With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board Business and Risk (public session)
Tuesday 22 October 2013 at 8:30
Small conference room, Learning and Development Centre, Fieldhead, Wakefield

AGENDA

1. Welcome, introduction and apologies

2. Declaration of interests

3. Minutes and matters arising from previous Trust Board meeting held on 24 September 2013

4. Performance reports month 6 2013/14

4.1 Section 1 – Quality performance report month 6 2013/14 (to follow)

4.2 Section 2 – Finance report month 6 2013/14 (to follow)

4.3 Section 3 – Strategic human resources report (to follow)

4.4 Section 4 – Exception reporting and action plans

(i) Quarterly serious incident report Q2 2013/13
(ii) Working capital facility
(iii) Patient-led assessment of the care environment (PLACE)

5. Governance issues

5.1 Monitor Risk Assessment Framework
5.2 Changes to the Trust's Constitution
5.3 Outcome of Members' Council evaluation session

6. Monitor quarterly return

7. Assurance Framework and organisational risk register

8. Date and time of next meeting

The next meeting of Trust Board will be held on Tuesday 17 December 2013 in the small conference room, Learning and Development Centre, Fieldhead, Wakefield, WF1 3SP.

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Minutes of Trust Board meeting held on 24 September 2013

Present:	Ian Black	Chair
	Peter Aspinall	Non-Executive Director
	Julie Fox	Non-Executive Director
	Jonathan Jones	Non-Executive Director
	Helen Wollaston	Deputy Chair
	Steven Michael	Chief Executive
	Nisreen Booya	Medical Director
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Alan Davis	Director of Human Resources and Workforce Development
	Alex Farrell	Deputy Chief Executive/Director of Finance
In attendance:	Adrian Berry	Director, Forensic Services (for item 9)
	Dawn Stephenson	Director of Corporate Development
	Bernie Cherriman-Sykes	Board Secretary (author)
Apologies:	Bernard Fee	Non-Executive Director
Guests:	Hilary Brearley	Members' Council (appointed, Barnsley Hospital NHS FT)
	Wendy Dixon	Compliance Manager, Care Quality Commission (to item 7)
	Nadim Ghani	Badenoch and Clark
	Bronwyn Gill	Head of Communications
	Alison Green	Shadowing Steven Michael
	Bob Mortimer	Members' Council (public, Kirklees)
	Jeremy Smith	Members' Council (public, Kirklees)
	Praveen Thyarappa	Consultant, Wakefield
	Hazel Walker	Members' Council (public, Wakefield)

TB/13/44 Welcome, introduction and apologies (agenda item 1)

The Chair (IB) welcomed everyone to the meeting. The apology, as above, was noted.

TB/13/45 Declaration of interests (agenda item 2)

Trust Board considered the following additional declarations.

Name	Declaration
CHAIR	
Ian Black	Member, Advisory Group for the Point of Care Foundation's development of a report on health service leadership and management.
NON-EXECUTIVE DIRECTORS	
Peter Aspinall	Panel Member, Conduct Committee, Institute of Financial Accountants, and removal of Director, Primrose Mill Ltd.

There were no comments or remarks made on the declarations, therefore, **it was RESOLVED to formally note the declarations made above.** There were no other declarations made over and above those made in March 2013 and subsequently.

TB/13/46 Minutes of and matters arising from the Trust Board meeting held on 23 July 2013 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held on 23 July 2013 as a true and accurate record of the meeting. There were no matters arising.

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TB/13/47 Assurance from Trust Board Committees (agenda item 4)

IB confirmed the change in Chair of the Clinical Governance and Clinical Safety Committee (from BF to Helen Wollaston (HW)) from September's meeting, and of the Mental Health Act Committee (from HW to Julie Fox (JF)) from November. IB also explained that the Trust will seek a replacement for BF, whose term of office ends in May 2014, through a process overseen by the Nominations Committee. The intention is to seek to recruit an individual who can assume the role of Chair of the Audit Committee when Peter Aspinall's (PA) term of office ends in 2015 to enable and facilitate succession planning.

Audit Committee 9 July 2013 (agenda item 4.1)

PA raised one item in relation to the investigation into the suspected breach of standing orders. The review by KPMG found that there was no definitive evidence that standing orders and procurement processes had been breached; however, the review found that they have been misinterpreted by senior staff who, if they had checked and clarified their assumptions, should have taken different actions. The Committee has, therefore, asked for assurance in relation to the Trust's approach if professional standards are at odds with organisational policies. Alex Farrell (AF) added that a further report from KPMG will be presented to the Committee in October 2013 with an internal Trust action plan. She assured Trust Board that the Trust is taking the matter very seriously and formal guidance for staff will be issued as the report recommendations are worked through.

Clinical Governance and Clinical Safety Committee 17 June and 10 September 2013 (agenda item 4.2)

From the meeting on 10 September 2013, HW raised the following.

- The Committee received a verbal update on serious incidents. Nine of the 31 incidents related to pressure ulcers, which the Trust has not previously been required to report. Mental health incidents were broadly in line with previous years' figures.
- The Committee has asked for a review of the focus of the unannounced visits programme and has suggested that this should be on Trust quality priorities rather than Care Quality Commission (CQC) standards.

The Chief Executive (SM) alerted Trust Board to concerns in relation to a residential care home in Wakefield, which, although it does not involve Trust services, potentially creates opportunities for the development of the Trust's consultancy and advice offer for learning disability services as part of the learning disability strand of the transformation programme.

Mental Health Act Committee 6 August 2013 (agenda item 4.3)

HW reported on the poor recording of patients' rights, which has also been picked up through CQC Mental Health Act visits. Although a repeat audit is scheduled for 2014, the Committee has asked for this to be addressed to more urgent timescales.

Tim Breedon (TB) commented that Section 17 leave (authorised leave during detention) is another identified area of poor recording, which is being addressed as a priority.

Remuneration and Terms of Service Committee 16 July 2013 (agenda item 4.4)

IB alerted Trust Board to the consideration and approval by the Committee of the Directors' performance-related pay scheme for 2013/14.

TB/13/48 Chief Executive's report (agenda item 5)

SM began with the transformation programme, where good progress has been made over the last two months. A detailed paper will be presented to Trust Board in October 2013, which will outline the vision, timescales and implications for estate, IM&T and workforce. He

reminded Trust Board of the four strands (mental health services, general community services, learning disability services and forensic services).

He also alerted Trust Board to the changes in the funding formula for commissioners, which has resulted in shift of allocations from North to South nationally. The creation of an Integration Fund is also causing concern as it top-slices existing funds to support the integration of health and social care agenda.

SM also raised the following under his remarks.

- Commissioning developments in Barnsley.
- The resignation of Mike Farrar as Chief Executive of the NHS Confederation.
- Monitor's Risk Assessment Framework, which replaces the current Compliance Framework from 1 October 2013. A paper on the implications and risks will come to Trust Board in October 2013.

He also commented on his recent visit to India to attend an international conference on spirituality in healthcare and how it can be integrated in health services in the NHS.

Lastly, he commented on the recent unannounced visits by the CQC. SM welcomed the clear, straight forward and honest feedback. The Dales in Halifax was found to be compliant. There were some concerns in relation to seclusion, particularly in low secure provision in the Bretton Centre. Formal feedback has still to come from the CQC

TB/13/49 Wendy Dixon, Compliance Manager, Care Quality Commission (agenda item 6)

Wendy Dixon (WD) began by commenting that the CQC's visit to the Dales was a positive experience, particularly given the whistleblowing concerns expressed to the CQC in relation to capacity. The visit to the Fieldhead site found the majority of areas visited to be compliant; however, it is likely that there will be a compliance action (although not at a high level) in relation to seclusion in the Bretton Centre. She went on to comment that it would be unusual in an organisation so large and complex to find no areas of non-compliance. She expects the formal report to be with the Trust by the end of September 2013.

WD went on to outline the new inspection regime, which involves more inspectors over a longer period of time and provides organisations with four to six weeks' notice of a visit. The visit will be Trust-wide, including community services, and the intention is for visits to be annual (although they will become more targeted in future). Part of the new process is a meeting with Trust Board. It is unlikely that the Trust will be early in the new programme. Unannounced visits will continue but will be much more in response to concerns raised by the public and patients. There will also be a number of thematic inspections, such as dementia, which will cover provision by different organisations. WD confirmed that all reports will be public.

IB thanked WD for her contribution and for the positive remarks about the Trust.

TB/13/50 Quality Improvement Strategy (agenda item 7)

IB invited Trust Board to comment on the Strategy.

- HW commented that this was a useful document although she would like to see a focus on priorities through triangulation with other reports. She identified three priority areas in relation to access to care, partnerships and safeguarding through encouraging a culture

that encourages people to raise concerns. It was agreed there should be a further, more detailed discussion through the Clinical Governance and Clinical Safety Committee on the document.

- JF commented that she would like to see the Trust's approach to individuals with both physical and mental health disabilities more prominently in the Strategy.
- PA asked how the Trust would know that the Strategy is working at a service user level. TB responded that this would be through reporting of patient experience, particularly What Matters, and Dawn Stephenson (DS) confirmed that the Trust is working on development of a consistent approach to collection of service user and carer feedback linked back into Business Delivery Units (BDUs).
- AF commented that the Trust is developing quality metrics at all levels of the organisation, which can be triangulated and incorporated in the quality performance report. BDU governance groups will be responsible and accountable for delivery of the Strategy and for providing assurance that quality metrics are met.
- AF also commented that she would add clinical record keeping to the list of priorities and pathway management.
- TB commented that the Strategy provides an opportunity for the Clinical Governance and Clinical Safety Committee to review 'quality' within a defined framework.

It was RESOLVED to APPROVE the Quality Improvement Strategy.

TB/13/51 Performance reports month 5 2013/14 (agenda item 8)

TB/13/51a Performance report (item 8.1)

AF highlighted the following areas.

- The report from the CQC is still awaited but it is not anticipated that the outcome will have an adverse effect on the Monitor risk rating.
- There is a review of resources and capacity in relation to the in-patient acute pathway. SM commented that the transformation programme will look at how the acute pathway can work more effectively through crisis teams and liaison services, and how the Trust can work in partnership to develop and improve the pathway. He also referred to an initial discussion with the Priory Group to develop a relationship to manage activity more appropriately.
- CQUINs remain at amber/green; however, there has been an improvement in month 5.

IB invited comments from Trust Board.

- IB asked about the appraisal rate. Alan Davis (AGD) responded that 88.3% of staff have been appraised since the beginning of April 2013 against a target of 90%. There has been a positive response to the move to a values-based process and this will be further developed for 2014 in terms of refining the documentation and development of an electronic system.
- HW asked how the Trust can ensure that the process is undertaken in the spirit in which it is intended. AGD responded that the process offers the opportunity for managers to tackle poor performance within a defined framework. There are also a number of developments that will support development of leadership and management skills across the Trust.
- PA asked for an explanation of the disparity between the activity and statistics in relation to mental health payment by results. AF responded that there is a difference across BDUs, particularly in Barnsley due to the introduction of RiO. In relation to clustering, there has been a review at team, practitioner and service level to assess the cause and enable targeted action.

- SM commented that this demonstrates the need to foster support for services and teams to take time to reflect on their role, remit and development to engender continuous improvement.
- In response to a question from Jonathan Jones (JJ), AGD responded that the trend of sickness absence has levelled and is moving downwards. The figure is now 4.6% and a number of BDUs are below 4%. There is a mix of factors supporting this trend, including appraisal and wellbeing support for staff; however, the target remains stretching.
- SM added that the Trust needs to identify what organisational development work is needed in areas where absence levels remain high, such as low secure.
- HW asked whether the Trust could be more proactive in its approach towards getting service users into employment. AF responded that the Trust needs to take a broader view of its role and this has been picked up by the Executive Management Team (EMT).

TB/13/51b Finance report month 5 2013/14 (item 8.2)
AF highlighted the following.

- The overall income and expenditure position reflects that in the annual plan to Monitor.
- There is a year-to-date favourable variance of £600,000. This is due to underspends in:
  - Barnsley in relation to the telehealth contract and in-patient staffing, which is not expected to continue to the year-end;
  - support services as a result of the lease car scheme and facilities spend. Directors have been asked to review where underspends can be utilised to support transformation;
  - provisions, which will be utilised in the last six months of the year.
- However, Calderdale, Kirklees and Wakefield BDUs are overspent due to the level of spend on out-of-area placements. Capital expenditure to improve seclusion units will increase this pressure.
- In secure services, assumptions on cost improvements have changed and work has begun to make savings recurrent in 2014/15.
- In relation to the cost improvement programme, mitigating action has been taken by all BDUs on the shortfall on recurrent cost improvements and identification of non-recurrent savings as an alternative. The original plan to realise savings recurrently through e-rostering has presented a number of issues and work is underway to ensure these savings can be recurrent in 2014/15.

The Chair invited comments from Trust Board.

- PA asked whether the reduction in income represented a trend. AF responded that this will balance with the use of provisions.
- PA also asked whether the increase in operational expenses was sustainable. AF responded that the pressure of out-of-area placements is creating an imbalance and is not expected to continue. There will be a more in-depth report in October.
- HW asked about the use of PICU beds. AF responded that the level of demand occupies total capacity and there is still a requirement to go out-of-area. Therefore, Barnsley is unable to realise income for use of its beds.
- JF asked if the capital programme underspend was a cause for concern. AF responded that the slippage is mainly due to forecast spend on the Estates Strategy in two areas, namely notice given on Castleford, Normanton and District Hospital and transformation projects, such as community hubs. The Trust has a strong rationale for why it is over Monitor's threshold and can demonstrate how it intends to address the position.

TB/13/51c Exception reports and action plans – Quality Accounts severe harm and death mandated indicator (item 8.3(i))
It was RESOLVED to SUPPORT the changes to reporting as described in the paper.

TB/13/51d Exception reports and action plans – Marketing framework (item 8.3(ii))
SM took Trust Board through the paper.

- JJ commented that he would like to see a series of tangible actions to enable Trust Board to be assured that the Trust is taking this forward. SM responded that this will be clearly articulated in the Integrated Business Plan (IBP) and IB asked that the links are made clear in the presentation to Trust Board in October. The marketing 'role' was clarified and will include business intelligence and an analytical function, and will link with Trust communications and how the Trust is presented.
- PA was happy to support the direction of travel but he has reservations. He asked how the Trust would know it is delivering the framework and how the Trust 'brand' would appeal to the different 'customers' the Trust has. SM responded that increasingly people want to know what service they will receive. The 'brand' will articulate what difference the Trust will make to an individual's life; however, it is not focused on image or advertising.
- JJ was clear it represents more of a coherent articulation of what the Trust does and how it does it.
- HW commented that one area clear from the previous work was the need to identify what people who do not use Trust services value, how the Trust engages with these people and how the Trust meets their needs. This also applies to commissioners who do not currently commission services from the Trust.

It was RESOLVED to NOTE the update and SUPPORT the direction of travel set out in the paper.

TB/13/51e Exception reports and action plans – Health and Safety annual report 2012/13 and plan 2013/14 (item 8.3(iii))
HW, as Chair of the Clinical Governance and Clinical Safety Committee, asked that the paper was withdrawn to allow a further review by the Committee in November 2013 given the concerns expressed around managing aggression and violence. It was agreed that the action plan would go back to the Committee and the report and plan would then come to Trust Board for approval in December 2013.

TB/13/51f Exception reports and action plans – Care Quality Commission visits (item 8.3(iv))
This item was covered in items 5 and 6.

TB/13/52 Bretton Centre compliance (agenda item 9)

Adrian Berry (ABe) joined the meeting for this item.
ABe confirmed that the timescale to bring the unit into compliance is by the end of the 2014/15 financial year. SM commented that the approach will also enable the Trust to have additional dialogue with specialist commissioners and NHS England in relation to the policy adopted.

It was RESOLVED to APPROVE the position proposed by EMT to agree an action plan with NHS England to bring the low secure service within the Bretton Centre within the national service specification. It was also RESOLVED to APPROVE the timescale to resolve this during the 2014/15 financial year.

TB/13/53 Use of Trust seal (agenda item 10)

It was RESOLVED to NOTE that the Trust's seal has not been used since the last report in June 2013.

TB/13/54 Date and time of next meeting (agenda item 11)

The next meeting of Trust Board will be held on Tuesday 22 October 2013 in meeting room 1, Block 7, Fieldhead, Wakefield, WF1 3SP. The dates for 2014 were also noted.

Signed …… Date ……

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Quality Performance Report

Month 6 2013/14

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INTRODUCTION

Improve and be outstanding

The Quality Performance Report continues to be developed as part of a Total Quality Management approach where the Trust performance focus is on quality themes which drive metrics and use of resources. The quarterly review is a key tool to provide assurance to the Board that the organisation has the right focus and levels of performance to meet the requirements of the NHS Outcomes Framework; legislative requirements; external regulators; and the Trusts internal priorities which are reflected in the Quality Account. This encompasses providing the Board with a high level summary of performance year to date including compliance; review of progress on in year developments linked to quality and horizon scan for issues which require action now to meet future service requirements. Underpinned by the balanced scorecard there is reporting against each of the Trust's 7 key quality priorities:

- To **LISTEN** to our service users and carers and act on their feedback
- Timely **ACCESS** to services
- Improve **CARE and CARE PLANNING**
- Improve the **RECORDING and EVALUATION OF CARE**
- Improve **TRANSFERS OF CARE** by working across the Care Pathway
- Ensure our staff are professionally, physically and mentally **FIT TO UNDERTAKE THEIR DUTIES**
- Improve the **SAFETY** of our service users, carers, staff and visitors.

The SWYPFT commitment to quality is expressed as: **Safety** – ensuring services are safe, clean, that people should not fear harm, that we learn from our mistakes and avoid all errors wherever possible; **Person centred** – services provided in a personal way with dignity and respect with the service user at the centre at all times – listening to what people say they require and responding appropriately; **Efficient and Effective** – ensuring we understand the benefit of interventions undertaken to achieve outcomes that are real for people who receive our service and their families

The NHS Outcomes Framework sets out what the NHS should be striving to achieve in terms of outcomes rather than inputs or measures of operational throughput. The Framework has five domains which have been cross- referenced to Trust strategy.

Domain 1 Preventing people from dying prematurely - **Effective and Efficient**
Domain 2 Enhancing the quality of life for people with long term conditions - **Effective and Efficient**
Domain 3 Helping people to recover from episodes of ill health or injury - **Effective and Efficient**
Domain 4 Ensuring people have a positive experience of care - **Person centred**
Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm – **Safety**

Quality improvement is a critical element of our clinical governance system. When coupled with robust assurance and strong leadership quality improvement is the final component of robust assurance. The Trust Quality Improvement Strategy provides an important framework to support further development of our quality reporting system and ensure that we remain focussed on key quality priorities during a time of substantial change. The strategy is framed around the following elements: Bringing clarity to quality; Measuring quality; Publishing quality; Partnerships for quality; Leadership for quality; Innovation for quality; Safeguarding quality.

EXTERNAL REGULATION & DIRECTION

MONITOR:

From October 2013 Monitor's new Risk Assessment Framework will replace the current Compliance Framework. The aim of the risk assessment framework is to show when there is a significant risk to financial sustainability which endangers continuity of services and/or poor governance. These will be assessed separately and trusts will be assigned two ratings. Ratings will indicate a cause for concern and prompt Monitor to consider where more detailed investigation may be necessary to establish the scale and scope of any risk. SWYPFT has implemented measures to self-assess and report against the risk assessment framework from quarter 3.

CARE QUALITY COMMISSION:

- The Trust currently has no compliance actions in relation to inspection visits. Reports still awaited on inspection visits which took place in July/August to the Dales (Ashdale, Elmdale and Beechdale) and Fieldhead (Trinity 2, Newton Lodge and Bretton). Informal verbal feedback indicated a good standard of care had been observed but questions were raised around seclusion facilities and practice with additional information requested and provided. There is a possibility of a compliance action.
- There were 2 CQC Mental Health Act visits in Quarter 2 to Trinity 1 Fieldhead (report received) and Beamshaw ward Barnsley (report awaited). The CQC found Trinity 1 to be generally clean and well maintained, a range of activities available and patients lawfully detained. There were some identified record keeping deficits but the main concern related to the seclusion facility remaining 'unfit for purpose'.
- In regard to previous bed management whistleblowing concerns, the CQC written response received on 19th August thanks the Trust for constructive discussion and the honest and genuine attempts being made to resolve the issue. No formal regulatory action is to be taken although the CQC continue to closely monitor the situation.
- In the latest Quality Risk Profile re-fresh (August 13) all 16 risk estimates remain in the 'reduced risk of non-compliance' range.
- The 2012/13 CQC national Community Mental Health Service User results have now been published involving 58 trusts across England. The Trust was rated 'about the same' as the majority of other trusts for all sections which represents some change from the previous survey when two sections (care plan and care review) were identified as 'worse'. SWYPFT scored most positively in sections related to health & social care workers and the care co-ordinator. The lowest section score was day to day living. The question *'overall how would you rate the care you have received from NHS Mental Health Services in the last 12 months'* achieved a score of 7 out of 10 (top score nationally being 7.4). Lowest scoring individual questions related to people receiving support in getting help with care responsibilities and *'being given or offered a written or printed copy of your NHS care plan'*. The Trust will continue to use the national survey results as a tool for identification of aspects in need of improvement. However the results will be triangulated with other sources of patient experience feedback in order that we can successfully focus on the most critical areas. Full analysis report and recommendations to be provided to EMT in October and Trust Board in December.

OFSTED:

The new OFSTED inspection framework (safeguarding children) has been published. Over the next 15 months inspections will be undertaken solely by OFSTED, will last 4 weeks and will scrutinise all partner agencies. CQC will be informed of any failings found in health provision. After the 15 month period inspections will be undertaken jointly by OFSTED, CQC and HM Inspectorate of Constabulary.

QUALITY ACCOUNT PRIORITIES 2013/14

PRIORITY	PERFORMANCE INDICATORS	STANDARD	PERFORMANCE GREEN – fully achieved AMBER – partially achieved RED – not achieved							
			Q1			Q2			*Forecast Position*	
									Q3	*Q4*
Listen to service users and carers and act on feedback	% of people (inpatient mental health - CKW) rating care as excellent or good	90%	86%			82%			*a*	*g*
	% of people (community CKW) rating care as excellent or good	90%	95%			100%			*g*	*g*
	% of people (inpatient MVH) rating care as excellent or good (6 monthly report)	90%	100%						*g*	
	% of people (community general) rating care as excellent or good (B)	90%	97.34%			97.09%			*g*	*g*
	% involved as much as they wanted to be in decisions about care – LD services (CKW) – one audit reported Q3	75%							*g*	
	% complaints including staff attitude as an issue	<25	7%	21%	17%	17%	19%	17%	*g*	*g*
Timely access to services	Improving access for people experiencing acute MH problems (crisis) (CKW)	95%	91%			90%			*g*	*g*
	% assessments within 4 hours for people entering urgent care pathway (B)	95%	95.11%			87.3%			*g*	*g*
	Non-acute mental health (routine) face-face contact within 14 days of referral (CKW)	90%	68.83%			70.6%			*a*	*a*
	Non-acute MH (routine) treatment within 6 weeks of face-face contact (CKW)	90%	97.5%			92.5%			*g*	*g*
	Psychological therapies - new referrals assessed within 14 days (CKW)	95%	98%			97.8%			*g*	*g*
	Referrals non-urgent assessed within 14 days (B)	90%	81.2%			48.5%				
	% of service users who have had their gate kept admission kept	95%	100%	100%	93%	99%	100%	100%	*g*	*g*
	Referral to treatment within 18 weeks target achieved (B)	95%	100%			99.6%			*g*	*g*
Improve care and care planning	% of service users on CPA with a formal review within previous 12 months	95%	96%	92%	95%	94%	94%	97%	*g*	*g*
	% people offered copy of care plan	85%	73%	74%	74%	75%	75%	76%	*a*	*a*
	Improving health outcomes for people in secondary MH services (exercise)	90%	100%			100%			*g*	*g*
Improve recording and evaluation of care	% mental health patients with a valid diagnosis code at discharge	99%	100%	71%	98%	100	100%	95%	*g*	*g*
	% eligible cases assigned a cluster	100%	98%	92%	92%	87%	89%	90%	*a*	*g*
Improve transfers of care by working in partnership across the care pathway	% of people followed up within 7 days of discharge from inpatient care	95%	98%	95%	97%	97%	97%	97%	*g*	*g*
	Delayed transfers of care	≤ 7.5	3.9	3.5	4.1	3.1	3.4	3.8	*g*	*g*
	% mental health clustering assessments completed at discharge (CROM) – from Q3	95%							*g*	*g*
Ensure our staff are professionally, physically and mentally fit to undertake their duties	Sickness rate	≤ 4.00%	5.3	4.9	4.7	*4.8*	*4.6*	4.5	*r*	*a*
	Appraisal rate	90% at Q2	71.8%			90.6% at m6				
Improve the safety of our service users, carers and visitors	% of never events	0%	0	0	0	0	0	0	*g*	*g*
	Achievement of NICE guidance levels of non-amber/red risk assessment s	95%	98%			97%			*g*	*g*
	Effective monitoring and response to reported medication errors	100%	100%			100%			*g*	*g*
	Appropriate safeguarding referrals and response	100%	100%			100%			*g*	*g*

Green = achieving target
Amber = within 10% of target
Red = more than 10% away from target

TO LISTEN TO OUR SERVICE USERS AND CARERS AND ACT ON THEIR FEEDBACK

Listen and act on service user feedback with the aim of making demonstrable improvements to our services

SWYPFT continues to perform strongly in this area against challenging targets and we remain focused on conversion from listening to action

Q2 RAG RATING		
	A/G	

PERFORMANCE

- 3 performance indicators fully met, 1 partially met.
- There were 86 formal complaints in Q2 (Barnsley – 26, Kirklees – 18, Wakefield – 17, Calderdale – 11, Specialist services – 11, Forensic – 2, quality academy/support functions – 1). District Directors monitor delivery of action plans and ensure corrective action is implemented within service lines.
- In Q2 3 complainants asked for their cases to be reviewed by the Parliamentary and Health Service Ombudsman. There are two cases currently open with the Ombudsman (both Kirklees) one dating back to 2011 and the other December 2012. 2 cases were closed in Q2 one with no further input required by SWYPFT and the other where SWYPFT has been requested to resolve a complaint through financial redress.
- National Community Mental Health Survey: 'about the same' comparative rating for the section on health & social care workers (section score of 8.6 against top score of 9.0). Generally good scores for all questions including 8.4 (against top score of 9.2) *'did this person listen carefully to you'* and 9.1 (against top score of 9.5) *'did this person treat you with respect and dignity'*

OTHER EVIDENCE OF ACHIEVEMENT

Commitment: to develop a portfolio of improvements made as a result of feedback.

- Continued roll-out of patient experience use of technology project. System in place across mental health inpatient wards to collect patient experience data quarterly from November 2013. Community mental health services pilot in progress in Calderdale throughout October 2013 with plan for roll-out Trust-wide Q4. Pilot surveys in CAMHS and LD planned December 2013, pilot survey in health and wellbeing services planned for Q4. Currently working on technical solutions to make system 'real time' as opposed to 'near real time' from December 2013. Real time dashboards should be available from Q4.
- 'What Matters' published quarterly

ORGANISATIONAL DEVELOPMENT

Commitment: to develop and undertake a carer's survey.

- Scoping exercise being conducted to determine which clinical teams are undertaking carers' surveys, in what format, frequency and what action is being taken against the feedback. A carer's survey has been developed which is being piloted in Calderdale BDU throughout October 2013 as part of the community survey pilot. Questionnaires and surveys are in development for Mount Vernon and Newton Lodge.

Other developments

- Range of transformation events held involving stakeholders across different trust geographic areas
- Francis related work-streams include: on-going work to enable staff to better resolve issues at a local level; and 'right first time' training previously delivered to 250 front line staff to be repeated with a further 250 staff in January 14.

TIMELY ACCESS TO SERVICES

Improve the access times for people who are referred into our services to ensure the right support from the right service at the right time

Work completed in 12/13 identified gaps in SWYPFT access assessment which is being addressed.
We need a continuing focus on decreasing times people wait for non-urgent assessments.

Q2 RAG RATING		
	A/R	

PERFORMANCE

- Fully meeting 6/9 performance indicators, partially achieving 1 and failing 1 (non-urgent referrals assessed within 14 days, Barnsley) as at month 6
- National Community Mental Health Survey: questions related to access fell within the 'about the same' rating. Positively there is an improved score for the question about being given medication in a way that was easy to understand. Unfortunately there is a drop in score against questions relating to knowing who the care co-ordinator is and being able to contact them if there is a problem. The former identified as a statistically significant difference which needs to be reviewed in the context of the on-going care planning and review project.

OTHER EVIDENCE OF ACHIEVEMENT

- Recent CQC MHA visits to Trinity 1 (5th July), Bronte and Gaskell wards (26th June) identified that people were aware of the mental health tribunal process, their right to appeal and had information on access to advocacy

ORGANISATIONAL DEVELOPMENT

Commitment: to increase the number of survey questions relating to access

- On-going preparation work – access questions being developed as part of the patient experience project and co-produced with service users and carers. Workshop planned December 13 to finalise questions to be asked as part of trust-wide survey.

Commitment: to review single point of access services and implement any actions

- Redesign workshops planned for October 13. SPA managers have jointly specified the SPA function but how that function will be carried out will be addressed in the workshops. There has been GP engagement to understand their SPA requirements and the findings will inform the options appraisal.

IMPROVE CARE AND CARE PLANNING

Ensure that each service user has appropriate assessment, care plans and treatment options to enable them to achieve their goals

National survey results have improved with SWYPFT's position comparatively similar to most other trusts.
There is a continuing need to focus on care reviews and care planning.

Q2 RAG RATING		
	A/G	

PERFORMANCE

- Fully meeting 2/3 performance indicators and partially meeting another (people on CPA offered copy of care plan). In regard to the latter the overall level is 76% but we are still monitoring the trend as most Barnsley services are yet to fully utilise the electronic care record which may be distorting the overall figure – under review.
- National Community Mental Health Survey: responses indicate that service users remain positive in terms of how well the care co-ordinator organises care and services. There were improved scores for all questions on medication including one top rated 'green' score for the question as to whether the purpose of the medication was explained. However as in the previous survey SWYPFT had low scores on questions related to care planning and care reviews. There were a disappointing number of respondents indicating they had not been given or offered a written copy of their care plan. *Note: national survey includes both CPA and Standard Care service users. Local survey figures much better than national survey for people on CPA.* In the care review section responses improved for 4/6 questions but there was one 'red' rated question in regard to people not having had a care review in the last 12 months.

OTHER EVIDENCE OF ACHIEVEMENT

- Local service user survey information gathered using electronic tablets and kiosks between July and August (317 respondents) gave a 68% positive response in regard to people saying they were extremely likely to recommend the service ('Friends & Family test)
- The Trust continues to build on improvement work related to care planning and care reviews implemented in 2012/13. An improvement project is continuing following stakeholder engagement workshops and visits to trusts perceived to be performing well in care planning and care reviews based on the 2012 national community mental health survey results. Recent initiatives have seen the development of co-produced personal standards for care planning and care reviews.

ORGANISATIONAL DEVELOPMENT

Commitment: to monitor and report on progress implementing recovery through organisational change

IMROC - A draft approach document sets out the main themes of work. Completion of strengths self-assessment to identify recovery focused work taking place - two workshops where examples shared. Delivery structures developed and a communication & engagement plan to share information both internally and externally. Drawing linkages between different pieces of work including strengthening existing partnership relationships and developing new which is key in implementing recovery. Development of Recovery Colleges in all 4 Trust geographical areas.

Commitment: to implement actions from clinical audits that help provide personalised recovery based care across all services

System being established to monitor how clinical audit results are implemented in practice. From Q3 the Clinical Governance Support Team will be monitoring/reporting outcomes to the Clinical Governance and Clinical Safety Committee and commissioners. District Director final approval for process Oct 13.

IMPROVE THE RECORDING AND EVALUATION OF CARE

Ensure that each intervention is accurately recorded in a timely manner so that there is appropriate communication across the care team

There is targeted action on record keeping and this remains an area in need of significant improvement.

Q2 RAG RATING		
	A/R	

PERFORMANCE

- Partially meeting 2/2 performance indicators (adherence to cluster periods/MH patients with valid diagnosis code at discharge) as at month 6
- The criteria for reporting information governance incidents changed from June 2013. Now all incidents with a score of 2 or above must be reported. As a consequence a red incident was reported in Q2 which would not have reached the reporting threshold previously.
- CQC MHA visits continue to identify record keeping deficits including: recording of patients being informed of their rights, section 17 leave and recorded evidence of patient involvement in their care planning. However from the 4 most recently reported visits there were 2 relati8ng to Medium Secure Services suggesting improvements are being made: Priestley *'care plans detailed, holistic, up to date and showed appropriate level of patient involvement',* Bronte *'Files containing MHA section papers and associated documentation were found to be in excellent order and easily accessible'* .

OTHER EVIDENCE OF ACHIEVEMENT

- Projects on the 13/14 prioritised clinical audit and practice evaluation programme are on track for completion within agreed timescales.

ORGANISATIONAL DEVELOPMENT

- Continuing roll-out of the friends and family test
- Francis related work-streams include work initiated to develop products/tools to support understanding and application of appropriate staffing levels/ratios

Commitment: implementation of trust-wide record keeping audit

A trust-wide working group has been established to determine key standards of record keeping across the elements of the care pathway. The group have scoped out clinical record keeping activity; established key links with relevant work-streams and determined a draft set of standards for consultation. A trust-wide record keeping audit will be undertaken in Q4.

Commitment: implementation of record keeping action plans

Implementation of any recommendations from the trust-wide record keeping audit will roll into 2014/15

IMPROVE TRANSFERS OF CARE BY WORKING IN PARTNERSHIP ACROSS THE CARE PATHWAY

Ensure service users who are ready to move along the care pathway are supported across service

Performance remains strong but current economic pressures will challenge partnership working

Q2 RAG RATING		
	A/G	

PERFORMANCE

- Fully meeting 2/2 performance indicators (people followed up within 7 days of discharge/delayed transfers of care)
- National Community Mental Health Survey: continuing poorer feedback in relation to service users getting help with finding/keeping work, their care responsibilities and being asked about their physical health needs. However it should be noted that the day to day living section of the survey was generally low scoring nationally and this is not a specific SWYPFT issue. SWYPFT was given a top 'green' comparative rating for the question on people being given support in finding/keeping accommodation although the actual score was only 5.9 out of 10.

OTHER EVIDENCE OF ACHIEVEMENT

Commitment: Review of DToC processes to ensure we have consistent reporting across our services

- DToC operational process has been drafted. Workshop in October to agree process with clinical teams. (Q3 – implementation, Q4 re-audit of process to determine consistency across the organisation)

Commitment: Commence a trust-wide transformation programme to ensure our care pathways efficiently meet people's needs

- Multi-stakeholder engagement in transformation events trust-wide

ORGANISATIONAL DEVELOPMENT

- Working closely with commissioners in developing RAID models to support our acute hospital partners
- Creative Minds continues to promote partnerships. One example being the Equine Therapy Programme partnership between SWYPFT and Wakefield Riding for the Disabled. Funded through Creative Minds and the WRDA. Feedback from the first programme has been extremely positive both in terms of participant comments and facilitator impact observations. Staff observed an overall marked improvement in participants' wellbeing with people re-engaging with previous interests and developing new areas of interest.

ENSURE OUR STAFF ARE PROFESSIONALLY, PHYSICALLY AND MENTALLY FIT TO UNDERTAKE THEIR DUTIES

Ensure we have appropriately qualified, skilled, competent and professional staff to undertake the role that they are required to do and to support their health and wellbeing

Current performance indicates positive developments but workforce resilience will be tested during transformation

Q2 RAG RATING
A/G

PERFORMANCE

- Failing to meet the sickness rate performance indicator in Q2 but achieved target appraisal levels

OTHER EVIDENCE OF ACHIEVEMENT

- The Trust achieved the first stage Customer Services Excellence Award in July 2013. Staff were said to be extremely motivated and committed to providing highly effective services and overall good experiences for their many service users and carers. There was said to be structured learning and development linked to providing good customer services. Good evidence was provided of staff feeling empowered to deal with issues and then share the learning in order to develop services.
- Investors in People – demonstrating how we ensure all our systems/processes are devolved and exemplar employment

ORGANISATIONAL DEVELOPMENT

Francis related work-streams include such things as values based recruitment and appraisal, clinical apprenticeship scheme (HCSWs), application of the Leading to Quality research project taking work books and products into team development processes, 6 monthly staff survey (which will provide an opportunity to ask staff specific questions on areas of concern raised via the Francis review process), 360 degree feedback applied to all senior managers every 2 years

Commitment: Evaluation of Appraisal System: The new appraisal system was introduced from April 13 and has been subject to a detailed staff evaluation exercise via surveys and focus groups. Final report to be published November 13. Initial results indicate the system to be effective in facilitating reflection on behaviour at work and helping identify how improvements can be made. The evaluation has provided insight into how the process and documentation may be further improved, and barriers to effective appraisal in some teams. Improvement recommendations in the final report will lead to an update and re-launch of the appraisal system April 14.

Commitment: Trust-wide audit of clinical supervision: Planning in progress

Commitment: National and local staff audits: Action plan developed in response to 2012 (March 13) staff survey

Commitment: Develop and implement the staff survey action plan for the staff survey 2013: Pulse staff survey completed

IMPROVE THE SAFETY OF OUR SERVICE USERS, CARERS, STAFF AND VISITORS

Ensure that the people who work with us and visit us are safe from harm

Patient safety remains a critical priority at a time of transition – current indications are that systems and processes are robust enough to support this

Q2 RAG RATING
A

PERFORMANCE –

- Meeting 4/4 performance indicators. There have been no never events; SWYPFT currently carries amber risk ratings against 7 pieces of NICE guidance out of 214 applicable pieces of guidance/quality standards; robust systems in place with multiple checking which enables us to demonstrate that for each medication error or safeguarding referral appropriate action has been implemented.
- Serious Incident numbers appear to have increased comparatively with last year but a significant proportion relate to reported pressure ulcers following the application of new reporting thresholds. Many of the reported pressure ulcers fall within the 'unpreventable' category.
- There has been a decline in the number of reported child safeguarding incidents believed to relate to reporting practice deficits. Work being undertaken with BDUs and clinical teams to address this. The 80% target for clinical staff adult safeguarding training continues to be met trust-wide.
- Out of a total of 176 incidents of physical violence against staff by patients there was just 1 amber rated incident. None of the 49 incidents of physical violence against patients by patients were rated amber. As a consequence of the refresher period for MAV teamwork training changing to 12 months (more frequent) the percentage of staff trained has fallen to 76%. Additional courses have been added to bring the figure back above 80%
- 285 reported incidents had a recorded action of restraint, of which 65 had a recorded injury. There was one amber rated incident (Forensic Medium Secure). 96 incidents involved the use of prone restraint. MAV teamwork training ensures staff know how to use prone restraint safely and that they understand and assess the risks for individuals. All such incidents are reviewed by the MAV TAG with any appropriate action identified and implemented.
- There have been no Eliminating Mixed Sex Accommodation breaches. However the number of reported occurrences where a service user is placed on a corridor occupied by members of the opposite sex increased from 7 in Q1 to 24 in Q2. (Wakefield 10, Kirklees 10, Calderdale 5, Barnsley 0). This is being picked up as part of the bed management protocol review.

OTHER EVIDENCE OF ACHIEVEMENT

Commitment: Improve the structures to improve BDU governance: Governance groups have been established in Calderdale, Kirklees, Wakefield and Forensic services. Barnsley had existing systems. First meeting of a specialist services governance group in November 2013

ORGANISATIONAL DEVELOPMENT

CQC MHA and inspection visits identify the need for SWYPFT to make clear progress with the seclusion facilities refurbishment programme. A full programme is to be completed in 2013/14.

Commitment: Implementation of root cause analysis training: RCA training has been updated to reflect expectations of clinical staff in investigations. Updated training will be delivered to a cohort of 15-20 district nursing staff in October 13. Training will be evaluated and any necessary changes made. A decision to be taken if and how it may then be rolled out across the organisation.

EXCEPTION REPORT – BED MANAGEMENT

The Trust has experienced significant pressure on our acute bed base compounded by increasing difficulties securing out of area placements. The number of incidents where there were no trust or out of area beds immediately available for a service user for whom admission was requested increased substantially in the last 3 months of 2012/13, a trend which has continued into 2013/14 with increased bed management related incident reporting.

Whatever the circumstance our clear priority is our service users and how we can most safely and effectively address their needs. Wherever possible this will be through the provision of enhanced home based support but sometimes the safety and welfare of the service user requires that we do admit to a ward/unit where a bed is not immediately available. At all times staff are required to keep the needs both of the service user to be admitted and those service users already on the ward at the centre of their actions, fully exercising the duty of care to treat people as individuals and respect their dignity at all times.

Concerns about admissions to wards when no bed is immediately available were raised by the CQC and responded to by SWYPFT. In a letter from the CQC received in August 2013 it states that: *'It remains the commission's view that the admission of patients when there is no bed for them is not acceptable. However in our meeting you agreed that such practice was neither acceptable or in line with best practice and is a situation you also wish to address. You outlined to us a range of steps such as a review of your bed management protocol, a review of your DATIX reporting arrangements for such incidents and a re-design of a single 24/7 bed management service to try and tackle this issue. Despite our concerns we felt you were making genuine and honest attempts to resolve the issue. We further recognise that the nature and the scale of the changes and improvements could not be implemented immediately. For these reasons the Commission wishes to maintain a pragmatic stance on the matter and is not currently proposing any formal regulatory action against SWYP about it. As I'm sure you can appreciate this is not a matter which we can simply 'close' but will require ongoing monitoring by the commission.'*

The Trust has taken action to review and implement a revised bed management protocol reinforcing the fact that decisions relating to movement through the pathway must be clinically led. Additional resources continue to be accessible to enable increased staffing when necessary. The bed state is reviewed regularly at all organisational levels. A learning event is now planned to review the impact of the revised protocol and other improvement measures. However it is important to recognise that the longer-term solution is not the bed management protocol but the transition programme and clear clinical leadership within this.

PUBLICATIONS/CONSULTATIONS

CQC

- Consultation re: specific changes proposed to fees for providers. Describes CQC initial plans to be considered in the fees consultation next year
- CQC's Quality & Risk Profiles – update on plans from *A New Start* consultation. CQC new surveillance approach has started with acute and specialist NHS Trusts. CQC will no longer use QRPs in their monitoring of NHS acute and specialist hospitals and will update the datasets for mental health, community and ambulance QRPs in November. CQC plan to replace these QRPs with the new surveillance model from next year.
- CQC have published details of their planned child safeguarding and looked after children inspection programme. The review will run between 30 Sept 2013 to April 2015 and will look at how health services keep children safe and contribute to promoting the health and wellbeing of looked after children and care leavers. Inspections will look at the quality and effectiveness of the safeguarding arrangements

MONITOR

- Current consultation re: national tariff payment system

PATIENT EXPERIENCE REPORT

Annual CQC Community Mental Health Survey: The latest national survey has recently been published with comparative results for the trust of 'about the same' across all survey sections which represents some improvement against the previous year. The following table shows some comparative information from the latest CQC National Community Mental Health Survey. Analysis of national and local information plus scope of current improvement activity, gap analysis and recommendations will go to EMT in October and Trust Board in December 13.

SECTION	Highest Score	Lowest Score	SWYPFT		Some other Trusts/comparators					
					Greater Manchester West	Leeds/York Partnership	Manchester MH & Social Care	NAVIGO	RDASH	Sheffield Health & Social Care
Health & social care workers	**9**	**8**	**8.6**	***About the Same***	**8.8** About the Same	**8.5** About the Same	**9** Better	**8.5** About the Same	**6.8** About the Same	**8.7** About the Same
Medications	**7.9**	**5.6**	**7.5**	***About the Same***	**7.5** About the Same	**7.2** About the Same	**7.5** About the Same	**7.1** About the Same	**7.6** About the Same	**7** About the Same
Talking Therapies	**8.2**	**6.2**	**7.3**	***About the Same***	**7.2** About the Same	**7.4** About the Same	**7.7** Better	**6.9** About the Same	**6.5** About the Same	**7.6** About the Same
Care Coordinator	**8.6**	**7.3**	**7.7**	***About the Same***	**8.3** Better	**7.9** About the Same	**8.1** About the Same	**8.3** Better	**8.1** About the Same	**7.7** About the Same
Care Plan	**7.3**	**6**	**6.2**	***About the Same***	**7.1** Better	**6.2** About the Same	**6.9** About the Same	**7.3** Better	**6.8** About the Same	**6.6** About the Same
Care Review	**8**	**6.4**	**7**	***About the Same***	**7.6** About the Same	**7.2** About the Same	**7.8** Better	**7.4** About the Same	**7.1** About the Same	**7.3** About the Same
Crisis Care	**7.7**	**5.3**	**5.9**	***About the Same***	**5.9** About the Same	Not available	**6.3** About the Same	**7.3** Better	**6.1** About the Same	**6.1** About the Same
Day to Day Living	**6.2**	**4**	**5**	***About the Same***	**5.9** Better	**5.2** About the Same	**5.8** About the Same	**5.6** About the Same	**4.9** About the Same	**5.1** About the Same
Overall	**7.4**	**6.2**	**7**	***About the Same***	**7.1** About the Same	**7.1** About the Same	**6.6** About the Same	**7.1** About the Same	**7.1** About the Same	**7** About the Same

SWYPFT Higher scoring individual questions

- Did this person treat you with respect & dignity? – 9.4 (previous year 9.3)
- Did this person listen carefully to you? – 8.8 (previous year 8.9)
- Were the purposes of the medication explained to you? – 8.8 (previous year 7.9 – this represents a statistically significant increase from last year)
- Did this person take your views into account? – 8.3 (previous year 8.4)
- Did you have trust and confidence in this person? – 8.3 (previous year 8.4)
- How well does your care co-ordinator organise the care and services you need – 8.3 (previous year 8.4)
- Were you given enough time to discuss your condition and treatment? – 8.1 (previous year 8.2)
- Can you contact your care co-ordinator if you have a problem? – 8.1 (previous year 8.8 – although still a high score there has been a statistically significant drop from the previous year which will be reviewed)

SWYPFT Lower scoring individual questions

- In the last 12 months have you received support in getting help with finding and/or keeping your accommodation? – 5.9 (previous year 4.5)
- In the last 12 months did anyone in NHS MH services ask you about any physical health needs you might have? – 5.5 (previous year 4.6)
- Do you have the number of someone from your local NHS mental health service that you can phone out of hours – 5.4 (previous year 5.1)
- In the last 12 months have you had a care review meeting to discuss your care – 5.2 (previous year 5.0)
- Has anyone in NHS MH services ever asked you about your use of non-prescription drugs? – 5.1 (previous year 4.5)
- In the last 12 months have you received support in getting help with your physical health needs – 4.7 (previous year 4.7)
- In the last 12 months have you received support from anyone in NHS MH services in getting help with financial advice or benefits? – 4.4 (previous year 4.7)
- Have you been given (or offered) a written or printed copy of your NHS care plan – 4.0 (previous year 3.4)
- In the last 12 months have you received support in getting help with your care responsibilities – 4.0 (previous year 4.2)

Trust Board Performance Dashboard – Vital Signs (Month 6 2013/14)

Business Strategic Performance: Impact & Delivery

Month 6 2013/14

Section	KPI	Target	Current Position	Status	Trend	Forecast Position
Monitor Compliance	Monitor Governance Risk Rating (FT)	Green	Green	✓	↑	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%	48%	✗	↓	4
Inf' Prevent'	Infection Prevention (MRSA & C.Diff) All Cases	0	0	▼	↑	3
C-Diff	C Diff avoidable cases	0	0	✓	↑	4
PSA Outcomes	% SU on CPA in Employment	10%	**6.7%**	✗	↑	1
	% SU on CPA in Settled Accommodation	60%	**54.8%**	✗	↑	3

Customer Focus

Month 6 2013/14

Section	KPI	Target	Current Position	Status	Trend	Forecast Position
Complaints	% Complaints with Staff Attitude as an Issue	< 30%	17%9/52	✓	–	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%	95%	✓	–	4
Member's Council	% of Publicly Elected Council Members Actively Engaged in Trust Activity	> 50%	60%	✓	↑	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%	30%	▲	↑	3
	% of Service Users Requesting a Befriender Assessed Within 20 Working Days	> 80%	60%	▲	↑	3
	% of Potential Volunteer Befriender Applications Processed in 20 Working Days	> 90%	100%	✓	–	4

Operational Effectiveness; Process Effectiveness

Month 6 2013/14

Section	KPI	Target	Current Position	Status	Trend	Forecast Position
Inpatients	Delayed Transfers Of Care (DTOC) (Monitor)	< = 7.5%	**3.8%**	✓	↓	4
	% Admissions Gatekept by CRS Teams (Monitor)	95%	**100.0%**	✓	–	4
Community	% SU on CPA Followed up Within 7 Days of Discharge (Monitor)	95%	96.9%	✓	↓	4
	% SU on CPA Having Formal Review Within 12 Months (Monitor)	95%	**98.2%**	✓	↑	4
Breastfeeding	Prevalence of children breastfed at 6 - 8 weeks (Barnsley)	31.5%	30.16%	▲	↑	1
Data Quality	Data completeness: community services (Monitor)	50%	94%	✓	–	4
	Data completeness: Identifiers (mental health) (Monitor)	97%	**99.5%**	✓	↓	4
	Data completeness: Outcomes for patients on CPA (Monitor)	50%	**70.9%**	✓	↑	4
Mental Health PbR	% of eligible cases assigned a cluster	100%	90.2%	✗	↑	3
	% of eligible cases assigned a cluster within previous 12 months	100%	75.6%	✗	↑	3
	% Inpatients (All Discharged Clients) with Valid Diagnosis Code	99%	**94.9%**	▼	↓	4

Fit for the Future; Workforce

Month 6 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%	90.5	✓	↑	4
Sickness	Sickness Absence Rate (YTD)	<=4%	4.5	▼	–	3
Vacancy	Vacancy Rate	10%	5.3%	✓	↓	4
Safeguarding	Adult Safeguarding Training	80%	80.8%	✓	↓	3
Fire	Fire Attendance	>=80%	74.0	▼	↓	3
IG	IG Training	>=50%	19%	✗	↑	4

OVERALL FINANCE POSITION

	Performance Indicator	Month 6 Performance	Annual Forecast	Trend from last month	Last 6 Months - Most recent						Assur - ance
	Trust Targets				5	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 6 is showing a net surplus of £2.6m which is £0.9m ahead of plan. The planned surplus for the year is £3.7m and the current forecast is that this will be delivered.
2. At month 6 the cash position is £29.2m and is £2.5m ahead of plan.
3. Capital expenditure to September 2013 is £1.94m which is £1.1m behind plan. A revised capital programme has been approved to ensure that the full programme is delivered in 2013 / 2014.
4. At month 6 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 6 position.
5. The Financial Risk Rating at September 2013 is 4.1 which is ahead of the planned Q2 3.9 position.
6. At 30th September 94% of NHS and 97% of non NHS invoices have achieved the 30 day payment target. (95%)

FINANCIAL RISK RATING 2013/14				
	September 2013 Actuals		Annual Plan Quarter 2	
Metric	Score	Rating	Score	Rating
EBITDA margin	5.6%	3	5.2%	3
EBITDA, % achieved	100%	5	100%	5
ROA	7.6%	5	4.5%	5
I&E surplus margin	2.6%	4	1.9%	3
Liquid ratio	26.0	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 September 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				
	September 2013 Actuals		Annual Plan Quarter 2	
Metric	Score	Rating	Score	Rating
Capital Servicing Capacity	7.7 times	4	5.3 times	4
Liquidity	12.4	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.'

PERFORMANCE OVERVIEW

CQUINs

Barnsley

Overall Performance Rating : Amber/Green
Key Risk Areas:

- Clinical Communication Outpatients and discharge communication datasets – Failed to achieve quarter 2; improving performance in August and September indicates this will achieve in quarters 3 and 4.
- Increasing the number of people in secondary mental health in employment target not met, currently at 2.63% against a target of 6.6%. The target set is within realistic comparator group but will be difficult to achieve in the economic climate. Case to be built for continued discussion and negotiation with commissioners for 2014-2015 CQUIN to include apprenticeships', voluntary work and fulltime education.

All other targets have been achieved in quarter 2

Calderdale, Kirklees & Wakefield

Overall Performance Rating: Amber/Green
Key Risk Areas:
2.1 (a) Access MH Crisis 4 Hours
Although both Kirklees and Wakefield have achieved this target for the month of September, the Q2 accrued position does not meet the 90% aggregated target for WAA and OPS (87.8% and 86.8% respectively). The CQUIN Lead is currently addressing the reasoning behind the breaches and will be completing an exception report to be submitted to Commissioners.Q2 position for both Kirklees and Wakefield currently stands at Red.

2.2 (a&b) MH Access Routine
An improvement in performance can be noted for the month of September. However all BDUs continue to fail achievement of this CQUIN. Action remains ongoing to review the cases under target. There may be movement within the Wakefield, and potentially Kirklees, BDU after CQUIN Leads have interpreted the outliers. Q2 position for all three BDUs currently stands at Red.

2.2 (c&d) CAMHS Access Routine (Wakefield Only)
Work is ongoing with the Service to endure that the information from RiO accurately reflects the work of the service. The CQUIN Lead is preparing an exception report for Commissioners outlining the current work being undertaken to address CAMHS reporting of this CQUIN. Q2 position is Red.

Areas to Note:
3.3 LD Patient Experience
Commissioners have agreed to defer Q2 payment for this CQUIN until Q3 as the planned event originally planned for September is not going ahead until November.

Forensic
Quarter 2 Forensic submissions will be made by the Trust week commencing 21st October 2013.
Due to new Commissioning reporting arrangements CQUINs will now be signed off by the Nursing Team in the Commissioning Directorate, after recommendation by SYBAT. Notification of achievement will be sent to SWYPFT on the 25th November 2013.
It is envisaged that for Q2 all CQUINs will be achieved.

IMPACT AND DELIVERY

IAPT

The monthly IAPT recovery figure naturally fluctuates as it is dependent on a number of factors such as complexity of cases coming in to the team, whether group work starts or finishes in a month and how many cases are closed in that month. A better view of performance would be taken from a full quarter position (overall Q2 performance = 52.8%)

INFECTION PREVENTION

Hospital Acquired Infections: Achieving target for avoidable infections. However it is of note that Barnsley BDU currently have a total of 6 cases of clostridium difficile (most confirmed unavoidable) against a commissioner set trajectory of 8 cases for the full year. There is a strong possibility that this commissioner set target will be breached.

PSA OUTCOMES

Underperformance against both national Department of Health outcome measures (% on CPA in settled accommodation and in employment)

- No BDU achieving % on CPA in employment target
- Barnsley BDU and Wakefield BDU additionally not meeting national target % on CPA in settled accommodation(60%). Barnsley are meeting the local target (38%)

CUSTOMER FOCUS

MEMBERSHIP/BEFRIENDING SERVICES

There has been an improvement in performance this month following the befriender recruitment drive .Work has been focused on achieving accreditation The service have now revised processes to ensure targets are met in the future.

SERVICE USER SURVEY

CQUIN service user survey: % rating care as excellent or good - Inpatient survey 82%; Community survey 100%.

OPERATIONAL EFFECTIVENESS

BREASTFEEDING

Month 6 shows an improvement in breastfeeding prevalence at 6- 8 weeks, but continues to show an underperformance against threshold.
Local data shows a good level of maintenance of breastfeeding at 10-14 days through to 6-8 weeks and indicates that the prevalence issue relates to drop off rate between birth and 10 -14 days. Figures relating to this for 2012- 2013 show an overall level 2.8% less than the expected prevalence at 10-14 days.

Successful funding for the Altogether Better project will result in the recruitment of health champions who can influence and improve existing pathways and service delivery by providing greater insight in to what influences women's decisions about breast feeding and how current service delivery impacts on that decision.
The project will be focussed on reaching those vulnerable groups, recruiting health champions who want to provide active support to expectant and breastfeeding mums, spreading and reinforcing messages and telling people about how to get support.

MENTAL HEALTH CURRENCY DEVELOPMENT

External

- Monitor published their 2014/15 National Tariff Payment System consultation document. Trust members are attending HFMA, NHS England and Monitor events over the next few weeks to provide feedback which will be reflected in the final guidance to be published Nov/Dec.
- Quality & Outcomes indicators are being reviewed by the CPPP Q&O working group. Further analysis on number of contacts before clustering and joint visits are being carried out.
- Commissioner engagement events have taken place this month. Discussions have focused on the 2014/15 Service specification templates, Integration & Personal Health Budgets and updates on services currently excluded from MH currencies guidance which include Learning Disabilities Forensics, IAPTs, CAMHS and Liaison Services.

Internal

- Service transformation – support has been provided for the SPA, Rehab & Recovery and Long term conditions work streams.
- Mental Health Currency workshop took place in Barnsley in September. Action plans focus on maintaining progress, clinical engagement and embedding MHCT and clustering into mainstream clinical practice.
- A series of workshops targeted at clinicians are being developed to further embed MHCT and clustering across the Trust.
- The PbR Project plan has been completed and sent to Deloittes.

Mental Health Clustering

- The newly developed Data Quality dashboards have been used to identify teams who need focused training and support to improve their KPIs. Trajectories have been set with the clinical teams, and are being monitored monthly using information from the Data Quality dashboards. BDU and team reports have been produced and are being shared at Performance EMT and BDU meetings.

	Trajectories			Actual		
2013	% of eligible clustered	% reviewed within frequency	% Care Coordinator recorded	% of eligible clustered	% reviewed within frequency	% Care Coordinator recorded
Target	100%	100%	100%	100%	100%	100%
August Actual	89%	70%	70%	89%	73%	70%
September	91%	73%	73%	90%	74%	70%
October	92%	77%	77%			
November	93%	79%	79%			
December	93%	80%	80%			
January	93%	80%	80%			

- Quality & Outcomes KPIs with minimum expected levels are expected to be set as part of the 2014/15 contracting process, the CPPP Trusts are trying to anticipate KPIs, we are analysing our performance of these KPIs and providing support to teams as and when required.

FIT FOR FUTURE : WORKFORCE

Appraisal

(End of September Position) – 92.3% Overall. This shows a further increase from 88.3% in month 5. Target levels have been achieved in Calderdale, Forensic, Kirklees, Support Services, Barnsley and Wakefield. Specialist Services have yet to meet the 90% target (84.3%), however the BDU has improved their uptake figure from the end of August and are expected to achieve 90% by October.

Sickness

(End of August Position) – 4.50% Overall. The current year to date absence rate for the whole of SWYPFT is 4.50%. This shows a reduction from last month's figure of 4.56% and is a significant reduction from last year's YTD rate of 5.00% in August 2012.

The current 2013-14 projection is 4.80% which would be a 0.42% 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 August.

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

Barnsley BDU

- **Current YTD absence rate = 4.91%; Current projection by March 2014 = 5.05%; Projection Trend = Reducing**
- 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 = 3.34%; Current projection by March 2014 = 3.85%; Projection Trend = Reducing**
- Calderdale continues to see the lowest rates across the Trust as a BDU. Absence has been halved since May 2013.

Forensics BDU

- **Current YTD absence rate = 6.34%; Current projection by March 2014 = 6.60% Projection Trend = Unchanged**
- 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 (7.31% cumulative in August 2012 and rising).
- 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 8.47% and 8.6% respectively.

Kirklees BDU

- **Current YTD absence rate = 4.60%; Current projection by March 2014 = 4.43%; Projection Trend = Rising**
- Adult Services seeing much reduced overall rates and currently on target to meet 4% target (3.65% YTD)
- Older Peoples Services remains above target (6.81% 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 = 4.20%; Current projection by March 2014 = 4.40%; Projection Trend = Rising**
- Absence has been slowly rising since May through to August. BDU is still significantly reducing it's absence rate from last year. YTD absence at August last year stood at 5.43% - 1.235 higher than current YTD rate. Current rate still sees the BDU experiencing it's lowest BDU rate in the last 6 years

Specialist Services

- **Current YTD absence rate = 4.14%; Current projection by March 2014 = 4.30%; Projection Trend = Reducing**
- Seeing month on month absence reductions since June. 1.5% lower than for the same period last year. Absence rate however is expected to rise as errors have been found and are being rectified in management reporting.

Support Services

- **Current YTD absence rate = 3.63% - Current projection by March 2014= 3.50%; Projection Trend = Reducing**
- Overall, Support Services are currently meeting target levels - the only area of higher absence is in Estates (4.79%YTD).

Summary:

- With the exception of Barnsley, all BDUs are projecting a lower absence rate by March 2014 than last year.
- Of the 34 services lines across the whole of SWYPFT, 19 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.
- Both Calderdale and Support Services BDU are projected to achieve the SWYPFT target rate of 4% by the end of 2013-14 financial year.

Fire Training (End of September Position) – 74.0%

- Trust overall position remains below target at 74.0% (target = 80%). This has seen a 4% decline from last month
- Wakefield BDUs (81.9%) is currently meeting target levels.
- Calderdale (76.4%), Barnsley (74.8%), Forensics (69.6%), Kirklees (72.0%), Specialist Services (72.6%) and Support Services (70.7%) remain below target.

Information Governance (End September position)19%

The number of staff who had completed the training requirement in 2013/14 in September is 138.

- Less than 1 in 5 staff have completed the training in the first 6 months of the year, meaning that 4/5th of staff(625 staff per month) will need to complete it in the next 6 months.
- No service has achieved the 50% target
- The highest number of staff and % of staff have been achieved across Barnsley BDU and medium secure in Forensics.
- Particularly poor take up has occurred across AWA Kirklees and Calderdale which are still less than 10%.
- A full breakdown of staff who have completed or not completed the training is available on the intranet to help services develop their improvement plans.

GLOSSARY

AWA Adults of Working Age
AWOL Absent Without Leave
BDU Business Delivery Unit
CIP Cost Improvement Programme
CPA Care Programme Approach
CQC Care Quality Commission
CQUIN Commissioning for Quality and Innovation
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
PCT Primary Care Trust
PSA Public Service Agreement
PTS Post Traumatic Stress
Sis Serious Incidents
SYBAT South Yorkshire and Bassetlaw local area team
SU Service Users
TBD To Be Decided/Determined
YTD Year to Date

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

FINANCE REPORT

Month 6 (September 2013)

2013 / 2014

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Overall Financial Position

Performance Indicator		Month 6 Performance	Annual Forecast	Trend from last month	Last 3 Months - Most recent			Assurance	Page
Trust Targets					5	4	3		
1	£3.7m Surplus on Income & Expenditure	●	●	⇧	●	●	●	4	4 to 6
2	Cash position equal to or ahead of plan	●	●	⇧	●	●	●	4	15
3	Capital Expenditure within 5% of plan	●	●	⇩	●	●	●	4	17
4	In month delivery of recurrent CIPs	●	●	⇔	●	●	●	4	7 to 10
5	Monitor Risk Rating equal to or ahead of plan	●	●	⇔	●	●	●	4	11
6	In month Better Payment Practice Code	●	●	⇔	●	●	●	4	19

Summary Financial Performance

1. The year to date position, as at month 6, is showing a net surplus of £2.63m which is £0.89m ahead of plan. The Forecast for the year is £3.76m which is £0.04m better than planned.
2. At month 6 the cash position is £29.16m which is £2.48m ahead of plan.
3. Capital spend to September 2013 is £1.94m which is £1.1m (36%) behind plan.
4. At month 6 the Cost Improvement Programme is £0.18 (approx 2%) under the target of £3.54m.
5. The financial risk rating at September 2013 is 4.1 which is ahead of the planned 3.9 Quarter 2 position.
6. At 30th September 2013 94% of NHS and 97% of non NHS invoices have achieved the 30 day payment target (95%).

Income & Expenditure

Budget Staff in Post WTE	Actual Staff in Post WTE	Variance WTE	This Month Budget £m	This Month Actual £m	This Month Variance £m	Description	Year to Date Budget £m	Year to Date Actual £m	Year to Date Variance £m	Annual Budget £m	Forecast Outturn £m	Forecast Variance £m
			(3.64)	(3.60)	0.04	Wakefield	(21.81)	(21.54)	0.27	(43.64)	(43.55)	0.09
			(3.43)	(3.43)	0.00	Kirklees	(20.59)	(20.57)	0.02	(41.95)	(41.50)	0.45
			(1.89)	(1.89)	(0.00)	Calderdale	(10.77)	(10.76)	0.01	(21.55)	(21.51)	0.04
			(7.31)	(7.27)	0.04	Barnsley	(43.86)	(43.65)	0.21	(87.64)	(87.05)	0.59
			(1.99)	(1.99)	(0.00)	Secure Services	(11.93)	(11.93)	(0.00)	(25.00)	(23.70)	1.30
			(0.03)	(0.04)	(0.01)	Non Contract Income	(0.18)	(0.30)	(0.12)	(0.33)	(0.53)	(0.20)
			(18.30)	**(18.22)**	**0.08**	**Total Income**	**(109.14)**	**(108.75)**	**0.39**	**(220.10)**	**(217.84)**	**2.27**
524	503	(22)	1.79	1.84	0.05	Wakefield	10.95	11.08	0.13	21.89	22.27	0.38
587	566	(21)	1.98	2.02	0.04	Kirklees	11.98	12.39	0.41	24.36	24.95	0.60
339	319	(19)	0.82	0.79	(0.02)	Calderdale	6.61	6.81	0.20	13.50	13.65	0.16
1,716	1,568	(149)	7.16	6.84	(0.33)	Barnsley	35.43	34.42	(1.02)	71.15	69.63	(1.52)
310	281	(29)	0.13	0.24	0.11	LD & Specialist	7.19	6.97	(0.22)	14.34	13.91	(0.43)
431	443	12	1.38	1.39	0.01	Secure Services	8.10	8.13	0.03	16.25	16.52	0.27
699	685	(15)	3.60	3.43	(0.18)	Support	20.73	20.15	(0.58)	42.09	41.70	(0.40)
0	0	0	0.82	0.80	(0.02)	Provisions	2.49	2.29	(0.20)	5.37	4.08	(1.29)
4,607	**4,364**	**(243)**	**17.69**	**17.35**	**(0.34)**	**Total Operating Expenses**	**103.48**	**102.23**	**(1.24)**	**208.94**	**206.70**	**(2.23)**
4,607	**4,364**	**(243)**	**(0.61)**	**(0.87)**	**(0.26)**	**EBITDA**	**(5.66)**	**(6.51)**	**(0.85)**	**(11.17)**	**(11.13)**	**0.04**
			0.45	0.45	0.00	Depreciation	2.68	2.68	0.00	5.35	5.35	0.00
			0.14	0.14	(0.00)	PDC Paid	0.85	0.85	(0.00)	1.70	1.70	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
4,607	**4,364**	**(243)**	**(0.02)**	**(0.29)**	**(0.27)**	**Surplus**	**(1.74)**	**(2.63)**	**(0.89)**	**(3.72)**	**(3.76)**	**(0.04)**

Income and Expenditure Summary

Forecast

The planned surplus remains at £3.72m which was agreed by the Board in March 2013 and advised to Monitor in the Annual Plan submitted in May 2013.

The forecast for the year end position, as at month 6, is that this target will be exceeded by £0.04m and the key components of this are:

		£m
*	Operational Budgets Position	0.94
*	Provisions	1.29
*	Interest better than planned	0.08
		2.31
	Less:	
*	CQUIN Risk	0.60
*	Activity Income Risk	1.67
		2.27
		0.04

Month 6

The year to date position, as at month 6, reflects a £2.63m surplus which is £0.89m (51%) ahead of plan.

The components of this surplus are underspends in the Barnsley BDU, LD and Specialist Services, and in the Support Directorates.

These underspends are predominantly staffing related and are being managed to minimise the impact on service.

In contrast the Calderdale and Kirklees BDU's are showing overspends in out of area expenditure and expenditure on bank staff. The out of area spend have seen a reduction from previous months and this has been reflected in the revised BDU forecast positions.

In month 6 the Health & Wellbeing Services have been moved under the Barnsley BDU heading. As such this has moved the budget and costs from Calderdale BDU and LD & Specialist Services into Barnsley.

Income and Expenditure Detail

Healthcare Contract Income

Income is behind plan. This is due to:

* The shortfall against CQUIN income in Quarter 1 is £106k against a Quarter 1 budget of £1.05m.

* Barnsley BDU is not recovering budgeted income arising from Substance Misuse and PICU beds. These are under plan by £0.16m year to date.

* Non recurrent support from Wakefield CCG (£500k) has been bid for and a decision is being awaited from the Commissioner. The current position assumes that this additional income and expenditure will be incurred later in the year.

The CQUIN income for 2013 / 2014 is £4.7m. The current position assumes a shortfall of £600k against full delivery of the CQUIN targets. CQUIN performance continues to be monitored through the monthly Executive performance review and reported to Trust board.

BDU Operational Income & Expenditure

The key factors in the expenditure position are considered below:

* Wakefield BDU - The year to date position is £0.13m overspent. This is a £0.05m increased overspend from Month 5. The forecast overspend position is £0.38m which is a £0.06m increase from Month 5.

* Kirklees BDU - The year to date position is £0.41m overspent. This is a £0.04m increased overspend from Month 5. The largest cost pressures remain the usage of out of area beds and high staffing costs within Older People Services. Action has been taken on out of area beds and this has been reflected in the forecast overspend reducing from £0.73m to £0.6m.

* Calderdale BDU - The year to date position is £0.2m overspent. This is a £0.02m reduction in the overspend position from Month 5. Due to actions taken around the identification of CIP's the BDU forecast overspend has reduced to £0.16m.

* Barnsley BDU - The year to date position is £1.02m underspent. This is a £0.33m increased underspend from Month 5. The main components of this underspend relate to non recurrent underspends on telehealth and a level of vacancies across all service lines in the BDU. This level of vacancies is being managed and recruitment has been undertaken. The forecast underspend has increased to £1.52m, a movement of £0.54m.

* LD & Specialist - The year to date position is £0.22m underspend. This is a £0.11m reduction in the underspend position from Month 5. This position is reflective of the transfer of services for Health and Wellbeing to be included in the Barnsley BDU.

* Secure Services - The year to date position is £0.03m overspent. This is a £0.01m increased overspend position from Month 5. This is due to pay cost pressures arising from the usage of bank staff and additional recruitment undertaken within the BDU. However work has been completed to realign staffing requirements and this has been reflected in the reduced forecast overspend position. This has reduced from £0.38m in Month 5 to £0.27m overspend in Month 6.

* Support - The underspends are staff related, primarily within the Human Resources and Estates & Facilities teams.

Summary Performance of Cost Improvement Programme

Delivery of Recurrent Savings 2013 / 2014

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	276	552
	Actual	36	36	36	36	27	25							195	386
	Variance	(10)	(10)	(10)	(10)	(19)	(21)							(81)	(166)
LD & Specialist BDU	Target	24	24	24	24	24	24	24	24	24	24	24	24	144	288
	Actual	24	24	24	24	24	22							142	242
	Variance	0	0	0	0	0	(3)							(3)	(46)
Kirklees BDU	Target	25	25	25	55	55	55	55	55	55	55	55	55	240	570
	Actual	25	25	25	25	25	25							150	301
	Variance	0	0	0	(30)	(30)	(30)							(90)	(269)
Calderdale BDU	Target	20	20	20	37	37	37	37	37	37	37	37	37	171	393
	Actual	20	20	20	19	19	19							116	229
	Variance	0	0	0	(18)	(18)	(18)							(55)	(164)
Secure Services	Target	38	38	38	38	38	39	39	39	39	39	39	39	229	463
	Actual	27	27	27	27	27	28							164	333
	Variance	(11)	(11)	(11)	(11)	(11)	(11)							(65)	(130)
Barnsley BDU	Target	156	156	157	157	157	157	157	157	157	157	157	157	940	1,882
	Actual	134	134	135	135	135	135							806	1,615
	Variance	(22)	(22)	(22)	(22)	(22)	(22)							(134)	(267)
Support	Target	126	126	126	126	126	126	126	126	126	126	126	126	756	1,512
	Actual	115	115	115	104	109	114							674	1,353
	Variance	(11)	(11)	(11)	(22)	(17)	(12)							(82)	(159)
Trustwide	Target	253	253	253	253	253	253	253	253	253	253	253	252	1,518	3,035
	Actual	253	253	253	253	253	253							1,518	3,035
	Variance	0	0	0	0	0	0							0	0
Total	Target	688	688	689	736	736	737	737	737	737	737	737	736	4,274	8,695
	Actual	634	634	635	623	620	620							3,765	7,493
	Variance	(54)	(54)	(54)	(113)	(116)	(117)							(509)	(1,202)

Summary Performance of Cost Improvement Programme

Mitigation of CIP Shortfall 2013 / 2014

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	11							56	91
	Variance	9	9	9	9	9	11							56	91
LD & Specialist BDU	Target													0	0
	Actual	0	0	0	1	1	6							8	46
	Variance	0	0	0	1	1	6							8	46
Kirklees BDU	Target													0	0
	Actual	0	0	0	0	0	23							23	269
	Variance	0	0	0	0	0	23							23	269
Calderdale BDU	Target													0	0
	Actual	0	0	0	14	4	34							52	164
	Variance	0	0	0	14	4	34							52	164
Secure Services	Target													0	0
	Actual	0	0	0	0	0	0							0	23
	Variance	0	0	0	0	0	0							0	23
Barnsley BDU	Target													0	0
	Actual	22	22	22	22	22	22							134	267
	Variance	22	22	22	22	22	22							134	267
Support	Target													0	0
	Actual	9	9	9	20	15	9							69	159
	Variance	9	9	9	20	15	9							69	159
Trustwide	Target													0	0
	Actual	0	0	0	0	0	0							0	0
	Variance	0	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	105							342	1,020
	Variance	40	40	40	67	51	105							342	1,020

Summary Performance of Cost Improvement Programme

Total CIP Programme 2013 / 2014

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	276	552
	Actual	45	45	45	45	36	36	0	0	0	0	0	0	251	477
	Variance	(1)	(1)	(1)	(1)	(10)	(10)							(25)	(75)
LD & Specialist BDU	Target	24	24	24	24	24	24	24	24	24	24	24	24	144	288
	Actual	24	24	24	25	25	27	0	0	0	0	0	0	150	288
	Variance	0	0	0	1	1	3							6	(0)
Kirklees BDU	Target	25	25	25	55	55	55	55	55	55	55	55	55	240	570
	Actual	25	25	25	25	25	48	0	0	0	0	0	0	173	570
	Variance	0	0	0	(30)	(30)	(7)							(67)	0
Calderdale BDU	Target	20	20	20	37	37	37	37	37	37	37	37	37	171	393
	Actual	20	20	20	33	23	52	0	0	0	0	0	0	168	393
	Variance	0	0	0	(4)	(14)	15							(3)	0
Secure Services	Target	38	38	38	38	38	39	39	39	39	39	39	39	229	463
	Actual	27	27	27	27	27	28	0	0	0	0	0	0	164	356
	Variance	(11)	(11)	(11)	(11)	(11)	(11)							(65)	(107)
Barnsley BDU	Target	156	156	157	157	157	157	157	157	157	157	157	157	940	1,882
	Actual	156	156	157	157	157	157	0	0	0	0	0	0	940	1,882
	Variance	0	0	0	0	0	0							0	0
Support	Target	126	126	126	126	126	126	126	126	126	126	126	126	756	1,512
	Actual	124	124	124	124	124	123	0	0	0	0	0	0	743	1,512
	Variance	(2)	(2)	(2)	(2)	(2)	(3)							(13)	0
Trustwide	Target	253	253	253	253	253	253	253	253	253	253	253	252	1,518	3,035
	Actual	253	253	253	253	253	253	0	0	0	0	0	0	1,518	3,035
	Variance	0	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	725							3,382	8,513
	Variance	(14)	(14)	(14)	(47)	(65)	(12)							(155)	(182)

Delivery of Cost Improvement Plans

Delivery of Cost Improvement Programme

Forecast

The table on page 7 illustrates the delivery of the recurrent cost improvement programme for 2013 / 2014. The table on page 8 shows the value of non-recurrent substitutions identified by BDU's and the net overall position is shown on page 9.

The impacts of the Cost Improvement Programme are fully reflected in the Income & Expenditure position noted above.

The recurrent and overall Trust target is £8.7m. This represents a 4% saving against Trust healthcare income. The latest forecast is acheivement of £7.49m recurrently, a shortfall of £1.2m. A total of £1.02m is expected to be managed by recurrent and non-recurrent measures in year.

In the main the shortfall is due to timing delays against the original CIP plan, and therefore the schemes are still expected to deliver recurrently. The exception to this is the E-rostering scheme highlighted within Calderdale and Kirklees BDU's and recurrent alternatives have therefore been identified to replace this.

Month 6 Position

The year to date target is £3.54m and to date BDU's have allocated £3.38m. This leaves a shortfall of £155k.

* Wakefield BDU - the year to date position reflects slippage of 1 scheme, this is £25k. Overall the total forecast shortfall is £75k and a further substitution needs to be identified to resolve this.

* LD & Specialist - A number of schemes have slipped, totalling a forecast of £46k. These have been met with non recurrent substitutions.

* Kirklees BDU - The year to date position reflects the amendment of the original e-rostering scheme (£269k) to a number of different recurrent and non recurrent mitigations. The BDU need to finalise plans for all of these to be delivered recurrently.

* Calderdale BDU - The year to date position reflects the amendment of the original e-rostering scheme (£164k) to a number of different recurrent mitigations.

* Secure Services - The year date position is £65k under plan with a forecast of £130k. Forecast substitutions total £23k which leaves a shortfall of £107k still to be identified.

* Barnsley BDU - The recurrent year to date position is £134k under plan and forecast to be £267k under plan. This shortfall is being met by non recurrent savings identified in a number of areas such as drugs and Community equipment. Recurrent plans continue to be developed.

* Support - The year to date position is £82k due to delays in realising procurement CIP's and expected delays in recruitment. The forecast positon is a shortfall of £159k but non recurrent substitutions are being found.

Monitor Risk Rating

Financial Risk Rating 2013/ 2014

	September 2013 Actuals		Annual Plan Quarter 2	
Metric	Score	Rating	Score	Rating
EBITDA margin	5.61%	3	5.20%	3
EBITDA, % achieved	100%	5	100%	5
ROA	7.56%	5	4.50%	5
I&E surplus margin	2.60%	4	1.90%	3
Liquid ratio	26	4	27.4	4
Weighted Average		**4.1**		**3.9**

Financial Risk Rating 2013/ 2014

	September 2013 Actuals		Annual Plan Quarter 2	
Metric	Score	Rating	Score	Rating
Capital Servicing Capacity	7.7	4	5.3	4
Liquidity	12.4	4	12.1	4
Weighted Average		**4**		**4**

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

* EBITDA margin scores a 3 in line with plan.
* As a result EBITDA scores a 5 against plan.
* 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.

As part of the Risk Assessment Framework the Monitor Financial Risk Ratings will be revised from October 2013. 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.

Monitor Benchmarking

All Foundation Trusts

FRR	Governance Rating				
	Green	Amber - Green	Amber - Red	Red	**Total**
5	9	0	0	1	**10**
4	**21**	7	2	3	**33**
3	44	13	15	10	**82**
2	2	0	3	5	**10**
1	0	0	0	11	**11**
Total	**76**	**20**	**20**	**30**	**146**

Mental Health Trusts

FRR	Governance Rating				
	Green	Amber - Green	Amber - Red	Red	**Total**
5	4	0	0	1	**5**
4	**11**	1	0	1	**13**
3	20	2	1	0	**23**
2	0	0	0	0	**0**
1					**0**
Total	**35**	**3**	**1**	**2**	**41**

The table to the left shows overall performance by the 146 Foundation Trusts (monitored by Monitor) for the 3 months to the end of June 2013 (Quarter 1). Of these 41 are Mental Health Trusts.

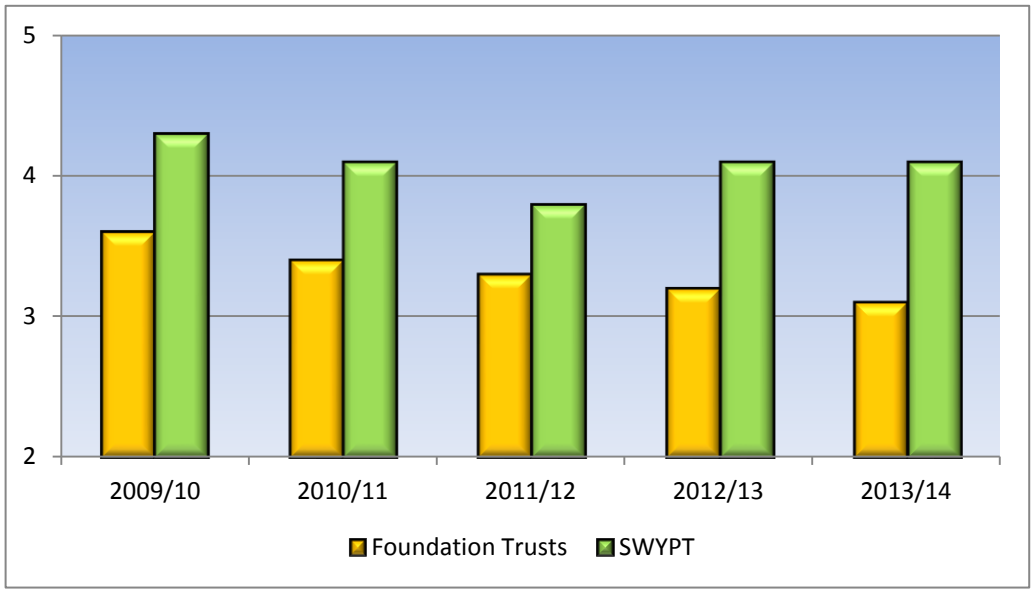
Highlighted within these numbers is the Trust performance as 4.1 (against the planned 3.9) and the correlation between Financial and Goverance Risk Ratings. The average FRR for Mental Health Trusts is 3.6.

Overall there are 20 Trusts under current Enforcement Action of which 1 is new in Quarter 1 2013 / 2014. (Dorset Health - the only Mental Health Trust subject to enforcement action.)

During 2012 / 2013 the correlation between financial performance and goverance was much clearer with most red trusts having financial ratings of 1 or 2. However in 2013 / 2014 this has increased with even a financially rated 5 Trust experiencing governance issues. (This is Dorset Health and relates to a warning notice from the CQC.)

The Trust remains, as per 2012 / 2013, in the FRR 4 / Green rating. Overall, within the Mental Health sector, this rating has reduced from 17 in March 2013 to 11 at the end of June 2013.

Monitor Benchmarking



As highlighted above the Trust has continued to show a positive risk rating performance. Over this 5 year period Foundation Trusts have experienced a reduction in their financial risk ratings whilst overall we have been able to maintain.

Analysis of Expenditure by Type 2013 / 2014

Type	Heading	Annual Budget	YTD Budget	YTD Actual	YTD Variance	Note
	Direct Credits & Income	(7.20)	(3.84)	(3.93)	(0.10)	
	Recharges	(4.58)	(2.55)	(2.65)	(0.09)	
Non-healthcare Income Total		(11.77)	(6.39)	(6.58)	(0.19)	
	Admin & Clerical	27.38	13.65	13.17	(0.49)	1
	Agency	2.39	1.26	1.43	0.17	2
	Ancillary	7.16	3.62	3.51	(0.11)	
	Medical	19.46	9.72	9.34	(0.38)	1
	Nursing	82.19	41.27	40.07	(1.19)	1
	Other Healthcare Staff	32.79	16.54	15.27	(1.27)	1
	Other Pay Costs	(4.48)	(2.65)	0.00	2.65	3
	Senior Management	1.42	0.71	0.64	(0.07)	
	Social Care Staff	2.34	1.20	1.20	0.00	
Pay- Expenditure Total		170.65	85.32	84.63	(0.69)	
	Clinical Supplies	2.52	1.07	1.02	(0.05)	
	Drugs	4.00	2.00	1.82	(0.18)	
	Healthcare subcontracting	2.71	1.36	1.92	0.56	
	Hotel Services	2.56	1.24	1.32	0.08	
	Office Supplies	3.88	1.95	1.81	(0.13)	
	Other Costs	6.33	3.13	2.92	(0.21)	
	Property Costs	6.62	3.40	3.56	0.17	
	Service Level Agreements	5.97	3.00	2.97	(0.04)	
	Training & Education	1.00	0.44	0.30	(0.14)	
	Travel & Subsistence	5.53	2.86	2.47	(0.39)	
	Utilities	2.00	0.78	0.82	0.04	
	Vehicle Costs	1.58	0.82	0.96	0.13	
Non-pay Expenditure Total		44.69	22.06	21.89	(0.17)	
	Provisions	5.37	2.49	2.29	(0.20)	
Grand Total		**208.94**	**103.48**	**102.23**	**(1.24)**	

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

This subjective analysis supports the I & E analysis.

* There is a £3.51m underspend on pay. This is being offset by the £2.65m staff vacancy factor and £0.17m agency overspend.

* Non pay shows relatively small variances over a number of catagories. 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.

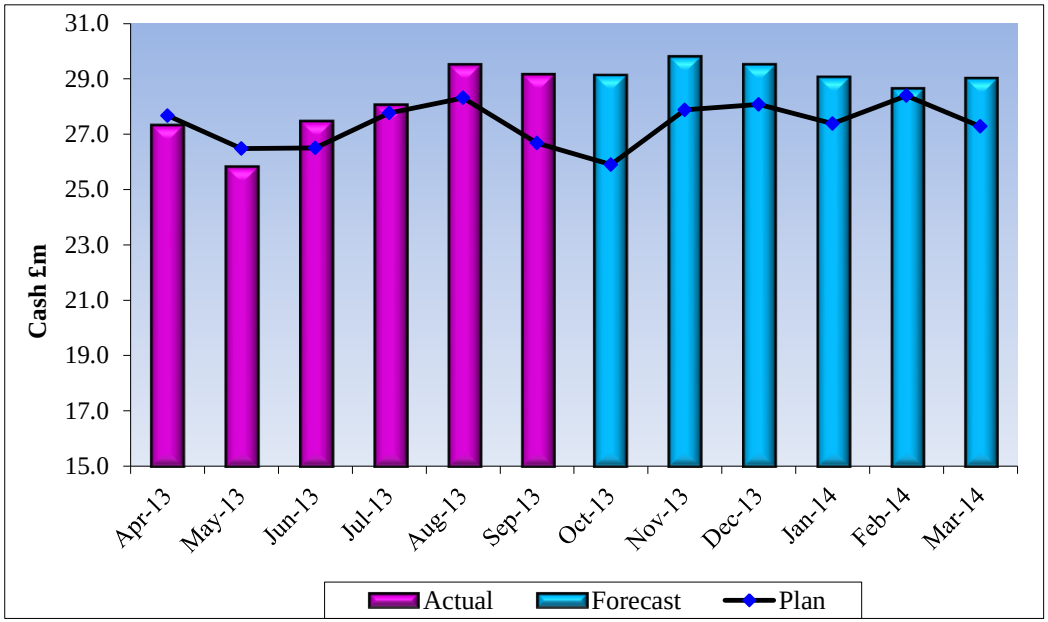
2. Agency costs are higher than planned. Spend is:

* Medical £519k
* Nursing £285k
* Social Workers £190k
* Admin & Clerical £432k

This is external agency costs only

3. This represents the recurrent staff vacancy factor. The savings requirement is £4.48m across the Trust and is planned to be acheived.

Cash Flow Forecast 2013 / 2014



The graph to the left shows the cash flow forecast position, at the end of the month, for 2013 / 2014.

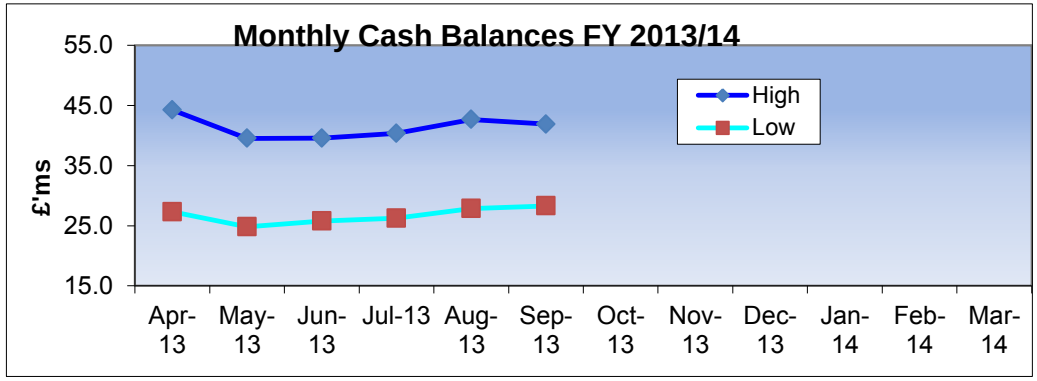
The plan is based upon the Annual Plan submitted to Monitor in May 2013.

The actual cash position for the month is £29.16m. This is £2.48m ahead of the planned cash value of £26.68m.

A breakdown of this movement is provided on page 16 as the Reconciliation of actual cash flow to plan.

Overall the forecast is that cash will be better than planned during 2013 / 2014 due to the cash implications arising from the forecast surplus position.

	Plan	Actual
	£m	£m
Opening Balance	28.31	29.51
Closing Balance	26.68	29.16



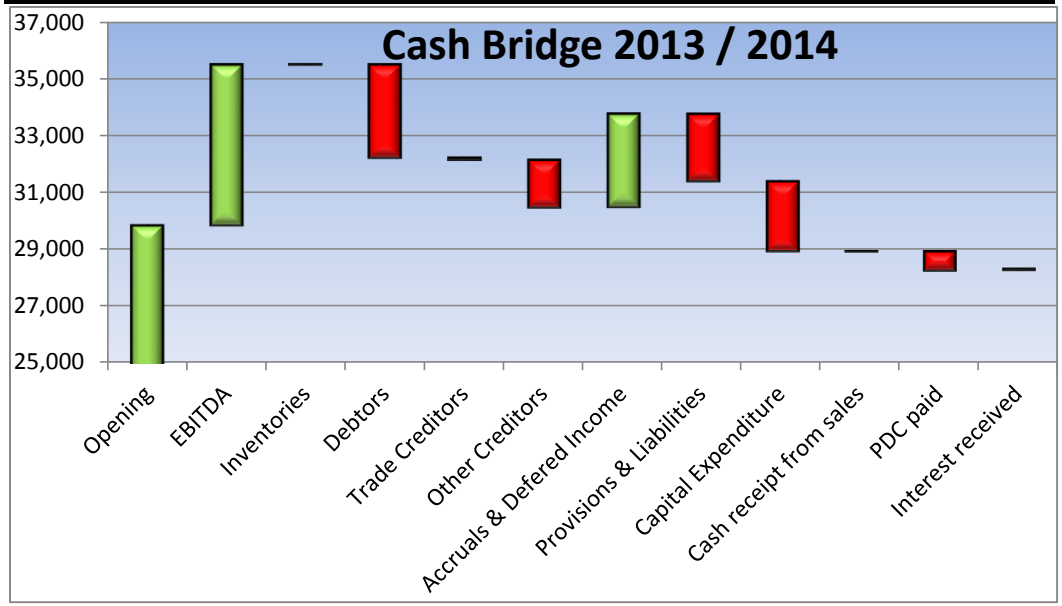
The graph to the left demonstrates the highest and lowest cash balances with each month. This is important to ensure that cash is available as required.

The highest balance is : £41.89m.
The lowest balance is : £28.3m.

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

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)	5.94	5.67	**(0.28)**	*1*
Movement in working capital:				
Inventories & Work in Progress	0.00	0.00	**0.00**	
Receivables (Debtors)	(1.74)	(3.27)	**(1.53)**	*4*
Trade Payables (Creditors)	0.37	(0.08)	**(0.45)**	
Other Payables (Creditors)	(2.77)	(1.68)	**1.09**	*2*
Accruals & Deferred income	0.84	3.29	**2.45**	*2*
Provisions & Liabilities	(1.64)	(2.36)	**(0.72)**	
Movement in LT Receivables				
Capital expenditure	(3.04)	(2.45)	**0.59**	*3*
Cash receipts from asset sales	0.00	0.00	**0.00**	
PDC Dividends paid	(1.13)	(0.69)	**0.44**	
PDC Received	0.00	0.00	**0.00**	
Interest (paid)/ received	0.00	0.04	**0.04**	
Closing Balances	**26.68**	**28.32**	**1.64**	



The Annual Plan reflects the May 2013 submission to Monitor.

Factors which increase the 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. Whilst amendments are being made to the Accounts Payable system this has led to accruals being higher than planned and creditors being lower than planned. Once this is implimented it is expected that these metrics will revert to a normal position.

3 Capital expenditure is lower than planned. As a result of the revised capital programme it is envisaged that we will continue to show a variance from the cash plan for capital during 2013 / 2014.

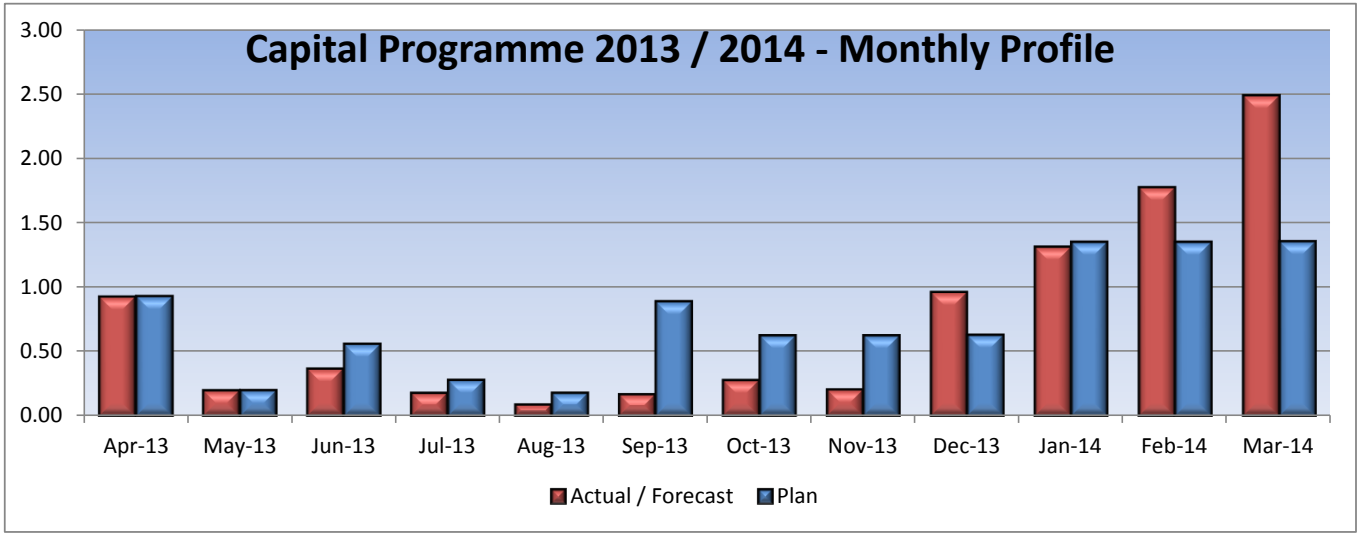
Factors which decrease the cash position against the plan:

4. Debtors are higher than planned. This is specifically non NHS debtors and relates to delayed payment received for block invoices for September 2013. Prompt payments are being chased.

Overall the cash bridge to the left depicts this reconciliation to demonstrate by heading the positive and negative impacts on the cash position.

Capital Programme 2013 / 2014

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	4.89	4.89	1.35	0.59	(0.75)	3.44	(1.45)	
Total Minor Capital		**4.89**	**1.35**	**0.59**	**(0.75)**	**3.44**	**(1.45)**	*2*
Major Capital Schemes								
Newton Lodge	11.80	1.32	1.32	1.13	(0.18)	1.32	(0.01)	
IM&T	1.60	0.85	0.28	0.17	(0.11)	0.85	0.00	
Estate Strategy	19.90	1.94	0.11	0.05	(0.06)	3.44	1.50	
Total Major Schemes		**4.11**	**1.70**	**1.35**	**(0.35)**	**5.60**	**1.49**	*3*
VAT Refunds		0.00	0.00	0.00	0.00	(0.05)	(0.04)	
TOTALS		**8.99**	**3.04**	**1.94**	**(1.10)**	**8.99**	**(0.00)**	*1*



Capital Expenditure 2013 / 2014

1. The total Capital Programme for 2013 / 2014 is £8.99m.

2. The year to date position is £1.1m under plan (36%) and as such breaches the 15% threshold set by Monitor. As a result the Trust will be required to reforecast it's capital programme for the remainder of the year. This detailed piece of work has been completed. The overall forecast is that the 2013 / 2014 programme will be delivered in full.

3. Upon submission and confirmation of this plan a revised budget allocation will be included within the table to the left. This will include a recatagorisation of budget from small schemes into the Estates strategy.

Balance Sheet

	Actual at 31/03/13	Plan at 30/09/13	Actual at 30/09/13	Note
	£m	£m	£m	
Non-Current (Fixed) Assets	**69.20**	**107.05**	**105.92**	*1*
Current Assets				
Inventories & Work in Progress	0.56	0.56	0.56	
NHS Trade Receivables (Debtors)	1.43	1.04	1.03	*2*
Other Receivables (Debtors)	3.15	5.42	6.82	*3*
Cash and Cash Equivalents	29.85	26.68	29.16	*9*
Total Current Assets	**34.99**	**33.70**	**37.56**	
Current Liabilities				
NHS Trade Payables (Creditors)	(2.48)	(2.85)	(2.41)	*4*
Non NHS Trade Payables (Creditors)	(3.88)	(1.86)	(2.46)	*4*
Other Payables (Creditors)	(3.36)	(3.50)	(3.25)	
Capital Payables (Creditors)	(1.25)	(0.50)	(0.71)	*5*
Accruals	(9.03)	(9.53)	(12.28)	*6*
Deferred Income	(0.79)	(1.13)	(0.82)	
Total Current Liabilities	**(20.79)**	**(19.37)**	**(21.93)**	
Net Current Assets/Liabilities	**14.20**	**14.33**	**15.64**	
Total Assets less Current Liabilities	**83.40**	**121.38**	**121.56**	
Provisions for Liabilities	(8.07)	(6.43)	(5.70)	*7*
Total Net Assets/(Liabilities)	**75.33**	**114.96**	**115.85**	
Taxpayers' Equity				
Public Dividend Capital	(41.99)	(41.99)	(41.99)	
Revaluation Reserve	(7.26)	(18.54)	(18.54)	
Other Reserves	(5.22)	(5.22)	(5.22)	
Income & Expenditure Reserve	(20.86)	(49.21)	(50.10)	*8*
Total Taxpayers' Equity	**(75.33)**	**(114.96)**	**(115.85)**	

The Balance Sheet analysis compares the current month end position to that with the Monitor Annual Plan, submitted May 2013. The previous year end positiuon 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 in line with planned. This value is higher than previously due to outstanding CQUIN payments.

3. Other debtors are higher than planned. This is due September block payments remaining outstanding for two councils (c. £1.2m).

4. Creditors continue to be managed in year. The biggest elements are 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. This is partially due to the changes in the capital programme.

6. Accruals are higher than planned and continue to be reviewed.

7. Payments against provisions have continued to be made under different timescales than planned.

8. These represent year to date surplus plus reserves brought forward.

9. The Reconciliation of Actual Cash Flow to Plan compares the current month end cash position to the LTFM forecast

Better Payment Practice Code

NHS		
	Number	Value
	%	%
Year to August 2013	94.9%	95.2%
Year to September 2013	94.2%	93.8%

Non NHS		
	Number	Value
	%	%
Year to August 2013	97.4%	96.0%
Year to September 2013	97.0%	96.0%

Local Suppliers - 10 days		
	Number	Value
	%	%
Year to August 2013	81.6%	81.8%
Year to September 2013	81.4%	78.9%

The Better Payment Practice Code requires the Trust 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% of the total number of invoices that have been paid within 30 days and 94% by the value of invoices.

The performance against target for Non NHS invoices is 97% of the total number of invoices that have been paid within 30 days and 96% by the value of invoices.

The Government has asked Public Sector bodies to try and pay Local Suppliers within 10 days, though this is not mandatory for the NHS. This was adopted by the Trust in November 2008.

To date the Trust has paid 81% of Local Supplier invoices by volume and 79% by the value of invoices within 10 days.

Transparency Disclosure

As part of the Government's commitment to greater transparency, there is a requirement to publish online, central governement 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 transparencty information for the current month is shown in the table below.

Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
23/08/2013	Drugs	Trustwide	Mid Yorkshire Hospitals NHS Trust	2145941	104,529
19/09/2013	Contribution - Service Review	Calderdale	NHS Calderdale CCG	2147554	100,000
04/09/2013	Lease Rents	Wakefield	Mid Yorkshire Hospitals NHS Trust	8096203	96,720
29/07/2013	Specialty Registrar (CT1-3)	Trustwide	Leeds and York Partnership NHS FT	2144322	66,406
03/09/2013	Specialty Registrar (CT1-3)	Trustwide	Leeds and York Partnership NHS FT	2146313	62,292
04/09/2013	Estate Managment SLA	Wakefield	Mid Yorkshire Hospitals NHS Trust	8096203	59,668
29/08/2013	FP10´S	Trustwide	NHSBSA Prescription Pricing Division	2146157	58,565
04/09/2013	Domestic SLA	Wakefield	Mid Yorkshire Hospitals NHS Trust	8096203	53,532
24/09/2013	Information SLA	Trustwide	Calderdale and Huddersfield NHS Foundation Trust	2147831	48,900
22/08/2013	Information SLA	Trustwide	Calderdale and Huddersfield NHS Foundation Trust	2145914	39,440
04/09/2013	Physiotherapy SLA	Wakefield	Mid Yorkshire Hospitals NHS Trust	8096203	33,488
04/09/2013	Pharmacy SLA	Wakefield	Mid Yorkshire Hospitals NHS Trust	8096203	32,080
16/09/2013	CNST contributions	Trustwide	NHS Litigation Authority	8096780	28,302
04/09/2013	Maintenance Management SLA	Wakefield	Mid Yorkshire Hospitals NHS Trust	8096203	27,364

Glossary of Terms & Definitions

* Recurrent - action or decision that has a continuing financial effect
* Non-Recurrent - action or decision that has a one off or time limited effect
* Full Year Effect (FYE) - quantification of the effect of an action, decision, or event for a full financial year
* Part Year Effect (PYE) - quantification of the effect of an action, decision, or event for the financial year concerned. So if a CIP were to be implimented half way through a financial year, the Trust would only see six months benefit from that action in that financial year

* Recurrent Underlying Surplus - We would not expect to actually report this position in our accounts, but it is an important measure of our fundamental financial health. It shows what our surplus would be if we stripped out all of the non-recurrent income, costs and savings.
* Forecast Surplus - This is the surplus we expect to make for the financial year
* Target Surplus - This is the surplus the Board said it wanted to achieve for the year (including non-recurrent actions), and which was used to set the CIP targets. This is set in advance of the year, and before all variables are known. Recently this has been set as part of the IBP/LTFM process. Previously we aimed to acheive breakeven.
* In Year Cost Savings - These are non-recurrent actions which will yield non-recurrent savings in year. So are part of the Forecast Surplus, but not pat of the Recurrent Underlying Surplus.
* Cost Improvement Programme (CIP) - We only agree actions which have a recurring effect, so these savings are part of our Recurrent Underlying Surplus.
* Non-Recurrent CIP - A CIP which is identified in advance, but which only has a one off financial beneift. This Trust has historically only approved recurrent CIP's. These differ from In Year Cost Savings in that the action is identified in advance of the financial year, whereas In Year Cost Savings are a target which budget holders are expected to deliver, but where they may not have identified the actions yielding the savings in advance.
* EBITDA - earnings before Interest, Tax, Depreciation and amoritisation. This strips out the expenditure items relating ot the provision of assets from the Trust's financial position to indicate the financial performance of it's services.
* IFRS - Internation Financial Reporting Standards, there are the guidance and rules by which financial accounts have to be prepared.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

TRUST BOARD: 22ND OCTOBER 2013

Human Resources Performance Report

July – September 2023

Section 1: Executive Summary

Section 2: HR Performance Dashboard

Section 3: Sickness Trajectories Report

Section 1: Executive Summary

1. Introduction

1.1 HR Performance Dashboard

- The year to date (April 2013 – August 2013) sickness absence rate for the Trust is 4.5% which is a fall of 0.2% from the first quarters report. Barnsley BDU is the only area with a higher projected sickness absence rate for 2013/2014 than 2012/2013. All other areas are showing a reduction from last year. A more detailed picture of sickness absence rates, trends and projections are given in Section 2 of this report.

- The Trust has now achieved its 90% appraisal target with all areas above this threshold. An evaluation of the new appraisal system is currently being finalised and will be reported back at a later meeting.

- The expenditure on bank/agency/overtime has fallen by over 500,000 in 2013/2014 compared to the same period as last year. All service areas are showing a fall in expenditure compared to last year.

1.2 Sickness/Absence Trajectories

- The sickness/absence trajectory continues to show a downward trend when compared to the last quarter's report and the sickness/absence pattern for 2012/ 2013. The projected year end position is an absence rate of 4.8%, whilst still above the 4% target, is 0.2% lower than the projected figure in the first quarter's report and would be 0.42% lower than last year.

- There are 2 areas Calderdale BDU and Support Services with a projected absence rate for 2013/2014 below 4%.

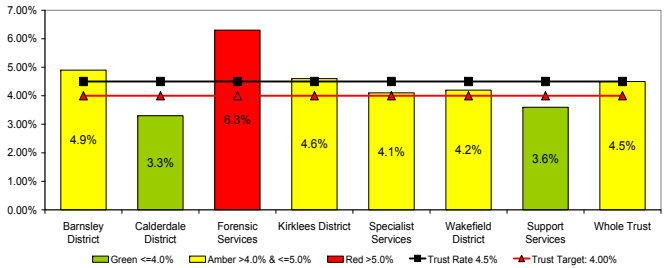
- Barnsley BDU is the only area with a projected higher absent rate this year compared to last year.

- Whilst Forensic Services continues to have the highest sickness rate, there is a significant reduction in absence when compared to last year and Medium Secure Services is still maintaining a significantly lower absent rate than last year.

Section 2: Human Resources Performance Dashboard (September 2013/2014)

Sickness Absence

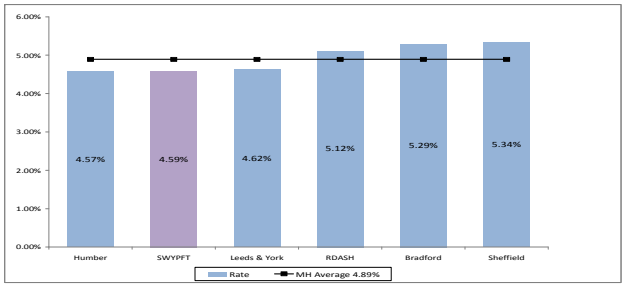
Sickness Absence by District – Year to Date



Current Absence Position – August 2013

	Barn	Cald	Fore	Kirk	Spec	Wake	Supp
Rate	5.0%	2.7%	5.9%	5.3%	3.0%	5.4%	2.9%
Trend	↑	↔	↓	↑	↓	↓	↑

Absence Benchmark Y&H MH/LD & Care Trusts



- The Trust YTD absence levels in August 2013 are above the 4.0% target at 4.5%.
- The chart above shows absence levels in MH/LD Trusts in our region for Q1 2013/14. During this time the Trust's absence was 4.59% which was below the regional average of 4.89%.

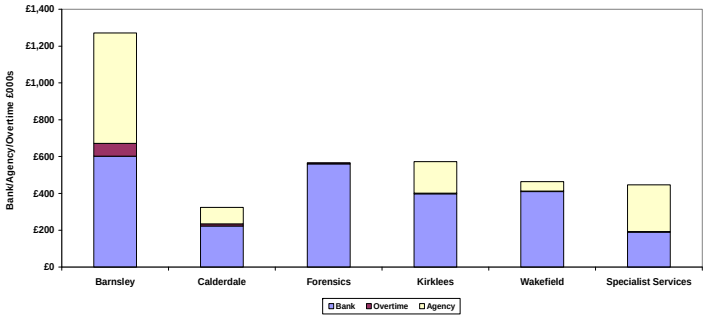
Staff Appraisal

BDU	Rate
Barnsley	92.2%
Calderdale	93.9%
Forensics	93.1%
Kirklees	93.3%
Specialist	90.1%
Wakefield	91.2%
Support	92.3%
Trust	92.3%

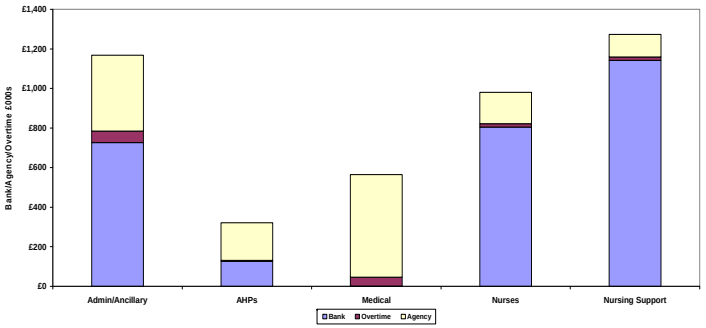
- Appraisal rates for the month ending September 2013 was 92.3%. This is just above the Trust's target of 90%.

Bank, Agency & Overtime Spend

Bank, Agency & Overtime Spend by BDU - YTD



Bank, Agency & Overtime Spend by Group - YTD



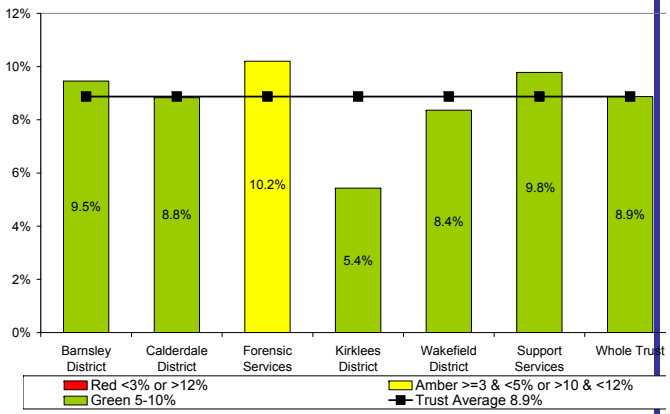
Overtime Spend by BDU - YTD ('000s)

BDU	A&C/ Ancil	AHPs	Medical	Nursing	Total
Barnsley	£11	£1	£33	£24	£70
Calderdale	£1	£1	£1	£8	£11
Forensics	£1	£0	£5	£0	£6
Kirklees	£0	£1	£2	£0	£4
Wakefield	£0	£0	£3	£0	£3
Specialist	£1	£1	£0	£0	£3
Support	£44	£0	£0	£1	£44
Total	£59	£5	£45	£34	£142

Agency Spend by BDU - YTD ('000s)

BDU	A&C/ Ancil	AHPs	Medics	Nursing	Total
Barnsley	£101	£124	£293	£82	£600
Calderdale	£25	£32	£21	£12	£89
Forensics	£0	£0	£0	£0	£0
Kirklees	£0	£4	£67	£99	£171
Wakefield	£6	£0	£27	£19	£52
Specialist	£9	£60	£110	£74	£253
Support	£242	-£31	£0	-£14	£198
Total	£382	£190	£519	£272	£1,363

Turnover Rates by Service – Year to Date



- Year to Date Turnover is 8.9% which is within the target range of 5-10%

Section 3: Sickness Trajectories Report – Month 5 – April – August 2013

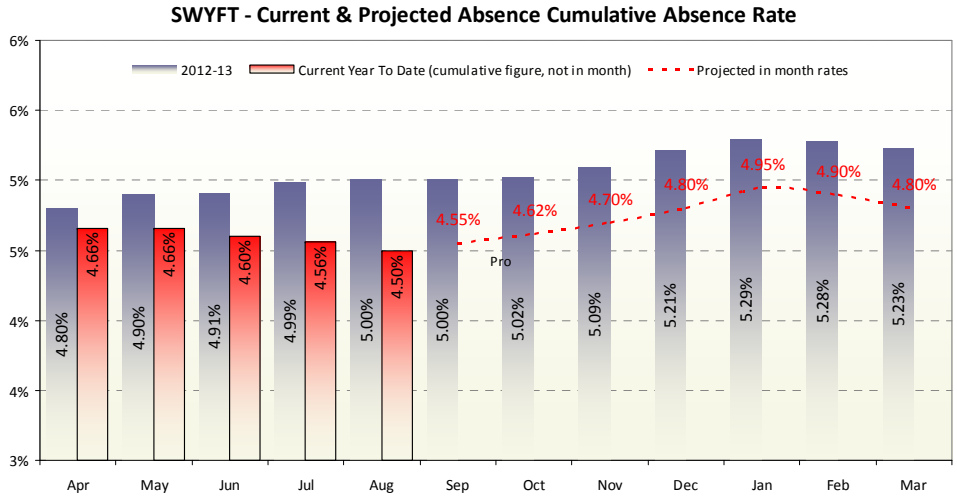
**Rates correct at the time of publication. Absence rates are liable to change following amended or late submission of absence returns from departments*

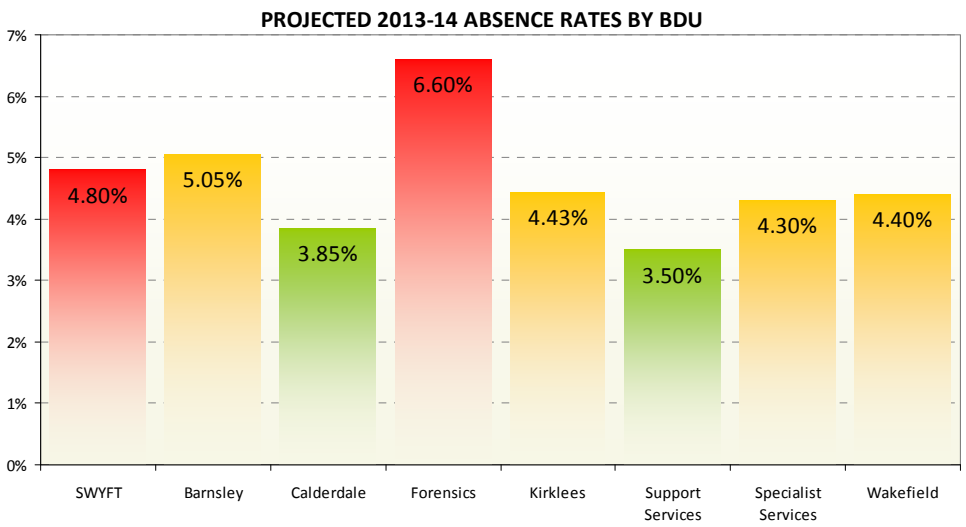
Current year to date (YTD) absence rate for the whole of SWYFT is 4.50%. This realises a reduction from last month's YTD figure of 4.56% and a significant reduction from last years YTD rate of 5.00% by August 2012.

2013-14 absence rate projection based on current trend is 4.80% which would be a 0.42% reduction from last year but still above the 4.0% Trust Board target. The current YTD SWYFT absence rate has now seen month on month reductions for the last 5 months.

The current year to date absence rate of 4.50% is above the Trust target, but the absence rate between April and August this year has been significantly reduced from much higher rates seen in January (6.02%) and February (5.13%). The 5 months since April 2013 have seen an in-month absence rate under 5% (4.66%, 4.66%, 4.6%, 4.56% and 4.50%). Whilst rates between January and March closely match previous year rates, April through to August sees a reduction from like for like rates last year. Last year the overall SWYFT rate rose month on month from April 2012 through to February 2013. This year has already seen a reduction in the cumulative rate from April to August.

The graph below shows the cumulative absence rate for SWYFT overall (red columns) against the cumulative rolling absence rate from last year (blue columns) with the projected cumulative rate for the coming year (red dotted line). SWYFT is projected to reduced it's absence rate by 0.23% from last year, down to 5.00%





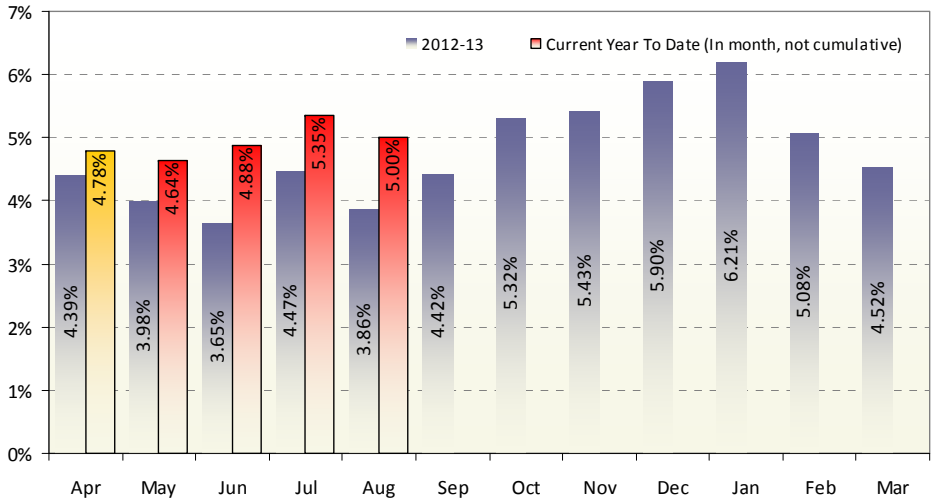
Barnsley BDU - **Current YTD absence rate 4.91%** - *Current projection by March 2014 – **5.05%*** **YTD Projection Trend =Down**
Last year: 4.77%

The BDU as a whole is seeing a higher than expected absence rate due to higher YTD rates in Children's Services (7.80%), Long Term Conditions (5.55%), Community MH Services (5.30%) and Specialist MH services (6.03%). All areas have higher instances of long term absence currently which are being managed. The overall absence in Barnsley BDU this month has reduced slightly from that seen in July. Long Term Conditions absence in August stands at 6.42%. As Long Term Conditions is a large establishment in the Barnsley BDU area this service gives a weighted influence to overall rates. Barnsley BDU is projected to increase its cumulative absence rate this year from 4.77% in 2012-13 to 5.05% on current absence trends. This shows a slight reduction from last month.

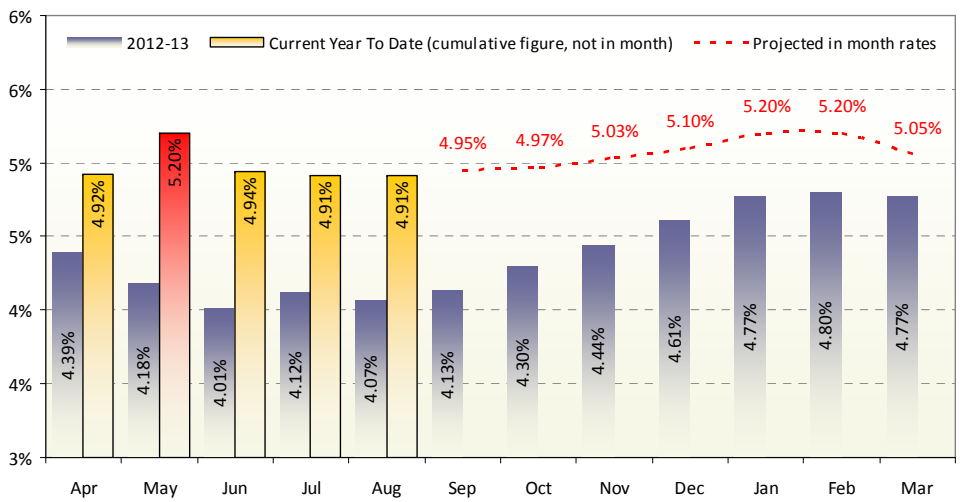
Current Barnsley Hotspots:

Children's Services: Health Visiting overall (7.80%), Mk Bretton team (7.25%), Mapplewell team (24.62%), Penistone team (14.96%), Stairfoot team (10.36%)
Inpatient Rehab: MVH Ward 4 (9.53%)
Local Authority Children's: School Nursing (5.96% cumulative, but above 7.5% in month since June)
Long Term Conditions: District Nursing (8.96% - an average of 28 days lost per absence episode since April 2013)
MHS Acute Care: Crisis Care Support (10.40%)
Community MH: MH Administration (31.86% cumulative – absence rate above 27% since April 2013)
Specialist MH: Early Intervention (7.37%)
Primary Care & Preventative – Health Trainers (11.47% - rate been reduced from 16% to 5.36% in last 2 months)

Barnsley BDU 2013-14 Absence v 2012-13 Absence in Month Rate



Barnsley BDU - Current & Projected Cumulative Absence Rate

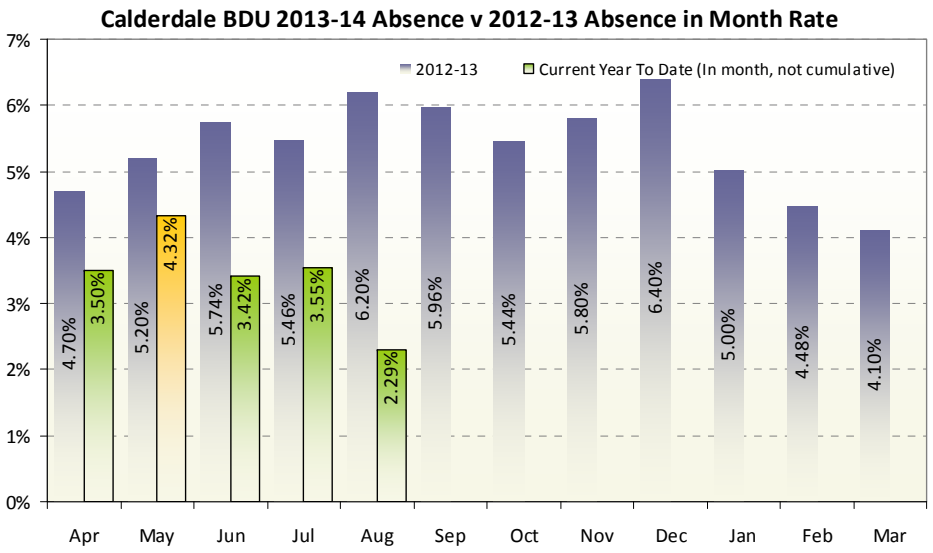


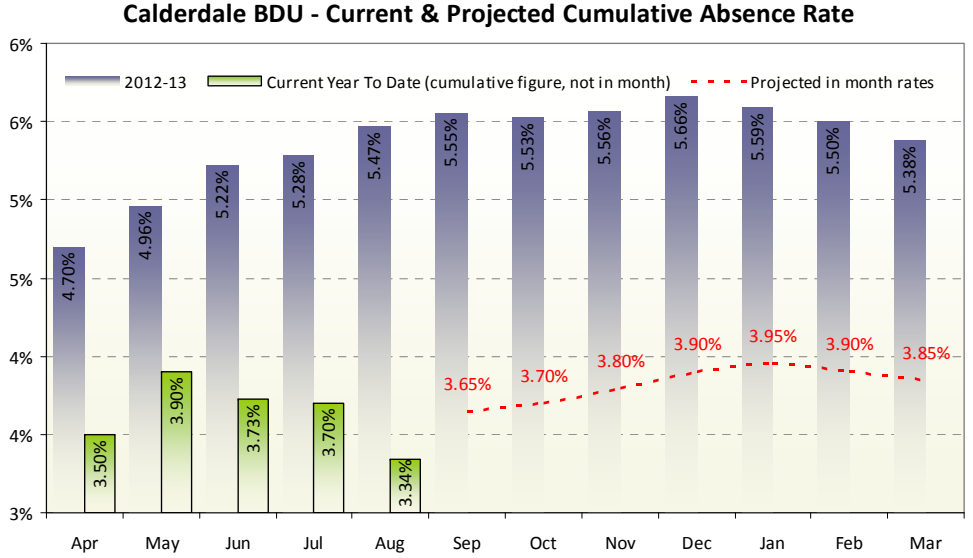
Calderdale BDU **- Current YTD rate 3.34% -** *Current projection by March 2014 –* ***3.85%*** **YTD Projection Trend = DOWN**
Last year: 5.38%

Calderdale continues to see the lowest rates across the Trust as a BDU. The cumulative rate in August of 3.34% is a significant reduction from last year where the cumulative rate by August 2012 was 5.47% and rising month on month. The BDU had seen month on month reductions in the cumulative absence rate since May 2013. Older Peoples Services have the lowest rate within SWYFT at the present time with a rate of only 1.65% from April to the end of August and this rate has remained constantly low since April. At the time of publication HR has reported that there are currently NO staff members on long term absence. This has never been achieved before in a BDU. The BDU is projecting an overall reduction of over 1.5% from last year's rate of 5.38%

Current Calderdale Hotspots:

Adult Services: Admin Support (12.76% cumulative – the service has had an absence rate above 10% since April)
Older Peoples Services – n/a





Forensics BDU - **Current YTD absence rate 6.34% -** *Current projection by March 2014 –* ***6.60%*** **YTD Projection Trend = UNCHANGED**

Last year: 7.16%

Forensics continues to see higher absence rates than the rest of the Trust, though the BDU has made reductions from this time last year when cumulative absence by August 2012 was 7.31% and rising. 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. The current YTD rate for Medium Secure is 4.90% and it should be noted that for the last 3 months the rate has been falling. The in-month rate for August within Medium Secure Services was 4.73% - the lowest monthly rate for the service in the last 3 months. 50% of all Forensics staff are employed within Medium Secure where absence is lowest and therefore this area has a weighted influence on overall rates within Forensics.
Long term absence is still being experienced in Low Secure and this is causing a current YTD rate of 8.47%. Newhaven saw a YTD rate of 8.6% through to August. The BDU is projected to reduce its cumulative absence by March 2014 to 6.60% however, which would mean a reduction overall of 0.56% from last year. The BDU does remain well above the 4% target and is 1.5% higher than the nearest projected absence rate of all other BDU's.

Current Forensics Hotspots:

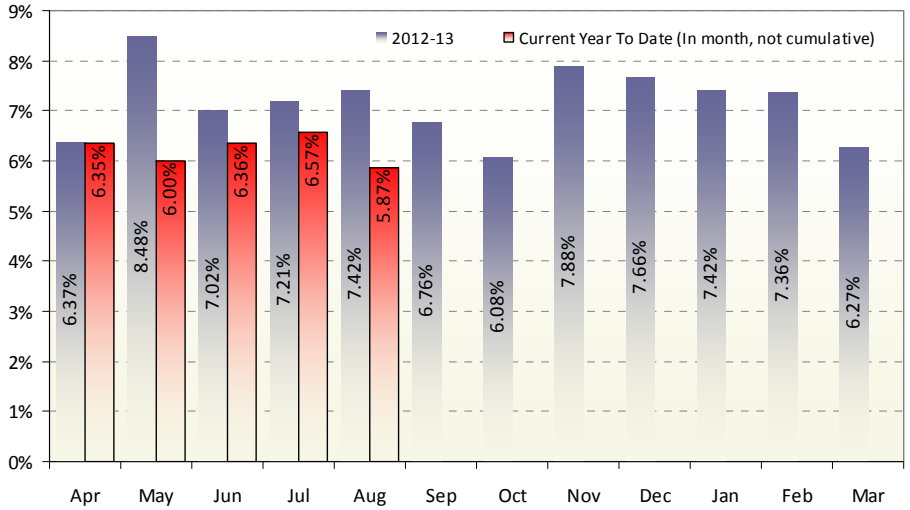
Low Secure: Admissions & Assessment Unit – Sandal (10.63%), Continuing Treatment – Thornhill (7.53%), Almondbury Rehab & Recovery (10.72% cumulative – absence rates have been halved in this area in the last 2 months)
Medium Secure: RSU Chippendale (8.62%), RSU Priestley (8.26% cumulative – this rate has been significantly reducing for the past 2 months after high absence between April and June)
Newhaven: Low Secure (11.36% cumulative - After an initial rate of 17.13% in April this area has seen month on month absence reductions to August and has been reduced by over 10% to 8.98% in August. 65% of all Newhaven staff are in this area)

Forensic Services Sickness Rates

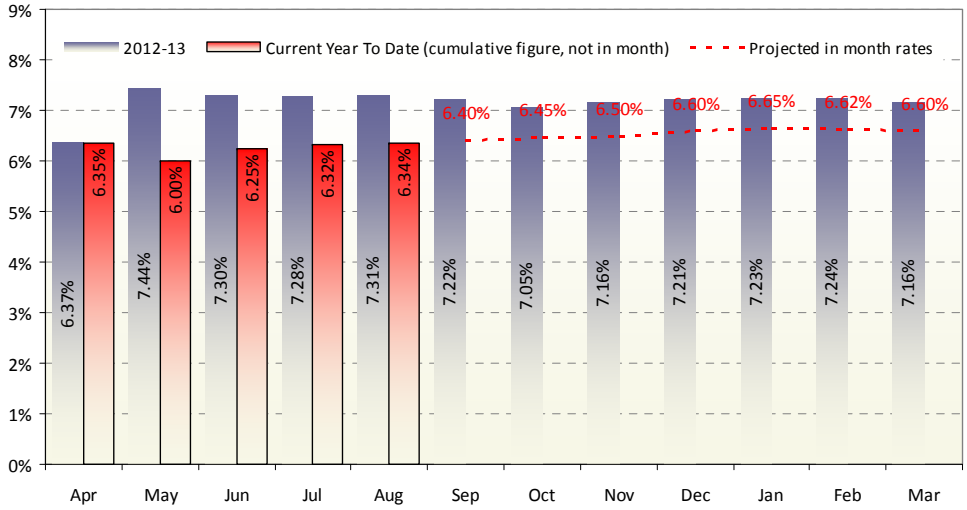
Service	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sep 12	Oct 12	Nov 12	Dec 12	Jan 13	Feb 13	Mar 13	Year to Date
Low Secure	5.6%	8.5%	7.2%	7.0%	5.1%	6.5%	5.7%	9.1%	7.2%	9.0%	10.4%	7.8%	7.4%
Newhaven	9.2%	17.5%	9.3%	5.5%	2.5%	4.7%	3.7%	10.1%	16.2%	10.2%	8.5%	11.8%	9.1%
Medium Secure	6.3%	7.0%	6.6%	7.6%	9.2%	7.2%	6.6%	7.0%	6.3%	6.2%	5.5%	4.7%	6.7%
Total	6.4%	8.5%	7.0%	7.2%	7.4%	6.7%	6.1%	7.9%	7.7%	7.4%	7.1%	6.3%	7.1%

Service	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Year to Date
Low Secure	7.8%	9.9%	10.0%	9.0%	8.5%	8.2%	8.9%
Newhaven	12.1%	7.6%	6.7%	8.0%	8.3%	6.8%	8.3%
Medium Secure	4.7%	4.1%	5.0%	6.0%	4.7%	5.2%	4.9%
Total	6.4%	6.0%	6.5%	7.0%	6.1%	6.1%	6.3%

Forensics BDU 2013-14 Absence v 2012-13 Absence in Month Rate



Forensics BDU - Current & Projected Cumulative Absence Rate

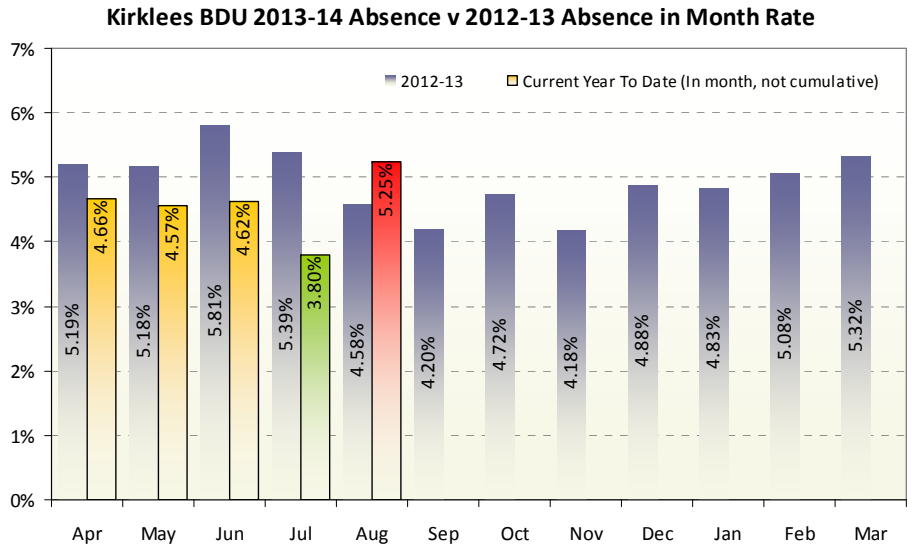


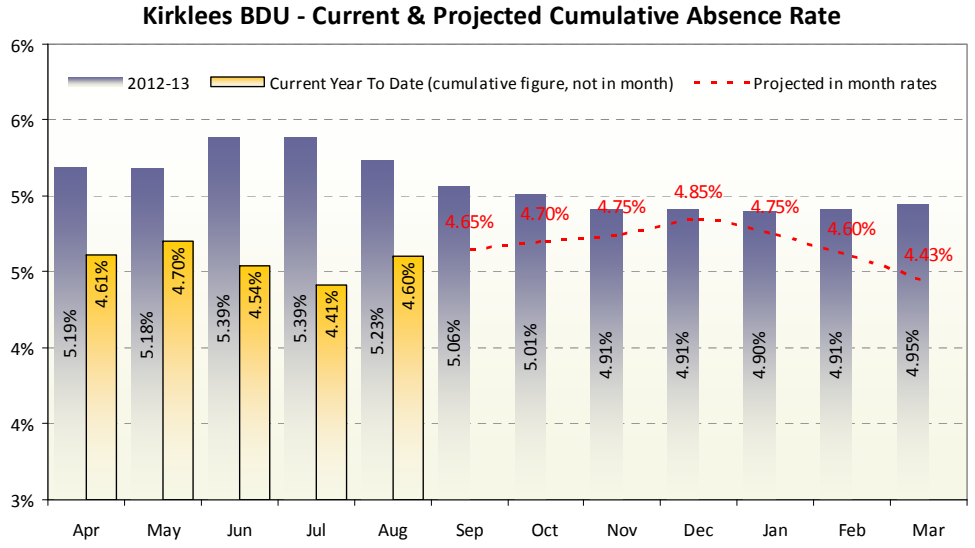
Kirklees BDU **- Current YTD absence rate 4.60% -** *Current projection by March 2014 –* ***4.43%*** **YTD Projection Trend = UP**
Last year: 4.95%

August saw the highest in-month rate for the BDU since April. Analysis shows that this has actually been due to a rise of short term absence from D&V illness in ward areas. Long term absence is being managed and recently staff have been dismissed through the Management of Ill Health Policy. Adult Services are currently experiencing lower than expected absence rates and the year to date rate is 3.65%. This is much lower than the same period by August 2012 (5.39%). Older Peoples Services are currently accounting for 53% of the total sickness burden within the BDU, but has only 28% of the total workforce. This is resulting in an overall absence rate of 6.81% from April 2013. OPS has experienced an in-month absence rate above 6% in 4 of the previous 5 months. Long term absence in specific areas is causing the rise in absence currently, but all long term absence is being managed effectively at this time between both service leads and HR services.
Overall despite higher rates in OPS, the BDU has achieved lower absence rates in like for like months from last year and is currently projected to return a revised rate of 4.43% by April 2014 which will be a 0.52% reduction on last years return of 4.95%.

Current Hotspots:

Adult Services: Care Management North Kirklees (7.32%), Ashdale (9.31% - average of 17 days lost per episode since April 2013), Enfield Down (6.84% - average of 22 days lost per episode since April 2013)
Older Peoples Services: Dewsbury OPS Ward 19 (12.29% cumulative – 38% of all absence in OPS experienced in Ward 19, but has 28% of the total staff of the department. In-month absence rate since June has been over 15%), North Kirklees CMHT (11.52% cumulative - absence has been reduced from 17% in April to 5.2% in August).

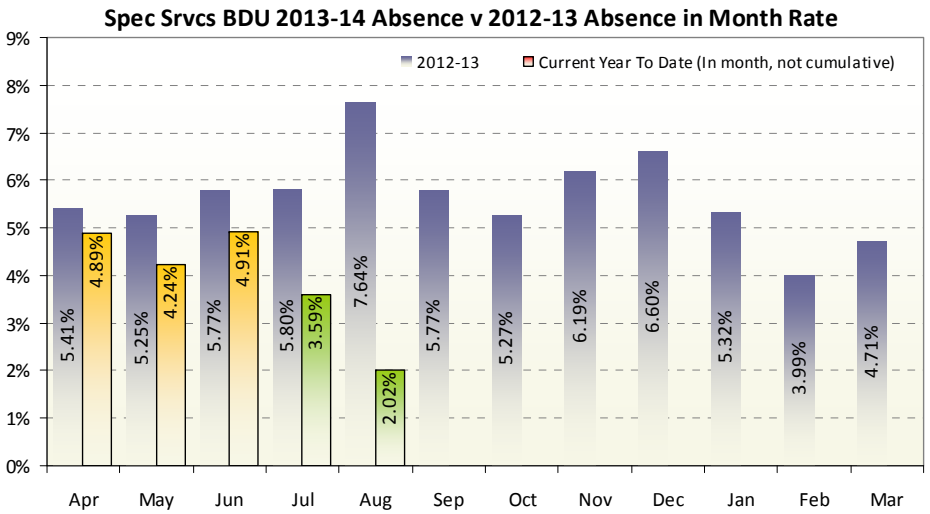


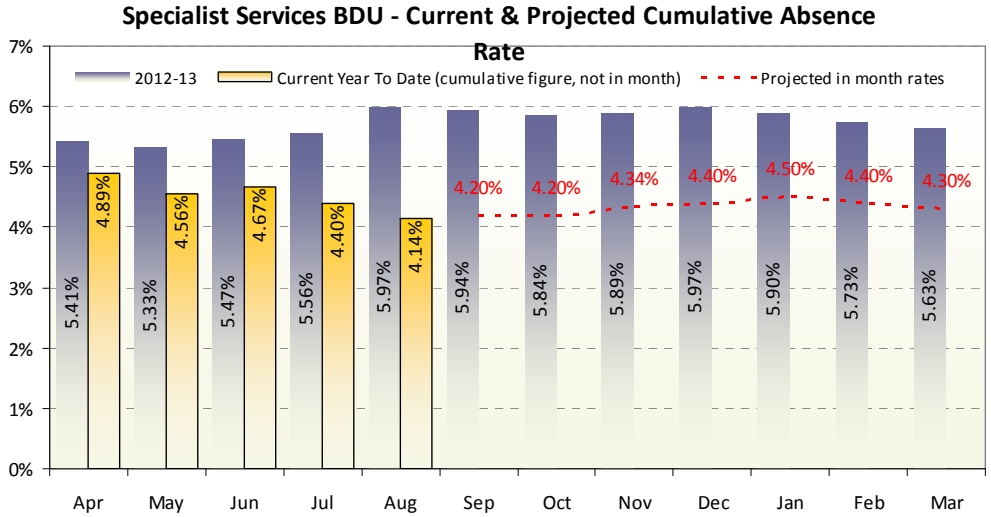


Specialist Services BDU **Current YTD absence rate 4.14% -** *Current projection by March 2014 –* ***4.30%*** **YTD Projection Trend = DOWN**
Last year: 5.63%

Specialist Services are seeing consistent absence rate reduction since June 2013. The BDU has more than halved it's in month absence rate in the last two months and August saw the lowest rate experienced since the implementation of ESR at 2.02%. The stability in absence rates is a positive sign as historically the area has suffered from high absence rates in the past. The 1st 4 months of 2012 saw rates of between April and July 2012 the BDU saw rates of 5.41%, 5.25%, 5.77% and 5.80%: all higher than this year. August 2012 saw a year high rate of 7.64% compared to the 2.02% in August 2013. The BDU is projected to significantly reduce its cumulative absence by 1.63% by April 2014 to 4.30%.

Current Specialist Services Hotspots:
Specialist Services: Calderdale CDLT (9.40%), Fox View Respite Care (11.04% - absence been above 9.9% all year – August at 10.01% Average of 23 days lost per episode since April 2013), HUD Day Services – PLD (10.19%),



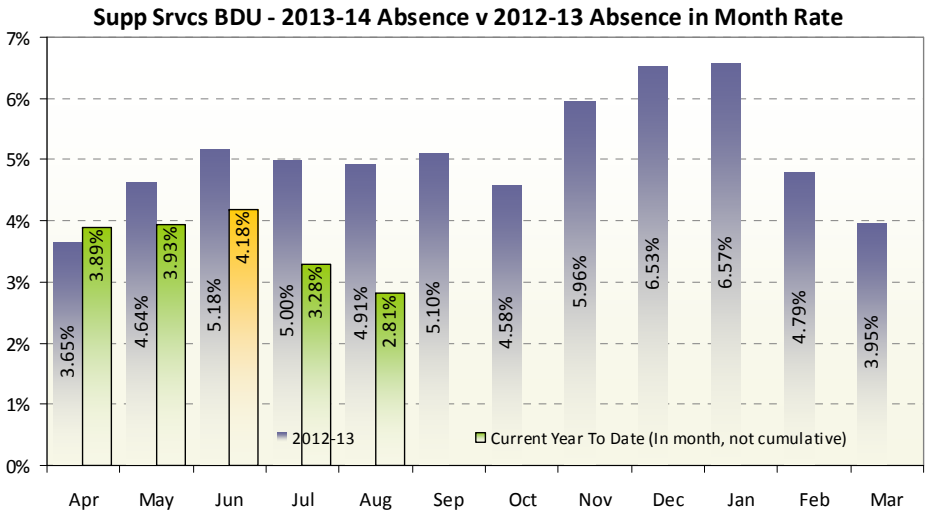


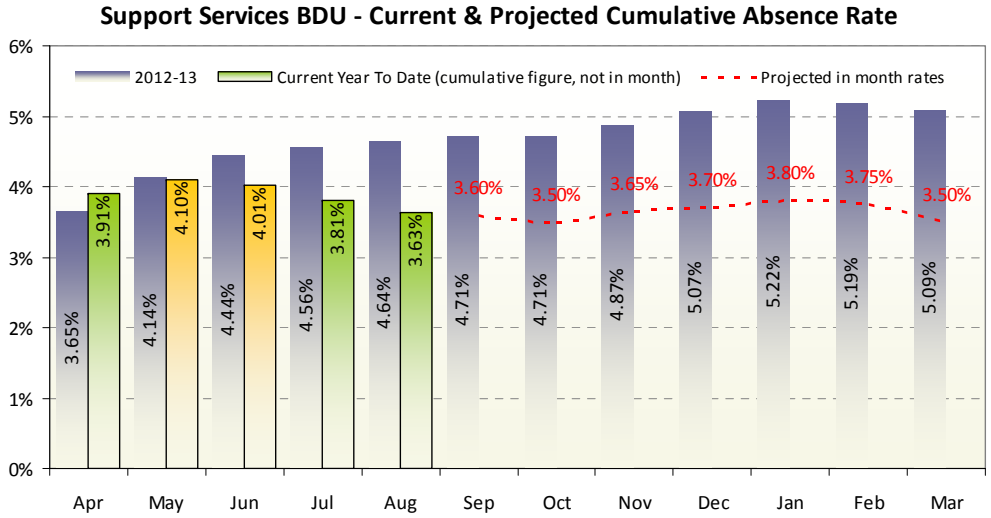
Support Services BDU **Current YTD absence rate 3.63% -** *Current projection by March 2014 –* ***3.50%*** **YTD Projection Trend = DOWN**
Last year: 5.09%

Support Services have seen stable cumulative absence returns since April 2013 which have fluctuated only slightly between 3.8% and 4.1%. August however saw a reduction to 3.63% as long term absence was further reduced in certain areas such as Estates & Facilities. Estates & Facilities staff account for over 50% of all calendar days lost per month within all support services areas and currently stands at 4.79%. This is the lowest return for the area for the past 6 years. Support Services is historically a stable absence rate area which was influenced last year by individual long term absences which are now no longer current. Support Services are projected to reduce their absence rate this year to 3.50%: below the Trustwide target of 4%.

Current Support Services Hotspots:

Estates & Facilities: Facilities Catering (8.65%), Domestics (7.32% - West side of the Trust) , Estates Management Engineering (26.00% - long term sickness currently. Average of 59 days lost per absence episode)



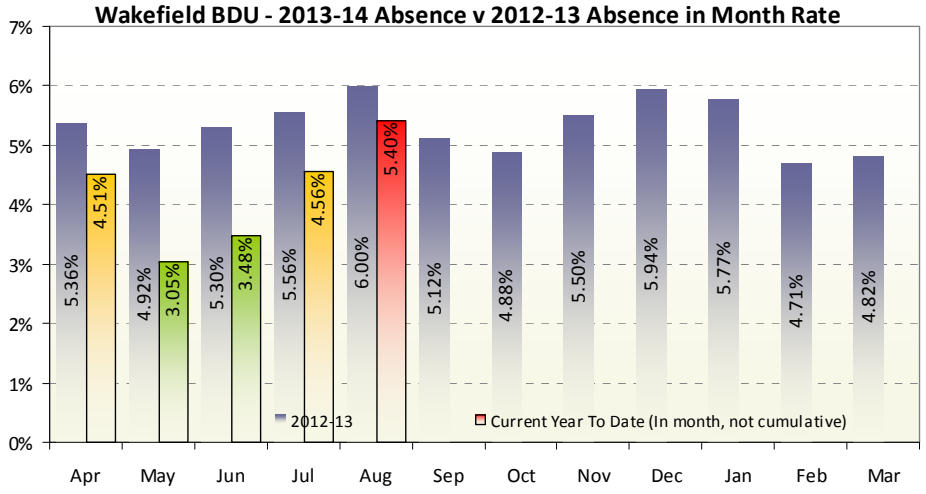


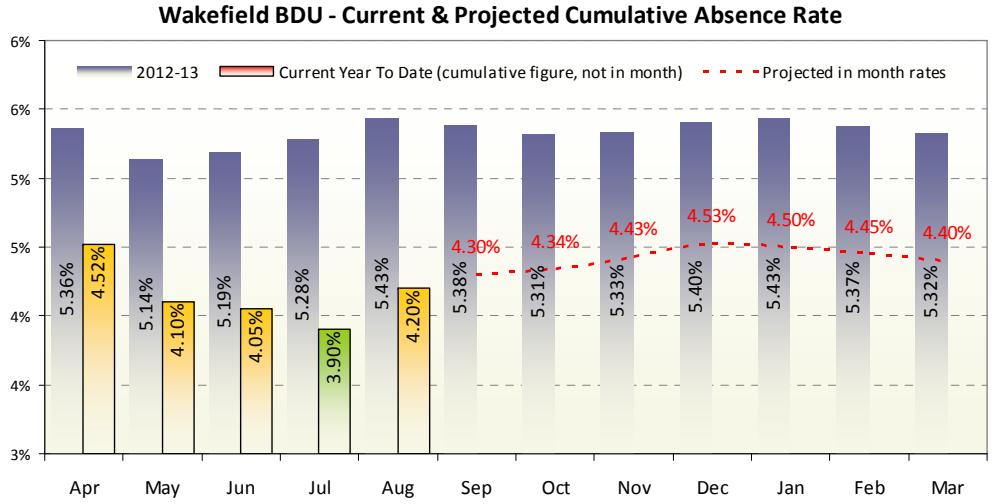
Wakefield BDU **- Current YTD absence rate 4.20% -** *Current projection by March 2014 – **4.40%*** **YTD Projection Trend = UP**
Last year: 5.32%

The BDU as a whole has seen month on month absence rate reductions from January through to May; however the BDU has since seen month on month rises from May through to August, peaking in August at 5.40%. Both Adult Services and Older Peoples Services have seen absence rises in that time, but significant increases have been seen in Adult Services from 3.7% in June to 5.9% in August. Despite this the BDU is still experiencing in month absence rates lower than like for like months last year. Cumulative absence by August 2012 stood at 5.43%, so the current rate of 4.20% is a significant reduction. The removal of Specialist Services in July 2013 has given cause to a slight overall rise in Wakefield's absence rate as lower rates in that area affected the overall Wakefield rate. The absence spike in July appears to have been caused by an increase in long term absence cases recorded in specific areas which are being managed.
Adult Services are still experiencing the lowest rates ever with the cumulative rate standing at 3.1% at the end of August. Older Peoples Services currently have 205 staff in post, so they are a small area liable to larger scale fluctuations in absence rates.
Absence is projected to rise from this low for the whole of Wakefield BDU as absence seasonality occurs and increases are experienced through the holiday period and into autumn and winter months. The rise in long term absence is also expected to see the BDU absence rate rise. Wakefield is projected to reduce its cumulative absence rate from 5.23% last year down to 4.40% this year.

Current Wakefield Hotspots:

Adult Services: Crisis Team (9.93%), Castle Lodge (11.31% - Absence rate has been above 10% since February 2013 – average of 31 days lost per absence episode since April 2013), Early Intervention (9.15% cumulative – absence has been halved in month between May and August),





Sickness Trajectories Summary – August 2013

Overall, 2 BDU's absence projections remain unchanged (*Barnsley, Forensics*), 3 BDU's show reduced projections (*Calderdale, Specialist Services, Support Services*) and 2 BDU's have seen increased projections (*Kirklees, Wakefield*) at the end of August 2013. The Overall absence projection for the whole of SWYFT however has reduced since month 4 report.

- All BDU's are projecting a LOWER absence rate by March 2104 compared to the previous year apart from Barnsley BDU.
- Of the 34 services lines (Department level) across the whole of SWYFT, 19 are currently experiencing absence rates beneath 4%. This shows a rise from last month.
- Stress related absence continues to be the main reason for absence across the Trust accounting for approximately 1 in every 4/5 days lost.
- Long term absence will continue to be a focus for reduction going forward. The Trust sees an average of around 71% of its absence attributed to long term at this time. This and the reduction of stress related absence will be the main focus regarding action plans going forward for individual BDU's.
- On current projections, Calderdale BDU and Support Services are projected to achieve the SWYFT target rate of 4% by the end of 2013-14 financial year.
- On current projections the Trust is on target to reduce it's absence rate by 0.56% to 4.50%

Action on Hotspots

There is ongoing work and initiatives to improve absence rates across the Trust including:

- The newly implemented HR structure of having 2 HR Business Partners has allowed for more joined up and concentrated working relationship regarding sickness absence monitoring. The partnership working between these 2 HR Business Partners is now leading to an increased ability to co-ordinate SWYFT wide initiatives, management and support to operational managers regarding absence management.
- HR advisors are working closely with individual Ops teams and service leads on targeted action plans and robust implementation of the revised Sickness Absence Policy from a corporate vision.
- Greater involvement of Occupational Health support with a focus on promoting wellbeing, which includes a fast-track physiotherapy support service.
- Both OH and HR are currently working on a major initiative to address work related stress across the Trust and Health and Safety are in the process of implementing quarterly workforce information which includes work related absence prevalence across the Trust.
- The implementation of the Sickness Absence Policy coupled with the increased focus on absence from HR teams and Service leads has seen a marked increase in staff being dismissed on reasons of ill health.
- Greater involvement of Staff Side support.
- Improvements to supporting workforce information, including top 200 absence report, monthly projections reports and hotspot areas identification in the Trust which are allowing stakeholders to implement action plans and target problem areas. Positive feedback has been received from various Ops Managers identifying an improvement in this area which is helping the management of absence as a whole.
- In all recorded hotspot cases referred to above, stringent and robust absence management is being carried out by both service leads and HR support to ensure all is being done to support staff back to work.

Trust Board 22 October 2013
Business and risk agenda item 4.4(i)

Title:	**Serious incidents Quarter 2 2013/14**
Paper prepared by:	Director of Nursing, Clinical Governance and Safety
Purpose:	To provide information in relation to serious incidents in Quarter 2.
Vision/goals:	• The organisation of choice for commissioners and partners • Developing the Quality Academy to support delivery of high quality services
Any background papers/ previously considered by:	Previous reports and the annual report, which have been submitted to Clinical Governance and Clinical Safety Committee, Trust Board and the Members' Council.
Executive summary:	➢ The paper provides data on the updated position of serious incidents within the organisation. ➢ Reporting criteria has changed with the publication of NHS Commissioning Board Serious Incident Framework March 2013. The significant changes now includes reporting grade 3/4 pressure ulcers on STEIS, tighter measures for information governance reporting and any incident involving a service user with twelve months of discharge (previously six months). The requirement to complete investigations at level was has reduced from 60 days to 45 days. The impact of these will require monitoring. Currently all Clinical Commissioning Groups are supportive ensuring the quality of the investigation and report. ➢ There have been no 'Never Events' reported in the Trust. ➢ There have been 31 SIs during quarter 2. This is a significant increase on last quarter but mainly due to the changes described above many are in relation to pressure ulcers. Of note, is that whenever there is a focus on one type of incident, reporting increases. Last year 234 incidents were reported across all categories of pressure ulcers, the first six months has resulted in 170. The reporting has increased in all categories. ➢ Fifteen incidents relate to pressure ulcers (twelve grade 3 and three grade 4). Work is taking place to capture numbers that are avoidable. ➢ One incident related to accidental disclosure information. ➢ Of the fifteen remaining incidents, six were suspected suicides, two self-harm, one tissue viability and five death – other (at this point until the inquest is held the cause of death is unknown). ➢ Fourteen reports have been completed and sent to commissioners this quarter. Six action plans have been sent and one still in process of being developed. Seven reports are in relation pressure ulcers and actions have not yet been reported on Datix. This will be reviewed and remedial action taken. The six action plans have resulted in 34 recommendations. These are across a number of themes. The themes with the highest number of recommendations are different from the last, this quarter they are care pathway(seven), care delivery(six) and team service system, roles and management (six). ➢ Only four of the current 33 investigations taking place are currently outside 60 working days. The impact of pressure ulcer reporting is impacting the amount of investigations. ➢ Pressure ulcers are subject to level 1 investigation which is a concise root cause analysis (RCA). To support this, patient safety support team have produced a template and guidance to support the writing of reports.

	Training is being put in place for district nursing team on RCA tools and their use. Datixweb has been changed to capture these incidents as serious incidents are they are graded amber. Datixweb is being reviewed to capture whether the pressure ulcer is preventable, this will support monitoring. ➢ The quarterly reports are being produced and will be shared with BDUs. The Clinical Governance and Clinical Safety Committee will receive a detailed report on quarter 2 for consideration at its meeting on 3 December 2013, which will include a detailed analysis of the incidents relating to pressure ulcers.
Recommendation:	**Trust Board is asked to receive the report and note the contents.**
Private session:	Not applicable

Trust Board 22 October 2013
Business and risk agenda item 4.4(ii)

Title:	**Working capital facility**
Paper prepared by:	Deputy Chief Executive/Director of Finance
Purpose:	To enable Trust Board to assess the risks and benefits of ending its working capital arrangement.
Vision/goals:	Robust governance arrangements are essential for the Trust to remain legally constituted, financially viable and sustainable as a Foundation Trust.
Any background papers/ previously considered by:	Papers to the Audit Committee in July and October 2013.
Executive summary:	<u>Background</u> Monitor's Risk Assessment Framework (see agenda item 5.1) introduces a new financial risk rating in the form of a continuity of services rating. This will be introduced from 1 October 2013 (with reporting to Monitor at the end of Q3). One part of this new risk rating is the liquidity ratio, which explicitly excludes the value of the working capital facility from its calculation. The forecast rating for liquidity in the three-year annual plan to Monitor is 4 for the years 2013/14 to 2015/16 respectively. This score is above the Monitor threshold for concern and excludes the working capital facility. The Trust's current facility is with Barclays and stands at £9.2 million with a cost of £32,200 per annum to maintain. The current agreement was due for renewal in July 2013 and the Audit Committee approved a recommendation in July 2013 that this is extended for a further twelve months. This extension included break clauses for three, six and nine months, which would not be subject to penalties. This provided the flexibility to cease the arrangement during 2013/14 if needed and is consistent with the approach adopted by other Foundation Trusts. The Committee was asked to support the proposal to retain the facility until October 2013 when the risk rating changes. This would also allow more work on the Integrated Business Plan, which provides more clarity on future capital investment requirements. The Trust has continued to review its requirement for a working capital facility and, now that the Risk Assessment Framework has been formally introduced, a Trust Board decision is needed on whether the facility is retained or ceased. The Chair of the Trust asked that the Audit Committee considers the detail of any proposal and makes a recommendation to Trust Board. <u>Proposal</u> Two options have been identified: 1. to retain the facility of £9.2 million at a cost of approximately £33,000 per annum; or 2. cease the facility with effect from October 2013. The Audit Committee will consider the two options at its meeting on 18 October and make a recommendation to Trust Board. The Director of Finance is recommending to the Audit Committee that option 2 is approved.

	The benefits of this approach is that: - it is in line with Monitor expectations and those being undertaken by other Foundation Trusts locally; - having reviewed the updated capital programme and its associated impacts on cash, etc., on the balance of probability the need for a facility is unlikely; - the changes to the Risk Assessment Framework mean this will have no impact on the Trust's Financial Risk Rating; - there will be no penalty for the cessation of this facility as the current facility is on a three-month rolling agreement. The only possible adverse impact of this decision would be that the Trust would not have pre-agreed access to funds should they be required. If a facility was retained, further work would be required to validate the terms of its use and of its retained value to ensure that it remained fit for purpose.
Recommendation:	**Trust Board is asked to support the recommendation of the Audit Committee following its discussion on 18 October 2013.**
Private session:	Not applicable

Trust Board: 22 October 2013
Business and risk agenda item 4.4(iii)

Title:	**Patient Led Assessment of the Care Environment (PLACE)**
Paper prepared by:	Director of Human Resources and Workforce Development
Purpose:	This paper provides Trust Board with the results of the 2013 PLACE results. The PLACE results for all NHS providers are published nationally and are used by the CQC to measure Trust compliance.
Vision/goals:	An important component of compassionate care is to ensure services are provided in environments which are clean, safe and promote dignity. In addition, hotel services (such as food provision and housekeeping) need to ensure they meet national standards and are built around the needs of service users. These are all key aspects of the Trust values.
Any background papers/ previously considered by:	The PLACE assessment replaces the Patient Environment Action Team (PEAT) Inspections, the results of which have previously been reported to Trust Board.
Executive summary:	PLACE (replacing PEAT) is designed to assess the quality of the patient environments, including hotel services. Whilst both processes have service user involvement, PLACE puts greater emphasis on this in terms of numbers and roles. The new PLACE assessment process focuses on four key areas: ➢ cleanliness – including hand hygiene; ➢ buildings and facilities – condition, appearance and maintenance of the building, fixtures and fittings; ➢ privacy and dignity; and ➢ food and hydration. All the Trust's inpatient facilities, including community units, were subject to PLACE assessments and the buildings covered were: Newton Lodge / Saville Park View / Castle Lodge The Dales / Priestley Unit / Enfield Down Kendray Hospital / The Poplars / Fieldhead Mount Vernon The results of the survey are published and compared against national averages and the overall results for the Trust in each of the four areas are as follows.

	<table><tr><th></th><th>National Average</th><th>Trust Score</th></tr><tr><td>Cleanliness</td><td>95.74%</td><td>99.92%</td></tr><tr><td>Condition, Appearance and Maintenance</td><td>88.75</td><td>95.66%</td></tr><tr><td>Privacy and Dignity</td><td>88.87%</td><td>95.83%</td></tr><tr><td>Food Hydration</td><td>84.98%</td><td>96.62%</td></tr></table> The Trust scores for each of the facilities were above the national average except for Privacy and Dignity in Enfield Down, The Poplars and Castle Lodge. The areas below the national average were community units and as a result of their size had problems related to identifying male and female designated lounges, family visiting areas and multi-faith rooms. Facilities are working with the service managers to see how we can improve the environment within our community units, to improve the privacy and dignity, although it is recognised that the physical limitations within smaller buildings presents particular difficulties. An agreed action plan will be developed through the Estates TAG.
Recommendation:	**Trust Board is asked to note the PLACE scores.**
Private session:	Not applicable

Trust Board 22 October 2013
Business and risk agenda item 5.1

Title:	**Monitor Risk Assessment Framework**
Paper prepared by:	Director of Corporate Development
Purpose:	The purpose of this paper is to alert Trust Board to any risks arising from the introduction by Monitor of its Risk Assessment Framework.
Vision/goals:	Compliance with Monitor's Risk Assessment Framework supports the Trust to meet the terms of its Licence and supports governance and performance management.
Any background papers/ previously considered by:	Monitor's Risk Assessment Framework published on 27 August 2013.
Executive summary:	Monitor introduced its Risk Assessment Framework on 1 October 2013 to replace the Compliance Framework as Monitor's approach to overseeing Foundation Trusts. The new framework has two main aims: - to show when there is a significant risk to the financial sustainability of a provider of key NHS services, which endangers the continuity of those services; and/or - to show where there is poor governance at an NHS Foundation Trust. The Framework links to the Trust's Licence (and any conditions of its Licence) although the Framework only applies to Licence holders who provide Commissioner Requested Services (CRS), previously mandated services so these can be non-NHS organisations. The 'governance condition' in the Licence ONLY applies to Foundation Trusts and the Framework is the method Monitor will use to assess Foundation Trusts against this condition of the Licence. The paper covers what the Trust is required to provide annually and in-year, an overview of the Risk Assessment Framework, the impact of the changes, and any risks or issues arising.
Recommendation:	**Trust Board is asked to note the introduction of the Risk Assessment Framework and any risks or issues arising.**
Private session:	Not applicable.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Monitor Risk Assessment Framework
Trust Board 22 October 2013

Background

Since 1 April 2013, all NHS Foundation Trusts need a licence from Monitor stipulating specific conditions that they must meet to operate. Key among these is financial sustainability and governance requirements. The Risk Assessment Framework, introduced on 1 October 2013, is Monitor's approach to overseeing the sector under the new rules. It explains how Monitor will use the Framework to assess individual Foundation Trusts' compliance with two specific aspects of their work:

- continuity of services; and
- governance conditions in provider licences.

From April 2014, the licence system will expand to cover all providers of NHS services and Monitor will add additional sections to the Risk Assessment Framework in order to assess these organisations.

The new framework has two main aims:

- to show when there is a significant risk to the financial sustainability of a provider of key NHS services, which endangers the continuity of those services through the continuity of services risk rating; and/or
- to show where there is poor governance at an NHS Foundation Trust through the governance rating.

From 1 October 2013, Monitor has assigned Foundation Trusts with a governance risk rating under the new Framework and this represents Monitor's current view of governance within an organisation. The Trust has been assigned a GREEN governance rating.

Monitor will also assign a 'shadow' continuity of services rating following its analysis of Q2 returns for 2013/14 alongside the current Compliance Framework risk rating.

From the end of Q2, Monitor will publish either a Green or Red rating or a description of factors driving concern and the actions Monitor is taking if the rating is neither Green nor Red, therefore, there will be no more Amber rating.

The paper covers what the Trust is required to provide annually and in-year, an overview of the Risk Assessment Framework, the impact of the changes, and any risks or issues arising.

Annual submissions

The Trust will be required to submit the following to Monitor on an annual basis.

Strategic overview

- Annual plan submission/three-year forward plan (as now).
- Submission of annual report and accounts, including annual governance statement (as now).

Corporate Governance Statement

- Statement of current and future compliance with Licence governance condition and identification of any risks to compliance.
- This is an enhanced appendix B12 (board statements) previously submitted with the annual plan.
- Monitor may ask for an auditor's statement to support the Trust's own statement.

Governor development and membership report

- Trusts will be asked to demonstrate what they have done/will do in terms of governor development, membership strategy and membership development.

Financial projections

- These will include an availability of resources statement (to meet Licence condition 7).

In-year submissions

The Trust will be required to submit the following to Monitor.

Quarterly information

- Applies to all providers of CRS (i.e. includes non-NHS organisations).

Exceptional in-year reports

- Triggered if Monitor detects risks to compliance, particularly financial prospects.

Additional in-year submissions required from NHS Foundation Trusts

- Governance risk rating (see below) to meet Monitor's statutory governance oversight role.

Exception reports

- Trusts are currently required to submit an exception report with quarterly returns; however, the quality and completeness of the information presented varies considerably amongst Foundation Trusts.
- The Framework is far more explicit about what the exception report should contain and describe, including provision of non-NHS services and changes in capital structure by more than 10% of capital employed.
- Foundation Trusts still have to report divergence of capital expenditure by 15% (either way).

Governance risk rating

The governance risk rating is generated by considering the following information regarding a Trust and whether it is indicative of a potential breach of the governance condition:

- performance against selected national access and outcomes standards;
- CQC judgments on the quality of care provided;
- relevant information from third parties;
- a selection of information chosen to reflect quality governance at the organisation (Quality Governance Indicators);
- the degree of risk to continuity of services and other aspects of risk relating to financial governance;
- any other relevant information.

Area	Impact/risk	Action
CQC judgments on the quality of care provided.	No significant change.	No additional action required and no increased risk.
Relevant information from third parties.	No significant change	No additional action required and no increased risk.
Degree of risk to continuity of services and other aspects of risk relating to financial governance *(Financial Risk)* - where there is a material risk to a trust's financial sustainability or overall compliance with the continuity of services licence conditions, Monitor will consider whether this may also reflect a governance issue.	No significant change	No additional action required and no increased risk.
Impact on performance against selected national access and outcomes standards.	Current indicators rolled-over with same targets and same weightings. However, there are minor changes to the way 'CPA with a review in 12 months' and 'PSA outcome measures accommodation and employment for people on CPA' are measured. Also change to '% on CPA review in 12 months' and '% on CPA with HoNOS'. This will now become a snapshot position at the quarter end.	No additional risk. Action required to ensure data is captured to meet the new requirements and change to internal data quality reports. Comparative data will be available for this Board meeting.
Quality Governance Indicators - Monitor will use a small number of indicators to identify whether any relevant potential patient or workforce concerns exist.	This area is new and will form a selection of information chosen to reflect quality governance at an organisation. There is no additional information in regard to the quality governance indicators to identify the sources of information Monitor will use	Not known what action the Trust will need to take or the potential risk until further guidance issued by Monitor.

Area	Impact/risk	Action
- Monitor will look at trends that suggest potential issues, such as increases in staff absenteeism. - Monitor will consider if further information is necessary to assess whether there may be issues with the quality governance at a Trust and/or to what extent the Trust Board is aware of the issue and is addressing it.	and where/how Monitor will retrieve this information. Published CQC annual staff and service user surveys are potentially key information sources. Metrics may be drawn from existing reporting processes or may require the Trust to provide additional information.	
Periodic governance review This is a new area and the Trust will be required to commission a rigorous external review of governance at least once every three years. Monitor considers that such a review should cover at least one of the four areas of governance: - Board governance and leadership; - organisational oversight; - quality governance; - Board capability.	Monitor guidance to be published late 2013/early 2014 setting out a proposed review scope, areas for inspection and indicative selection criteria (for an external reviewer) that could be used in line with procurement policies. Provided the reviews cover at least the scope set out in the guidance, trusts are free to set the overall review scope. Review findings must be reported to Monitor and where these raise issues of concern in relation to compliance with its Licence conditions, Monitor will consider whether to investigate further. Areas of governance identified relate to other aspects of assessment, such as the Monitor Quality Governance Framework, which should reduce risks of governance breaches exposed by external review.	It is likely that the Trust will need to commission its first review in 2014/15. Once Monitor guidance has been published, the Trust will have more specific information on process requirements and approved external agencies to conduct governance reviews. At that point, an assessment can be made of the risks and implications.

Finance risk rating

The focus of the finance rating will change from generation of surplus to Continuity of Service and early identification of financial risks. Five Financial Risk Ratings (rated 1 – 5) are replaced by two Financial Risk Ratings (rated 1 – 4), which cover, in layman's terms:

- liquidity – days of costs the Trust can cover based on cash readily available;
- Capital Servicing Capacity – to what degree does Trust income cover any debts/financial obligations it may have.

The metrics are based on debt minimisation and cash maximisation and have been monitored in shadow format since the Risk Assessment Framework consultation.

In terms of risk and implications, both metrics are favourable for the Trust. The Trust currently scores 4 out of 4 and this is planned to continue. There is a material level of headroom before movement in the metric. Therefore there is no anticipated risk or implication over and above continued regular monitoring.

Trust Board 22 October 2013
Business and risk agenda item 5.2

Title:	**Changes to the Trust's Constitution**
Paper prepared by:	Director of Corporate Development
Purpose:	Trust Board is required to approve changes to the Trust's Constitution.
Vision/goals:	Robust governance arrangements are essential for the Trust to remain legally constituted, financially viable and sustainable as a Foundation Trust and to continue to meet its obligations under its Constitution.
Any background papers/ previously considered by:	There are no background papers for this item.
Executive summary:	**Background** At its meeting in July 2013, the Nominations Committee considered the approach and process to recruit a Non-Executive Director to replace Bernard Fee, whose term of office comes to an end on 26 May 2014. As part of this discussion, the Committee gave some thought to its geographical boundaries and the need to recruit high calibre candidates. The Trust Secretary was asked to seek legal advice for further discussion with the Chair. It was also agreed with the Chair to seek advice on co-option of governors and extending the term of office of governors. **Proposals** <u>Public constituency</u> The Trust has to achieve a balance between attracting high calibre candidates for Non-Executive Director positions from a wider geographical area and ensuring membership of the Members' Council remains credible and representative. After a lengthy discussion, the Nominations Committee agreed that a proposal should be made to Trust Board and to the Members' Council to establish a constituency that covers South and West Yorkshire given the services provided in both areas. Legal advice would also be sought on the implications for appointed and staff representatives. ➢ Legal advice from Hempsons is that the Trust can establish a public constituency that covers Doncaster, Rotherham, Sheffield, Bradford and Leeds Councils (that is, the remainder of South and West Yorkshire not already covered by the existing public constituency). This gives the new public constituency the right to elect one governor. ➢ Hempsons has also confirmed that, as the Trust provides services to the wider population of South and West Yorkshire, this provides a robust rationale for extending membership to these areas as it ensures representation for people who use Trust services. ➢ Under the Trust's Constitution, there is a requirement for the Members' Council to have more than half of its governors elected by public members. This means that the current configuration of staff and appointed governors can remain given that public governors would still make up more than half of governors. ➢ The Trust would seek to elect a public governor for this new constituency as part of the election process starting early in 2014.

	Co-opted governors Hempsons advice is that the Constitution cannot allow for individuals to be formally co-opted onto the Members' Council; however, the Members' Council is free to invite individuals to attend meetings, as these are held in public, but they would not carry any voting rights and it would be at the discretion of the Chair as to the individual's involvement in, and contribution to, the formal meeting. Terms of office/maximum tenure of office The Trust also asked Hempsons for advice on its flexibility to increase the term of office for a governor and on its flexibility to increase the maximum tenure of office that can be served by a governor. Under the terms of the National Health Service Act, an elected governor may hold office for a period not exceeding three years so there is no flexibility to change the term of office for which a governor can be elected. However, the Act does not stipulate a maximum tenure and, when developing the Constitution, the Trust followed the model constitution published by Monitor and adopted a maximum term of six years (with no eligibility for re-election if the individual has already held office for more than three consecutive years). Guidance from Monitor in the Code of Governance also gives no maximum term. Hempsons advice, therefore, is that the Constitution could be changed to nine consecutive years as a maximum term and six consecutive years for re-election. The rationale for making this proposal is based on the reality of the time it takes governors to get to know the organisation, their role and to become effective, and to retain the skills and experience of 'mature' governors in a time of increasing change, both within the Trust and to the duties of governors.
Recommendation:	**Trust Board is asked to:** ➢ **approve the proposal to establish an additional public constituency to represent the remaining local authority areas in South and West Yorkshire;** ➢ **approve the proposal to increase the maximum term of office for governors from six to nine years and to increase the eligibility for re-election from three to six years; and** ➢ **as a consequence, approve the necessary changes to the Trust's Constitution.**
Private session:	Not applicable

Trust Board 22 October 2013
Business and risk agenda item 5.3

Title:	**Members' Council evaluation**
Paper prepared by:	Director of Corporate Development
Purpose:	The purpose of this paper is to inform Trust Board of the outcome of the Members' Council evaluation session held on 10 September 2013.
Vision/goals:	An effective and engaged Members' Council is a key element of the Trust's governance arrangements, which are essential for the Trust to remain legally constituted, financially viable and sustainable as a Foundation Trust and to continue to meet its obligations under its Constitution.
Any background papers/ previously considered by:	There are no background papers for this item.
Executive summary:	Since it was authorised as a Foundation Trust in May 2009, the Trust has held an annual evaluation/assessment event for the Members' Council, supported by the Chair and Deputy Chair of the Trust, and the Director of Corporate Development. These sessions have been facilitated by an external consultant to ensure independence and impartiality. In 2013, the Trust followed the approach adopted in 2012 of an interactive and participative session. The focus of the session was to assess the contribution governors have made, both collectively and individually. All governors came away with actions for the coming year in terms of involvement. The session also offered governors the opportunity to discuss what practical help is needed to develop governors' contributions further. This will be reviewed with the Chair to inform the Members' Council work programme and development activity in 2014. The notes from the session are attached. In summary, governors do feel they are contributing effectively, at the right level; however, it was recognised that there is scope for development, particularly in light of the new duties for the Members' Council as a result of the Health and Social Care Act 2012. Participants were also asked to evaluate the session and a summary of this is included at the end of the paper. The comments will be used to inform development of the session in 2014.
Recommendation:	**Trust Board is asked to note the outcome of the Members' Council evaluation session.**
Private session:	Not applicable.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Summary of the Members' Council evaluation session
10 September 2013

Present:	Ian Black	Chair
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Doug Dale	Public – Wakefield
	Adrian Deakin	Staff – Nursing
	Nasim Hasnie	Public – Kirklees
	John Haworth	Staff – non-clinical support staff
	Ruth Mason	Appointed – Calderdale and Huddersfield NHS Foundation Trust
	Bob Mortimer	Public – Kirklees
	Kath Padgett	Appointed – University of Huddersfield
	Jules Preston	Appointed – Mid-Yorkshire Hospitals NHS Trust
	Sean Rayner	District Service Director, Barnsley and Wakefield
	Kevan Riggett	Public – Barnsley
	Dave Rigby	Public – Kirklees
	Jeremy Smith	Public – Kirklees
	Michael Smith	Public – Calderdale
	Dawn Stephenson	Director of Corporate Development
	Karen Taylor	District Service Director, Calderdale and Kirklees
	Hazel Walker	Public – Wakefield
	Laura Wharmby	Appointed – staff side organisations
	Tony Wilkinson	Public – Calderdale
	Helen Wollaston	Deputy Chair
	David Woodhead	Public – Kirklees
In attendance:	Bernie Cherriman-Sykes	Board Secretary (author)
	Ken Tooze	Facilitator

1. Welcome and introductions

Ian Black welcomed everyone to the fourth Members' Council evaluation session. He hoped that everyone would enjoy and be challenged by the session and feedback on the format and content was welcomed.

2. Practicing reflection and self-discipline

Governors were asked to identify their birth year under the Chinese horoscope and agree key personality and characteristics with fellow 'animals' that defined strengths and weaknesses.

<u>Pigs</u>
S – determined
S – optimistic
W – indulgent

<u>Tigers</u>
S – courageous
S – ambitious
W – demanding

<u>Rats</u>
S – imaginative
S – constructive critic
W – critical nit-pickers
W – overambitious

<u>Roosters</u>
S – courageous
S – resilient
W – argumentative

<u>Rabbits</u>
S – well organised
S – principled
W – pedantic

<u>Dogs</u>
S – tolerant
S – dutiful
W – cynical/fatalistic

<u>Singles</u>
S – enthusiastic
S – wise
W – intolerant

3. Personal reflection on contribution

This session involved personal reflection on the statement "My biggest contribution this year to the success of the Trust has been ……." building on the strengths and weaknesses identified in the first exercise, and to identify areas individuals could do more of/do better.

Name	Strengths	Weaknesses	Contribution	Better/more of
Ian Black	Tolerant Dutiful	Cynical	Facilitative leadership Membership-led agenda More open	Emphasise achievements 'good news' Improve relationship with health trust (local) Improve national health service links
Tim Breedon	Determined Optimistic	Indulgent	Commitment to attendance Approachable	Improve engagement around Quality Accounts
Doug Dale	Constructive critic Opportunistic	Critical nit-picker	Bring experience and knowledge of other organisations such as Citizens' Advice Bureau	More of 'doing less'
Adrian Deakin	Clear thinking Reliable Passionate →	Intolerant Hot-tempered	Develop clearer language understandable to all Bridge between Members' Council and 'shop floor'	Louder voice for service delivery and day-to-day work of Trust; bringing real stories from services.
Nasim Hasnie	Resilient Courageous	Argumentative	Co-working and learning from contributions from others in meetings. Sharing knowledge about equality and diversity	Better and more inclusive care for all communities via better involvement
John Haworth	Courageous Resilient	Vulnerable	Getting involved Commitment Promote the Trust Raise awareness	Promote Trust – get more members Trust Board attendance
Ruth Mason	Dynamic Enthusiastic	Demanding Over zealous	Facilitate contribution of others. Provide CHFT strategic perspective.	Getting to know others More links into Creative Minds
Bob Mortimer	Constructive Ambitious	Over-ambitious	Links with national and local bodies Different viewpoint	Strengthen links with local authority partners Public meetings

Name	Strengths	Weaknesses	Contribution	Better/more of
			Raise profile national/local Knowledge Unannounced visits Time Foundation Trust Governors' Association role	Awareness of Government policy
Kath Padgett	Careful Optimistic	Over-indulgent	More transparency and forward planning for Non-Executive Director appointments via Nominations Committee	More support for staff to have a voice and input to Board
Jules Preston	Tolerant (only at work!) Dutiful	Fatalistic Cynical	Intent – bring understanding and knowledge	Continuing development Real contribution
Dave Rigby	Imaginative Constructive critic	Nit-picker	Involvement in unannounced visits from governors	Better follow through on key issues raised by Members' Council (such as cancelled appointments)
Kevan Riggett	Reflective Wise	Calculating	Observation, scoping, analysing, reflecting How achieving aims personally	Continue to observe, scope, analyse and reflect Locality governor meetings to provide a locality perspective Build better links with staff – a detached perception
Jeremy Smith	Cheerful Enthusiastic	Insecure	Patient perspective, asking the insightful questions.	Participate in unannounced mental health community visits.
Michael Smith	Determination Optimistic	Indulgence	Getting Health Navigator project off the ground to improve integrated care using volunteers	Membership of Audit Committee
Dawn Stephenson	Imaginative Honest	Calculating Quick tempered	Facilitate others to contribute	More 1:1 contact (unannounced visits, etc.)
Karen Taylor	Principled Diplomatic	Pedantic Secretive	Raising profile of services. Need to change to a language people understand.	Raising profile of operational delivery. Make connections.
Hazel Walker	Uncomplaining	Gullible	Buddying system for new	Attend more meetings

Name	Strengths	Weaknesses	Contribution	Better/more of
	Diligent	Indulgent	governors Advocate	leading to a better contribution
Laura Wharmby	Determined Loyal	Stubborn	Putting self forward as staff representative on the Members' Council Bring younger element	Raise awareness of Members' Council to staff
Tony Wilkinson	Astute Quick-witted	Fickle	Being here and existing Challenge the Board Cross-fertilisation with other organisations	Better at positively representing
Helen Wollaston	Courageous Determined	Impatient	Facilitating Members' Council meetings/discussions within meeting	Disappointed with vacant positions – wants to increase awareness/promotion
David Woodhead	Loyal Ambitious	Impetuous	Expertise in estates Time Commitment Tenants' Association knowledge	Attend more

4. Looking to the future – understanding the new world

A group exercise to examine what is important and what is not (three piles exercise). Top three 'issues' identified by each group.

Group 1	Group 2	Group 3	Group 4
➢ Hold Non-Executive Directors to account ➢ Living our values ➢ Reputation, brand management and marketing	➢ Transform services ➢ Achieve key performance indicators ➢ Improve the patient experience	➢ Improve the patient experience ➢ Transform the workforce ➢ Partnership management	➢ Improve the patient experience/deliver patient-centred care ➢ Transform the service offer ➢ Live our values

5. Looking to the future – what practical help do I/we need to develop my/our contributions further

- Small group development supported by synopsis of key issues (such as, nationally (Francis Report) and locally).
  Workshops to explain national/local services to understand how services work and are interlinked.
  Less strategic; more operational understanding of services.
  Networking – discuss issues; use of workshops; without Directors (executive and non-executive).
- Patient stories – link with the way the services operate to deliver those outcomes.
  More 'shopfloor' presentations – so what does it feel like out there?
- Improve awareness of Members' Council
  - Blog on the intranet
  - Promotional material
  - 'Day in the life' staff magazine
  - Higher profile in local communities
- Facilitate local governor meetings
- Members' Council information pack
  - Who's who
  - Local information
- Involve Members' Council in key transformation events.
  Improve communications and consultation with Members' Council and through Members' Council to the communities we serve.
- Scanning to give overview of new developments and more engagement with staff, which needs a proactive approach.
- Mentoring to support individual contributions.
- Focus on breaking stigma around mental illness (which could help raise profile of the Trust).
- <u>Members' Council challenge</u>
  Why are we using jargon? If people have to ask, we have not got it right. Directors need to sense check.

6. Evaluation of the session

<u>What key messages will you take away from today?</u>

- The importance of making a contribution to the Members' Council.
- Members' Council has a 'thirst' for continued support.
- Role clarification.
- The need for a continuing education programme for governors.
- That the Trust really values its Members' Council.
- Still much to achieve to have a Members' Council that feels empowered.
- Could do better; more involvement; proactive/over reactive.
- People want to contribute and be involved. People understand the need to transform our services.
- Some direction.
- There needs to be greater awareness of the Members' Council and its role. More support for new governors.
- Things are not as difficult as they seem.
- A focus on getting behind the jargon.
- Think about language all the time.
- Reinforces the complexities of such a large organisation and balancing the business-side with service user-focussed interventions/services.
- Priorities for future.
- More positive approach.
- Important to get input from staff and from wider communities.

- I have value as a member but my value's multiplied when I communicate openly and clearly with others.

What personal actions will you take away from today?

- Try to spend more time digesting information given at meetings.
- Engage with the Members' Council to continue and develop that support.
- Representation.
- Continue my total commitment to the Trust.
- To say 'yes' to more opportunities to get involved.
- Ensure full attendance and participation.
- Attend more Trust Board meetings; take on more responsibilities; education.
- Improve engagement in development of Quality Accounts.
- To ask how to contact other governors in same locality and ask if would like to meet to discuss how effective we are as governors and what we can do better.
- Inform my colleagues about the Members' Council. Approach staff side to look at ideas/ways to promote Members' Council.
- Be more open-minded and not scared.
- Raise issue of follow up on key actions.
- Try and make papers more real.
- Bring more focus on specific issues.
- More communications with patients, staff, local authorities, etc.
- More commitment.
- Promote Members' Council and Non-Executive Director roles to diverse communities.
- Speak to staff on ward regarding their feelings about everyday work – find a way to feedback to Members' Council.

What would you like to do differently next year?

- Make a greater contribution to the work of the Members' Council.
- More small group work.
  Some small group working, in which I could pass on my experience to new governors.
- To get more involved.
- Pursue the change to the Health and Social Care Act; increase involvement in promotion to staff and geographical representatives; develop locality workshops.
- Still learning what I'm doing this year.
- Support new governors and talk about my experiences. Promote the Members' Council more and its role.
- Attend better and participate in unannounced visits.
- Spend more time with different governors.
- Get more involved with supporting staff side.
- More involvement with wards.
- Devote more time.
- Some feedback from service users/carers/staff and community organisations on their perceptions of the Members' Council.
- Have more of a voice supporting staff on the shopfloor.

Based on your experience today, do you have any suggestions on how we should review the Members' Council contribution in future?

- Develop small local groups for governors to discuss issues, providing an opportunity to ask questions and make suggestions to contribute to discussions and decisions.
  Create locality governor meetings with aims and objectives (i.e. support, questions for Non-Executive Directors, etc.).
  Form local Members' Council meetings to give governors opportunity to meet within their locality.
- Good format – small group discussions work better than a larger group.

- This was more than a review but the basic review was a (simple) activity list that presumed completed activities were useful.
- Continue to evolve and monitor as a group.
- More of these types of days, please.
- Holding Non-Executive Directors to account seems to be a real concern. Could Non-Executive Directors attend Members' Council meetings? Suggest lead on presentation from 'their' Committee (such as Audit, workforce).
- Similar format to promote honesty in a relaxed environment.
- Involve the Members' Council in all areas.
- Today's programme was a good and valued way of identifying key issues.
- Keep it fun and interactive.
- More involvement of a wider range of staff.
- One review per annum.
- Survey governors not able to attend the evaluation session.
- More involvement in communication with staff groups on an individual/group basis.

Interesting	**15**	Exciting	
Challenging	6	Revealing	4
Fascinating	1	Entertaining	2
Boring		Confusing	
Difficult	2	Basic	
Easy	1	Clear	4
Realistic	4	Practical	8
Theoretical		Irrelevant	
Useful	**12**	New	
Innovative	2	Complicated	1
Comprehensive	5	Enjoyable	8
Valuable	8	Inspiring	3
Over-ambitious		Unfocused	
Thought-provoking	**9**	Waste of time	
Stimulating	7	Fun	4
Exhausting		Nothing new	
Thorough	2	Changed my life	
Rushed			

Additional words/comments

- Very much appreciated and would value more similar sessions.
- Good mix of activity to stimulate discussions.
- An excellent development morning.
- Worthwhile.

Trust Board 22 October 2013
Business and risk agenda item 6

Title:	**Trust Board self-certification – Monitor Quarter 2 return 2013/14**
Paper prepared by:	Director of Corporate Development
Purpose:	To enable Trust Board to be assured that sound systems of control are in place including mechanisms to identify potential risks to delivery of key objectives.
Vision/goals:	Links to corporate objective of flawless execution ensuring the Trust has effective systems to support service development and delivery of high quality care in line with national standards by highlighting any exceptions.
Any background papers:	The exception report to Monitor highlights issues previously reported to Trust Board through performance and compliance reports.
Executive summary:	Based on the evidence received by Trust Board through performance reports and compliance reports, the Trust is reporting a governance risk rating of **green** after applying the Monitor Compliance Framework 2013/14. Trust Board will note that the Compliance Framework is replaced from 1 October 2013 by the Risk Assessment Framework. An assessment of the changes and risks the new Framework presents to the Trust is considered in the paper to form agenda item 5.1. Based on performance information set out in the performance report, the Trust is reporting a score of **4.1** with a financial risk rating of **green**. Monitor has issued Q1 benchmarking figures and the headlines are as follows. - There are now 146 foundation trusts with total revenue of £9,982 million in Q1, an average financial risk rating 3.1, 20% with a red governance risk rating. This represents a worsening position when compared to the end-of-year position for 2012/13. - Of these 147, 21 are subject to enforcement action and a further nine are being formally investigated for potential licence breaches. Six foundation trusts are in special measures as a result of the Keogh Review. - There are still 41 mental health trusts with total revenue of £2,017 million, an average financial risk rating of 3.6 and 7% with a red governance risk rating. There is one mental health trust subject to enforcement action. Both represent a worsening position when compared to the end-of-year position for 2012/13. - Also of note is that acute trusts have the poorest governance risk rating with 30% red. Of the total number of trusts, 52% have green governance risk ratings, 20% red, 14% amber/red and 14% amber/green. The Midlands is the poorest region making up 37% of red rated trusts. London is the best, partly due to the lower proportion of acute trusts. ➢ Monitor authorises NHS foundation trusts on the basis that they are well-governed, financially robust, legally constituted and meet the required quality threshold. Monitor's Compliance Framework is designed to ensure that NHS foundation trusts maintain their viability, through a philosophy of no surprises, open communication and self-governance. As such NHS foundation trusts are required to provide board statements certifying ongoing compliance with their Authorisation and other legal

	requirements In order for Monitor to operate a compliance regime combining the principles of self-regulation and limited information requirements, it must be able to rely on the accurate assessment of risk by NHS foundation trust boards via the self-certification process: - For finance that the Trust will continue to maintain a financial risk rating of at least 3 over the next twelve months based on the 2013/14 Compliance Framework. - For governance that the board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets and a commitment to comply with all known targets going forward. Subject to any changes required by the Board, as a result of earlier board papers and the resultant discussion, the attached report will be submitted to Monitor in respect of Quarter 2 and the in-year governance declaration on behalf of the board will be made to confirm compliance with governance and performance targets.
Recommendation:	**Trust Board is asked to approve the exception report to Monitor, subject to any changes/additions arising from papers discussed at the Board meeting around performance, compliance and governance.**
Private session:	Not applicable

Trust Board self-certification - Monitor Quarter 2 return 2013/14
Trust Board 22 October 2013

Mandatory services
There have been no changes to mandatory services since Quarter 1.

Trust Board
The interviews to appoint to the vacant post of Director of Service Innovation and Health Intelligence were held on 1 October 2013. No appointment was made. The Chief Executive has re-evaluated the current position and has sought the support of the Remuneration and Terms of Service Committee to test the market again.

A Non-Executive Director vacancy remains on the Board following the appointment of Ian Black as Chair and the decision by the Nominations Committee not to appoint to this vacancy immediately. The balance of the Board remains with six Non-Executive Directors (including the Chair) and five Executive Directors (including the Chief Executive). The Nominations Committee (of the Members' Council) met in July to agree the process to recruit to fill the Non-Executive Director vacancy from the end of May 2014 when Bernard Fee's term of office ends.

Members' Council
Renewed approaches were made to Kirklees Metropolitan Council and Calderdale Metropolitan Borough Council to identify a representative to fill allocated seats. The Calderdale Council seat has been filled but there has been no response from Kirklees Council. There has also been a change of representative from Mid-Yorkshire Hospitals NHS Trust. The Members' Council is carrying two public vacancies (one in Calderdale and one in Wakefield) and two staff vacancies for psychological therapies and social care staff working in integrated teams.

Absent without Leave (AWOL)
During quarter 21, there was one CQC notifiable AWOL relating to a service user in medium secure services who failed to return from authorised leave. The service user was returned from the police station by hospital staff.

Care Quality Commission (CQC)
- Following investigation of whistleblowing concerns received by the CQC, a written response was received on 19 August 2013 thanking the Trust for the constructive discussion and the honest and genuine attempts being made to resolve the issue. No formal regulatory action is to be taken although the CQC continues to monitor the situation. A formal response from the CQC has not yet been received.
- As at the end of September 2013, the Trust had no compliance actions related to CQC inspection visits. Reports are still awaited on inspection visits that took place in July/August 2013 at the Dales (Ashdale, Elmdale and Beechdale) and Fieldhead (Trinity 2, Newton Lodge and Bretton). Informal verbal feedback indicated a good standard of care had been observed but questions were raised around seclusion facilities and practice with additional information requested and provided.
- In the latest QRP re-fresh (August 2013) all sixteen risk estimates fall in the 'reduced risk of non-compliance' range. There are no amber or red risk ratings. The Trust monitors any changes to the QRP as re-freshed versions are published, organisational

leads for each of the outcomes review with the relevant lead director, any specific action felt to be required in regard to individual or grouped data items attracting a 'worse than expected' rating.

- There were two CQC Mental Health Act visits in Q2 to Trinity 1, Fieldhead, and Beamshaw ward, Barnsley. The CQC found Trinity 1 to be generally clean and well maintained, a range of activities available and patients lawfully detained. There were some identified record keeping deficits but the main concern related to the seclusion facility remaining 'unfit for purpose'. The report on Beamshaw ward has yet to be received.

Eliminating Mixed Sex Accommodation (EMSA)

There have been no breaches reported on Datix in Q2. The Trust continues to monitor where service users are placed in an individual room on a corridor occupied by members of the opposite sex. There have been 24 such instances reported on Datix in Q2, which represents an increase over Q1. All incidents have been appropriately care-managed with required levels of observation and support implemented.

Health and Safety Executive (HSE)

No unannounced visits received during Q2.

Infection prevention and control

There have been two cases of Clostridium Difficile in Barnsley BDU and one case for Wakefield reported in Q2. There have been no MRSA bacteraemia cases reported and no infection outbreaks in the Trust during Quarter 2.

Information Governance

There has been one information governance serious incidents reported during the quarter that the Trust is required to report to the Information Commissioner due to the reduced threshold now applied for external reporting (from July 2013 all category 2 incidents will be reportable where previously this was category 3 and above).

National Specialised Services Specification Compliance

Following publication by NHS England of clinical commissioning policies and service specifications for directly commissioned services, which covers Trust forensic services, the Trust undertook a self-assessment exercise during the summer. The Trust was found to be compliant in all areas except one. This relates to seven beds 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. It was agreed that the Trust would submit notification to NHS England of this area of non-compliance. An action plan dealing with issues of non-compliance and other service development needs has been agreed with the local area team by the required deadline of September 2013. Trust Board approved submission of the action plan and for the required works to be completed by the end of the 2014/15 financial year.

It was originally understood that, if a service is not able to meet specifications by the end of October 2013, then derogation from the contract could be agreed with commissioners whilst plans are implemented. However, following further guidance received from NHS England, it appears this may not be the case. Further clarification has been requested.

NHS Litigation Authority Risk Management Standards
The Trust was reassessed in November 2012 and continues to meet level 1.

Rule 43
As previously reported, in March 2013, the Coroner issued a joint Rule 43 Letter to Mid-Yorkshire Hospitals NHS Trust (MYT) and this Trust in relation to a lady who died at MYT in January 2011. An independent report was commissioned to review the liaison between the two Trusts to ensure mental health staff provide appropriate assessment and treatment in an acute Trust setting. A joint action plan was developed from the report and submitted to the Coroner by the required deadline. No response has been received from the Coroner; however, it should be noted that the Coroner would only normally respond if the submission did not meet his requirements under the Rule 43 Letter. Both Trusts are implementing the action plan to agreed timescales.

Safeguarding Children
- There were fifteen reported incidents Trust-wide directly relating to issues of child protection in Q2. All of the incidents were reviewed by the Named Nurses and were assessed to have been appropriately reported and managed.
- The OfSTED report into Calderdale Children's Services has been published and a further notice to improve served. The Trust is working closely with partners to support this process.
- Feedback from the first of four Local Safeguarding Board section 11 audits undertaken in Kirklees have been received and reflects positively on working standards.

Safeguarding Vulnerable Service Users
No referrals have been made to the Disclosure and Barring Service this quarter.

Serious Incidents
During the course of Q2 there have been 31 SIs reported to commissioners (21 in Barnsley of which, fifteen related to pressure ulcers, two in Calderdale, five in Kirklees and three in Wakefield). SI investigations and reports are being completed within timeframes agreed with the relevant commissioners. No 'Never Events' occurred in the Trust during this quarter.

Summary Performance Position
Based on the evidence received by the Trust Board through performance reports and compliance reports, the Trust is reporting the achievement of all relevant targets.

Third party reports
In addition to the CQC reports referred to earlier, the following audit report (with either no assurance or limited assurance) has been received by the Trust during the quarter, and reported through the Audit Committee:

- Data quality - (limited assurance)
  The key risks being the recording of information on progress notes rather than specific screens, in some instances inadequate documented evidence of level 2 risk assessments being undertaken and time taken to assign cluster group.

Action plans in respect of the issues raised and recommendations made within the reports, have been developed, approved through the Executive Management Team.

The Audit Committee will also receive the following internal audit reports at its meeting on 18 October 2013.

- Corporate Governance – substantial.
- Payroll – substantial.
- Estate Strategy management – substantial.
- SLA management (non-healthcare) – limited.
- Procurement (non-pay purchasing) – none.

Robust management action is in place to address the recommendations in both the SLA management and procurement reports.

The Trust has also been selected for the national NHS Protect counter fraud assessment process, which will take place on 29 October 2013.

Trust Board 22 October 2013
Business and risk agenda item 7

Title:	**Assurance framework and organisational risk register Q2 2013/14**
Paper prepared by:	Director of Corporate Development
Purpose:	Trust Board to be assured that a sound system of control is in place with appropriate mechanisms to identify potential risks to delivery of key objectives.
Vision/goals:	The Assurance Framework and risk register are part of the Trust's governance arrangements and integral elements of the Trust's system of internal control, supporting the Trust in meeting its goal of flawless execution and in meeting its constitutional, legal and equality and diversity obligations.
Any background papers:	Previous quarterly reports to Trust Board.
Executive summary:	**Background** The Trust Board has a duty to ensure that the organisation delivers healthcare and health improvements, promotes good health within a system of effective controls, and within the Governments objectives for the NHS. The Board needs to be confident that the systems, policies and people in place are operating in a way that is effective in driving the delivery of objectives by focusing on minimising risk. This paper and supporting appendix set out the systems and processes in place and the assurances derived. This report provides an update as at Quarter 2 covering the Assurance Framework and Organisational Risk Register. **Assurance framework 2013/14** The Board needs to evidence that it has systematically identified its objectives and managed the principal risks to achieving them. The Trust's Assurance Framework is designed as a tool for the Board to fulfil this objective. Trust Board provides leadership, sets values and standards, sets the organisations strategic objectives, monitors and reviews management performance and ensures that obligations to stakeholders are met. To ensure that these obligations are met there must be a sound system of internal controls, and the Board is required at least annually, to conduct a review of these internal controls. Whilst the risks to achieving the organisation's strategic objectives should be reduced through these internal controls, they can rarely be eliminated. The Assurance Framework provides Trust Board with a simple but comprehensive method for the effective and focused management of the principal risks to meeting their objectives. It simplifies Board reporting and the prioritisation of action plans allowing more effective performance management. It sketches an outline of the controls and where assurances can be sought. Lead Directors are responsible for identifying the controls that are in place or need to be in place for managing the principle risks, and providing assurance to the Board. An Annual Governance Statement (AGS) has to be signed by the Chief Executive every year and is based on the systems in place, particularly the Assurance Framework. The AGS forms part of the annual accounts and, without this, the annual accounts cannot be approved. The Assurance Framework informs the appropriate declarations to be made in the AGS, including any

	significant control issues in line with current guidance where appropriate. The strategic corporate objectives for 2013/14 were approved by the January Trust Board and form the basis of the assurance Framework for 2013/14. In respect of the Assurance Framework for 2013/14, the Director of Corporate Development will work with each lead Director to identify the principle high level risks to delivery of our principle objectives. For each of these risks the key controls in place and the sources of assurances have been identified and any material gaps are identified through the performance and risk management process. The Chief Executive uses the Assurance Framework at each Director's quarterly review meeting to ensure Directors are delivering against agreed objectives and action plans are in place to address any areas of risk identified. The Director of Corporate Development will also work with the Chairs and lead Directors of each of the sub-committees of the Board to identify which of the sub-committees of the Board, through their Annual Work Plans, is seeking and providing assurance to the Board, that the key controls are in place and operating satisfactorily. (This does not reduce individual Director's accountability in respect of their identified areas of responsibility.) **External Assurance** The Trust's internal auditor (KPMG) undertook a review of the Corporate Governance arrangements of the Trust during 2012/13, to assess the risk management arrangements and assurance framework in place and consider the operation and efficiency of the Trust's corporate governance arrangements, including board committee structures and effectiveness comparing the approach to maintaining and reporting the Board Assurance Framework (BAF) to best practice and seeking evidence that the BAF is used to drive the Board's agenda. As a consequence of the review an assessment of substantial assurance was made. This provides a good platform for the 2013/14 Assurance Framework. **Organisational risk register** The organisational risk register records high level risks in the organisation and the controls in place to manage and mitigate the risks. The risk register has been reviewed by the Executive Management Team during the last quarter, risks are re-assessed based on current knowledge and proposals made in relation to this assessment, including the addition of any high level risks from BDUs, Corporate or Project specific risks and the removal of risks from the register. The risk register contains the following risks: - issues around data and information; - impact on services as a result of local authority spending cuts and changes to the benefits system; - the Care Packages and Pathways project for mental health; - expectations of emerging Clinical Commissioning Groups; - transformational service change programme; - the Trust's marketing approach. Two additional risks have been added in relation to changes to national funding arrangements and contract renewal for intermediate care and memory services in Barnsley.

Recommendation:	**Trust Board is asked to:** ➢ **note the assurances provided for Q2 of 2013/14;** ➢ **note those areas where gaps in assurance have been identified, through the Trust wide risk register and are being addressed through specific action plans as appropriate led by the lead Director;** ➢ **note the key risks for the organisation subject to any changes/additions arising from papers discussed at the Board meeting around performance, compliance and governance.**

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

ASSURANCE FRAMEWORK 2013/14 – as at Q2 2013/14

Principal objective 1 Strategy: Ensure the Trust continues to identify the key strategic priorities required to maintain organisational success in a rapidly changing environment.

Principal risks (including potential risks)	Lead Direct	Key controls * (Systems/processes)	Assurance on controls * (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurance	Gaps in control	Gaps in assurance
1. Failure to understand and respond to changing market forces leading to loss of market share.	▪ DSD ▪ DDs	▪ C1, C2, C3, C4, C8, C32 ▪	▪ A4, A5, A40	A4, A5, A40		
2. Lack of engagement and ownership with key stakeholders to manage risk in the local economy impacting on available resources.	▪ DoC ▪ DDs	▪ C4, C5, C6, C7, C8, C9, C10	▪ A28, A29, A35, A39	A28, A29, A35, A39		ORR 275
3. Failure to develop required relationships or commissioner support to develop new services/ expand existing services, contracts awarded to other providers.	▪ DoF ▪ DDs	▪ C1, C4, C5, C8, C10	▪ A1, A36, A40, A40	A1, A36, A40, A40		
4. Staff and other key stakeholders not fully engaged in process around redesign of service offer, resulting in inertia and lack of progress.	▪ DDs	▪ C4, C7, C8, C10, C11, C12, C16	▪ A1, A4, A39	A1, A4, A39		
5. Failure to listen and respond to our service users, service offer not being patient centred, impacting on reputation and leading to loss of market share.	▪ DDs	▪ C7, C13, C15, C16, C40, C42, C43	▪ A2, A20, A21, A29, A45, A51	A2, A20, A21, A29, A45, A51		

[* Note Appendix 1 - sets out the list of Key Controls C1, C2.and Assurances A1, A2.]

Principal objective 2 Flawless execution: Ensure the Trust identifies the best possible means to support the flawless execution of its strategy; manage risk and deliver safe, high quality services, within available resources; ensure the Trust remains viable and sustainable; and meets both service user and commissioner expectations.

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurance	Gaps in control	Gaps in assurance
1. Inadequate capture of data resulting in poor data quality impacting on ability to deliver against care pathways and packages and evidence delivery against performance targets and potential failure regarding Monitor Compliance Framework.	▪ DoF	▪ C17, C19, C20, C21, C22	▪ A1, A9, A10, A11,A13, A15, A16, A17, A43	A1, A9, A10, A11,A13, A15, A16, A17, A43		ORR 267 ORR 268 ORR 270
2. Unexplainable variation in clinical practice resulting in differential patient experience	▪ MD ▪ DN	▪ C4, C23, C24, C25, C26, C43	▪ A1, A8, A33, A36, A46, A52	A1, A8, A33, A36, A46,		

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurance	Gaps in control	Gaps in assurance
and outcomes and impact on Trust reputation.	▪ DDs			A52		
3. Changing service demands and external financial pressures in local health and social care economies have an adverse impact on achieving local and national performance targets and ability to manage within available resources.	▪ DDs	▪ C4, C5, C20, C22, C27, C28	▪ A1, A8, A9, A10, A11, A15, A16, A23, A30	A1, A8, A9, A10, A11, A15, A16, A23, A30		ORR 275
4. Failure to deliver level of transformational change required impacting on ability to deliver required change management programme.	▪ DSD ▪ DoF	▪ C17, C18, C30	▪ A1, A2, A4, A5, A35, A37	A1, A2, A4, A5, A35, A37		
5. Lack of sign up from staff in recognising the need for change leading to lack of engagement and benefits not being realised through delivery of revised models.	▪ DDs	▪ C31, C32, C33, C34	▪ A3, A35, A52	A3, A35, A52		
6. Workforce plan doesn't support identification and recruitment of suitably competent and qualified staff to deliver the service offer.	▪ DoH	▪ C1, C12, C29, C35, C67	▪ A1, A10, A20, A21, A22, A24, A47	A1, A10, A20, A21, A22, A24, A47		
7. Not having a clearly defined Estates Strategy to support the revised service offer.	▪ DoH ▪ DDs	▪ C1, C17, C32, C36, C37, C38	▪ A1, A4, A5, A6A18, A26, A27, A44	A1, A4, A5, A6A18, A26, A27, A44		
8. Lack of suitable technology and infrastructure to support delivery of revised service offer.	▪ DoF	▪ C1, C17, C32, C39	▪ A1, A4, A5, A14, A26	A1, A4, A5, A14, A26		

Principal objective 3 Culture: Create and sustain a culture of continuous quality improvement, focussed on delivering the best possible service outcomes, through a co-production approach engaging service users, carers, staff and partners, which embraces equality and diversity.

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurances	Gaps in control	Gaps in assurance
1. Failure to motivate and engage clinical staff through culture of quality improvement, benchmarking and changing clinical practice, impacting on ability to deliver best possible outcomes.	▪ MD ▪ DoN	▪ C31, C32, C34, C44, C45, C46	▪ A1, A11,A21, A29, A35, A49, A52	A1, A11,A21, A29, A35, A52	A49	
2. Failure to create and communicate a coherent articulation of Trust Mission, Vision and Values leading	▪ CE	▪ C31, C33, C44, C48, C49, C68	▪ A1, A7, A35, A42	A1, A7, A35, A42		

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurances	Gaps in control	Gaps in assurance
to inability to identify and deliver against strategic objectives.						
3. Failure to create a learning environment leading to repeat incidents impacting on service delivery and reputation.	▪ DoN	▪ C23, C41, C50, C51	▪ A15, A19, A24, A27, A46, A48	A15, A19, A24, A27, A46, A48		
4. Failing to achieve the right balance of devolution and local autonomy for BDU's versus corporate cohesion.	▪ DDs	▪ C1, C3, C33, C52, C53, C54, C55	▪ A1, A5, A26, A33, A35,	A1, A5, A26, A33, A35,		
5. Failure to develop a culture of tackling poor performance at all levels.	▪ DDs ▪ CDs	▪ C12, C26, C33, C56	▪ A15, A16, A22, A31, A32	A15, A16, A22, A31, A32		

Principal objective 4 Structure: Achieve the best possible structure for the Trust through Business Delivery Unit and Quality Academy development.

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurances	Gaps in control	Gaps in assurance
1. No clear lines of accountability and responsibility within Directorates and between BDUs and Quality Academy.	▪ DDs ▪ CDs	▪ C17, C23, C33, C53	▪ A12, A15, A16, A23, A35	A12, A15, A16, A23, A35		
2. Lack of relevant skills and expertise to deliver the service offer and meet national and local targets and standards.	▪ DDs ▪ CDs	▪ C23, C26, C30,C35, C44, C57	▪ A3, A22, A39, A40, A47	A3, A22, A39, A40, A47		
3. Lack of capacity and resources not prioritised leading to none delivery of key organisational priorities and objectives.	▪ DDs ▪ CDs	▪ C17, C18, C23, C33, C35,	▪ A1, A3, A4, A5, A42	A1, A3, A4, A5, A42		ORR431
4. Inability of organisation to develop effective leadership and succession planning.	▪ DoHR	▪ C23, C34, C35, C58	▪ A1, A22, A35	A1, A22, A35		

Principal objective 5 Partnerships: To maximise the benefit of both external and internal partnerships in support of improving the service offer, delivering better outcomes, and efficiency, economy and effectiveness.

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurances	Gaps in control	Gaps in assurance
1. Failure to respond to market forces and on-going development of new	▪ DDs ▪ DoCD	▪ C1, C2, C3, C6, C16, C30	▪ A26, A29, A40, A39	A26, A29, A40, A39		

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurances	Gaps in control	Gaps in assurance
partnerships.						
2. Risk of sustainability of partnerships and relationships in a resource constrained environment causing internal not system-wide focus.	▪ DDs ▪ DoCD	▪ C4, C6, C10, C59	▪ A1, A10, A35, A39	A1, A10, A35, A39		
3. Lack of investment in capacity and skills required to build and deliver on partnerships.	▪ DoF	▪ C23, C26, C30, C33, C35, C44, C57	▪ A1, A3, A5, A35	A1, A3, A5, A35		

Principal objective 6 Innovation: Drive a commitment to innovation at all levels within the Trust, with a view to the Trust being viewed as a 'brand leader' in the leadership of systems and the provision of mental health and community services, utilising the freedoms and flexibilities of foundation trust status to best effect.

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurances	Gaps in control	Gaps in assurance
1. Risk of lack of stake holder engagement needed to drive innovation, key stakeholders not fully engaged in process around redesign of service offer.	• MD, • DoN, • DDs • DoCD,	▪ C10, C11, C16, C17, C18, C30, C32	• A1, A4, A35, A39	A1, A4, A35, A39		
2. Lack of commitment to make necessary changes across the organisation	▪ DDs	▪ C11, C12, C13, C16, C31, C60, C61, C63,	• A2, A5, A7	A2, A5, A7		
3. Lack of clarity on tools and processes required to enable a quick, effective approach.	▪ DoSD	▪ C30, C62, C63	• A4, A5	A4, A5		
4. Lack of availability of resources to pump prime innovation.	▪ DoF	▪ C30, C62, C63	• A5, A7, A34, A35	A5, A7, A34, A35		

Principal objective 7 Talent Management: Create an organisational approach, which harnesses the best talents available from all backgrounds, through the talent management programme.

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurances	Gaps in control	Gaps in assurance
1. Lack of clear consistent approach and co-ordination across directorates, which doesn't link with organisational objectives.	▪ DoHR	▪ C1, C17, C33, C64	▪ A1, A3, A7, A25,	A1, A3, A7, A25,		
2. Lack of resources to support development and delivery of plan	▪ DDs, CDs,	▪ C44, C54, C63,	▪ A5, A34, A35, A38	A5, A34, A35	A38	
3. Failure to identify, harness and	▪ DDs	▪ C26, C44, C65	▪ A3, A22, A35,	A3, A22,		

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurances	Gaps in control	Gaps in assurance
support talent through personal development to maximise potential.	▪ CDs			A35,		

Principal objective 8 Leadership Development: Foster a progressive approach to leadership development across all levels and disciplines within the Trust, striking an effective balance between clinical, managerial and corporate leadership.

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurances	Gaps in control	Gaps in assurance
1. Failure to articulate leadership requirements, Inability to develop effective leadership and succession planning	▪ DDs ▪ CDs	▪ C26, C34, C44, C64	▪ A3, A25, A35	A3, A25, A35		
2. Failure to develop leadership culture, managers fails to support and prioritise development programmes.	▪ DDs, CDs,	▪ C26, C31, C33, C44	▪ A3, A15, A22	A3, A15, A22		
3. Lack of resources to support development and delivery of programmes.	▪ DDs ▪ CDs	▪ C31, C34, C54, C63	▪ A5, A34, A35, A47	A5, A34, A35, A47		

Abbreviations:

DoN		Director of Nursing	DSD	-	Director of Service Development
DDs	-	District Directors	MC	-	Members Council
DoF	-	Director of Finance	AC	-	Audit Committee
DoCD	-	Director of Corporate Development	CGCSC	-	Clinical Governance and Clinical Safety Committee
DoH	-	Director of Human Resources	RC	-	Remuneration Committee
MD	-	Medical Director	MHAC	-	Mental Health Act Committee
CDs	-	Corporate Directors	TAG	-	Trust Action Group

Appendix 1

Control (C...)	Key Control (Systems/processes)
1.	Strategic Executive Management Team ensuring alignment of developing strategies with Trust vision and strategic objectives. 1.1, 1.3, 2.6, 2.7, 2.8, 3.4, 5.1, 7.1,
2.	Production of market assessment against a number of frameworks inc. PESTEL and threat of new entrants/substitution, partner/buyer power. 1.1, 5.1
3.	Production of Annual Business Plan and Monitor 3 year Plan demonstrating ability to deliver agreed service specification and activity within contracted envelope or actions investment required to achieve service levels and mitigate risks. 1.1, 3.4, 5.1
4.	Formal contract negotiation meetings established with PCTs and Specialist Commissioners underpinned by legal agreements to support strategic review of services. 1.2, 1.3, 1.4, 2.3, 5.2,
5.	Development of joint QIPP plans with commissioners to improve quality and performance, reducing risk of decommissioning, change of provider 1.2, 1.3, 2.3,
6.	Third Sector Strategy and action plan in place approved by the Board, promoting and developing key relationships 1.2, 5.1, 5.2,
7.	Involving People Strategy and action plan in place approved by the Board, promoting and developing key relationships 1.2, 1.4, 1.5, 3.1,
8.	GP Engagement Strategy's and action plan in place approved by the Board, promoting and developing key relationships 1.2, 1.3, 1.4
9.	Care Pathways and personalisation Project Board established with PCT and Local Authority Partners 1.2,
10.	Engagement processes in place with shadow/clinical commissioning groups, membership of Clinical Commissioning sub-groups 1.2, 1.3, 1.4, 5.2, 6.1
11.	Creative Minds Strategy and action plan in place approved by the Board, promoting different ways of working and partnership approach 1.4, 6.1, 6.2,
12.	Partnership Boards established with Trade Unions to mange and facilitate necessary change 1.4, 2.6, 3.5, 6.2,
13.	Framework in place to ensure feedback from customers both internal and external including feedback loop and delivery of action plans through Local Action Groups 1.5, 3.1, 6.2,
14.	Not used
15.	Member Council engagement and involvement in working groups 1.5, 3.1
16.	Change Lab process establish to identify and invest in key prototypes with existing and new partner organisations to optimise and sustain market position 1.4, 1.5, 5.1, 6.1, 6.2
17.	Director leads in place for key change management projects linked to corporate and personal objectives, resources and deliverables identified. 2.1, 2.2, 2.4, 2.7, 2.8, 4.3, 6.1, 7.1,
18.	Project Boards for key change management projects established, with appropriate membership skills and competencies, PIDs, Project Plans, project governance, risk registers for key projects in place. 2.4, 4.3, 6.1
19.	Risk assessment and action plan for data quality assurance in place 2.1,
20.	Risk assessment and action plan for delivery of CQUIN indicators in place. 2.1, 2.3,
21.	Cross BDU performance meetings established to identify performance issues and learn from good practices in other areas 2.1,
22.	Performance Management system in place, with KPI's covering National and local priorities 2.1,
23.	Development of Quality Academy approach and Quality Strategy approved by Board, 2.2, 3.3, 4.2, 4.3, 4.4, 5.3
24.	Process in place for systematic use of benchmarking to identify areas for improvement and identifying CIP opportunities. 2.2,
25.	Peer review and challenge processes in place i.e. Medium Secure Quality Network 2.2,
26.	PDP and appraisal process in place and monitored through KPI 2.2, 3.5, 4.2, 5.3, 7.3, 7.4, 8.1, 8.2
27.	Internal control processes in place to produce and review monthly budget reports and take mitigating actions as appropriate. 2.3
28.	PCT/Provider performance monitoring regime of compliance with QIPP plan and CQUIN targets in place. 2.3
29.	HR processes in place ensuring defined job description, roles and competencies to meet needs of service, pre-employment checks done re qualifications, CRB, work permits 2.6
30.	Director lead for Service Development, supported by team of change management agents providing support and coaching around lean methodology and other frameworks, horizon scanning re market opportunities and centres of excellence 2.4, 4.2, 5.1, 5.3, 6.1, 6.3, 6.4,
31.	Middle Ground Programme developed and delivered and performance monitored linked to organisational and individual resilience helping staff prepare for change, transition and explore new ways of working 2.5, 3.1, 3.2,, 6.2, 8.2, 8.3,
32.	BDU revised service offer, work streams and resources in place performance managed through BDU Board 1.1, 2.5, 2.7, 2.8, 3.1, 6.1,
33.	Alignment and cascade of Trust Board approved corporate objectives supporting delivery of Trust Mission, Vision and Values through appraisal process down through director to team and individual team member 2.5, 3.2, 3.4, 3.5, 4.1, 4.3, 5.3, 7.1, 8.2,
34.	Medical Leadership Programme in place with external facilitation. 2.5, 3.1, 4.4, 8.1, 8.3
35.	Workforce plans in place identifying staffing resources required to meet service offer and meeting statutory requirements re training, equality and diversity. 2.6, 4.2, 4.3, 4.4, 5.3

36.	Six facet surveys undertaken to identify possible infrastructure, services risks and linked into forward capital programme. 2.7
37.	Estates Forum in place with defined Terms of Reference chaired by a NED 2.7
38.	Estate TAG in place ensuring alignment of Trust strategic direction, with estates strategy and capital plan 2.7
39.	IM&T strategy in place 2.8
40.	Public Engagement and Consultation Events gaining insight and feedback, including identification of themes and reporting on how feedback been used. 1.5
41.	Weekly Serious Incident summaries (incident reporting system) to EMT and monthly risk scan to Extended EMT 3.1 Incident reporting and management (including serious incidents) systems in place with reports to EMT. 2.2, 3.2, 3.3,
42.	Staff wellbeing survey conducted, with facilitated group forums to review results and produce action plans 1.5
43.	Complaints policy and complaints protocol covering integrated teams in place. 1.5, 2.2
44.	OD Framework and Plan in place 3.1, 3.2, 4.2, 5.3, 7.2, 7.4, 8.1, 8.2,
45.	Clinical/managerial partnerships established at service line level with key focus on clinical engagement and delivery of services 3.1
46.	Facilitated engagement of clinicians in TAGs 3.1
47.	No longer used
48.	Trust induction policy in place covering Mission, vision, values, key policies and procedures. 3.2
49.	Communication Strategy in place 3.2
50.	Risk Management Strategy in place facilitating a culture of horizon scanning, risk mitigation and learning lessons supported through appropriate training 3.3
51.	Audit of compliance with policies and procedures co-ordinated through clinical governance team. 3.3
52.	Annual Business planning guidance issued standardising process and ensuring consistency of approach 3.4,
53.	Standing Orders, Standing Financial Systems, scheme of Delegation and Trust Constitution in place and publicised re staff responsibilities 3.4, 4.1,
54.	Standardised process in place for producing businesses cases and benefits realisation cards. 3.4, 7.2, 8.3,
55.	Policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval. 3.5
56.	Audit of compliance with policies and procedures through annual programme with performance management framework in place. 3.5,
57.	Review of skills and gaps leading to Identification of programme of events to address gaps 4.2, 5.3,
58.	A set of leadership competencies developed as part of Leadership and Management Development Plan 4.4,
59.	Member of local partnership boards, building relationships, ensuring transparency of agenda's and risks, facilitating joint working, cohesion of policies and strategies 5.2,
60.	Staff excellence award schemes in place to encourage and recognise best practice and innovation. 6.2
61.	Fostering links to Jonkoping in Sweden as part of on-going development of Quality Academy Approach and learning from best practice. 6.2,
62.	Investment Appraisal framework including ensuring both a financial and social return on investment providing clarity of approach 6.3, 6.4,
63.	Innovation fund established to pump prime investment to deliver service change and innovation 6.2, 6.3, 6.4, 7.2, 8.3
64.	Leadership and Management Development Plan in place covering development framework, talent management and succession planning. 7.1, 8.1
65.	Secondment policy and procedure in place 7.3
66.	Board strategic development sessions setting overarching strategy and strategic direction scheduled 3.2,
67.	Mandatory Training Review Group in place ensuring mandatory training policy and programme linked to delivery of statutory requirements and delivery of corporate objectives. 2.6

Assurance (A..)	Assurance on controls (Planned outputs)	Board reports received (including sub-committees, EMT)
1.	Quarterly documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. 1.2, 1.4,2.1, 2.2, 2.3, 2.4, 2.6, 2.7, 2.8, 3.1, 3.2, 3.4, 4.3, 4.4, 5.2, 5.3, 6.1, 7.1	➢ CE summary letters to Director following each quarterly review. ➢ Update reports to Remuneration and Terms of Service Committee by the Chief Executive
2.	Production of Patient Experience quantitative and qualitative reports, triangulating themes, you said to Board and Members Council. 1.5, 6.2	➢ Quality report to Trust Board April and July 2013
3.	Annual appraisal, objective setting and PDPs to be completed in Q1 of financial year, performance managed by EMT. 2.4, 4.2, 4.3, 5.3, 7.1, 7.3, 8.1, 8.2	➢ Performance reports and HR performance reports to Trust Board and EMT (monthly) ➢ HR performance reports to R&TSC ➢ Appraisal records kept by line managers ➢ Revised appraisal process rolled-out to all staff from 1 April 2013 following positive feedback from pilot of values-based system.
4.	Change Management Plan performance managed through performance EMT ensuring co-ordination across directorates, identification of and mitigation of risks. 1.1, 1.4, 2.4, 2.7, 2.8, 4.3, 6.1, 6.3,	➢ Transformational service change reports to EMT (monthly) ➢ Report to Trust Board April and July 2013
5.	Business cases for expansion/change of services approved by approvals EMT and or Trust Board subject to delegated limits ensuring in line with strategic direction and investment framework. 1.1, 2.4, 2.7, 2.8, 3.4, 4.3, 5.3, 6.2, 6.3, 6.4, 7.2, 8.3	➢ Innovation Fund bids to EMT during 2013/14 ➢ Investment Appraisal Framework papers to Trust Board on quarterly basis, which includes investment in specific initiatives ➢ Transfer of children's health services from Barnsley Council Trust Board June and September 2013
6.	Performance management of estates schemes against resources through Estates TAG, deviations identified and remedial plans requested. 2.7	➢ Estates TAG minutes and papers ➢ Estates Forum minutes and papers through 2013/14 ➢ Newton Lodge/gainshare EMT May 2013 ➢ Bretton Centre compliance Trust Board September 2013 ➢ Hepworth refurbishment Trust Board September 2013 ➢ Estates Strategy implementation plan update Trust Board September 2013
7.	Board Strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives. 3.2, 6.2, 6.4, 7.1	➢ Strategy session of Trust Board May 2013 ➢ Achieving service transformation and marketing and strategic planning papers to Trust Board April 2013
8.	Quarterly compliance reports to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken. 2.2, 2.3,	➢ Quality report to Trust Board April and July 2013 ➢ Quarterly compliance reports to EMT to inform presentation to Trust Board
9.	Quarterly Monitor exception report to Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken. 2.1, 2.3,	➢ Monitor quarterly return (April and July 2013)
10.	Quarterly Assurance Framework, Risk Register and Risk Triangulation report to Board providing assurances on actions being taken. 2.1, 2.3, 5.3,	➢ Assurance Framework and risk register to Trust Board (April and July 2013) ➢ Risk register reviewed monthly by EMT
11.	Assurance reports to CG&CSC covering key areas of risk in the organisation seeking assurance on robustness of systems and processes in place. 2.1, 2.3, 3.1,	➢ Clinical Governance and Clinical Safety Committee minutes ➢ Suicide audit – presentation of findings and action plan (April and June 2013) ➢ Francis report action plan (April and June 2013) ➢ Winterbourn View action plan (April and June 2013) ➢ Unannounced visits plan and outcomes (April, June and September 2013) ➢ Quality Impact Assessment of CIPs (April, June and September 2013) ➢ Serious incidents quarterly reports during 2013/14 and annual report June 2013 ➢ CQUIN achievement and forecast (June 2013) ➢ Clinical audit and effectiveness plan 2013/14 (June 2013) ➢ Health and safety annual report 2012/13 and plan 2013/14 (September 2013) ➢ Self-assessment against MIND report on prone restraint (September 2013)
12.	Annual Governance Statement (SIC) reviewed by Audit Committee and Board and Externally audited. 4.1	➢ Approval of annual report and accounts at Audit Committee May 2013 and Trust Board June 2013
13.	Monitor Compliance Assurance group review performance before Trust Board	➢ Process in place to review compliance with Monitor targets on quarterly basis

Assurance (A..)	Assurance on controls (Planned outputs)	Board reports received (including sub-committees, EMT)
	B&R meeting ensuring all exceptions identified and reported to Trust Board and Monitor. 2.1	➢ Progress reviewed monthly at EMT evidenced through EMT minutes
14.	IG Toolkit provides assurance and evidence that systems and processes in place at the applicable level, reported through IG TAG, deviations identified and remedial plans requested receive, performance monitored against plans. 2.8,	➢ Information Governance TAG papers and minutes ➢ Performance EMT meetings and papers ➢ Monthly performance reports
15.	Monthly review and monitoring of performance reports through Performance EMT deviations identified and remedial plans requested. 2.1, 2.3, 3.3, 3.5, 4.1, 8.2.	➢ Performance reports to EMT ➢ Minutes from performance EMT meetings ➢ Transformational service change progress reports to EMT (monthly) ➢ Sickness absence (currently standing item) ➢ Risk assessment of target, CQUINs, etc. EMT May 2013 and Trust Board April 2013 ➢ Cost improvement programme (July 2013)
16.	Monthly review and monitoring of Integrated Performance Report by Trust Board with exception reports requested around risk areas. 2.1, 2.3, 3.5, 4.1,	➢ Performance reports to Trust Board ➢ Minutes from Trust Board meetings ➢ Risk assessment of performance targets 2013/14 to Trust Board April 2013 ➢ CQUIN performance and risk assessment Clinical Governance and Clinical Safety Committee June 2013 ➢ Quality Impact Assessment Audit Committee April 2013, Clinical Governance and Clinical Safety Committee April, June and July 2013
17.	Annual report to Business and Risk Board to risk assess changes in compliance requirements. 2.1,	➢ Risk assessment of performance targets 2013/14 to Trust Board April 2013
18.	Independent PEAT Audits undertaken and results and actions to be taken reported to EMT Members Council and Board. 2.7,	➢ PLACE results to EMT August 2013
19.	CQC registration certificate in place. 2.3,	➢ Care Quality Commission registration certificates ➢ Application for addition Trust Board June 2013
20.	Announced and unannounced inspection visits undertaken by CQC, independent reports on visits provided to the Trust Board. 1.5, 2.6,	➢ Updates provided to Trust Board on unannounced visits to Newton Lodge and the Dales (formal report awaited) ➢ Trust Board and Members' Council informed of CQC investigation into whistleblowing regarding bed pressures
21.	Unannounced internal visits to support staff and ensure compliance with CQC standards through the delivery of supported action plans.1.5, 2.6, 3.1,	➢ Clinical Governance and Clinical Safety Committee April, June and July 2013
22.	Remuneration Terms of Service Committee receive HR Performance Reports and monitor compliance against plans and receive assurance from reports around staff development, workforce resilience. 2.6, 3.5, 4.2, 4.4, 7.3, 8.2,	➢ Sickness absence R&TSC April and July 2013 ➢ Exception report R&TSC April and July 2013 ➢ Interim results of staff wellbeing survey July 2013 ➢ Update on achievement of appraisal target July 2013
23.	Audit Committee review evidence for compliance with policies, process, SO's, SFI's, SofD, mitigation of risk, best use of resources. 2.3, 4.1,	➢ Annual report and accounts ➢ Standing item on service line reporting and currency development ➢ Standing item on procurement and review of procurement strategy ➢ Standing item on progress against counter fraud plan ➢ Head of Internal Audit Opinion May 2013
24.	Independent CQC Reports to MHA Committee providing assurance on compliance with MH ACT2.6, 3.3, 4.2,	➢ All Mental Health Act Committee meetings
25.	External accreditation IIP, supported by internal assessors, ensuring consistency of approach in the support of staff development and links with organisational objectives. 7.1, 8.1,	
26.	Annual Plan approved by Board, externally scrutinised and challenged by Monitor. 2.7, 2.8, 3.4, 5.1,	➢ Monitor commentary on annual plan ➢ Annual plans, budgets and minor capital programme 2012/13 approved by Trust Board March 2013 ➢ Monitor annual plan approved by Trust Board May 2013

Assurance (A..)	Assurance on controls (Planned outputs)	Board reports received (including sub-committees, EMT)
		➢ Monitor quarterly returns
27.	Health and Safety TAG monitor performance against plans deviations identified and remedial plans requested. 2.7, 3.3,	➢ Health and Safety TAG minutes ➢ Health and safety arrangements peer review outcome to Clinical Governance and Clinical Safety Committee April 2013
28.	Staff Opinion Survey results reported annually to board and action plans produced as applicable. 1.2,	
29.	Service user survey results reported annually to board and action plans produced as applicable. 1.2, 1.5, 3.1, 5.1,	➢ Quarterly quality and compliance reports to Trust Board ➢ CQC registration quarterly reports to EMT
30.	Annual Reports of sub-committees of the Board to Audit Committee, attendance by Chairs of sub-committees and director leads to provide assurance against annual plan	➢ Audit Committee annual report to Trust Board 2012/13 April 2013 ➢ Review of other risk Committees' effectiveness and integration AC April 2013
31.	External and Internal Audit Reports to Audit Committee setting out level of assurance received. 3.5 ,	➢ Internal audit update reports to Audit Committee ➢ External audit update reports to Audit Committee ➢ Annual report and accounts to Audit Committee May 2013 ➢ Quality Accounts progress standing item on CG&CS agenda ➢ Quality Accounts final report to CG&CS Committee May 2013
32.	External and internal Audit reports performance managed through approvals EMT. 3.5,	➢ Internal audit follow up reports to EMT and consideration of internal audit reports with limited assurance throughout 2013/14 ➢ Quality Accounts external assurance Audit Committee May 2013 and Trust Board June 2013
33.	Audit of compliance with policies and procedures in line with approved plan co-ordinated through clinical governance team in line with Trust agreed priorities. 2.2, 3.4,	➢ Reports to Clinical Governance and Clinical Safety Committee ➢ Monitoring of action plan following medicines management audit CG&CS Committee April and June 2013, and update July 2013 ➢ Limited assurance reports considered by EMT ➢ Internal audit reports on clinical governance (substantial), compliance CQC standards (moderate), quality governance (substantial), change management programme (moderate), health record (SystmOne) (moderate), adult safeguarding (limited), IG toolkit (substantial), facilities (moderate), revalidation (substantial) and financial affairs – community patients (limited progress), data quality (limited), clinical leadership (advisory), self-directed support (advisory), local authority partners (substantial)
34.	Innovation bids approved through approvals EMT ensuring consistency of approach and alignment with strategic priorities and corporate objectives. 6.4, 7.2, 8.3,	➢ Innovation Funds bids forms and benefits realisation and minutes EMT throughout 2013/14
35.	Monitoring of OD Plan through EMT group deviations identified and remedial plans requested. 1.2, 2.4, 3.1, 3.2, 3.4, 4.1, 4.4, 5.2, 5.3, 6.1, 6.4, 7.2, 7.3, 8.1, 8.3.	➢ OD group led by CE established to review OD plan.
36.	QIPP performance monitored through Performance EMT deviations identified and remedial plans requested. 2.2, 2.4,	➢ Performance reports to EMT ➢ Performance EMT minutes
37.	Sustainability action plans monitored through Sustainability TAG deviations identified and remedial plans requested. 1.3, 2.4,	➢ Sustainability TAG minutes
38.	Annual Report and feedback on undergraduate medical training 4.2,	
39.	Strategic overview of partnerships and growth in line with Trust vision and objectives provided through Strategic EMT. 1.2, 1.3, 1.4, 5.1, 5.2, 6.1	➢ Stakeholder updates at Strategic EMT ➢ Chief Executive's reports to Trust Board (formal and informal) – standing item from December 2012
40.	Marketing analysis reviewed through Strategic EMT, Market Assessment to Business and Risk Trust Board ensuring identification of opportunities and threats. 1.1, 1.3, 5.1,	➢ Market analysis at Strategic EMT and time out sessions ➢ Trust Board April 2013 ➢ Chief Executive's reports to Trust Board (formal and informal)

Assurance (A..)	Assurance on controls (Planned outputs)	Board reports received (including sub-committees, EMT)
		➢ Additional support commissioned November 2012
41.	Production of Monitor B12 setting out evidence of compliance/assurance against the statements reviewed by Trust Board	➢ Monitor annual plan, including Trust Board self-certification, approved by Trust Board April 2013 ➢ Approval by Trust Board of Monitor annual plan May 2013 ➢ Monitor Compliance Framework to Trust Board April 2013 ➢ Monitor Code of Governance to Trust Board April 2013 ➢ Monitor Quality Governance Framework Clinical Governance and Clinical Safety Committee April 2013
42.	Results from appraisal monitoring process reported to EMT and Trust Board ensuring communication of MVV through the Trust.3.2, 4.3,	➢ Performance reports to Trust Board and EMT ➢ Transformational service change consultation and engagement events June/July 2013 ➢ Revised appraisal process rolled-out to all staff from 1 April 2013 following positive feedback from pilot of values-based system.
43.	Data quality Improvement plan monitored through EMT deviations identified and remedial plans requested. 2.1,	
44.	Estates Forum monitors delivery against Estates Strategy. 2.7,	➢ Estates forum minutes and papers outlining development of Estates Strategy
45.	Equality and Involvement Strategy into Action Group established monitoring delivery of equality, involvement and inclusion action plans, reporting into CG&CS Committee. 1.5	➢ Equality and Involvement Strategy into Action Group terms of reference and minutes
46.	Serious Incidents from across the organisation are reviewed through the Incident Review Panel including the undertaking of root cause analysis and dissemination of lessons learnt and good clinical practice across the organisation. 2.2, 3.3,	➢ Incident Review Sub-Committee minutes and reports to Clinical Governance and Clinical Safety Committee ➢ Serious incidents quarterly reports to Clinical Governance and Clinical Safety Committee and Trust Board
47.	Mandatory training review group in place ensuring consistency of approach across Trust and compliance with legislation. 2.6, 4.2, 8.3, 7.2,	➢ Review group terms of reference ➢ Revised mandatory training policy approved by EMT October 2012
48.	Assurances received by sub-committees of the Board reported quarterly to Trust Board, providing Board assurance on systems and controls in place and operating. 3.3	➢ Assurance from Trust Board Committees to Trust Board (June and September 2013)
49.	Medium secure quality network undertake annual peer reviews providing external assurance on systems and controls in place and operating. 3.1,	
50.	Independent Hospital Managers review detentions providing external assurances of compliance with MH Act.4.2, 1.5,	All detained but non-restricted patients have their renewal of section examined at a formal meeting with independent hospital managers who examine legality and appropriateness of detention. Also able to identify any concerns voiced by patients/advocates about care given. Feedback given to Mental Health Act Committee through standing item on the agenda (feedback from Hospital Managers' Forum).
51.	LINKs undertake unannounced visits to services providing external assurance on standards and quality of care.	➢ Draft reports provided to services, final report agreed and action plans developed
52.	Appraisal and revalidation in place evidenced through ORSA and supported through Appraisers forum. 2.2, 2.5, 3.1, 4.2,	➢ Medical Appraisers' Forum minutes

South West Yorkshire Partnership NHS

	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Green	**1 - 3**	**Low risk**
Yellow	**4 - 6**	**Moderate risk**
Amber	**8 - 12**	**High risk**
Red	**15 - 25**	**Extreme risk**

ORGANISATIONAL LEVEL RISK REPORT

Date: **Trust Board 22 October 2013**

Risk ID	Hist. Ref	Source	Risk Responsibility	BDU/Directorate	Service	Specialty	Description of risk	Current control measures	Consequence (Current)	Likelihood (Current)	Rating (current)	Risk level (current)	Summary of risk action plan	Fin cost (£)	Risk Owner	Expected date of completion	Monitoring & Reporting Requirements		Risk level (Target)	Is this rating acceptable?	Comments	Risk Review Date
267	8	Risk Assessment	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			Data quality and capture of clinical information on RiO will be insufficient to meet future compliance and operational requirements to support service line reporting and the implementation of the mental health currency leading to reputational and financial risk in negotiation of contracts with commissioners.	Data quality Strategy approved by Board Oct 2011. Annual report produced for Business and Risk Board to identify risks and actions required in order to comply with regulatory and contract requirements. >Data quality framework is monitored by the Data quality Steering group which is chaired by the Director of Nursing > Key issues in relation to data quality and clinical practice to support mental health currency implementation are included in the Data quality action plan which is reviewed by the Steering group. > All BDUs have individual data quality action plan which is reviewed internally. > Accountability for data quality is held jointly by Director of Nursing and Director of Finance. >Responsibility for data quality is delivered by BDU directors, BDU nominated quality leads and clinical governance. >Key metrics for Data quality are produced monthly in BDU and trust dashboards and reviewed by Performance EMT . >Annual clinical audit programme is planned to reflect data quality priorities.	5 Catastrophic	4 Likely	20	Red/extreme /SUI risk (15-25)	>Specific project arrangements for implementation of mental health currency - Project Board and Project team in place. Director lead Director of Finance. > Engagement plan for 2013-14 in place for commissioners and implementation plan reflected in contract monitoring agreed. >Engagement plan and resource plan in place to support implementation of currency internally through project team and practice governance coach >Baseline reports produced to communicate where teams are not meeting standards and need to focus efforts. >Project arrangements designed to identify key issues - clarity on services offer;clarity of clinical process; improve configeration of clinical system; link to transformation; benchmarking use of resources. >Changes to clinical systems to support mental health currency implementation and to improve data quality is managed by the RiO Development Board which is chaired by the DoF and includes DoN and Medical Director and BDU Director. This is supported by network of clinicians and managers - RiO Clinical Reference Group.	100K est additional capacity	DoF Lead and Medical Director	Implementation of national guidance during 2013-14.	EMT and Trust Board monthly review for data quality indicators.Steering group review for > Data quality Board > PbR Project Board > RiO system development Board.	16	Red/extreme /SUI risk (15-25)	Yes		Monthly at EMT and Trust Board 22 October 2013
270	34	Risk Assessment	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			The Care Packages and Pathways project will not deliver an improvement in service quality and outcomes through the roll out of clustering and mental health currency.	>Accountability arrangements in place for delivery of mental health currency Project- lead Director of Finance. Key project Board members DoN and Medical Director. > Progress reviewed by Audit Committee and Board. >Key issues / risks and progress monitored by EMT through Performance EMT. > Key representation at national level for development of costing by CEO and DoF through CPPP programme.	5 Catastrophic	4 Likely	20	Red/extreme /SUI risk (15-25)	>Project management arrangements established to include EMT, co-ordinating group and BDU specific working groups links to commissioners in Calderdale/Kirklees/Wakefield formalised.(see Risk 267) >Work on currency and benchmarking included in the Mental Health "Big ticket " transformation programme to evidence benefits. > Input and participation in CPPP programme to share best practice and benchmark progress, > Revised Project plan Sept 2013 shared with external audit . > Trajectory developed to meet data quality requirements for March 2014.	included in 267	Mental Health Big ticket leads - BDU director kirklees and calderdale and medical director/ DoF	Finaings from Pbr implementation reported to Performance EMT and to be incorporated into benchmarking for trasnformation work.	>EMT Progress reports >Report on progress to every Audit Committee >Regular Board updates	16	Red/extreme /SUI risk (15-25)	Yes		Monthly at EMT and Trust Board 22 October 2013
275	6	Risk Assessment	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			Reduction in Local authority funding and changes in benefits system will result in increased demand of health services - due to potential increase in demand for services and reduced capacity in integrated teams- which will create risk of a negative impact on the ability of integrated teams to meet performance targets.	>District integrated governance boards established to manage integrated working with good track record of cooperation. >Maintenance of good operational links though BDU teams and leadership. >Monthly review through Performance EMT of key indicators which would indicate if issues re delivery i.e. Delayed transfers of care and service users in settled accomodation.	4 Major	4 Likely	16	Red/extreme /SUI risk (15-25)	[25/04/2013 10:03:36 Ros Taylor] > Using mental health transformation programme to engage local authority in solutions which maintain quality and enable statutory organisations to live within resources. >Participation in transformation programmes at system level to deliver improvements - for example Greater Huddersfield and Calderdale transformation programme has developed financial baseline which recognises commissioner and provider financial pressures and targets for the system including the local authorities. > Creating opportunities to reduce reliance on statutory sector through support to third sector providers e.g.through Creative Minds Strategy and Innovation Fund investment. > Development of ImROC implementation plan in parternship with service users to promote recovery e.g. Moorland Court development in Barnsley. [23/10/2012 10:36:51 Ros Taylor] Joint assessment of potential impact of LA partners through governance boards. Support to third sector providers through Creative Minds Strategy and Innovation Fund investment. BDU review of governance board position. Regular review with LA leads to monitor impact of changes. Annual plans and CIPs have been developed and agreed in context of CSR for 2012/13. Senior level dialogue with key local authority leaders to gather intelligence on likely		District Service Directors	Big ticket vision and plan in place by end of August 2013. System transformation programmes milestones in 2013-14	EMT (monthly) and Trust Board (monthly)	12	Amber/ high (8-12)	Yes		Monthly at EMT and Trust Board 22 October 2013

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462	N/A	Risk Assessment	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			Risk that the expectations of emerging CCGs for mental health and community services will create a potential reputational and financial risk for the Trust.	> Clear accountability at BDU level for managing stakeholder relationships with support from Quality academy Directors through professional networks. >Agreed joint governance arrangements for management of service contracts > Review of contract and stakeholder issues monthly through EMT > Regular review by Board of effectiveness of stakeholder management.	5 Catastrophic	4 Likely	20	Red/extreme /SUI risk (15-25)	> Contract terms agreed for 5 out of 8 commissioners. Three outstaning issues which there are proposals being considered for resolution. > Using contract and quality Board meetings to forge relationships and better understanding with commissioners > Development of team to team meetings to strengthen partnership working >Development of marketing strategy to ensure good communication and understanding of service offer.		District Service Directors supported by CEO and quality academy directors		EMT (monthly) and Trust Board (quarterly)	16	Red/extreme /SUI risk (15-25)	Yes		Monthly at EMT and Trust Board 22 October 2013
463		Risk Assessment	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			Risk that the planning and implementation of transformational change through the Big Ticket programmes will increase clincial and reputational risk in in year delivery by imbalance of staff skills and capacity between the "day job" and the "change job". Areas rated as red (Trust Board july 2013) currently are identified as adult mental health services, community mental health services and older people's services under the mental health strand; and the general community services strand. Mitigating action is in place to ensure the first key milestone of the end of August for an outline of the vision, implementation plan, timescales and key milestones.	> Scrutiny of performance dashboards and weekly risk reports by BDU s and EMT to ensure performance issues are picked up early. >Weekly risk review by Director of Nursing and Medical Director to ensure any emerging clinical risks are identified and mitigated. >Monthly performance review by Board > Clear accountability arrangements for leadership and milestones for the transformation programme which are monitored by Director of Service Development and EMT. >Engagement of extended EMT in managing and shaping transformational change and delivering in year performance.	5 Catastrophic	4 Likely	20	Red/extreme /SUI risk (15-25)	> Additional resouces and external consultancy recruited to support the transformation programme. > Key deliverables reviewed and monitored by EMT.	£500,000	Leads for Big ticket programmes Director of Service Improvement/ EMT - in year performance	Big ticket vision and plan in place by end of August 2013. System transformation programmes milestones in 2013-14	EMT (monthly) and Trust Board (quarterly)	16	Red/extreme /SUI risk (15-25)	Yes		Monthly at EMT and Trust Board 22 October 2013
464	N/A	Risk Assessment	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			Risk that the Trust does not have a clear marketing approach to enable it to maximise opportunities and mitigate threats in an increasingly competitive market.	>Develop a clear marketing and commercial approach within the organisation, building on existing arrangements. > Marketing approach reviewed and approved by Board and EMT	5 Catastrophic	3 Possible	15	Red/extreme /SUI risk (15-25)	> Enagement of specialist resource to shape marketing strategy > Reports to Board April and September 2013 >Implementation plan in 2013-14 >Key intelligence and actions reflected in Monitor Plan (May 2013) IBP (October 2013). Branding policy agreed by EMT October 2013. CRM system specification and procurement November 2013 to March 2014	£100,000	CEO lead & EMT	First draft Monitor Plan May 2013 Implementation plan qtr one 2013 Updated version stategy in IBP Oct 2013	Monthly strategic and business and risk EMT meetings. Trust Board reports as appropriate.	12	Amber/ high (8-12)	Yes		Monthly at EMT and Trust Board 22 October 2013
465	N/A	Risk Assessment	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			Changes to national funding arrangements i.e. CCG allocation , creation of Integration Fund and local initiatives e.g.revenue consequences of the Mid Yorks reconfigeration and local re tendering will increase the risk that in 2014-15 contracting round the monies prioritised by commissioners for SWYPFT services will be increase the elvel of savings required to > 5.5 % to maintain financial viability.	>Develop a clear service strategy through the internal Transformation Programmes to engage commissioners and service users on the value of services delivered. > Ensure appropriate SWYPFT participation in system tramsformation programmes. >Robust process of stakeholder engagement and management in place through EMT > Progress on Transformation reviewed by Board and EMT	5 Catastrophic	3 Possible	15	Red/extreme /SUI risk (15-25)	> Enagement of specialist resource to ensure transformation work capacity in place. > EMT review of commissioer intentions and contract management >Key intelligence and actions reflected in Monitor Plan (May 2013) IBP (October 2013).	£100,000	Deputy CEO lead & Directors	First draft Monitor Plan May 2013 Implementation plan qtr one 2013 Updated version stategy in IBP Oct 2013	Monthly strategic and business and risk EMT meetings. Trust Board reports as appropriate. Business case for RAID approved by C & K commissioner. Wakefield case submitted.	12	Amber/ high (8-12)	Yes		Monthly at EMT and Trust Board 22 October 2013
466	N/A	Risk Assessment	Corporate/ organisation level risk (corporate use only EMT)	Barnsley BDU	General community services		Commissioning intentions of Barnsley CCG may lead to loss of contract for intermediate care and memory services representing a risk to the Trust's reputation, provision of a full pathway to service users and income/contribution.	Trust is working with commissioners to revise the service specification. Trust is reviewing organisational arrangements for intermediate care to more closely align to district nurses and community matrons to ensure integration in pathways. Trust is working with Barnsley CCG to develop transformation programmes jointly.	4 Major	3 Possible	12	Amber/ high (8-12)	Agreement reached with commissioners to roll-over contract at end of March 2014. Trust will continue to work with commissioners on a revised service specification. As part of its transformation of general community services, intermediate care will be more closely align to district nurses and community matrons to ensure integration in service pathways. The Trust will continue to work with Barnsley CCG both to develop transformation programmes jointly and to ensure the Trust's own transformation programme meets commissioner needs and specification.	£5/6 million	District Service Director, Barnsley and Wakefield	Sep-14	Monthly strategic and business and risk EMT meetings. Trust Board reports as appropriate. Monitoring of transformation programme progress.	12	Amber/ high (8-12)	Yes		Bi-monthly at EMT