Trust Board 24 September 2013
Agenda item 2

Title:	**Declaration of interests by the Chair and Directors of the Trust**
Paper prepared by:	Director of Corporate Development on behalf of the Chair of the Trust
Purpose:	To ensure the Trust continues to meet the NHS rules of Corporate Governance, the Combined Code on Corporate Governance, Monitor's Code of Governance and the Trust's own Constitution in relation to openness and transparency.
Vision/goals:	The vision and values of the Trust reflect the need for the Trust to be open and act with probity. The Declaration of Interests and independence process undertaken annually supports this.
Any background papers/ previously considered by:	Annual declaration made by the Chair and Directors of the Trust March 2013.
Executive summary:	The Trust's Constitution and the NHS rules on corporate governance, the Combined Code of Corporate Governance, and Monitor require Trust Board to receive and consider the details held for the Chair of the Trust and each Director, whether Non-Executive or Executive, in a Register of Interests. During the year, if any such Declaration should change, the Chair and Directors are required to notify the Company Secretary so that the Register can be amended and such amendments reported to Trust Board. Trust Board receives assurance that there is no conflict of interest in the administration of its business through the annual declaration exercise, received in March 2013, and the requirement for the Chair and Directors to consider and declare any interests at each meeting. There are no legal implications; however, the requirement for the Chair and Directors of the Trust to declare interests on an annual basis and for Non-Executive Directors to declare their independence is enshrined in the Health and Social Care Act 2012 in terms of the content of the Trust's Constitution. The following declarations have been made. Peter Aspinall – Panel Member, Conduct Committee, Institute of Financial Accountants. Directorship, Primrose Mill Ltd. is to be removed. Ian Black – Member, Advisory Group for the Point of Care Foundation's development of a report on health service leadership and management. It should be noted that this is a time limited appointment.
Recommendation:	**Trust Board is asked to consider the above Declarations and, subject to any comment, amendment or other action, to formally note the details in the minutes of this meeting.**
Private session:	Not applicable

Minutes of Trust Board meeting held on 23 July 2013

Present:	Ian Black	Chair
	Peter Aspinall	Non-Executive Director
	Bernard Fee	Non-Executive Director
	Julie Fox	Non-Executive Director
	Helen Wollaston	Deputy Chair
	Nisreen Booya	Medical Director
	Alan Davis	Director of Human Resources and Workforce Development
	Alex Farrell	Deputy Chief Executive/Director of Finance
In attendance:	Adrian Berry	Director, Forensic Services
	James Drury	Deputy Director, Strategic Planning
	Dawn Gibson	Deputy Director of Finance
	Sean Rayner	District Director, Barnsley and Wakefield
	Dawn Stephenson	Director of Corporate Development
	Karen Taylor	District Service Director, Calderdale and Kirklees (from item 4)
	Bernie Cherriman-Sykes	Board Secretary (author)
Apologies:	Jonathan Jones	Non-Executive Director
	Steven Michael	Chief Executive
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
Guests:	Penelope Fairmann	Regional account manager, Otsuka Pharmaceuticals (UK) Ltd.

TB/13/36 Welcome, introduction and apologies (agenda item 1)
The Chair (IB) welcomed everyone to the meeting. The apologies, as above, were noted.

TB/13/37 Declaration of interests (agenda item 2)
There were no declarations over and above those made in March 2013 and subsequently.

TB/13/38 Minutes of and matters arising from the Trust Board meeting held on 25 June 2013 (agenda item 3)
It was RESOLVED to APPROVE the minutes of the public session of Trust Board held on 25 June 2013 as a true and accurate record of the meeting. There were no matters arising.

The Chair made a number of remarks.

- Monitor has established regional teams and embarked on a schedule of annual visits to all Foundation Trusts. This Trust met with Monitor at Fieldhead on 15 July 2013. The Executive Management Team (EMT) met with the Senior Regional Manager and the Regional Manager, which was followed by a meeting with Chair and then the Chair and the Chair of the Clinical Governance and Clinical Safety Committee. The visit ended with a tour of Newton Lodge hosted by the Director of Forensic Services. The meetings were positive and key issues raised related to cost improvements in future years, how the Board works and succession planning, and partnerships and relationships in the local health and social care economy.
- A Board-to-Board meeting was held on 18 July 2013 with Barnsley Care Commissioning Group (CCG). The Trust is keen to also include Barnsley Hospital NHS Foundation Trust and the model provides a good example to replicate in other Business Delivery Unit (BDU) areas.
- There appears to have been little impact on Trust services as a result of the recent hot weather, particularly in areas that have access to outside areas. Adrian Berry (ABe)

added that there had been little impact on forensic services, particularly in Newton Lodge where the investment in the new building and courtyard arrangements are a vast improvement.

TB/13/39 Transformational service change (agenda item 4)

Alex Farrell (AF) introduced this item, which is a key workstream for 2013/14 for implementation in 2014/15. An EMT time out in July focussed on placement and processes within the organisation and links with the Trust's vision and values. Sean Rayner (SR) took Trust Board through the paper and explained that it linked to previous papers presented. It also describes links with other Trust activity, such as the Talent Pool, values-based appraisal and partnership working. The ultimate aim is to facilitate a smooth journey through service pathways, particularly those services provided by the Trust, for service users and their carers.

The following points were raised during the discussion.

- Helen Wollaston (HW) asked what the clinical impact would be on current services. SR responded that there would be no impact in in-patient areas as these are likely to continue in the current configuration; however, there will be parts of the Trust where service changes will impact on staff and management of this process will be an integral part of the service change agenda.
- HW also asked about outcome measures for the programme. SR responded that a clear set of qualitative and quantitative measures will be developed and these will be reported to Trust Board.
- Bernard Fee (BF) asked how the effect of the transformation and associated cost improvements on clinical quality would be assessed. He also commented that he was unsure what the transformation would deliver each year and in what areas.
- BF commented that non-clinical services also need to be transformed to protect services undergoing transformation. He would like to see these brought together to support service transformation. AF responded the technology and estate are key to the programme and the contribution of both areas will be articulated in the integrated business plan in October 2013. James Drury (JD) added that 'back office' functions will be a common theme in the transformation programme and will also involve and enable a wider set of people to contribute to the change agenda. IB asked whether areas such as technology and estate should have higher visibility in the programme. AF responded that this was a difficult balance. The Trust must ensure the enablers do not drive services; therefore, the emphasis is on clinical models. BF commented that he thought the Trust could identify bigger savings by changing the way it runs its business and by taking a more aggressive approach to enabling strategies. IB asked that an update on these areas is included in the next report to Trust Board.
- Julie Fox (JF) commented that it is apparent from the staff wellbeing survey that staff are becoming more concerned about job security and change. The Trust needs to be conscious of this, particularly when looking at absence levels.
- ABe confirmed that expansion of community forensic teams was considered as a service development; however, NHS England has excluded this area from specialist provision and, therefore, it can only be provided through local CCGs. BF suggested that the Trust could take a different approach to risk and develop an extension to the pathway. JF asked if it was possible to do this in just one area as a pilot. AF responded that there are a number of options for step-down provision; however, specialist commissioners cannot currently take this forward. This is despite a strong argument for commissioners that funding step-down services puts service users at the heart of commissioning.
- Peter Aspinall (PA) commented that it is difficult to see how the transformation programme will cover services provided in integrated teams and where Trust staff work in other organisations. AF responded that there will be an articulation of the vision and

associated plans by the end of August 2013, which will include integrated teams and other partnership working. SR added that the Trust has a major role in working with partners to identify areas where cost shifting is necessary and in supporting organisations de-stabilised by the changes in commissioning.

- BF commented that there has to be a balance between the resources available to the Trust and service users' and carers' expectations. The Trust needs to be clear on its own 'bottom line'. There may be a need for compromise and the Trust needs to be careful that the engagement process does not build an expectation that change will provide exactly what people want. IB added that the Trust must explain what it has and has not done as a result of the engagement and involvement events.
- IB also asked about the next steps for reporting to Trust Board, particularly on the conversion of plans to action. It was agreed a further report would come to Trust Board in October 2013, which would outline the vision for each strand, a hypothesis of what would change, milestones, outcome measures and the implications for and support from support functions.

TB/13/40 Performance reports month 3 2013/14 (agenda item 5)

TB/13/40a Quality performance report (item 5.1)

Karen Taylor (KT) took Trust Board through the key points in the report.

- The report continues to develop and feedback on the format from Trust Board was welcomed. BF commented that the report is improving but he found it difficult to read. He also felt there was a disconnect between the graphics and narrative.
- The Trust continues to fail the routine access target. A review of the pathway will be undertaken to understand the issues behind non-achievement.
- Work has begun with the University of Huddersfield to review single point of access arrangements across the Trust.
- The Trust will look at local measures to assess performance against improved care and care planning targets on a more regular basis as the current measure is based on an annual national survey. JF asked about the quality of care plans, which need to be understandable, meaningful and helpful for service users and carers. KT acknowledged that this was an area that requires more work and services can learn from best practice arrangements already in place within the Trust. The Trust does have standards in place and areas of poor performance are being targeted.
- Delays to transfers of care continue to be an issue and the Trust is working with local authority partners to resolve current difficulties. PA asked whether the Trust has a solution. KT stressed that the Trust is in active discussion with local authorities; however, there are some hotspots and these need to be individually reviewed to understand the cause to ensure that these are not due to internal issues.
- The Trust is undertaking a review of all clostridium difficile cases to understand their origin.
- There has been a reduction in reporting days for serious incidents from 60 to 45 days. The implications are being assessed.
- The Trust currently operates within national guidelines for face-down restraint; however, it is reviewing best practice to identify areas where practice could be improved. A further report will be brought back into the Clinical Governance and Clinical Safety Committee.
- The Trust has reviewed its policies and procedures in relation to end-of-life care following the recent guidance on the Liverpool care pathway.
- JF asked whether the Trust recorded its own practice in relation to getting people into employment. Alan Davis (AGD) responded that the Trust has signed up to the Mindful Employer principles to enable people to apply for posts within the Trust and to help staff already employed. Nisreen Booya (NHB) also commented on a research and development project to assist and support service users into employment. She added that the Trust must also take the opportunity to learn from other areas.

- In relation to proposed unannounced visits by CCGs, Dawn Stephenson (DS) has explained Trust assurance processes through unannounced visits and the '15 Steps' initiative. She has suggested a structured approach to any involvement of third parties in such visits, which is being considered by CCGs.
- The Care Quality Commission (CQC) consultation, 'New Start', proposes a four-point rating scale. It was agreed the Clinical Governance and Clinical Safety Committee will monitor and scrutinise the proposals and final approach. HW commented that she would like the Trust to be proactive in assessing the Trust's position and IB added that he would want to see a plan in place if any Trust service was seen to be less that 'good' or 'outstanding'.
- BF expressed a concern that data quality appears as amber in the report when it occurs continuously as an issue in various guises through both the Audit and Clinical Governance and Clinical Safety Committees. AF responded that data quality is reflected on the organisational risk register; however, in the performance report, it represents a snapshot of current measures on the dashboard.

TB/13/40b Service user and carer experience report quarter 1 2013/14 (item 5.2)

DS explained that the report is now produced in line with the quality performance report and the front sheet outlined the focus of the quarter 1 report.

- JF commented that this was a good report and helpful for service users; however, BF held the opposite view in that he still did not understand the purpose of the report. He thought the original plan was to produce a highly objective report, which identifies areas for the Trust to improve.
- PA asked how the Trust will report and respond to issues raised during the engagement events. This will come through reports to Trust Board on the transformational service change programme.
- IB asked whether the Members' Council was involved in the style and layout of the report. DS confirmed that governors had been asked for views.
- HW felt that the report works well as a 'PR' document but a gap remains in terms of an analytical report to Trust Board. She also felt that a mechanism for staff to feed service user and carer comments into any process was needed. AF responded that any objective and analytical assessment should be included in the performance report.
- IB summarised that this is a good document but does not meet Trust Board's needs as a tool for analysis. He asked for clarity at the report's next presentation of its purpose for Trust Board.

TB/13/40c Finance report month 3 2013/14 (item 5.3)

Dawn Gibson (DG) highlighted the following.

- The overall position at month 3 is a £1.1 million surplus, which is £423,000 ahead of plan. The forecast for the year is £4.17 million, which is £0.45 million ahead of plan.
- The cash position is £27.1 million, which is £600,000 ahead of plan.
- Capital expenditure to June is £1.5 million, which is £190,000 (11%) below plan.
- The Cost Improvement Programme is £185,000 (9%) under a plan of £2.1 million. The majority of this shortfall is being met non-recurrently.
- The financial risk rating is 4.1, which is ahead of plan at quarter 1 (3.9%) due to the additional surplus position.

At the end of the meeting, BF asked what actions, finance-wise, the Trust was taking to address the current financial position. AF responded that:

- a paper on the end-of-year outturn would come to Trust Board in October;
- variations are expected on the side of a surplus rather than a deficit;
- provisions provide headroom for the transformation programme;

- performance management and service line reporting provide the focus to identify opportunities to improve effectiveness and efficiencies;
- the current position provides a framework that will concentrate efforts on transformation and not remedial action.

BF asked if this was a trend or an issue with budgeting in the first three months. IB felt what the Trust does about the current position is more of an issue, for example, converting the estates plan into action seems to have stalled and this was an area in which he would like to see more progress. He also wanted to see the report in October including mitigating action in relation to the end-of-year outturn. AF responded that, in terms of budgeting, unexpected items are still emerging that had not been planned. The Trust is improving in this area but more work is needed. The process has also flushed out core issues around the transformation programme and how this impacts on enabling strategies.

AGD commented that the Estates Strategy was always intended to be a fluid plan to reflect the needs of services. Prioritisation of the plan will be reviewed to ensure it meets service need.

BF expressed a concern that, working on the position at quarter 1, the Trust would make a surplus of £6 million. Trust Board needs to come to a view on the use of any additional surplus. AF responded that Trust Board needs to distinguish between and take into account recurrent and non-recurrent items in the overall financial position.

TB/13/40d Strategic human resources report quarter 1 3 2013/14 (item 5.4)

AGD reported that the Trust achieved an appraisal rate of 80.9% at the end of June 2013 against a target of 90%. This target will be achieved by the end of July 2013. This does represent a good performance considering the Trust introduced a new values-based appraisal system on 1 April 2013.

JF asked whether the Trust is learning from best practice in relation to tackling absence. AGD responded that it is part of the performance management framework and managers' objectives and the Trust is embedding good practice where performance is poorer. IB asked whether the Trust would achieve the 4% target. AGD responded that it would be nearer 4% than 5% but the Trust is unlikely to achieve the target set by the end of 2013/14. IB asked what the Trust intended to do about this. AGD responded that the performance trajectory becomes important and how the Trust sustains management action, particularly to address cultural issues in areas of poor performance.

BF felt that the presentation of absence performance information provided an excellent explanation of performance, both current and planned, and shows the challenge in an appropriate way. AGD highlighted the excellent achievement in medium secure services, which reflects the management approach taken. This needs to be replicated in low secure services.

In terms of 'seasonal' absence, the two highest causes of absence are stress and anxiety, and musculo-skeletal issues, which are not necessarily subject to seasonal variations.

IB asked that the wellbeing survey comes back to Trust Board when trends begin to emerge.

TB/13/40e Exception reports and action plans – Update on cost improvement programme (item 5.5(i))

IB asked whether there were any concerns about the 2013/14 position. AF responded that these were small and that BDUs have mitigating action in place for any shortfall. The issue is more with timing than with non-achievement. Approximately £250,000 has been identified as 'at risk'.

BF commented that he would like to see more detail behind the figures, particularly in relation to the impact on services and how this is tested. AF responded that there is no intelligence currently that cost improvements are affecting or impacting on services but BDUs have identified hotspots and have a clear insight on where to focus efforts. NHB commented that both the quality impact assessment process and the transformation programme are flushing out areas of clinical risk where the service model needs to change or where there are clear leadership and management issues to be addressed.

BF was hoping for a report that would identify where cost improvements are impacting on the quality of care or the quality of service provided. HW added that she would like to see this come through the Clinical Governance and Clinical Safety Committee for further scrutiny. IB summarised that Trust Board, therefore, wished to see a further assessment of the impact of cost improvements, what BDUs are confident of delivering or not, and mitigating action to address any shortfall.

In terms of 'hotspots', BDU Directors identified the following.

- The approach to bed management across Calderdale, Kirklees and Wakefield, which is also affecting Barnsley.
- IB asked what the impact would be if the clostridium difficile target was exceeded. SR responded that, if the cases are found to be attributable to the Trust, this would be a real issue. Root cause analysis of four incidents suggests they are not attributable to the Trust with one outstanding. SR was asked to indicate this in the next performance report.
- Clinical safety in relation to savings in Calderdale and Kirklees as a result of e-rostering and what is a safe level of realisable savings.
- Key metrics for benchmarking are also being developed, which will identify other areas for review.

HW commented that most of the discussion focused on in-patient areas. NHB responded that delivery of mental health services in the community, particularly by Community Mental Health Teams, is a key focus of the transformation programme.

It was RESOLVED to NOTE the report.

TB/13/40f Exception reports and action plans – Serious incidents report quarter 1 2013/14 (item 5.5(ii))

IB asked for inclusion of information regarding 'never events' and a trend analysis of serious incident in quarterly reports in future. He also asked if there was a 'hierarchy' of incidents. NHB responded that each incident is RAG rated and trend analysis is very important as it identifies themes that could indicate a higher level of risk. She also commented that the quality of reporting is improving. BF commented that there could be some lower level incidents where the Trust could really make a difference.

It was RESOLVED to NOTE the report.

TB/13/40g Exception reports and action plans – Annual report on the Innovation Fund (item 5.5(iii))

HW commented that she would like to see future reports present a bigger picture in terms of the effectiveness of the fund as a whole rather than by individual projects, including where bids come from and where bids did not work.

It was RESOLVED to NOTE the annual report.

TB/13/40h Exception reports and action plans – Treasury management update (item 5.5(iv))
DG confirmed that the working capital facility will no longer be considered as part of the Monitor risk rating from October 2013 and, therefore, the intention is to recommend to the Audit Committee that the arrangement ceases from October 2013. IB asked for an analysis of the cash position to ensure clarity for Trust Board before any decision is made on the working capital facility.

It was RESOLVED to CONSIDER the Audit Committee's recommendation regarding the working capital facility in October 2013.

TB/13/41 Trust Board self-certification – Monitor quarter 1 2013/14 return (agenda item 6)
HW asked that the report notes that the action plans from Mental Health Act visits by the Care Quality Commission are considered in the Mental Health Act Committee.

AF confirmed that the Trust does use its track record on sustainability and viability with the Regulator in its bids and tenders. NHB commented that the Trust also needs to be more proactive in demonstrating its experience and track record in integrated services, particularly following the transfer of community services under Transforming Community Services. The Trust can be an exemplar. BF commented that the Trust needs to focus on making itself sustainable and viable by focusing on the transformation programme to strengthen the Trust rather than dilute management capacity further by seeking to expand or grow, except in pockets of identified niche services.

It was RESOLVED to APPROVE the exception report to Monitor.

TB/13/42 Assurance framework and organisational risk register quarter 1 2013/14 (agenda item 7)
It was RESOLVED to:
- **NOTE the process for producing the 2013/14 assurance framework and assurances provided for quarter 1 of 2013/14;**
- **NOTE those areas where gaps in assurance have been identified and are being addressed through specific actions; and**
- **NOTE the key risks for the organisation.**

TB/13/43 Date and time of next meeting (agenda item 8)
The next meeting of Trust Board will be held on Tuesday 24 September 2013 in seminar room 1, Textile Centre of Excellence, Textile House, Red Doles Lane, Huddersfield, HD2 1YF.

Signed …… Date ……

Minutes of Audit Committee held on 9 July 2013

Present:	Peter Aspinall	Chair of the Committee
	Ian Black	Chair of the Trust
	Bernard Fee	Non-Executive Director
Apologies:	Members	
	Jonathan Jones	Non-Executive Director
	Others	
	Paul Thomson	Partner, Deloitte
In attendance:	Robert Adamson	Head of Finance
	Susan Baines	Head of Financial Accounting
	Tim Breedon	Director of Nursing, Clinical Governance and Safety (item 13)
	Bernie Cherriman-Sykes	Integrated Governance Manager (author)
	Jon Cohen	Assistant Manager, Counter Fraud, KPMG
	Tony Cooper	Head of Procurement
	Tim Cutler	Head of Internal Audit, KPMG
	Alex Farrell	Deputy Chief Executive/Director of Finance
	Julie Fox	Non-Executive Director
	Paul Hewitson	Senior Audit Manager, Deloitte
	Clare Partridge	Senior Manager, KPMG
	Dawn Stephenson	Director of Corporate Development

AC/13/42 Welcome, introduction and apologies (agenda item 1)
The Chair of the Committee (PA) welcomed everyone to the meeting. The apologies were noted.

AC/13/43 Minutes and matters arising from the meeting held on 23 May 2013 (agenda item 2)
It was RESOLVED to APPROVE the minutes of the Audit Committee held on 23 May 2013 as a true and accurate record of the meeting. There were no matters arising.

AC/13/44 Matters arising from the meeting held on 9 April 2013 (agenda item 3)
AC/13/18 Issues arising out of the Committee's self-assessment April 2013 (page 1)
Taken under agenda item 11.

AC/13/21 Internal audit assessment of risks in relation to information management and technology (page 5)
Alex Farrell (AF) confirmed that a number of areas relating to IM&T, such as the Information Governance Toolkit, data quality and the use of data in the transformational service change programme, were already included in the internal audit plan approved by the Committee. For current IT procurement initiatives, external advice from the Procurement Collaborative and legal advice on contract terms has been sought and the process is overseen and scrutinised by the IM&T Forum. The Forum would be asked to consider any other areas as they arise.

AC/13/25 Changes to treatment of cash balances (page 8)
Taken under agenda item 7.

AC/13/26 Internal audit progress report (clinical audit) (page 9)
Bernard Fee (BF) commented on the triangulation between internal audit reviews. In particular, he felt that a risk remains in terms of learning lessons from clinical audits to foster a culture of continuous improvement and using clinical audit to improve services. AF agreed to follow this up with Tim Breedon (TB).

Action: Alex Farrell

BF added that advice would be welcome from KPMG. Clare Partridge (CP) responded that the audit of clinical audit did focus on high risk areas and tested action plans arising from clinical audits. These were found to be satisfactory. BF commented that he would like to see more transparency and a clearer indication of whether the findings of clinical audits are 'good' or 'bad' throughout the year. Tim Cutler (TCu) responded that KPMG would be happy to facilitate 'output' sessions with clinical audit in support of reporting of findings, dissemination of outcomes and learning lessons.

AC/13/26 Internal audit progress report (Disclosure and Barring Service process)
On behalf of Alan Davis, Dawn Stephenson (DS) updated the Committee on the outstanding issue around the DBS checks (formerly CRB checks). There were 338 staff identified as high priority due to their roles of which 300 have now completed their checks. A further 21 forms have been completed and sent to the DBS. The remaining seventeen outstanding consist of four who have a scheduled appointment to bring the required documents and complete the form; eight on long-term sick or maternity leave (who will be picked up on their return to work); five who have been referred to their Director for failing to complete the necessary checks, which may potentially lead to suspension.

Non-priority areas are staff who may come into contact with service users in the discharge of their duties. These include 107 estates and facilities staff and 145 administrative staff. Of these, 86 out of the 107 estates and facilities staff have completed CRB checks, a further four are with the DBS, eight have appointments and nine have been referred to their manager. For administrative staff, 126 out of 145 have completed the checks, a further thirteen are with the DBS and the remaining six have appointments.

AC/13/26 Integration of facilities functions (page 9)
On behalf of Alan Davis, DS updated the Committee on the plan to introduce a new integrated structure from 1 August 2013. There will be one Head of Estates (operational services) and one Head of Estates (capital and estates planning) across the Trust, which will include security and emergency planning.

AC/13/33 Re-appointment of the Trust's external auditor (page 11)
Paul Hewitson left the meeting for this item.

It was RESOLVED to MAKE A PROPOSAL to the Members' Council at its meeting on 26 July 2013 to extend the contract with Deloitte for a further two years from 1 October 2013.

AC/13/45 Update on Transforming Community Services (agenda item 4)
AF introduced this paper, which shows some demonstrable benefits and achievements following the transfer of services in 2011; however, there are some

service areas that will depend on the service transformation agenda to fully demonstrate value for money and identify how benefits will be realised. It was agreed to receive a further paper in October 2013.

Action: Alex Farrell/Dawn Stephenson

AC/13/46 Charitable Funds annual report and accounts 2012/13 (agenda item 5)

Julie Fox (JF), as Chair of the Charitable Funds Committee, took the Committee through the report and accounts.

PA queried the £525,000 for Creative Minds awarded by commissioners in Calderdale and Kirklees at the end of the previous financial year. It was confirmed that the Charitable Funds Committee is the overarching body to ensure the funds are utilised effectively. PA also asked how the Committee would ensure value for money. AF responded that it is now timely to review the objective criteria for assessing the way Creative Minds is utilised and she would bring this back to the next meeting in October 2013.

Action: Alex Farrell/Dawn Stephenson

It is important that the Trust encourages applications under Creative Minds and ensures the funds can be utilised effectively and efficiently without deterring organisations through bureaucracy and procurement rules. Tony Cooper (TCo) commented that there have been a number of waivers created as a result of Creative Minds and there is some concern about the viability and sustainability of some organisations and their ability to manage funds awarded by the Trust. DS responded that the Trust needs to create a framework to demonstrate a sensible and prudent approach whilst adopting a flexible approach for organisations who apply for funds.

BF reminded the Committee that there is a more fundamental issue around the management of Creative Minds and this needs to be formalised by Trust Board. AF assured the Committee that a proposal will come back to Trust Board later in the year.

Action: Alex Farrell/Dawn Stephenson

It was RESOLVED to APPROVE the charitable funds annual report and accounts for 2012/13.

AC/13/47 External agencies annual report 2012/13 (agenda item 6)

DS introduced this item. BF commented that it would have been helpful to understand which of the reports were important or valuable to the Trust, which had been reviewed and where action plans had been developed. Ian Black (IB) commented that he was assured by the report that there is a process in place and it is working adequately. AF responded that some areas are reported through Trust Board and its Committees, for example, the Francis Report, Monitor licensing and the Winterbourne View report. It was agreed to provide examples in the next report to the Committee that demonstrate the outcome of review. TCu also suggested reporting by theme as this might make the report clearer.

Action: Tim Breedon

AC/13/48 Treasury Management Policy and working capital facility (agenda item 7)

IB asked for clarification that, from October 2013, the Trust would no longer require a working capital facility and the Committee was being asked to approve this. AF responded that the expectation is that the Trust will not need a working capital facility from October 2013. A formal proposal will be made for the Audit Committee to consider at its meeting in October 2013 and a recommendation made to Trust Board at its meeting on 22 October 2013.

It was RESOLVED to APPROVE the proposals to:

- **have no external investment until such time that it is favourable to do so with all surplus cash remaining with the Government Banking Service; and**
- **extend the Trust's working capital facility with penalty free break clauses to enable the Trust to end the facility in October 2013, subject to Trust Board approval.**

AC/13/49 Service line reporting, currency development and reference costs (agenda item 8)

AF explained that the paper was presented to the Committee as the Department of Health has asked Audit Committees to confirm there has been scrutiny of the process and methodology. Information regarding costs included and excluded from the reference costs calculation was tabled for clarity. AF agreed to circulate the detail of the excluded costs to the Committee.

Action: Alex Farrell

When published, reference costs will be aligned with service line reporting and it was agreed to bring a report to the October meeting, which would also identify any anomalies. AF was also asked to include comparison/benchmarking with other Trusts in the Consortium and an indication of areas where the Trust can learn from others.

Action: Alex Farrell

BF commented that he would like assurance that the Trust is acting on the information not necessarily the actual figures but in terms of where the Trust is 'cheaper' or more 'costly' than other Trusts and the reasons underlying these figures. IB asked how the Trust can take assurance of comparison with other Trusts given the subjective nature of the quantum reconciliation. AF responded that assurance depends on the quality of all submissions and provides an opportunity to undertake internal benchmarking, in other words, to use this as a tool to describe activity across the Trust and how it links to service line reporting. IB commented that reference costs would be good for internal benchmarking and learning from the top ten Trusts but beyond this he was struggling to see the benefit. Also, reference costs will be used to judge this Trust in comparison with others using subjective data.

BF commented that, if the Trust is content that reference costs have been devised fairly, then the Trust has to accept the outcome and implications. Paul Hewitson (PH) commented that reference costs have always been treated with scepticism by Trusts. TCu added that Monitor has tried to put some rigour and transparency into the measurement of reference costs although there may be some way to go before

Trusts can take full assurance from the outcome. AF added that there is a common perception of the score above or below 100. It is not always a case of 'bad' or 'good' and needs to be aligned with service line reporting to understand the outcome and ensure no value judgements are made, particularly by commissioners.

It was RESOLVED to:

- **NOTE the progress to date with regard to the reference costs submission for 2012/13; and**
- **NOTE the costing process supporting the reference costs submission and PROVIDE assurance to Trust Board of the process undertaken.**

AC/13/50 Counter fraud annual report 2012/13 (agenda item 9)

Jon Cohen (JC) introduced this item. In terms of the requirement for the Trust to comply with NHS Protect's Standards for Providers: Fraud, Bribery and Corruption, the overall self-assessment was found to be green for 2012/13. Two areas were assessed as weaker relating to information and involvement, and holding to account, and these will be included in the workplan for 2013/14.

PA asked whether there was any evidence that staff are working elsewhere whilst on sick leave from the Trust. JC responded that there is an inherent risk that this is possible; however, there are robust checks in place both locally and nationally to mitigate the risk.

It was RESOLVED to RECEIVE the counter fraud annual report for 2012/13.

AC/13/51 Process to review the Assurance Framework 2013/14 (agenda item 10)

The paper outlining the process was noted. PA asked what work had been done across BDUs to share and learn in relation to governance. All BDUs have governance groups and this is high on the agenda for all groups along with the work undertaken by Practice Governance Coaches.

AC/13/52 Audit Committee self-assessment – areas identified for development (agenda item 11)

The paper was noted. In terms of training, both KPMG and Deloitte offer training for Audit Committees, which would be outside of their regular contracts and could be tailored to the Committee's needs; however, this type of training is usually facilitated by the organisation and there may be an opportunity to adopt a more pro-active approach to taking up training by Committee members. IB commented that there is merit in differences in expertise and approach on the Committee as long as the Chair has the relevant expertise, training and induction.

The issues raised in the self-assessment were noted and PA will resolve appropriately with Committee members.

Action: Peter Aspinall

AC/13/53 Triangulation of risk, performance and governance (agenda item 12)

The report was noted by the Committee. AF confirmed that the risk register is reviewed monthly by the Executive Management Team and quarterly by Trust Board. This provides an opportunity to review whether risks are up-to-date, to identify any other risks as necessary and to escalate any risks from BDUs, Trust Board committees, etc.

AC/13/54 Internal audit progress report (agenda item 13)

Five reports were completed and presented to the Committee. Of these:

- two reports in relation to clinical leadership and self-directed support were advisory and no opinion was given; and
- one report on local authority partners received substantial assurance with four low level recommendations and action rests with TB and Karen Taylor.

<u>Clinical record keeping (data quality)</u>

Limited assurance was given following this audit. Six recommendations were made (three high risk, two medium and one low). TB commented that the Data Quality Steering Group will work with BDU Directors to implement and monitor action plans. An immediate reminder of processes and reinforcement of standards has been issued to staff. JF asked if the Trust has asked staff why they are not complying in this area. TB responded that staff know what is required but record keeping is not always done in the right way, in sufficient detail or to high enough standards. AF added that this has a direct impact on currency development in terms of development of clusters (a description of what the Trust provides) and related clinical standards. The Trust is working with teams with dedicated clinical leads and Practice Governance Coaches to provide professional leadership and management.

AF also clarified that recommendation 2 (documentation on RiO) relates to prioritisation of documentation on RiO and assured the Committee that the date for completion is March 2014. CP added that progress reviews of all areas of data quality will demonstrate progress during 2013/14 to provide assurance to the Committee along with a wider review of data quality. IB was concerned that the Trust is not moving sufficiently quickly to demonstrate progress, particularly if this impacts on other outcomes, such as the Head of Internal Audit Opinion, with no contingency if there is no improvement.

BF was not surprised at the outcome of the audit as it has been a prevailing issue for the Trust and he sees the ability of the Trust to shift the internal audit opinion as minimal. AF responded that the approach is now different in that it is very much about good clinical practice and what is expected of staff rather than a tick-box exercise based on a bureaucratic system. It is also being addressed at team level with targeted support for services. BF asked what HR support or mechanisms are in place to prompt consequences for staff actions. AF responded that this was another area under development. JF asked whether the issue also relates to the degree of skill level in the use of IT and suggested it should be raised in parallel with other actions.

PA commented on the gravity of the task facing the Trust and asked whether the Committee was content with the management response. TCu provided some assurance that KPMG realises some actions are longer-term and out of the scope of the data quality review; therefore, KPMG will review progress with this in mind. It was agreed that a follow up report would be made to the Committee in January/February next year.

Action: Alex Farrell/KPMG

Investigation into a suspected breach of standing orders

The review found that there was no definitive evidence that standing orders and procurement procedures had been breached; however, it is apparent that they have been misinterpreted by senior staff who, if they had checked and clarified their assumptions, should have taken different actions.

AF commented that the outcome of the audit has raised awareness of both procurement and estates teams of performance standards pertaining to both and the expectations of staff in fulfilling their roles. There is an expectation, therefore, that this would not re-occur.

IB commented that there is a fine line between a breach and misinterpretation, and this is KPMG's judgement. CP responded that it is difficult to pin a breach down to the wording of the standing orders, therefore, KPMG's judgement is that it is a misinterpretation. BF commented that this raises a further issue of whether the work was delivered satisfactorily and offered value for money and he asked whether the Trust needed an independent assessment of the work undertaken. AF responded that verbal assurance in this regard had been provided by the Head of Estates.

PA asked how the Trust intends to address a failing at such a high level. AF responded that the matter has been discussed with the Director of Human Resources and seen as a misinterpretation. If it happened again, it would be a matter for disciplinary action.

IB asked whether there were other policies open to misinterpretation, how the Trust would know and should other policies be reviewed. PA responded that, as staff are expected to work to professional standards and to use their professional judgement, there should be no need to review other policies. IB concurred but added that he would not be able to accept another finding of misinterpretation. PA asked what the Trust's approach would be if professional standards were at odds with organisational policies. AF agreed to take this back to the Executive Management Team for further discussion.

Action: Alex Farrell

BF commented that he still did not understand how a policy could be misinterpreted or misunderstood. He remained uncomfortable with the way the money was spent and he would like to see an independent view of the work actually undertaken. This was considered to be outside of the remit of the Committee.

The concerns of the Committee were noted by KPMG and the Trust.

The follow up report was noted. AF assured the Committee follow-up processes have been strengthened through the Executive Management Team as timescales seem to have slipped in the early months of 2013.

The Committee also noted the technical update. IB asked if the report was meant to inform discussion. CP responded that the report was intended to cover items issued between meetings and would usually be up-to-date items not retrospective. Items would be discussed if considered appropriate and if they had not been considered elsewhere by the Trust.

AC/13/55 Counter fraud progress report (agenda item 14)
This item was taken under item 9.

AC/13/56 External audit update (agenda item 15)
PH highlighted the following.

Charitable funds annual report and accounts 2012/13

- An unqualified opinion was issued on the charitable funds accounts for 2012/13. One recommendation was made in relation to clarity of compliance with any wishes of donors particularly where the intention is to place a retraction on the use of the funds. It was agreed that this would be implemented by 31 December 2013.
- He also pointed out a non-standard clause in the Letter of Representation (item 7) in relation to confirmation that the reserves identified as unrestricted within the financial statements are free from any restriction or expression of binding wish on the part of the donor.

'Raising the Bar' key issues

- Increased scrutiny and reporting of risk assessment.
- More robust assessment of Trust Board and Audit Committees effectiveness.
- Improvements to audit reporting.
- Changes to the definition of a going concern. In relation to this, IB asked whether there is any threat to the Trust's going concern basis in respect of pensions. PH responded that there is no change to pension rules on the horizon and the Trust would be unlikely to remove itself from the NHS pension scheme in any case.

Key performance indicators

- The Committee noted the self-assessment against key performance indicators.

AC/13/57 Procurement report (agenda item 16)
TCo took the Committee through his report. He agreed to report Creative Minds spend separately in future reports. BF commented that the report highlights the need for robust management of Creative Minds funding.

Action: Tony Cooper

A self-assessment against the NHS Standards of Procurement will be reported to the Committee in October 2013 with an action plan and timescales.

Action: Tony Cooper

PA asked about the waiver for the University of Huddersfield HEC tender for £42,000. This related to the development of an innovation scorecard, which the Trust is supporting, led by the Department of Health. AF agreed to provide more detail to the Chair of the Committee.

Action: Alex Farrell

AC/13/58 Losses and special payments report (agenda item 17)
The report was noted.

AC/13/59 Date of next meeting (agenda item 18)
The next meeting will be held on Tuesday 8 October 2013 at 14:00 in meeting room 1, Block 7, Fieldhead, Wakefield.

AC/13/60 Any other business (agenda item 19)
One item of other business was raised.

Present for this item were Peter Aspinall, Ian Black, Bernard Fee, Tim Cutler, Alex Farrell, Clare Partridge and Dawn Stephenson.

Investigation into a suspected breach of standing orders
The investigation by KPMG into a possible breach of standing orders identified that for one transaction tested there was insufficient evidence to support that key internal controls had been complied with.

As a result, an independent investigation was undertaken by the Trust and a review of the investigation findings and purchasing procedures by KPMG was commissioned by DS in her role as Company Secretary. KPMG will also review causal factors and underlying cultural issues. The report will be finalised and an action plan developed by the end of July 2013. At this stage, any decision regarding HR consequences will be taken.

BF commented that this appears to be a 'fudge'. If individuals have not followed policies and procedures, this is an HR issue and should be dealt with as such. However, it is difficult to come to a conclusion or comment when the Committee has not seen the report.

IB asked why the Senior Independent Director had not been involved. AF responded that the matter had been discussed with the Accounting Officer and agreed the review should be commissioned by a member of the Executive Management Team. Given the independence of the Company Secretary role, DS was asked to commission the review.

The Committee noted that an independent review had been commissioned and a copy of the full report and action plan would be presented to the Committee in October 2013.

Minutes of Clinical Governance and Clinical Safety Committee held on 17 June 2013

Present:	Bernard Fee	Non-Executive Director (Chair)
	Helen Wollaston	Deputy Chair of the Trust
	Nisreen Booya	Medical Director
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Alan Davis	Director of Human Resources and Workforce Development
Apologies:	Julie Fox	Non-Executive Director
	Dawn Stephenson	Director of Corporate Development
In attendance:	Bernie Cherriman-Sykes	Integrated Governance Manager (author)
	Karen Holland	Assistant Director, Compliance
	Praveen Thyarappa	Consultant, Wakefield Crisis Service

CG/13/42 Welcome, introduction and apologies (agenda item 1)

The Chair of the Committee (BF) welcomed everyone to the meeting. The apologies were noted. He thanked Karen Batty and Tim Breedon (TB) for the work on the Quality Accounts over the past year, particularly in light of the positive comments made by Deloitte at the Audit Committee and in its formal report.

CG/13/43 Minutes of the previous meetings held on 16 April and 7 May 2013 (agenda item 2)

It was RESOLVED to APPROVE the minutes of the Clinical Governance and Clinical Safety Committee meetings held on 16 April and 7 May 2013.

CG/13/44 Matters arising (agenda item 3)

There were three matters arising from the meeting on 16 April 2013.

CG/12/34 Update on progress to devolve pharmacy services to BDUs (item 3.1)

TB reported that a framework for devolution of pharmacy services to BDUs has been developed. Sean Rayner is the lead BDU Director and will be taking forward with Sarah Hudson following a review of timescales. It was agreed to circulate the timeline to the Committee (with the minutes if available).

Action: Tim Breedon

CG/13/12 Safeguarding adults final action plan from internal audit (item 3.2)

The final action plan will be presented to the Committee at the next meeting.

Action: Tim Breedon

CG/13/26 Confirmation of timescales for emergency arrangements and timing of repeat health and safety audit by KPMG (item 3.3)

Alan Davis (AGD) reported on the externally facilitated test of the emergency planning system on 5 June 2013. A report and learning points from the process is in development and will be presented to the next meeting.

Action: Alan Davis

There will be a further exercise later in the year around the Trust's decant facility.

In terms of health and safety, the structure has been reviewed and revised into one Trust-wide structure. The health and safety annual report and annual plan require further work. BF suggested circulating a summary of key objectives, risks and activity to the Committee.

Action: Alan Davis

KPMG will build a re-audit of health and safety and audit of emergency planning into its work plan for 2013/14.

AC/13/18 Addition to Committee terms of reference and work programme (item 3.4)
The Committee agreed to refer specifically to the Quality Improvement Strategy under its objectives to approve relevant strategies and to monitor implementation of significant and relevant strategic developments.

CG/13/45 Francis report – Trust action plan (agenda item 4)

TB reminded the Committee that, wherever possible, any actions identified would be embedded into existing organisational development and improvement plans. Any specific action over and above this would be addressed in a measured and proportionate way. Karen Holland (KH) took the Committee through the paper and the key issues raised through the staff workshops and self-assessment against the recommendations.

The Committee accepted the report and acknowledged the hard work that had gone into the review process undertaken to date and the further work required to respond to the issues raised in response to the recommendations. However, the Committee felt that the report raised a number of questions over and above those specifically covered in the response, such as the role of senior clinicians, training and staff confidence in raising and reporting concerns. Helen Wollaston (HW) commented that some views expressed were not reflected or addressed through the responses in the action plan. It was agreed that these were covered at various points on the agenda and the Committee should review in this context at the end of the meeting.

CG/13/46 Winterbourne View action plan (agenda item 5)

TB reported that the Deloitte report, "Impact of Winterbourne", had been reviewed and the Trust is satisfied that the key issues raised have been picked up in the Trust's response and action plan. An updated action plan is to be circulated to the Committee.

Action: Tim Breedon

The Trust's approach will be part of the learning disabilities transformation service plan, with specific reference to the development of a robust consultancy and advice offer.

CG/13/47 Quality Accounts 2012/13, quality priorities for 2013/14 and development of the Quality Accounts for 2013/14 (agenda item 6)

The full Quality Accounts for 2012/13 was included in the papers to ensure the Committee had sight of the final document. Lessons learned from this year's process will inform the approach for 2013/14. A plan will come to the next meeting,

including communications and engagement with stakeholders, the Members' Council and Deloitte.

Action: Tim Breedon

BF commented that priority 1, listening and acting on patient feedback, is a key priority for 2013/14 and the Trust needs to accelerate action in this respect.

TB commented on two developments in 2013:

- aligning the quality priorities to quarterly performance reporting to Trust Board; and
- development of a more accessible summary of the Quality Report for launch later in the year.

HW asked how the Trust responds to the issues raised by stakeholders on the Quality Accounts. TB responded that the Trust will talk to all responders in terms of the comments made and continue dialogue with stakeholders throughout 2013/14.

BF also asked that there is a planned succession for management of the Quality Accounts process and development of the report.

It was agreed this should remain as a standing item on the Committee's agenda in terms of process, governance and progress against priorities.

Action: Tim Breedon

CG/13/48 Serious incidents report Q4 2012/13 (agenda item 7)

TB reported that the serious incidents annual report for 2012/13 will be presented to Trust Board on 25 June 2013. Two issues were raised.

- The external review in Barnsley is complete and the report signed off under delegated authority from Trust Board. An action plan has been developed as appropriate.
- BF commented that the bed sore incident in Barnsley was a cause for concern. This was noted and Nisreen Booya (NHB) responded that the Trust needs to understand where the sores originated and respond appropriately.

CG/13/49 Health and safety annual report 2012/13 and annual plan 2013/14 (agenda item 8)

See agenda item 3.3

CG/13/50 Sub-groups (agenda item 9)

The following issues were highlighted.

Incident review sub-committee

- BDUs are responding well to the reporting on implementation of action plans as a result of incidents and attendance at meetings has improved. Non-Executive Director attendance is welcome at the sub-committee rather than the reference

group. There will be a further review of arrangements in February 2014 in terms of providing assurance to the Committee.

Action: Tim Breedon/Nisreen Booya

Drugs and therapeutics

- The terms of reference and membership of the Drugs and Therapeutics TAG will be reviewed in August 2013.

Health and safety

- AGD reported on three ongoing issues in relation to the Health and Safety TAG.
  - Multi-occupancy buildings.
  - Ensuring policies reflect the Trust's management structure and accountability.
  - Sharps policy and approach.

Infection prevention and control

- TB reported that staff pressures in the infection prevention and control team have largely been resolved with a successful recruitment process completed. BF asked whether the Trust needed to review its approach in this area to make it more visible to visitors and staff (along the same lines as the approach adopted by acute trusts). TB agreed this would be considered.

Action: Tim Breedon

Managing aggression and violence

- TB reported that a model has been developed to provide support and advice to staff in care homes to ensure a safe environment. This has been done without compromising the Trust's position.

CG/13/51 Quality improvement (agenda item 10)

CG/13/51a Quality Improvement Strategy (item 10.1)

TB explained that the paper provides a framework for the Strategy and the key criteria for inclusion in the Strategy. It will be important for the Strategy to link to quality priorities and the Quality Accounts, and that any reference to quality aligns with the Trust's framework. The Strategy will come back to the Committee in due course.

Action: Tim Breedon

CG/13/51b Quality Impact Assessment – monitoring of the impact of CIPs on quality and safety of services (item 10.2)

The report was noted. HW commented that the Trust needs to be clear at what point it would not implement a cost improvement following an assessment. It was agreed that the Committee needs assurance of the pressure points in the organisation in relation to CIPs and cost pressures. HW suggested also identifying areas where CIPs are rated 'good' and 'excellent'. It was agreed this should be a standing item on the Committee's agenda, particularly as the Trust moves into the transformational service change programme.

Action: Tim Breedon

CG/13/51c Unannounced visits (item 10.3)

The report on the unannounced visits programme for 2013/14 was noted. HW fed back from the pilot community visit earlier that day.

CG/13/52 CQUIN achievement 2012/13 and forecast 2013/14 (agenda item 11)

AGD asked the Committee to note that, of the £4.6 million CQUIN in 2013/14, £2.8 million is rated green and £1.8 million is linked to schemes that fall within the amber category. The initial risk assessment assesses a risk of non-achievement of £900,000. The Committee accepted this was a financial assessment of CQUINs and of as much relevance is the intention of the targets in terms of improving quality and/or effectiveness and efficiency, and why the CQUINs were suggested, negotiated and accepted by the Trust.

CG/13/53 Suicide audit – action plan arising from the findings of the presentation in April 2013 (agenda item 12)

The action plan was noted.

CG/13/54 Professional and managerial interface between health visiting and safeguarding services in Barnsley (agenda item 13)

The report from TB was noted.

CG/13/55 NICE guidance update (agenda item 14)

KH updated on the Trust's approach and required reporting and assurance by clinical commissioning groups.

CG/13/56 Annual reports (agenda item 15)

CG/13/56a Research and development annual report 2012/13 (item 15.1)

The annual report was noted.

CG/13/56b Drugs and therapeutic TAG annual report November 2011 to October 2012 (item 15.2)

The annual report was noted.

CG/13/57 Clinical audit and practice effectiveness plan 2013/14 (agenda item 16)

The Committee supported the plan for 2013/14 and noted that the discussion document will inform an update of the priorities.

CG/13/58 Any risks not previously covered (agenda item 17)

CQC whistleblowing and bed pressures

The Trust sent its response to the CQC last Friday as requested and a meeting took place on 17 June 2013 where the responses were reviewed. The CQC considers the Trust has taken a reasonable approach; however, two key issues remain.

- A policy of 'no admission without a bed' would cause major issues for the Trust. The CQC is clear on the Trust's position and that this situation could happen again.

- Of concern is how the Trust got into the position where no beds were available.

The CQC will review the Trust's response and action plan in more detail and with the Regional Director. The CQC will then respond to the Trust and outline any action it expects the Trust to take.

CG/13/59 Issues to bring to the attention of Trust Board (agenda item 18)
KH raised one issue in relation to a change to the Trust's Statement of Purpose to inform its registration with the CQC in relation to an additional activity to cover midwifery as a result of the Family Nurse Partnership service in Barnsley

CG/13/60 Date of next meeting (agenda item 19)
The next meeting will be held on Tuesday 10 September 2013 at 14:00 in meeting room 1, Fieldhead, Wakefield.

Minutes of Clinical Governance and Clinical Safety Committee held on 10 September 2013

Present:	Julie Fox	Non-Executive Director
	Helen Wollaston	Deputy Chair of the Trust (Chair)
	Nisreen Booya	Medical Director
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Dawn Stephenson	Director of Corporate Development
Apologies:	Bernard Fee	Non-Executive Director
	Alan Davis	Director of Human Resources and Workforce Development
In attendance:	Martin Brandon	Head of Security and Emergency Resilience (for Alan Davis)
	Bernie Cherriman-Sykes	Integrated Governance Manager (author)
	Karen Holland	Assistant Director, Compliance
	Mary McSharry	Practice Governance Coach (forensic services)
	Anne Rolfe	Compliance Manager

CG/13/61 Welcome, introduction and apologies (agenda item 1)

Following a review of committee membership and chairing arrangements by the Chair of the Trust, Helen Wollaston (HW) has taken over as Chair of this Committee from Bernard Fee (BF). She welcomed everyone to the meeting and the apologies were noted.

CG/13/62 Minutes of the previous meeting held on 17 June 2013 (agenda item 2)

It was RESOLVED to APPROVE the minutes of the meeting held on 17 June 2013.

CG/13/63 Matters arising (agenda item 3)

There were five matters arising.

CG/12/34 Update on progress to devolve pharmacy services to BDUs (item 3.1)

Tim Breedon (TB) reported that Lynn Haygarth has retired from the Trust and Sarah Hudson is acting Chief Pharmacist pending a formal appointment; therefore the process had been delayed due to the staff changes. A job description for the Chief Pharmacist will include leading the transformation of the pharmacy service as agreed previously and a further update will be provided to the Committee at either the November 2013 or February 2014 meeting.

Action: Tim Breedon

CG/12/53 Stronger Families project update (item 3.2)

TB provided an update on the project on behalf of Sean Rayner.

CG/13/46 Winterbourne View action plan (item 3.3)

TB agreed to circulate the final version of the action plan to the Committee. He provided assurance that the Trust has reviewed the report and the implications for the Trust.

Action: Tim Breedon

AC/13/50 Approach to infection prevention and control (item 3.4)
Taken under agenda item 14.

AC/13/59 Trust Statement of Purpose
Karen Holland (KH) confirmed that the Care Quality Commission (CQC) has approved the Trust's application to amend its registration to include maternity and midwifery services.

CG/13/64 Impact of cost improvement programme 2013/14 (agenda item 4)
TB outlined the process for BDU cost improvement programme quality impact assessment review. When complete, it will be reviewed cross-Trust by TB, Nisreen Booya (NHB) and Alan Davis (AGD) and any issues identified and raised with the Executive Management Team (EMT).

Julie Fox (JF) urged caution that the system/process is not too bureaucratic and suggested this should be part of the cost improvement programme process rather than running two separate processes. She also questioned the rating descriptions as these do not seem to adequately describe what the reviews are seeking to achieve.

HW asked what would happen if a cost improvement is poor or weak. TB responded that the initial assessment is taken into EMT to decide whether the cost improvement should go ahead. Those assessed as poor or weak on review would be taken into EMT for discussion. If the risk cannot be mitigated, then an alternative cost improvement would be identified.

It was agreed that a summary/overview would come to Committee in November 2013 with identification of areas where cost improvements were identified as poor/weak, any that may need to be re-visited because of unintended negative impact on quality, and what action will be taken for the Committee to provide assurance to Trust Board, linked to Trust Board performance reports and triangulation with other sources of information.

Action: Tim Breedon

The Committee will also discuss key lines of enquiry in relation to cost improvements in 2014/15 at the February 2014 meeting.

Action: Tim Breedon

CG/13/65 Quality Accounts 2013/14 (agenda item 5)
The plan and summary progress against quality priorities were noted by the Committee. A paper on the serious harm and death mandated indicator will be presented to Trust Board on 24 September 2013. TB confirmed that the proposal will be to align Trust reporting arrangements with national reporting arrangements, which will support benchmarking with other organisations and the Trust's duty of candour.

CG/13/66 Serious incidents update (agenda item 6)

TB reported that there have been 31 serious incidents across the Trust. Nine of these relate to pressure ulcers, which the Trust was not previously required to report as a serious incident. Changes to information governance incidents the Trust is required to report and reporting of incidents where an individual had contact with Trust services in the last twelve months (as opposed to six as previously) has also affected the numbers reported. Without the pressure ulcer incidents, the figure would be broadly in line with 2012/13.

TB confirmed that a report has been commissioned on the numbers of pressure ulcers reported against previous years and whether these are attributable to the Trust or not. He agreed to bring a summary of this report to the next Committee, which would include information on thresholds for reporting and how these have changed.

Action: Tim Breedon

CG/13/67 Health and safety annual report 2012/13 and annual plan 2013/14 (agenda item 7)

Martin Brandon (MB) presented this item on behalf of AGD. NHB asked if there were any aspects of policy implementation that are audited. MB responded that there is a Trust-wide audit schedule in place and will be included in the health and safety monitoring tool, which will be developed to include learning lessons. JF suggested including two/three important policies in the unannounced visits programme to monitor policy implementation.

JF expressed a concern about the level of managing aggression and violence (MAV) incidents and commented that she would like to see action included in the action plan or an explanation included in the narrative as to why incidents have increased. MB was asked to ensure the comments made by the Committee were taken back to the MAV TAG for further discussion. TB suggested that the Committee needs to understand where the data will be reviewed and action agreed and then receive feedback, particularly in relation to MAV, at the next meeting.

Action: Tim Breedon/Martin Brandon

CG/13/68 Sub-groups (agenda item 8)

The following issues were highlighted.

Incident review sub-committee

TB highlighted the following.

- The introduction of a bed management protocol and governance in relation to reporting.
- The move from 60-day incident reporting to 45 days, which clinical commissioning groups (CCGs) are re-considering as other areas appear to be retaining 60 days.
- BDU serious incidents investigation processes are under development and beginning to mature. There will be a report into the Clinical Reference Group at the end of October 2013.

Drugs and therapeutics

NHB highlighted the following.

- A review of the Drugs and Therapeutic TAG has taken place resulting in a smaller membership, a clearer remit and fewer sub-groups with clearer terms of reference.
- Policy and procedure development sits with the Quality Academy but implementation and management sits within BDUs. Pharmacy will be part of the clinical/managerial partnership within BDUs.

Health and safety

No issues were raised although JF raised a concern regarding the cancellation of the Steering Group meeting and, therefore, the length of time between meetings. [*It should be noted that the meeting has been re-scheduled for 14 October 2013.]*

Infection prevention and control

No issues were raised.

Safeguarding sub-committee

Terms of reference have been established for the overarching Safeguarding sub-committee, which covers both vulnerable adults and children, and ways of working with other safeguarding bodies agreed. An outline work programme will be developed.

Managing aggression and violence

No issues were raised.

CG/13/69 Care Quality Commission visits (agenda item 9)

The CQC has visited the Dales, Newton Lodge, the Bretton Centre and Trinity 2. This set of visits has been more focused and reviewed six standards. Informal feedback raised two issues in relation to practice around seclusion, timespans and recording, and the timescales for refurbishment of seclusions facilities. Further information was provided to the CQC, including a revised timetable for the refurbishment programme. The Trust has asked the CQC for a view on whether this is now acceptable. A risk of a compliance action in relation to practice within seclusion units remains. The Trust meets with the CQC on 20 September 2013 and a formal response is unlikely before. The Committee was concerned at the length of time it has taken to address the issues around seclusion units when these were first raised back in 2011. The Committee asked that the work is expedited as quickly as possible.

Action: Alan Davis

The CQC has also clarified that it should be given access to the RiO system, whether under a generic login or under that of a member of staff (despite the issues around information governance raised by the Trust). Staff need to be aware that the Trust's approach is to enable access for CQC staff and this may or may not be with Trust staff present during the access period.

CG/13/70 Trust unannounced visits (agenda item 10)

Update on outcome of repeat unannounced visits

Two out of the four planned visits took place in Castle Lodge, where significant progress has been made, although there was some concern around a ligature risk in the refurbished bathrooms, and Ward 19, Priestley Unit. Concerns remain around Ward 19 and the feedback from the visit will help inform the review of the unit, which has begun.

Pilot community visits

KH will develop a viable proposal for a fuller programme in 2014.

Action: Karen Holland

Planning the next visits programme

The Committee was of the view that there is a perception that the process has become too bureaucratic whereas the repeat visits have been more spontaneous, open and transparent. KH responded that the visits were specifically focused on CQC regulation outcomes and the 15 Steps programme might be more appropriate for Non-Executive Directors and the Members' Council. TB commented that the programme was introduced at a point in time and it might be a good time to re-focus on culture. HW suggested that the quality priorities should be the focus. NHB suggested tailoring the programme to different units and areas and setting up a group to undertake a fundamental review, based on evaluation of previous visits. It was agreed this could be a way forward; however, it would have an impact on the proposed round of visits in November 2013. The group could consider whether to retain this round of visits but with a revised focus to use as a test for a revised approach in May 2014.

Action: Tim Breedon/Karen Holland

CG/13/71 Safeguarding adults action plan from internal audit (agenda item 11)

TB apologised that the report was not available for the Committee. He will ensure it is circulated as soon as possible and it was agreed the item could be closed.

Action: Tim Breedon

CG/13/72 Self-assessment against the MIND report on prone restraint (agenda item 12)

Revised NICE guidance on restraint is anticipated in 2014. In the meantime, the MAV TAG will review the approach outlined in the MIND report and agree a Trust position on application, including visiting areas of best practice identified by MIND. A report will come back to the Committee in November 2013.

Action: Tim Breedon

CG/13/73 Report and action plan from external review of emergency planning (agenda item 13)

MB outlined the outcome of the emergency planning exercise and further work required as a result of the exercise. An opinion of significant assurance had been given. JF asked how this provided assurance in relation to other buildings. MB

responded that there is a review currently of other buildings within BDUs, the policies and plans that support emergency arrangements and identification of a number of areas where plans will be tested. The Trust will also have to consider guidance from NHS England, which is due in the next 18 months.

CG/13/74 Infection prevention and control annual work programme (agenda item 14)
The annual work programme was noted.

CG/13/75 NICE annual report 2012/13 (agenda item 15)
The annual report was noted.

CG/13/76 Information governance 2013/14 update (agenda item 16)
HW asked for clarification on what the 42% score represents. The remainder of the report was noted.

Action: Tim Breedon to raise with Alex Farrell

CG/13/77 Any risks not previously covered (agenda item 17)
Staffing levels
TB reported on the focus on staffing levels across different services as a result of recommendations arising from national reports, such as the Francis Report. Work has begun to come to an 'as is' position on in-patient staffing levels, benchmarked internally, triangulated with serious incidents, etc. Agreement would then be sought on an optimum position and how the Trust will meet this or a rationale for why not. A report will come back to this Committee and TB will advise on timing.

Action: Tim Breedon

Suicide levels
Suicides for mental health trusts will become a key issue in the coming year, probably via the CQC and the National Inspector of Hospitals inspection programme. The Trust will need to ensure it is ready for this.

CG/13/78 Issues to bring to the attention of Trust Board (agenda item 18)
The Committee agreed two issues in relation to assurance around serious incidents and the unannounced visits programme.

CG/13/79 Date of next meeting (agenda item 19)
The next meeting will be held on Tuesday 12 November 2013 at 14:00 in room 52, Ground Floor, Large Mill, Folly Hall, Huddersfield.

Minutes of the Mental Health Act Committee Meeting held on 6 August 2013

Present:	Julie Fox	Non-Executive Director
	Helen Wollaston	Non-Executive Director (Chair)
	Nisreen Booya	Medical Director
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Dawn Stephenson	Director of Corporate Development
In attendance:	Shirley Atkinson	Barnsley Council (for Kyra Ayre)
	Julie Carr	Mental Health Act/Mental Capacity Act Manager
	Sangeetha Chinnadurai	Consultant Psychiatrist, Wakefield
	Yvonne French	Assistant Director, Legal Services
	Paul Gillespie	Workforce Development (Wakefield) – local authority representative
	Antonis Lakidis	Associate Specialist, Calderdale
	Sarah Millar	PA to Director of Forensic Services (author)
	Ian Priddey	Professional Lead and Development Co-ordinator (Mental Health) (Calderdale) – local authority representative
	Vinod Shukla	Associate Specialist, Kirklees
	Jane Smith	General Manager, Learning Disability Services
	Praveen Thyarappa	Specialist Registrar, Calderdale
Apologies:	**Members**	
	Jonathan Jones	Non-Executive Director
	Attendees	
	Kyra Ayre	Acting Head of Service, Mental Health and Assessment and Care Management (Barnsley) – local authority representative
	Craig Limbert	AMHP Manager (Kirklees) – local authority representative
	Geoff Naylor	Independent Associate Hospital Manager
	June Stokes	Independent Associate Hospital Manager

MHAC/13/21 Welcome, introduction and apologies (agenda item 1)

Helen Wollaston (HW) welcomed everyone to the meeting and the apologies, as above, were noted.

MHAC/13/22 Compliance and Assurance Pathway Presentation (agenda item 2)

Vinod Shukla (VS) presented two case studies in older people's services. A discussion on the use of the Mental Health Act and Mental Capacity Act followed. Jane Smith (JS) spoke about issues in relation to capacity and capacity to consent to treatment in learning disability services. The Committee also noted the concern that use of the Mental Health Act for older people with dementia is a risk if used for expediency when the Mental Capacity Act might be more appropriate.

MHAC/13/23 Legal update (agenda item 3)

The Committee was notified of the following issues.

- A consultation on a proposal to amend the Tribunal Procedure to make medical examinations relating to treatment orders discretionary prior to Tribunal hearings.
- Ethnicity is not a predictor of detention under the Mental Health Act.
- A briefing on use of restraint in relation to Radcliffe le Brasseur briefing 197. Tim Breedon (TB) advised that the Managing Aggression and Violence TAG is

leading on a Trust-wide review of restraint practices and will report back to the Clinical Governance and Clinical Safety Committee. It was noted that the current policy and procedure is compliant with guidelines but is due for review.

- A briefing on how long a patient can be held in police custody under Section 136 MHA (Radcliffe le Brasseur briefing 194). It was noted that, as the Trust has Section 136 suites, this is unlikely to affect the Trust; however, staff need to be aware of potential issues.

MHAC/13/24 Minutes from the previous meeting held on 7 May 2013 (agenda item 4)
It was RESOLVED to APPROVE the minutes from the meeting held on 7 May 2013.

MHAC/13/25 Matters arising from previous meeting (agenda item 5)
There were seven matters arising.

MHAC/12/29a Advocacy Services
It was noted that the Trust needs to be able to alert commissioners to any concerns arising about advocacy provision to service users and this will be raised with District Service Directors. Written feedback from dialogue groups held in June/July will be provided to the next meeting.

Action: Dawn Stephenson

MHAC/13/04 Ethnicity monitoring
It is unclear if a solution has been found in relation to ethnicity monitoring on RiO. This will be taken forward and brought back to the Committee once resolved.

Action: Tim Breedon

MHAC/13/06 Tribunal Services – Estates Strategy
TB confirmed that this has been added to the Estates Strategy.

MHAC/13/13 Yorkshire Ambulance Service
The protocol in relation to the Yorkshire Ambulance Service needs to be reviewed. TB and Nisreen Booya (NHB) have tried unsuccessfully to arrange a meeting with the ambulance service. Ian Priddey (IP) reported attending a recent meeting with the ambulance and police services. It was not clear where the driver for this forum had come from but Trust representatives had not been invited. IP advised that the meeting was useful and well attended. It was agreed that the ambulance service where appropriate, not the police, should provide the initial conveyance to a place of safety. A follow up meeting is being arranged, which TB or NHB will attend.

Action: Tim Breedon/Nisreen Booya

TB will disseminate the current Trust protocol for information.

Action: Tim Breedon

It was agreed to keep this item on the Committee agenda to monitor progress.

Action: Bernie Cherriman-Sykes

MHAC/13/15 CQC MHA/MCA annual report
This is being picked up by the Practice Governance Coaches.

MHAC/13/13 Section 17 leave
TB plans to meet with District Directors next week in relation to the recording of Section 17 leave. This has also been raised at Performance EMT and Julie Carr (JC) recently presented at a JAPS meeting. Yvonne French (YF) advised that information on completion of paperwork will be available on the Trust intranet.

MHAC/13/16 Intercom Ashdale
The Committee has been advised that there is an intercom at the main entrance to the Dales and a doorbell to access Ashdale.

MHAC/13/26 Audit and Compliance Reports (agenda item 6)
Section 132 patients' rights
JC reported variable practice in relation to Section 132 and a need to address training. Work is ongoing to add a reiteration of rights to the system. A review of Trust policy was also suggested. The Committee agreed that this should remain on the audit work programme for the next year in order to monitor any improvement. HW suggested spot checks should be done to ensure patients are being correctly advised and paperwork is in order.

It was agreed that a regular message needs to be filtered through BDUs in relation to recording and this will link to the clinical record keeping work.

HW will suggest to the Chair of the Audit Committee that this is included in next year's internal audit programme

Action: Helen Wollaston

Section 58 (consent to treatment)
The Committee noted that 83 records were audited and several records were incorrect, out-of-date or incomplete. It was reported that there are several measures being put in place to improve the system including the use of different coloured cards for patients requiring consent to treatment.

MHAC/13/27 Care Quality Commission Visits (agenda item 7)
Willow Ward – received 15 April 2013
JC updated that all outstanding actions have been completed.

Lyndhurst – received 16 May 2013
JC updated that all outstanding actions have been completed.

Newhaven – received 29 May 2013
There was no update to report although it was noted that some outstanding actions remain in timescale. Julie Fox (JF) suggested writing to the relevant manager on behalf of the Committee expressing concern that an update has not been received and bring forward to the next meeting.

Action: Yvonne French

Beamshaw – received 31 May 2013
It was noted that all actions are to be completed by September and an update will be brought to the November meeting.

Action: Yvonne French

Priestley Ward (Newton Lodge) – received 3 July
No update has been received although the majority of outstanding actions are due to be completed by December.

TB advised that the Trust had received a letter from the CQC on 2 August requesting a progress report on the planned seclusion room upgrades. CQC has requested information relating to the Trust Plans to upgrade the seclusion rooms on Trinity 1 and ward 18 by 13 August and TB assured the Committee that the deadline would be met. TB further assured the Committee that there is a clear plan to resolve all seclusion room issues and the only concern raised is around pace. It was agreed that once the report is received, the Executive Management Team will discuss whether the work can be expedited. TB will forward the report to HW and JF once submitted.

Action: Tim Breedon

MHAC/13/28 Monitoring Information (agenda item 8)
Paper 1 – Ethnicity Monitoring Annual report 2012/13 (Trust-wide and by locality)
Dawn Stephenson (DS) suggested adding an extra column to the monitoring spreadsheet as it is not clear, for example, what percentage of service users are white British.

Action: Yvonne French

Paper 1 – Ethnicity Monitoring Annual report 2011/12-2012/13 (Trust-wide and by locality)
It was noted that population figures have changed for this year.

Paper 1-Paper 8 monitoring information Trust wide April to June 2013
The Committee considered the Quarter 1 figures and it was noted that there was an increase in external transfers, particularly specialist female PICU. It was agreed that this would be checked at Quarter 2 to monitor any themes. This may also prompt discussions with Commissioners in relation to services the Trust does not currently provide. YF will provide a one-sheet overview for the next meeting with all transfers from the last year.

Action: Yvonne French

It was noted that Kirklees has recorded a total of nine cancelled appeals in Quarter 1. NHB will consider the activity data.

Action: Nisreen Booya

YF added that eight appeals had been cancelled in Wakefield in the last quarter due to unavailability of clinical staff, solicitors or Mental Health Act staff. It was noted that there are a number of factors affecting appeals including legal aid budgets being cut resulting in limited availability of solicitors. It was agreed that the main point is that

patients receive at least one review within each period of detention. This is being monitored by the MHA staff.

Action: Yvonne French

Local Authority Monitoring Information

Paul Gillespie (PG) noted a high number of requests for assessment in Calderdale/Kirklees in Quarter 1. NHB suggested that there are different interpretations of urgent and crisis cases in Barnsley and Calderdale, where there is better continuity of care for patients than in Kirklees and Wakefield. HW asked TB and NHB to use the data provided to begin conversations with Kirklees and Wakefield to address this.

Action: Tim Breedon/Nisreen Booya

MHAC/13/29 Matters Arising (agenda item 9)

Hospital Managers Forum Notes – 23 May 2013

Minutes of the meeting held on 23 May were received and noted.

Travelling expenses – Hospital Managers

YF advised the Committee that Hospital Managers travelling expenses have changed to reflect NHS mileage to 67p per mile for the first 3,500 miles.

Local Authority update

There were no issues raised from Wakefield.

IP updated that it was unclear how many people eligible to use the advocacy service were actually using it. It was noted that although the Trust's service users use the service, it is contracted by Commissioners and the Trust has little input and no data available.

Section 136 MHA update

It was noted that the Section 136 update had been covered earlier in the agenda. TB will bring an update paper to the next Committee. TB also asked for an update on the utilisation of 136 suites at the next meeting.

Action: Tim Breedon

MHAC/13/30 Any other business

NHB queried if there is an overarching professional body for AMHPs that enshrines the code of conduct. PG responded that local authorities are responsible for approving AMHPs and carry a vicarious liability. Any issues should be reported in the first instance to the relevant local authority, which would then refer to the regulatory body if necessary.

MHAC/13/31 Date of next meeting

The next meeting will be held on Wednesday 6 November from 13:00 to 15:30 in Training Room 3, Learning and Development Centre, Fieldhead, Wakefield.

HW informed the Committee that JF would be taking over as Chair of the Committee from November.

Minutes of the Remuneration and Terms of Service Committee held on 16 July 2013

Present:	Ian Black	Chair of the Trust (Chair)
	Helen Wollaston	Deputy Chair of the Trust
	Steven Michael	Chief Executive (by telephone for items 2, 3, 4 (part) and 8)
Apologies:	Jonathan Jones	Non-Executive Director
In attendance:	Alan Davis	Director of Human Resources and Workforce Development
	Bernie Cherriman-Sykes	Integrated Governance Manager

RTSC/13/37 Welcome, introduction and apologies (agenda item 1)
The Chair (IB) welcomed everyone to the meeting. The apology was noted; however, Jonathan Jones (JJ) had fed comments into the Chair directly on agenda item 5. It was also noted that the Chief Executive (SM) would be joining the meeting for items 4 and 8 by telephone.

RTSC/13/38 Minutes of the previous meeting held on 21 May 2013 (agenda item 2)
It was RESOLVED to APPROVE the minutes from the meeting held on 21 May 2013.

RTSC/13/39 Matters arising from previous meetings (agenda item 3)
There were no matters arising.

RTSC/13/40 Human resources exception reports (agenda item 4)
Sickness absence
Alan Davis (AGD) reported that sickness in April and May had reduced over 2012/13 although the trend is heading upwards. SM asked for the information in the Trust Board report on the forensic service to be split between medium and low secure given the excellent improvement in performance in the medium secure service.

Action: Alan Davis

Appraisal
Performance is nearing 90% but some areas will underperform at the end of June 2013. An 80% achievement is anticipated. AGD will provide an update to Trust Board on 23 July 2013 and provide an indication of when the 90% target will be achieved. IB indicated that he would be comfortable with the end of July 2013 but felt any later would not be acceptable to the Board.

Action: Alan Davis

AGD reported that general feedback on the new system has been positive. An electronic system will be developed during 2013/14 and, from 2014/15, staff incremental progression will be based on performance.

Wellbeing survey

The results from the wellbeing survey pilot were included in the report. It is anticipated that the survey will be repeated every six months and tailored to the Trust's needs in terms of questions to ask staff.

Steven Michael left the meeting at this point in the item.

IB asked for any further comments on the report.

Helen Wollaston (HW) commented on the variations in use of bank, agency and overtime. AGD responded that use of medical locums will distort BDU figures quite considerably; however, this should be addressed through recruitment, which is currently underway. Recruitment to medical posts is generally positive currently.

IB commented that, based on the current trajectory, the Trust was unlikely to achieve the 4% sickness absence target. He asked, therefore, what BDUs were planning to do to address this. It was agreed to provide a supplementary paper to Trust Board from BDUs on actions to address the shortfall.

Action: Alan Davis

Regarding the wellbeing survey, AGD reported that some areas had seen improvement; however, the overall response has moved to a more negative view from staff. HW was concerned that this should be the case. AGD responded that undertaking the survey on a regular basis will provide a good benchmark for indicators of wellbeing and continued engagement of staff. The Committee also suggested that a target should be set for the response rate. The Committee also commented that the bullying outcome was a cause for concern and should be monitored closely.

Action: Alan Davis

RTSC/13/41 Chief Executive salary review (agenda item 5)

It was RESOLVED to APPROVE the proposal regarding the Chief Executive's remuneration from 1 August 2013.

RTSC/13/42 2013/14 pay award (Directors) (agenda item 6)

Alan Davis left the meeting for this item.

IB and HW agreed the proposal was fair and reasonable. Therefore, **it was RESOLVED to APPROVE the proposal to award a 1% uplift to Directors' salaries and payscales in line with the national awards with effect from 1 April 2013.**

RTSC/13/43 Directors' performance related pay scheme 2013/14 (agenda item 7)

AGD explained the background and rationale for the proposals and outlined the proposed revisions, which offer more discretion and flexibility in terms of the gateway objectives, and place greater emphasis on individual performance. The proposals were considered in turn.

- The Committee agreed to continue with the concept of a performance related pay (PRP) scheme for Directors.
- The Committee agreed an overall maximum performance award for an individual of 10% of base salary.
- A maximum of 5% will be available for achievement of gateway targets and a maximum of 5% for achievement of personal objectives.
- There will be a control of 7.5% of the total Directors' paybill. This is a finite pot of money and only includes Directors within the scheme at 31 March 2014. If a Director joins the Directors team part-way through the year, the salary would be pro-rated for inclusion in the 'pot' and the individual's own allocation also pro-rated accordingly.
- The Committee supported the proposal to consider an award if all three gateway targets were not achieved (see below), which would place a greater emphasis on achievement of personal objectives. The comment from HW that Directors have a corporate responsibility and, therefore, individual performance cannot be acceptable without achievement of organisational objectives was noted in the discussion.

<u>Gateway objectives</u>

- The broad areas for gateway objectives were agreed as follows.
  - Effective financial management and planning.
  - Effective governance, maintaining compliance and service quality.
  - Service transformation.
- It was agreed to include an objective relating to staff management and leadership.
- It was agreed that the objectives should be linked strongly to outcomes.
- IB commented that the objectives proposed introduce a level of subjectivity and, therefore, may lead to partial achievement of a gateway objective. It was agreed a partial award could be made at the discretion of the Committee.

AGD was asked to clarify the gateway objectives based on the proposal in the paper and the comments made by the Committee.

<u>Action: Alan Davis</u>

<u>Payment of award</u>

After some discussion, the following was agreed.

- Achievement of one gateway objective would result in no payment for gateway objectives and no individual payment for personal objectives.
- Achievement of two gateway objectives would result in a 2% payment plus individual payment for personal objectives achieved to a maximum of 5% per Director, subject to a maximum of 4.5% of the overall Directors' playbill.
- Achievement of three gateway objectives would result in a 5% payment plus individual payment for personal objectives achieved to a maximum of 5% per Director, subject to a maximum 7.5% of the overall Directors' paybill.
- The award will be made to Directors employed by the Trust on 31 March 2014. Directors who resign before this date will not qualify, therefore, if a Director leaves before 31 March 2014, no award is made and this salary is not included in the 7.5% pot.

The rules of the scheme will be ratified at the next meeting. AGD was asked to circulate a formal proposal to the Committee in advance of the next meeting.

Action: Alan Davis

RTSC/13/44 Director-level structure (agenda item 8)

SM confirmed that Karen Taylor has assumed responsibility as District Director for Calderdale, Kirklees and Trust-wide specialist services, and Sean Rayner for Barnsley and Wakefield. Both are substantive appointments. The new arrangement offers a balanced perspective in terms of relationship management and provides a focus for locality-based performance management. Adrian Berry remains as Director of the Forensic BDU.

IB asked if there had been any negative feedback from commissioners. SM responded that he had informally contacted Chief Officers before the appointments and the response had been supportive.

IB also commented that, as geographical expansion has been re-established as a strategic objective, the Trust would need to look at where any services would be incorporated in the structure in future.

The next step is to ensure deputy director arrangements are in place. AGD commented that, for BDU Directors, their span of control and outward-facing focus means that operational management support is needed. A job description has been produced for the Deputy Director role with the intention to strengthen clinical leadership, ensure robust medical leadership is in place, embed Practice Governance Coaches, and provide a strong general management layer based on service lines. The current 'service level' management layer between general management and team/ward manager is to be reviewed in the broader management and leadership structure.

SM added that deputies will also be appointed for Executive Directors, with the exception of the Medical Director, and plans are in place to fill these posts by Christmas 2013. Funding is in place as the appointments will be cost-neutral through structural changes.

A gap remains around the previous service improvement and development portfolio. The Trust requires an element of service innovation and improvement at Director-level; however, there is recognition of the need to develop the health intelligence resource within the Trust linked to the emerging health and wellbeing, and public health agendas, emerging primary care and commissioning agendas, and service developments needed to support emergent populations and markets. The proposal would be to appoint to a Director of Service Innovation and Health Intelligence, which would be a non-voting Director role.

HW asked where this fitted with the marketing discussions at Trust Board. SM responded that James Drury was asked to identify and develop a proposal to support the marketing function linked to business planning; however, there is also a lack of health intelligence expertise to support business development and planning, and

marketing. SM confirmed that the Trust's involvement with Douglas Quigg will end in August 2013.

HW asked how this would be resourced. SM responded that AGD has been asked to work with Alex Farrell to develop a process and identify the budget available or in already in place to support innovation and health intelligence, marketing, ImROC, and transformation.

RTSC/13/45 Mutually agreed resignation scheme (agenda item 9)
AGD confirmed that, in both cases, the proposals provided an opportunity to undertake service re-design and achieve cost savings.

It was RESOLVED to APPROVE the two business cases for the applications under MARS. It was also RESOLVED to APPROVE the additional proposal under MARS, subject to continued support following circulation of the business case to the Committee.

Action: Alan Davis

RTSC/13/46 Update on Compromise Agreements and Judicial Mediation (agenda item 10)
Monitor has asked all Foundation Trusts to report any judicial mediation cases. The Trust has one case in Barnsley, which was an ongoing case and in train at the time services transferred from NHS Barnsley. Due to a change in the rules, this should have been subject to Treasury approval. Such cases have previously been excluded from the need to seek such approval. The Committee noted the position and the return made to Monitor.

RTSC/13/47 Date of next meeting (agenda item 11)
The next meeting will be held on Tuesday 15 October 2013 at 14:00 in the Chair's office at Fieldhead, Wakefield.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Integrated Performance Report: Strategic Overview

Month 5 2013/14

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Introduction

Dear Board Member/Reader

Welcome to the Trust's Integrated Performance Report: Strategic Overview for month 5 2013/2014 (August 2013 information). 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

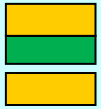
KPIs provide a high level view of actual performance against target and assurance to the Board about the delivery of the strategic objectives and adhere to the following principles:

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

HIGH LEVEL PERFORMANCE SUMMARY (YEAR TO DATE)

OUTCOMES: **RAG Rating**

- **Monitor Governance risk rating**
- **Monitor Finance Risk Rating**
- **CQUINs**



CUSTOMER FOCUS

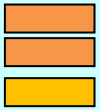
- **Complaints**
- **Members Council**
- **Annual Community Survey**

OPERATIONAL EFFECTIVENESS

- **Caseload management (7 day follow up; CPA review; gatekept admissions; DTOC)**
- **Data Quality**

FIT FOR THE FUTURE –WORKFORCE

- **Sickness**
- **Training**
- **Appraisals**



Trust Board Performance Dashboard – Vital Signs (Month 5 2013/14)

Business Strategic Performance: Impact & Delivery

Month 5 2013/14

Section	KPI	Target	Current Position	Status	Trend	Forecast Position
Monitor Compliance	Monitor Governance Risk Rating (FT)	Green	Amber/G	▲	↓	4
	Monitor Finance Risk Rating (FT)	3.9	4.1	✓	–	4
CQC	CQC Quality Regulations (compliance breach)	Green	Green	✓	–	4
CQUIN	CQUIN Barnsley	Green	Amber/G	▲	–	3
	CQUIN Calderdale	Green	Amber/G	▲	–	3
	CQUIN Kirklees	Green	Amber/G	▲	–	3
	CQUIN Wakefield	Green	Amber/G	▲	–	3
	CQUIN Forensic	Green	Green	✓	↑	3
IAPT	IAPT Kirklees: % Who Moved to Recovery	52%	55%	✓	↓	4
Inf' Prevent'	Infection Prevention (MRSA & C.Diff) All Cases	0	1	✗	–	3
PSA Outcomes	% SU on CPA in Employment	10%	**6.3%**	✗	↑	1
	% SU on CPA in Settled Accommodation	60%	**54.0%**	✗	↓	2

Customer Focus

Month 5 2013/14

Section	KPI	Target	Current Position	Status	Trend	Forecast Position
Complaints	% Complaints with Staff Attitude as an Issue	< 30%	19%10/52	✓	↓	4
MAV	Physical Violence - Against Patient by Patient	19-25	Within ER	✓	–	4
	Physical Violence - Against Staff by Patient	51 - 65	Within ER	✓	–	4
FOI	% of Requests for Information Under the Act Processed in 20 Working Days	100%	100%	✓	–	4
Media	% of Positive Media Coverage Relating to the Trust and its Services	> 60%	92%	✓	–	4
Member's Council	% of Publicly Elected Council Members Actively Engaged in Trust Activity	> 50%	53%	✓	↑	4
	% of Quorate Council Meetings	100%	100%	✓	–	4
Membership	% of Population Served Recruited as Members of the Trust	1%	1%	✓	–	4
	% of 'Active' Members Engaged in Trust Initiatives	> 50%	40%	▲	–	3
Befriending services	% of Service Users Allocated a Befriender Within 16 Weeks	> 70%	0%	▼	↓	3
	% of Service Users Requesting a Befriender Assessed Within 20 Working Days	> 80%	0%	▼	↓	3
	% of Potential Volunteer Befriender Applications Processed in 20 Working Days	> 90%	100%	✓	–	4

Operational Effectiveness; Process Effectiveness

Month 5 2013/14

Section	KPI	Target	Current Position	Status	Trend	Forecast Position
Inpatients	Delayed Transfers Of Care (DTOC) (Monitor)	< = 7.5%	**3.4%**	✓	↓	4
	% Admissions Gatekept by CRS Teams (Monitor)	95%	**100.0%**	✓	↑	4
Community	% SU on CPA Followed up Within 7 Days of Discharge (Monitor)	95%	97.2%	✓	↑	4
	% SU on CPA Having Formal Review Within 12 Months (Monitor)	95%	**90.2%**	✗	↓	3
Breastfeeding	Prevalence of children breastfed at 6 - 8 weeks (Barnsley)	31.5%	27.64%	✗	–	3
Data Quality	Data completeness: community services (Monitor)	50%	94.2%	✓	–	4
	Data completeness: Identifiers (mental health) (Monitor)	97%	**99.6%**	✓	–	4
	Data completeness: Outcomes for patients on CPA (Monitor)	50%	**69.5%**	✓	↓	4
Mental Health PbR	% of eligible cases assigned a cluster	100%	89.3%	✗	↑	3
	% of eligible cases assigned a cluster within previous 12 months	100%	75.0%	✗	↑	3
	% Inpatients (All Discharged Clients) with Valid Diagnosis Code	99%	**99.6%**	✓	↓	4
C-Diff	C Diff avoidable cases	0	0	✓	–	4

Fit for the Future; Workforce

Month 5 2013/14

Section	KPI	Target	Current Position	Status	Trend	Forecast Position
Appraisal	% of Staff Who Have Had an Appraisal in the Last 12 Months	>=90%	83.3	▼	↓	4
Sickness	Sickness Absence Rate (YTD)	<=4%	4.6	▼	–	3
Vacancy	Vacancy Rate	10%	4.5%	✓	–	4
Safeguarding	Adult Safeguarding Training	80%	81.3%	✓	↑	4
Fire	Fire Attendance	>=80%	77.8	▲	↓	3
IG	IG Training	>=50%	16.0	✗	↑	4

Integrated Performance Report: Strategic Overview

Overall Financial Position

	Performance Indicator	Month 5 Performance	Annual Forecast	Trend from last month	Last 6 Months - Most recent						Assur - ance
Trust Targets					4	3	2	1			
1	£3.7m Surplus on Income & Expenditure	●	●	⇔	●	●	●	●			4
2	Cash position equal to or ahead of plan	●	●	⇔	●	●	●	●			4
3	Capital Expenditure within 5% of plan	●	●	⇔	●	●	●	●			4
4	In month delivery of recurrent CIPs	●	●	⇔	●	●	●	●			4
5	Monitor Risk Rating equal to or ahead of plan	●	●	⇔	●	●	●	●			4
6	In month Better Payment Practice Code	●	●	⇔	●	●	●	●			4

Summary Financial Performance

1. The overall position at month 5 is showing a net surplus of £2.4m which is £0.6m ahead of plan. The planned surplus for the year is £3.7m and the current forecast is £3.9m which is £ 0.2m ahead of plan.
2. At month 5 the cash position is £29.5m and is £1.2m ahead of plan.
3. Capital expenditure to August 2013 is £2.15m which is £0.4m behind plan.
4. At month 5 the cost improvement programmes are recurrently behind plan by £1.2m. Non recurrent substitutions have been identified for £1.0m which means that an unidentified risk of £0.2m is included in the overall month 5 position.
5. The Financial Risk Rating at August 2013 is 4.1 which is ahead of the planned Q2 3.9 position.
6. At 31st August 95% of NHS and 96% of non NHS invoices have achieved the 30 day payment target. (95%)

Integrated Performance Report: Strategic Overview

Financial Risk Rating 2013/14				
	August 2013 Actuals		Annual Plan Quarter 2	
Metric	Score	Rating	Score	Rating
EBITDA margin	5.9%	3	5.2%	3
EBITDA, % achieved	100%	5	100%	5
ROA	7.0%	5	4.5%	5
I&E surplus margin	2.9%	4	1.9%	3
Liquid ratio	30.0	4	27.4	4
Weighted Average		4.1		3.9

The Monitor Financial Risk Rating (FRR) is 4.1 against a plan for Quarter 2 of 3.9.This is ahead of plan due to the underlying surplus position at August 2013.

- EBITDA margin scores 3 in line with plan.
- As a result EBITDA plan achieved scores 5 against a target of 5.
- Return on Assets remains on target at 5.
- Surplus margin scores 4 ahead of plan.
- Liquidity Ratio scores 4 against a plan of 4

Financial Risk Rating 2013/14				
	August 2013 Actuals		Annual Plan Quarter 2	
Metric	Score	Rating	Score	Rating
Capital Servicing Capacity	8.1 times	4	5.3 times	4
Liquidity	11.0	4	12.1	4
Weighted Average		4		4

The Monitor Risk Assessment Framework has proposed that the current 5 risk ratings are replaced by the 2 above. These will be shadow monitored at the beginning of 2013 / 2014. These are designed to demonstrate that a Trust remains a 'Going Concern.'

Flawless Execution

PERFORMANCE OVERVIEW

1.0 OUTCOMES: IMPACT AND DELIVERY

1.1 Monitor Compliance Framework

- The Monitor Compliance risk rating for month 4 is amber/green. This is due to in month under-performance against the % of service users on CPA who have had a formal review recorded within the last 12 months indicator (August position is 90.2%; target = 95%). The Trust achieved target levels in the Quarter 1 Monitor submission. Detailed summaries of outstanding action have been distributed to BDU's .

1.2 Care Quality Commission (CQC)

There were CQC visits to the Dales (Ashdale, Beechdale and Elmdale) and Fieldhead (Trinity 2, Bretton and Newton Lodge) in July/early August. The Trust has received informal feedback but is still awaiting the formal reports. There is a possibility of a regulatory compliance action but the CQC are giving consideration to further information that has been submitted from the Trust before making a judgement. Compliance actions are used in response to breaches of regulations with a minor impact on people or where the impact is moderate but it has happened for the first time. Compliance actions are unlikely to impact on the governance risk rating but the Trust will have to inform Monitor and provide a report setting out how it intends to address the problem and the action that will be taken to become compliant

1.3 CQUINs

1.3.1 Barnsley

Overall Performance Rating: **Amber/Green**

Key risk areas:

- Increasing the number of people in secondary mental health in employment target not met (currently at 2.5% against a target of 6%) The target set is within realistic comparator group but will be difficult to achieve in the economic climate.
- Pressure Ulcer target reduction as part of National Safety Thermometer CQUIN – robust exception report will be required to ensure achievement.
- Clinical Communication (Outpatients) and Clinical communications (Discharge) – some risk associated with minimum data sets; work on going to target services where improvement is needed.

Flawless Execution Continued

Systematic monthly monitoring and reporting is now embedded for all existing CQUIN schemes where appropriate, with monthly meetings between CQUIN leads, business managers and Quality Academy representatives to agree and implement remedial action.

1.3.2 Calderdale, Kirklees & Wakefield

Overall Performance Rating: **Amber/Green**

Key Risk Areas:

- Improving access for people with acute mental health problems; referrals to Crisis services seen within 4 hours of referral
  - CQUIN achieved in Quarter 1
  - Target increased to 90% from July
  - Both Kirklees and Wakefield have not met target levels in month 5. Performance is being reviewed on a case by case basis to address data quality issues and/or to produce exception reports for commissioners to consider. The expectation is that this work will enable the CQUIN to be met in Quarter 2 for Kirklees. Wakefield is forecast Red
- Improving access for people with non-acute mental health problems (routine); assessment within 14 days of referral and treatment within 6 weeks of assessment
  - Current performance remains at red across all BDUs.
  - A detailed review will be finalised by week end which will outline the reasons behind the outliers and potential actions required to improve. It is not envisaged that this CQUIN will be achieved by the end of Q2.
  - 6 Weeks assessment target: In August, Kirklees are not attaining the treatment within 6 weeks target (currently underperforming at 93.3% - target of 95%).
  -
- Improving access for people with non-acute mental health problems (routine); assessment within 4 weeks of referral to CAMHS (Wakefield only)
  - Current performance remains red. Data submission for month 5 are from manual collections .Action is on-going to review data and substantiate figures. After a further review of performance and current position with the Service it is envisaged that this CQUIN will not achieve by the end of Q2.

- LD Patient Experience.
  Due to the number of engagement events already undertaken this year the planned event will not be going ahead in September as originally agreed. An exception report is being prepared for commissioners to try and enable negotiation for an extension of the timeframes for having this event. Current forecast is Amber-Red

Flawless Execution Continued

1.3.3 Forensic

Overall Performance Rating: **Green**

Key Risk Areas:

- Confirmation received from commissioners that CQUINS have been met in Q1.
- There remains an on-going risk relating to achieving Optimising Pathways, Improving Physical Healthcare and Wellbeing of Patients and Improving Service User Experience through Innovative Access CQUINs in subsequent quarters. This is due to
    - the complexity of the individual CQUINs - individual CQUINs include multiple components all of which have to be delivered to achieve the CQUIN
    - incrementally increasing target level of performance are required over the 4 quarters

1.4 Infection Prevention

- One case of C Difficile was reported in August; one case in Barnsley and one in Wakefield. No avoidable cases have been reported.
- Barnsley BDU have had 6 cases to date against the CCG set yearly target of < 8 however exception reports have been submitted as all cases were deemed as unavoidable.

1.5 PSA Outcomes

- % Service users on CPA in employment under target (10%) at 6.3%. Overall recording of status 57.6%.
- % Service users in settle accommodation 54% under target (60%) Overall recording of status 58.7%.
- Performance team are working with BDU's to improve recording of PSA status.

2.0 CUSTOMER FOCUS

2.1 Befriending services

The befriending services targets for allocation and assessment have not been met in August. This was expected and is due to planned work that is focussing on the recruitment of befrienders. Targets will be achievable once sufficient volunteers have been recruited. The recruitment process has been scoped and planned.

Flawless Execution Continued

3.0 OPERATIONAL EFFECTIVENESS

3.1 Breastfeeding Prevalence 6 – 8 weeks

- Quarterly target - continues to show an underperformance against threshold (27.64% against a target of 31.5%)
- Analysis of data suggests that underperformance by the Midwifery services is adversely impacting on the ability of SWYPFT Health Visitors to achieve the 6 – 8 week target.
- A report has been submitted to NHS England. The feedback received supports the trusts perspective and will be included in the discussions with Barnsley CCG.

3.2 Mental Health Currency Development

External

- Further workshops to be booked with commissioners
- Work progressing to standardise Commissioner Action Plans
- Service Specifications: commissioners are being consulted through the CPPP Lead for an agreed template across all CCGs

Internal

- Project resources re organised following change in personnel.
- Project Plan in place
- Internal meeting to be arranged to review Service Specifications templates
- Care pathways: completion by end of Sept
- BDU now receiving Highlight reports/Clinical Dashboard

3.2.1 Mental Health Clustering

KPI	Target	Trust wide	Barnsley	Calderdale	Kirklees	Wakefield
% eligible clustered	100%	89.3%	75.8%	94.4%	94%	94.3%
% clustered within the last 12 months	100%	75%	68.2%	75.4%	74.3%	82.7%

- Targeted work through the PbR project to identify reasons for current performance and key actions to be taken. This will be reviewed in September by the Executive Management Team (EMT)
- Communication:- Workshop carried out in Barnsley with Team Managers/Ward managers 12th Sept.

Flawless Execution Continued

4.0 FIT FOR THE FUTURE: WORKFORCE

4.1 Appraisal

Current Position (End of August) – 88.3% Overall. This shows a further increase from 71% in month 4. The appraisal figure for month 5 is now based solely on the new appraisal system which was rolled out across the Trust in April. Target levels have been achieved in Calderdale, Forensic, Kirklees and in Support Services. Barnsley, Wakefield BDU's, and Specialist Services have yet to meet the 90% target (84.6%; 88.1% and 80.4% respectively), however all 3 BDU's have improved their uptake figure from month 4.

4.2 Sickness (End of July Position)

The current year to date absence rate for the whole of SWYPFT is 4.56%. This shows a reduction from last month's figure of 4.61% and is a significant reduction from last year's YTD rate of 4.99% in July 2012.

The current 2013-14 projection is 4.85% which would be a 0.37% reduction from last year but would still be above the 4.0% Trust Board target. The current (YTD) SWYPFT absence rate has now seen month on month reductions between April and July.

4.2.1 Current Year to Date (YTD) Sickness Absence Rates by BDU (End of July Position)

Barnsley BDU

- Current YTD absence rate = 4.91%; Current projection by March 2014 = 5.10%
- Hot spots include: Children's Services, Inpatient Rehabilitation, Long Term Conditions and Specialist mental health services. The higher rates seen in these areas are due to long term absence which is being proactively managed.

Calderdale BDU

- Current YTD absence rate = 3.70%; Current projection by March 2014 = 4.00%
- Calderdale continues to see the lowest rates across the Trust as a BDU.

Forensics BDU

- Current YTD absence rate = 6.32%; Current projection by March 2014 = 6.60%
- Forensics continues to see higher absence rates than the rest of the Trust; the BDU has however made significant reductions from this time last year (7.28% cumulative in July 2012).

Flawless Execution Continued

- The reduction overall is as a result of significant absence rate reductions in Medium Secure Services which sees the service enjoying their lowest rates for the past 3 years.
- Long term absence is still being experienced in both Low Secure and Newhaven and this is causing high rates of 8.59% and 8.67% respectively.

Kirklees BDU

- Current YTD absence rate = 4.41%; Current projection by March 2014 = 4.35%
- Adult Services continue to reduce their absence rate month on month and are currently meeting target levels (3.56% YTD)
- Older Peoples Services remains above target (6.51% YTD). This is mainly due to long term absence in specific areas which is being closely managed by both service leads and HR services.

Wakefield BDU

- Current YTD absence rate = 3.90%; Current projection by March 2014 = 4.20%
- Continued month on month reduction in absence rate to 3.90% which is the lowest BDU rate in the last 6 years

Specialist Services

- Current YTD absence rate = 4.40%; Current projection by March 2014 = 4.76%
- Month on month, absence rates continue to be approximately 1% lower than for the same period last year .

Support Services

- Current YTD absence rate = 3.81% - Current projection by March 2014= 4.20%
- Overall, Support Services are currently meeting target levels - the only area of higher absence is in Estates (5.57%YTD). .

4.2.2 Key points:

- With the exception of Barnsley, all BDUs are projecting a lower absence rate by March 2014.
- Of the 32 services lines across the whole of SWYPFT, 8 are currently achieving absence rates below 4%.
- Stress continues to be the main reason for absence across the Trust accounting for approximately 1 in every 4 to 5 days lost.
- Reducing absence related to stress and reducing long term absence (currently accounts for approximately 70% of absence) are the main focus of BDU action plans.
- Only Calderdale BDU is projected to achieve the SWYPFT target rate of 4% by the end of 2013-14 financial year.

Flawless Execution Continued

4.3 Fire Training (End of August Position)

- Trust overall position remains below target at 77.8% (target = 80%)
- Calderdale (84%) and Wakefield BDUs (83.9%) are currently meeting target levels.
- Barnsley (78%), Forensics (73%), Kirklees (76%), Specialist Services (79%) and Support Services (79%) remain below target.

4.4 IG Training

- 16% of Trust staff have completed their IG training.
- The forecast is that the Trust will meet this annual IG Toolkit requirement by March 2014
- Current in-month performance is lower than might be expected due in part to changes made to the way IG training uptake has being measured from April. The reason for the change was to alleviate pressure on Services in February and March by spreading & monitoring staff training more equally across the 12 months.
- To meet the Trust's 2013/14 quarterly trajectories, some staff would need to bring their training forward in year and would therefore complete refresher training sooner than the required 12 month period. In subsequent years staff would do their training once in any 12 month period.
- Staff who need to bring forward their training dates from February and March may also find it easier to pass the test which takes only 30 minutes including refresher module.

GLOSSARY

AWA	Adults of Working Age
AWOL	Absent Without Leave
BDU	Business Delivery Unit
CCG	Clinical Commissioning Groups
CIP	Cost Improvement Programme
CPA	Care Programme Approach
CPPP	Care Packages & Pathway Project
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CROM	Clinician rated outcome measure
CRS	Crisis Resolution Service
DTOC	Delayed Transfers of Care
EIA	Equality Impact Assessment
EIP/EIS	Early Intervention in Psychosis Service
FOI	Freedom of Information
FT	Foundation Trust
HONOS	Health of the Nation Outcome Scales
IAPT	Improving Access to Psychological Therapies
Inf Prevent	Infection Prevention
KPIs	Key Performance Indicators
MAV	Management of Aggression and Violence
MT	Mandatory Training
NICE	National Institute for Clinical Excellence
OPS	Older People's Services
PBR	Payment by Results
PREM	Patient reported experience measure
PROM	Patient reported outcome measure
PSA	Public Service Agreement
PTS	Post Traumatic Stress
Sis	Serious Incidents
SU	Service Users
TBD	To Be Decided/Determined
YTD	Year to Date

South West Yorkshire Partnership NHS Foundation Trust

Finance Report – Month 5 FY 2013/14

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Overall Financial Position

Finance Key Performance Indicators

	Performance Indicator	Month 5 Performance	Annual Forecast	Trend from last month	Last 3 Months - Most recent			Assurance	Page
Trust Targets					4	3	2		
1	£3.7m Surplus on Income & Expenditure	●	●	⇧	●	●	●	Excellent	*4 to 6*
2	Cash position equal to or ahead of plan	●	●	⇧	●	●	●	Excellent	*14*
3	Capital Expenditure within 15% of plan	●	●	⇩	●	●	●	Poor	*17 to 18*
4	In month delivery of recurrent CIPs	●	●	⇩	●	●	●	Fair	*7 to 11*
5	Monitor Risk Rating equal to or ahead of plan	●	●	⇔	●	●	●	Excellent	*12*
6	In month Better Payment Practice Code	●	●	⇔	●	●	●	Excellent	*20*

Summary Financial Performance

1. The year to date position at month 5 is showing a net surplus of £2.35m which is £0.62m ahead of plan. Forecast for the year is £3.74m which is £0.02m ahead of plan.
2. At month 5 the cash position is £29.5m and is £1.2m ahead of plan.
3. Capital spend to August is £2.1m which is £360k (17%) below target.
4. At month 5 the cost improvement programme is £155k (approx. 4%) under the target of £3.5m.
5. The Financial Risk Rating at August is 4.1 which is ahead of the planned 3.9 Quarter 2 position.
6. At 31st August 95% of NHS and 96% of non NHS invoices have achieved the 30 day payment target. (95%)

Overall Income & Expenditure Position

Budget Staff in Post WTE	Actual Staff in Post WTE	Variance Staff in Post WTE	This Month Budget £m	This Month Actuals £m	This Month Variance £m	Income & Expenditure Account	Year to Date Budget £m	Year to Date Actual £m	Variance (Fav'ble)/ Adverse £m	Annual Budget £m	Forecast Outturn £m	Forecast Variance (Fav'ble)/ Adverse £m
						Healthcare Income						
			(3.80)	(3.56)	0.24	Wakefield	(18.17)	(17.94)	0.23	(43.63)	(43.03)	0.59
			(3.43)	(3.43)	(0.00)	Kirklees	(17.16)	(17.14)	0.02	(41.95)	(41.12)	0.83
			(1.78)	(1.78)	(0.00)	Calderdale	(8.88)	(8.87)	0.01	(21.32)	(21.28)	0.04
			(7.31)	(7.27)	0.04	Barnsley	(36.55)	(36.38)	0.17	(87.64)	(86.96)	0.68
			(1.99)	(1.99)	(0.00)	Secure Services	(9.94)	(9.94)	(0.00)	(25.00)	(23.70)	1.30
			(0.03)	(0.06)	(0.03)	Other Non-Contract Healthcare Income	(0.14)	(0.26)	(0.11)	(0.32)	(0.52)	(0.20)
			(18.34)	**(18.10)**	**0.24**	**Total HC Income**	**(90.85)**	**(90.53)**	**0.32**	**(219.85)**	**(216.61)**	**3.24**
						Operating Expenses						
525	514	-11	1.82	1.84	0.03	Wakefield	9.16	9.24	0.08	21.89	22.21	0.32
586	566	-20	1.98	2.12	0.13	Kirklees	10.00	10.36	0.36	24.39	25.11	0.73
361	348	-13	1.19	1.22	0.03	Calderdale	5.79	6.02	0.22	14.06	14.33	0.26
1,613	1,496	-117	5.59	5.44	(0.15)	Barnsley	28.27	27.58	(0.69)	67.66	66.68	(0.98)
387	353	-33	1.42	1.33	(0.09)	LD & Specialist	7.06	6.73	(0.33)	16.88	16.35	(0.53)
432	437	5	1.32	1.36	0.03	Secure Services	6.72	6.74	0.02	16.21	16.58	0.38
697	679	-19	3.32	3.26	(0.06)	Support & Central Services	17.12	16.72	(0.40)	41.88	41.42	(0.46)
0	0	0	0.52	0.33	(0.19)	Provisions	1.67	1.49	(0.17)	5.71	2.81	(2.90)
4,602	**4,394**	**(208)**	**17.17**	**16.89**	**(0.27)**	**Total Operating Expenses**	**85.79**	**84.88**	**(0.90)**	**208.68**	**205.50**	**(3.19)**
4,602	**4,394**	**(208)**	**(1.17)**	**(1.20)**	**(0.03)**	**EBITDA**	**(5.06)**	**(5.64)**	**(0.59)**	**(11.17)**	**(11.11)**	**0.05**

Budget Staff in Post	Actual Staff in Post	Variance Staff in Post	This Month Budget	This Month Actuals	This Month Variance	Income & Expenditure Account	Outturn Budget	Outturn Actual	Variance (Fav'ble)/ Adverse	Annual Budget	Forecast Outturn	Forecast Variance (Fav'ble)/ Adverse
WTE	WTE	WTE	£m	£m	£m		£m	£m	£m	£m	£m	£m
4,602	**4,394**	**(208)**	**(1.17)**	**(1.20)**	**(0.03)**	**EBITDA**	**(5.06)**	**(5.64)**	**(0.59)**	**(11.17)**	**(11.11)**	**0.05**
			0.45	0.45	0.00	Depreciation	2.23	2.23	0.00	5.35	5.35	0.00
			0.14	0.14	(0.00)	PDC Paid	0.71	0.71	(0.00)	1.70	1.70	0.00
			0.00	0.00	0.00	Interest Paid	0.00	0.00	0.00	0.00	0.00	0.00
			0.00	(0.01)	(0.01)	Interest Received	0.00	(0.04)	(0.04)	0.00	(0.08)	(0.08)
			0.00	0.00	0.00	Impairment of Assets	0.40	0.40	0.00	0.40	0.40	0.00
4,602	**4,394**	**(208)**	**(0.58)**	**(0.62)**	**(0.04)**	**Outturn**	**(1.72)**	**(2.35)**	**(0.62)**	**(3.72)**	**(3.74)**	**(0.02)**

Summary Performance of Cost Improvement Programme

Delivery of Recurrent Savings 2013/14

Recurrent CIPs		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
Wakefield BDU	Target	46	46	46	46	46	46	46	46	46	46	46	46	230	552
	Actual	36	36	36	36	27								170	386
	Variance	(10)	(10)	(10)	(10)	(19)								(60)	(166)
LD & Specialist BDU	Target	24	24	24	24	24	24	24	24	24	24	24	24	120	288
	Actual	24	24	24	24	24								120	242
	Variance	0	0	0	0	0								0	(46)
Kirklees BDU	Target	25	25	25	55	55	55	55	55	55	55	55	55	185	570
	Actual	25	25	25	25	25								125	301
	Variance	0	0	0	(30)	(30)								(60)	(269)
Calderdale BDU	Target	20	20	20	37	37	37	37	37	37	37	37	37	134	393
	Actual	20	20	20	19	19								98	229
	Variance	0	0	0	(18)	(18)								(36)	(164)
Secure Services	Target	38	38	38	38	38	39	39	39	39	39	39	39	190	463
	Actual	27	27	27	27	27								136	333
	Variance	(11)	(11)	(11)	(11)	(11)								(54)	(130)
Barnsley BDU	Target	156	156	157	157	157	157	157	157	157	157	157	157	783	1,882
	Actual	134	134	135	135	135								672	1,615
	Variance	(22)	(22)	(22)	(22)	(22)								(111)	(267)
Support	Target	126	126	126	126	126	126	126	126	126	126	126	126	630	1,512
	Actual	115	115	115	104	109								559	1,353
	Variance	(11)	(11)	(11)	(22)	(17)								(71)	(159)
Trustwide	Target	253	253	253	253	253	253	253	253	253	253	253	252	1,265	3,035
	Actual	253	253	253	253	253								1,265	3,035
	Variance	0	0	0	0	0								0	0
Total	Target	688	688	689	736	736	737	737	737	737	737	737	736	3,537	8,695
	Actual	634	634	635	623	620								3,145	7,493
	Variance	(54)	(54)	(54)	(113)	(116)								(392)	(1,202)

Non Recurrent CIPs		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
Wakefield BDU	Target													0	0
	Actual	9	9	9	9	9								45	91
	Variance	9	9	9	9	9								45	91
LD & Specialist BDU	Target													0	0
	Actual	0	0	0	1	1								2	46
	Variance	0	0	0	1	1								2	46
Kirklees BDU	Target													0	0
	Actual	0	0	0	0	0								0	269
	Variance	0	0	0	0	0								0	269
Calderdale BDU	Target													0	0
	Actual	0	0	0	14	4								19	164
	Variance	0	0	0	14	4								19	164
Secure Services	Target													0	0
	Actual	0	0	0	0	0								0	23
	Variance	0	0	0	0	0								0	0
Barnsley BDU	Target													0	0
	Actual	22	22	22	22	22								111	267
	Variance	22	22	22	22	22								111	267
Support	Target													0	0
	Actual	9	9	9	20	15								61	159
	Variance	9	9	9	20	15								61	159
Trustwide	Target													0	0
	Actual	0	0	0	0	0								0	0
	Variance	0	0	0	0	0								0	0
Total	Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	40	40	40	67	51								238	1,020
	Variance	40	40	40	67	51								238	1,020

Recurrent & Non Recurrent CIPs		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
Wakefield BDU	Target	46	46	46	46	46	46	46	46	46	46	46	46	230	552
	Actual	45	45	45	45	36	0	0	0	0	0	0	0	215	477
	Variance	(1)	(1)	(1)	(1)	(10)								(15)	(75)
LD & Specialist BDU	Target	24	24	24	24	24	24	24	24	24	24	24	24	120	288
	Actual	24	24	24	25	25	0	0	0	0	0	0	0	122	288
	Variance	0	0	0	1	1								2	(0)
Kirklees BDU	Target	25	25	25	55	55	55	55	55	55	55	55	55	185	570
	Actual	25	25	25	25	25	0	0	0	0	0	0	0	125	570
	Variance	0	0	0	(30)	(30)								(60)	0
Calderdale BDU	Target	20	20	20	37	37	37	37	37	37	37	37	37	134	393
	Actual	20	20	20	33	23	0	0	0	0	0	0	0	116	393
	Variance	0	0	0	(4)	(14)								(18)	0
Secure Services	Target	38	38	38	38	38	39	39	39	39	39	39	39	190	463
	Actual	27	27	27	27	27	0	0	0	0	0	0	0	136	356
	Variance	(11)	(11)	(11)	(11)	(11)								(54)	(107)
Barnsley BDU	Target	156	156	157	157	157	157	157	157	157	157	157	157	783	1,882
	Actual	156	156	157	157	157	0	0	0	0	0	0	0	783	1,882
	Variance	0	0	0	0	0								0	0
Support	Target	126	126	126	126	126	126	126	126	126	126	126	126	630	1,512
	Actual	124	124	124	124	124	0	0	0	0	0	0	0	620	1,512
	Variance	(2)	(2)	(2)	(2)	(2)								(10)	0
Trustwide	Target	253	253	253	253	253	253	253	253	253	253	253	252	1,265	3,035
	Actual	253	253	253	253	253	0	0	0	0	0	0	0	1,265	3,035
	Variance	0	0	0	0	0								0	0
Total	Target	688	688	689	736	736	737	737	737	737	737	737	736	3,537	8,695
	Actual	674	674	675	689	671								3,382	8,523
	Variance	(14)	(14)	(14)	(47)	(65)								(155)	(172)

Monitor Risk Rating

Financial Risk Rating 2013/ 2014

	August 2013 Actuals		Annual Plan Qtr 2	
Metric	Score	Rating	Score	Rating
EBITDA margin	5.9%	3	5.2%	3
EBITDA, % achieved	100%	5	100%	5
ROA	7.0%	5	4.5%	5
I&E surplus margin	2.9%	4	1.9%	3
Liquid ratio	30	4	27.4	4
Weighted Average		4.1		3.9

The Monitor Financial Risk Rating (FRR) is 4.1 against a planned position at the end of Quarter 2 2013 / 2014 of 3.9.

- EBITDA margin scores 3 in line with plan
- As a result EBITDA plan achieved scores 5 against a target of 5.
- Return on Assets remains on target at 5.
- Surplus margin scores 4 which is ahead of plan.
- Liquidity Ratio scores 4 against a plan of 4.

Overall the current Financial Risk Rating is better than planned for the end of Quarter 2 as the I& E surplus is rated as 4 compared to the planned 3. The threshold for this metric is 2%. The threshold to achieve a rating of 5 is 3%.

REVISED
Financial Risk Rating 2013 / 2014

	August 2013 Actuals		Annual Plan Qtr 2	
Metric	Score	Rating	Score	Rating
Capital Servicing Capacity	8.1 times	4	5.3 times	4
Liquidity	11.0	4	12.1	4
Weighted Average		4		4

As part of the Risk Assessment Framework the Monitor Financial Risk Ratings will be revised in 2013 / 2014. The Trust is assessing its performance against these in shadow form. The current 5 ratings will be replaced by the 2 highlighted in the table to the left.

These have a rating matrix of 1 to 4 with 4 being the best. For both Annual Plan and current performance the Trust would be rated at 4.

Analysis of Expenditure by Type

Type	Heading	Annual Budget	YTD Budget	YTD Actual	YTD Variance	Note
	Direct Credits & Income	(7.16)	(3.18)	(3.24)	(0.06)	
	Recharges	(4.57)	(2.15)	(2.23)	(0.08)	
Non-healthcare Income Total		(11.73)	(5.33)	(5.47)	(0.14)	
	Admin & Clerical	27.09	11.33	10.99	(0.35)	1
	Agency	2.33	1.03	1.20	0.17	2
	Ancillary	7.20	3.03	2.92	(0.11)	
	Medical	19.43	8.11	7.72	(0.39)	1
	Nursing	82.30	34.42	33.40	(1.02)	1
	Other Healthcare Staff	32.82	13.83	12.78	(1.04)	1
	Other Pay Costs	(4.62)	(2.25)	0.00	2.25	3
	Senior Management	1.43	0.59	0.54	(0.06)	
	Social Care Staff	2.38	1.00	1.00	0.00	
Pay- Expenditure Total		170.34	71.10	70.56	(0.54)	
	Clinical Supplies	2.52	1.05	1.00	(0.04)	
	Drugs	3.82	1.59	1.46	(0.13)	
	Healthcare subcontracting	2.71	1.13	1.68	0.55	4
	Hotel Services	2.52	1.06	1.11	0.04	
	Office Supplies	3.78	1.56	1.48	(0.07)	
	Other Costs	6.25	2.53	2.35	(0.17)	
	Property Costs	6.60	2.83	2.95	0.13	
	Service Level Agreements	6.14	2.52	2.47	(0.04)	
	Training & Education	0.96	0.33	0.23	(0.10)	
	Travel & Subsistence	5.51	2.41	2.07	(0.34)	
	Utilities	2.00	0.66	0.69	0.02	
	Vehicle Costs	1.57	0.69	0.80	0.11	
Non-pay Expenditure Total		44.36	18.36	18.31	(0.05)	
Provisions Expenditure Total		5.71	1.67	1.46	(0.21)	
Grand Total		**208.68**	**85.79**	**84.85**	**(0.94)**	

This table analyses operating expenditure by type of expenditure and reconciles to the operating expenses (including provisions) in the I&E summary.

This subjective analysis supports the I&E analysis:

- There is a £2.97m underspend on pay. This is being offset by the £2.25m staff vacancy factor and £0.17m agency overspend.
- Non pay shows relatively small variances over a number of categories. The most significant is Healthcare Subcontracting which includes the out of area spending relating to PICU and acute beds.

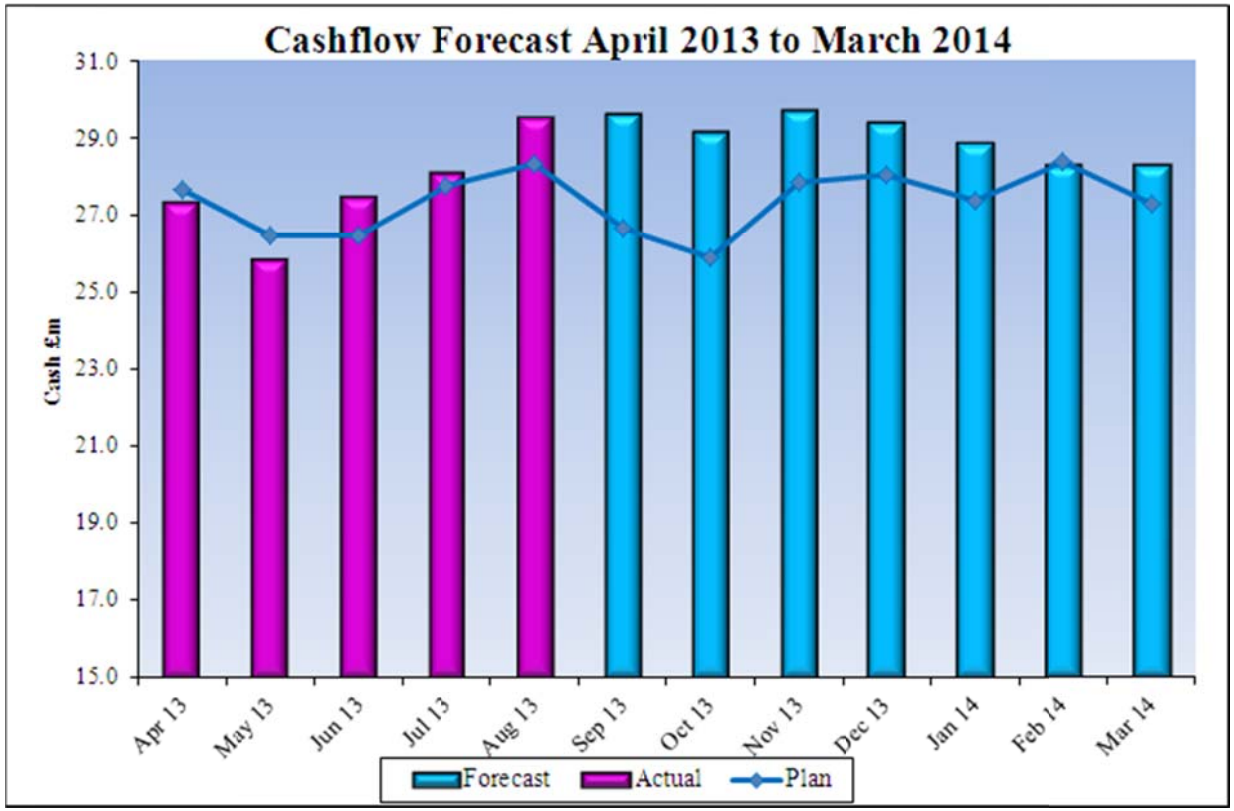
1. Actual expenditure on Administrative & Clerical, Medical and, Nursing staff is less than planned mostly as a result of vacancies. Some of these savings are offset by the cost of agency and bank staff.

2. Agency costs are marginally higher than planned. Spend year to date is Agency Medical costs £455k, Nursing £215k, Social Workers £142k and Admin and Clerical £325k. This is external agency costs only.

3. This represents the recurrent staff vacancy factor. The savings requirement is £4.62m (approx. 2.5%) across the Trust and is planned to be achieved.

4. Non pay cost pressure exists with the purchase of external beds. At month 5 this is £0.55m above plan and represents a risk within the overall Trust forecast.

Rolling Cash-flow Forecast



This analysis shows the cash flow for the year as per the plan. The current plan is based on the forecast submitted to Monitor in May 2013.

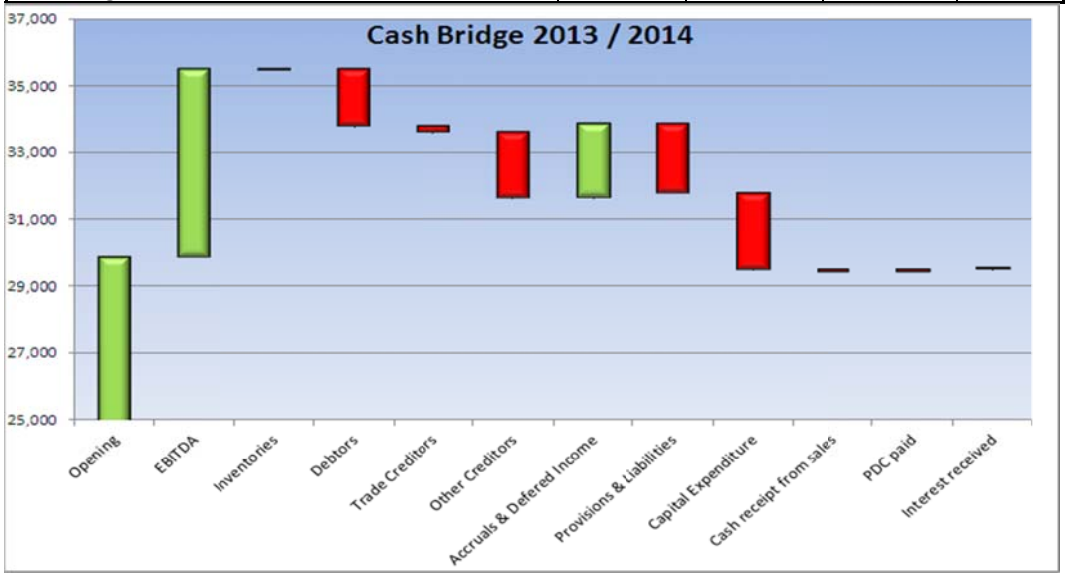
The actual cash position for the month is £29.5m, which is £1.2m ahead planned cash of £28.3m.

A further breakdown on the movement compared to plan is provided on page 16.

Overall the current forecast is that cash will be better than planned during 2013 / 2014 due to both the forecast surplus position and forecast capital programme.

Reconciliation of Actual Cash-flow to Plan

	LTFM Plan £m	Actual £m	Variance £m	Note
Opening Balances	**29.85**	**29.85**	**0.00**	
EBITDA (Exc. non-cash items & revaluation)	4.95	5.64	0.69	*1*
Movement in working capital:				
Inventories & Work in Progress	0.00	0.00	**0.00**	
Receivables (Debtors)	(1.78)	(1.75)	**0.03**	*2*
Trade Payables (Creditors)	0.62	(0.17)	**(0.79)**	*4*
Other Payables (Creditors)	(2.62)	(1.93)	**0.69**	
Accruals & Deferred income	0.56	2.17	**1.61**	*3*
Provisions & Liabilities	(1.32)	(2.02)	**(0.70)**	*5*
Movement in LT Receivables				
Capital expenditure	(1.95)	(2.32)	**(0.37)**	*6*
Cash receipts from asset sales	0.00	0.00	**0.00**	
PDC Dividends paid	0.00	0.00	**0.00**	
PDC Received	0.00	0.00	**0.00**	
Interest (paid)/ received	0.00	0.04	**0.04**	
Closing Balances	**28.31**	**29.51**	**1.19**	



The plan reflects the May 2013 submission to Monitor.

At the end of the period the Trust is ahead of plan.

Factors which increase cash position against plan:

1. EBITDA, arising from the underspends on operational budgets, is better than planned as per the Income & Expenditure position discussed previously.

2. Debtors are lower than planned and therefore more cash has been received than expected. As shown within the Balance Sheet this is NHS debtors specifically.

3. Accruals are higher than planned which means that invoices expected have not yet been received and this therefore improves the cash position. In particular this relates to April – August 2013 NHS invoices from Mid Yorks and NHS Property Services not yet received. (Elements received from Mid Yorks in September 2013)

Factors which decrease the cash position against the plan:

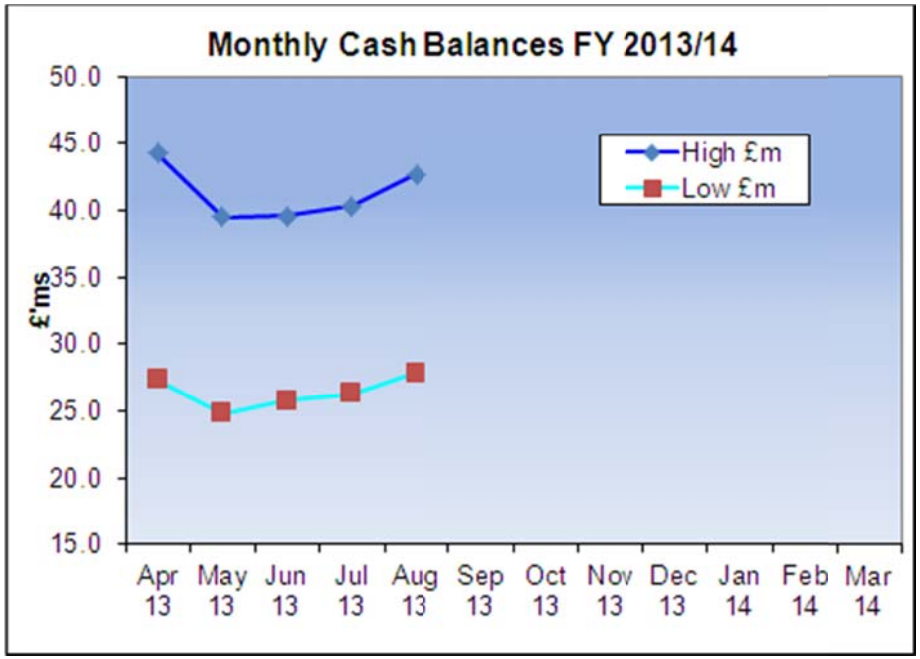
4. Creditors are lower than planned and therefore the Trust has paid more invoices than expected. This is connected to the accruals position as some invoices have not yet been received and are therefore not yet included as creditors.

5. Release of provisions are higher than planned as redundancy payments have been paid earlier than expected.

6. Capital expenditure, taking account of both actual expenditure and the movement in capital creditors, is higher than planned.

Cash Position

Cash Balances	LTFM Plan £m	Actual £m
Opening Balance	27.8	28.1
Closing Balance	28.3	29.5



The cash position at period end is £29.5m. The lowest balance of £27.8m was on the 8th. The highest balance for the month was on the 15th and was £42.7m. This reflects cash balances built up from historical surpluses that are available to finance capital expenditure in the future.

The graph illustrates the high and low cash balances each month this financial year. The peak for the month is due to the NHS SLA income being received between the 13th and 21st of the month.

Resources Available for Capital Expenditure

Source of Funds	£m
Depreciation	5.35
Income & Expenditure Reserve	2.06
Disposal Proceeds	1.58
Total Resources for Capital Expenditure	**8.99**

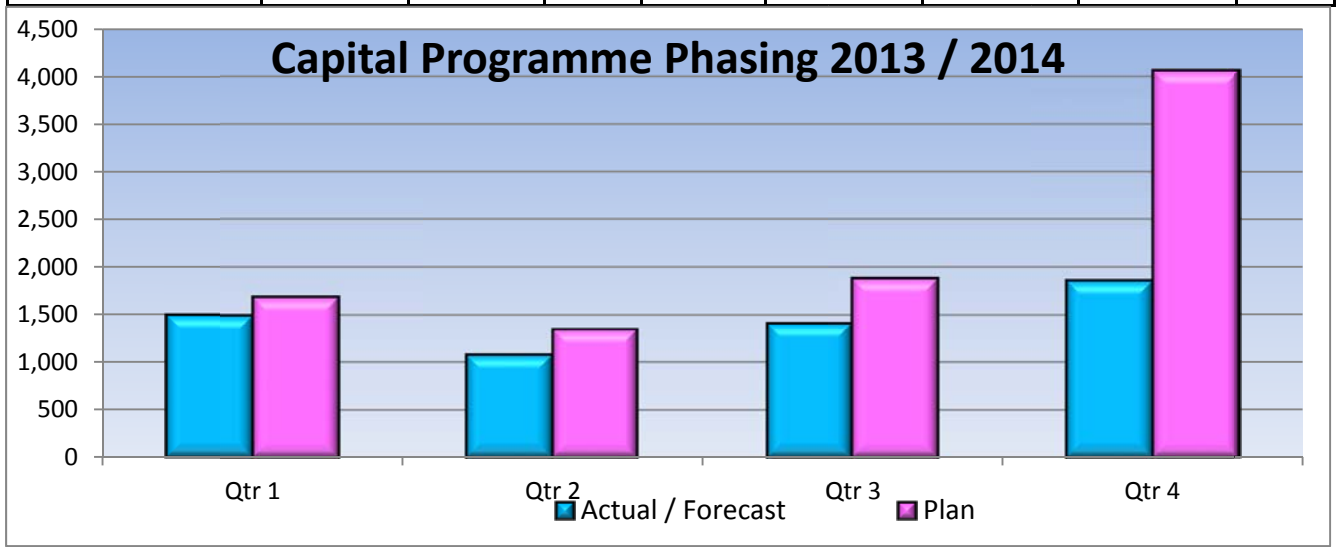
Capital Resources

The capital programme for 2013/14 will be funded from cash available from depreciation, disposals and previously generated surpluses. Any surpluses generated during the year will not be required to fund this year's capital expenditure.

The Trust's capital plans reflected here are consistent with the 3 year Annual Plan submitted to Monitor in May 2013.

Capital Expenditure

Capital Expenditure Plans - Application of funds	Scheme Total £m	Annual Budget £m	Year to Date Plan £m	Year to Date Actual £m	Year to Date Variance £m	Forecast Actual £m	Forecast Variance £m	Note
Maintenance (Minor) Capital								
Small Schemes	2.66	2.66	0.70	0.58	(0.12)	2.23	(0.43)	
Quality of Environment	2.23	2.23	0.00	0.00	0.00	1.9	(0.33)	
Total Minor Capital		**4.89**	**0.70**	**0.58**	**(0.12)**	**4.13**	**(0.76)**	*2*
Major Capital Schemes								
Newton Lodge	11.8	1.32	1.32	1.11	(0.21)	1.17	(0.15)	
IM&T	1.6	0.85	0.11	0.11	0.00	0.85	0.00	
Estate Strategy	19.9	1.94	0.02	0.02	0.00	0.54	(1.4)	
Total Major Schemes		**4.11**	**1.45**	**1.24**	**(0.21)**	**2.56**	**(1.55)**	*3*
VAT Refunds		0.00	0.00	(0.05)	(0.05)	(0.06)	(0.06)	
TOTALS		**8.99**	**2.15**	**1.77**	**(0.38)**	**6.63**	**(2.37)**	*1*



Capital Expenditure 2013 / 2014

1. The total Capital Programme for 2013 / 2014 is £8.99m.
2. Within the small scheme programme, £0.76m is yet to be allocated. This may be used to support the major scheme at Hepworth (see 4 below). Within the £4.13m forecast there are a number of schemes that will be delivered by third party contractors and these may be at risk due to current contractor engagement issues.
3. Within the Estates Strategy there is a forecast £1.55m underspend, however the Hepworth scheme described below is anticipated to recover this position..
4. The overall Capital plan is forecast to underspend by £2.37m. This headroom has been created to allow the Hepworth scheme to be brought forward into this year's programme and delivered whilst the opportunity presents. This business case is being worked through and will be presented for Board approval.
5. The year to date capital programme is 17% underspent which exceeds the monitor threshold for reporting of 15%.

Balance Sheet

	Actual at 31/03/13	Plan at 31/08/13	Actual at 31/08/13	Note
	£m	£m	£m	
Non-Current (Fixed) Assets	**69.2**	**106.8**	**106.2**	*1*
Current Assets				
Inventories & Work in Progress	0.6	0.6	0.6	
NHS Trade Receivables (Debtors)	1.4	1.0	0.8	*2*
Other Receivables (Debtors)	3.1	5.5	5.5	*3*
Cash and Cash Equivalents	29.9	28.3	29.5	*9*
Total Current Assets	**35.0**	**35.4**	**36.4**	
Current Liabilities				
NHS Trade Payables (Creditors)	(2.5)	(3.1)	(2.3)	*4*
Non NHS Trade Payables (Creditors)	(3.9)	(2.1)	(2.2)	*4*
Other Payables (Creditors)	(3.5)	(3.5)	(3.2)	
Capital Payables (Creditors)	(1.3)	(0.4)	(0.7)	*5*
Accruals	(8.9)	(10.2)	(11.7)	*6*
Deferred Income	(0.8)	(1.1)	(0.9)	
Total Current Liabilities	**(20.8)**	**(20.4)**	**(21.0)**	
Net Current Assets/Liabilities	**14.2**	**14.9**	**15.4**	
Total Assets less Current Liabilities	**83.4**	**121.4**	**121.6**	
Provisions for Liabilities	(8.1)	(6.8)	(6.1)	*7*
Total Net Assets/(Liabilities)	**75.3**	**114.6**	**115.6**	
Taxpayers' Equity				
Public Dividend Capital	(42.0)	(42.0)	(42.0)	
Revaluation Reserve	(7.3)	(18.5)	(18.5)	
Other Reserves	(5.2)	(5.2)	(5.2)	
Income & Expenditure Reserve	(20.9)	(48.9)	(49.8)	*8*
Total Taxpayers' Equity	**(75.3)**	**(114.6)**	**(115.6)**	

The Balance Sheet analysis compares the current month end position to that within the Monitor Annual Plan, submitted May 2013. The previous year end position is included for information.

1. Fixed assets include the April 2013 transfer of Estate from Barnsley (£37.9m). As noted above the capital programme is currently behind plan.
2. NHS debtors are lower than planned.
3. Other Debtors are in line with plan whilst specifically non NHS trade debtors (predominantly relating to council payments) have reduced in month.
4. Creditors continue to be managed in year in line with the Trust payment policy. The biggest elements remain Superannuation, income tax and National Insurance which are all paid monthly in arrears.
5. Capital payables, although at a low level are higher than planned.
6. Accruals are higher than planned. A number of expected invoices have not been received. The largest are NHS and related to expected charges for April – August 2013.
7. Payments against provisions have been made in August 2013 meaning that the year to date position is ahead of plan.
8. These represent year to date surplus plus reserves brought forward.
9. The *Reconciliation of Actual Cash-flow to Plan* analysis on page 14 compares the current month end cash to the LTFM forecast for the same period.

Better Payment Practice Code

	Number %	Value %
NHS		
Year to July 2013	95.0	95.9
Year to August 2013	94.9	95.2
Non NHS		
Year to July 2013	97.9	96.7
Year to August 2013	95.5	92.2

	Number %	Value %
Payments to Local Suppliers		
Year to July 2013	83.8	82.6
Year to August 2013	81.6	81.8

The Better Payment Practice Code requires the Trust to aim to pay 95% of valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

The performance against target for NHS invoices is 94.9% of the total number of invoices that have been paid within 30 days and 95.2% by the value of invoices.

To date the Trust has paid 95.5% of Non NHS by volume within 30 days and 92.2% of Non NHS invoices by value.

With the current economic climate the Government has asked the Public Sector to try and pay Local Suppliers within 10 days, though this is not mandatory for the NHS. Given the Trust's position within the community this was adopted in November 2008.

To date the Trust has paid 81.6% of Local Suppliers invoices by volume and 81.8% of invoices by value within 10 days.

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 (£)
22/07/2013	Availability Charge SLA	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	8095168	196,254
26/07/2013	Occupational Health SLA	Trustwide	Leeds and York Partnership NHS FT	2144301	70,083
21/06/2013	FP10´S	Trustwide	NHSBSA Prescription Pricing Division	2142298	62,308
30/07/2013	FP10´S	Trustwide	NHSBSA Prescription Pricing Division	2144480	61,017
06/08/2013	Local Authority Social Workers	Wakefield	Wakefield MDC	2144889	44,596
19/07/2013	Lease Rents	Trustwide	Department Of Health	2143874	42,677
02/08/2013	Local Authority - Other Staff	Calderdale	Calderdale Metropolitan Borough Council	2144744	34,540
15/08/2013	CNST contributions	Trustwide	NHS Litigation Authority	8095025	28,302

Glossary of Terms & Definitions

- Recurrent – action or decision that has a continuing financial effect
- Non-recurrent – action or decision that has a once-off or time limited effect
- Full Year Effect – quantification of the effect of an action, decision or event for a full financial year.
- Part Year Effect - 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 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 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 had 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 part of the Recurrent Underlying Surplus.
- Cost Improvement Programme (CIP) – We only agree actions which are 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 once-off financial benefit. This Trust has historically only approved recurrent CIPs. 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 amortization. This strips out the expenditure items relating to the provision of assets from the Trust's financial position to indicate the financial performance of its services.
- IFRS – International Financial Reporting Standards, these are the guidance and rules by which financial accounts have to be prepared.

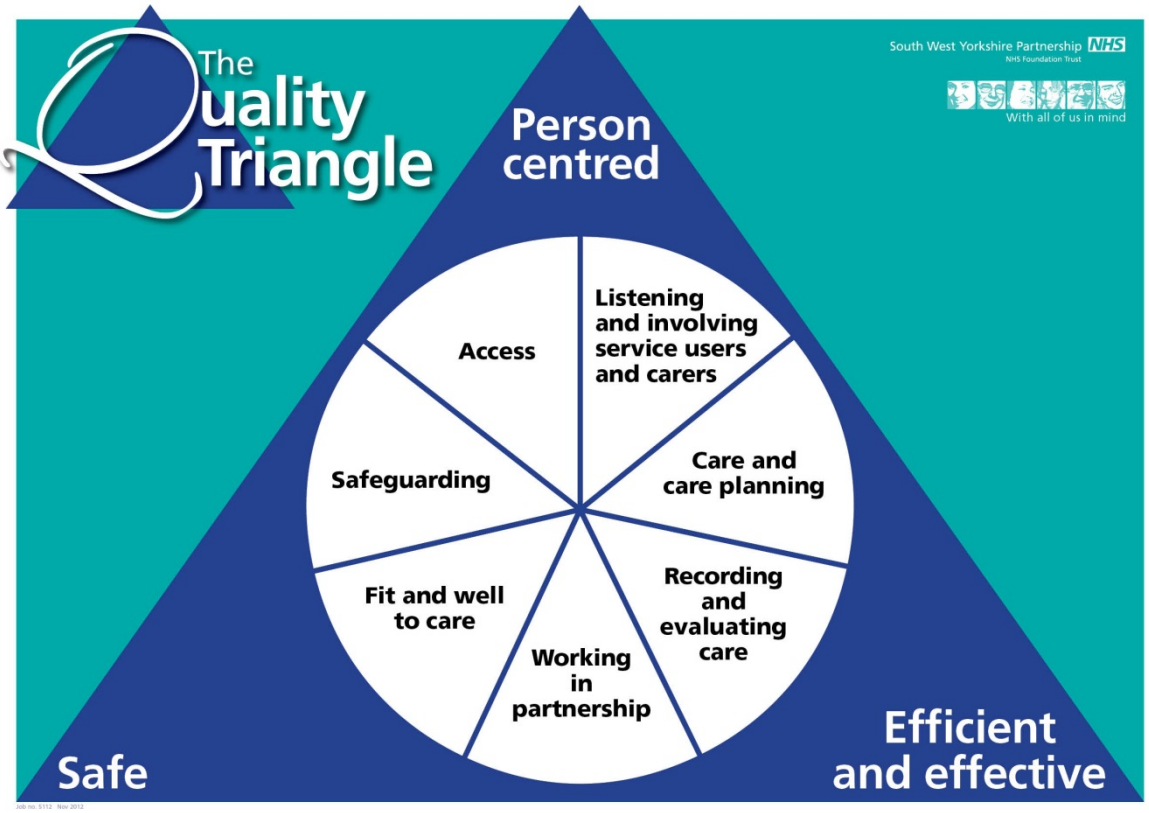
Trust Board 24 September 2013
Agenda item 7

Title:	**Quality Improvement Strategy**
Paper prepared by:	Director of Nursing, Clinical Governance and Safety
Purpose:	The paper describes the Trust's approach to quality improvement.
Vision/goals:	The strategy supports the Trust's mission to enable people to meet their potential and live well in their communities
Any background papers/ previously considered by:	Quality improvement framework approved by Trust Board. Quality improvement strategy development approach reviewed at Clinical Governance and Clinical Safety Committee
Executive summary:	Trust Board approved the adoption of a seven-step quality improvement framework (QIF) during 2013. This framework has been utilised to develop a systematic approach to quality improvement throughout the organisation. The Quality Improvement Strategy has been developed following a review of our position against our seven quality priorities using the QIF. During this review it became clear that there are a number quality initiatives underway within the organisation; however they often require a clear strategic fit. The review also highlighted a need for a consistent message across the workforce that clinical and support staff could relate to and provide a context for their local improvement activity, particularly in view of the plethora of national and local quality initiative documents. It was also clear that we required a document that describes our quality improvement plans in a way that key clinicians and support teams can identify with to ensure local ownership. To support this, the strategy has been developed close to clinical services. This strategy document describes the key aims for each quality area, immediate priorities for action and examples of activity required using the QIF. The strategy should be considered as a live document and should be subject to regular review during our transformation work. Most importantly the document will be utilised as the reference point for quality improvement discussions at all levels. Implementation of the Strategy will be monitored by the Clinical Governance and Clinical Safety Committee, providing assurance to Trust Board, and a summary of progress against priorities will be reported to Trust Board on a quarterly basis through the quality performance report.
Recommendation:	**Trust Board is asked to approve the quality improvement strategy**
Private session:	Not applicable

Quality Improvement Strategy

"A Three Year Strategy for the Development of High Quality Services within South West Yorkshire Partnership NHS Foundation Trust"

"Improve & be Outstanding"



Introduction

"High Quality Care for All" was published in June 2008 and it set out a challenging agenda to make quality the key drive within the NHS. Quality improvement becomes even more important when challenging economic circumstances present themselves. If quality is at the heart of everything that we do, it must be understood from a patient and service user perspective. People take note of clinical outcomes and their own experience of services. They will understand that all treatments and interventions are not perfect, but they will always expect to be treated with dignity and respect. They also expect that we should never place them at risk from any harm. Our key drive is to ensure that we should systematically improve quality throughout our services. In order to do this, we have adopted a seven element Quality Improvement Framework which is used in this document.

For us in South West Yorkshire Partnership Foundation Trust we define quality as follows.

Safety
The first dimension of Quality must be that we do no harm to people. This means ensuring that the services we provide are safe and that people should not fear harm. We must learn from our mistakes and avoid all errors wherever possible.

Person Centred
Our services should be provided in a personal way with dignity and respect with the person first and in the centre. This means we need to listen to what people say about what they require and respond appropriately.

Efficient and Effective
Our services must demonstrate value for money and understand the benefits of the interventions that we undertake to achieve the outcomes that people are asking for. The outcomes need to be real for people who receive our services and for their families. Things like getting back into work and feeling symptom free or able to live an independent life. We believe that there are opportunities where we can improve quality and reduce cost.

The Francis report has recently indicated a number of failures in the quality of services that have put people at risk. This reminds us that things can go wrong when quality is not at the centre of what we are trying to do.

South West Yorkshire Partnership Foundation Trust is continually driving to improve quality. This is reflected in our mission statement "Enabling people to reach their potential and live well in their community".

South West Yorkshire Partnership Foundation Trust has identified seven key priorities for quality improvement as follows.

- Access
- Listening and involving
- Care and care planning
- Recording and evaluating care
- Working in partnership
- Fit and well to care
- Safeguarding

This document describes our improvement plan against all these priorities using our seven-step Quality Improvement Framework as follows.

Our seven Quality Priorities

To listen to our service users and carers and act on their feedback (Listen & Act)

Our Aim
Patient experience is a recognised component of high-quality care and trust boards must understand how their patients are experiencing care if they are to effectively translate their needs and preferences into higher quality, safer and more efficient services. Aside from striving to provide high-quality clinical care for patients, improving their experience as a whole is complex. It involves looking at every aspect of how care is delivered, including how the patient comes into contact with the 'health system' in the first place. Efficient processes and good clinical outcomes are critical components of a patient's experience, but these alone are not enough to achieve an excellent experience. Experience is also determined by the physical environment patients are in and how they feel about the care they receive, including the way staff interact with them. Improving the experiences of all patients starts by treating each of them individually to ensure they receive the right care, at the right time, in the right way for them.

Our immediate priorities are:
- Achieve top 20% for patient experience surveys (overall score)
- Achieve 90% - 95% in local patient experience audits (e.g. CPA)
- Achieve 90% - in patient experience CQUIN's
- All clinical teams to be compliant with NICE guidance 136 & 138
- All clinical teams to be compliant with essential care standards.
- Establish a trust wide carers survey to obtain feedback and improve our offer to carers.
- Develop a portfolio of evidence of service improvements as a response to feedback
- Continue to develop 'story circles' and 'both sides now' initiatives.

Timely Access to Services (Access)

Our Aim
We know that when people need services they want to access them simply and in a timely manner. We therefore see timely and easy access to services for all people a key priority as an organisation. As access to and response from our services is central to the safety and effectiveness of the care received by service users it is essential that people can access the most appropriate service that will meet their needs. We know that currently some service users are not seen quickly enough and so we are committed to making this a priority.

Our immediate priorities are:
- All clinical teams to be compliant with essential care standards.
- Achieve 95% in all access CQUIN targets across the organisation
- To create clear access pathways through the transformation programme
- Be compliant with NICE quality standards which refer to access to treatment pathways.
- Increase the number of survey questions relating to access to improve monitoring and response.
- To achieve a 95% positive response to patient experience survey questions related to timely access to services.
- Review our Single Point of Access services and implement any recommendations

Improve care and care planning (Care and care planning)

Our Aim
Care planning is fundamental to providing the right support for individuals, whatever their reason for accessing services and regardless of the service that is being provided. Each person should have an appropriate assessment of their needs and the opportunity to develop individualised care plans that support personal recovery.

Our immediate priorities are:
- All people who enter our services will receive a timely assessment of their health and social care needs and risk, have active involvement in developing a care plan to meet their personal needs, receive timely treatment options and interventions and have their care evaluated at regular intervals in accordance with their clinical needs.
- Each individual will be allocated a named person to coordinate their package of care.
- Development and implementation of standardised clinical care pathways across our mental and physical health services
- Development of outcome based service specifications.
- Drive the Implementing Recovery through Organisational Change (IMRoC) project.
- Implement actions from clinical audits that help provide personalised recovery based care across all services.
- Achieve top 20% for national patient survey in the areas of care planning and care reviews.

Improve the recording and evaluation of care (Recording and Evaluating Care)

Our Aim
Ensure each intervention is accurately recorded in a timely manner so that there is appropriate communication across the care team to support the individuals care and maintain safe clinical practice.
Our review of complaints, incidents, investigations and CQC visit reports has indicated that we do not always have consistent quality across our services in the way we record and evaluate care that we provide. As accurate recording in care records is a fundamental way of communicating with others who work alongside us, we need to improve this element of our care.

Our immediate priorities are:
- Undertake an annual trust wide record keeping audit. Develop action plans to address specific concerns at BDU level and monitor via governance meetings.
- Targeted record keeping campaigns planned to address areas of concern from annual audit process.
- All clinical teams to be compliant with essential care standard related to record keeping.
- Reduce the number of serious incidents that highlight clinical record keeping as an area for improvement.
- Invest in electronic clinical record keeping systems to ensure they are fit for purpose.
- Provide clinical record training to staff as identified as part of continued professional development.
- Monitor and implement action plans on clinical performance data.

Transfers across Care Pathways (Working in Partnership)

Our Aim
We know that when someone is transferred from one service to another or from one team to another there is a greater risk for the service user. This is because it is a time of change, more people are involved, new relationships have to be developed. We have had isolated incidences where serious incidents have occurred at this critical time and we want to ensure

that these type of incidents do not occur again. We want to ensure our service users are transferred to the most appropriate service and team in a safe and effective way and that there are no delays between services.
Ensure service users who are ready to move along the care pathway are supported across service boundaries in a timely way or those services that are seeing the same person communicate effectively to prevent duplication or gaps in service provision.

Our immediate priorities are:
- Implement the care pathways that have been developed through transformational change utilising the skills we now have within the organisation to develop pathways across physical, health and wellbeing and mental health services.
- All clinical teams to be compliant with essential care standards.
- Develop transition protocols across all trust services and partner organisations
- Work with service users, carers and staff to develop a core set of quality standards to apply to transfers of care.
- Review our Delayed Transfers o Care processes to ensure we have improved consistency of reporting across our services.

Ensure that our staff are professionally, physically and mentally fit to undertake their duties (Fit and well to care)

Our Aim
Our aim is to continue to develop a skilled workforce that is able to deliver care that meets the present and future needs of people we serve. We recognise that it is important to have appropriately qualified, skilled, competent and professional staff to undertake the role that they are required to and to provide them with support so that their health and well-being needs are being met.
We know that our staff are the most valuable asset we have in our organisation. We are committed to valuing our workforce and know that staff that feel valued are more likely to provide excellent care to people who use our services.

Our immediate priorities are:
- Achieve and improve on appraisal target each year. Evaluate the impact of appraisal system on staff well- being and motivation.
- Undertake a trust wide clinical supervision audit cycle.
- Undertake both national and local staff audits and develop and implement action plans.
- Achieve top 20% for national staff survey (overall score)
- Achieve and improve on staff absence target each year
- Achieve mandatory training targets.
- Demonstrate impact of training on clinical care.
- Work with clinical staff to develop high performing teams
- Continue the development of the talent pool
- Continue and develop values based recruitment and induction. Include ‘experts by experience’ in recruitment activity.
- Undertake an analysis of workload for clinical staff.
- Review appropriate staffing establishments and skill mix in clinical teams.
- Development of a coaching strategy.

Improve the safety of people who use our services, carers, staff and visitors. (Safety)

Our Aim
We aim to ensure that the people that work with us and visit us are safe from harm.
As one of the Darzi quality domains we know that we have a duty of care to people who use our services, carers, staff and visitors to ensure no undue harm comes to them. Safety within

this priority area covers areas including safeguarding and physical environment as well as ensuring that we are delivering safe, effective and appropriate treatment.

Our immediate priorities are:

- Everyone accessing our services will have a comprehensive assessment of their needs by competent staff.
- Continue to upgrade the estate to ensure it provides a safe environment for our staff and service users.
- All staff will undertake safeguarding training appropriate to their role.
- The mandatory training programme will be reviewed and staff will undertake all mandatory training appropriate to their role.
- Datixweb will be rolled out across the organisation so that all incidents are recording and reported in a single place, supporting the organisation to understand trends and develop learning.
- Continue to strengthen the governance arrangements to support patient safety (BDU governance groups, Incident review sub-committee, clinical reference group).
- Research and evaluate tools to support decision making in risk assessment and management.
- Development of a quality assurance tool (self- assessment tools, organisational tools and quality impact assessment)
- Identify, review and implement lessons from serious incidents, serious case reviews, disciplinary investigations. Share the lessons trust wide via the BDU governance groups.
- Utilise the safety thermometer to measure care.
- Review medication errors and prescribing practices and learn lessons from the reviews.

Key activity to deliver the quality priorities:

Bringing Clarity:	There must be a clear and accepted definition of quality that is understood and owned by people who use services and their carers, staff and commissioners.
• Horizon scanning and interpretation of regulatory and other relevant national strategy for local implementation • Enhanced service offer documents for all service lines • Translate and provide compliance intelligence, ensuring Board, EMT, BDUs and Quality Academy Directorates all sighted on critical issues • Horizon scanning of how the Government will measure progress linked with the Health Outcomes frameworks • Review and development of key operational policy and procedure • Mental health currency development	

Measure Quality:	We can only demonstrate improvement if we measure quality. This means robust, timely and relevant information must be available at all levels in our delivery system.
• On-going development of quality dashboards, at all levels in the system. • Feedback from people who use the services (service users and carers) that the care that they experienced was rated good or excellent. • Develop a portfolio of service improvements as a result of patient feedback • Monitor and act on customer compliments and complaints. • Benchmarking against the CQC standards and NICE Quality Standards for	

Measure Quality:	We can only demonstrate improvement if we measure quality. This means robust, timely and relevant information must be available at all levels in our delivery system.

Patient Experience.

- Facilitate the Implementation of the recommendations from the Customer Service Excellence Accreditation.
- Improve processes to ensure receipt, review and triangulation of relevant information - Facilitate organisational and service self-assessment against CQC outcomes and NICE guidance
- Facilitating/supporting organisational and BDU quality impact assessments
- Enabling identification, development and delivery of quality indicators and health outcome measures
- Ensuring that critical quality targets/indicators within local contracts are understood and processes are in place for effective monitoring & reporting
- Service line reporting

Publish Quality:	The publishing of accessible information about our quality performance improves our accountability, empowers users / carers and informs decisions on priority for action

- Quarterly publication of the 'What Matters' report sharing good practice.
- 'Real time' feedback reports.
- Analysis of customer services received compliments and complaints.
- CQC and other inspection reports.
- Internal quality reporting designed and delivered around quality priorities
- Timely provision of appropriate internal assurance specialist advice, guidance and reports to Trust Board, Clinical Governance Committee, EMT, members council, BDUs, TAGs and other relevant parties
- Timely provision of appropriate external assurance reports to Commissioners and Regulators.
- Internal quality reporting designed and delivered around quality priorities
- Timely provision of appropriate internal assurance specialist advice, guidance and reports to Trust Board, Clinical Governance Committee, EMT, members council, BDUs, TAGs and other relevant parties.
- Quality Accounts annual report.
- Excellence awards programme

Partnerships:	We recognise that we are just a guest in people's lives and therefore we need to work with others to support people to "live life to the full"

- Effective organisational liaison, communication and engagement with Care Quality Commission, Monitor, NICE, Commissioners and Members Council
- BDU governance groups established and supported
- Integrated delivery team development
- Develop/improve strategic alliances internally between Quality Academy and BDUs with particular reference to CQC outcomes, NICE guidance review and implementation, service user experience, service transformation
- Develop and maintain productive partnerships to ensure whole system working e.g. creative minds

Leadership for Quality:	Leadership is required at all levels to ensure that quality is centre stage and incentives for quality are highlighted. Clinical, managerial and professional leadership all have a fundamental role to play in improving and maintaining quality.
• Horizon scanning, analysis and interpretation of national and local policy and guidance • Develop strong professional leadership networks • Finalise clinical / managerial leadership structures to ensure strong influential leadership as a driver for improved quality, ensuring that listening and acting that is owned in the whole organisation at all levels. • Mentorship, supervision and coaching • Support organisational talent management programme	

Innovate for quality	Continuous improvement requires us to be alert to and seek out opportunities for innovation. Improving quality through identification and application of best practice is essential at a time when transformation is our key activity.
• Develop innovations in information technology that enables accurate feedback from people who use services which can be acted on in a timely way. • Continued use of tele-health programmes • Continued use of agile working • Further exploration of technology to assist staff deliver safe effective care • Provide opportunities for talent to flourish • Service transformation initiatives • International and national best practice scanning and networking	

Safeguard Quality:	Maintaining a drive on quality improvement is essential but it is vital that we ensure essential standards of safety and quality are maintained. Embedding quality in our delivery system will ensure that this happens.
• Enable an organisational response to national and local safeguarding reports/audits in a timely manner • Unannounced visit programme • Quality reporting mechanisms • Clinical audit programme • Francis “values into action” programme	

Trust Board 24 September 2013
Agenda item 8.3(i)

Title:	**Quality Accounts severe harm and death mandated indicator reporting**
Paper prepared by:	Director of Nursing, Clinical Governance and Safety
Purpose:	The purpose of this paper is to recommend a change in severe harm and death reporting arrangements.
Vision/goals:	The change supports the Trust's commitment to being "Open, Honest & Transparent".
Any background papers/ previously considered by:	The matter has been considered by the Clinical Governance and Clinical Safety Committee.
Executive summary:	As part of the Quality Accounts for 2012/13, the indicator for incidents resulting in severe harm or death was audited by Deloitte. This was completed by reviewing data held for severe harm and death incidents on Datix compared with that held on the National Patient Safety Agency (NPSA) National Reporting and Learning System (NRLS). The Trust captures the severity of incidents locally on Datix using the risk matrix which scores incidents ranging from green through to red. This includes actual and potential harm of incidents and near misses (i.e. psychological harm, potential risks). The Trust uploads patient safety incidents from Datix to the NRLS, where local information is mapped to national coding. The NRLS scores the severity of incidents by the **actual** degree of harm caused, as opposed to including potential harm as collected locally. During the audit, it became apparent that from our local Datix system that the Trust was unable to extract the same information from Datix as was available from NRLS. This is because of the difference in how the Trust captures information locally and how this is interpreted and captured nationally (as described above). The Trust has been uploading data to NRLS since 2006, and there has not been a national mandate to record severity of incidents by the actual degree of harm alone. The development of the NRLS was on the basis that local systems, such as Datix, should not have to be changed to accommodate the national reporting requirement and that manipulation would occur nationally. It should be noted that the Trust did implement the risk grading matrix recommended by the NPSA in approximately 2010. Presently, because the Trust is not able to capture like-for-like data between Datix and the NRLS system, the Patient Safety Support Team has to carry out several workarounds to ensure severe harm and death incidents are uploaded correctly. In addition, the requirement to implement Duty of Candour for incidents resulting in moderate, severe harm or death is also based upon the actual degree of harm, which is not currently available. After careful consideration, it is proposed to carry out work on Datix to restructure how the severity is captured (for local use) and capture the actual degree of harm (for external and internal use). The impact of this proposal is as follows.

	➢ The Patient Safety Support Team will no longer need to complete complex workarounds. ➢ The NRLS would receive information that could be identified locally on Datix. ➢ The change would allow accurate data for Duty of Candour requirements. ➢ Because of how the system would be changed, end users (reporters and managers) would not see any system change; however communications with users will need to be considered and managed to ensure any issues are anticipated. ➢ The majority of the work on Datix will not be visible to users, but will involve extensive work over a period of time to adjust how searching and reporting are carried out. This will need to be over a transition period where some functionality will not be available as work is carried out in the background. ➢ The option to make changes would need to be aligned with the start of a financial quarter to ensure complete reporting over a reporting period. Quarter 4 (1 January 2014) would be the next available period for this work to be completed. ➢ This work will have to take priority over other work of the team and any gaps will require Director support/understanding. ➢ If this change was implemented, then data for reporting on the indicator would only be possible for Quarter 4 of 2013/14. This needs to be considered in production of Quality Accounts 2013/14 ➢ From 2014/15, if mandated by Monitor, the full data can be extracted from the system locally.
Recommendation:	**Trust Board is asked to support the changes in reporting as described above.** This recommendation is supported by the Clinical Governance and Clinical Safety Committee.
Private session:	Not applicable

Trust Board 24 September 2013
Agenda item 8.3(ii)

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Title:	**Marketing Framework**
Paper prepared by:	Chief Executive
Purpose:	Trust Board is invited to consider the proposal for the further development of the Trust's strategic approach to marketing in support of the Trust's Integrated Business Plan.
Vision/goals:	This proposal is pertinent to all the Trust's values but in particular: ➢ always put the person first and in the centre; ➢ always strive to improve and be outstanding; ➢ be relevant today, ready for tomorrow In addition, it supports the delivery of the following Trust objectives: ➢ Strategy – ensuring the key strategic priorities are clear and focused on maintaining organisational success in a rapidly changing environment. ➢ Flawless Execution – ensuring the Trust is able to identify, generate and act upon business development opportunities. ➢ Partnership – through the coordination and direction of partnership relationships, in pursuit of business development opportunities.
Any background papers/ previously considered by:	➢ Trust Strategic Delivery Framework and Corporate Objectives 2013/14. ➢ Marketing Strategy Development Paper 1 March 2013. ➢ Delivering Marketing and Strategic Planning April 2013
Executive summary:	The Trust recognises a need to develop a marketing framework which enables it to compete and collaborate effectively within an increasingly market-oriented NHS. Specifically the Trust must ensure the following. • A thorough understanding of the needs of service users now and in the future. This goes beyond understanding their level of satisfaction with current service offers and builds upon existing involvement and insight activities. • A thorough understanding of the markets in which it operates and could operate in the future. This will include competitor analysis, commissioner analysis, and horizon scanning of the wider environment. • A clear and balanced view of its own strengths and weaknesses with regard to delivery on contracts and meeting quality expectations of service users and regulators. • Identify and prioritise areas for action, ensuring alignment to strategic objectives. It will be as important to be clear about what the Trust will not do, as to identify those things it does. • Develop and implement a marketing approach which supports the delivery of the Trust's strategic objectives and directs the way in which the Trust promotes and sells its services. • Proactively manage partner relationships in order to shape the environment and deliver on marketing and sales goals. This includes how the Trust supports system-wide innovation.
Recommendation:	**Trust Board is asked to:** ➢ **note the update;** ➢ **support the direction of travel as set out in the conclusions and way forward**
Private session:	Not applicable

MARKETING FRAMEWORK

1. INTRODUCTION

This paper sets out a broad framework for action for marketing within the Trust. The intention is to build on the work that has been undertaken within this area over the past year. General awareness has been raised regarding the concept of marketing through the work undertaken by Douglas Quigg and James Drury. This has full Trust Board support, but to make any meaningful impact; priorities, timescales, responsibilities and associated resources need to be made much clearer.

2. WHAT DOES MARKETING MEAN WITHIN THE TRUST?

In order to make progress, it is important that the Trust has a clear working definition for marketing, as it can mean many things to many people.

"Marketing is a 'matching' exercise which matches the inherent potential of the organisation, both now and in the future, to the external environment within which it operates, and in doing so maximises opportunity and minimises threat."

The link, therefore, to integrated business planning is crucial. In recognition of this, James Drury's portfolio, as Deputy Director of Strategic Planning has been widened to encompass marketing. In support of this, Director accountabilities have also been clarified at Director level with Dawn Stephenson carrying the customer relationships manager lead and Alex Farrell the business planning and contracting accountability.

3. SO WHAT IS THE TRUST'S OFFER?

To be confident that the Trust understands the power and relevance of its offer in a rapidly changing environment, the organisation must challenge its sense of core purpose and identity. If this is not clear, the potential for confusion arises, leading to a fragmented presentation of what is seen to be important.

Despite a lot of good work to describe the Trust's offer and 'brand', there is still a degree of confusion and fragmentation existing within the Trust and also with partners. Essentially, the brand of the organisation is there to reflect the core purpose of the organisation which is defined through its mission as:

'Enabling people to reach their potential and live well in their community'.

In addition, the brand must reflect the Trust's values which are:

- **Honest, open and transparent**
- **Respectful**
- **Person first and in the centre**
- **Improve and be outstanding**
- **Relevant today, ready for tomorrow**
- **Families and carers matter**

The opportunity to create an ambassadorial role for all staff members will be a powerful way of supporting the brand.

In terms of marketing, this brand has been created through a process of co-production involving service users, carers, staff and the general public. This approach of co-producing an organisational vision, way of behaving and, ultimately a way of delivering services, will be central to the Trust's brand going forward.

Essentially, there are two distinct elements to the Trust's brand, which are not mutually exclusive. These are:

1. being seen as a safe and effective provider of services with a reputation for delivering high quality within defined resources;
2. being seen as a transformative organisation, capable of co-producing through partnership working, improved outcomes for service users and carers which enable them to reach their potential and live well in their community.

Central to achieving the above is the notion of partnership. When becoming a Foundation Trust, Trust Board took a decision to move from being described as a 'specialist mental health service provider' to one of being a partnership based organisation. It would be fair to say this reflects a general sense of intent to work differently, although the true reality and implications of this were not fully understood at the time.

As work has progressed it has become increasingly apparent that partnership, collaboration and co-production are at the heart of the Trust's identity and therefore need to be reflected in the brand.

Initiatives such as Creative Minds, Right First Time, Change Lab and the partnership work the Trust is undertaking with organisations such as Spectrum and acute trust partners, point to a new way of being which needs to be captured much more explicitly going forward. The Trust is engaged in a wide variety of partnership activities and associated transformation work.

Going forward, the organisation needs to be much clearer as to how it directs its efforts and clarifies its intent in every area of partnership. In particular, from a marketing perspective, due consideration needs to be given as to where thought leadership can be demonstrated and value added.

In addition, it is important to recognise that central to the brand of the Trust is the brand of the NHS. The organisation is an NHS body and therefore needs to understand how this is reflected in its branding and how this can add to the public and customer perception of the organisation. Coupled with this is the strength of the Foundation Trust brand rooted in public accountability, financial freedoms and a mutual stake in the organisation's future success.

4. SO WHAT DOES OUR CURRENT BRANDING APPROACH TELL US ABOUT THE TRUST?

The Trust's brand is what it wants to be recognised for and associated with, by its stakeholders. 'Brand' can be defined as a business tool, which aims to support a competitive advantage and a sustainable future. Brand performance denotes the relationship between brand and business and is where there is a clear definition of what

makes the service offer 'desirable', supporting increased interest in the service offer and an increase in contracts, therefore supporting delivery of business goals.

Corporate image is all the knowledge and beliefs that individuals hold about the organisation at any one time. It is a mixture of rational and emotional attributes, the collective assessment of both knowledge and beliefs, which should, when taken together create a positive reputation, which is sustained despite any fluctuation in opinion over time. The Trust's corporate image is positioned in, and presented through, its mission and values as set out above, developed through a process of co-production, this partnership approach being central to the Trust's brand going forward.

The visual identity for the Trust was developed in partnership with service users some years ago. It consists of a logo depicting '**heads**' – representing age, gender and ethnicity and a strapline '**With all of us in mind**'. The use of this identity has evaluated well, has 'brand recognition' and continues to be relevant in light of the recently revised mission and values. The brand is being 'refreshed' to reflect the Trust's current service offer, particularly the provision of children's and adolescents' mental health services. The change is subtle enough to maintain recognition, whilst at the same time ensuring a representation of current services. This sits alongside the NHS branding of the Trust, which the Trust is required to carry as a public body, meaning the Trust must retain the NHS lozenge and the format for the title of the organisation.

Note
NHS England has taken over the responsibility for the NHS identity from the Department of Health. NHS England will be presenting its thinking on brand and the future development of the NHS identity at the September meeting of the Foundation Trust Network. Output from these discussions will be shared with all Foundation Trusts as members of the network. The Trust will take account of development issues in redefining its branding policy. NHS England has assigned guardianship of the NHS identity as part of its Patients and Information Directorate and has introduced a 'Values and Standards' team.

Although there is much to commend the Trust's current brand, the approach is somewhat fragmented and needs to be rationalised, as application of the brand over the past few years has resulted in:

- a degree of flexibility that has permitted the brand to be applied alongside a range of design styles;
- a degree of flexibility which has allowed the use of any colour from the extensive NHS palette;
- a degree of flexibility that has permitted use of the brand alongside images that do not perhaps present the Trust in line with corporate business goals;
- a degree of flexibility that has permitted services to use external design services which in some cases have not produced work true to brand.

Recent external review of the Trust's visual identity, by an industry expert, has determined that:

- visual representation of the Trust's brand is confusing and indistinct;
- there is no Trust-wide/whole-service brand management;
- the application is too broad, with different manifestations, sub brands and different campaigns;
- the brand loses impact due to inconsistency of application.

By adopting a more disciplined approach to marketing, which is well managed, efficient and 'clean', with revised Trust policy on branding and effective 'policing' of policy application by service leads and directors, linked to business goals, the Trust can really start to drive performance in real, measurable terms.

The next phase of branding is critical. As part of the rationalisation process, a much clearer and explicit link needs to be made to transformation work at the next stage development of the Integrated Business Plan. Greater focus and clarity needs to be brought to the development of the brand. Promotional products, for example, need to be developed in line with a clear set of business rules. This will necessitate an urgent review of the Trust's branding policy. Application of the Trust's visual identity is currently limited to information resources. Consideration could be given to extending the visual identity to cover, for example:

- external and internal signage;
- décor in public areas of Trust buildings;
- creating commonality to all reception facilities;
- uniforms for 'front of house' staff and volunteers'

5. SO WHO ARE OUR CUSTOMERS?

In essence, the core customer is the user of the service. However, it would be a dangerous over simplification to think that, from a marketing perspective, the organisation should solely concentrate its efforts on working with service users. Undoubtedly, they are the most important group, but thought and consideration needs to be given to other stakeholders who have a legitimate interest, financial or otherwise, in the Trust's activities.

Other customers include:

- clinical commissioning groups;
- specialist commissioners;
- local authorities;
- regulators (Monitor/Care Quality Commission);
- overview and scrutiny committees;
- health and wellbeing boards;
- local MPs;
- partner organisations;
- general practitioners as providers.

The above list is not exhaustive; however, much effort can be expended at the margins of our customer base, leading to a lack of focus and discipline in targeting marketing initiatives in the right areas. A clear, Customer Relations Management (CRM) approach will be developed which enables engagement with ***'the right customers, at the right time, by the right people with the right information'.***

6. BUSINESS PLANNING PRIORITIES

Work around service transformation in the four 'big ticket' areas of mental health, general community services, services for people with a learning disability and forensic services has intensified over recent months and reached a critical first stage of development at the end of August. This has seen a first stage articulation of a service vision which will then need to

be ‘hard wired’ into the Integrated Business Plan and will provide a strong focal point for all marketing initiatives going forward.

Included in this work will be identifying how both the Creative Minds and the Implementing Recovery Through Organisational Change initiatives can become both a guiding philosophy, driver and strong example of thought leadership. Marketing will play a key role in identifying how this can be best promoted in support of business planning priorities.

Ensuring the link to business planning can be achieved becomes a key priority.

A paper concerning the relevant functions required to support this and associated structures with timescales for recruitment was discussed at a recent Executive Management Team (EMT) meeting, identifying necessary support structures for strategic planning, marketing, support for transformation, service innovation and health intelligence and the recovery agenda. This work is being progressed through the EMT, and will be fully completed by October and presented to the Board.

7. THOUGHT LEADERSHIP

There has been much discussion as to where the Trust can demonstrate true thought leadership. The answer, it seems, is staring the Trust in the face. The work to progress service transformation through a process of co-production is potentially ground breaking. The challenge going forward will be to demonstrate, through the application of strong service innovation approaches and associated health intelligence, what difference this is making to the lives of service users and local communities. This will prove to be a challenge and will need a strong marketing drive behind it in all of the areas described above.

In addition, the Trust needs to focus on how it celebrates its achievements much more explicitly. This applies, not only to internal initiatives such as Excellence Awards, but also seeking regional and national recognition, particularly in the area of thought leadership. To date, although the intent to address this matter has been there, the actual approach has generally been weak and needs to be picked up as part of the review of marketing as a matter of priority. Key awards which would have the maximum impact should be actively targeted going forward.

The fact that the Trust has achieved Investors in People status and, very recently, achieved the Customer Service Excellence Award should be recognised, and built into the marketing work to support the Trust’s role as a thought leader.

8. CONCLUSION AND WAY FORWARD

This paper has endeavoured to identify the key aspects of marketing which need to be addressed as a matter of urgency. The intent has been to provide an outline framework for action.

In summary, the key elements are as follows.

(i) Define marketing and how it applies to the Trust as set out above.
(ii) Clarify the Trust’s offer and the associated brand. The offer will be defined in the Integrated Business Plan to be presented to the Trust Board in October (led by Alex Farrell).

(iii) Rationalise and improve the approach to branding. The Trust's visual identity application will be subject to review, with policy and guidance developed in support of a well governed approach to its application. A revised policy will be presented to EMT in October (led by Dawn Stephenson).
(iv) Make a stronger and more explicit link to business planning priorities with specific reference to service transformation. The scope and timeframes to be determined through Business Planning Process (led by Alex Farrell).
(v) Provide a sharper focus and discipline to the customer relations management agenda, which will be considered by EMT in October (led by Dawn Stephenson).
(vi) Identify and promote co-production as the key element to thought leadership through ongoing service transformation work with service users, carers, staff and the Trust's key partners (led by Dawn Stephenson and Alex Farrell).

In the spirit of co-production, the marketing work will be taken forward on an EMT basis to ensure universal ownership.

Trust Board 24 September 2013
Agenda item 8.3(iii)

Title:	**Health and Safety Annual Report 2012/13 and plan 2013/14**
Paper prepared by:	Director of Human Resources and Workforce Development
Purpose:	The Trust Board has a duty to ensure that the health, safety and welfare of service users, staff and visitors remains a high priority within the organisation and as far as reasonably possible risks are mitigated or reduced. This paper is devised to give assurance on the on-going management of health and safety in the Trust.
Vision/goals:	True effective management of health and safety is key to the delivery of safe and high quality services.
Any background papers/ previously considered by:	This report has been considered by the Clinical Governance & Clinical Safety Committee.
Executive summary:	The Health and Safety Annual Report 2012/13 has been developed to provide an overview of the leadership and management of health and safety during the last 12 months. The executive summary attached gives an update on: ➢ the development of the structure for the management and engagement of key stakeholders in health and safety; ➢ the arrangements for on-going monitoring and auditing of health and safety in the workplace and action taken; ➢ key health and safety risks and action to mitigate them; ➢ health and safety training activity; ➢ Trust response to changes in legislation. ➢ overview of health and safety incidents during 2012/13. The 2013/14 action plan is designed to: ➢ strengthen the health and safety monitoring and audit programme; ➢ develop and update Health and Safety policies to reflect changes in legislation; ➢ strengthen and ensure a consistent approach to risk assessment; ➢ ensure health and safety training is effective, accessible and relevant.
Recommendation:	**Trust Board is asked to note the health and safety annual report for 2012/13 and agree the action plan for 2013/14.**
Private session:	Not applicable.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Annual Health & Safety Report 2012/13: Executive Summary and 2013/14 Action Plan

June 2013
Estates and Facilities

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Health & Safety Annual Report 2012/2013 and Annual Objectives 2013/2014

1 INTRODUCTION

This report is designed to provide an overview of the management of Health & Safety within the organisation during 2012/2013 and key areas for developments for 2013/2014.

A significant amount of work has been undertaken throughout 2012/2013 to ensure the Trust effectively manages health and safety risks and a number of key issues addressed over the past 12 months. It is, however, important to acknowledge the health and safety agenda continually develops with new legislation, outcomes of national reviews or enquiries and organisational learning.

The 2013/2014 Health & Safety action plan builds on the achievements of the 2012/2013 plan and addresses key risks identified in the year.

In 2012/2013 whilst there has been no new significant health & safety risks identified the staff involved continue to take a proactive approach, working with managers, staff, partner organisations and stakeholders in an effort to mitigate risks to the Service Users, Staff and Visitors.

2 EXECUTIVE SUMMARY

2.1 Health and Safety TAG and Sub-Groups

The Trust has a well defined structure to ensure health & safety matters can be effectively discussed and where appropriate action agreed. A new Trust Wide Health and Safety TAG was established in 2012 supported by two Sub-Groups (West & South).

The Health & Safety TAG meets on a quarterly basis and the Sub-Groups meet bi-monthly all of which are well attended by managers, and staff representatives. Issues covered by the TAG included Fire, Moving & Handling, Security, Waste Disposal, partnership working, risk assessments and horizon scanning issues.

Some of the key areas for the TAG in 2012/2013 were:

- Community buildings – joint working with Social Services and NHS Partners;
- Clarification of Organisational structures and responsibilities within policies;
- Safer Sharps EU Directive and its effective implementation within the Trust.

2.2 Trust Wide Annual Health and Safety Monitoring

The Trust's Health & Safety monitoring tool continues to be the major vehicle for auditing health and safety practice and management, and it supports the proactive health & safety management at a local level.

A total of 180 managers and 110 buildings surveys were received by the Clinical Governance Support Team for detailed analysis. The response rate was 99% across the Trust and from this a work programme to address issues was identified. In addition there 40 scheduled audits by Specialist Advisers.

Issues arising from the monitoring tool are shared with the Health & Safety Sub-Groups and overarching TAG and a detailed action plan to address identified areas for improvement.

2.3 Key Health & Safety Risks

A total of 5400 health & safety related incidents were reported during 2012 – 2013, and the key risks identified in the year were broadly:-

- Violence & aggression
- Stress
- Slips Trips and Falls of patients.
- Slips Trips and Falls of staff
- Managing Contractors

The Health & Safety Team worked closely with colleagues across the Trust to address key risks. The Sub-groups allows for close working with the BDU's on mitigating risks in these areas. The Health and Safety team also work closely with specialist advisers and clinical staff to support safe and effective services. The Health and Safety Manager and the Local Security Management Specialist attend the Management of Aggression and Violence (MAV) TAG and share good practice as appropriate.

2.4 Health and Safety Training Statistics

Health & Safety training was reported in the NHS staff survey of being just 59%. However the Trust's Health & Safety Monitoring tool, which reached 99% of teams and departments, indicated an actual figure of 80%. This was further audited with attendance at courses and showed a true figure of 6338 of individual student training events throughout the year.

Examples of safety related training provided included:-

COURSE	NUMBERS
Trust Induction – basic safety awareness	325
Health & Safety Awareness	429
Fire Training	4415
Moving & Handling Patient/Service User	431
Moving & Handling Load	514
Conflict Resolution	363
Root Cause Analysis	13
Display Screen Equipment	148
Total	**6338**

2.5 Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR)

The legislation changed on 6 April 2012 regarding RIDDOR which moved from reporting absences of 3 days or greater to only absences of 7 days or more being reportable, making comparisons with previous years impossible. However, in future reports we will be able to benchmark RIDDOR across services and BDUs.

2.6 Safer Sharps – Health and Safety (Sharp Instruments in Healthcare) Regulations 2013

The Regulations implement aspects of the European Council Directive 2010/32/EU (the Sharps Directive) that are not specifically addressed in existing GB legislation and apply from 11th May 2013.

A sub-group of the Health & Safety TAG, consisting of representatives from Infection Control, Pharmacy and nursing staff from different disciplines have been working together to identify safer sharps practices and where this is not possible to provide information to staff. A review of Safer Sharps use was subsequently undertaken, risk assessments updated and specific information made available on the Intranet.

3. MANAGEMENT OF HEALTH AND SAFETY 2012/2013

The aim of this report is to give an overview of the progression of Health & Safety, Security, Fire Safety and Moving and Handling arrangements during 2012/13.

A key objective in 2012/2013 has been to centralise key processes from across the Trust to reflect core working arrangements.

Key drivers were to embrace the Trust's mission and values and to support staff in delivering high quality, effective care in a safe environment, whilst maintaining compliance with the regulators, (Monitor and CQC), and relevant health & safety legislation.

3.1 Key Health & Safety Risks

A total of 5400 health & safety related incidents were reported during 2012 – 2013, Key risks identified in the year were identified as:-

- **Violence & aggression** which accounted for 54% of all reported incidents. The Health & Safety Team work closely with MAV TAG colleagues, identifying a number of key issues of joint interest to continually assess and reduce the risk from violence and aggression to service users and staff alike.
- **Stress.** The wellbeing & resilience of staff to stress in the work place is a high priority for the Trust and work is over seen by the Well-being at Work Partnership Group and a number of sub-groups. Work streams include healthy life styles, shift working and staff retreats. During March, in partnership with Robertson Cooper Occupational Psychologists, the well publicised pulse survey was commissioned and analysed to understand stressors staff were facing in the workplace and to identify hot spots.
- **Slips Trips and Falls of patients** accounted for 16% of all reported incidents throughout the year and the Health & Safety Team have worked closely with the clinicians in forming a Trust wide strategic Falls Strategy Group with the aim of reducing falls to service users whilst in the care of the Trust. The health and safety input is specifically designed to help identify measures in clinical, ward environments that lead to a reduction in and the severity of subsequent falls.
- **Slips Trips and Falls of staff equated to**1.6% of reported incidents throughout the year. Coupled with the potential effects of falls on individuals and the age profile of a number of the more experienced, staff, prevention of slips, trips and falls represents a high priority for 2013 – 2014.
- **Managing Contractors.** Contractors of all types, commissioned to undertake work on behalf of the Trust represent a key risk when brought onto site. A robust Control of Contractor's Policy covering individuals from consultants, caterers, information technology to traditional trades employed was developed and implemented during 2012 - 2013

The Health & Safety Executive particularly require re-assurance that effective joined up working and co-operation exists between organisations, which is demonstrated within this report.

A 2 year action plan was established to prioritise work streams for 2011/2012 and 2012/2013 identified best working practices from the previous organisations and outlined actions to establish new overall health & safety arrangements.

The 2012/2013 plan has been revised further in light of the annual review and updated accordingly with good progress being made.

Health & Safety, Security, Fire Safety and Moving and Handling have all made significant progress within the past twelve months amalgamating working practices and procedures.

The 2012/2013 report focuses on the following key areas:-

- Annual Health & Safety Monitoring Tool;
- Audits & Inspections;
- Health & Safety Action Plan;
- Health & Safety Incidents;
- Legal Issues;
- Moving and Handling;
- National Issues;
- Partnership Working;

4. INTEGRATED HEALTH & SAFETY ACTION PLAN

In order to identify business critical and operational functions, that required attention a review of key Health & Safety policies, training and procedures within Corporate Services was undertaken.

On completion of the review, a 2 part action plan which included key milestones was developed.

The Action Plan is a live document with regular amendments being made as any actions are completed. The action plan is separated into three key areas:

1 Policies;
2 Training;
3 Processes.

These areas are discussed in more detail below:

4.1 Policies

Policies scheduled for review or completion during year 2 of post merger that were approved and implemented by the Executive Management Team (EMT) are listed below:-

- Over arching Health & Safety Policy;
- Display Screen Equipment Policy;
- First Aid Policy;
- Slips, Trips & Falls Policy;
- Health & Safety Risk Assessment Policy;
- Safe & Secure Environment Policy;
- Legionella.

It is a point of note that although the CCTV (Closed Circuit Television) Policy was identified for completion within Quarter 3, year 2; the policy has been subject to substantial review to ensure it's relevence Trust wide and is currently out for consultation.

4.2 Training

Information taken from the NHS staff survey indicated that only 59% of staff who responded, stated they had received Health & Safety related training throughout the year. A total of 430 staff completed and returned the Staff Survey Questionnaire.

Analysis of responses from the Annual Staff Survey and the training provided by Specialist Advisers has identified the strong possibility of staff not identifying specific areas of training as safety related.

In response to the survey results, an action plan has been produced to promote the types of training available to staff and increase awareness of the health & safety workbook and e-learning packages. The Trust's Intranet site is also updated to further promote services and availability of training.

4.3 Processes

There were a number of business critical processes identified within the action plan with a milestone for completion within year 2. These processes included:

- A centralised Alert Management System i.e. NHS Protect, Department of Health and Estates and Facilities Alerts;
- A centralised RIDDOR reporting system;
- The provision of Trustwide Lone Worker devices being utilised Trust wide.

All processes identified for completion within year 2 have been achieved.

5. ANNUAL TRUST WIDE HEALTH & SAFETY MONITORING

The Clinical Governance Support Team (CGST) was commissioned by the Health and Safety TAG and Sub-Groups to undertake the annual audit of general health and safety issues. The CGST provided vital support with the data entry, analysis and report.

The aim of the audit was to provide a review of health and safety issues across the Trust. The 2011/2012 audit tool was revised in line with the National Health and Safety Executive and approved by the Health and Safety TAG and Sub-Groups

The revised audit tool for the 2012/2013 audit was divided the tool into two surveys – firstly the Health and Safety audit tool for managers which was disseminated to all team, unit and departmental managers; and secondly the Health and Safety audit tool for buildings which was disseminated to the Health and Safety Specialists/representatives or designated persons with the responsibility for managing buildings

It is recognised that this report is not used in isolation to review health & safety activity within the Trust, but is an important element of the whole process supporting HSG65, with audits to verify claims by managers' submissions and/or concerns raised from members of the Health & Safety TAG/Sub-Groups undertaken to manage and enhance the overall health & Safety performance in the Trust.

5.1 Aim of the Annual Health and Safety Monitoring

The aim of the audit was to provide a comprehensive view of health and safety issues across the Trust with the following objectives:-

- To monitor health and safety areas across the Trust
- To highlight areas of good practice and areas of concern
- To ensure that an action plan is provided for areas of concern that will feed into the Health & Safety annual improvement programme.

A total of 180 managers' surveys and 110 buildings surveys were received by the Clinical Governance Support Team for detailed analysis. The response rate was a healthy 99% across the Trust.

5.2 Key Highlights Issues and Action

As with previous, monitoring exercises between 2007 and 2011 the Health and Safety TAG & Sub-Groups have concluded that the annual self monitoring regime provides a valuable snap shot in time of Trust wide performance in respect of Health and Safety.

390 completed returns (99%) have shown a healthy increase on 2011; the results reflecting the embedment of proactive monitoring in the organisation.

The results of the 2012 audit provided sufficient detail for the Health and Safety TAGs to devise and implement formal audits of departments and clinical areas. This process will fully commence in July 2013.

The principle recommendation from the Health and Safety TAG arising from the report is that the results of the monitoring exercise should be presented to individual Business Delivery Units to oversee BDU action plans.

The full Annual Health & Safety Monitoring Audit Report was presented to the Health and Safety TAG with the following key actions agreed:

Action Plan:

Issue	Status & comment	Lead
First aid	Issue of teams not always having cover when staff are on duty will be tackled through support & advice to managers through audits and routine site visits. The key recommendation is for teams and units to share First Aid cover. There is no legal	Health & Safety TAG & Sub Groups

Issue	Status & comment	Lead
	requirement for each team to have to employ trained first aid personnel.	
Moving and handling	Support Trust wide in terms of Moving & Handling has been challenging up to the appointment of a WTE assistant to Ali.	Ali Roper & Donna Kirby
Work systems, risk assessments and incident reporting	With just 62% managers reporting that risk assessments had been carried out from accidents/incidents recorded, checks will made during health & safety audits throughout the year that managers are reviewing risk assessments resulting from incidents.	All safety related personnel
Security and Safety	Lock down issues are a fundamental element of the 2013/2014 security work plan.	LSMS specialists
Medical devices training	With only 87% of respondents reporting they kept a record of training / competency assessments for medical devices, the issue has been referred to the Medical Devices/Safety Alerts group.	Ann Hargate
Electrical Safety	With 36% of respondents identifying trailing cables in the workplace as a risk, the issue of potential of slips, trips & falls will be addressed through the Health & Safety TAG & Sub Groups and Estates TAG and on site audits.	Health & Safety TAG & Sub Groups and Estates TAG
Hot water and patients	With local procedures for checking water temperatures were in place for just 70% cases in the manager's survey and in only 81% in the buildings survey, the issue has been referred to the Medical Devices/Safety Alerts group.	Ann Hargate
COSHH and personal protective equipment	COSHH and rolling out the Trust SYPOL system continues to be priority for the current work programme into 2014.	Steve Amos, supported by Trust managers
Individual staff health and safety	With the Staff survey stating only 59% of personnel had received some form of safety training and the Manager's survey identifying an 80% score, the Health & Safety TAG & Sub-Groups have identified a number of key measures, including greater publicity and workbooks to increase uptake and subsequent compliance in safety related training.	Roland Webb, Health & Safety Professionals

The following specific recommendations were made by the Health and Safety TAG and will be pursued during 2012/2013.

- Continued review, development and amalgamation of applicable Trust wide Health & Safety Policies;

- Continual Development of the monitoring tool;

- A programme of publicity and feedback to managers & staff around the 2012/2013 results and early introduction of the 2013/2014 monitoring tool;
- Further development of the Trust Wide Health & Safety TAG to over see the work of Barnsley BDU & Forensics, Wakefield, Calderdale, Kirklees Health & Safety Sub-Groups;

- That individual departments and clinical areas fully comply with the monitoring programme in 2013/2014 within the allotted time scale;

- The Trust Board endorse and support the continual development of the annual health and safety monitoring programme.

Record of Appreciation

The Health and Safety TAG wish to place on record their thanks and appreciation for the professional analysis and presentation prepared by the CGST team, and look forward to the fully integrated 2013/14 round of monitoring.

The Health and Safety Audit has been used on the basis for the development of the 2013/2014 Health and Safety objectives detailed below.

6. 2013/2014 HEALTH AND SAFETY ACTION PLAN

The Health and Safety audit together with relevant new legislation has been used as the basis for the development of the 2013/2014 action plan. The details of the action plan are shown in Appendix 2.

Appendix 1

2012/2013 HEATH & SAFETY INCIDENTS

A total of 6367 non clinical incident were reported during 2012/2013; an increase of 1002 (+15.7%) from the previous reporting period.

Figure 1 demonstrates the types of incidents reported during 2012/2013:

Incident Type	Total 2011/12	Total 2012/13	Percentage
All Other Incidents	372	473	+27.1%
Health & Safety	1001	892	-10.9%
Security Incidents	-	497	N/A
Smoking Incidents	191	162	-15.2%
Slips, Trips and Falls	1051	1019	-3.1%
Violence and Aggression	2750	3324	+209%
Grand Total	**5365**	**6367**	**+15.7%**

Figure 1.

An increase in reported incidents was noted during 2012/13, in particular in the Violence and Aggression category. However in contrast a reduction of Smoking incidents and Slips, trips and falls were noted.

Incidents reported occurred within the following BDU's:

BDU	Total 2011/12	Total 2012/13	Percentage
Barnsley	854	829	-2.9%
Calderdale	586	775	+32.3%
Forensic Service	1211	1827	+50.8%
Kirklees	813	973	+19.7%
Trust wide (Corporate support services)	73	57	-22%
Wakefield	1889	1906	+0.9%
Grand Total	**5365**	**6367**	**+15.7%**

Figure 2.

Key Performance Indicators

A number of Key Performance Indicators (KPI's) were introduced to improve the management of non clinical incidents. The KPI's are listed below:

- Violence & Aggression;
- Moving & Handling;
- Slips/Trips/Falls (including clinical incidents);

- Fire;
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR).

The summary below provides an overview of all incidents relative to each KPI within the reporting period.

These figures are reported regularly into the Health and Safety Trust Action Group (TAG). They will be used for benchmarking performance for 2013/2014.

Violence & Aggression

Out of the 6367 incidents reported within Datix 3324 (52.2%) were categorised as Violence & Aggression. Figure 3 provides a breakdown of incidents within each BDU:

BDU	Total 2011/12	Total 2012/13	Percentage
Barnsley	206	240	+16.5%
Calderdale	302	438	+45%
Forensic Service	671	1079	+60.8%
Kirklees	402	420	+4.5%
Trust wide (Corporate support services)	12	6	+50%
Wakefield	1157	1141	+1.4%
Grand Total	**2750**	**3324**	**+20.9%**

Figure 3.

Figure 4 demonstrates a further breakdown of the number of Violence and Aggression incidents within each BDU and their subsequent category:

	Barnsley	Calderdale	Forensic Service	Kirklees	Trust wide (Corporate support services)	Wakefield	Totals
Allegation of violence or aggression	14	20	19	12	0	14	79
Inappropriate Sexual Behaviour (including assault)	3	3	10	10	1	26	53
'Inappropriate violent/aggressive behaviour (not against person)	24	39	96	31	0	107	297
'Physical aggression/threat (no physical contact)	74	117	413	154	1	456	1215
'Physical violence (contact made)	60	176	219	182	0	400	1037
Physical/sexual violence	3	3	0	2	2	2	12
Verbal aggression/threat (no physical contact)	62	80	322	29	2	136	631
Total	**240**	**438**	**1079**	**420**	**6**	**1141**	**3324**

Figure 4.

Of the 3324 Violence and Aggression incidents reported during 2012/13, 3289 incidents were graded as a low or medium risk, 33 recorded as high risk and 2 as very high risk.

MOVING AND HANDLING

A total of 24 Moving and Handling incidents were noted during the reporting period; figure 5 below shows respective totals within BDU's:

BDU	Total 2011/2012	Total 2012/2013	Percentage
Barnsley	15	9	-40%
Calderdale	3	3	-
Forensic Service	4	5	+25%
Kirklees	4	0	-100%
Trust wide (Corporate support services)	2	2	-
Wakefield	5	5	-
Total	**33**	**24**	**-27.8%**

Figure 5.

Of the 24 reported incidents Moving and Lifting patients were the main cause of injury followed by Staff Moving and Lifting objects. Figure 6 provides a full breakdown:

	Barnsley	Calderdale	Forensic Service	Kirklees	Trust wide (Corporate support services)	Wakefield	Totals
Building design issues/office planning	0	0	0	0	0	1	1
Issues related to travelling/using car on trust business	1	0	0	0	0	0	1
Moving/Lifting Patient	2	1	2	0	0	3	8
Office Layout	0	0	1	0	0	0	1
Patient Moving/Lifting Object	1	0	0	0	1	0	2
Staff Moving/Lifting Object	4	1	0	0	1	1	7
Staff Stretching/Bending	1	1	2	0	0	0	4
Total	**9**	**3**	**5**	**0**	**2**	**5**	**24**

Of the 24 Moving and Handling incidents reported during 2012/13, all incidents were graded as a low or medium risk. All incidents were investigated accordingly and appropriate actions were put in place to minimise future risk to staff.

SLIPS/TRIPS/FALLS

A total of 1002 Slips/Trips/Falls were reported during the 2012/13 reporting year. It is a point of note that Barnsley BDU figures do not include clinical slips/trips/falls between 01 April 2011 and 30 June 2011. Figure 7 below demonstrate those figures reported:

BDU	Total 2011/2012	Total 2012/2013	Percentages
Barnsley	293	235	-19.8%
Calderdale	107	136	+27.1%
Forensic Service	74	66	-10.9%
Kirklees	225	260	+15.5%
Trust wide (Corporate support services)	3	7	+133.3%
Wakefield	349	298	-14.6%
Total	**1051**	**1002**	**+4.7%**

Figure 8 demonstrates the number of Slips/Trips/Falls incidents within each BDU and the party affected:

	Barnsley	Calderdale	Forensic Service	Kirklees	Trust wide (Corporate support services)	Wakefield	Totals
Slip, trip or fall - other/visitor	3	0	1	1	0	0	5
Slip, trip or fall - patient	203	130	54	251	0	270	908
Slip, trip or fall - staff member	29	6	11	8	7	28	89
Total	**235**	**136**	**66**	**260**	**7**	**298**	**1002**

Of the 1002 Slips/Trips/Falls incidents reported during 2012/13, 997 incidents were graded as a low or medium risk. 4 “amber” and 1 “red” incidents were noted. All incidents were investigated accordingly and appropriate actions were put in place to minimise future risk to staff.

FIRE

A total of 106 fire related incidents occurred during the reporting period ranging from accidental fires to the purposeful activation of fire alarms.

Please note that this does not encompass smoking related incidents that activated false alarms; these are captured in the Legislation and Policy category within Datix.

Figures 9 and 10 provide further details:

BDU	Total 2011/2012	Total 2012/2013	Percentages
Barnsley	15	15	-
Calderdale	22	14	-36.4%
Forensic Service	25	27	+8%
Kirklees	11	32	+190.9%
Trust wide (Corporate support services)	2	2	-
Wakefield	27	16	-40.8%
Total	**102**	**106**	**+3.9%**

	Barnsley	Calderdale	Forensic Service	Kirklees	Trust wide (Corporate support services)	Wakefield	Totals
Deliberate Alarm Activation (No Fire)	2	3	1	0	0	0	6
Fire - Accidental	1	0	2	0	0	0	3
Fire - Cause Unknown	0	0	2	0	0	0	2
Fire - Deliberate by Patient	2	2	2	5	0	1	12
Fire - Electrical	2	0	0	0	1	1	4
Fire - Smoking Related (Caused by Cigarettes - Accidental)	1	3	1	6	0	1	12
Fire Alarm System - faulty	1	0	3	2	0	3	9
Non-Deliberate/False Alarm (No Fire)	5	5	15	17	1	10	53
Prevented Fire	1	0	1	2	0	0	4
Total	**15**	**13**	**27**	**32**	**2**	**16**	**106**

Of the 106 Fire incidents reported during 2012/13, 105 incidents were graded as a low risk and 1 as a high risk. All incidents were investigated accordingly and appropriate actions were put in place to minimise future risk to staff.

Appendix 2

South West Yorkshire Partnership NHS
NHS Foundation Trust

Health & Safety Action Plan – 2013/2014

Task/objective	Lead Director/ Senior Manager	Lead Officer(s)	Rationale	Target Date For Completion	Comments/Progress
Development of Trust wide audit/inspection schedules linked into the Health & Safety Monitoring Tool.	Alan Davis/Jerry Murphy	Roland Webb	Rolling programme required to build on annual monitoring report. Audit/inspection programme will be flexible and risk based.	October 2013	Building on the annual health and safety monitoring programme and 40 audits, a structured approach to ensure compliance is to be constructed. Future Health & Safety audits will be a mix of scheduled and risk assessment/intelligence based visits to individual team's services and departments.
Complete the RIDDOR policy and procedure roll-out to reflect HSE & CQC Liaison Agreement.	Alan Davis/Jerry Murphy	Roland Webb	Evidence indicates there are hot spots in the Trust where managers are not aware of their responsibilities with this legal requirement. Fresh policy and guidance will address this	September 2013	With the risk of inspections from the Health & Safety Executive on back of each RIDDOR notification a robust approach to ensure accurate concise reporting that satisfies regulatory agencies is due to be produced.

Task/objective	Lead Director/ Senior Manager	Lead Officer(s)	Rationale	Target Date For Completion	Comments/Progress
Establish and implement generic risk assessment templates and processes Trust wide.	Alan Davis/Jerry Murphy	Roland Webb	To have a standardised approach across the Trust to back the H&S Risk Assessment policy.	October 2013	Liaison with the Patient Safety team has been ongoing to evaluate the potential and cost of incorporating overarching health & safety risk assessments in toe the Datix system. Individual specialist risk assessments will still be available for staff when evaluating straight forward operational risks.
Complete Property, Occupiers and Teams Information Packs for all BDU's and Quality Academy.	Alan Davis/Jerry Murphy	Roland Webb/ Steve Amos	To improve on information available to specialist advisors in order to develop audit/inspection programme	March 2014	The production of information for managers and staff of a spreadsheet covering details of local arrangements Trustwide is under construction. This will facilitate easy, ready access of pertinent information in an emergency.
Fully implement COSHH SYPOL package Trust-wide; to include the creation and implementation of a COSHH e-learning package.	Alan Davis/Jerry Murphy	Roland Webb/ Steve Amos	Building on the health & Safety Monitoring results from the last 2 years the COSHH SYPOL package will support managers discharge their COSHH duties	March 2014	Supporting effective implementation of COSHH information throughout the Trust, investment of SYPOL will facilitate mandatory information for managers and staff. The COSHH programme includes the development of training in COSHH to supplement Health & Safety Awareness training. COSHH training will include e-learning and work books.
Develop Health & Safety Workbook package.	Alan Davis/Jerry Murphy	Roland Webb/ Steve Amos/ Alison Roper	To open up and improve flexibility for managers seeking H&S training for their staff	March 2014	With pressure being reported to Health & Safety TAG and sub Groups around releasing staff for training, alternative methods of delivering training is being developed. The training

Task/objective	Lead Director/ Senior Manager	Lead Officer(s)	Rationale	Target Date For Completion	Comments/Progress
					packages under development will include a manager's workbook for newly qualified staff.
Develop Harmonised Travel at Work Policy	Alan Davis/Tim Breedon/Jerry Murphy	Roland Webb	To formalise Trust approach to travel at work including staff travel and transport of service users	March 2014	Managing the risks to staff who drive at work requires more than just compliance with road traffic legislation. The Health and Safety at Work etc Act 1974 requires the Trust to take appropriate steps to ensure the health and safety of their employees and others who may be affected by their activities when at work. This includes the time when they are driving or riding at work, whether this is in a company or hired vehicle, or in the employee's own vehicle and the issue is high on the agenda of the HSE

Trust Board 24 September 2013
Agenda item 9

Title:	**Bretton Centre Compliance**
Paper prepared by:	Director of Forensic Services
Purpose:	The purpose of the paper is to enable Trust Board to consider the current compliance issue with NHS England requirements in the Bretton Centre.
Vision/goals:	Maintaining compliance of the low secure service within national specifications
Any background papers/ previously considered by:	None
Executive summary:	Recent changes to commissioning arrangements for low secure services and the publication of detailed service specifications have required that the Trust informs NHS England that part of the low secure service is not compliant with current regulations. An action plan needs to be agreed with the commissioning team prior to October 2013. The risks associated involve the potential for a part of the low secure service to be no longer commissioned by NHS England or alternatively there may be financial implications for works required to bring the service fully into line with national service specifications.
Recommendation:	**Trust Board is asked to approve the position proposed by the Executive Management Team to agree an action plan with NHS England to bring the low secure service within the Bretton Centre within national service specification.**
Private session:	Not applicable

Bretton Centre compliance

Introduction

The Bretton Centre provides 38 beds in conditions of low security on the Fieldhead site and serves the geographical catchment area of Wakefield, Kirklees and Calderdale. At the time of its development it was commissioned by the three local PCTs and only subsequently was commissioning responsibility passed to the Specialist Commissioning Group and more recently to the South Yorkshire and Bassetlaw Area Team on behalf of NHS England.

Seven of the beds are located in the Ryburn building which is outside of the perimeter fence and not directly attached to the remaining secure element of the service. This was specifically designed in order to have seven rehabilitation beds which would facilitate easier discharge to the community. This clinical model has worked well and is valued by the service but also does pose significant difficulties in terms of effective staffing, particularly with regard to 24 hour nursing. It has also presented some security issues given the lack of immediately available support, particularly out of hours. Nonetheless the service had been designated as low secure by the Specialist Commissioning Team and responsibility for commissioning the service transferred en bloc to South Yorkshire and Bassetlaw Area Team on behalf of NHS England on 1 April 2013.

Compliance Issues

Service specifications for low secure services across the country have been in development for many years with a first draft published in 2008. A final version of the specification was released in the spring of 2013 following the transfer of responsibility to NHS England. It was announced that compliance with the latest version of the service specification should occur by October 2013 and instructions were sent to providers to rate their compliance with specification, with a return to the Department of Health by July 2013. It has also become clear that local area teams do not have the same degree of flexibility and discretion as was employed in the past and that a service which failed to meet low secure specification could no longer be commissioned by NHS England. Discussions with commissioners confirmed the view that all areas of the Bretton Centre were compliant with the new service specification other than the seven beds located in Ryburn Ward. It was therefore agreed that the Trust would submit notification of this area of non-compliance. An action plan dealing with issues of non-compliance and other service development needs has to be agreed with the local area team by the end of September 2013 and if a service is not able to meet specifications then a derogation from the contract can be agreed whilst plans are implemented.

Action Plans

There are fundamentally two options available for the Trust to pursue with regard to its notification to NHS England of non-compliance with the low secure specification.

Option 1 – Plans can be put in place in order to bring the seven rehabilitation beds up to low secure specification. This would essentially

require either an extension of the physical perimeter fence around the Ryburn unit and ensuring that the physical environment, particularly with regards to perimeter security was within standard. A second option would be to relocate the rehabilitation ward within the existing secure perimeter. This would have significant benefits in terms of the flexible use of workforce across the four ward areas within one building and would address the previous concerns with regard to the physical security of the unit. This option has been considered within the Fieldhead Master Plan workstream facilitated by Willmott Dixon and a number of potential options are currently being explored. The financial implications of potential solution have not as yet been finalised but early indication indicated very dramatic variation depending on the level of re-provision and the extent to which reconfiguration of the Ryburn beds is associated with wider site re-provision.

Option 2 – The rehabilitation ward can be accepted as non-compliant. This will lead to the local area team having to decommission that aspect of the service and negotiations would then be required with local clinical commissioning groups in terms of potential transfer of commissioning responsibilities.

Proposal

It is recommended that whilst options are being explored for the redevelopment of the Fieldhead site and potential relocation of low secure rehabilitation beds that the Trust agrees an action plan with commissioners to bring the Ryburn beds up to low secure specification and maintain commissioning through the local area team. This would not preclude any subsequent move to transfer commissioning responsibility to CCGs at a later date nor would it commit to any particular design option at this stage.

Trust Board 24 September 2013
Agenda item 10

Title:	**Use of Trust seal**
Paper prepared by:	Chief Executive
Purpose:	The Trust's Standing Orders, which are part of the Trust's Constitution, require a report to be made to Trust Board on the use of the Trust's seal every quarter. The Trust's Constitution and its Standing Orders are pivotal for the governance of the Trust, providing the framework within which the Trust and its officers conduct its business. Effective and relevant Standing Orders provide a framework that assists the identification and management of risk. This report also enables the Trust to comply with its own Standing Orders.
Vision/goals:	The paper ensures that the Trust meets its governance and regulatory requirements.
Any background papers/ previously considered by:	Quarterly reports to Trust Board
Executive summary:	The Trust's Standing Orders require that the Seal of the Trust is not fixed to any documents unless the sealing has been authorised by a resolution of Trust Board, or a committee thereof, or where Trust Board had delegated its powers. The Trust's Scheme of Delegation implied by Standing Orders delegates such powers to the Chair, Chief Executive and Director of Finance of the Trust. The Chief Executive is required to report all sealing to Trust Board, taken from the Register of Sealing maintained by the Chief Executive. The seal has not been used since the report to Trust Board in June 2013.
Recommendation:	**Trust Board is asked to note that the Trust's seal has not been used since the last report in June 2013.**
Private session:	Not applicable