points and issues summarised following each review.
6	Monthly review and monitoring of performance reports through Delivery EMT deviations identified and remedial plans requested	Monthly performance and finance reporting to EMT and Trust Board.
7	Monitoring of organisational development plan through General EMT group deviations identified and remedial plans requested	Organisational development framework next steps reviewed and agreed by EMT August 2015.
8	Serious incidents from across the organisation reviewed through the Clinical Reference Group including the undertaking of root cause analysis and dissemination of lessons learnt and good clinical practice across the organisation	Quarterly reports to EMT, Clinical Governance and Clinical Safety Committee and Trust Board and learning lessons report.
9	CQC registration in place and assurance provided that Trust complies with its registration	Trust is registered with the CQC and assurance process in place through the Director of Nursing to ensure continued compliance. CQC inspection visit week beginning 7 March 2016.
10	Planned internal visits to support staff and ensure compliance with CQC standards through the delivery of supported action plans	Unannounced and planned visits programme in place.
11	Rolling programme of staff, stakeholder and service user/carer engagement and consultation events, listening and responding to needs	Staff engagement strategy approved by Trust Board with implementation plan approved by EMT. Programme of visits to services by CE during Q2. Middleground 4 (rolling programme) with involvement of CE, Executive and Non-Executive Directors. Changes instigated to approach to communications with staff. Involvement and engagement with service users/carers through Friends and Families test. Staff wellbeing and national surveys, which includes Friends and Families test for staff. Planned programme of service user/carer events, including transformation, and planned Insight events in Q4. Equality and diversity engagement events for service users/carers in Q3.

Gaps in control and what do we need to do to address these and by when	Date
Mandatory training standards not being delivered in all areas, routine reports to teams identifying individuals out of compliance.	Ongoing

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	Date
Delivery of staff engagement strategy action plan and improvement in staff survey scores	March 2016
Meridian review of work flow in community and in-patient services being commissioned to work with front line teams, increasing productivity.	Ongoing
Risk register no. 851 – CAMHS sustainability of funding, being mitigated through action plans as set out in the organisational risk register	Ongoing
Risk register no. 852 – IG incidents, being mitigated through action plans as set out in the organisational risk register	Ongoing
Risk register no. 850 – RiO upgrade implementation, being mitigated through action plans as set out in the organisational risk register	Ongoing

Rationale for current assurance level
- Recent well-led review undertaken by independent reviewer demonstrated through stakeholder engagement that the Trust's mission and values were clearly embedded through the organisation. - Staff 'living the values' as evidenced through values into excellence awards. - Informal feedback from Care Quality Commission inspection in the main positive. Trust commended for caring approach of staff within services. - In the main, positive Friends and Family Test feedback from service users and staff.

Principle Delivery Objective: - Structure Delegated decision making to the front line, improving quality and use of resources, embedded meta, macro, meso and micro view of the external and internal environment.	Lead Director(s)	Key Board or Committee	Current Assurance Level			
			Q1	Q2	Q3	Q4
	Director of HR	CG & CS B & R TB	A/G	A/G	A/G	A/G

Principle Strategic Risks that need to be controlled and consequence of non-controlling and current assessment		Rag Rating
St1	Unclear lines of accountability and responsibility within Directorates and between BDUs and Quality Academy impacting on ability to deliver safe, effective and efficient services	A/G
St2	Failure to achieve devolution and local autonomy for BDUs within the new leadership and management arrangements impacting on ability to deliver safe, effective and efficient services	A/G
St3	Lack of suitable technology and infrastructure to support delivery of revised service offer leading to lack of support for services to deliver revised service offers	A/R

Controls – systems and processes (what are we currently doing about the Strategic Risks?)	
1	Alignment and cascade of Trust Board – approved corporate objectives supporting delivery of Trust mission, vision and values through appraisal process down through director to team and individual team member (St1)
2	Standing Orders, Standing Financial Systems, scheme of Delegation and Trust Constitution in place and publicised re staff responsibilities (St1, St2)
3	Production of annual plan and five-year strategic plan demonstrating ability to deliver agreed service specification and activity within contracted resource envelope or investment required to achieve service levels and mitigate risks (St1)
4	Director leads in place for transformation programme and key change management projects linked to corporate and personal objectives, with resources and deliverables identified (St1)
5	Through General EMT, Executive Management Team ensures alignment of developing strategies with Trust vision and strategic objectives (St3)
6	Policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval (St1)
7	Standardised process in place for producing businesses cases with full benefits realisation (St2)
8	Creative Minds Strategy and action plan in place approved by Trust Board, promoting different ways of working and partnership approach (St3)
9	Annual Business planning guidance in place standardising process and ensuring consistency of approach (St1)
10	IM&T Strategy in place and assured through IM&T Forum (St3)

Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)		Date
1	Business cases for expansion/change of services approved by EMT and/or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework	Bids and tenders report (standing item delivery EMT), Public Health Education Team (October 2015), Meridian productivity proposal (October 2015), resuscitation (November 2015), records management and scanning (November 2015), Fieldhead non-secure business case (EMT and Trust Board October, November and December 2015), disclosure and barring checks (November 2015), ASD adult services diagnostic (November 2015), adult ADHD specialist services QIPP workstream (December 2015), Barnsley Healthy Child Programme (EMT and Trust Board standing item to March 2016), forensic CAMHS (March 2016), pharmacy services (March 2016). Child and adolescent mental health services (October and December 2015), Transformation update (Trust Board December 2015 and March 2016), possible Tier 4 CAMHS development services (October and December 2015, March 2016)
2	Annual Governance Statement reviewed and approved by Audit Committee and Trust Board and externally audited	Approved by Audit Committee May 2015. Audit Committee also received confirmation of effectiveness of the Annual Governance Statement from the Trust's external auditor. Received by Trust Board June 2015 and Members' Council July 2015. First draft of 2015/16 Statement approved by Trust Board March 2016.
3	Monthly review and monitoring of integrated and quality performance reports by Trust Board with exception reports requested	Monthly performance and finance reporting to Trust Board.

Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)		Date
	around risk areas	
4	Audit Committee review evidence for compliance with policies, process, standing orders, standing financial instructions, scheme of delegation, mitigation of risk, best use of resources	October 2015 – Internal Audit Charter, approval of Charitable Funds annual report and accounts, Trust arrangements for whistleblowing, data quality, pricing strategy, service line reporting and reference costs, currency development February 2016 – review of accounting policies, progress and approach to annual accounts, decision-making framework Standing items – triangulation of risk, performance and governance, Treasury Management, internal, external and counter fraud reports, procurement report and losses and special payments report
5	Annual plan and budget and five-year strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by Monitor	Annual plan and budget approved by Trust Board and submitted to Monitor (March and May 2015). Through 2015/16, supported by monthly financial reporting to Trust Board and Monitor and quarterly exception reports. Budget and draft operational plan approved by Trust Board March 2016. External review of plan undertaken by Deloitte undertaken March 2016 (reporting to April 2016 Trust Board).
6	Quarterly documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems	Quarterly reviews with Directors undertaken by the Chief Executive and key points and issues summarised following each review.
7	Transformation plans monitored and scrutinised through EMT ensuring co-ordination across directorates, identification of and mitigation of risks.	Bi-monthly meetings of EMT (general) provide focus for the Trust's transformation plans.
8	Information Governance Toolkit provides assurance and evidence that systems and processes in place at the applicable level, reported through IM&T TAG, deviations identified and remedial plans requested receive, performance monitored against plans	IM&T TAG minutes. Presentation to Extended EMT November 2015. Weekly risk scan (Director of Nursing/Medical Director; EMT), internal audit (October 2015), revised approach in place (THINK IG) to raise staff awareness
9	Monitoring of organisational development plan through EMT, deviations identified and remedial plans requested	Organisational development framework next steps reviewed and agreed by EMT August 2015.
10	Monthly review and monitoring of performance reports through Delivery EMT deviations identified and remedial plans requested	Monthly performance reports to EMT
11	Audit of compliance with policies and procedures in line with approved plan co-ordinated through clinical governance team in line with Trust agreed priorities	Clinical audit and practice effectiveness annual report to CG&CS September 2015 and Q2 report November 2015.

Gaps in control and what do we need to do to address these and by when	Date
Meridian review of work flow in community and in-patient services being commissioned to work with front line teams, increasing productivity.	Ongoing
Risk register no. 851 – CAMHS sustainability of funding, being mitigated through action plans as set out in the organisational risk register	Ongoing
Risk register no. 850 – implementation of upgrade to RiO, being mitigated through action plans as set out in the organisational risk register	Ongoing
Risk register (new) – staff pressures in Wakefield, being mitigated through action plans as set out in the organisational risk register	Ongoing

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	Date
SITREP reports being reviewed by ORG and assurance provided through EMT	Form Nov 2015
Completion of review of decision-making framework (Scheme of Delegation) to inform delegated authority at all levels (to Audit Committee)	Q1 2016/17

Rationale for current assurance level
- Embedding of new Trio model bringing together clinical, managerial and governance roles working together at service line level, with shared accountability for delivery. - EMT workshops clarifying accountabilities and responsibilities and ways of working. - Robust internal/external review of RiO upgrade and implementation of action plans.

Principle Delivery Objective: - partnerships Co-production is the Trusts way of designing and delivering services.	Lead Director(s)	Key Board or Committee	Current Assurance Level			
			Q1	Q2	Q3	Q4
	CEO Med. Dir	B & R Strategic Audit Co.	A/G	A/G	A/G	A/G

	Principle Strategic Risks that need to be controlled and consequence of non-controlling and current assessment	Rag Rating
P1	Failure to develop required relationships or commissioner support to develop new services/expand existing services leading to contracts being awarded to other providers	A/R
P2	Failure to respond to market forces and on-going development of new partnerships leading to loss of market share and possible de-commissioning of services	A/G
P3	Failure to clearly articulate intent and purpose of relationships leading to misunderstanding and conflict	A/G
P4	Failure to listen and respond to our service users and, as a consequence, service offer is not patient-centred, impacting on reputation and leading to loss of market share	A/G
P5	Risk of lack of stakeholder engagement needed to drive innovation resulting in key stakeholders not fully engaged in process around redesign of service offer	A/G
P6	Failure to deliver relationships with the third sector to delivery alternative community capacity leading to loss of market share and Trust inability to optimise business opportunities	A/G

	Controls – systems and processes (what are we currently doing about the Strategic Risks?)
1	Framework in place to ensure feedback from customers, both internal and external, including feedback loop, is collected, analysed and acted upon by through delivery of action plans through Local Action Groups (P4)
2	Member Council engagement and involvement in working groups (P3, P5)
3	Production of market assessment against a number of frameworks including PESTEL/SWOT and threat of new entrants/substitution, partner/buyer power (P5)
4	Formal contract negotiation meetings with clinical commissioning groups and specialist commissioners underpinned by legal agreements to support strategic review of services (P1)
5	Development of joint QIPP plans with commissioners to improve quality and performance, reducing risk of decommissioning (P1)
6	Care Pathways and personalisation Project Board established with CCG and Local Authority Partners (P1, P3)
7	Member of local partnership boards, building relationships, ensuring transparency of agenda's and risks, facilitating joint working, cohesion of policies and strategies (P1, P3)
8	CCG/Provider performance monitoring regime of compliance with QIPP plan and CQUIN targets in place (P1)
9	Framework in place to ensure feedback from customers, both internal and external, including feedback loop, is collected, analysed and acted upon by through delivery of action plans through Local Action Groups (P4)
10	Involving People Strategy and action plan in place approved by Trust Board, promoting and developing key relationships (P4, P6)
11	Project Management office in place led at Deputy Director level with competencies and skills to support the Trust to make best use of its capacity and resources and to take advantage of business opportunities (P2)
12	Public engagement and consultation events gaining insight and feedback, including identification of themes and reporting on how feedback been used (P4)
13	Staff wellbeing survey conducted, with facilitated group forums to review results and produce action plans (P5)
14	Complaints policy and complaints protocol covering integrated teams in place (P4)
15	Creative minds strategic partnering framework in place securing alternative capacity to support service offer (P4)

	Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)	Date
1	Announced and unannounced inspection visits undertaken by CQC, independent reports on visits provided to the Trust Board	CQC Mental Health Act visits – outcome reported to each Mental Health Act Committee and issues and follow up action agreed. Clinical and environmental issues reported to Clinical Governance and Clinical Safety Committee at each meeting. Preparation for CQC visit (beginning of March 2016) standing item on EMT, Trust Board and Clinical Governance and Clinical Safety Committee agenda. Annual report on unannounced visits to Clinical Governance and Clinical Safety Committee and Trust Board April

Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)		Date
		2015.
2	Service user survey results reported annually to Trust Board and action plans produced as applicable	Community mental health survey Trust Board December 2015
3	Equality and Inclusion Forum established to drive improvement in delivery of equality, involvement and inclusion agenda reporting into Trust Board	Equality and Inclusion Forum established May 2015 with approved terms of reference and chaired by Non-Executive Director. Key issues reported to Trust Board after each meeting.
4	Quarterly documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems	Quarterly reviews with Directors undertaken by the Chief Executive and key points and issues summarised following each review.
5	Transformation plans monitored and scrutinised through EMT ensuring co-ordination across directorates, identification of and mitigation of risks.	Bi-monthly meetings of EMT (general) provide focus for the Trust's transformation plans.
6	Monitoring of organisational development plan through Chief Executive-led group deviations identified and remedial plans requested	Organisational development framework next steps reviewed and agreed by EMT August 2015.
7	Strategic overview and analysis of partnerships in line with Trust vision and objectives provided through EMT and Trust Board	Bi-monthly meetings of EMT (general) include an assessment and analysis of Trust relationship and partnership with its stakeholders. This includes an analysis of risk and mitigation. Formal quarterly report on stakeholder relationships at Trust Board with regular updates on any key issues through Chair and Chief Executive remarks at Trust Board. Key part of Trust Board strategy meetings.
8	Market analysis reviewed through EMT, market assessment to Trust Board ensuring identification of opportunities and threats	Bi-monthly meetings of EMT (general) provide focus for the Trust's stakeholders and market position. Quarterly reports to Trust Board on Trust's market position, its business and strategic risks.
9	HealthWatch undertake unannounced visits to services providing external assurance on standards and quality of care	Healthwatch has the 'power' to enter and view Trust services. This is mostly managed by service lines who are approached directly. Examples of 'corporate' activity are from Barnsley Healthwatch who follow up on all Healthwatch England special enquiry agenda items. In 2015, Barnsley Healthwatch reviewed young people's services through the Children and Young People Engagement Officer at Voluntary Action Barnsley. The action plans were owned within the service and shared with Healthwatch. Barnsley Healthwatch has been commissioned by NHS England to look at how the Friends and Family Test is embedded in mental health services in Barnsley. This review will look at CAMHS, community mental health services and Kendray Hospital services.
10	QIPP performance monitored through delivery EMT, deviations identified and remedial plans requested	Monthly performance and finance reports to EMT
11	Planned internal visits to support staff and ensure compliance with CQC standards through the delivery of supported action plans	Unannounced and planned visits programme in place.
12	Rolling programme of staff, stakeholder and service user/carer engagement and consultation events	Staff engagement strategy approved by Trust Board with implementation plan approved by EMT. Programme of visits to services by CE during Q2. Middleground 4 (rolling programme) with involvement of CE, Executive and Non-Executive Directors. Changes instigated to approach to communications with staff. Involvement and engagement with service users/carers through Friends and Families test. Staff wellbeing and national surveys, which includes Friends and Families test for staff. Planned programme of service user/carer events, including transformation, and planned Insight events in Q4. Equality and diversity engagement events for service users/carers in Q3.

Gaps in control and what do we need to do to address these and by when	Date
Risk register no. 270 – contracting mechanisms and pricing for mental health and community services, being mitigated through action plans as set out in the organisational risk register and development of pricing strategy.	On-going

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	Date
Co-ordinated approach to stakeholder engagement in each locality, addressed through horizon scanning at EMT, quarterly strategic Trust Board meetings and quarterly report to Trust Board on strategic overview of business and associated risks, development of Customer Relationship Management system.	On-going

Rationale for current assurance level
- Strong and robust partnership working with local partners, such as Locala to deliver the Care Close to Home contract and establishment of Programme Board. - Establishment of locality Recovery Colleges and production of co-produced prospectus. - Increasing capacity of Creative Minds through partnership development. - Development of Spirit in Mind partnership network. - Regular Board-to-Board meetings with partners (such as Calderdale and Huddersfield NHS Foundation Trust). - Trust involved in local Vanguards. - Chair and Chief Executive have key roles in Mental Health Network (NHS Confederation) and NHS Providers. - Involved in development of Accountable Care Organisation in Barnsley.

Principal Delivery Objective: Leadership Embedded leadership and competency framework across the Trust describing the competencies and behaviours required.	Lead Director(s)		Current Assurance Level			
	Dir of HR		Q1	Q2	Q3	Q4
			A/G	A/G	A/G	A/G

	Principle Strategic Risks that need to be controlled and consequence of non-controlling and current assessment	Rag Rating
L1	Lack of clear service model(s) to support a workforce plan to identify, recruit and retain suitably competent and qualified staff with relevant skills and experience to deliver the service offer and meet national and local targets and standards	A/G
L2	Failure to articulate leadership requirements to identify, harness and support talent to drive effective leadership and succession planning	A/G

	Controls – systems and processes (what are we currently doing about the Strategic Risks?)
1	Executive Management Team ensures alignment of developing transformation plans with Trust vision and strategic objectives (L1)
2	OD Framework and plan in place (L2)
3	Partnership Boards established with staff side organisations to manage and facilitate necessary change (L1)
4	Leadership and management development programme in place with on-going evaluation and adaption (L2)
5	HR processes in place ensuring defined job description, roles and competencies to meet needs of service, pre-employment checks done re qualifications, DBS, work permits (L1)
6	Workforce plans in place identifying staffing resources required to meet current and revised service offers and meeting statutory requirements re training, equality and diversity (L1, L2)

	Pres	Date
1	Quarterly Assurance Framework and Risk Register report to Board providing assurances on actions being taken. Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place	Presentation of assurance framework and risk register to Trust Board quarterly. Triangulation of risk, performance and governance received as a standing item by the Audit Committee.
2	Announced and unannounced inspection visits undertaken by CQC, independent reports on visits provided to the Trust Board	CQC Mental Health Act visits – outcome reported to each Mental Health Act Committee and issues and follow up action agreed. Clinical and environmental issues reported to Clinical Governance and Clinical Safety Committee at each meeting. Preparation for CQC visit (beginning of March 2016) standing item on EMT, Trust Board and Clinical Governance and Clinical Safety Committee agenda. Annual report to Clinical Governance and Clinical Safety Committee and Trust Board April 2016.
3	Remuneration and Terms of Service Committee receive HR Performance Reports, monitor compliance against plans and receive assurance from reports around staff development, workforce resilience	HR performance reporting standing item on Remuneration and Terms of Service Committee agenda. Exception reports received as appropriate.
4	Independent CQC reports to Mental Health Act Committee provided assurance on compliance with Mental Health Act	CQC Mental Health Act visits – outcome reported to each Mental Health Act Committee and issues and follow up action agreed. Clinical and environmental issues reported to Clinical Governance and Clinical Safety Committee at each meeting.
5	Quarterly documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems	Quarterly reviews with Directors undertaken by the Chief Executive and key points and issues summarised following each review.
6	Monitoring or organisational development plan through EMT, deviations identified and remedial plans requested	Organisational development framework next steps reviewed and agreed by EMT August 2015.
7	Annual appraisal, objective setting and PDPs to be completed in Q1 of financial year for staff in Bands 6 and above and in Q2 for all other staff, performance managed by EMT	March 2016 98.6% B6+ (target 95% in Q1) and 98.2% B5- (target 95% in Q2)
8	Planned internal visits to support staff and ensure compliance with CQC standards through the delivery of supported action plans	Unannounced and planned visits programme in place.

Gaps in control and what do we need to do to address these and by when	Date
Mandatory training standards not being delivered in all areas, routine reports to teams identifying individuals out of compliance. Appraisal targets not met in Q1 and Q2 2015/16, routine reporting to EMT and R&TSC	February 2016

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	Date
Workforce plans require on-going development as transformation standard operating procedures are being finalised to deliver the revised service offers, transformation reports to EMT setting out time lines for changing workforce plans, skills and competencies to deliver revised service offers.	For annual plan 2016/17

Rationale for current assurance level
- Well-led review of governance arrangements - Internal Audit report on leadership development – significant assurance with minor improvement opportunities. - Trust Board-level posts recruited to and clear transition plans in place led by Chair and Director of Human Resources and monitored through Remuneration and Terms of Service Committee.

Principle Delivery Objective: - Innovation Evidenced based recovery approach to delivery of services across the Trust.	Lead Director(s)	Key Board of Committee	Current Assurance Level			
			Q1	Q2	Q3	Q4
	D of H & Inn Med Direc.	Strategic Board CG & CS	A/G	A/G	A/G	A/G

	Principle Strategic Risks that need to be controlled and consequence of non-controlling and current assessment	Rag Rating
I1	Lack of resources to support development and foster innovation to support delivery of plan	G
I2	Lack of engagement with staff, particularly clinical staff, which means they are unable to participate in research and development, or in development of innovative approaches	A/G
I3	Lack of analytical capacity and skills to support transformation and bids and tenders	A/G

	Controls – systems and processes (what are we currently doing about the Strategic Risks?)
1	OD framework and implementation plan in place (I1)
2	Standardised process in place for producing businesses cases with full benefits realisation (I1, I3)
3	Innovation fund established to pump prime investment to deliver service change and innovation (I1)
4	Innovation Framework in place (I1, I3)
5	Thinking differently training in place tailored to BDU's/Quality Academy (I2)
6	Communications and Engagement Strategies and approaches in place for service users/carers, staff and stakeholders/partners (I2)

	Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)	Date
1	Business cases for expansion/change of services approved by EMT and/or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework	Bids and tenders report (standing item delivery EMT), Public Health Education Team (October 2015), Meridian productivity proposal (October 2015), resuscitation (November 2015), records management and scanning (November 2015), Fieldhead non-secure business case (EMT and Trust Board October, November and December 2015), disclosure and barring checks (November 2015), ASD adult services diagnostic (November 2015), adult ADHD specialist services QIPP workstream (December 2015), Barnsley Healthy Child Programme (EMT and Trust Board standing item to March 2016), forensic CAMHS (March 2016), pharmacy services (March 2016). Child and adolescent mental health services (October and December 2015), Transformation update (Trust Board December 2015 and March 2016), possible Tier 4 CAMHS development services (October and December 2015, March 2016)
2	Innovation fund allocation approved through EMT with guidance to ensure consistency of approach and alignment with strategic priorities and corporate objectives	Allocation of Innovation Fund monies and guidance on its use agreed by EMT as part of the budget setting process each year.
3	Monitoring of organisational development plan through EMT deviations identified and remedial plans requested	Organisational development framework next steps reviewed and agreed by EMT August 2015.
4	Development of health intelligence manual	Presentation of approach to EMT January 2016.
5	Benchmarking of services and action plans in place to address variation	Trust is member of NHS benchmarking club. Reports considered by EMT and shared with BDUs. Regular reporting of development and introduction of service line reporting to Audit Committee (standing item). Benchmarking information used to inform discussion on caseload and ethnicity Equality and Inclusion Forum December 2015.

Gaps in control and what do we need to do to address these and by when	Date
On-going delivery of thinking differently training, monitoring of take up by Directorate/BDU and Service line.	March 2016

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	Date
Development of Health Intelligence Manual (presented to EMT January 2016)	March 2016

Rationale for current assurance level
- Involvement of senior leadership team through Extended EMT in innovation framework development and integrated performance report redesign fostering and promoting appetite for co-production and change. - Ongoing work to develop Health Intelligence Manual. - Ongoing work to develop i-hub. - Ongoing work to develop new ways of working to improve service user and staff experience.

Principle Delivery Objective: - Talent Developed talent management programme and succession planning for key organisational roles.	Lead Director(s)	Key Board of Committee	Current Assurance Level			
			Q1	Q2	Q3	Q4
	D of HR	RTSC Business & Risk	A/G	A/G	A/G	A/G

Principle Strategic Risks that need to be controlled and consequence of non-controlling and current assessment		Rag Rating
T1	Lack of strategic approach to talent management linked to clinical leadership, clinical specialist and senior management roles	A/G
T2	Lack of strategic approach to address potential shortages in certain staff groups	A/G
T3	Lack of strategic approach to succession planning	A/G

Controls – systems and processes (what are we currently doing about the Strategic Risks?)	
1	Staff Engagement Strategy approved by Board and action plan in place (T1)
2	Values-based appraisal process in place and monitored through KPI's (T3)
3	OD Framework and plan in place (T1)
4	HR processes in place ensuring defined job description, roles and competencies to meet needs of service, pre-employment checks done re qualifications, DBS, work permits (T2)
5	Further round of Middleground developed, delivered and evaluated linked to organisational and individual resilience to support staff prepare for change and transition and to support new ways of working (T1, T3)
6	Medical Leadership Programme in place with external facilitation (T2)
7	Workforce plans in place identifying staffing resources required to meet current and revised service offers and meeting statutory requirements re training, equality and diversity (T2)
8	Values-based Trust induction policy in place covering mission, vision, values, key policies and procedures (T1)
9	A set of leadership competencies developed as part of Leadership and Management Development Plan supported by coherent and consistent leadership development programme (T2)
10	New leadership and management arrangements established and embedded at BDU and service line level with key focus on clinical engagement and delivery of services (T1, T3)

Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)		Date
1	Staff opinion and wellbeing survey results reported to Trust Board and/or Remuneration and Terms of Service Committee and action plans produced as applicable	Reports to Remuneration and Terms of Service Committee July 2015
2	Medical staff appraisal and revalidation in place evidenced through annual report to Trust Board and supported through Appraisers forum	Independent desk-top review of revalidation process during Q3, which found the process in place is robust, comprehensive and fit for purpose. Annual report to Trust Board June 2015. Appraisers' Forum held three times/year.
3	Annual appraisal, objective setting and PDPs to be completed in Q1 of financial year for staff in Bands 6 and above and in Q2 for all other staff, performance managed by EMT	March 2016 98.6% B6+ (target 95% in Q1) and 98.2% B5- (target 95% in Q2)
4	Monitoring of organisational development plan through General EMT deviations identified and remedial plans requested	Organisational development framework next steps reviewed and agreed by EMT August 2015.
5	External accreditation against IIP GOLD supported by internal assessors, ensuring consistency of approach in the support of staff development and links with organisational objectives	
6	Risk assessment of nurse re-validation proposals	Risk assessment undertaken and reported to EMT, Clinical Governance and Clinical Safety Committee and Trust Board. Trust Board request for inclusion on the organisational risk register until clear guidance available. Removed from risk register following risk assessment by EMT.
7	Rolling programme of staff, stakeholder and service user/carer engagement and consultation events	Staff engagement strategy approved by Trust Board with implementation plan approved by EMT. Programme of visits to services by CE during Q2. Middleground 4 (rolling programme) with involvement of CE, Executive and Non-Executive Directors. Changes instigated to approach to communications with staff. Involvement and engagement with service users/carers through Friends and Families test. Staff wellbeing and national surveys, which includes

Assurance outputs: Guidance/reports (how do we know if the things we are doing are having an impact internal and external)	Date
	Friends and Families test for staff. Planned programme of service user/carer events, including transformation, and planned Insight events in Q4. Equality and diversity engagement events for service users/carers in Q3.

Gaps in control and what do we need to do to address these and by when	Date
Interim Director and transition arrangements in place, addressed through recruitment process.	Dec 2015

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	Date
Interim Director of Finance in place with process completed to appoint to substantive post	March 2016

Rationale for current assurance level
- Internal Audit report on leadership development – significant assurance with minor improvement opportunities. - Appointment made to Director of Forensic and Specialist Services. - Trust Board-level posts recruited to and clear transition plans in place led by Chair and Director of Human Resources and monitored through Remuneration and Terms of Service Committee.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Risk profile 28 April 2016

Consequence (impact/severity)	Likelihood (frequency)				
	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost certain (5)
Catastrophic (5)				= Trust sustainability declaration made in five-year strategy plan (695) = Transformation programme (463) = Trust transformation aligned with commissioners' transformation programmesand intentions (773) = Reduction in local authority funding to commission services (772) = Local commissioning intentions (812) = Sustainable child and adolescent mental health service funding (851) ! Staffing pressures in Wakefield	
Major (4)				= Mechanisms for contracting and pricing for mental health and community services (270) = Data quality and capture of clinical! Information governance incidents (852) = Capture of clinical information of RiO (267)	> Reduction in local authority funding to provide services (275) = Upgrade to RiO (850)
Moderate (3)					
Minor (2)					
Negligible (1)					

= same risk assessment as last quarter
! new risk since last quarter
< decreased risk rating since last quarter
> increased risk rating since last quarter

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South West Yorkshire Partnership NHS
NHS Foundation Trust

ORGANISATIONAL LEVEL RISK REPORT

DATE: 28 April 2016 Trust Board (business and risk)

	Likelihood				
Consequence	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

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

Risk ID	Hist Ref.	Source	Risk Responsibility	BDU / Directorate	Service	Speciality	Description of risk	Current control measures	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Summary of risk action plan	Fin cost (£)	Risk owner	Expected date of completion	Monitoring & reporting requirements		Risk level (target)	Is this rating acceptable?	Comments	Risk review date
695			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			Risk of adverse impact on clinical, operational and financial risk if the Trust is unable to manage the transition in year 3 of the five-year plan, as the plan states that the Trust would be operationally, clinically and financially unsustainable by the end of 2016/17 in its current configuration.	Risk scenario modelled in five-year plan submitted to Monitor in June 2014, which identified a tiered strategy to achieve sustainability which assumes consolidation of pathways and efficiencies in existing services, substitution of current service models for recovery-based alternative service offers at lower cost, and strategic consolidation of key services to drive savings through critical mass. Updated position submitted in 2016/17 operational plan submitted to NHS Improvement on 18 April 2016. Demonstrates recurrent financial surplus after achievement of challenging CIP	5 Major	4 Likely	20	Red/extreme /SUI risk (15-25)	➢ Active stakeholder management to create opportunities for partnership and collaboration which are reflected in corporate objectives. ➢ Development of preferred partners through Memorandum of Understanding and joint tender bids. ➢ Quarterly review of strategy by Trust Board every quarter. ➢ Recruitment to key areas of expertise to enable five-year plan to be realised through health intelligence, marketing and commercial skills, strategic planning and programme management. ➢ Increased used of service line reporting information. ➢ Increase in joint bids and projects to develop strategic partnerships which will facilitate the transition to new models and sustainable services. ➢ Active engagement in Strategic Transformation Plan/Leadership of West Yorkshire STP. ➢ Development of pricing strategy to engage with commissioners in 2016/17 ➢ Enhanced management of CIP programme in 2016/17 including targeted admin review; effective management of interims		EMT	Plan submitted to regulator May 2015 Updated operational plan submitted to Monitor April 2016	Monthly review EMT Transformation Board review Quarterly updates to Board	12	Amber/ high (8-12)			Trust Board April 2016
463			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			Risk that the planning and implementation of transformational change through the transformation programme will increase clinical and reputational risk in in-year delivery by imbalance of staff skills and capacity between the 'day job' and the 'change job'.	➢ Scrutiny of performance dashboards and review at EMT and ORG to ensure performance issues are picked up early. ➢ Weekly risk review by Director of Nursing and Medical Director to ensure any emerging clinical risks are identified and mitigated. ➢ Monthly performance review by Trust Board. ➢ Clear accountability arrangements for leadership and milestones for the transformation programme which are monitored by EMT. ➢ Engagement of extended EMT in managing and shaping transformational change and delivering in year performance.	5 Catastrophic	4 Likely	20	Red/extreme /SUI risk (15-25)	➢ Ongoing internal engagement events programme on transformation programme. ➢ Staff engagement strategy approved by Trust Board. ➢ Results of staff wellbeing survey used to target engagement. ➢ Director objectives linked to deliverables in the transformation programme and engagement. ➢ Roll-out of mental health acute commissioning implementation starting January 2016. ➢ Regular updates on progress and implementation through EMT and Trust Board. ➢ Quality impact assessment process well established. ➢ Clear SOPs for revised areas of operation e.g. Acute and Community Mental Health which are developed with staff from all BDUs prior to implementation to ensure that new ways of working are owned and understood ➢ Gateways between 'as is' and 'to be' implementation ensure that BDU leadership teams and Trios agree each phase of implementation to ensure clinical and operational effectiveness maintained throughout.	£0.9m	Work stream leads	Acute and Community Mental Health on track for implementation in Q1 and Q2 of 16/17 LD on track for implementation in Q1 16/17	Bi-monthly focus by EMT on transformation. Trust Board reports as appropriate. Business cases approved by Calderdale, Kirklees and Wakefield commissioners.	15	Red/extreme /SUI risk (15-25)	Yes		Trust Board April 2016

773			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			Risk that the planning and implementation of transformational change through the transformation programme is not aligned to CCG and LA commissioning intentions and will increase clinical, operational, financial and reputational risk through potential implementation of service models which are not supported by commissioners.	➢ Transformation projects required to include engagement with external partners to ensure alignment. ➢ Communications through contract meetings and other working groups to ensure appropriate sharing of information. ➢ Development of team-to-team meetings with commissioner organisations to ensure strategic alignment. ➢ Scheduled review of stakeholder engagement including external relationship management at EMT. ➢ Interim Director of Marketing, Engagement and Commercial Development to increase capacity and skills to support this agenda.	5 Catastrophic	4 Likely	20	Red/extreme /SUI risk (15-25)	➢ Development of engagement plan by Interim Director of Marketing, Engagement and Commercial Development. ➢ Active participation at all levels in service integration initiatives across all LA/CCG patches, including West Yorkshire urgent care. ➢ Forging stronger links with national bodies to influence local and national systems thinking in relation to mental health and community services, for example, Trust Chair member of NHS Providers Board and Chief Executive Chair of Mental Health Network at NHS Confederation. ➢ Strengthen link between transformation programme and contracting in particular using the transformation programme to identify areas for QIPP savings. ➢ Agreement of number of key transformation projects in 2015/16 which have also been reviewed by Overview and Scrutiny. ➢ Links strengthened with CCGs to ensure that mental health commissioning intentions are relevant and appropriate. ➢ Consistent alignment of all Trust activity with CCG Service Reviews, and GP Federation provider aspirations in relation to transformation of the Trust's general community services. ➢ Alignment of Trust transformation plans for mental health with commissioner's plans as set out in local STP place based plans ➢ Agreement of Learning Disability transformation plans through every Health and Wellbeing Board in the Trust's operating area, as part of local Transforming Care Plan ➢ Lead clinician to clinician conversations planned re Rehab and Recovery to test agreement with Calderdale and Kirklees commissioners		Interim Director Strategic Planning, DoF, Workstream leads	Annual plan	Bi-monthly focus by EMT on transformation. Trust Board reports as appropriate. Business cases approved by Calderdale, Kirklees and Wakefield commissioners.	15	Red/extreme /SUI risk (15-25)	Yes		Trust Board April 2016
772			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			*Risk related to local authority as commissioner* Impact of continued reduction in Local Authority budgets may have negative impact on level of financial resources available to commission services from NHS providers which represents a clinical, operational and financial risk, in particular for services commissioned by public health, which includes 0-19 services, health and wellbeing and drugs misuse.	➢ District integrated governance boards established to manage integrated working with good track record or co-operation. ➢ In all geographic areas, the Trust is a partner in developing integrated working to reduce overall costs in the system. ➢ Maintenance of good strategic partnerships through maintenance of positive relationships with Local authority staff through EMT and operational contacts and positive engagement of overview and scrutiny and other system 'transformation' boards. ➢ Monthly review through Delivery EMT of key indicators which would indicate if issues arose regarding delivery, such as delayed transfers of care and service users in settled accommodation. ➢ At least monthly review of bids management in relation to services commissioned by local authorities.	4 Major	4 Likely	16	Red/extreme /SUI risk (15-25)	➢ Continues to be monitored through BDU/commissioner forums. Given latest round of austerity measures and planning guidance, review of position in progress. ➢ Board-to-Board meeting with Barnsley senior team, where objectives were agreed which should facilitate a system response to current challenges. ➢ Agreement of safe transfer plan for 0–19 services in Barnsley with local authority. ➢ Joint commissioned work between Trust and Wakefield Council to provide baseline for ensuring joint service provision for mental health service is fit for purpose linked to system wide transformation and MCP Vanguard. ➢ With Calderdale Council, joint working under review through consideration of new ways of working in the MCP Vanguard. ➢ Part of Integration Board which is chaired by Locala and includes local authority to develop wider system integration following award of Care Closer to Home contract for community services in Kirklees. ➢ Service Line strategy review work tested with Trust Board identified direction of travel for service lines which are challenged by local authority austerity and commissioning practices. Enables timely decision making (exit/ partner etc.) as opportunities arise.		EMT	Annual plan	EMT (monthly) and Trust Board (monthly). EMT review of 2015/16 contracts each month at Delivery EMT Review of 2016/17 contract by EMT from January to March 2016. Bid management team update to EMT monthly	12	Amber/ high (8-12)	Yes		Trust Board April 2016
812			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			Risk that Trust's clinical operational and financial sustainability will be adversely impacted on in 2016/17 by impact of local commissioning intentions from CCGs and local authorities which include reductions in national funding due to impact of changes in national	➢ Develop a clear service strategy through the internal Transformation Programmes to engage commissioners and service users on the value of services delivered. ➢ Ensure appropriate Trust participation in system transformation programmes. ➢ Robust process of stakeholder engagement and management in place through EMT. ➢ Progress on Transformation	5 Catastrophic	4 Likely	20	Red/extreme /SUI risk (15-25)	➢ Trust is proactive in involvement in system transformation programmes which are led by commissioners, including four Vanguard programmes. ➢ Internal Trust transformation programme linked to CCG commissioning by including schemes within the QIPP in 2014/15 and 2015/16. ➢ Planned improvement in bid management process including additional skills building and increase in joint bids with partners.	Loss of income could be in the order of £1m - £5m	EMT Senior leads for planning transformation and contracting plus Deputy Directors of operations	Annual plan Contract development plans Including in Vanguard action plans	Monthly at EMT. Quarterly risk and business board.	15	Red/extreme /SUI risk (15-25)	Yes		Trust Board April 2016

							allocation, level and pace of requirement by CCGs for QIPP savings, and level of priority for spending on mental health and community services versus other system pressures.	reviewed by Board and EMT.					➢ Horizon scanning for new business opportunities. ➢ Increased capacity and skills to support stakeholder engagement in place. ➢ Effective communication of successes to build Trust in delivery and increase likelihood of future business. ➢ Maintain tight control on costs to maximise contribution. ➢ Review of CQUIN income attainment by EMT and ORG and action plan to improve for Q4. ➢ Local CCG finance directors have agreed to review of pricing strategy which supports development of mental health currency and transparency in the contract arrangements. ➢ 2016/17 annual plan and strategy revision is key action for Trust Board to manage this risk. ➢ Review of commissioning intentions by EMT and contract negotiation stances and meetings in place to progress agreement of contracts for 2016/17. ➢ Further alignment of Contracting and Business Development functions to support a proactive approach to retention of contract income and growth of new income streams									
275			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			*Risk linked to local authority as providers.* Continued reduction in Local Authority funding and changes in benefits system will result in increased demand for health and social care services, which may impact on capacity and resources within integrated teams for mental health and community provision. Reduced funding in provision by local authorities will reduce the service capacity within integrated teams and pathways which creates potential service and clinical risks, including impact on waiting times, assessment and management of risk.	➢ District integrated governance boards established to manage integrated working with good track record of co-operation. ➢ Agreed joint arrangements for management and monitoring delivery of integrated teams. ➢ Maintenance of good operational links though BDU teams and leadership. ➢ Monthly review through Delivery EMT of key indicators, which would indicate if issues arose regarding delivery, such as delayed transfers of care and service users in settled accommodation.	4 Major	5 Almost certain	20	Red/extreme /SUI risk (15-25)	➢ Continues to be monitored through BDU/commissioner forums. Given latest round of austerity measures (July 2015) and current planning guidance (December 2015), review of planned activity in each service line is reflected in Annual Plan submission. ➢ Board-to-Board meeting with Barnsley senior team where objectives were agreed which should facilitate a system response to current challenges. ➢ Joint commissioned work between Trust and Wakefield Council to provide baseline for ensuring joint service provision for mental health service is fit for purpose linked to system wide transformation and MCP Vanguard ➢ With Calderdale Council, joint working under review through consideration of new ways of working in the MCP Vanguard. ➢ Use of service line reporting and health intelligence to drill down to facilitate early detection of quality issues. ➢ Weekly risk scan by Director of Nursing and Medical Director to identify any emerging issues reported weekly to EMT. ➢ Identification of leading indicators to highlight where local authority service change and or benefits changes lead to increased demand. To be led by Health Intelligence team		BDU Directors	Included in annual plan	EMT (monthly) and Trust Board (monthly) EMT review of 2015/16 contracts each month at Delivery EMT Review of 2016/17 contract by EMT from January to March 2016. Bid management team update to EMT monthly	16	Red/extreme /SUI risk (15-25)	Yes		Trust Board April 2016
270			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			Implementation of new currency models for mental health and community services will move the current funding arrangements from block contracts to activity-based contracts. This may present clinical, operational and financial risk if cost and pricing mechanisms are not fully understood at local, regional and national level.	➢ Accountability arrangements in place for delivery of mental health currency. Incorporated into transformation workstream for mental health. Data quality and clinical system linkages picked up through the data quality steering group and the System development Board respectively. ➢ Progress reviewed by Audit Committee and Trust Board. ➢ Key issues/risks and progress monitored through Delivery EMT. ➢ Key representation at national level for development of costing by Chief Executive and Director of Finance.	5 Catastrophic	4 Likely	20	Red/extreme /SUI risk (15-25)	➢ All mental health transformation projects consider the impact of mental health clustering and the four-tier pathway for mental health services is cross referenced to the 21 clusters. ➢ Contract agreements and monitoring in place with commissioners for 2016/17. This includes CQUIN targets to incentivise key metrics for the embedding of the mental health clusters in clinical practice. This is currently under review as the Trust is not maximising CQUIN income in this area ➢ Specific case review project in progress to ensure only 'live' caseload included on clinical system. ➢ Monitoring at service line by practice governance coach, general manager and clinical lead with escalation of issues which need Trust-wide response. ➢ Scheduled reviews at EMT on progress and metrics included in monthly performance report. ➢ Mental health currency and service line reporting standing items on Audit Committee agenda, which has included presentation from BDU Directors on implementation within BDUs.		DoF, BDU lead director for MH transformation DoN Medical Director	As above and included in transformation programme and operational plan	➢ EMT Progress reports ➢ Report on progress to every Audit Committee ➢ Regular Board updates ➢ Review on action plans by ORG (meets weekly)	16	Red/extreme /SUI risk (15-25)	Yes		Trust Board April 2016

													➢ Ongoing review by Operational Review Group (ORG) through 2016/17 to monitor effectiveness of action plan									
267			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			Capture of clinical information on RiO will be insufficient to meet future compliance and operational requirements to support service line reporting and the implementation of the mental health currency leading to reputational and financial risk in negotiation of contracts with commissioners.	➢ Data quality Strategy approved by Board Oct 2011. ➢ Annual report produced for Business and Risk Board to identify risks and actions required in order to comply with regulatory and contract requirements. ➢ Data quality improvement plans are monitored by the Data Quality Steering group. Chaired by the Director of Nursing. ➢ Accountability for data quality is held jointly by Director of Nursing and Deputy Chief Executive. ➢ Responsibility for data quality is delivered by BDU directors, BDU nominated quality leads and clinical governance. ➢ Key metrics for data quality are produced monthly in BDU and Trust dashboards and reviewed by Delivery EMT. ➢ Annual clinical audit programme is planned to reflect data quality priorities.	4 Major	4 Likely	16	Red/extreme /SUI risk (15-25)	➢ Progress against data quality action reviewed at Delivery EMT on ongoing basis. ➢ Communication via Team Brief and Extended EMT on key messages. ➢ Performance on Payment by Results metrics reviewed at EMT. Dedicated clinical resource in each BDU through practice governance coaches. ➢ Upgrade of RiO to version 7 will facilitate data quality compliance though, for example, spine connectivity. ➢ Roll-out plan reviewed by Systems Development Board. ➢ Wider system development network established with clinicians and managers including secondment of consultant medic as advisory post. ➢ Data quality metrics included in monthly performance reports. ➢ EMT agreed additional resources to be managed by BDUs to support clean-up of caseloads in 2015. This is now part of service line management by 'trios'. ➢ Link of clustering data to mental health transformation work in business cases for acute and community to ensure mainstreamed into redesigned services. ➢ Report to Audit Committee October 2015 and standing item on the agenda for Clinical Governance and Clinical Safety Committee. ➢ Five priorities identified for focus (monitoring, supporting with guidance/SOPs, learning from each other's experiences, looking for ways to improve quality, and champion the importance of this work).		Deputy CEO and Director of Nursing	Implementation of national guidance during April 2016	EMT and Trust Board monthly review for data quality indicators. Steering group review for data quality board, Clinical Governance and Clinical Safety Committee and System Development Board. Monthly System Development Board for RiO system. Agreed work plan and prioritisation.	12	Amber/ high (8-12)	Yes		Trust Board April 2016
850			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			The upgrade to RiO V7 has resulted in system functionality and operational issues in several areas which are impacting on the Trust's ability to effectively support clinical services operationally and in the production and submission of central returns and accurately record clinical coding information.	➢ Daily issue management ongoing ➢ IM&T co-ordinating with clinical services and P&I colleagues in reviewing /testing resolutions provided by system supplier Servelec Healthcare in respect of system usability and dataset submission reporting ➢ Issues identified and raised with the supplier and the proposed solution is currently being tested with the Trust. ➢ Update of national OCS files to RiO. ➢ New version of medicode available for install which includes the Diagnosis module. Not yet implemented by supplier due to system performance issues the lack of this module is impacting on the clinical coding accuracy ➢ Lack of access to RiO and information not always saving has resulted in a reduction in activity volumes and data quality. ➢ The Health & Social Care Information Centre have been informed and a request to put a health warning on our data has been sent. Commissioners are being updated during monthly routine meetings. ➢ Executive management meetings held with Servelec Executive Team to ensure focus and prioritisation of issues ➢ Support Contract under review	4 Major	5 Almost certain	20	Red/extreme /SUI risk (15-25)	➢ Issue management activities ongoing on a daily basis internally to review and monitor progress resolution and to manage effective communications ➢ Daily liaison ongoing with RiO system supplier regarding issue resolution and updates on progress ➢ Issue management resolution separated into technical (IT infrastructure) and functional (clinical system) ➢ All Technical issues resolved locally by Trust/Daisy with functional issues being addressed by RiO system supplier ➢ Internal Trust investigation to serious untoward incident completed ➢ External Audit of RiO V7 implementation commissioned and underway ➢ Programme of refresher training for staff and teams established together with additional specialist support to enable staff work through and address issues resolved – being conducted on a site by site basis in collaboration with PGCs. ➢ Weekly monitoring of RiO V7 issue resolution and progress ongoing at Trust Executive Management Team level and at ORG. ➢ Issue resolution testing has been formalised and issues are not closed until positive confirmation has been obtained from clinical services impacted ➢ Contract terms reviewed – this will be in conjunction with the supplier		Deputy CEO and Director of Nursing	Completion of issue resolution 31/3/2016	Trust Board (Monthly), EMT (Weekly), ORG (weekly). within IM&T senior Management Team (daily) Weekly with BDU clinical representatives Trust wide communications issued twice a week	12	Amber/ high (8-12)	Yes		Trust Board April 2016
851			Corporate/ organisation level risk (corporate use only EMT)	Calderdale and Kirklees	CAMHS		Risk in 2016/17 that the Trust will be unable to secure sufficient funding to support a sustainable child and adolescent mental health service	➢ From transfer of service in April 2013 contract management and review arrangements in place with the commissioner. ➢ Joint action plan in place from 2013 to address waiting times,	5	4	20	Red/extreme /SUI risk (15-25)	➢ Introduction of CAMHS summit meetings across all partners in 2015/16 including commissioners and local authority. ➢ Reviewed at regular contract meetings and Quality Board.	Income at risk circa £1.3m	BDU Director Deputy CEO DoF	Completion of negotiations 31 May 2016	Negotiation process monitored through EMT Regular report to Board on progress	15	Red/extreme /SUI risk (15-25)	Yes		Trust Board April 2016

								caseload management and data quality. ➢ Intensive support provided internally by Trust to support the action plan and service transferred to RiO system to support data quality. ➢ Cost pressure absorbed internally of £500,000 in 2014/15 and 2015/16 to support recruitment and capacity. Provision agreed within the 2016/17 contract to continue negotiations with commissioners to meet the £500k cost pressure. ➢ Progress is reviewed regularly within Clinical Governance and Clinical Safety Committee and contract meetings.					➢ This has led to system action plan and identified key issues to address outside the remit of this contract. ➢ Evidence of improvement in delivery of service. ➢ Update on progress reported to Board monthly. ➢ Joint work in place with commissioners as part of 2016/17 contract negotiation to secure sustainable funding. Provision has been made in the contract for negotiations with commissioners to continue beyond the contract sign off. ➢ Calderdale and Kirklees Commissioners have indicated their intention each to procure CAMHS separately in 2017/18. ➢ CAMHS are working with the strategic planning and business development team to prepare for a procurement process. ➢ Calderdale CCG is leading a commissioner consortium across the four CCGs to commission an Eating Disorder service from the Trust as part of the Future in Mind investment.									
852			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			Reputational risk and financial risk due to increase in reported information governance incidents to Information Commissioner	➢ Trust maintains access to information governance training for all staff and has track record of achieving the mandatory training target. ➢ Trust employs appropriate skills and capacity to advise on policies, procedures and training for Information Governance. ➢ Trust has appropriate policies and procedures in place. ➢ Trust has good track record for recording incidents and all incidents are reviewed weekly by Deputy Director of IM&T and Information Governance Manager. ➢ Data Quality Improvement TAG in place, which is the governance group with oversight of IG issues. ➢ EMT reviews any escalation issues from TAG. ➢ Internal audit perform annual review of IG as part of IG Toolkit ➢ IT forum, which is a sub-committee of Trust Board, reviews implementation of IM&T strategy and any items for escalation.	5	4	20	Red/extreme /SUI risk (15-25)	➢ Increase in incidents noted in 2015/16 including serious incidents. ➢ Additional action taken to review guidance and polices. ➢ Targeted approach to advice and support from Information Governance Manager through proactive monitoring of incidents. ➢ Awareness raising sessions including Extended EMT. ➢ Rebranded materials and advice to increase awareness in staff and reduce incidents. ➢ Increase in training available to teams including additional e–learning and face-to-face training from Q4.	Risk of fine up to £500,000	SIRO Deputy CEO DoN BDU Directors	ICO external monitoring of progress by external evidence/desk based reviews	Progress monitored through EMT and weekly risk scan	15	Red/extreme /SUI risk (15-25)	Yes	Trust signed an undertaking with the Information Commissioner's Office in June 2015 due to continued breaches of Principle 7. Half year review by ICO repots good progress to date. ICO will undertake audit in 2016 of all Data Protection Practices w/c 28th November 2016)	Trust Board April 2016
TBA			Corporate/ organisation level risk (corporate use only EMT)	Wakefield BDU			Risk that current difficulties in maintaining adequate levels of registered nursing staff in working age adults acute services in Wakefield could lead to unsafe staffing levels.	Detailed Action Plan in place, monitored weekly by the BDU Trios, twice-weekly by the Ward Managers and monthly by the Service Line Meeting Recruitment process in underway. Action plan New escalation plan agreed in March 2016, which includes use of additional hours, bank/agency staff, review of staff on secondment, review of leave, review of registered nurses in other services and other staff, re-deployment of community/non-ward clinical staff within ward, re-deployment of registered nursing staff. Weekly review to limit admissions on Trinity 2.	5	4	20		➢ Recruitment process underway. ➢ Overtime payments agreed on a temporary basis to ensure continuity of care for Service users and reduce reliance on agencies. ➢ Business Continuity Plan in place		BDU Directors		Monitored daily at BDU level and weekly by EMT through risk scan process	6		Yes		Trust Board April 2016