With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board (public session)
Tuesday 17 December 2013 at 13:45
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 22 October 2013

4. Assurance from Trust Board Committees
- 4.1 Audit Committee 18 October 2013
- 4.2 Clinical Governance and Clinical Safety Committee 3 December 2013
- 4.3 Mental Health Act Committee 5 November 2013
- 4.4 Remuneration and Terms of Service Committee 15 October 2013

5. Chief Executive's report

6. Performance reports month 8 2013/14

6.1 Section 1 – Performance report month 8 2013/14

6.2 Section 2 – Finance report month 8 2013/14

6.3 Section 3 – Exception reporting and action plans
- (i) Quality Governance Framework
- (ii) Health and safety annual report 2012/13
- (iii) Corporate governance internal audit report

7. Developing the Estates Strategy
- 7.1 P21+ - appointment of partner organisation

8. Strategies and policies

8.1 Risk management strategy
8.2 Customer services policy
8.3 Treasury management policy
8.4 Declaration of interests policy (Trust Board)

9. Use of Trust seal

10. Date and time of next meeting

The next meeting of Trust Board will be held on Tuesday 28 January 2014 in the small conference room, Learning and Development Centre, Fieldhead, Wakefield, WF1 3SP.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Minutes of Trust Board meeting held on 22 October 2013

Present:	Ian Black	Chair
	Peter Aspinall	Non-Executive Director
	Bernard Fee	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
	Sean Rayner	District Service Director, Barnsley and Wakefield
	Bernie Cherriman-Sykes	Board Secretary (author)
Apologies:	Dawn Stephenson	Director of Corporate Development
	Karen Taylor	District Service Director, Calderdale and Kirklees
Guests:	Penny Fairmann	Otsuka Pharmaceuticals
	Bronwyn Gill	Head of Communications
	Michael Smith	Members' Council (public, Calderdale)

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TB/13/55 Welcome, introduction and apologies (agenda item 1)

The Chair (IB) welcomed everyone to the meeting. The apologies, as above, were noted. He began the meeting by referring to the Annual Members' Meeting held the previous day, which had been a good meeting and well attended. He particularly liked the showcase for services. He brought three items to the attention of Trust Board.

1. The Trust's perception of the level of engagement is not always that of others. He accepted that the Trust needs to do more and to go out to people and groups to gain their views.
2. The impact on individuals of the configuration of services, particularly in-patient beds in Huddersfield.
3. The public sees the NHS as one organisation. The Trust will suggest to partners that they take the opportunity to talk to individuals who raise questions. Differences in who does what within the NHS are not relevant to the public.

Trust Board provided good feedback on the event although Julie Fox (JF) commented that the Trust comes across as being white and male and the Trust should, therefore, think carefully about how the organisation is portrayed.

TB/13/56 Declaration of interests (agenda item 2)

Trust Board considered the following additional declaration.

Name	Declaration
Directors	
Karen Taylor	Trustee, Barnsley Hospice

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

TB/13/57 Minutes of and matters arising from the Trust Board meeting held on 24 September 2013 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held on 24 September 2013 as a true and accurate record of the meeting, subject to one item of clarification in relation to JF's comment that she would like to see the Trust's approach to individuals with multiple issues, both physical and mental health, more prominently in the Quality Improvement Strategy.

There were two matters arising.

TB/13/49 Care Quality Commission (CQC) visit to the Dales The Trust has received a draft report on the visit to the Dales in the summer for factual accuracy checking. The unit was found to be fully compliant. No report has yet been received for the visits to the other sites. IB asked for Trust Board to be informed as soon as the reports are received and Tim Breedon (TB) agreed to do so by email.

TB/13/51a Supporting service users into employment This will be discussed by the Executive Management Team (EMT) and then reported to the Clinical Governance and Clinical Safety Committee. It was suggested to also include developments around social enterprise, use of local organisations and development of Creative Minds initiatives, particularly those that employ service users. Alan Davis (AGD) added that the introduction of Peer Support Workers will support the Trust's approach to service user employment. IB asked for an update to Trust Board following discussion at EMT.

TB/13/58 Performance reports month 6 2013/14 (agenda item 4)

TB/13/58a Quality performance report (item 4.1)
TB highlighted the following areas.

- There has been national media interest in bed management following recent publicity about the reduction in beds for mental health patients. The Trust continues to monitor its position closely and the review of the Trust-wide protocol has been brought forward to review the impact on services, which will take the form of a learning event. Bed pressures continue although the protocol is operating well to make the best and most efficient use of beds. The review of the protocol will also inform the Trust's approach to the acute care pathway within the transformation programme.
- Themes from complaints are shared with Business Delivery Unit (BDU) Directors and reviewed monthly by TB and Dawn Stephenson (DS). Key issues relate to care and treatment, often related to communications between the Trust, service users and their carers. Reviews of complaints are undertaken at BDU and Trust-wide level.
- The 14-day access target remains an issue and is a key focus for EMT.
- In relation to care planning, visits to other Trusts have taken place to look at best practice. The role of the CPA Co-ordinator will be reinforced.
- Data recording remains an issue and is a focus for EMT.
- A Clinical Reference Group has been established to review and evaluate serious incidents.
- There has been an increase in reports under Eliminating Mixed Sex Accommodation although no breaches have occurred. This will form part of the review of the bed management protocol.
- A plan will be developed from the Quality Improvement Strategy for individual BDUs and cross-Trust. This will form the basis of the quality performance report in future.

The Chief Executive (SM) commented on the acute care pathway. He would find it particularly helpful to focus on this area given the pressure on beds currently. Alex Farrell

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(AF) commented that admissions are not increasing, an increasing number of people are placed out-of-area and pressures are not universal across the Trust. As a result, EMT has asked for a further review of the issues to understand where the problems are. The issue will also be considered at the Clinical Governance and Clinical Safety Committee and at the learning event to inform the bed management protocol review.

JF commented that the Trust needs to be clear where out-of-area placements are for clinical or medical reasons and where they are due to bed pressures. SM added that there will also be a review of the function of the crisis and intensive home-based treatment teams as part of the transformation of mental health services.

Bernard Fee (BF) commented that Trusts nationally have been encouraged by Monitor to reduce their bed base, therefore, it should come as no surprise that this has resulted in increased bed pressures. Helen Wollaston (HW) added that there was also a danger of individuals being sectioned in order to access a bed. AF responded that there was no evidence that this is the case in this Trust.

The patient experience report will be presented to Trust Board in December. IB asked that this includes information on care plans, the perception of service users in relation to whether they have one, and what the Trust is doing to address perceptions.

Lastly, BF asked why there was a drop in the number of urgent referrals between quarters. AF responded that there had been a review by EMT of themes within BDUs (which are different in each BDU) and management action is in place.

TB/13/58b Finance report month 6 2013/14 (item 4.2)
AF highlighted the following.

- The income and expenditure position is on an improvement trajectory although cost pressures through out-of-area placements and underspend due to vacancies remain.
- In relation to the cost improvement programme, £200,000 remains to be found. The Trust will meet its target through non-recurrent savings and this will be managed recurrently in 2014/15.
- The report includes an analysis of benchmarking against other mental health trusts in relation to the Monitor financial risk rating.
- There is an underspend on the capital programme, which is more than the threshold set by Monitor. The Trust will provide a rationale for the underspend and assurance on plans to meet the capital plan in its quarterly report to Monitor.

The Chair invited comments from Trust Board.

- BF commented that the Trust has a £1 million surplus above plan but is forecasting to achieve its target surplus. AF responded that this is due to recruiting to a number of vacancies, additional investment in in-patient areas, and spend on telehealth procurement. Provisions are also mainly 'back ended' to the last six months of the year and, therefore, £1 million will be invested in the next six months.
- Peter Aspinall (PA) commented that the Trust is £1 million short on its cost improvement programme and asked where this will come from. AF responded that page 7 of the report contains an analysis of the current delivery, which shows a £500,000 shortfall. Mitigation will be found within BDUs and support services not through provisions. Sean Rayner (SR) added that it is clear that management of the cost improvement programme sits with BDU Directors and it is for BDUs to identify where shortfalls will be found. AF confirmed that under/overspend by BDUs is outside of the cost improvement programme performance.

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- IB asked how confident the Trust is that it can start to spend money on appropriate projects to achieve the required capital spend. AGD responded that well tested plans are in place to realise the plan and he is confident that the plan will be delivered. Subject to Trust Board approval of larger schemes, the £8.9 million should be spent. IB also asked how confident the Trust is that it has the capacity and capability to deliver the schemes. AGD responded that there will be a more balanced profile across the organisation for capital schemes rather than the traditional 'back ending' and work on profiling has begun with finance.
- SM added that much clearer service visions and models linked to the integrated business plan with a much clearer statement of intent will inform estate and capital spend. BF commented that it is also important that the Trust invests in 'spend to save' initiatives to achieve cost improvements and efficiencies in the future.
- PA commented on the release of provisions of £1.29 million on page 5 of the report and the reduction in income of £2.27 million. He asked if the two were related. AF responded that £600,000 of provision against CQUIN risk has been released following a further assessment of the income derived from CQUINs. PA asked that Trust Board is aware that it appears that the Trust is subsidising income shortfall through provisions, which is unsustainable.

Nisreen Booya joined the meeting at this point.

TB/13/58c Strategic human resources report (item 4.3)
The report was considered in detail at the Remuneration and Terms of Service Committee on 15 October 2013.

JF offered congratulations to the Trust for reducing the sickness figures. Figures for Calderdale show what is achievable and Trust Board should recognise this achievement. Adrian Berry (ABe) commented that the difference between low and medium secure services demonstrates the time lag to put effective management action in place to reduce sickness. This is now in place in low secure services and should begin to mirror progress in medium secure. SR commented that there are understandable issues in relation to some areas in Wakefield and management action is in place.

PA asked whether the Trust was too generous in its approach given the frustration of operational managers in relation to processes and policies to manage absence and the promotion of wellbeing practices. AGD responded that the Trust has to balance a cultural management shift of attitudes towards and toleration of sickness absence and supporting staff in terms of wellbeing. The Trust's approach is more generous than the private sector; however, if sickness does not continue to reduce, the Trust may have to take a more draconian view. Staff side is supportive of the Trust's approach.

BF commented that, in his view, the variations remain too big. He asked what Calderdale was doing that other BDUs were not. HW asked if there was a correlation between the increase in the span of responsibility for BDU Directors and the rise in the Barnsley BDU sickness rate. SR responded that there has been a rise in long-term sickness absence in Barnsley, which has not been there previously. Therefore, Trust Board needs to look at each BDU separately. He was disappointed at the Barnsley position but the reasons were genuine cases of absence. AGD added that, when Directors drill down and look at hotspots, the percentages involve very small numbers. He did, however, agree to additionally report figures without long-term absence to a future meeting.

TB/13/58d Exception reports and action plans – Serious incidents Q2 2013/14 (item 4.4(i))
TB highlighted three areas in relation to changes in the reporting framework and the reduction in reporting timescales from 60 to 45 days. The Clinical Governance and Clinical

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Safety Committee will receive a report at its meeting on 3 December 2013 on the analysis of pressure sores incidents.

It was RESOLVED to NOTE the report.

TB/13/58e Exception reports and action plans – Working capital facility (item 4.4(ii))
PA reported on the discussion at the Audit Committee on 18 October 2013. The Committee was assured that the downside scenario could be managed through capital expenditure reduction should the need arise. It was noted that ending the facility should save the Trust £30,000 per annum.

It was RESOLVED to APPROVE the recommendation from the Audit Committee to cease the Trust's working capital facility from October 2013.

TB/13/58f Exception reports and action plans – Patient-led assessment of the care environment (PLACE) (item 4.4(iii))
Jonathan Jones (JJ) asked if there was any provision in the capital programme to address the issues identified in the PLACE visits. AGD responded that there is a sum of money identified in the main budget to address issues raised in 2013/14. SM added that this was also linked to the transformation agenda and Trust plans for rehabilitation and recovery units, which will see an emphasis placed on the provision of a home address for individuals rather than wards in the community. JJ commented that, if this was the case, he reiterated his comment made at the last Trust Board meeting that the Trust should get on with this sort of investment as a matter of urgency.

HW commented on the visit to Ward 19 at the Priestley Unit in Dewsbury. A number of areas of concern were identified regarding the environment, which have not been addressed. AGD confirmed that a more detailed review of the issues and concerns on Ward 19 has been requested. However, both BF and HW had continuing concerns given the feedback from staff on the ward. IB asked that an update is provided under matters arising at the next meeting.

IB also commented that he would like to see a budget set aside to address small issues identified by visit teams. He would not want money to be the reason for not addressing small concerns. JF commented that there is a perception that staff do report issues around environment but, when issues are not addressed, no longer pursue them. ABe commented that this was not his experience in forensic services. AF added that this is also an issue of ownership and the challenge is to ensure and encourage ownership at team and ward level. BF also commented that this is part of the culture and the Trust should ensure that staff are able to influence their own environment.

It was RESOLVED to NOTE the PLACE scores.

TB/13/59 Governance issues (agenda item 5)

TB/13/59a Monitor Risk Assessment Framework (agenda item 5.1)
AF introduced this item and commented that it is intended to keep an overview of the Trust position as Licensing conditions become clearer and the impact of these can be assessed, particularly around commissioner requested services and the risk pooling arrangements.

It was RESOLVED to NOTE the introduction of the Risk Assessment Framework and the risk assessment undertaken.

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TB/13/59b Changes to the Trust's Constitution (agenda item 5.2)

Nisreen Booya (NHB) expressed her thanks to governors on the Members' Council who hold Trust Board to account and provide effective challenge. She commented that three terms would enable governors to build personal relationships and so become a little too 'cosy' with Trust Board. She also commented that service users have little voice and this should come through the Members' Council. She would worry that a longer overall term of office would preclude this. She would prefer to see the process opened up to service users and carers to represent their interests through challenge and the role of a critical friend.

HW added that she shared these concerns and asked whether it is common to allow a third term. AF responded that governors need time to build knowledge and expertise to provide appropriate and effective challenge and a longer term could provide this. The challenge to the Members' Council is how they assure themselves that they represent the public and engage with communities to ensure all 'voices' are represented.

JJ was supportive of the option to extend the term of office given his own experience that it has taken the first three-year term to get to know the complexity of the Trust. To feel that an individual is making a contribution, that individual needs to understand the Trust and the issues it faces. It would, therefore, be a loss to the Trust if governors went at a time when they become most effective.

PA agreed with NHB's challenge and suggested that the Trust should acknowledge that there are certain skills and experience needed to be an effective governor.

IB invited Michael Smith, Chair of the Members' Council Co-ordination Group and publicly elected governor for Calderdale, to comment. He concurred that it takes time for a governor to be effective and he would be supportive of the option of a third term.

IB concluded by saying that the third term was not intended as a standard term of office although he would not want the Constitution to be prescriptive with only a certain number allowed to serve such a term.

ABe supported the larger footprint as services provided by the Trust cover a wider area than Barnsley, Calderdale, Kirklees and Wakefield. BF added that the Trust is currently looking at a smaller pool for no reason, particularly as other Trusts are doing this already. HW was also supportive of the extension to the footprint.

It was RESOLVED 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 eligibility for re-election from three to six years; and**
- **as a consequence, APPROVE the necessary changes to the Trust's Constitution.**

The proposals will also be considered by the Members' Council at its meeting the following day.

TB/13/59c Members' Council evaluation (agenda item 5.3)

It was RESOLVED to NOTE the outcome of the Members' Council evaluation session.

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TB/13/60 Trust Board self-certification – Monitor quarter 2 return 2013/14 (agenda item 6)

AF confirmed that the exception report would include additional information following the Audit Committee on Friday regarding the audit report on procurement (non-pay purchasing), which was given a 'no assurance' opinion. She will contact Monitor before submission of the quarter 2 return.

JJ asked how the report would affect the report to Monitor. AF responded that it will be taken seriously by Monitor; however, Monitor will be more concerned about what action the Trust is going to take. PA commented that the 'no assurance' finding may have implications for the Head of Internal Audit Opinion and the Annual Governance Statement if the Trust cannot demonstrate progress against the action plan to address the recommendations. AF added that of most importance is external and internal audit assurance regarding actions, how effective they are, how KPMG can give the assurance the Audit Committee needs that the Trust is addressing the recommendations, and can provide substantial assurance in the Head of Internal Audit Opinion at the year-end.

IB suggested that PA and AF contact Monitor together to demonstrate Non-Executive Director and Audit Committee involvement.

SM commented that, in terms of comparison, the Trust's current organisational form makes it difficult to compare and benchmark against other Trusts and, therefore, there is more work to be done in terms of benchmarking.

It was RESOLVED to APPROVE the exception report to Monitor and the ongoing compliance with the Trust Board self-certification requirements.

TB/13/61 Assurance Framework and organisational risk register quarter 2 return 2013/14 (agenda item 7)

SM commented that the Assurance Framework continues to provide a good tool for use in Directors' quarterly reviews.

HW suggested adding a risk in relation to bed management and bed pressures and this was supported. SM suggested this should be extended to management of the acute care pathway. JJ also suggested the addition of the 'no assurance' internal audit report, which was also supported. It was also agreed to provide a summary of the changes within the quarter in the summary front sheet.

It was RESOLVED to:

- **NOTE the assurances provided for quarter 2 of 2013/14;**
- **NOTE those areas where gaps in assurance have been identified;**
- **NOTE the key risks for the organisation; and**
- **INCLUDE the two additional risks identified around the acute care pathway and the 'no assurance' internal audit report.**

TB/13/62 Date and time of next meeting (agenda item 8)

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.

Signed …… Date ……

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Minutes of Audit Committee held on 18 October 2013

Present:	Peter Aspinall	Chair of the Committee
	Bernard Fee	Non-Executive Director
	Jonathan Jones	Non-Executive Director
Apologies:	Members	
	None	
	Others	
	Tim Cutler	Head of Internal Audit, KPMG
	Dawn Stephenson	Director of Corporate Development
In attendance:	Robert Adamson	Head of Finance
	Bernie Cherriman-Sykes	Integrated Governance Manager (author)
	Jon Cohen	Assistant Manager, Counter Fraud, KPMG
	Tony Cooper	Head of Procurement
	Alex Farrell	Deputy Chief Executive/Director of Finance
	Richard Ford	Interim Deputy Director of Finance
	Paul Hewitson	Senior Audit Manager, Deloitte
	Clare Partridge	Senior Manager, KPMG
	Michael Smith	Publicly elected Governor, Calderdale
	Paul Thomson	Partner, Deloitte
	Salma Younis	Manager, KPMG

AC/13/61 Welcome, introduction and apologies (agenda item 1)
The Chair of the Committee (PA) welcomed everyone to the meeting. The apologies were noted.

AC/13/62 Minutes and matters arising from the meeting held on 9 July 2013 (agenda item 2)
It was RESOLVED to APPROVE the minutes of the Audit Committee held on 9 July 2013 as a true and accurate record of the meeting. There were five matters arising.

AC/13/26 Internal audit progress report (clinical audit) (page 2)
Alex Farrell (AF) has agreed with Tim Breedon (TB), as lead Director, that learning lessons from clinical audits to foster a culture of continuous improvement and using clinical audit to improve services will be part of the Quality Improvement Strategy. An update on how this will be built into the process will come to the Committee in January 2014.

Action: Tim Breedon

AC/13/45 Transforming Community Services (page 2)
A further paper that links services that transferred under TCS to the community services transformation workstream will be presented to the Committee in January 2014 from the perspective of what transferred, how it will change, savings and synergies.

Action: Alex Farrell/Dawn Stephenson

AC/13/49 Reference costs (page 4)
AF confirmed that reference costs have not yet been published nationally, therefore, no benchmarking information is available. She will bring back to the January meeting.

Action: Alex Farrell

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AC/13/52 Audit Committee self-assessment

In terms of Audit Committee training, Paul Thomson (PT) suggested that this should focus on areas of need or take an in-depth look at one particular area. Deloitte would be happy to facilitate a joint session with KPMG. Clare Partridge (CP) commented that KPMG facilitates an ongoing programme for Audit Committee members and she would be happy to take suggestions on areas that would be of value. Bernard Fee (BF) commented that he would have found a session on the role of a Non-Executive (who is not an accountant and with little experience of Audit Committees) and the approach to adopt very helpful on joining the Committee. It was suggested that information/training sessions could be held prior to formal Committee meetings for members of the Committee and this will be discussed further with the Chair of the Committee.

Action: Peter Aspinall

AC/13/57 Procurement report

The Standards of Procurement will be circulated following the meeting.

Action: Tony Cooper

AC/13/63 Creative Minds – governance and assurance arrangements (agenda item 3)

AF confirmed that the Trust's position is to retain Creative Minds within the Trust in order to continue its development and as it represents a key USP for the organisation. It will retain its charitable funds status and link to the recovery college work as part of the transformation programme. Further development of Creative Minds may enable it to become a stand-alone body at some point in the future. AF will feedback to Trust Board on 22 October 2013 through the Investment Appraisal Framework item.

Action: Alex Farrell

PA asked whether the Trust would provide funding prior to goods or services being received. Tony Cooper (TCo) responded that, as Trust support and contribution is based on the principle of matched funding, it would. The process is managed through the Creative Minds team and he assured the Committee that the Trust does turn down requests for funding if it is not satisfied or assured regarding the governance arrangements or financial standing of a body/organisation.

PA asked how the Committee could be assured. AF responded that a financial report is produced. This could be circulated to members and an exception report brought to the Committee if this was thought appropriate. However, the nature of innovation means that there is an inherent risk of failure for some projects and the Trust has to accept this as part of running a creative and innovative programme.

BF commented that he was more concerned about the organisational form and, therefore, the financial reporting from a clinical perspective, particularly with regard to success and failure of particular schemes. AF responded that a steering board, chaired by the Chief Executive (SM), manages Creative Minds and ensures fit with the direction of travel for services and everyday service delivery. The Trust is also looking at a methodology to assess social return on capital.

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Jonathan Jones (JJ) asked how the Members' Council could be involved and how the Trust ensures governor participation. AF agreed to take this back to SM as Chair of the steering board. The Committee saw involvement of the Members' Council as an excellent idea.

Action: Alex Farrell

It was also agreed, in principle, to bring an annual report to the Committee (as with the Innovation Fund), which would include an evaluation of specific projects and an assessment of risk. AF will discuss with Dawn Stephenson (DS).

Action: Alex Farrell/Dawn Stephenson

AC/13/64 Treasury management update and working capital facility (agenda item 4)

PA asked about the worst case scenario and the consequences for the Trust. AF explained that the Trust's downside scenario is a loss of income and a reduced cash balance. Mitigating action would focus on reducing expenditure and reducing capital expenditure. Not having a working capital facility, therefore, would not present a big risk as it is not part of the mitigating action the Trust would take. The bigger risk is around income and expenditure. If the Trust agreed to spend large amounts of capital, it would put pressure on working capital; however, working capital is currently well managed, capital spend is under the control of the Trust and would be considered in the Trust's forward capital plan. The Executive Management Team, therefore, considers that the very worst downside plan scenario can be managed through capital expenditure reduction, should the need arise. **It was RESOLVED to make a recommendation to Trust Board that the Trust ceases its working capital facility from October 2013.**

Action: Peter Aspinall

AC/13/65 Changes to the Trust's accounting policies (agenda item 5)

Rob Adamson (RA) confirmed there were no major risks or changes to presentation as a result of the changes to the Trust's accounting policies arising from Monitor guidance. Paul Hewitson (PH) confirmed Deloitte support for the proposed changes. Deloitte will also clarify what it expects in terms of accounts presentation when Monitor's annual reporting manual is published. **It was RESOLVED to APPROVE the changes to the Trust's accounting policies.**

AC/13/66 Wakefield Council internal audit of mental health joint working arrangements (agenda item 6)

AF commented that this was a very positive report and she will follow up management action agreed as part of the audit to ensure it is approved and owned internally at the right level.

Action: Alex Farrell

As integrated working and information sharing is becoming increasingly important, the Committee suggested it would be timely to consider a proactive review as part of the internal audit plan for 2014/15.

Action: KPMG/Alex Farrell

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AF also agreed to ask BDU Directors to follow up with other local authorities whether there are similar audit reports of joint arrangements.

Action: Alex Farrell

AC/13/67 Service line reporting, currency development and reference costs (agenda item 7)

Richard Ford (RF) took the Committee through the paper. AF confirmed that the overarching payment by results (PbR) plan had been sent to Deloitte following a recommendation from the value for money review at the year-end 2012/13.

In terms of service line management, a key concern for the Committee is how the Trust will be assured it is embedded. Service line reporting has been used to form the baseline for the transformation programme. PA questioned the gap between development and use. In his view, the finance team has done all that it has been asked to do to develop service line management. What appears to be missing is ownership and use by BDUs. AF responded that the report highlights a number of issues, particularly around use of data, forming conclusions from such data, and translating data and figures into what actually happens within services. The data currently includes direct and absorbed costs and, therefore, it is difficult for services to see what costs they can control. This will be resolved in the continued development of the system.

BF commented that, in his view, this is more of a cultural/behavioural issue in terms of services using and applying the data operationally. AF responded that introduction of service line management is challenging for staff and the transformation agenda is a way of bringing it into use to explain the 'as is' position in readiness for the future position. BF added that there does not seem to be any evidence of staff questioning the figures or challenging the data. AF responded that, again, it will be part of the transformation programme to present services with baseline data; however, she reiterated that this is challenging for staff. BF remained of the view that managers should be motivated in wanting and using the information as a tool to improve services.

PA asked, again, how the Committee can be assured the information is embedded and being used within the Trust. CP agreed to include in the objectives for the audit of the transformation programme scheduled for December 2013 with a verbal report to the January 2014 meeting.

Action: KPMG

AC/13/68 Triangulation of risk, performance and governance (agenda item 8)

BF questioned whether the risk register reflects all risks, particularly those raised at the Non-Executive Directors' briefing on the Integrated Business Plan earlier in the week. PA added that the document must be current. AF noted the comments.

AC/13/69 Internal audit progress report (agenda item 9)

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

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- three reports on corporate governance, payroll and estates strategy management received substantial assurance with low level recommendations;
- one report on service level agreement (SLA) management (non-healthcare) received limited assurance; and
- one report on procurement (non-pay purchasing) received no assurance.

Procurement (non-pay purchasing)

KPMG was asked by the Trust to undertake a follow up review into the potential breach of standing financial instructions (SFIs). The audit concluded that, given the specific instructions in the SFIs and the responsibility of operational managers to ensure that SFIs are implemented, there was a breach of SFIs in relation to goods receipting and Creditor Payment controls; however, there was no evidence to suggest that there was, at any time, intent to deceive or defraud the Trust. The practice could, however, leave the Trust open to the risk of fraud and a significantly weakened audit trail should fraud take place. KPMG then reviewed the issues underlying the breach of SFIs and made four high and two medium priority recommendations in relation to processes and procedures, communications and culture.

RF took the Committee through the management response and outlined the action taken as a result of the audit recommendations to end practice within the Trust contrary to the SFIs.

BF questioned the role and functions of supervisors and managers in the process. RF responded that practices represented custom and practice rather than any fraudulent intent. AF added that it also demonstrated the degree of silo working and lack of solution-focussed approach, two key areas for cultural change as a result of this audit. Some individuals also need to take professional responsibility and status seriously. Using the issue of which version of Agresso was available to staff, BF commented that it was surely management responsibility to be aware of the difficulties and shortcomings of the system and to take management action to resolve these. TCo assured the Committee that lessons have been learnt, the recommendations have been addressed and such a situation would not occur again.

The Recommendation Tracker Report was noted. The Committee noted that 50% of the actions for which there was an expectation of completion have not been. BF asked for the Trust's view and PA asked what the Executive Management Team's (EMT) position was on this. AF responded that EMT receives a report in advance of the Audit Committee and she expects the position to be addressed.

AF confirmed that management's view is that the non-completion rate is higher than it should be. She highlighted a change in the follow-up process and the evidence required by KPMG has changed what is expected of Trust staff. When accepting recommendations and agreeing timescales, Directors need to consider and agree the evidence that will be provided to KPMG.

In relation to the audit of the change management programme, this was undertaken before SM took personal responsibility for the transformation programme and the assurance and management arrangements have changed completely. It was agreed

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to review the residual recommendations with KPMG in terms of changes to the management of the programme by December.

Action: Alex Farrell/KPMG

BF expressed a concern that the tracking process failed to pick up that someone is on sick leave and asked why, if this was escalated up the management chain, the recommendation still had not been addressed. This seems to indicate the process is not working.

The Committee also noted the technical update.

AC/13/70 Counter fraud progress report (agenda item 10)

Jon Cohen (JC) introduced this item and the report was noted. Feedback will be given to the Committee in January 2014 on the outcome of the NHS Protect focussed counter fraud assessment that will take place on 29 October 2013.

The Bribery Act risk assessment concluded that the Trust has comprehensive and up-to-date policies and procedures in place to govern appropriate business behaviour. Ten recommendations were made, of which three are high priority, and these will be taken forward by the appropriate Director lead.

AC/13/71 External audit update (agenda item 11)

PT provided a brief update on activity since the last meeting.

- A planning document will be presented to the January 2014 meeting.

  Action: Deloitte
- Monitor publication of the Quality Accounts guidance for 2013/14 has been delayed until January 2014, which will leave little time to formulate a plan; however, there is interim work Deloitte can do with the Trust to prepare.

AC/13/72 Procurement report (agenda item 12)

BF commented on the principle applied to some of the tenders reported in terms of organisational responsibility to promote services. AF responded that it would depend on what the Trust has been commissioned to provide as, in some instances, the Trust will be commissioned to promote services as well as provide them.

The report was noted.

AC/13/73 Losses and special payments report (agenda item 13)

The report was noted.

AC/13/74 Committee meeting dates for 2014 (agenda item 14)

The date of the next meeting is Tuesday 21 January 2014 at 14:00 in the Wainhouse room, 5th Floor, F Mill, Dean Clough, Halifax. Dates for the remainder of 2014 are:

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- Tuesday 8 April 2014 at 14:00 in training room 5, Learning and Development Centre, Fieldhead, Wakefield;
- Tuesday 8 July 2014 at 14:00 (venue TBA); and
- Tuesday 7 October 2014 at 14:00 in the boardroom, Kendray Hospital, Barnsley.

There will also be a meeting late in May to approve the annual report and accounts

AC/13/75 Any other business (agenda item 15)

No other business was raised.

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Minutes of Clinical Governance and Clinical Safety Committee held on 3 December 2013

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

CG/13/80 Welcome, introduction and apologies (agenda item 1)

The Chair, HW welcomed everyone to the meeting and the apology was noted.

CG/13/81 Minutes of the previous meeting held on 10 September 2013 (agenda item 2)

It was RESOLVED to APPROVE the minutes of the meeting held on 10 September 2013.

CG/13/82 Matters arising (agenda item 3)

There were five matters arising.

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

Tim Breedon (TB) reported that a revised job description has been developed for the Chief Pharmacist and this is likely to include a degree of re-structuring. A formal recruitment process will begin in January 2014. A key part of the role will be to lead the transformation and devolution of the pharmacy service. TB will provide a further update to the Committee in February 2014.

Action: Tim Breedon

CG/13/46 Winterbourne View action plan

The Committee noted that a process is in place to review the action plan. Further guidance received as part of the Green Light Toolkit will be incorporated into the plan and presented to the Committee in due course.

Action: Tim Breedon

AC/13/69 Update on upgrade of seclusion units (item 3.2)

Alan Davis (AGD) reported that a prioritised programme of work has been agreed around this complex agenda. The outcome of a clinical review of seclusion rooms was presented to the Executive Management Team (EMT) in October 2012 and a prioritised action plan developed as a result. This has been reviewed in light of the development of the Estates Strategy and re-prioritisation of the capital programme.

Currently, the upgrade to the room on Hepworth ward is incorporated into the capital scheme approved by Trust Board in October 2013. This work should be completed by the beginning of the 2014/15 financial year. A programme for all other areas has been agreed with

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services for this financial year with the exception of the Dales (as this has to be considered as part of the PFI arrangements) and Trinity, where a new seclusion unit will be built. It is expected that this will be completed in April/May 2014 and the Dales in June 2014. All work should, therefore, be completed by the end of June 2014 with the exception of Gaskell ward, which is currently being used as a decant facility for Hepworth. The seclusion room will, therefore, be upgraded during 2014/15.

The Director of Forensic Services is addressing a number of clinical issues to ensure the Trust meets Care Quality Commission (CQC) requirements although there are areas where the environment prevents compliance, such as the height of some ceilings. The Trust will identify the mitigating action it will put in place to address these issues. The comments made by Bernard Fee (BF) on the consequences of this approach were noted.

There has been a significant shift in the budget from £300,000 to an expected spend of £1 million, which is covered in the re-prioritised capital plan.

AC/13/70 Unannounced visits – community services
Karen Holland (KH) will provide an update at the next meeting.

Action: Karen Holland

AC/13/77 Staffing levels
An update on the report on staffing levels will be given to the Committee in February 2014 with a paper on the final position in April 2014.

Action: Tim Breedon

CG/13/83 Impact of cost improvement programme 2013/14 (agenda item 4)

The Committee noted the outcome of the quarter 2 review process. There were no major issues although TB commented that any issues were more likely to arise in quarters 3 and 4. Four areas were identified for improvement.

1. The Committee will be asked to give early consideration to the key lines of enquiry for 2014/15 (at the February 2014 meeting).
2. The process will be extended to ensure that all Directors, including Quality Academy, conduct quality impact assessments of cost improvements.
3. Business Delivery Units (BDUs) will determine the appropriate mechanisms to give direction and provide ongoing oversight/monitoring to the quality impact of a cost improvement.
4. The EMT will be encouraged to provide greater challenge on proposed cost improvements where there is insufficient information or analysis to come to a view of quality impact.

The Committee asked that the process does not become overly bureaucratic or complex or that it deflects from the achievement of cost improvements in services. BF commented that the process does provide support and assurance to the Committee; however, there is no indication of the scale of each cost improvement in the paper. TB agreed to ensure this is included in future presentations.

Action: Tim Breedon

BF also commented that he was still unsure how the cost improvement programme is made up across the Trust. TB thought this would become clearer when the process was applied to all areas, including the Quality Academy, and it will also be applied to the transformation programme for 2014/15. TB also confirmed that involvement of service users and carers will come through the patient experience work.

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CG/13/84 Quality Accounts 2013/14 (agenda item 5)

The key performance indicators against priority areas were noted. The update on the Deloitte action plan was also noted. A further review of reporting gatekept admissions by Deloitte indicates significant progress.

The concerns raised and suggestions made in relation to consultation with partners on their contributions were noted.

CG/13/85 Serious incidents quarterly report (agenda item 6)

TB took the Committee through the key points in the report. The analysis of pressure ulcer incidents was noted. A key concern for the Committee was how the Trust can prevent sores from occurring and, when they do occur, from deteriorating. The Committee was also concerned about the level of incidents so far this year although it was recognised that this was mainly due to the changes in reportable incidents.

In relation to the Local Government Ombudsman's report, HW asked what the process for learning lessons was, which TB agreed to clarify. Further scrutiny was suggested in the Mental Health Act Committee.

Action: Tim Breedon/Dawn Stephenson

CG/13/86 Health and safety annual report 2012/13 and annual plan 2013/14 (agenda item 7)

AGD introduced the report and made the following comments.

- The focus of the report is on the robustness of integrated systems, common across the Trust supported by a comprehensive health and safety audit.
- Health and safety links to other areas, such as managing aggression and violence, which are subject to different Director leads and governance arrangements. The report highlights links between specialist advisers.
- The report is intended as an executive summary, which may previously have omitted some key information.

A key concern for the Committee is to ensure that BDUs learn from each other and replicate good practice.

CG/13/87 Sub-groups (agenda item 8)

The following issues were highlighted.

- The Drugs and Therapeutic TAG held its annual awayday to review the Medicines Management Strategy, which will be presented to the Committee in due course.

  Action: Nisreen Booya
- The dip in take-up of infection prevention and control training was noted. Further work will be done to understand the reasons for this.

  Action: Tim Breedon
- There has been a significant increase in interest in the Trust's safeguarding arrangements during Serious Case Reviews. TB will review capacity to ensure the Trust is represented at the right level on Safeguarding Boards.

  Action: Tim Breedon
- The Committee noted the Trust's re-accreditation against the BILD standards.

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CG/13/88 Francis Report action plan (agenda item 9)

TB explained that the action plan was intended to demonstrate the seriousness with which the Trust is taking the Francis Report recommendations and the robustness of its response. Following publication by the Government of its response, 'Hard Truths', the Francis Values into Action Steering Group will particularly focus on staffing and duty of candour. There will be a further round of engagement events for staff in the new year. The Committee noted that the response to recommendations about Trust Boards and governors will be reviewed by Dawn Stephenson and action agreed.

The Committee supported the approach and was keen that this leads to a cultural change, is embedded and ensures staff live the values of the organisation.

CG/13/89 Quality Improvement Strategy (agenda item 10)

Five key areas are to be further discussed at EMT to support the Strategy:

- structure to support quality;
- identify the overarching quality framework;
- establish a quality forum;
- quality impact assessments; and
- use of appreciative inquiry.

The Strategy will be linked to the performance report and the suggestion to include key drivers, such as Francis, was noted.

CG/13/90 Unannounced visits programme update (agenda item 11)

KH will circulate a report on the themes and learning lessons to the Committee when it is available prior to presentation to Trust Board in January 2014 and detailed scrutiny at the Committee's meeting in February 2014.

Action: Karen Holland

When complete, the reports on each area will be sent to BDUs for action and liaison with estates.

CG/13/91 Trust approach to prone restraint (agenda item 12)

The report was noted. TB will meet with MIND to review the Trust's approach in January 2014 and feedback to the Committee in February 2014.

Action: Tim Breedon

CG/13/92 Information Governance Toolkit (agenda item 13)

The report was noted. TB provided assurance that the Trust will achieve level 2 by the end of March 2014.

CG/13/93 Care Quality Commission regulations compliance – self-assessment (agenda item 14)

The report was noted.

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CG/13/94 Discussion items (agenda item 15)

Children's services (item 15.1)

Sue Wing and Ann Brown presented to the Committee on children's services across the Trust. The Committee expressed concern at the level and scale of the risk inherent in children's services now provided by the Trust and agreed the need for an action plan to manage the risks. The Committee asked that this came back to the Committee for scrutiny.

Action; Tim Breedon (to raise with Karen Taylor)

The Committee also expressed a concern in relation to the inconsistencies of level and standards of service across the Trust and supported the recommendation for a new post of Assistant Director for children's services to provide leadership.

It was agreed these issues should be raised at Trust Board and the Committee will suggest it continues to scrutinise progress in more detail.

Action: Helen Wollaston

Trust position on bed pressures (item 15.2)

TB reported that bed pressures remain; however, there is a robust bed management protocol in place and the CQC has confirmed its support of the Trust's approach. An action plan will be developed following the bed management event.

The Committee asked for further information on how often, why and where the bed management protocol is used over a three-month period and the mitigating action put in place. The Committee asked that this includes the pressure on beds for emergency use by young people under 18. It was agreed this should also be presented to the Mental Health Act Committee as well.

Action: Tim Breedon

Cross-district position on safeguarding boards (item 15.3)

Taken under agenda item 8.

CG/13/95 Issues to bring to the attention of Trust Board (agenda item 16)

The Committee agreed the key issue in relation children's services.

CG/13/96 Meeting dates for 2014 (agenda item 17)

The meeting dates for 2014 were noted. The next meeting will be held on Tuesday 11 February 2014 at 14:00 in the Wainhouse meeting room, 5th floor, F Mill, Dean Clough, Halifax.

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

Present:	Julie Fox	Non-Executive Director (Chair)
	Helen Wollaston	Non-Executive Director
	Nisreen Booya	Medical Director
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Dawn Stephenson	Director of Corporate Development
In attendance:	Kyra Ayre	Acting Head of Service, Mental Health and Assessment and Care Management (Barnsley) – local authority representative
	Julie Carr	Mental Health Act/Mental Capacity Act Manager
	Yvonne French	Assistant Director, Legal Services
	Craig Limbert	AMHP Manager (Kirklees) – local authority representative
	Martin Mullen	Wakefield Council (for Paul Gillespie)
	Geoff Naylor	Independent Associate Hospital Manager
	Ian Priddey	Professional Lead and Development Co-ordinator (Mental Health) (Calderdale) – local authority representative
	James Todd	Consultant Psychiatrist, Newton Lodge
Apologies:	**Members**	
	Jonathan Jones	Non-Executive Director
	Attendees	
	Paul Gillespie	Workforce Development (Wakefield) – local authority representative
	Antonis Lakidis	Associate Specialist, Calderdale

MHAC/13/32 Welcome, introduction and apologies (agenda item 1)

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

MHAC/13/33 Compliance and Assurance Pathway Presentation (agenda item 2)

James Todd, Consultant Psychiatrist, Newton Lodge, presented on Tribunal and Hospital Managers' appeals.

MHAC/13/34 Legal update/horizon scanning (agenda item 3)

House of Commons Health Committee – post-legislative scrutiny of the Mental Health Act 2007

A number of recommendations were made by the Health Committee and the Department of Health has now published its response. JF asked that this is circulated to the Committee.

Action: Yvonne French

The Department, within its consultation on the Mental Health Act Code of Practice, intends to strengthen areas in the Code that relate to issues raised by the Health Committee. It was noted that changing from an opt-in approach to advocacy to opt-out would require a change in legislation and is, therefore, unlikely to be supported. However, there is potential for referral to advocacy services to be promoted in a different way through the Code of Practice. It is also likely that the duty for commissioners of advocacy services to commission sufficient provision will be strengthened.

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Helen Wollaston (HW) asked whether there were any areas the Trust can address proactively in advance of any guidance from the Department. Yvonne French (YF) agreed to review the recommendations.

Action: Yvonne French

The Department has also suggested that instances of detention to secure a bed should be reported to the organisation itself and potentially to the Care Quality Commission. This will link into the Trust's review of its own Bed Management Protocol during November 2013.

The action plan will be presented to the Committee at the next meeting and will also include recommendations in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards.

Action: Tim Breedon/Yvonne French

Prone restraint

The paper was noted by the Committee. A further report will be presented to the Clinical Governance and Clinical Safety Committee on the Trust's approach to eliminate usage and next steps.

Action: Tim Breedon

R (Zhang) vs. Whittington Hospital

The report was noted.

Community Care briefing – bed occupancy

The report was noted. Tim Breedon (TB) confirmed that pressure on beds has increased (and this is a national issue) and the capacity in the private/independent sector is reducing as more organisations pre-book bed capacity.

MHAC/13/35 Minutes from the previous meeting held on 6 August 2013 (agenda item 4)

It was RESOLVED to APPROVE the minutes from the meeting held on 6 August 2013.

MHAC/13/36 Matters arising from previous meeting (agenda item 5)

There were six matters arising.

MHAC/12/29a Advocacy Services

Dawn Stephenson (DS) provided feedback from dialogue groups on advocacy services.

MHAC/13/04 Ethnicity monitoring

TB confirmed that 'not known'/'not specified' are options available on RiO for recording of ethnicity. Some consideration is needed, therefore, of whether there should be one or the other as options as it is not always appropriate to ascertain ethnicity on admission. He confirmed that recording of ethnicity is mandatory.

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MHAC/13/13 Yorkshire Ambulance Service

A further meeting has been arranged on 6 December 2013, which TB will attend. It was agreed to receive a further update at the next meeting.

Action: Tim Breedon

MHAC/13/26 S132 Patients' rights

HW discussed inclusion on the internal audit plan with the Chair of the Audit Committee and it will be suggested to KPMG that this includes all Mental Health Act documentation and record keeping.

MHAC/13/28 Audit of cancellations

An audit of the reason for cancellations and discharge before a Tribunal across the Trust has been commissioned. The Committee also asked to receive the internal audit report on assessment and admissions at either the next meeting or the meeting in May 2014.

Action: Tim Breedon

MHAC/13/29 S136 suites

TB agreed to circulate the report on usage for further discussion as an agenda item at the next meeting.

Action: Tim Breedon

MHAC/13/37 Audit and Compliance Reports (agenda item 6)

Advocacy services

The Committee noted that only two of the five advocacy services covering the Trust had responded to the request for information, which was a disappointing outcome. The Committee asked for further assurance regarding the information provided for Calderdale and asked that the information is fedback to services. A further update at the next meeting was requested.

Action: Yvonne French

Local authority representatives were asked to provide information to YF on who in the local authority is responsible for commissioning advocacy services.

Action: local authority representatives

Nisreen Booya (NHB) suggested awareness raising for in-patient staff on the Mental Capacity Act and the Committee also noted the development of an e-learning package for the Mental Health and Mental Capacity Acts. The Committee also asked for further assurance that training arrangements were in place for all staff across the Trust for whom it is mandatory and that this was taken up.

Action: Yvonne French

Annual review of Independent Hospital Managers

The report was noted. Geoff Naylor (GN) commented that the review process was seen to be a positive and helpful one. HW added that it provides assurance that individuals take their role very seriously and are keen to seek ways for continued improvement.

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MHAC/13/38 Care Quality Commission Visits (agenda item 7)

Recent visits

The three monitoring visits to Bronte and Gaskell at Newton Lodge, and Trinity 1 at Fieldhead were noted.

Outstanding actions/progress report

TB confirmed that the Trust has received a final report on the visit to the Dales in August 2013 and was found to be compliant. A draft report for factual accuracy checking on Newton Lodge, Bretton and Trinity 2 has also been received and a summary circulated to Trust Board. A minor impact compliance action was issued in relation to safeguarding in terms of seclusion of patients longer than necessary due to review periods. A moderate impact compliance action was issued in relation to the environment of the seclusion facilities in Newton Lodge. The Trust has a plan in place to upgrade seclusion facilities across the Trust and will ensure that the plan addresses the issues raised about Newton Lodge. The plan represents quite a significant environmental change for some seclusion areas. It was agreed to provide a further update at the next meeting.

Action: Tim Breedon

HW commented that she was concerned about the findings regarding practice in relation to seclusion. She asked for assurance that the Trust is addressing the issues raised as a matter of urgency. A further piece of work is also needed to ensure estates related issues are addressed to provide assurance to the Committee. JF asked for a summary report as a standing agenda item as well as the clinical issues log. The Committee was happy for actions to be removed when completed.

Action: Tim Breedon/Yvonne French

Assurance of the action taken around non-compliance with the requirements for recording under the Mental Health Act Code of Practice will also come back to the Committee at its next meeting.

Action: Yvonne French

MHAC/13/39 Monitoring Information (agenda item 8)

Paper 5 – Hospital Managers' appeal data

The new format for the report was thought to be useful and the Committee agreed it would like to receive the data in this way for all BDUs in future.

Action: Yvonne French

No further issues were raised on the monitoring information.

Local authority information

Calderdale and Kirklees – concerns have been raised by the Police of the numbers still going through to cells rather than places of safety suites; however, this contradicts the data that most assessments take place in suites. This appears to be an issue nationally.

TB agreed to follow up the suggestion that this information could be included on RiO and, therefore, could be extracted routinely. YF clarified that Mental Health Act administration is on RiO; however, the data that can be extracted from RiO is

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insufficient for the Committee and, therefore, statistics still have to be manually collected.

It was agreed that TB and YF would discuss a common assessment form for RiO with the four local authority representatives.

Action: Tim Breedon/Yvonne French

Annual report – transfers under Section 19(1) and 19(3)
The annual report was noted.

Hospital Managers Mental Health Act appeals/reviews
The Forum notes from 20 August 2013 were received and noted. GN apologised that no-one from the Forum was able to attend the last Committee meeting and the Forum has now agreed that, if the Chair or Deputy Chair cannot attend, another Hospital Manager will be nominated to attend.

MHAC/13/40 Matters Arising (agenda item 9)
Local Authority update
There were no issues raised.

Children's and adolescents' mental health and other children's services
The Committee noted that children's services in Barnsley transferred to the Trust on 1 October 2013 and the Committee will begin to receive monitoring information. TB and YF will review the form and content of this information and agreed what should be presented to the Committee with JF.

Action: Tim Breedon/Yvonne French

MHAC/13/41 Key messages for Trust Board
These were agreed as:

- bed occupancy and pressures;
- Care Quality Commission reports, particularly in relation to estate and environment; and
- training for the Mental Capacity Act.

MHAC/13/42 Date of next meeting
The next meeting will be held on Tuesday 25 February 2014 from 14:00 to 16:30 in the Wainhouse room, 5th floor, F Mill, Dean Clough, Halifax.

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Minutes of the Remuneration and Terms of Service Committee held on 15 October 2013

Present:	Ian Black	Chair of the Trust (Chair)
	Jonathan Jones	Non-Executive Director
	Helen Wollaston	Deputy Chair of the Trust
	Steven Michael	Chief Executive
Apologies:	None	
In attendance:	Alan Davis	Director of Human Resources and Workforce Development
	Bernie Cherriman-Sykes	Integrated Governance Manager

RTSC/13/48 Welcome, introduction and apologies (agenda item 1)
The Chair (IB) welcomed everyone to the meeting. There were no apologies.

RTSC/13/49 Minutes of the previous meeting held on 16 July 2013 (agenda item 2)
It was RESOLVED to APPROVE the minutes from the meeting held on 16 July 2013.

RTSC/13/50 Matters arising from previous meeting (agenda item 3)
RTSC/13/40 Wellbeing survey
Alan Davis (AGD) confirmed that it is planned to include a set of more detailed questions in the next wellbeing survey around bullying and harassment.

RTSC/13/51 Human resources exception reports (agenda item 4)
Appraisal
AGD confirmed that the appraisal target has now been achieved. The Committee saw attainment of the 90% target as a significant achievement. An evaluation of the new system has been undertaken and the outcome of this will inform the 2014/15 appraisal process. Helen Wollaston (HW) asked whether this would highlight areas where appraisals may not be delivered by managers in a way that reflects the values of the organisation. AGD responded that this links to the development and introduction of values-based leadership and management practices and development of competencies for managers.

AGD also reported that national guidance on linking pay and performance through Agenda for Change has been considerably watered down on the original proposals and the onus would be on Trusts to justify why an incremental increase was not given to a member of staff rather than staff evidencing achievements. The guidance, when issued, will be reviewed internally and options considered.

Zero-hours contracts
AGD confirmed that the Trust has no zero-hours contracts as part of its establishment; however, individuals on the bank and agency staff would have no

regular or guaranteed hours. These would not, however, be under zero-hours contracts.

Sickness absence
The current year-to-date figure is 4.5% with a projection for the year of 4.8%. AGD highlighted two hotspots.

- Barnsley is projecting an increase on last year.
- Low secure services continue to perform above target.

The performance report for Trust Board will include a statement of management action from BDU Directors in relation to BDU hotspots. The challenge for BDU Directors is to demonstrate effectiveness of the implementation of exemplar HR policies through devolvement of management functions. HW asked if there was any way of acknowledging good performance in terms of sickness absence. AGD responded that this should come through individual appraisals.

HR Strategy organisational development framework 2013/16
IB welcomed the document as a clear indication of the implementation of the Strategy over the coming years. He commented that he would be interested to know other Trusts' approach to reforming and refreshing Agenda for Change and development of local pay and conditions when any initial proposal comes back to the Committee or to Trust Board for consideration.

The Chief Executive (SM) asked AGD to work with BDU Directors to ensure the framework is used to address performance issues. AGD confirmed that the framework would include medical staff where separate arrangements are not in place (such as values-based recruitment) but not in areas where separate arrangements exist (such as appraisal and job planning).

RTSC/13/52 Updated Director PRP scheme (agenda item 5)
AGD commented that the paper represents a summary of the discussion at the meeting on 16 July 2013. SM confirmed that individual Director objectives have been set and his quarterly reviews with Directors against these have begun.

The Committee had considered the position of those Directors not included in the scheme and SM confirmed that they would still be subject to the same process, the outcome of which will be reported to the Committee with other Directors at the year-end.

The Committee supported the detail of the final scheme.

RTSC/13/53 Director level structure (agenda item 6)
Director of Service Improvement and Health Intelligence
Two good calibre candidates were interviewed for the post on 1 October 2013. Both were considered to be above the line. The first choice candidate declined to take up the offer and a decision was made not to make an appointment. SM's preferred

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option is to test the market again but to advertise wider than NHS Jobs. This was supported by the Committee.

Recruitment and retention of Directors

The recruitment exercise for the Director of Service Improvement highlighted the current shifting market at senior level. The development of posts at second and third tier at NHS England and the numbers of Clinical Commissioning Groups has had a particular impact with the market becoming increasingly competitive. This has a corresponding impact on salaries, and terms and conditions, particularly to attract high calibre candidates. He raised two issues in relation to the Trust's position.

- Can the Trust offer competitive terms and conditions?
- The impact on existing Directors, particularly voting Directors.

The Committee agreed to receive an objective report at a future meeting on Director bandings, pay levels and pay progression outside of performance related pay, particularly:

- whether the bandings in the Hay report in July 2011 still represent a reasonable arrangement;
- taking account of changes to climate and job role since 2011;
- reflecting current market position and conditions; and
- to provide a system that continues to differentiate between voting and non-voting Directors.

It was agreed to commission either Hay or Capita to undertake such a review (or, in the case of Hay, a refresh) of the original report. It was agreed to circulate the specification and terms of reference for such a review for comment prior to the next meeting in February 2014.

Action: Alan Davis

RTSC/13/54 Senior managers' pay arrangements under Agenda for Change (agenda item 7)

AGD confirmed that this would cover staff in Band 8c and above and take them outside of national terms and conditions. The Trust will introduce this approach but it will initially mirror national terms and conditions but without automatic incremental increases. This will provide sufficient time to review local terms and conditions and performance arrangements for senior managers outside of Agenda for Change through a senior managers' pay framework (which will come back to the Committee in due course).

Action: Alan Davis

RTSC/13/45 Date of next meeting (agenda item 8)

The next meeting will be held on Tuesday 4 February 2014 at 14:00 in the Halifax room, 4th floor, F Mill, Dean Clough, Halifax. The remaining meeting dates for 2014 are:

Tuesday 1 April at 14:00 in the Chair's office at Fieldhead;

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Tuesday 15 July at 14:00 in the Chair’s office at Fieldhead;
Tuesday 14 October at 14:00 in the Chair’s office at Fieldhead;

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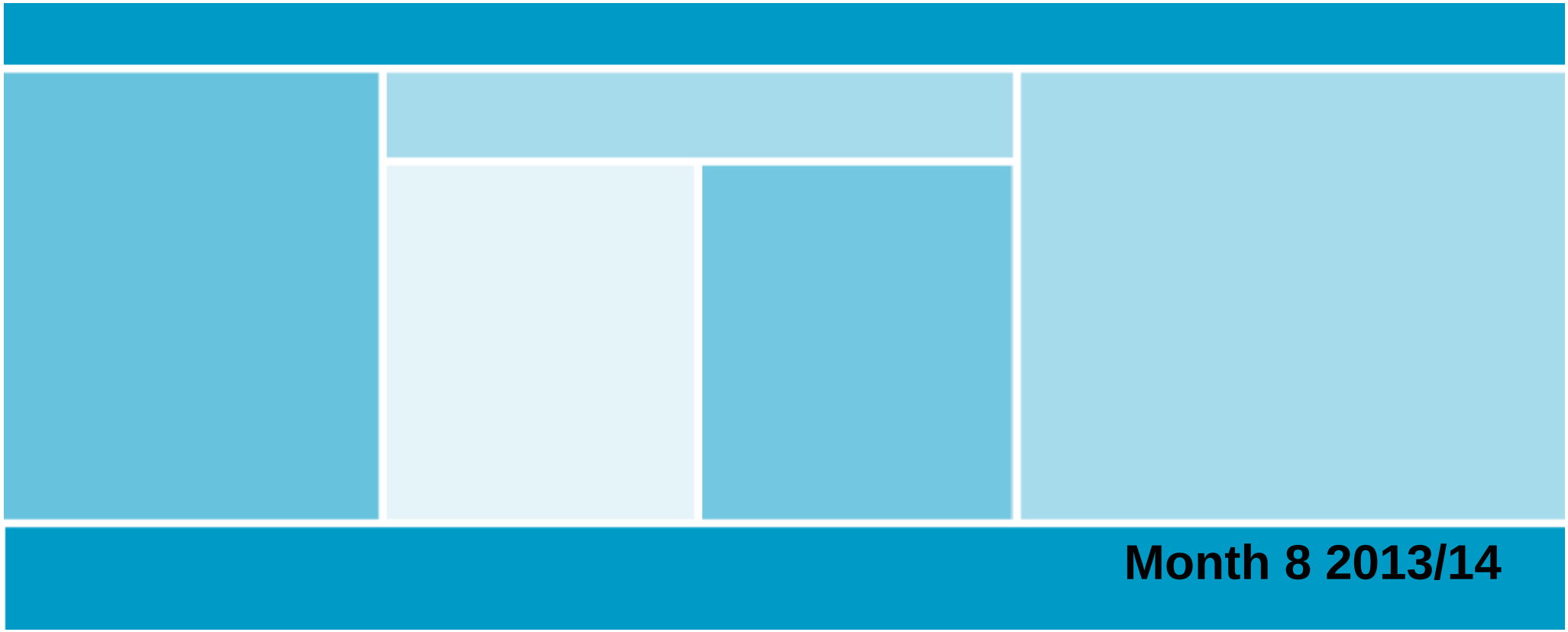
With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Integrated Performance Report: Strategic Overview



Month 8 2013/14

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Introduction

Dear Board Member/Reader

Welcome to the Trust's Integrated Performance Report: Strategic Overview for month 8 2013/2014 (November 2013 information unless stated). The integrated performance strategic overview report is a key tool to provide assurance to the Board that the strategic objectives are being delivered and to direct the Board's attention to significant risks, issues and exceptions.

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

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

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

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

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

HIGH LEVEL PERFORMANCE SUMMARY (YEAR TO DATE)

OUTCOMES	RAG RATING
• Monitor Governance Risk Rating	G
• Monitor Finance Risk Rating	G
• CQUINs	A/G

CUSTOMER FOCUS	
• Complaints	G
• Members council	G
• Annual community survey	A/G

OPERATIONAL EFFECTIVENESS	
• Case load management (7 day follow-up; CPA review; gate kept; DTOC)	G
• Data Quality	G

FIT FOR THE FUTURE WORKFORCE	
• Sickness	A/G
• Training	A/G
• Appraisal	G

Trust Board Performance Dashboard – Vital Signs (Month 8 2013/14)

Business Strategic Performance: Impact & Delivery

Month 8 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)	4.1	4.1	✓	–	4
CQC	CQC Quality Regulations (compliance breach)	Green	A/G	▲	–	3
CQUIN	CQUIN Barnsley	Green	Amber/G	▲	–	3
	CQUIN Calderdale	Green	Amber/G	▲	–	3
	CQUIN Kirklees	Green	Amber/G	▲	–	3
	CQUIN Wakefield	Green	Amber/G	▲	–	3
	CQUIN Forensic	Green	Green	✓	–	3
IAPT	IAPT Kirklees: % Who Moved to Recovery	52%	55%	✓	–	4
Inf' Prevent'	Infection Prevention (MRSA & C.Diff) All Cases	0	0	▼	–	3
C-Diff	C Diff avoidable cases	0	0	✓	–	4
PSA Outcomes	% SU on CPA in Employment	10%	**6.9%**	✗	↑	4
	% SU on CPA in Settled Accommodation	60%	**60.5%**	✓	↑	4

Customer Focus

Month 8 2013/14

Section	KPI	Target	Current Position	Status	Trend	Forecast Position
Complaints	% Complaints with Staff Attitude as an Issue	< 30%	25%	✓	↓	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 8 2013/14

Section	KPI	Target	Current Position	Status	Trend	Forecast Position
Inpatients	Delayed Transfers Of Care (DTOC) (Monitor)	< = 7.5%	**3.5%**	✓	↑	4
	% Admissions Gatekept by CRS Teams (Monitor)	95%	**99.2%**	✓	↑	4
Community	% SU on CPA Followed up Within 7 Days of Discharge (Monitor)	95%	96.0%	✓	↑	4
	% SU on CPA Having Formal Review Within 12 Months (Monitor)	95%	**95.6%**	✓	↓	4
Breastfeeding	Prevalence of children breastfed at 6 - 8 weeks (Barnsley)	31.5%	30.4%	▲	–	2
Data Quality	Data completeness: community services (Monitor)	50%	94%	✓	–	4
	Data completeness: Identifiers (mental health) (Monitor)	97%	**99.4%**	✓	–	4
	Data completeness: Outcomes for patients on CPA (Monitor)	50%	**75.0%**	✓	↑	4
Mental Health PbR	% of eligible cases assigned a cluster	100%	93.1%	✗	↑	3
	% of eligible cases assigned a cluster within previous 12 months	100%	77.4%	✗	↑	3
	% Inpatients (All Discharged Clients) with Valid Diagnosis Code	99%	**95.8%**	▲	↑	3

Fit for the Future; Workforce

Month 8 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%	92.3	✓	–	
Sickness	Sickness Absence Rate (YTD)	<=4%	4.7	▼	↓	3
Vacancy	Vacancy Rate	10%	4.8%	✓	–	4
Safeguarding	Adult Safeguarding Training	80%	80.3%	✓	↓	4
Fire	Fire Attendance	>=80%	–	–	–	
IG	IG Training	>=75%	32.7	✗	↑	4

Overall Financial Position

	Performance Indicator	Month 8 Performance	Annual Forecast	Trend from last month	Last 6 Months - Most recent						Assur - ance
	Trust Targets				7	6	5	4	3	2	
1	£3.7m Surplus on Income & Expenditure	●	●	⇔	●	●	●	●	●	●	4
2	Cash position equal to or ahead of plan	●	●	⇔	●	●	●	●	●	●	4
3	Capital Expenditure within 15% 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 8 is showing a net surplus of £3.7m which is £1.2m 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 8 the cash position is £32.7m and is £4.8m ahead of plan.
3. Capital expenditure to November 2013 is £2.8m which is £1.5m behind plan. A revised capital programme has been approved to ensure that the full programme is delivered in 2013 / 2014.
4. At month 8 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 8 forecast position.
5. The financial risk rating applied by Monitor has changed in October 2013. Against the new metrics the rating is 4 against a target of 4. The scale is 1 – 4 with 4 being the highest. Monitored in shadow form the previous Financial Risk Rating scores a 4.1 against a planned 4.1 (based upon a 1 – 5 scoring method)
6. At 30th November 93% of NHS and 96% of non NHS invoices have achieved the 30 day payment target. (95%)

Financial Risk Rating 2013/14				
	November 2013 Actuals		Annual Plan Quarter 3	
Metric	Score	Rating	Score	Rating
Capital Servicing Capacity	7.7 times	4	6.0 times	4
Liquidity	16.9	4	15.1	4
Weighted Average		4		4

Under the Monitor Risk Assessment Framework change implemented in October 2013 the Trust financial risk rating is revised from 5 ratings to the 2 above. These are designed to demonstrate that a Trust remains a 'Going Concern.' These are scored on a 1 – 4 rating, with 4 being the highest.

Financial Risk Rating 2013/14				
	November 2013 Actuals		Annual Plan Quarter 3	
Metric	Score	Rating	Score	Rating
EBITDA margin	5.6%	3	5.2%	3
EBITDA, % achieved	100%	5	100%	5
ROA	6.6%	5	6.2%	5
I&E surplus margin	2.6%	4	2.6%	4
Liquid ratio	32.0	4	30.3	4
Weighted Average		4.1		4.1

The table above shows the previous regime for Trust financial risk rating. These metrics will continue to be monitored in shadow form for the remainder of 2013 / 2014. These are rated on a 1 – 5 measure.
Overall the Trust continues to perform better than planned against all of these metrics.

Flawless Execution

PERFORMANCE OVERVIEW

1.0 IMPACT AND DELIVERY

1.1 Monitor Compliance Framework

- The Monitor Compliance risk rating for month 8 is Green. The monthly self-assessment highlighted only 1 area with a rating below green. This was in relation to KPMG internal audit report on procurement (non-pay purchasing) Included in Q2 exception report submitted to Monitor on 30.10.13.

1.2 Care Quality Commission (CQC)

- The final CQC inspection report for Fieldhead has been received (covering Trinity 2, Newton Lodge and the Bretton Centre). The Trust has 2 compliance actions (one minor and one moderate concern) in relation to design and layout of seclusion rooms, the general decor and environment of Hepworth ward (within Newton Lodge) and how some patients' seclusions had been reviewed and continued. The Trust action plan was submitted on 06.12.13. with a timescale for completion of the end of May 2014. However many of the issues raised have already been addressed.

1.3 CQUINs

1.3.1 Barnsley

Overall Performance Rating : Amber/Green
Key Risk Areas:

- Clinical Communication discharge communication datasets – Improved rates in November . Failed to achieve Quarter to date.
- Increasing the number of people in secondary mental health in employment target not met, currently at 3% against a target of 7.2%. (2.65% month 7) 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.

1.3.2 Calderdale, Kirklees & Wakefield

Overall Performance Rating: Amber/Green
Key Risk Areas:
2.2 (a) MH Access Routine 14 Days
All three BDUs are currently failing this part of the joint CQUIN at month 8. All BDU CQUIN Leads are reviewing the cases under target.
2.2 (b) MH Access Routine 6 Weeks
Kirklees have now started to underperform against 6 weeks of assessment target. This is being picked up by the BDU CQUIN Lead.

Flawless Execution Continued

2.1 (c&d) & 2.2 (c&d) CAMHS Access Crisis (2hrs) & Routine (4 Weeks) (Wakefield Only)
Work continues with the Service to ensure that the information from RiO accurately reflects the work of the service.
Month 7 position is Red.

Areas to Note:
Current reporting is showing the following under-achievement of target, however with remedial action it is envisaged that all 3 CQUINs will achieve at quarter end:

1.2 Falls Assessment/Care Planning
Kirklees: OPS & WAA both failing target (72.2% & 78.8% respectively).
CQUIN Lead is picking up with the BDU CQUIN Lead
Achievement of this CQUIN is expected by quarter end.

2.1 (a) Access MH Crisis 4 Hours
At month 8 Wakefield are the only BDU to not achieve this CQUIN (84.9% against a target of 90%). This is being picked up with the BDU CQUIN Lead.
Achievement of this CQUIN is expected by quarter end.

3.1 LD Introduction of TOMs Outcome Measures into Adult LD Services
At Month 8 this CQUIN is below target (40% against a target of 50%). The CQUIN Lead is currently reviewing this data with Service Managers. Achievement of this CQUIN is expected by quarter end.

1.3.3 Forensic- Green
Forensic CQUINs are submitted on a quarterly basis.
Q3 Forensic submissions will be made week commencing 27th January 2014. It is envisaged that all CQUINs will be achieved for Q3.
Q2 Forensic submissions were made by the Trust week commencing 21st October 2013. It is envisaged that Commissioners will approve CQUIN achievement for all 6 CQUINs for Q2.
Payment for Q1 achievement for all 6 CQUINs was received 22nd November 2013.

1.4 Infection Prevention

Hospital Acquired Infections: Achieving target for avoidable infections. No further cases in October and November. 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.

1.5 PSA Outcomes

Underperformance against national Department of Health outcome measures % on CPA in employment (Target >10%)
Position in Wakefield, Kirklees and Barnsley improved in Month 8, Calderdale remained static.

Flawless Execution Continued

- Wakefield 6.1%, Kirklees 8.9%, Calderdale 7.8%, Barnsley 3%
- Barnsley have a local target of 7.2%

2.0 CUSTOMER FOCUS

2.1 Membership/befriending services

This measure is reported quarterly, current dashboard displays quarter 2 figures. As at quarter 2 this is showing there had been an improvement in performance in the quarter following the befriender recruitment drive .Work had been focused on achieving accreditation The service have now revised processes to ensure targets are met in the future. A new position will be reported at the end of quarter 3.(January)

3.0 OPERATIONAL EFFECTIVENESS

3.1 Breastfeeding

Quarter 2 showed an improvement in breastfeeding prevalence at 6- 8 weeks, but continues to show an underperformance against threshold.

The Altogether Better Health Champions have very recently been recruited and are undergoing an induction programme, the champions will be fully operational in the New Year when they will be identifying the hard to reach vulnerable groups and begin targeted support to expectant and breastfeeding mums.

SWYT also recently became the provider organisation for the provision of school nursing this provides key public health opportunities to work with school age children and young people to promoting the advantages of breast feeding proactively.

3.2 Mental Health Currency Development (November 2013 – Month 8)

External

- IAPT services mandated collection data has been delayed from 1st April 2014 to mid 2014/15
- The IAPT, CAMHS, LD and Liaison national projects are making progress but are not expected to transit to in scope teams until at least 2015/16.
- Care Packages and Pathways Programme (consortium of all north east MH providers) have designed a state of readiness templates for use of Mental health Pbr in 2014-15. The templates have been completed and submitted. Both providers and commissioners are submitting returns.

Internal

- Action plans continue to focus on maintaining progress, clinical engagement and embedding MHCT and clustering into mainstream clinical practice.
- Presentation delivered to medics (Joint Academic Psychiatric Seminar) on current Quality Indicator performance and future focus areas including caseload size, cluster profiles and reviewing within cluster frequency.

Mental Health Clustering

November's data has not yet been published. Performance is expected to increase but further actions are being discussed to ensure performance trajectories for key quality indicators are met.

Flawless Execution Continued

4.0 FIT FOR THE FUTURE: WORKFORCE

4.1 Appraisal

Current Position (End of October) – 92.3% Overall. This shows no change from month 6 figures. Target levels have been achieved in all BDU's and all are currently experiencing rates above 90% *(Barnsley 92.2%, Calderdale 93.9%, Forensics 93.1%, Kirklees 93.3%, Specialist Services 90.1%, Wakefield 91.2%, Support Services 92.3%)*

4.2 Sickness (End of October Position) – 4.68% Overall.

The current year to date absence rate for the whole of SWYPFT is 4.68%. This shows a slight increase from last month's figure of 4.57%, but shows a significant reduction from last year's YTD rate of 5.02% in October 2012.

The current 2013-14 (end of March 2014) projection is 4.77% which would be a 0.46% reduction from last year but would still be above the 4.0% Trust Board target. The current (YTD) SWYPFT absence rate has now seen slight month on month increases between the end of August through to October, though increases have been lower than projected and expected levels when factoring in seasonality of short term absence giving pressure to winter absence increases.

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

Barnsley BDU

- **Current YTD absence rate = 4.99%; Current projection by March 2014 = 5.07%; Projection Trend = Increasing *(+0.02%)***
- 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 (District Nursing)

Calderdale BDU

- **Current YTD absence rate = 3.36%; Current projection by March 2014 = 3.40%; Projection Trend = Reducing *(-0.04%)***
- 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 = 6.56%; Current projection by March 2014 = 6.70% Projection Trend = Increasing *(+0.10%)***
- Forensics continues to see higher absence rates than the rest of the Trust; the BDU has however made reductions from this time last year (7.05% cumulative in October 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 (5.47% cumulative).
- Long term absence is still being experienced in both Low Secure and Newhaven and this is causing high rates of 8.63% and 7.95% respectively and both rates have seen further increases in October from September. Increases are due to a slight rise in short term and long term sickness in specific areas which are being managed.

Flawless Execution Continued

Kirklees BDU

- **Current YTD absence rate = 5.12%; Current projection by March 2014 = 5.24%; Projection Trend = Increasing *(+0.10%)***
- Adult Services seeing much reduced overall rates and currently just above 4% target (4.34% YTD)
- Older Peoples Services remains above target (7.05% YTD). This is mainly due to long term absence in specific areas which is being closely managed by both service leads and HR services. Overall absence has been above 5.7% in-month in the last 3 months from August.

Wakefield BDU

- **Current YTD absence rate = 4.37%; Current projection by March 2014 = 4.40%; Projection Trend = Unchanged**
- Absence has been slowly rising since May through to October. The BDU is still significantly reducing its absence rate from last year at the same point of the year (5.31% in October 2012 - 0.88% higher than current YTD rate). Current rate still sees the BDU experiencing its lowest BDU rate in the last 6 years.

Specialist Services

- **Current YTD absence rate = 3.70%; Current projection by March 2014 = 3.98%; Projection Trend = Reducing *(-0.26%)***
- The BDU has returned an in-month absence rate under 4% since July. BDU overall cumulative absence is 2.24% lower than for the same period last year.

Support Services

- **Current YTD absence rate = 3.67% - Current projection by March 2014= 3.50%; Projection Trend = Unchanged**
- Overall, Support Services are currently meeting target levels and are projected to do so by April 2014 - the only area of higher absence is in Estates (4.79%YTD).

4.4.2 Summary:

- Whilst SWYT overall rate has risen for 2nd month in a row, increase not as great as would be expected within winter months.
- With the exception of Barnsley and Kirklees, all BDU's are projecting a lower absence rate by March 2014 than last year.
- Of the 34 services lines across the whole of SWYPFT, 17 are currently achieving absence rates below 4% (a reduction of 1 from September).
- Stress continues to be the main reason for absence across the Trust accounting for approximately 1 in every 4 to 5 days lost.
- The main reason for the further rise in October is due to expected increases in short term seasonal absence. This is projected to continue to rise until January 2014.
- 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 and the Wellbeing Agenda with full support from OH.
- Calderdale, Specialist Services and Support Services BDU are projected to achieve the SWYPFT target rate of 4% by the end of 2013-14 financial year.

4.3 Fire training

- Fire Lecture figures will be delayed whilst validation work is undertaken.

Flawless Execution Continued

4.4 Information Governance Training (End of November Position)

- Nearly a third of staff (32.7%) have completed the training as at the end of November.
- 344 completed in November more than any previous month but less than half of the 700 target.
- The monthly target has increased to 750 as a result. Unless 750 complete in December the monthly target will rise again.
- A small number of staff have never completed the training, putting the trust at risk in the event of an incident.
- All Directors have been briefed as to their position and their target.

Glossary

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

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Integrated Performance Report: Strategic Overview

Month 7 2013/14

Table of Contents

Introduction

Dear Board Member/Reader

Welcome to the Trust's Integrated Performance Report: Strategic Overview for month 7 2013/2014 (October 2013 information). The integrated performance strategic overview report is a key tool to provide assurance to the Board that the strategic objectives are being delivered and to direct the Board's attention to significant risks, issues and exceptions.

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

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

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

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

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

HIGH LEVEL PERFORMANCE SUMMARY (YEAR TO DATE)

OUTCOMES	RAG RATING
• Monitor Governance Risk Rating	A/G
• Monitor Finance Risk Rating	G
• CQUIN's	A/G

CUSTOMER FOCUS	
• Complaints	G
• Members council	A/G
• Annual community survey	A/G

OPERATIONAL EFFECTIVENESS	
• Case load management (7 day follow-up; CPA review; gate kept; DTOC)	A/G
• Data Quality	A/G

FIT FOR THE FUTURE WORKFORCE	
• Sickness	A/G
• Training	A/G
• Appraisal	G

Trust Board Performance Dashboard – Vital Signs (Month 7 2013/14)

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	% of eligible cases assigned a cluster within previous 12 months	100%	75.8%	✗	↑	3
	% Inpatients (All Discharged Clients) with Valid Diagnosis Code	99%	**94.5%**	▼	↓	4

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Overall Financial Position

	Performance Indicator	Month 7 Performance	Annual Forecast	Trend from last month	Last 6 Months - Most recent						Assur - ance
Trust Targets					**6**	**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 15% 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 7 is showing a net surplus of £3.3m 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 7 the cash position is £29.3m and is £3.4m ahead of plan.

3. Capital expenditure to October 2013 is £2.4m which is £1.3m behind plan. A revised capital programme has been approved to ensure that the full programme is delivered in 2013 / 2014.

4. At month 7 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 7 forecast position.

5. The financial risk rating applied by Monitor has changed in October 2013. Against the new metrics the rating is 4 against a target of 4. The scale is 1 – 4 with 4 being the highest. Monitored in shadow form the previous Financial Risk Rating scores a 4.1 against a planned 4.1 (based upon a 1 – 4 scoring method)

6. At 31st October 94% of NHS and 97% of non NHS invoices have achieved the 30 day payment target. (95%)

Financial Risk Rating 2013/14				
	October 2013 Actuals		Annual Plan Quarter 3	
Metric	Score	Rating	Score	Rating
Capital Servicing Capacity	7.8 times	4	6.0 times	4
Liquidity	16.4	4	15.1	4
Weighted Average		4		4

Under the Monitor Risk Assessment Framework change implemented in October 2013 the Trust financial risk rating is revised from 5 ratings to the 2 above. These are designed to demonstrate that a Trust remains a 'Going Concern.' These are scored on a 1 – 4 rating, with 4 being the highest.

Financial Risk Rating 2013/14				
	October 2013 Actuals		Annual Plan Quarter 3	
Metric	Score	Rating	Score	Rating
EBITDA margin	5.7%	3	5.2%	3
EBITDA, % achieved	100%	5	100%	5
ROA	6.6%	5	6.2%	5
I&E surplus margin	2.7%	4	2.6%	4
Liquid ratio	32.0	4	30.3	4
Weighted Average		4.1		4.1

The table above shows the previous regime for Trust financial risk rating. These metrics will continue to be monitored in shadow form for the remainder of 2013 / 2014. These are rated on a 1 – 5 measure.
Overall the Trust continues to perform better than planned against all of these metrics.

Flawless Execution

PERFORMANCE OVERVIEW

1.0 IMPACT AND DELIVERY

1.1 Monitor Compliance Framework

- The Monitor Compliance risk rating for month 4 is amber/green. This is due to in month under-performance against the % SU on CPA Followed up Within 7 Days of Discharge indicator (October position is 92.4%; target = 95%). The Trust achieved target levels in the Quarter 2 Monitor submission. Action is being taken in the BDUs to ensure an improved position in month 8.

1.2 Care Quality Commission (CQC)

- The draft CQC inspection report for Fieldhead has been received (covering Trinity 2, Newton Lodge and the Bretton Centre). The Trust will be submitting a factual accuracy return for consideration prior to publication of the final report. The draft report states that overall CQC found patients were receiving a good level of service however the Trust may be subject to 2 compliance actions relating primarily to seclusion (practice and facilities). *'However, we also found some concerns regarding the design and layout of some of the hospital's seclusion rooms, and the general decor and environment of Hepworth ward (within Newton Lodge). We also identified some concern regarding how some patients' seclusions had been reviewed and continued.'*

1.3 CQUINs

1.3.1 Barnsley

Overall Performance Rating : Amber/Green
Key Risk Areas:

- Clinical Communication discharge communication datasets – Failed to achieve in October. 75% (target 90%)
- Increasing the number of people in secondary mental health in employment target not met, currently at 2.65% against a target of 6.6%. (2.63% month 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.

1.3.2 Calderdale, Kirklees & Wakefield

Overall Performance Rating: Amber/Green
Key Risk Areas:

- 2.1 (a) Access MH Crisis 4 Hours
  At month 7 Calderdale are the only BDU to not achieve this CQUIN (85.7% against a target of 90%). This is being picked up with the BDU CQUIN Lead.

- 2.2 (a&b) MH Access Routine 14 Days
  Both Calderdale and Kirklees are failing this CQUIN at month 7 (62% and 69.1% respectively against a target of 80%). Wakefield have however maintained achievement of this CQUIN at the start of Q3. BDU CQUIN Leads are reviewing the cases under target.

Flawless Execution Continued

- 2.1 (c&d) & 2.2 (c&d) CAMHS Access Crisis (2hrs) & Routine (4 Weeks) (Wakefield Only)
  Work continues with the Service to ensure that the information from RiO accurately reflects the work of the service.
  Month 7 position is Red.

Areas to Note:

- 3.1 LD Introduction of TOMs Outcome Measures into Adult LD Services
  At Month 7 this CQUIN is below target (24% against a target of 50%). The CQUIN Lead is currently reviewing this data with Service Managers. Achievement of this CQUIN is expected by quarter end.

- 4.3 Weight Management BMI>27 with additional risk factors has care plan in place
  Calderdale BDU did not meet the target for this CQUIN. An exception report has already been provided but may not necessarily be needed at quarter end once the numbers increase next month.

1.3.3 Forensic- Green

Forensic CQUINs are submitted on a quarterly basis. For Q3 the submission date is 27th January 2014.
The current forecast is for all CQUIN's to achieve in Q3
Q2 Forensic submissions were made by the Trust week commencing 21st October 2013.The trust is awaiting approval of the Q 2 CQUIN submission. Confirmation is expected 25th November 2013 It is envisaged that Commissioners will approve CQUIN achievement for all 6 CQUINs for Q2.

1.4 Infection Prevention

Hospital Acquired Infections: Achieving target for avoidable infections. No further cases in October. 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.

1.5 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
- Calderdale is the only BDU meeting national target % on CPA in settled accommodation(60%).
- Barnsley are meeting the local target (38%).

Flawless Execution Continued

2.0 CUSTOMER FOCUS

2.1 Membership/befriending services

This measure is reported quarterly, current dashboard displays quarter 2 figures. As at quarter 2 this is showing there had been an improvement in performance in the quarter following the befriender recruitment drive .Work had been focused on achieving accreditation The service have now revised processes to ensure targets are met in the future. A new position will be reported at the end of quarter 3.(January)

3.0 OPERATIONAL EFFECTIVENESS

3.1 Breastfeeding

Quarter 2 showed 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.

Team are awaiting funding for the Altogether Better project , this 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.

3.2 Mental Health Currency Development (October 2013 – Month 7)

External

- Feedback has been sent to Monitor in response to the 2014/15 National Tariff Payment System Consultation document.
- The Quality & Outcomes National Group are reviewing each Trusts performance against the 10 recommended Quality Indicators identified in the consultation document with an aim to recommend a threshold to inform 2014/15 CQUIN measures.
- IAPT services are mandated to collect clusters from 1st April 2014.
- LD CPPP subgroup is meeting and will be compiling a recommendation on the structure and methodology for integrating LD into MH currencies in 2014.

Internal

- CAMHS services which transferred from CHFT this year are part of the CAMHS currencies pilot. A working group has been established to maintain our commitment to the pilot.
- Action plans continue to focus on maintaining progress, clinical engagement and embedding MHCT and clustering into mainstream clinical practice.

Flawless Execution Continued

Mental Health Clustering

Performance against trajectories has improved on month 6 but continues to be behind plan. Processes are being reviewed and further training delivered to ensure teams performance improves. Medics have been identified as a staff group that require the biggest input to improve Quality Indicator performance.

	Trajectories			Actual		
	% of eligible clients clustered	% reviewed within frequency	% Care Coordinator recorded	% of eligible clients 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%	91%	76%	71%
November	93%	79%	79%			
December	93%	80%	80%			
January	93%	80%	80%			

4.0 FIT FOR FUTURE : WORKFORCE

4.1 Appraisal

Current Position (End of October) – 92.3% Overall. This shows no change from month 6 figures. Target levels have been achieved in all BDU's and all are currently experiencing rates above 90%.

4.2 Sickness (End of September Position) – 4.57% Overall.

The current year to date absence rate for the whole of SWYPFT is 4.57%. This shows a slight increase from last month's figure of 4.50% and is a significant reduction from last year's YTD rate of 5.00% in September 2012.

The current 2013-14 projection is 4.80% which would be a 0.43% 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 through to August with a slight rise (0.07%) in September largely due to an expected rise in short term seasonal sickness.

Flawless Execution Continued

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

Barnsley BDU

- **Current YTD absence rate = 4.97%; Current projection by March 2014 = 5.05%; Projection Trend = Unchanged**
- 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 (District Nursing)

Calderdale BDU

- **Current YTD absence rate = 3.13%; Current projection by March 2014 = 3.44%; 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 (7.22% cumulative in September 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 8.16% and 6.76% respectively, though both rates have reduced since August.

Kirklees BDU

- **Current YTD absence rate = 5.14%; Current projection by March 2014 = 5.14%; Projection Trend = Rising**
- Adult Services seeing much reduced overall rates and currently just above 4% target (4.10% YTD)
- Older Peoples Services remains above target (7.08% 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 = 4.40%; Current projection by March 2014 = 4.40%; Projection Trend = Unchanged**
- Absence has been slowly rising since May through to September. BDU is still significantly reducing its absence rate from last year at the same point of the year. YTD absence at September last year stood at 5.38% - 0.98% 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 = 3.62%; Current projection by March 2014 = 4.24%; Projection Trend = Reducing**
- Seeing month on month absence reductions since June. 1.4% lower than for the same period last year.

Support Services

- **Current YTD absence rate = 3.62% - Current projection by March 2014= 3.50%; Projection Trend = Unchanged**
- Overall, Support Services are currently meeting target levels and are projected to do so by April 2014 - the only area of higher absence is in Estates (4.79%YTD).

Flawless Execution Continued

4.4.2 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, 18 are currently achieving absence rates below 4% (a reduction of 1 from August).
- Stress continues to be the main reason for absence across the Trust accounting for approximately 1 in every 4 to 5 days lost.
- The main reason for the slight rise in absence in September is due to expected increases in short term seasonal absence. This is projected to continue to rise until January.
- 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 and the Wellbeing Agenda with full support from OH.
- Both Calderdale and Support Services BDU are projected to achieve the SWYPFT target rate of 4% by the end of 2013-14 financial year.

4.3 Fire Training (End of October Position) – 74.3%

- Trust overall position remains below target at 74.3% (target = 80%). September saw a 0.3% increase from Augusts figure.
- At present all BDU's have uptake levels between 70.6% and 78.5%.

4.4 Information Governance Training (End of October Position)

- 23.7% of staff have now completed their IG training since 1st April 2013.
- 231 completed their training in October nearly twice as many as in September.
- In the remaining 5 months just over 700 staff per month need to complete the training, in order to meet the target.
- The current position is better than the October 2013, but needs continuous effort by managers to ensure that we don't end up with excessive pressure on service delivery in the last quarter of the year.

Glossary

AWA	Adults of Working Age
AWOL	Absent Without Leave
BDU	Business Delivery Unit
CCG	Clinical Commissioning Groups
CIP	Cost Improvement Programme
CPA	Care Programme Approach
CPPP	Care Packages & Pathway Project
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CROM	Clinician rated outcome measure
CRS	Crisis Resolution Service
DTOC	Delayed Transfers of Care
EIA	Equality Impact Assessment
EIP/EIS	Early Intervention in Psychosis Service
FOI	Freedom of Information
FT	Foundation Trust
HONOS	Health of the Nation Outcome Scales
IAPT	Improving Access to Psychological Therapies
Inf Prevent	Infection Prevention
KPIs	Key Performance Indicators
MAV	Management of Aggression and Violence
MT	Mandatory Training
NICE	National Institute for Clinical Excellence
OPS	Older People's Services
PBR	Payment by Results
PREM	Patient reported experience measure
PROM	Patient reported outcome measure
PSA	Public Service Agreement
PTS	Post Traumatic Stress
Sis	Serious Incidents
SU	Service Users
SYBAT	South Yorkshire and Bassetlaw local area team
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 8 2013 / 2014

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Overall Financial Position

Performance Indicator		Month 8 Performance	Annual Forecast	Trend from last month	Last 3 Months - Most recent			Assurance	Page
Trust Targets					7	6	5		
1	£3.7m Surplus on Income & Expenditure	●	●	⇧	●	●	●	4	4 to 6
2	Cash position equal to or ahead of plan	●	●	⇧	●	●	●	4	14
3	Capital Expenditure within 15% of plan.	●	●	⇩	●	●	●	4	16
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	18

Summary Financial Performance

1. The year to date position, as at November 2013 is showing a net surplus of £3.7m which is £1.2m ahead of plan. The Forecast for the year remains consistent at £3.79m which is £0.069m marginally above plan.

2. At November 2013 the cash position is £32.7m which is £4.8m ahead of plan.

3. Capital spend to November 2013 is £2.81m which is £1.49m (35%) behind plan.

4. At Month 8 the Cost Improvement Programme is £0.22m (approx 3%) under the target of £5.75m.

5. The previous financial risk rating methodology at November 2013 is 4.1 which is in line with plan 4.1 Quarter 3 position.
N.B. The Revised Monitor Risk Assessment Framework ("RAF") Monitor risk rating is 4 actual Vs. 4 plan.

6. At 31st November 2013 93% of NHS and 96% of non NHS invoices have achieved the 30 day payment target (95%).
N.B. Better Payment Practice performance is expected to drop during December 2013 (as a minimum) as system processes are updated.

Income & Expenditure

Budget Staff in Post	Actual Staff in Post	Variance		This Month Budget	This Month Actual	This Month Variance	Description	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Forecast Outturn	Forecast Variance
WTE	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**		**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
				(3,637)	(3,612)	25	Wakefield Commissioners	(29,092)	(28,750)	342	(43,639)	(43,549)	90
				(3,560)	(3,427)	133	Kirklees Commissioners	(27,710)	(27,409)	301	(41,951)	(41,497)	454
				(1,796)	(1,801)	(5)	Calderdale Commissioners	(14,364)	(14,349)	16	(21,546)	(21,509)	37
				(7,297)	(7,282)	15	Barnsley Commissioners	(58,451)	(58,127)	323	(87,638)	(86,976)	662
				(2,178)	(1,988)	190	Secure Services Comm's	(16,286)	(15,907)	379	(24,998)	(23,699)	1,299
				(35)	(54)	(19)	Non Contract Income	(246)	(418)	(172)	(350)	(550)	(200)
				(18,503)	**(18,164)**	**339**	**Total Income**	**(146,149)**	**(144,960)**	**1,189**	**(220,122)**	**(217,780)**	**2,343**
524	504	(20)	3.8%	1,821	1,800	(21)	Wakefield	14,597	14,770	172	21,889	22,209	319
588	578	(10)	1.7%	2,006	2,108	102	Kirklees	16,018	16,534	516	24,426	24,966	540
339	323	(16)	4.8%	1,169	1,128	(42)	Calderdale	8,866	9,039	173	13,578	13,687	109
1,711	1,567	(144)	8.4%	5,917	5,658	(259)	Barnsley	47,218	45,737	(1,481)	71,161	69,657	(1,504)
429	441	11	-2.6%	1,352	1,374	22	Secure Services	10,797	10,914	117	16,250	16,452	203
308	281	(26)	8.6%	1,208	1,129	(79)	LD & Specialist	9,589	9,285	(304)	14,363	13,859	(504)
700	686	(15)	2.1%	3,718	3,684	(34)	Support	27,910	27,230	(680)	42,279	41,901	(378)
0	0	0		665	334	(331)	Provisions	3,593	2,827	(767)	5,006	4,018	(988)
4,599	**4,379**	**(220)**	**4.8%**	**17,857**	**17,215**	**(642)**	**Total Operating Expenses**	**138,589**	**136,335**	**(2,254)**	**208,955**	**206,750**	**(2,204)**
4,599	**4,379**	**(220)**		**(646)**	**(949)**	**(303)**	**EBITDA**	**(7,560)**	**(8,625)**	**(1,065)**	**(11,168)**	**(11,029)**	**138**
				446	435	(11)	Depreciation	3,570	3,481	(88)	5,354	5,222	(132)
				142	141	(0)	PDC Paid	1,132	1,132	(0)	1,698	1,698	0
				0	(7)	(7)	Interest Received	0	(58)	(58)	0	(75)	(75)
				0	0	0	Impairment of Assets	396	396	0	396	396	0
4,599	**4,379**	**(220)**	**4.8%**	**(58)**	**(380)**	**(321)**	**Surplus**	**(2,462)**	**(3,674)**	**(1,211)**	**(3,719)**	**(3,788)**	**(69)**

Income and Expenditure Summary

Forecast

The Trust annual plan surplus is £3.72m.

The forecast for the year end position, as at month 8, is that this target will be marginally exceeded by £69k and the key components of this are:

		£k	
*	Operational Budgets Position	1,216	
*	Provisions	988	
*	Depreciation	132	
*	Interest better than planned	75	
		2,412	
	Less:		
*	CQUIN Risk	600	
*	Activity Income Risk	1,743	
		2,343	
		69	Favourable

Month 8

The year to date position, as at month 8, reflects a £3.674m surplus which is £1.211m (49%) ahead of plan.

The principal components of this year to date surplus continue to be 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 continuing overspends mainly on out of area expenditure and expenditure on bank staff. The out of area spend have seen a continued reduction from previous months and this has been reflected in the revised BDU forecast positions.

Income and Expenditure Detail

Healthcare Contract Income

Income is behind plan. This is due to:

* The shortfall against CQUIN income in Quarter 1 & 2 is £0.20m against a Quarter 1 & 2 budget of £2.18m. (9%) This represents additional income recovered by the Trust as retrospective acheivement has been awarded for a number of CQUIN's.

* Barnsley BDU is not able to recover planned (budgeted) income arising from available PICU beds and Substance Misuse. These are under plan by £0.2m 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 associated expenditure will be incurred later in the year.

The CQUIN income target for 2013/2014 is £4.7m. The current position assumes a current shortfall of £600k to target. CQUIN performance continues to be managed 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 £172k overspent. This is a £21k reduction in overspend from Month 7. The forecast overspend position is £319k which is a £92k reduction from Month 7. This is primarily due to additional income being received to offset costs already being incurred.

* Kirklees BDU - The year to date position is £516k overspent. This is a £102k significantly increased overspend from Month 7. 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 £551k to £540k.

* Calderdale BDU - The year to date position is £173k overspent. This is a £42k reduction in the overspend position from Month 7 and relates to updated assumptions on out of area expenditure.

* Barnsley BDU - The year to date position is £1481K underspent. This is a £259k increased underspend from Month 7. The main components of this underspend relate to non recurrent underspends on service developments 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 remained broadly static at £1504k.

* LD & Specialist - The year to date position is £304k underspend. This is a £79k increase in the underspend position from Month 7. A high level of vacancies remain within these areas.

* Secure Services - The year to date position is £117k overspent. This is a £22k increased overspend position from Month 7. This is due to pay cost pressures arising from the usage of bank staff and client acuity needs. The forecast has reduced from £294k in Month 7 to £203k overspend in Month 8 due to resolution of a HR issue and reviewed recruitment assumptions.

* Support - The underspends are principally staff related, primarily within the Human Resources and Estates & Facilities (some non-pay) 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	368	552
	Actual	36	36	36	36	27	25	25	25					245	386
	Variance	(10)	(10)	(10)	(10)	(19)	(21)	(21)	(21)					(123)	(166)
LD & Specialist BDU	Target	24	24	24	24	24	24	24	24	24	24	24	24	192	288
	Actual	24	24	24	24	24	22	17	17					175	242
	Variance	0	0	0	0	0	(3)	(7)	(7)					(17)	(46)
Kirklees BDU	Target	25	25	25	55	55	55	55	55	55	55	55	55	350	570
	Actual	25	25	25	25	25	25	25	25					201	301
	Variance	0	0	0	(30)	(30)	(30)	(30)	(30)					(149)	(269)
Calderdale BDU	Target	20	20	20	37	37	37	37	37	37	37	37	37	245	393
	Actual	20	20	20	19	19	19	19	19					154	229
	Variance	0	0	0	(18)	(18)	(18)	(18)	(18)					(91)	(164)
Secure Services	Target	38	38	38	38	38	39	39	39	39	39	39	39	307	463
	Actual	27	27	27	27	27	28	28	28					220	333
	Variance	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)					(87)	(130)
Barnsley BDU	Target	156	156	157	157	157	157	157	157	157	157	157	157	1,254	1,882
	Actual	134	134	135	135	135	135	135	135					1,076	1,615
	Variance	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)					(178)	(267)
Support	Target	126	126	126	126	126	126	126	126	126	126	126	126	1,008	1,512
	Actual	115	115	115	104	109	114	111	111					895	1,353
	Variance	(11)	(11)	(11)	(22)	(17)	(12)	(15)	(15)					(113)	(159)
Trustwide	Target	253	253	253	253	253	253	253	253	253	253	253	252	2,024	3,035
	Actual	253	253	253	253	253	253	253	253					2,024	3,035
	Variance	0	0	0	0	0	0	0	0					0	0
Total	Target	688	688	689	736	736	737	737	737	737	737	737	736	5,748	8,695
	Actual	634	634	635	623	620	620	612	612					4,990	7,493
	Variance	(54)	(54)	(54)	(113)	(116)	(117)	(125)	(125)					(758)	(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	10	10					76	91
	Variance	9	9	9	9	9	11	10	10					76	91
LD & Specialist BDU	Target													0	0
	Actual	0	0	0	1	1	6	6	6					21	46
	Variance	0	0	0	1	1	6	6	6					21	46
Kirklees BDU	Target													0	0
	Actual	0	0	0	0	0	23	4	48					75	269
	Variance	0	0	0	0	0	23	4	48					75	269
Calderdale BDU	Target													0	0
	Actual	0	0	0	14	4	34	15	19					87	164
	Variance	0	0	0	14	4	34	15	19					87	164
Secure Services	Target													0	0
	Actual	0	0	0	0	0	0	0	0					0	23
	Variance	0	0	0	0	0	0	0	0					0	23
Barnsley BDU	Target													0	0
	Actual	22	22	22	22	22	22	22	22					178	267
	Variance	22	22	22	22	22	22	22	22					178	267
Support	Target													0	0
	Actual	9	9	9	20	15	9	15	15					98	159
	Variance	9	9	9	20	15	9	15	15					98	159
Trustwide	Target													0	0
	Actual	0	0	0	0	0	0	0	0					0	0
	Variance	0	0	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	72	121					536	1,020
	Variance	40	40	40	67	51	105	72	121					536	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	368	552
	Actual	45	45	45	45	36	36	35	35	0	0	0	0	321	477
	Variance	(1)	(1)	(1)	(1)	(10)	(10)	(11)	(11)					(47)	(75)
LD & Specialist BDU	Target	24	24	24	24	24	24	24	24	24	24	24	24	192	288
	Actual	24	24	24	25	25	27	23	23	0	0	0	0	196	288
	Variance	0	0	0	1	1	3	(1)	(1)					4	(0)
Kirklees BDU	Target	25	25	25	55	55	55	55	55	55	55	55	55	350	570
	Actual	25	25	25	25	25	48	29	74	0	0	0	0	276	570
	Variance	0	0	0	(30)	(30)	(7)	(26)	19					(74)	0
Calderdale BDU	Target	20	20	20	37	37	37	37	37	37	37	37	37	245	393
	Actual	20	20	20	33	23	52	34	38	0	0	0	0	241	393
	Variance	0	0	0	(4)	(14)	15	(3)	1					(4)	0
Secure Services	Target	38	38	38	38	38	39	39	39	39	39	39	39	307	463
	Actual	27	27	27	27	27	28	28	28	0	0	0	0	220	356
	Variance	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)					(87)	(107)
Barnsley BDU	Target	156	156	157	157	157	157	157	157	157	157	157	157	1,254	1,882
	Actual	156	156	157	157	157	157	157	157	0	0	0	0	1,254	1,882
	Variance	0	0	0	0	0	0	0	0					0	0
Support	Target	126	126	126	126	126	126	126	126	126	126	126	126	1,008	1,512
	Actual	124	124	124	124	124	123	125	125	0	0	0	0	994	1,512
	Variance	(2)	(2)	(2)	(2)	(2)	(3)	(1)	(1)					(14)	0
Trustwide	Target	253	253	253	253	253	253	253	253	253	253	253	252	2,024	3,035
	Actual	253	253	253	253	253	253	253	253	0	0	0	0	2,024	3,035
	Variance	0	0	0	0	0	0	0	0					0	0
Total	**Target**	**688**	**688**	**689**	**736**	**736**	**737**	**737**	**737**	**737**	**737**	**737**	**736**	**5,748**	**8,695**
	Actual	**674**	**674**	**675**	**689**	**671**	**725**	**685**	**733**					**5,525**	**8,513**
	Variance	(14)	(14)	(14)	(47)	(65)	(12)	(52)	(4)					(223)	(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 8 Position

The year to date target is £5.75m and to date BDU's have allocated £5.53m. This leaves a shortfall of £223k.

* Wakefield BDU - the year to date position reflects slippage of 1 scheme, this is £47k. 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 £87k 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 £178k 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 £113k due to delays in realising procurement CIP's and expected delays in recruitment. The forecast position is a shortfall of £159k but non recurrent substitutions are being found.

Monitor Risk Rating

Financial Risk Rating 2013/ 2014

	November 2013 Actuals		Annual Plan Quarter 3	
Metric	Score	Rating	Score	Rating
Capital Servicing Capacity	7.7	4	6.0	4
Liquidity	16.9	4	15.1	4
Weighted Average		**4**		**4**

Financial Risk Rating 2013/ 2014

	November 2013 Actuals		Annual Plan Quarter 3	
Metric	Score	Rating	Score	Rating
EBITDA margin	5.59%	3	5.20%	3
EBITDA, % achieved	100%	5	100%	5
ROA	6.62%	5	6.20%	5
I&E surplus margin	2.64%	4	2.60%	4
Liquid ratio	32	4	30.3	4
Weighted Average		**4.1**		**4.1**

The introduction of the Risk Assessment Framework in October 2013 means that the Trust financial rating, the Continuity of Service Risk Rating, is now based upon 2 metrics.

Both of these are currently better than planned.

These are rated on a scale of 1 - 4 with 4 being the highest possible score.

We will continue to monitor the previous ratings in shadow form for the immediate future.

The Monitor Financial Risk Rating is 4.1 against a planned position at the end of Quarter 3 2013 / 2014 of 4.1.

All 5 metrics are better than planned.

Monitor Benchmarking

All Foundation Trusts

FRR	Governance Rating			
	Green	Red	TBC	**Total**
5	8	1	0	**9**
4	**30**	0	5	**35**
3	66	6	10	**82**
2	1	7	4	**12**
1	0	9	0	**9**
Total	**105**	**23**	**19**	**147**

Mental Health Trusts

FRR	Governance Rating			
	Green	Red	TBC	**Total**
5	4	1	0	**5**
4	**12**	0	3	**15**
3	21	0	0	**21**
2	0	0	0	**0**
1	0	0	0	**0**
Total	**37**	**1**	**3**	**41**

The table to the left shows overall performance by the 147 Foundation Trusts (monitored by Monitor) for the 6 months to the end of September 2013 (Quarter 2). Of these 41 are Mental Health Trusts.

Financial Risk Ratings scores, at the end of Quarter 2, are scored on the 1 - 5 matrix. It is envisaged that benchmarking against the current Risk Assessment Framework will be available for Quarter 3.

The governance rating is rated on a Green / Red rating with a number of Trusts still to be confirmed. Monitor have identified concerns for these Trusts but not yet taken action.

Highlighted within these numbers the Trust performance is 4.1 (against a planned 4.1) and the correlation between Financial and Governance Risk Ratings. The average FRR for Mental Health Trusts remains 3.6 which is higher than the Foundation Trust average of 3.2.

Overall there are 21 Trusts subject to enforcement action by Monitor. This is an increase of 1 from Quarter 1. (North Lincolnshire and Goole)

Analysis of Expenditure by Type 2013 / 2014

Type	Heading	Annual Budget	YTD Budget	YTD Actual	YTD Variance	Note
	Direct Credits & Income	(7.32)	(5.07)	(5.20)	(0.13)	
	Recharges	(4.98)	(3.60)	(3.74)	(0.14)	
Non-healthcare Income Total		(12.30)	(8.66)	(8.93)	(0.27)	
	Admin & Clerical	27.51	18.23	17.59	(0.64)	1
	Agency	2.49	1.70	1.95	0.25	2
	Ancillary	7.17	4.78	4.68	(0.10)	
	Medical	19.51	12.98	12.52	(0.46)	1
	Nursing	82.29	54.97	53.43	(1.54)	1
	Other Healthcare Staff	32.88	22.05	20.30	(1.75)	1
	Other Pay Costs	(4.48)	(3.45)	0.00	3.45	3
	Senior Management	1.42	0.95	0.84	(0.11)	
	Social Care Staff	2.39	1.61	1.55	(0.06)	
Pay- Expenditure Total		171.18	113.81	112.86	(0.95)	
	Clinical Supplies	2.68	1.51	1.47	(0.03)	
	Drugs	4.10	2.73	2.58	(0.16)	
	Healthcare subcontracting	2.71	1.81	2.69	0.89	
	Hotel Services	2.43	1.65	1.72	0.08	
	Office Supplies	3.94	2.64	2.54	(0.09)	
	Other Costs	6.27	4.15	3.60	(0.55)	
	Property Costs	6.67	4.57	4.78	0.21	
	Service Level Agreements	5.90	3.93	3.94	0.00	
	Training & Education	1.08	0.73	0.46	(0.27)	
	Travel & Subsistence	5.62	3.84	3.31	(0.53)	
	Utilities	2.00	1.12	1.15	0.03	
	Vehicle Costs	1.67	1.17	1.34	0.17	
Non-pay Expenditure Total		45.06	29.85	29.58	(0.27)	
	Provisions	5.01	3.59	2.83	(0.77)	
Grand Total		**208.95**	**138.59**	**136.33**	**(2.25)**	

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 £4.66m underspend on pay. This is being offset by the £3.45m staff vacancy factor and £0.25m 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.

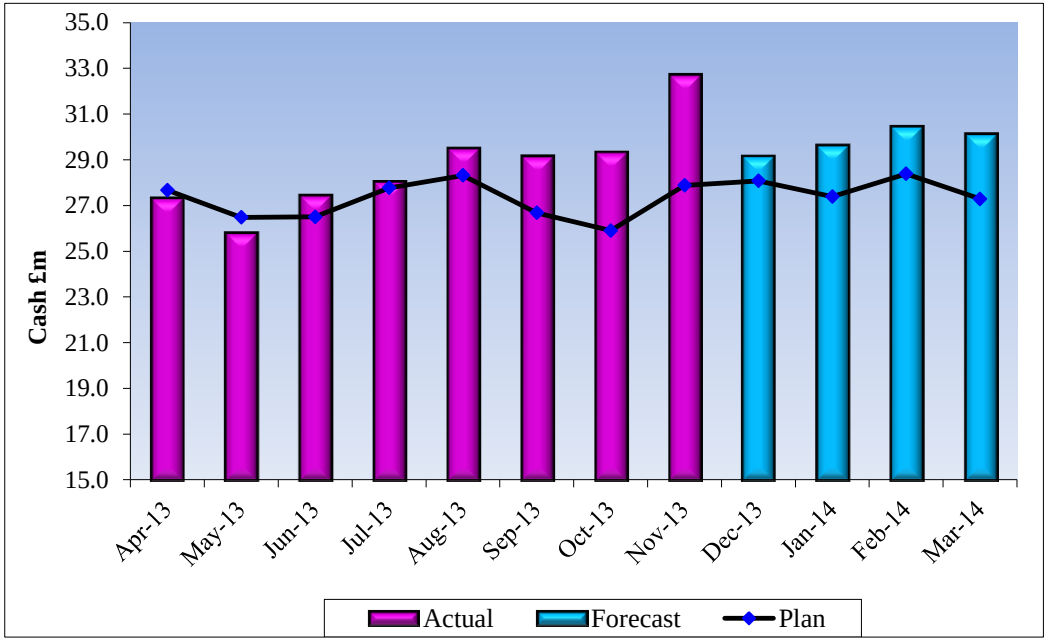
2. Agency costs are higher than planned. Spend is:

* Medical £663k
* Nursing £404k
* Social Workers £281k
* Admin & Clerical £602k

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.

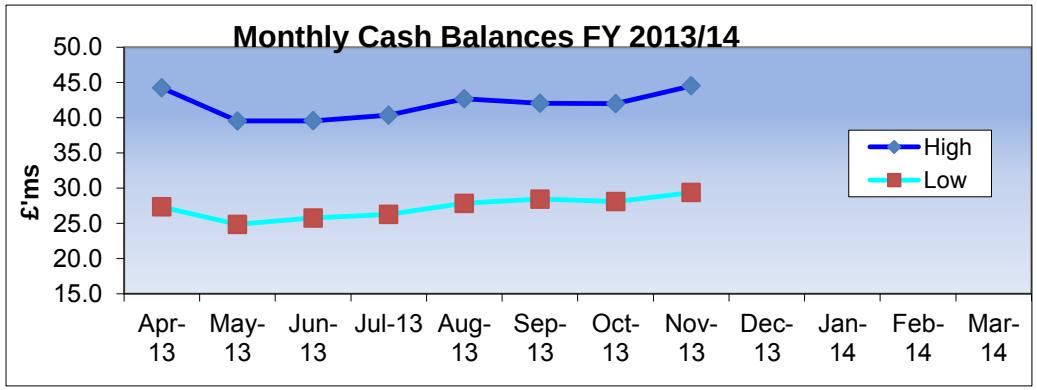
The actual cash position for the month is £32.72m. This is £4.83m ahead of the planned cash value of £27.88m.

A breakdown of this movement is provided on page 15 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.

There is a forecast reduction in the cash position in December 2013 as it is expected that a large proportion of the outstanding creditors will be resolved.

	Plan	Actual
	£m	£m
Opening Balance	25.90	29.34
Closing Balance	27.88	32.72



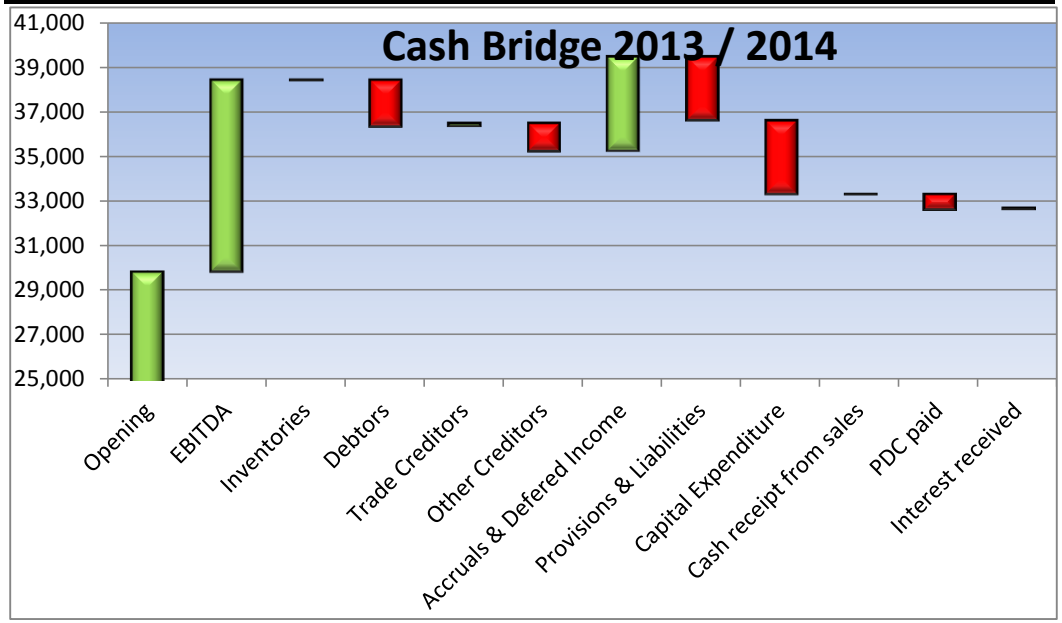
The graph to the left demonstrates the highest and lowest cash balances with each month. This is important to ensure that cash is available as required.

The highest balance is : £44.52m.
The lowest balance is : £29.37m.

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)	7.92	8.63	**0.70**	*1*
Movement in working capital:				
Inventories & Work in Progress	0.00	0.00	**0.00**	
Receivables (Debtors)	(1.69)	(2.09)	**(0.41)**	*4*
Trade Payables (Creditors)	0.62	0.14	**(0.48)**	
Other Payables (Creditors)	(2.74)	(1.26)	**1.49**	*2*
Accruals & Deferred income	0.51	4.25	**3.74**	*2*
Provisions & Liabilities	(2.30)	(2.86)	**(0.56)**	
Movement in LT Receivables				
Capital expenditure	(3.16)	(3.30)	**(0.14)**	*3*
Cash receipts from asset sales	0.00	0.00	**0.00**	
PDC Dividends paid	(1.13)	(0.70)	**0.43**	
PDC Received	0.00	0.00	**0.00**	
Interest (paid)/ received	0.00	0.06	**0.06**	
Closing Balances	**27.88**	**32.72**	**4.83**	



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 and other creditors being higher than planned. Once this is implemented it is expected that these metrics will revert to a normal position.

Factors which decrease the cash position against the plan:

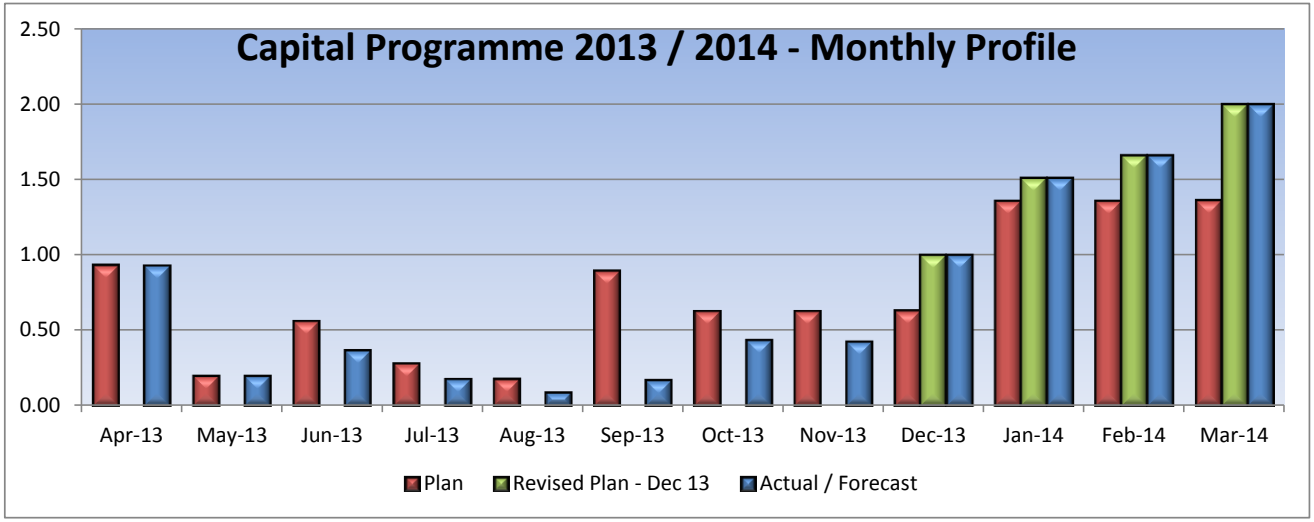
3. As a result of changes in the capital programme it is anticipated there will be a variance in the cash plan. Currently this is having a marginally negative impact.

4. Debtors are higher than planned. However this is a reduction in excess of £1m from last month as delays with non NHS debtors have been paid. As a consequence this has had a positve impact on the overall cash position this month.

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	2.28	1.21	(1.06)	3.87	(1.02)	
Total Minor Capital		**4.89**	**2.28**	**1.21**	**(1.06)**	**3.87**	**(1.02)**	*2*
Major Capital Schemes								
Newton Lodge	11.80	1.32	1.32	1.20	(0.11)	1.31	(0.01)	
IM&T	1.60	0.85	0.45	0.18	(0.27)	0.85	0.00	
Estate Strategy	19.90	1.94	0.25	0.21	(0.04)	2.57	0.63	
Total Major Schemes		**4.11**	**2.02**	**1.60**	**(0.42)**	**4.73**	**0.62**	*3*
VAT Refunds		0.00	0.00	(0.00)	(0.00)	(0.13)	(0.12)	
TOTALS		**8.99**	**4.30**	**2.81**	**(1.49)**	**8.48**	**(0.51)**	*1*



Capital Expenditure 2013 / 2014

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

2. The year to date position is £1.49m under plan (35%) and as such breaches the 15% threshold set by Monitor. This has been reported to Monitor as part of the Quarter 2 return. An additional Capital Forecast will be submitted to Monitor on 18th December 2013.

3. The largest element of risk concerning this forecast position is that £5.17m is forecast to be spent in Quarter 4. This accounts for 58% of the overall capital programme.

4. Of this spend the main schemes relate to:

Forensic Ward Refurbishment	£1.51m
Seclusion Facilities	£0.54m
Major Utilities Upgrade	£0.79m
Calderdale Hub	£0.33m
Total	**£3.07m**

5. Due to this element of risk it was communicated to Monitor in the Quarter 2 return that there was a potential £500k slippage against Capital Programme for 2013 / 2014.

Balance Sheet

	Actual at 31/03/13	Plan at 30/11/13	Actual at 30/11/13	Note
	£m	£m	£m	
Non-Current (Fixed) Assets	**69.20**	**106.28**	**105.42**	*1*
Current Assets				
Inventories & Work in Progress	0.56	0.56	0.56	
NHS Trade Receivables (Debtors)	1.43	1.04	1.11	*2*
Other Receivables (Debtors)	3.15	5.36	5.56	*3*
Cash and Cash Equivalents	29.85	27.88	32.72	*9*
Total Current Assets	**34.99**	**34.85**	**39.95**	
Current Liabilities				
NHS Trade Payables (Creditors)	(2.48)	(3.10)	(2.62)	*4*
Non NHS Trade Payables (Creditors)	(3.88)	(1.89)	(2.88)	*4*
Other Payables (Creditors)	(3.36)	(3.50)	(3.54)	
Capital Payables (Creditors)	(1.25)	(0.50)	(0.73)	*5*
Accruals	(9.03)	(9.66)	(13.06)	*6*
Deferred Income	(0.79)	(1.05)	(1.00)	
Total Current Liabilities	**(20.79)**	**(19.69)**	**(23.84)**	
Net Current Assets/Liabilities	**14.20**	**15.16**	**16.11**	
Total Assets less Current Liabilities	**83.40**	**121.44**	**121.53**	
Provisions for Liabilities	(8.07)	(5.77)	(5.21)	*7*
Total Net Assets/(Liabilities)	**75.33**	**115.67**	**116.32**	
Taxpayers' Equity				
Public Dividend Capital	(41.99)	(41.99)	(41.99)	
Revaluation Reserve	(7.26)	(18.54)	(18.17)	
Other Reserves	(5.22)	(5.22)	(5.22)	
Income & Expenditure Reserve	(20.86)	(49.92)	(50.94)	*8*
Total Taxpayers' Equity	**(75.33)**	**(115.67)**	**(116.32)**	

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

1. Fixed assets include the April 2013 transfer of Estate from Barnsley (£37.9m). As noted previously the Trust capital programme is currently behind plan.

2. NHS debtors are £1.11m - broadly in line with plan. Of this £0.16m are older than 60 days.

3. Other debtors are £0.20m higher than planned. Following a number of payments from Local Authorities this is a favourable movement back in line with plan.

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 compared to previous years, 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 for the same period.

Better Payment Practice Code

NHS		
	Number	Value
	%	%
Year to October 2013	93.7%	94.2%
Year to November 2013	93.3%	94.3%

Non NHS		
	Number	Value
	%	%
Year to October 2013	96.5%	95.6%
Year to November 2013	96.2%	94.4%

Local Suppliers - 10 days		
	Number	Value
	%	%
Year to October 2013	80.9%	77.4%
Year to November 2013	79.0%	73.5%

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 93% 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 96% of the total number of invoices that have been paid within 30 days and 94% 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 79% of Local Supplier invoices by volume and 74% by the value of invoices within 10 days.

Due to upgrades to the Trust financial systems, and an on going review of processes, it is expected that there will be a drop in performance against these metrics during December 2013 and January 2014 (as a minimum.) This impact will continue to be assessed.

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 (£)
24/10/2013	Lease Rents	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	2149359	240,037
04/11/2013	Lease Rents	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	8099741	196,254
08/11/2013	Rendered by PCT	Barnsley	Barnsley Metropolitan Borough Council	2150195	102,819
25/10/2013	Rendered by PCT	Barnsley	Barnsley Metropolitan Borough Council	2149385	98,255
16/10/2013	Drugs	Trustwide	Mid Yorkshire Hospitals NHS Trust	2148972	97,884
23/10/2013	FP10´S	Trustwide	NHSBSA Prescription Pricing Division	2149307	70,644
29/10/2013	Occupational Health SLA	Trustwide	Leeds and York Partnership NHS FT	2149577	70,083
29/10/2013	Specialty Registrar (CT1-3)	Trustwide	Leeds and York Partnership NHS FT	2149578	64,244
18/10/2013	Local Authority Social Workers	Wakefield	Wakefield MDC	2149083	54,604
08/11/2013	Drugs	Barnsley	Sheffield City Coucil	2150202	51,702
24/10/2013	Information SLA	Trustwide	Calderdale and Huddersfield NHS Foundation Trust	2149353	48,900
28/10/2013	FP10´S	Trustwide	NHSBSA Prescription Pricing Division	2149539	45,333
14/11/2013	Contra account	Trustwide	Mid Yorkshire Hospitals NHS Trust	2150532	45,108
15/11/2013	Lease Rents	Trustwide	Department Of Health	2150647	42,677
06/11/2013	Pathology SLA	Trustwide	Mid Yorkshire Hospitals NHS Trust	2149999	36,337
04/10/2013	Rent	Wakefield	Wakefield MDC	2148365	30,000
02/10/2013	Contra account	Calderdale	Calderdale Metropolitan Borough Council	2148139	28,327
15/11/2013	CNST contributions	Trustwide	NHS Litigation Authority	8100386	28,302
14/11/2013	Radiology SLA	Trustwide	Mid Yorkshire Hospitals NHS Trust	2150623	25,677
14/10/2013	Local Authority Social Workers	Calderdale	Calderdale Metropolitan Borough Council	2148765	25,166

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

FINANCE REPORT

Month 7 (October 2013)

2013 / 2014

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Overall Financial Position

Performance Indicator		Month 7 Performance	Annual Forecast	Trend from last month	Last 3 Months - Most recent			Assurance	Page
Trust Targets					6	5	4		
1	£3.7m Surplus on Income & Expenditure	●	●	⇧	●	●	●	4	4 to 6
2	Cash position equal to or ahead of plan	●	●	⇧	●	●	●	4	13
3	Capital Expenditure within 15% of plan.	●	●	⇩	●	●	●	4	15
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	17

Summary Financial Performance

1. The year to date position, as at October 2013 is showing a net surplus of £3.3m which is £0.9m ahead of plan. The Forecast for the year is £3.76m which is £0.045m marginally above plan.
2. At October 2013 the cash position is £29.3m which is £3.4m ahead of plan.
3. Capital spend to October 2013 is £2.38m which is £1.29m (35%) behind plan.
4. At Month 7 the Cost Improvement Programme is £0.22m (approx 3%) under the target of £5.01m.
5. The previous financial risk rating methodology at October 2013 is 4.1 which is in line with plan 4.1 Quarter 3 position.
   N.B. The Revised Monitor Risk Assessment Framework ("RAF") Monitor risk rating is 4 actual Vs. 4 plan.
6. At 31st October 2013 94% of NHS and 97% of non NHS invoices have achieved the 30 day payment target (95%).
   N.B. Better Payment Practice performance is expected to drop during November and December 2013 (as a minimum) as system processes are updated.

Income & Expenditure

Budget Staff in Post	Actual Staff in Post	Variance	This Month Budget	This Month Actual	This Month Variance	Description	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Forecast Outturn	Forecast Variance
WTE	**WTE**	**WTE**	**£k**	**£k**	**£k**		**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
			(3,642)	(3,597)	45	Wakefield Commissioners	(25,455)	(25,138)	317	(43,639)	(43,549)	90
			(3,560)	(3,414)	146	Kirklees Commissioners	(24,150)	(23,983)	168	(41,951)	(41,497)	454
			(1,796)	(1,786)	10	Calderdale Commissioners	(12,569)	(12,548)	21	(21,546)	(21,509)	37
			(7,297)	(7,198)	99	Barnsley Commissioners	(51,154)	(50,846)	308	(87,638)	(87,083)	556
			(2,178)	(1,988)	190	Secure Services Comm's	(14,108)	(13,918)	190	(24,998)	(23,699)	1,299
			(31)	(64)	(32)	Non Contract Income	(211)	(364)	(153)	(339)	(539)	(200)
			(18,504)	**(18,047)**	**457**	**Total Income**	**(127,646)**	**(126,796)**	**851**	**(220,111)**	**(217,875)**	**2,236**
523	513	(11)	1,825	1,891	66	Wakefield	12,776	12,970	194	21,889	22,300	411
589	564	(25)	2,032	2,039	6	Kirklees	14,012	14,425	413	24,406	24,957	551
339	324	(15)	1,088	1,102	15	Calderdale	7,697	7,912	215	13,484	13,664	179
1,709	1,570	(139)	5,869	5,663	(206)	Barnsley	41,301	40,078	(1,223)	71,152	69,647	(1,505)
428	442	13	1,343	1,408	65	Secure Services	9,445	9,539	95	16,247	16,541	294
307	284	(23)	1,192	1,184	(8)	LD & Specialist	8,381	8,156	(225)	14,345	13,894	(451)
699	678	(21)	3,466	3,396	(70)	Support	24,192	23,545	(646)	42,133	41,768	(365)
0	0	0	440	201	(239)	Provisions	2,928	2,493	(435)	5,287	4,099	(1,188)
4,595	**4,374**	**(221)**	**17,254**	**16,885**	**(370)**	**Total Operating Expenses**	**120,732**	**119,119**	**(1,612)**	**208,943**	**206,870**	**(2,073)**
4,595	**4,374**	**(221)**	**(1,249)**	**(1,162)**	**87**	**EBITDA**	**(6,914)**	**(7,676)**	**(762)**	**(11,168)**	**(11,005)**	**163**
			446	369	(77)	Depreciation	3,123	3,046	(77)	5,354	5,222	(132)
			142	141	(0)	PDC Paid	990	990	(0)	1,698	1,698	0
			0	(7)	(7)	Interest Received	0	(51)	(51)	0	(75)	(75)
			0	0	0	Impairment of Assets	396	396	0	396	396	0
4,595	**4,374**	**(221)**	**(662)**	**(659)**	**3**	**Surplus**	**(2,404)**	**(3,294)**	**(890)**	**(3,719)**	**(3,764)**	**(45)**

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 7, is that this target will be exceeded by £45k and the key components of this are:

		£k	
*	Operational Budgets Position	885	
*	Provisions	1,188	
*	Depreciation	132	
*	Interest better than planned	75	
		2,281	
	Less:		
*	CQUIN Risk	600	
*	Activity Income Risk	1,636	
		2,236	
		45	Favourable

Month 7

The year to date position, as at month 7, reflects a £3.294m surplus which is £0.89m (37%) ahead of plan.

The principal components of this surplus continue to be 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 continuing overspends mainly on 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.

Income and Expenditure Detail

Healthcare Contract Income

Income is behind plan. This is due to:

* The shortfall against CQUIN income in Quarter 1 & 2 is £0.22m against a Quarter 1 & 2 budget of £2.21m. (10%)

* Barnsley BDU is not able to recover planned (budgeted) income arising from available PICU beds and Substance Misuse. These are under plan by £0.18m 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 associated expenditure will be incurred later in the year.

The CQUIN income target 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 managed 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 £194k overspent. This is a £66k significant increased overspend from Month 6. The forecast overspend position is £411k which is a £34k increase from Month 6. This increase is due to exceptional costs relating to 1 out of area placement.

* Kirklees BDU - The year to date position is £413k overspent. This is a £6k minor increased overspend from Month 6. 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 £596k to £551k.

* Calderdale BDU - The year to date position is £215k overspent. This is a £15k minimal increase in the overspend position from Month 6.

* Barnsley BDU - The year to date position is £1223K underspent. This is a £206k increased underspend from Month 6. The main components of this underspend relate to non recurrent underspends on service developments 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 remained broadly static at £1505k.

* LD & Specialist - The year to date position is £225k underspend. This is a £8k increase in the underspend position from Month 6. A high level of vacancies remain within these areas.

* Secure Services - The year to date position is £95k overspent. This is a £65m increased overspend position from Month 6. This is due to pay cost pressures arising from the usage of bank staff and client acuity needs. This has been reflected in the forecast which has increased from £269k in Month 6 to £294k overspend in Month 7.

* Support - The underspends are principally staff related, primarily within the Human Resources and Estates & Facilities (some non-pay) 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	322	552
	Actual	36	36	36	36	27	25	25						220	386
	Variance	(10)	(10)	(10)	(10)	(19)	(21)	(21)						(102)	(166)
LD & Specialist BDU	Target	24	24	24	24	24	24	24	24	24	24	24	24	168	288
	Actual	24	24	24	24	24	22	17						158	242
	Variance	0	0	0	0	0	(3)	(7)						(10)	(46)
Kirklees BDU	Target	25	25	25	55	55	55	55	55	55	55	55	55	295	570
	Actual	25	25	25	25	25	25	25						175	301
	Variance	0	0	0	(30)	(30)	(30)	(30)						(120)	(269)
Calderdale BDU	Target	20	20	20	37	37	37	37	37	37	37	37	37	208	393
	Actual	20	20	20	19	19	19	19						135	229
	Variance	0	0	0	(18)	(18)	(18)	(18)						(73)	(164)
Secure Services	Target	38	38	38	38	38	39	39	39	39	39	39	39	268	463
	Actual	27	27	27	27	27	28	28						192	333
	Variance	(11)	(11)	(11)	(11)	(11)	(11)	(11)						(76)	(130)
Barnsley BDU	Target	156	156	157	157	157	157	157	157	157	157	157	157	1,097	1,882
	Actual	134	134	135	135	135	135	135						941	1,615
	Variance	(22)	(22)	(22)	(22)	(22)	(22)	(22)						(156)	(267)
Support	Target	126	126	126	126	126	126	126	126	126	126	126	126	882	1,512
	Actual	115	115	115	104	109	114	111						784	1,353
	Variance	(11)	(11)	(11)	(22)	(17)	(12)	(15)						(98)	(159)
Trustwide	Target	253	253	253	253	253	253	253	253	253	253	253	252	1,771	3,035
	Actual	253	253	253	253	253	253	253						1,771	3,035
	Variance	0	0	0	0	0	0	0						0	0
Total	Target	688	688	689	736	736	737	737	737	737	737	737	736	5,011	8,695
	Actual	634	634	635	623	620	620	612						4,377	7,493
	Variance	(54)	(54)	(54)	(113)	(116)	(117)	(125)						(634)	(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	10						66	91
	Variance	9	9	9	9	9	11	10						66	91
LD & Specialist BDU	Target													0	0
	Actual	0	0	0	1	1	6	6						15	46
	Variance	0	0	0	1	1	6	6						15	46
Kirklees BDU	Target													0	0
	Actual	0	0	0	0	0	23	4						27	269
	Variance	0	0	0	0	0	23	4						27	269
Calderdale BDU	Target													0	0
	Actual	0	0	0	14	4	34	15						67	164
	Variance	0	0	0	14	4	34	15						67	164
Secure Services	Target													0	0
	Actual	0	0	0	0	0	0	0						0	23
	Variance	0	0	0	0	0	0	0						0	23
Barnsley BDU	Target													0	0
	Actual	22	22	22	22	22	22	22						156	267
	Variance	22	22	22	22	22	22	22						156	267
Support	Target													0	0
	Actual	9	9	9	20	15	9	15						84	159
	Variance	9	9	9	20	15	9	15						84	159
Trustwide	Target													0	0
	Actual	0	0	0	0	0	0	0						0	0
	Variance	0	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	72						415	1,020
	Variance	40	40	40	67	51	105	72						415	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	322	552
	Actual	45	45	45	45	36	36	35	0	0	0	0	0	286	477
	Variance	(1)	(1)	(1)	(1)	(10)	(10)	(11)						(36)	(75)
LD & Specialist BDU	Target	24	24	24	24	24	24	24	24	24	24	24	24	168	288
	Actual	24	24	24	25	25	27	23	0	0	0	0	0	173	288
	Variance	0	0	0	1	1	3	(1)						5	(0)
Kirklees BDU	Target	25	25	25	55	55	55	55	55	55	55	55	55	295	570
	Actual	25	25	25	25	25	48	29	0	0	0	0	0	202	570
	Variance	0	0	0	(30)	(30)	(7)	(26)						(93)	0
Calderdale BDU	Target	20	20	20	37	37	37	37	37	37	37	37	37	208	393
	Actual	20	20	20	33	23	52	34	0	0	0	0	0	202	393
	Variance	0	0	0	(4)	(14)	15	(3)						(6)	0
Secure Services	Target	38	38	38	38	38	39	39	39	39	39	39	39	268	463
	Actual	27	27	27	27	27	28	28	0	0	0	0	0	192	356
	Variance	(11)	(11)	(11)	(11)	(11)	(11)	(11)						(76)	(107)
Barnsley BDU	Target	156	156	157	157	157	157	157	157	157	157	157	157	1,097	1,882
	Actual	156	156	157	157	157	157	157	0	0	0	0	0	1,097	1,882
	Variance	0	0	0	0	0	0	0						0	0
Support	Target	126	126	126	126	126	126	126	126	126	126	126	126	882	1,512
	Actual	124	124	124	124	124	123	125	0	0	0	0	0	868	1,512
	Variance	(2)	(2)	(2)	(2)	(2)	(3)	(1)						(14)	0
Trustwide	Target	253	253	253	253	253	253	253	253	253	253	253	252	1,771	3,035
	Actual	253	253	253	253	253	253	253	0	0	0	0	0	1,771	3,035
	Variance	0	0	0	0	0	0	0						0	0
Total	**Target**	**688**	**688**	**689**	**736**	**736**	**737**	**737**	**737**	**737**	**737**	**737**	**736**	**5,011**	**8,695**
	Actual	**674**	**674**	**675**	**689**	**671**	**725**	**685**						**4,792**	**8,513**
	Variance	(14)	(14)	(14)	(47)	(65)	(12)	(52)						(219)	(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 7 Position

The year to date target is £5.01m and to date BDU's have allocated £4.79m. This leaves a shortfall of £219k.

* Wakefield BDU - the year to date position reflects slippage of 1 scheme, this is £36k. 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 £76k 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 £156k 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 £98k due to delays in realising procurement CIP's and expected delays in recruitment. The forecast position is a shortfall of £159k but non recurrent substitutions are being found.

Monitor Risk Rating

Financial Risk Rating 2013/ 2014

	October 2013 Actuals		Annual Plan Quarter 3	
Metric	Score	Rating	Score	Rating
Capital Servicing Capacity	7.8	4	6.0	4
Liquidity	16.4	4	15.1	4
Weighted Average		**4**		**4**

Financial Risk Rating 2013/ 2014

	October 2013 Actuals		Annual Plan Quarter 3	
Metric	Score	Rating	Score	Rating
EBITDA margin	5.69%	3	5.20%	3
EBITDA, % achieved	100%	5	100%	5
ROA	6.62%	5	6.20%	5
I&E surplus margin	2.73%	4	2.60%	4
Liquid ratio	32	4	30.3	4
Weighted Average		**4.1**		**4.1**

The introduction of the Risk Assessment Framework in October 2013 means that the Trust financial rating, the Continuity of Service Risk Rating, is now based upon 2 metrics.

Both of these are currently better than planned

These are rated on a scale of 1 - 4 with 4 being the highest possible score.

We will continue to monitor the previous ratings in shadow form for the immediate future.

The Monitor Financial Risk Rating is 4.1 against a planned position at the end of Quarter 3 2013 / 2014 of 4.1.

All 5 metrics are better than planned.

Analysis of Expenditure by Type 2013 / 2014

Type	Heading	Annual Budget	YTD Budget	YTD Actual	YTD Variance	Note
	Direct Credits & Income	(7.54)	(4.60)	(4.69)	(0.09)	
	Recharges	(4.85)	(3.13)	(3.15)	(0.03)	
Non-healthcare Income Total		(12.39)	(7.73)	(7.84)	(0.11)	
	Admin & Clerical	27.47	15.94	15.39	(0.55)	1
	Agency	2.43	1.48	1.63	0.15	2
	Ancillary	7.17	4.18	4.09	(0.09)	
	Medical	19.39	11.31	10.93	(0.38)	1
	Nursing	82.30	48.14	46.74	(1.39)	1
	Other Healthcare Staff	32.87	19.31	17.81	(1.51)	1
	Other Pay Costs	(4.48)	(3.06)	0.00	3.06	3
	Senior Management	1.42	0.83	0.74	(0.09)	
	Social Care Staff	2.34	1.39	1.39	(0.00)	
Pay- Expenditure Total		170.92	99.51	98.72	(0.79)	
	Clinical Supplies	2.63	1.29	1.22	(0.07)	
	Drugs	4.10	2.39	2.15	(0.24)	
	Healthcare subcontracting	2.71	1.58	2.42	0.83	
	Hotel Services	2.43	1.41	1.47	0.06	
	Office Supplies	3.87	2.26	2.11	(0.14)	
	Other Costs	6.54	3.76	3.33	(0.43)	
	Property Costs	6.67	3.99	4.13	0.14	
	Service Level Agreements	5.90	3.45	3.46	0.01	
	Training & Education	1.05	0.58	0.40	(0.18)	
	Travel & Subsistence	5.58	3.35	2.89	(0.46)	
	Utilities	2.00	0.94	0.97	0.04	
	Vehicle Costs	1.64	1.01	1.20	0.18	
Non-pay Expenditure Total		45.12	26.02	25.75	(0.27)	
	Provisions	5.29	2.93	2.49	(0.44)	
Grand Total		**208.94**	**120.73**	**119.12**	**(1.61)**	

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 £4.01m underspend on pay. This is being offset by the £3.06m staff vacancy factor and £0.15m 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.

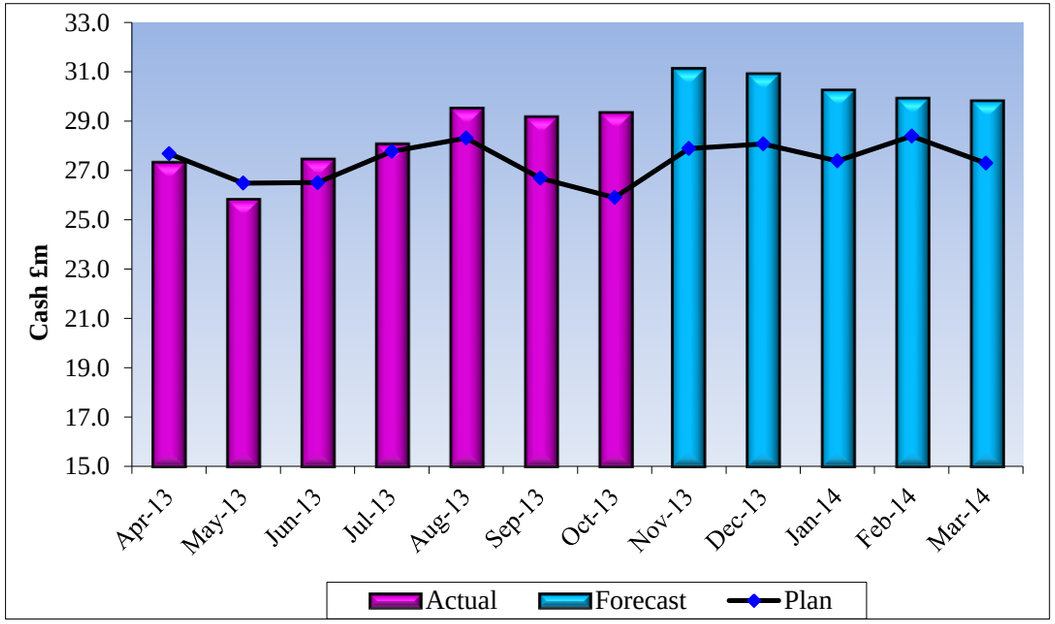
2. Agency costs are higher than planned. Spend is:

* Medical £579k
* Nursing £337k
* Social Workers £224k
* Admin & Clerical £492k

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.

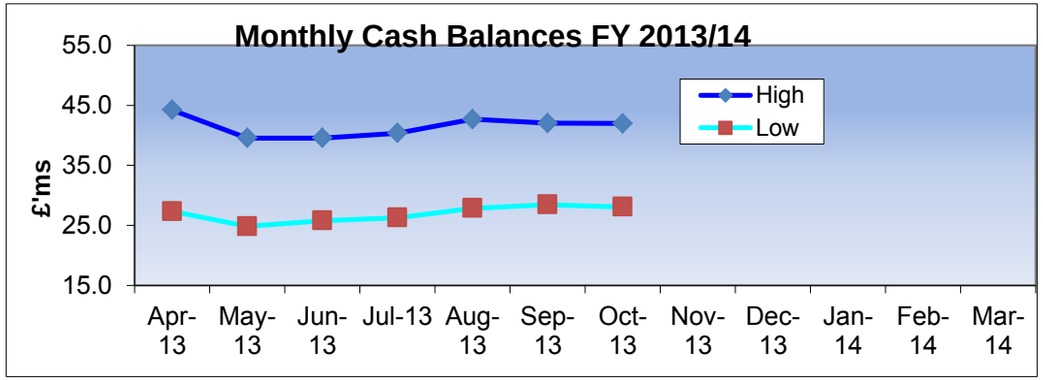
The plan is based upon the Annual Plan submitted to Monitor in May 2013.

The actual cash position for the month is £29.34m. This is £3.43m ahead of the planned cash value of £25.9m.

A breakdown of this movement is provided on page 14 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	26.68	29.16
Closing Balance	25.90	29.34



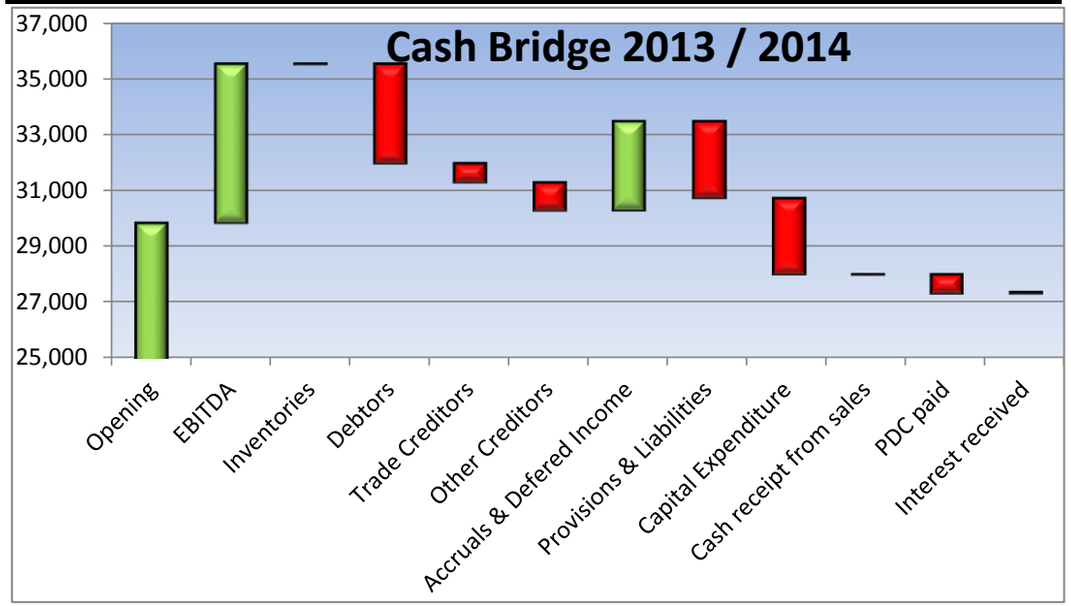
The graph to the left demonstrates the highest and lowest cash balances with each month. This is important to ensure that cash is available as required.

The highest balance is : £42.02m.
The lowest balance is : £28.43m.

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)	6.93	5.70	**(1.24)**	*1*
Movement in working capital:				
Inventories & Work in Progress	0.00	0.00	**0.00**	
Receivables (Debtors)	(3.13)	(3.57)	**(0.44)**	*4*
Trade Payables (Creditors)	0.87	(0.67)	**(1.54)**	
Other Payables (Creditors)	(2.74)	(1.02)	**1.73**	*2*
Accruals & Deferred income	0.30	3.20	**2.90**	*2*
Provisions & Liabilities	(1.97)	(2.75)	**(0.78)**	
Movement in LT Receivables				
Capital expenditure	(3.08)	(2.74)	**0.35**	*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	**25.90**	**27.36**	**1.46**	



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 and other creditors being higher 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.

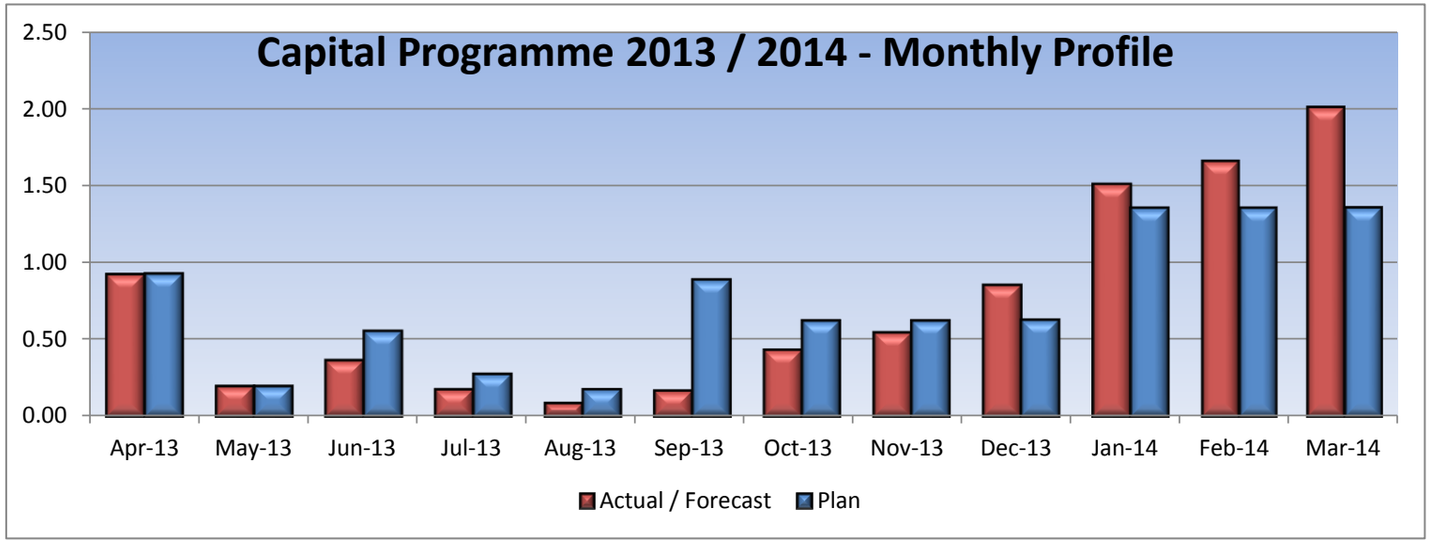
Factors which decrease the cash position against the plan:

4. Debtors are higher than planned. This is specifically non NHS debtors and relates to delayed payment received for block invoices for October 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	1.81	0.88	(0.93)	4.13	(0.76)	
Total Minor Capital		**4.89**	**1.81**	**0.88**	**(0.93)**	**4.13**	**(0.76)**	*2*
Major Capital Schemes								
Newton Lodge	11.80	1.32	1.32	1.18	(0.13)	1.32	(0.01)	
IM&T	1.60	0.85	0.36	0.18	(0.19)	0.85	0.00	
Estate Strategy	19.90	1.94	0.18	0.14	(0.04)	2.82	0.88	
Total Major Schemes		**4.11**	**1.86**	**1.50**	**(0.36)**	**4.98**	**0.87**	*3*
VAT Refunds		0.00	0.00	0.00	0.00	(0.13)	(0.12)	
TOTALS		**8.99**	**3.67**	**2.38**	**(1.29)**	**8.98**	**(0.01)**	*1*



Capital Expenditure 2013 / 2014

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

2. The year to date position is £1.29m under plan (35%) and as such breaches the 15% threshold set by Monitor. This has been reported to Monitor as part of the Quarter 2 return.

3. The largest element of risk concerning this forecast position is that £5.19m is forecast to be spent in Quarter 4. This accounts for 58% of the overall capital programme.

4. Of this spend the main schemes relate to:

Hepworth	£1.4m
Seclusion Facilities	£0.55m
Ring Mains	£0.79m
Laura Mitchell	£0.33m
Total	**£3.07m**

5. Due to this element of risk it was communicated to Monitor in the Quarter 2 return that there was a potential £500k slippage against Capital Programme for 2013 / 2014.

Balance Sheet

	Actual at 31/03/13	Plan at 31/10/13	Actual at 31/10/13	Note
	£m	£m	£m	
Non-Current (Fixed) Assets	**69.20**	**106.65**	**105.36**	*1*
Current Assets				
Inventories & Work in Progress	0.56	0.56	0.56	
NHS Trade Receivables (Debtors)	1.43	1.73	0.88	*2*
Other Receivables (Debtors)	3.15	6.12	7.27	*3*
Cash and Cash Equivalents	29.85	25.90	29.34	*9*
Total Current Assets	**34.99**	**34.31**	**38.04**	
Current Liabilities				
NHS Trade Payables (Creditors)	(2.48)	(3.35)	(1.81)	*4*
Non NHS Trade Payables (Creditors)	(3.88)	(1.89)	(3.11)	*4*
Other Payables (Creditors)	(3.36)	(3.50)	(3.40)	
Capital Payables (Creditors)	(1.25)	(0.50)	(0.81)	*5*
Accruals	(9.03)	(9.22)	(12.13)	*6*
Deferred Income	(0.79)	(1.09)	(0.88)	
Total Current Liabilities	**(20.79)**	**(19.54)**	**(22.14)**	
Net Current Assets/Liabilities	**14.20**	**14.76**	**15.90**	
Total Assets less Current Liabilities	**83.40**	**121.41**	**121.26**	
Provisions for Liabilities	(8.07)	(6.10)	(5.32)	*7*
Total Net Assets/(Liabilities)	**75.33**	**115.31**	**115.94**	
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)	(49.56)	(50.19)	*8*
Total Taxpayers' Equity	**(75.33)**	**(115.31)**	**(115.94)**	

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

1. Fixed assets include the April 2013 transfer of Estate from Barnsley (£37.9m). As noted above the capital programme is currently behind plan.

2. NHS debtors are £0.85m (49%) lower than planned. Of this £0.18m is older than 60 days. No peak expected at the end of a previous Quarter have been experienced.

3. Other debtors are £1.15m higher than planned. This is due October block payments remaining outstanding for three councils (c. £1.76m). £0.74m was paid 4th November 2013.

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 compared to previous years, 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 for the same period.

Better Payment Practice Code

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

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

Local Suppliers - 10 days		
	Number	Value
	%	%
Year to September 2013	81.6%	81.8%
Year to October 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.

Due to upgrades to the Trust financial systems, and an on going review of processes, it is expected that there will be a drop in performance against these metrics during November and December 2013 (as a minimum.) This impacgt will continue to be assessed.

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 17 December 2013
Agenda item 6.3(i)

Title:	**Quality Governance Framework**
Paper prepared by:	Director of Corporate Development/Director of Nursing
Purpose:	To provide sufficient information for Trust Board to be assured that the Trust is meeting Monitor's Quality Governance Framework.
Vision/goals:	The paper supports the Trust's vision, putting patients at the centre and enables the Trust to remain compliant with Monitor's licence conditions as assessed against Monitor's Risk Assessment Framework.
Any background papers/ previously considered by:	Reports to the Clinical Governance and Clinical Safety Committee and to Trust Board (December 2012).
Executive summary:	The attached paper provides a summary for Trust Board of the Quality Governance Framework, how it fits with Monitor's governance requirements, the process to provide an assessment of the Trust's position and how assurance is provided to Trust Board that quality governance criteria are being achieved. The assurance provided will enable Trust Board to provide the self-certification to Monitor that the Trust has in place effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients. The Quality Governance Framework is a tool for self-assessment to ensure Trust Board has the organisational framework (the '4+4') right in terms of setting up: - governance and accountability; - reporting process and performance; - alignment of purpose at all levels in the organisation; - backed up by evidence. <u>Strategy</u> - The Trust's Quality Improvement Strategy provides a framework for delivering quality to define, measure, publish, partner, lead, innovate and safeguard. The Strategy also sets the overall framework for Directors' objectives. - Corporate objectives reflect the Trust's seven quality priorities around listening and acting, access, care and care planning, recording and evaluating care, working in partnership, staff fit and well to car, and safety. <u>Flawless execution</u> - The seven quality priorities form the basis of annual plans. - As part of developing these plans, BDUs and teams have undertaken self-assessments of the impact of their plans in relation to the quality priorities. - Quality Impact Assessments ensure that change does not impact adversely on quality. - Metrics to measure quality will be included in the performance report and against the actions in the framework. <u>Culture of quality</u> - The Trust's values underpin quality and have undergone a wide-ranging review. The values are strongly linked to team performance through the introduction of values-led approaches, such as appraisal. - Service user feedback was fundamental to the review of the Trust's values and development of a set of values that reflect the Trust aims and ambition moving forward.

	- Development of a customer service ethos. Structure - Quality is an essential component of accountability (operational and clinical) and governance, through Trust Board Committees and Executive Management Team reporting. Leadership - How the Trust reflects the importance of quality in leadership through values-based work, such as Middleground. Innovation - How the Trust demonstrates innovation in quality through innovative approaches, such as Creative Minds and the Innovation Fund set aside for quality improvements. Talent management - How the Trust demonstrates the importance of quality in recognising and developing the talent of its staff through initiatives such as the Talent Pool to engage staff in projects to improve quality.
Recommendation:	**Trust Board is asked to note the approach the Trust has taken to ensure there are effective arrangements in place to monitor and improve the quality of healthcare provided to its patients, allowing Trust Board to make its Corporate Governance Statement in support of the Trust's annual plan and quarterly returns to Monitor, as set out in Monitor's Risk Assessment Framework.**
Private session:	Not applicable

Trust Board 17 December 2013
Quality Governance Framework

1. Introduction

Monitor introduced the Quality Governance Framework in 2010/11 as a self-assessment tool for Trust Boards in response to the lessons learned from the failings at Mid Staffordshire NHS Foundation Trust and to a climate of tighter public finances increasing the risk that financial savings might affect quality of care.

Assessment against the Framework enables Trust Board to satisfy itself, its patients and Monitor that effective arrangements are in place to continuously monitor and improve the quality of the care the Trust provides and that areas highlighted through the process as requiring further work are effectively addressed.

Originally, under the requirements of the Compliance Framework 2011/12, Trust Board was required to 'have regard to' the Framework when submitting its annual plan. This changed in 2012/13 and Trust Board was required to positively state there had been an assessment against the framework in its annual and quarterly submissions to Monitor. With the introduction of the licensing regime for providers of healthcare from 1 April 2013, for the financial year 2013/14 Trust Board was required to demonstrate how it meets the Framework in the Corporate Governance Statement. This was approved by Trust Board in April 2013.

In support of the Framework, Monitor issued guidance in April 2013 to Foundation Trust Boards to enable them to more effectively assess their performance against the Framework to support them to continue to perform their role in improving health services for patients.

This paper utilises this guidance to provide further assurance to Trust Board, in advance of the Corporate Governance Statement for 2014/15, that the Trust is meeting the requirements of the Framework.

2. The Framework

The findings of the Francis Reports reinforce that quality should be at the heart of a patient-centred NHS. Quality of care is a key responsibility of Trust Board, and maintaining and improving quality is an important indicator of the effectiveness of governance within a Trust. This is particularly relevant as the NHS changes and finances become more stretched.

Trust Boards have been urged to scrutinise data and be confident that the data they receive is meaningful and trustworthy. Trust Boards need assurance that the processes for the governance of quality are embedded throughout the organisation.

The quality governance framework asks questions about Trust Board's knowledge, experience and the extent to which Trust Board is assured across the following areas.

- Does quality drive the trust's strategy?
- Is the board sufficiently aware of potential risks to quality?
- Does the board have the necessary leadership and skills and knowledge to ensure delivery of the quality agenda?
- Are there clear roles and accountabilities in relation to quality governance?
- Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?

- Is appropriate quality information being analysed and challenged?
- Is the board assured of the robustness of the quality information?
- Is quality information being used effectively?

The further guidance issued by Monitor provides key questions a Board should ask itself to gain assurance that the Trust has good quality governance arrangements in place.

3. Process

The Trust undertook an initial self-assessment following the publication of the Framework. During 2012/13, regular reviews against the Framework were undertaken to identify a range of evidence to demonstrate compliance. The outcome was reported to the Clinical Governance and Clinical Safety Committee.

The Trust's internal auditor, KPMG, undertook an audit of the Framework in December 2012 to ensure the Trust has a robust process for self-certification and that the Trust's self-certification was supported by sufficient evidence to demonstrate compliance against the Framework. The audit provided an opinion of substantial assurance and scored the Trust at 1.5, which satisfies Monitor's criteria for authorisation as a Foundation Trust.

In the summer of 2013, following further discussion at the Clinical Governance and Clinical Safety Committee and with the Chair of the Trust, the Directors of Nursing and Corporate Development commissioned a further review, using Monitor's guidance, of the evidence against the Framework to provide assurance to Trust Board.

The Quality Governance Framework links closely to the Trust's quality priorities and the work undertaken to respond to the recommendations in the second Francis Report, which is led by the Director of Nursing through the Francis into action steering group.

4. Outcome

The outcome of the assessment is outlined below. The areas for development will be discussed with the Chair and Chief Executive and action agreed. The table outlines the detailed questions to support quality governance assurance and how these link to the Quality Governance Framework domains.

Question	Evidence	Link to Quality Governance Framework domains	Areas for development
Engagement on quality: ➢ ***Does the board provide a clear steer on the strategic and operational quality outcomes it expects the organisation to achieve?*** ➢ ***Do you know that a quality culture exists across the different layers of clinical and non-clinical leadership? What is your evidence for this?*** ➢ ***Does the board understand the effectiveness of the methods used by the trust for communicating to and involving staff, patients and stakeholders in the quality agenda?***			
1. The board has put in place a leadership development programme that: ➢ reviews the skills and capabilities of the board in relation to quality governance; ➢ demonstrates learning and impact on behaviours; ➢ considers the skills of non-executive directors in relation to quality governance; ➢ encourages and trains clinical leadership and non-clinical management to participating in setting the quality agenda; and ➢ identifies and develops future leaders.	➢ Executive Directors have quarterly reviews with the Chief Executive with identified objectives and areas for development. ➢ The Chief Executive has annual and half-yearly reviews with the Chair, with identified objectives and areas for development. ➢ The Executive Management Team has undertaken a programme of work on organisational development with Myron Rogers to support transformation programme, both collectively and individually. ➢ Trust Board development session with Baz Hartnell November 2011 and follow up in May 2013, which looked at behaviours, strengths and weaknesses. ➢ Trust Board development session with Ken Tooze to reflect on strategy and individual involvement. ➢ Trust Board Committees' annual self-assessments as part of annual reporting process. ➢ Networking opportunities at Trust Board/strategic level (such as Foundation Trust Network, NHS Confederation, Mental Health Network, Chairs' Network and Director of Finance network. ➢ Trust Board and Non-Executive Director skills reviewed by Nominations Committee in July 2013 in preparation of the recruitment of a Non-Executive Director.	1A: Does quality drive the trust's strategy? 2A: Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda? 2B: Does the board promote a quality-focused culture throughout the trust? 3C: Does the board actively engage patients, staff and other key stakeholders on quality?	A Trust Board development programme was developed as part of the Trust's application for Foundation Trust status. There will be a review of this programme to ensure there is a programme in place. The organisational development framework is current being updated to support quality, driven and linked to service transformation.

Question	Evidence	Link to Quality Governance Framework domains	Areas for development
	➢ Development opportunities for staff of all bands such as Middleground, the Talent Pool, Magnificent 7, 'Right first time, every time' programme. ➢ Continued development of the agenda and work programme for Extended EMT. ➢ Quality Accounts engagement processes to set quality priorities. ➢ Values-based appraisal recruitment and induction processes. ➢ Customer Service Excellence (achieved Trust-wide July 2013) ➢ Whistleblowing and Being Open policies. ➢ Risk and incident reporting procedures. ➢ Engagement events to support the Trust's transformation programme (first series undertaken in the summer of 2013 and the second series in November 2013). A further series of events is planned for spring 2014. The themes emerging from the events have been used to inform the visions for the transformation workstreams and the design of services.		
2. The board encourages the development of an open and quality culture through: ➢ a participative approach to staff and clinical engagement; ➢ the investment of resource to promotion of the change; and ➢ the use of quality walks, surveys and peer reviews.	➢ Trust response to the second Francis Report led by the Director of Nursing through the Francis into action steering group. ➢ Development of quality priorities and form basis for annual plans in 2014/15. ➢ Transformation engagement events (see above). ➢ Transformation service change programme. ➢ Mission and values engagement with service users and carers, staff and stakeholders. ➢ 'Year of Values' in 2014. ➢ Chief Executive 'drop-in' sessions ➢ Creation of the Innovation Fund to support innovative projects aimed at improving services or the environment services are provided in. ➢ Innovative ways of creating alternative ways of delivering services, such as Creative Minds and	2B: Does the board promote a quality-focused culture throughout the trust?	

Question	Evidence	Link to Quality Governance Framework domains	Areas for development
	Change Lab. ➢ Strengthened service improvement, innovation, business intelligence, business planning and development, marketing and customer relations management arrangements. ➢ Appointment of Practice Governance Coaches and Serious Incidents Investigators. ➢ Identified resource to support transformation. ➢ Clinical engagement in annual planning and, in particular, the Quality Impact Assessment of cost improvement programme (which will be extended to the transformation programme). ➢ Unannounced visits programme involving Trust Board members.		
3. The board has developed its quality improvement strategy through: ➢ the creation of systematic processes for engaging staff in development, communication and devising indicators; ➢ involvement of commissioners, partners, patients; ➢ analysis of the organisation's performance on key quality indicators; ➢ directly linking the Quality Accounts with the quality improvement strategy.	➢ Strategic direction for quality expressed in Quality Accounts with clear quality priorities, developed through a process of engagement and communication. ➢ Quality Improvement Strategy approved by Trust Board Near to completion of Quality Improvement Framework, which has included communication and engagement process. ➢ Trust response to the second Francis Report led by the Director of Nursing through the Francis into action steering group. ➢ CQUINs and contract quality schedules and quality report to commissioners through Quality Boards. ➢ Seven quality priorities with clear key performance indicators and actions to demonstrate how Trust is meeting these, which are included in the Trust's Quality Accounts. Progress is reported to the Clinical Governance and Clinical Safety Committee. ➢ Quarterly reporting to Trust Board of progress against priorities. ➢ Patient-led assessment of the care environment (PLACE) visits and revised minor capital programme. ➢ Development of 'What Matters' and patient experience	1A: Does quality drive the trust's strategy? 2B: Does the board promote a quality-focused culture throughout the trust? 3C: Does the board actively engage patients, staff and other key stakeholders on quality?	Further development of the Trust's approach to achieving the quality goals and priorities (Clinical Governance and Clinical Safety Committee 3 December 2013 discussion paper). Link to annual planning will be embedded at team level with evidence to support the seven quality priorities.

Question	Evidence	Link to Quality Governance Framework domains	Areas for development
	reporting. ➢ Quality Accounts engagement (Members'' Council, Healthwatch, commissioners, etc.) ➢ Trust annual Excellence Awards ➢ Development of the 'Right first time, every time' programme for support staff. ➢ Achievement of Customer Service Excellence.		
4. The board applies good principles of effective staff engagement such as: ➢ considering harder to reach staff; ➢ actively considering how staff will be engaged in strategic and service development; ➢ communicating data and information that the board receives to the relevant staff; ➢ ensuring that staff know how to raise issues; and ➢ seeking out and reviewing the results of staff feedback using regular 'local' staff surveys.	➢ Trust response to the second Francis Report led by the Director of Nursing through the Francis into action steering group, which includes consideration of the Trust's response to the Nursing and Midwifery Council's report on staffing capacity and capability. ➢ Transformation programme engagement events. ➢ Chief Executive briefings, particularly in relation to the transformation programme. ➢ Weekly staff news. ➢ Development of service line reporting and platform to enable front-line staff and managers to access immediate performance information. ➢ Performance reports (available on the Trust's website). ➢ Extended EMT feedback from Trust Board. ➢ Whistleblowing policy. ➢ Trust response to Francis Report and establishment of the Francis into action steering group. ➢ Continued development of the '6 ➢ Strengthened service improvement, innovation, business intelligence, business planning and development, marketing and customer relations management arrangements. ➢ Twice-yearly wellbeing survey and annual national staff survey. ➢ Engagement and consultation on service changes, such as Newton Lodge, in-patient services in Kirklees and upgrade of seclusion units.	3C: Does the board actively engage patients, staff and other key stakeholders on quality?	Trust needs to ensure it is effectively communicating with 'hard to reach' staff, particularly those that do not have regular (or any) access to emails and the intranet. Develop communication of data and information Trust Board receives to staff. Continued action to address Francis development areas, particularly Trust response to staff feedback.
5. The board uses the following principles to ensure effective	Trust Board adopts these principles as evidenced by: - transformation engagement events;	3C: Does the board actively engage	Connections with Healthwatch to be developed.

Question	Evidence	Link to Quality Governance Framework domains	Areas for development
engagement with the public: ➢ uses public consultation to shape strategy and process design; ➢ uses a wide variety of methods to engage a cross-section of the public; ➢ promotes a culture of communication; and ➢ feeds back the outcomes from engagement and consultation.	- mission and values engagement events; - patient experience feedback, summarised in 'What Matters'; - robust and valued approach to Customer Services arrangements; - dialogue groups; - members' events; - engagement and consultation on service changes, such as Newton Lodge, in-patient services in Kirklees and upgrade of seclusion units; - engagement and consultation with the Members' Council on a range of issues; - regular engagement and consultation with Overview and Scrutiny Committees.	patients, staff and other key stakeholders on quality?	Ensure feedback from engagement and consultation events is integral to the visions for transformational service change.
6. The board uses patients to design improvements, and monitor whether they have the desired impact through an approach that includes: ➢ capturing a broad range of patients and carers; ➢ embedding patient engagement and involvement into the quality improvement programme; ➢ including patients in service and process redesign; ➢ ensuring engagement processes are user-friendly; ➢ encouraging staff to take ownership by leading responses to patient engagement; and ➢ ensuring patient feedback demonstrates impact.	➢ Engagement and consultation on service changes, such as Newton Lodge, in-patient services in Kirklees, upgrade of seclusion units, ADHD service development and Bretton Centre. ➢ Transformation programme communications, consultation and engagement plan. ➢ Capturing patients' views where have people have difficulty in communicating and have complex and difficult problems (during 2013). ➢ Evidence though Excellence Awards of service-specific improvements on back of patient feedback. ➢ Unannounced visits where members of Trust Board have the opportunity to talk to service users/carers and have opportunity on follow up visits to follow up actions. ➢ The 'You said, we did' section in 'What Matters' by service area.	3C: Does the board actively engage patients, staff and other key stakeholders on quality?	Using service user and carer feedback to improve services and maintaining the impact of service user input. Ensure feedback from engagement and consultation events is integral to the visions for transformational service change and the Trust's integrated business plan.
7. The board engages with commissioners and partners through: ➢ proactive and early consultation;	➢ Transformation programme engagement events. ➢ Quality Accounts engagement. ➢ Quality reporting through Quality Boards to	3C: Does the board actively engage patients, staff and other	

Question	Evidence	Link to Quality Governance Framework domains	Areas for development
➢ ensuring that commissioners' views are considered in setting and monitoring quality goals; and ➢ collaborating with local authorities and GPs on quality improvement strategies.	commissioners. ➢ Engagement with local authorities through Health and Wellbeing Boards and Clinical Commissioning Groups. ➢ Team-to-team meetings with commissioners and other NHS partners.	key stakeholders on quality?	
Gaining insight and foresight into quality: ➢ ***How are you assured that the board is receiving the right type and level of quality information?*** ➢ ***Have you compared the information you receive with other trusts of similar type and complexity?*** ➢ ***Are the 'hard' facts and data consistent with what you are hearing and observing around your trust?*** ➢ ***How are you assured that the data you use to inform decisions is robust and valid?*** ➢ ***Could you name the best and worst performing services from a quality perspective within your trust and how these services compare with other trusts?***			
8. The board uses a strategic integrated performance dashboard which includes: ➢ quality, performance, activity and finance; ➢ aligning performance scorecards to strategic goals; ➢ expanding to ward- and service-level dashboards; ➢ explanation for variances; ➢ analyses and comments; ➢ performance projection and trends; ➢ risk analysis on achieving trajectory; and ➢ overview summary of the impact on quality by division or service.	➢ Monthly performance and finance reports. ➢ Quarterly quality performance and HR reports. ➢ Quarterly 'What Matters' report. ➢ Customer Services arrangements. ➢ Serious incidents arrangements and quarterly reports to both Clinical Governance and Clinical Safety Committee and Trust Board. ➢ Quality Accounts. ➢ Exception reports commissioned by Trust Board. ➢ Annual risk assessment of targets, CQUINs, etc. ➢ Organisational risk register and BDU risk registers. ➢ Development of service line reporting. ➢ Performance reports Trust-wide and by BDU level. ➢ CQC self-assessment twice-yearly. ➢ Quality Impact Assessment process. ➢ Annual review of compliance with requirements of the Trust's Licence.	4A Is appropriate quality information being analysed and challenged? 4C Is quality information used effectively?	Continued development and utilisation of mental health currency and further development of outcome metrics across all services.
9. The board has a strategic approach to data quality which drives quality improvement with: ➢ SMART objectives;	➢ Data Quality Strategy. ➢ Data quality group (chaired by Director of Nursing) and clinically-led. ➢ Use of internal audit.	4B: Is the board assured of the robustness of the quality information?	Use of data linked to mental health currency development. To support the transformation programme, broader outcome-based metrics for

Question	Evidence	Link to Quality Governance Framework domains	Areas for development
➢ data quality metrics; and ➢ data quality assurance and audit programme.	➢ Ongoing monitoring and scrutiny by Audit and Clinical Governance and Clinical Safety Committees. ➢ Continued implementation of and upgrades to RiO (the Trust's clinical information system) across the Trust.		all services.
10. The board benchmarks performance: ➢ with comparable organisations where possible; ➢ based on risk assessing greatest need; ➢ using internal benchmarking and 'peer reviews'; and ➢ analysing historical data.	➢ National surveys. ➢ Reference costs. ➢ Human resources data. ➢ Wellbeing survey and national staff survey. ➢ Service line reporting development and internal benchmarking. ➢ Incidents reported to the National Patient Safety Agency. ➢ Accredited services such as ECT, library, Investors in People, Customer Service Excellence, etc. ➢ Peer review at Newton Lodge. ➢ KPMG report on benchmarking of foundation trust forward plans. ➢ Deloitte support of development of Quality Accounts.	4A Is appropriate quality information being analysed and challenged? 4C Is quality information used effectively?	Increased utilisation of benchmarking, both internally and externally.
Accountability for quality: ➢ ***What are the key sources of assurance upon which you rely?*** ➢ ***Are you able to distinguish between assurance and reassurance?*** ➢ ***Is there a clear trail of assurance underpinning the board statements and declarations?*** ➢ ***Do you understand how quality governance assurance processes operate across the organisation's committee structure?*** ➢ ***Do you understand the role that your audit functions have in supporting board assurance on quality governance?***			
11. The board supports its Corporate Governance Statement on quality and quality governance through: ➢ a clearly understood structure of assurance and baseline assessments supporting statements and declarations by the board; ➢ utilising the internal audit function to provide an overview of the	➢ Currently set out in Annual Governance Statement, Corporate Governance Statement (including assessment against Trust Board self-certification) for Monitor quarterly return and governance statement for annual plan. ➢ Review of risk associated with Monitor's Risk Assessment Framework and Monitor's licensing conditions. ➢ External assurance on Quality Accounts. ➢ Process in place to assess compliance against Quality	1B: Is the board sufficiently aware of potential risks to quality? 2A: Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda? 3A: Are there clear roles	Clearer link between Quality Accounts and the organisational risk register.

Question	Evidence	Link to Quality Governance Framework domains	Areas for development
quality governance assurances; ➢ mapping quality improvement strategies to the *Quality Governance Framework* to ensure visibility at the board and within the organisation as to how the trust's quality activities are aligned with the regulatory regime and the coverage provided by the audit and risk escalation processes.	Governance Framework, which will inform Corporate Governance Statement for 2014/15 and Annual Governance Statement 2013/14. ➢ Internal audit utilised to provide assurance on compliance with Framework. ➢ Risk register process clearly linked to Board Assurance Framework evidenced through internal audit review. ➢ Committee structure provides assurance to Trust Board evidenced through internal audit review and annual reports to Trust Board, with clear responsibility of Clinical Governance and Clinical Safety Committee for quality. ➢ Clear roles and accountabilities through the Executive Management Team for quality across the Trust and across Directors' portfolios. ➢ Quality Improvement Strategy sets out Trust approach to quality.	and accountabilities in relation to quality governance?	
12. The board has effective supporting structures to enable the board to carry out its role efficiently by: ➢ ensuring that the committee structures can demonstrate that the quality governance agenda is being adequately covered; ➢ reviewing the tiers of supporting committees to ensure that they do not impede board assurance; ➢ ensuring that clinical quality remains a core feature of mainstream reporting at board level; ➢ reviewing the effectiveness of the role of the audit committee and other board committees to ensure that the systems and	➢ Terms of reference for committees. ➢ Annual reports of committees and Audit Committee annual report to Trust Board. ➢ Annual self-assessments by Committees on their effectiveness. ➢ Quarterly assurance reports to Trust Board. ➢ Sub-committee reports to Clinical Governance and Clinical Safety Committee. ➢ Establishment of Estates and Information Management and Technology Forums of Trust Board. ➢ Focus on clinical quality at Trust Board through development of the quality performance report. ➢ Internal audit report on corporate governance arrangements and the Board assurance framework.	1B: Is the board sufficiently aware of potential risks to quality? 2A: Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda? 3A: Are there clear roles and accountabilities in relation to quality governance? 3B: Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?	Continued Trust Board development and review to test Trust approach to quality.

Question	Evidence	Link to Quality Governance Framework domains	Areas for development
process are functioning effectively in relation to assurance; and ➢ clearly setting out the roles and terms of reference of each committee and sub-committee in relation to assurance on quality governance.			
13. The board effectively uses audit functions to support quality governance assurance by: ➢ developing a narrative assurance and escalation framework to provide a clear outline of audit and assurance of processes and controls; ➢ using audit to conduct baseline assessments or specific elements of the *Quality Governance Framework* within the organisation; ➢ using audit to review and provide independent assurance against the trust's self-assessment; and ➢ ensuring that the internal audit and clinical audit work programmes are collaborative and cohesive and aligned to the quality governance agenda.	➢ Annual Governance and Corporate Governance Statements. ➢ Clear internal audit programme approved at Board level by Audit Committee. ➢ Internal audit used to review and provide independent assurance against Trust's self-assessment against Quality Governance Framework. ➢ Prioritised clinical audit programme approved by the Clinical Governance and Clinical Safety Committee. ➢ Annual and quarterly reviews of the Assurance Framework at Trust Board and annual review of development process by the Audit Committee. ➢ Risk register reviewed monthly by the Executive Management Team and quarterly by Trust Board. ➢ Risk management strategy reviewed annually by Trust Board. Supported by risk procedures.	1B: Is the board sufficiently aware of potential risks to quality? 2A: Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda? 3A: Are there clear roles and accountabilities in relation to quality governance? 3B: Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?	Embedding of DATIX risk processes across the Trust within BDUs and support services. Further work to ensure internal audit and clinical audit work programmes are co-ordinated. Further work to ensure learning from clinical audits.
Managing risks to quality: ➢ ***Are your BAF and local risk registers effective in capturing the risks to quality with your trust?*** ➢ ***How assured are you that patient safety incidents are being reported and dealt with correctly and escalated to the board appropriately?*** ➢ ***How are you assured that efficiency programmes are not adversely impacting on the quality of patient care?***			
14. The board has taken steps to	➢ Assurance Framework reviewed quarterly by Trust	1B: Is the board	Further development of training

Question	Evidence	Link to Quality Governance Framework domains	Areas for development
ensure that it can identify and address the risks to its quality objectives: ➢ the BAF should be reviewed and if necessary revised quarterly; ➢ the risk management frameworks explicitly outline the processes for local risk management and registers; ➢ board members are aware of the risk escalation process at and beneath clinical unit level; ➢ management and staff with responsibility for risk are supported by training; ➢ local risk registers are supported by local audit and a centrally coordinated risk register library; and ➢ there is an audit programme of regular review of the completion of local risk registers.	Board. ➢ Risk Management Strategy sets out clearly risk management processes, which explicitly outline process for local risk management and registers, and escalation of risk. ➢ Support functions are supported by risk training. Clinical risk management training exists through clinical risk management policy. ➢ Statutory risk training (such as health and safety, fire training) in place with robust systems to ensure staff access and take-up training. ➢ Trust Board and senior management undertake risk training annually. ➢ Internal audit of both assurance framework and risk registers annually. ➢ 'Library' co-ordinated through DATIX. ➢ Local risk registers are the responsibility of the BDU management structure and BDU processes. BDU processes are not determined centrally.	sufficiently aware of potential risks to quality? 3B: Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?	package to support staff in risk management.
15. The board uses good practice to improve incident reporting by: ➢ issuing clear guidance on risk categorisation of patient safety incidents and reporting; ➢ staff trained and inducted on the importance of reporting incidents and the processes involved; ➢ a duty to comply with the policy on incident reporting is set out in staff terms of employment; ➢ using a tailored incident recording and reporting system to minimise manual reconciliation	➢ Guidance included in Incident Management Policy. ➢ Policies and processes in place for training and induction, including at team level. ➢ DATIX used as incident recording system, which has been tailored to Trust needs. ➢ Quarterly incident reporting to Trust Board and Clinical Governance and Clinical Safety Committee. ➢ Serious incidents annual report to Trust Board and Members' Council. ➢ Weekly incident report to the Executive Management Team. ➢ All Trust staff have a duty to comply with the policy on incident reporting.	1B: Is the board sufficiently aware of potential risks to quality? 3B: Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?	

Question	Evidence	Link to Quality Governance Framework domains	Areas for development
or manipulation; and ➢ reporting increases in incident reporting to the board.			
16. The board ensures that it understands the potential risks to quality as a consequence of CIPs by: ➢ ensuring that development of CIP schemes begins at clinical unit management level and ownership is cascaded down to individual level; ➢ informing staff that they should raise concerns where they feel quality is being compromised as the result of cost improvements or efficiencies; ➢ implementing a QIA to support the identification and mitigation of risks and ensuring this is linked to local risk registers; ➢ carrying out post-implementation review of CIPs carrying a higher risk of impacting on quality; and ➢ reporting CIPs at board with clear metrics showing the impact on quality of the efficiency programme.	➢ Quality Impact Assessment and quarterly review of the cost improvement programme led by Director of Nursing and Medical Director. ➢ BDU processes for development of cost improvements. ➢ Bottom-up approach to annual planning ensures cost improvement proposals come from individual units/clinical teams. ➢ Annual plan risks and mitigating action discussed at Trust Board through budget setting in March, Monitor annual plan (now in March) and outturn assessment in October. Any risks highlighted within monthly performance reports. ➢ Scrutiny through Clinical Governance and Clinical Safety Committee. ➢ Improved cost improvement programme reporting in finance report to Trust Board. ➢ Planned session for Members' Council to understand and contribute to annual plan for 2014/15. ➢ Risks to achievement of targets outlined in performance report to Trust Board, including quality and finance. ➢ Human resources pressures scrutinised by Remuneration and Terms of Service Committee and Trust Board quarterly via strategic human resources report.	1B: Is the board sufficiently aware of potential risks to quality?	Increased emphasis on understanding the cost base of services linked to effective performance management through refinement of service line reporting and development of the Quality Academy approach as a support function for BDUs. Supported by an external review of the Quality Academy commissioned by the Chief Executive.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 17 December 2013
Agenda item 6.3(ii)

Title:	**Health and safety annual report 2012/13**
Paper prepared by:	Director of Human Resources and Workforce Development
Purpose:	Trust Board has a duty to ensure that the health, safety and welfare of service users, staff and visitors remains a high priority within the organisation and as far as reasonably possible risks are mitigated or reduced. This paper is devised to give assurance on the on-going management of health and safety in the Trust.
Vision/goals:	True effective management of health and safety is key to the delivery of safe and high quality services.
Any background papers/ previously considered by:	This report has been considered by the Clinical Governance and Clinical Safety Committee at its meeting on 3 December 2013.
Executive summary:	The Health and Safety Annual Report 2012/13 was developed to provide an overview of the leadership and management of health and safety during the last twelve months. It was first considered by the Clinical Governance and Clinical Safety Committee in September 2013. The Committee asked for further assurance in the area of managing aggression and violence and this was provided at the meeting on 3 December 2013. The report is re-presented to Trust Board. The executive summary attached gives an update on: ➢ the development of the structure for the management and engagement of key stakeholders in health and safety; ➢ the arrangements for on-going monitoring and auditing of health and safety in the workplace and action taken; ➢ key health and safety risks and action to mitigate them; ➢ health and safety training activity; ➢ Trust response to changes in legislation. ➢ overview of health and safety incidents during 2012/13. The 2013/14 action plan is designed to: ➢ strengthen the health and safety monitoring and audit programme; ➢ develop and update Health and Safety policies to reflect changes in legislation; ➢ strengthen and ensure a consistent approach to risk assessment; ➢ ensure health and safety training is effective, accessible and relevant.
Recommendation:	**Trust Board is asked to note the health and safety annual report for 2012/13 and agree the action plan for 2013/14.**
Private session:	Not applicable.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

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

September 2013
Estates and Facilities

CONTENTS

APPENDICES

Health & Safety Annual Report, Executive Summary 2012/2013 and Annual Objectives 2013/2014

1 INTRODUCTION

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

A significant amount of work has been undertaken throughout 2012/2013 to ensure the Trust effectively manages health and safety risks and a number of key issues addressed over the past 12 months. It is, however, important to acknowledge the health and safety agenda continually develops with new legislation, outcomes of national reviews or enquiries and organisational learning. A key objective in 2012/2013 has been to standardise core processes from across the Trust to reflect a consistent approach to Health & Safety.

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

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

The executive summary focuses on 8 areas:-

- Health and Safety Organisation Structure
- Key Health & Safety risks
- Trust Wide Annual health & Safety Monitoring & Audits
- Health & Safety Incidents
- New Legislation and National Development in Health and Safety
- Policies
- Training
- Health & Safety Action Plans 2013/2014

2 EXECUTIVE SUMMARY

2.1 Health and Safety Organisational Structure

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

The Health & Safety TAG meets on a quarterly basis and the Sub-Groups meet bi-monthly all of which are well attended by managers, specialist advisors and staff representatives. Issues covered by the TAG included Fire, Moving & Handling,

Security, Waste Disposal, partnership working, risk assessments and horizon scanning issues.

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

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

2.2 Key Health & Safety Risks and Action

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

- **Violence & aggression** which accounted for 54% of all reported incidents. The Health & Safety Team work closely with MAV TAG colleagues, identifying a number of key issues of joint interest to continually assess and reduce the risk from violence and aggression to service users and staff alike. This report and action plan deliberately does not cover management of aggression and violence as there is a separate government arrangement with the Director of Nursing, Clinical Governance and Safety having Board level responsibility. There is a separate annual report, for management of aggression and violence.
- **Stress.** The wellbeing & resilience of staff to stress in the work place is a high priority for the Trust and work is over seen by the Well-being at Work Partnership Group and a number of sub-groups. Work streams include healthy life styles, shift working and staff retreats. During March, in partnership with Robertson Cooper Occupational Psychologists, the well publicised pulse survey was commissioned and analysed to understand stressors staff were facing in the workplace and to identify hot spots.
- **Slips Trips and Falls of patients** accounted for 16% of all reported incidents throughout the year and the Health & Safety Team have worked closely with the clinicians in forming a Trust wide strategic Falls Strategy Group with the aim of reducing falls to service users whilst in the care of the Trust. The health and safety input is specifically designed to help identify measures in clinical, ward environments that lead to a reduction in and the severity of subsequent falls.
- **Slips Trips and Falls of staff equated to**1.6% of reported incidents throughout the year. Coupled with the potential effects of falls on individuals and the age profile of a number of the more experienced, staff, prevention of slips, trips and falls represents a high priority for 2013 – 2014.
- **Managing Contractors.** Contractors of all types, commissioned to undertake work on behalf of the Trust represent a key risk when brought onto site. A robust Control of Contractor's Policy covering individuals from consultants, caterers, information technology to traditional trades employed was developed and implemented during 2012 - 2013

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

A 2 year action plan following NHS Barnsley Provider Services joining the Trust was developed to prioritise work streams for 2011/2012 and 2012/2013 to identify the best working practices from the two organisations and safety to establish new overall integrated health & safety arrangements.

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

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

2.3 Trust Wide Annual Health and Safety Monitoring and Auditing

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

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

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

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

2.3.1 Aim of the Annual Health and Safety Monitoring

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

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

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

2.3.2 Key Highlights Issues and Action

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

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

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

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

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

2.3.3 Action Plan:

Issue	Status & comment	Lead
First aid	Issue of teams not always having cover when staff are on duty will be tackled through support & advice to managers through audits and routine site visits. The key recommendation is for teams and units to share First Aid cover. There is no legal requirement for each team to have to employ trained first aid personnel.	Health & Safety TAG & Sub Groups
Moving and handling	Support Trust wide in terms of Moving & Handling has been challenging up to the appointment of a WTE assistant to Ali.	Ali Roper & Donna Kirby
Work systems, risk assessments and incident reporting	With just 62% managers reporting that risk assessments had been carried out from accidents/incidents recorded, checks will made during health & safety audits throughout the year that managers are reviewing risk assessments resulting from incidents.	All safety related personnel
Security and Safety	Lock down issues are a fundamental element of the 2013/2014 security work plan.	LSMS specialists
Medical devices training	With only 87% of respondents reporting they kept a record of training / competency	Ann Hargate

Issue	Status & comment	Lead
	assessments for medical devices, the issue has been referred to the Medical Devices/Safety Alerts group.	
Electrical Safety	With 36% of respondents identifying trailing cables in the workplace as a risk, the issue of potential of slips, trips & falls will be addressed through the Health & Safety TAG & Sub Groups and Estates TAG and on site audits.	Health & Safety TAG & Sub Groups and Estates TAG
Hot water and patients	With local procedures for checking water temperatures were in place for just 70% cases in the manager's survey and in only 81% in the buildings survey, the issue has been referred to the Medical Devices/Safety Alerts group.	Ann Hargate
COSHH and personal protective equipment	COSHH and rolling out the Trust SYPOL system continues to be priority for the current work programme into 2014.	Steve Amos, supported by Trust managers
Individual staff health and safety	With the Staff survey stating only 59% of personnel had received some form of safety training and the Manager's survey identifying an 80% score, the Health & Safety TAG & Sub-Groups have identified a number of key measures, including greater publicity and workbooks to increase uptake and subsequent compliance in safety related training.	Roland Webb, Health & Safety Professionals

2.4 2012/2013 HEATH & SAFETY INCIDENTS

A total of 6367 non clinical incident were reported during 2012/2013; an increase of 387 (+6.07%) from the previous reporting period.

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

Figure 1

Incident Type	Total 2011/12	Total 2012/13	Percentage
All Other Incidents	372	473	+27.15%
Health & Safety	1001	892	-10.88%
Security Incidents	-	497	N/A
Smoking Incidents	191	162	-15.18%
Slips, Trips and Falls	1051	1019	-3.04%
Violence and Aggression	3365	3324	-1.21%
Grand Total	**5980**	**6367**	**+6.47%**

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

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

MOVING AND HANDLING

A total of 24 Moving and Handling incidents were noted during the reporting period; figure 3 below shows respective totals within BDU's:

Figure 3

BDU	Total 2011/2012	Total 2012/2013	Percentage
Barnsley	15	9	-40%
Calderdale	3	3	-
Forensic Service	4	5	+25%
Kirklees	4	0	-100%
Trust wide (Corporate support services)	2	2	-
Wakefield	5	5	-
Total	**33**	**24**	**-27.27%**

Of the 24 reported incidents Moving and Lifting patients were the main cause of injury followed by Staff Moving and Lifting objects. Figure 4 provides a full breakdown:

Figure 4

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

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

SLIPS/TRIPS/FALLS

A total of 1002 Slips/Trips/Falls were reported during the 2012/13 reporting year. It is a point of note that Barnsley BDU figures do not include clinical slips/trips/falls between 01 April 2011 and 30 June 2011. Figure 5 below demonstrate those figures reported:

Figure 5

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

Figure 6 demonstrates the number of Slips/Trips/Falls incidents within each BDU and the party affected:

Figure 6

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

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

FIRE

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

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

Figures 9 and 10 provide further details:

Figure 9

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

Figure 10

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

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

2.5 Health and Safety Training Statistics

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

Examples of safety related training provided included:-

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

2.6 New Legislation

2.6.1 The legislation changing on 6th April regarding RIDDOR which moved from 3 days absence to 7 days making comparisons with previous years impossible. However, in future reports we will be able to benchmark RIDDOR across services and BDUs.

2.6.2 Safer Sharpes – Health and Safety (Sharp Instruments in Healthcare) Regulation 2013

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

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

2.7 Integrated Health & Safety Action Plan

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

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

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

1. Policies;
2. Training;
3. Processes

These areas are discussed in more detail below:

2.7.1 Policies

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

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

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

2.7.2 Training

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

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

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

2.7.3 Processes

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

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

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

3.0 2013/2014 HEALTH AND SAFETY ACTION PLAN

The Health and Safety audit together with relevant new legislation has been used as the basis for the development of the 2013/2014 action plan. The details of the action plan are shown on Appendix 1.

Appendix 1

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Health & Safety Action Plan – 2013/2014

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

Task/objective	Lead Director/ Senior Manager	Lead Officer(s)	Rationale	Target Date For Completion	Comments/Progress
			the H&S Risk Assessment policy.		assessments in toe the Datix system. Individual specialist risk assessments will still be available for staff when evaluating straight forward operational risks.
Complete Property, Occupiers and Teams Information Packs for all BDU's and Quality Academy.	Alan Davis/Jerry Murphy	Roland Webb/ Steve Amos	To improve on information available to specialist advisors in order to develop audit/inspection programme	March 2014	The production of information for managers and staff of a spreadsheet covering details of local arrangements Trustwide is under construction. This will facilitate easy, ready access of pertinent information in an emergency.
Fully implement COSHH SYPOL package Trust-wide; to include the creation and implementation of a COSHH e-learning package.	Alan Davis/Jerry Murphy	Roland Webb/ Steve Amos	Building on the health & Safety Monitoring results from the last 2 years the COSHH SYPOL package will support managers discharge their COSHH duties	March 2014	Supporting effective implementation of COSHH information throughout the Trust, investment of SYPOL will facilitate mandatory information for managers and staff. The COSHH programme includes the development of training in COSHH to supplement Health & Safety Awareness training. COSHH training will include e-learning and work books.
Develop Health & Safety Workbook package.	Alan Davis/Jerry Murphy	Roland Webb/ Steve Amos/ Alison Roper	To open up and improve flexibility for managers seeking H&S training for their staff	March 2014	With pressure being reported to Health & Safety TAG and sub Groups around releasing staff for training, alternative methods of delivering training is being developed. The training packages under development will include a manager's workbook for newly qualified staff.
Develop Harmonised Travel at Work Policy	Alan Davis/Tim Breedon/Jerry Murphy	Roland Webb	To formalise Trust approach to travel at work including staff travel and transport of service users	March 2014	Managing the risks to staff who drive at work requires more than just compliance with road traffic legislation. The Health and Safety at Work etc Act 1974 requires the Trust to take appropriate steps to ensure the health and safety of their

Task/objective	Lead Director/ Senior Manager	Lead Officer(s)	Rationale	Target Date For Completion	Comments/Progress
					employees and others who may be affected by their activities when at work. This includes the time when they are driving or riding at work, whether this is in a company or hired vehicle, or in the employee's own vehicle and the issue is high on the agenda of the HSE

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South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 17 December 2013
Agenda item 6.3(iii)

Title:	**Corporate governance internal audit**
Paper prepared by:	Director of Corporate Development
Purpose:	To inform Trust Board of the outcome of KPMG's review of the Trust's corporate governance arrangements.
Vision/goals:	The Trust's corporate governance arrangements provide a framework to ensure the systems and processes in place to support the delivery of services are robust and appropriate.
Any background papers/ previously considered by:	Internal audit report to Audit Committee 18 October 2013.
Executive summary:	As the Trust's internal auditors, KPMG undertook a review of the Trust's corporate governance arrangements in 2012. The review provided a substantial assurance opinion with five low priority recommendations. KPMG followed up last year's audit by assessing progress against the recommendations made and the findings were that the corporate governance arrangements at the Trust continue to be well-structured and in line with practice elsewhere in the sector. The recommendations have been implemented. A substantial assurance opinion was given and the report presented to the Audit Committee on 18 October 2013. KPMG has also looked in more detail at the Mental Health Act Committee and the following were noted. - The recommendation to review and rationalise the membership had been undertaken by the Chair. This has improved the contributions of all attendees and discussions and decisions are more focused as a result. - The Committee was found to be acting fully within the requirements of its terms of reference. - The review of the Committee's annual report and work programme showed that agenda items and planned discussions are in line with its terms of reference. Three low priority recommendations were made. 1. Approval of a change to the Committee's terms of reference by Trust Board was not formally minuted. The Trust has accepted the observation and will ensure in future that approval (or otherwise) of changes is recorded in Trust Board minutes. 2. In relation to quoracy of meetings, the Trust accepted the observation that one meeting was not quorate. Whilst every effort is made to ensure meetings are organised to enable all Committee members to attend and that sufficient notice is given of Committee meeting dates, priorities can and do change and, on rare occasions, this will happen too close to a meeting to enable deferment. The Chair makes the decision whether to continue with the meeting or not. The suggestion of identifying deputies was noted and again considered. The specialist knowledge to understand a Committee's work and the span of Executive Director portfolios makes it difficult to identify deputies to cover the business of the

	Committee effectively. The observation regarding decisions being taken whilst the Committee was inquorate was also noted. 3. KPMG also recommended consideration of a Trust Board-type cover sheet for Committees. It has been agreed with the Director of Corporate Development that this is not a practical solution for Committees. However, both the Audit and Clinical Governance and Clinical Safety Committees have a cover sheet for each item, clearly indicating the agenda item number, the title of the item and what the Committee is asked to do. This will be replicated for the Mental Health Act Committee from February 2014. Where an item is not covered by a paper, it will be made clear on the agenda that it is a verbal item. Advice will also be given to authors of papers to ensure a clear purpose is set out at the beginning of any paper and a clear indication given of what is required of the Committee.
Recommendation:	**Trust Board is asked to note the findings from the corporate governance internal audit.**
Private session:	Not applicable

Trust Board 17 December 2013
Agenda item 7.1

Title:	**P21+ - appointment of new partner organisation**
Paper prepared by:	Director of Human Resources and Workforce Development
Purpose:	The purpose of this paper is to update Trust Board on the position with the Trust's P21+ partner.
Vision/goals:	The appointment of a P21+ partner organisation for the Trust supports the implementation of the Trust's Estates Strategy, which ensures the Trust's estate is fit for purpose for service needs.
Any background papers/ previously considered by:	This paper was considered by the Estates Forum at its meeting on 2 December 2013.
Executive summary:	Background The Trust appointed Willmott Dixon as its P21+ supplier in 2011 on the basis of a high level specification with an emphasis on a strategic partnership. The development and agreement of the Trust's Estate Strategy has enabled the Trust to gain a clear vision of the strategic estates issues aligned to its service and financial plans. The next phase is delivery of the Estates Strategy and it was felt appropriate that the high level specification should be revised and updated to reflect this change of emphasis. In consultation with the Department of Health's P21+ team, it was agreed, given the revision of the specification, that the Trust should seek an expression of interest from all six P21+ supplier organisations. Four organisations expressed an interest in working with the Trust: • Interserve; • IHP (Vinci); • Kier; • Miller. Wilmott Dixon decided, following discussions with the Trust, not to express an interest and, therefore, the current agreement will terminate on completion of the schemes agreed in the 2013/14 capital programme. Appointment Process Initial interviews were held on 20 November 2013. The four organisations were scored against criteria set out in a High Level Information Pack approved by the Department of Health and shared with all the supply partners. The scoring panel consisted of senior members of Facilities, Finance and Procurement. Following this initial scoring process, Miller was eliminated from the process. The remaining organisations have been invited to interview on 11 December 2013. The same team, with support from the Trust's independent financial consultant and a senior representative from the Department of Health's P21+ team, will undertake the interviews based on the scores from the initial exercise. Following these interviews, the group will collectively review the scoring matrix and a recommendation to Trust Board for the appointment of a new Supply Partner will be made at the meeting on 17 December 2013.

	All scores and decisions are documented on the Department of Health's P21+ electronic database.
Recommendation:	**Trust Board is asked to approve the recommendation for the appointment of a new P21+ supply partners.**
Private session:	Not applicable.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 17 December 2013
Agenda item 8.1

Title:	**Risk Management Strategy**
Paper prepared by:	Director of Corporate Development
Purpose:	The Trust's Risk Management Strategy ensures there are appropriate and adequate risk management processes in place within the Trust to manage and mitigate risk. The Strategy also ensures compliance with Care Quality Commission and NHS LARMS requirements.
Vision/goals:	The Risk Management Strategy provides a framework for the continuous development of systems and processes to support assurance, compliance and risk management.
Any background papers/ previously considered by:	None
Executive summary:	The Risk Management Strategy is reviewed annually to reflect changes in the internal and external environment in relation to risk and was last reviewed in October 2012. The Risk Management Strategy enables the Trust to identify key risks in the external environment and in its forward plans. Planned actions to mitigate risks are described in the Trust's Business Plan, and in its Assurance Framework and risk register, which are reviewed by Trust Board on a quarterly basis. The Strategy has been reviewed to ensure it is fit for purpose for a further year and the following minor changes have been made; however, Trust Board should note that most of the content has not been subject to change. ➢ The strategic context has been updated to reflect the current position (page 3). ➢ References to the Trust's terms of authorisation have been changed as the Trust now has a Licence from Monitor. ➢ The introduction of the Quality Impact Assessment has been reflected in the narrative (page 11). ➢ The implementation plan at appendix 5 has been updated. ➢ An Equality Impact Assessment has been added at appendix 8.
Recommendation:	**Trust Board is asked to approve the revised Risk Management Strategy.**
Private session:	Not applicable

Document name:	**Risk Management Strategy**
Document type:	**Trust-wide Strategy**
What does this policy replace?	**Update of previous strategy (requirement for annual review by Trust Board)**
Staff group to whom it applies:	**All staff within the Trust**
Distribution:	**The whole of the Trust**
How to access:	**Intranet and internet**
Issue date:	**V1 issued December 2008** **V2 issued October 2010** **V3 issued December 2011** **V4 issued October 2012**
Revised date:	**Revised December 2013**
Next review:	**December 2014**
Approved by:	**Trust Board 20 December 2011** **Trust Board 30 October 2012** **Trust Board 17 December 2013**
Developed by:	**Director of Corporate Development**
Director leads:	**Director of Corporate Development**
Contact for advice:	**Director of Corporate Development /Integrated Governance Manager**

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Risk Management Strategy
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RISK MANAGEMENT STRATEGY

1. Introduction

South West Yorkshire Partnership NHS Foundation Trust is an NHS foundation trust, providing a range of community, mental health and learning disability services to the people of Barnsley, Calderdale, Kirklees and Wakefield, a population of over 1.2 million. The Trust also provides some specialist medium and low secure services to the whole of Yorkshire and the Humber. In April and May 2011, a range of NHS services transferred to the Trust, including all community and mental health services in Barnsley. This was as a result of the Government's plans to transform the way community health services are provided to improve quality of care and outcomes for patients.

Foundation Trusts are required to demonstrate financial viability, sound governance and legality of constitution. The Risk Management Strategy describes the development of internal control systems to enable the organisation to achieve an appropriate focus on both delivery of high quality, safe and effective services and financial sustainability, and make timely decisions in order to develop the business. The Strategy is refreshed annually to ensure it remains responsive to changes in circumstances. Its approval is a matter reserved for Trust Board.

The purpose of this strategy is to set out the Trust's strategic approach to the anticipation, prevention, mitigation and management of risk, linked to the Trust's Business Plan. The strategy describes the systems the Trust has in place at a strategic, corporate and operational level to ensure that assurance is provided to Trust Board through its governance arrangements and to external bodies that risk is being effectively managed within the Trust. It also sets out the framework through which Trust Board drives a culture of proactive risk management.

2. Strategic context

The Trust was authorised as a Foundation Trust in May 2009. The process leading to authorisation provided assurance that the Trust has effective governance arrangements in place at Board level and throughout the organisation to enable the Trust to remain financially viable and sustainable.

As a Foundation Trust, the organisation operates in a different context to that of an NHS Trust. The autonomy and freedom from central Government control afforded by Foundation Trust status requires the Trust to have skills and systems in place to manage its own business. Trust Board must be assured of the safety and effectiveness of services and the financial sustainability of the organisation and, to this end, is responsible for developing the appetite of the Trust to take risks and the ability of the Trust to manage risk. In turn, Trust Board must be able to provide assurance to its external regulators, Monitor and the Care Quality Commission (CQC). This includes registration with the CQC to be a provider of NHS commissioned services and adherence to Monitor licensing conditions. The Trust has also implemented the changes introduced by the Health and Social Care Act 2012.

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3. Definition of risk

The Trust is a large and complex organisation, operating in an increasingly competitive and contestable health economy and, as such, faces service, political and financial challenges. The Trust is also subject to public scrutiny and providing services to people whose conditions or behaviour may be unpredictable. In this context, risk cannot be completely eliminated and the Trust's approach is to have in place systems and processes that enable it to anticipate where risks might occur and make sound decisions based on information and to minimise the likelihood or impact of potential risks.

These can be broadly defined as:

- strategic risks – risks generated by the national and political context in which the Trust operates that could affect the ability of the Trust to deliver its plans;
- clinical risks – risks arising as a result of clinical practice or those which are created or exacerbated by the environment, such as cleanliness or ligature risks;
- financial or commercial risks – risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income, inability to recruit or retain an appropriately skilled workforce, damage to the Trust's public reputation which could impact on commissioners' decisions to place contracts with the organisation;
- compliance risks – failure to comply with the terms of authorisation, CQC registration standards, NHS LARMS, or failure to meet statutory duties, such as compliance with health and safety legislation.

4. Aims of the strategy

The risk management strategy is designed to ensure a systematic and focused approach to clinical and non-clinical risk assessment and management is in place to support the Trust in meeting the needs of decision makers throughout the organisation and to meet all external compliance and legislative requirements, including those set by Monitor. Robust risk management systems, supported by effective training, need to be in place throughout the organisation and to be routinely used to support planning and delivery of services.

The Risk Management Strategy is a key strategy for the organisation and its objectives are to:

- provide a framework for risk management that assures Trust Board that the Trust is delivering against the strategy set out in its plan;
- clarify responsibility and accountability for management of risk throughout the organisation from Trust Board to the point of delivery and support greater devolution of decision-making linked to Business Delivery Units and service line management;
- define the processes, systems and policies throughout the Trust which are in place to support effective risk management and ensure these are integral to activities in the Trust;
- promote a culture of performance monitoring and improvement, which informs the implementation of the Business Plan and ensure risks to the delivery of the Trust's plans and market position are identified and addressed;

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- ensure staff are appropriately trained to manage risks within their own work setting and clear processes are in place for managing, analysing and learning from experience, including incidents and complaints;
- ensure approaches to individual risk assessment and management balance the rights of individuals to be treated fairly, the rights of staff to be treated reasonably and the rights of the public in relation to public protection;
- support Trust Board in being able to receive and provide assurance that the Trust is meeting all external compliance targets and legislative responsibilities, including standards of clinical quality, Monitor compliance requirements and the Trust's licence.

5. Monitoring

Monitoring of risk and the effectiveness of the Risk Management Strategy is undertaken through:

- review of the Strategy by Trust Board annually;
- scrutiny of Trust Board Committee minutes on a quarterly basis;
- internal and external audit activity;
- scrutiny of the assurance framework and risk register by Trust Board quarterly and by the Executive Management Team monthly;
- Directors' quarterly reviews with the Chief Executive;
- the Chief Executive's quarterly reviews with the Chair.

6. Current control systems

Trust Board has overall responsibility and accountability for setting the strategic direction of the Trust and ensuring there are sound systems in place for the management of risk. This includes responsibility for standards of public behaviour and accountability for monitoring the organisation's performance against the agreed direction, ensuring corrective action where necessary. Trust Board must be confident that systems and processes are in place to support corporate, individual and team decision making and accountability for the delivery of safe and effective, person-centred care within agreed resources.

Trust Board is required to provide assurance to Monitor and to local people through the Members' Council that it is compliant with its licence, which encompasses financial viability, governance and clinical service quality.

The agenda and focus of Trust Board meetings, which include a quarterly Business and Risk meeting, is continuously reviewed to ensure attention is given to both strategy and implementation and regular, detailed reports are provided on performance and market assessment.

There are currently four risk **committees of Trust Board**:

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

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Each of these committees has clearly defined **terms of reference** which set out the functions that the committee carries out on behalf of the Board. All Committees are chaired by a Non-Executive Director. Minutes are formally presented to Trust Board and assurance is provided to Trust Board by the Committee Chair. The Audit Committee Chair does not routinely attend any other committees to ensure objectivity; however, the Chair of the Audit Committee has the opportunity to attend each committee once a year as part of providing assurance to Trust Board on effectiveness of other risk committees.

Membership of committees is organised to ensure good linkages. The Director of Corporate Development attends all committees in the capacity of Company Secretary (with the exception of the Remuneration and Terms of Service Committee) and oversees the administration of all Committees.

The **Audit Committee** is responsible for assessing the adequacy of systems of controls assurance and governance in the organisation as described in the Annual Governance Statement and that the systems and processes used to produce information taken to Trust Board are sound, valid and complete. This includes ensuring there is independent verification of the systems in place for risk management. Responsibility for monitoring financial performance is held by Trust Board but the Audit Committee scrutinises the financial management systems through its links to internal and external audit.

The **Clinical Governance and Clinical Safety Committee** provides assurance to Trust Board on service quality and the application of controls assurance in relation to clinical services. It scrutinises the systems in place for effective care co-ordination and evidence-based practice, and focuses on quality improvement to ensure a co-ordinated holistic approach to clinical risk management and clinical governance is in place, protecting standards of clinical and professional practice. The Committee has a particular focus on ensuring standards of clinical care are improved in a climate of cost control.

The **Mental Health Act Committee** is responsible for ensuring the organisation is working within the legal requirements of the Mental Health Act (1983), as amended by the 2007 Act and Mental Capacity Act 2005, and with reference to guiding principles as set out in the Code of Practice and associated legislation as it applies to the Mental Health Act, the Mental Capacity Act and Deprivation of Liberty.

The **Remuneration and Terms of Service Committee** is responsible for developing and determining appropriate pay and reward packages for the Chief Executive and Executive Directors and a local pay framework for senior managers as appropriate, which contribute to the achievement of the Trust's aims. The Committee also has delegated authority to approve any termination payments for the Chief Executive and Executive Directors and is also responsible for approving Clinical Excellence awards for Consultant Medical staff. The Committee also supports the strategic development of human resources and workforce development and considers issues and risks relating to the broader workforce strategy. On behalf of Trust Board, it reviews in detail key workforce performance issues.

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Trust Board and its Committees are reviewed on an ongoing basis to ensure that Trust Board adds value to the organisation in terms of setting strategy, monitoring performance and managing risk. This includes:

- a development programme based on continuous review of the combined skills and competencies of the Trust Board;
- ongoing review of the format of Board meetings to ensure best use of time and appropriate balance between strategy development and retrospective performance monitoring;
- an annual review of the Committee structure, membership and terms of reference to ensure clarity of role and optimise their effectiveness.

The **Members' Council** plays a key role in the Trust's governance arrangements. It provides a bridge to the community, supporting the Trust to engage with its membership and acting in an advisory role in the development of strategy and plans. Under the Health and Social Care Act 2012, the Members' Council has a duty to hold Non-Executive Directors to account for the performance of Trust Board. Its work programme is specifically designed to reflect this duty.

The Members' Council is also responsible for monitoring the effectiveness of Trust Board including the appraisal of the Chair and appointment and removal of Non Executive Directors. The Members' Council has a **Nominations Committee** to support this role.

Development of the Members' Council focuses on:

- development of the interface between the Trust Board and Members' Council;
- public and staff elections to attract people who represent the diversity of the community served by the Trust and effective induction of new members;
- development of individual and collective skills of the whole Members' Council;
- development of the interface between the Members' Council and the wider membership to optimise the Members' Council's role.

The **Chief Executive** is the Accounting Officer of the Trust and has responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding its resources. The Accounting Officer's approach to this is set out in the Annual Governance Statement, which describes the system of internal control within the organisation. This is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The Chief Executive provides leadership to the **Executive Management Team**. The Executive Management Team is made up of Executive and Operational Directors and is responsible for ensuring implementation of the strategy, plans and policies agreed by Trust Board. The Executive Management team reviews the risk register and scans clinical incidents, claims and complaints to ensure they are being effectively managed and action is being taken to minimise the risk of recurrence. The Executive Management Team also reviews the strategic position of the Trust

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and any potential threats to income or achievement of its plans. Meetings are organised into strategic, business and risk, and performance sessions to ensure risks to delivery of the Trust's plans are closely monitored and that the Trust remains forward looking.

The **Extended EMT** meets monthly. The Extended EMT comprises all Executive Directors and senior staff, including heads of service and clinical and general management leads from Business Delivery Units. Currently, the role of the Extended EMT is focussed on the Trust's transformation programme, acting as a guiding coalition for the overarching programme. As part of this role, it will continue to ensure clinical and non-clinical risks are identified within services and that these are recorded on risk registers with appropriate mitigating action taken, taking into account external guidance and intelligence that might affect the Trust's ability to deliver its strategy. Additionally, part of its role is to provide a forum for learning from clinical incidents, complaints and human resources processes and external inquiries and to maintain a focus on compliance with external targets.

Business Delivery Units (BDUs) are responsible for delivering safe and effective services within agreed resources to specific localities and Forensic Services, within a framework of devolved responsibility.

The executive functions of the organisation have been reviewed to support the ongoing development of BDUs and devolution of decision-making to service lines. The Executive Management Team has reviewed the way that it works to ensure effective matrix working between the BDUs and the support directorates through a Quality Academy approach designed to ensure capacity in the organisation is prioritised towards delivering high quality, sustainable services.

Each BDU has both clinical and managerial leadership at senior level. Where this is not a practising clinician, formal arrangements for clinical leadership are in place. Where this is a practicing clinician, appropriate management and business development arrangements are in place.

Business Delivery Unit Directors are responsible for determining the configuration of service lines within the BDU to optimise quality and efficiency.

As part of the Quality Academy approach, a contracting framework between BDUs and support services has been agreed to ensure that BDUs receive a combined support service offer to enable them to deliver services on a devolved basis at the highest quality and optimum cost. This framework covers the following areas.

1. **Key elements of the support service offer** to cover standards of service linked to key domains and the structure and process to be adopted in terms of devolved support, including people, resources and time.
2. **Maintaining corporate accountability** to ensure that corporate accountabilities linked to Executive roles are met, in particular, statutory and legal, and to identify the split of resources to be devolved and those that will be held centrally.
3. **Delivering synergies and cost improvements** to provide a clear outline of synergies, improvement and efficiency savings.
4. **Ensuring linkage across key domains of the Quality Academy**.

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Trust-wide action groups (TAGs) focus on specific issues and ensure these are being properly addressed through the service delivery groups. Executive Directors may establish TAGs to support them to discharge their accountability.

Professional leadership arrangements are in place within the Trust for nursing, allied health professionals, medicine and pharmacy, psychological therapies and social care staff to support the delivery of safe clinical services through development of the knowledge and skills of staff. This is led by the Director of Nursing.

The Trust has a dedicated **Contracting Team** to manage the relationship with commissioners ensuring there are sound systems in place for responding to issues which might affect future commissioning intentions and provide a forum for exploring opportunities for service development. These are supported by Director-level Contracting and Quality Boards in each district. Identification of risks to income, opportunities for expansion, risks to achieving targets and key performance indicators are reported and considered through performance EMT meetings where appropriate action is agreed.

Effective management of the Trust's relationships with commissioners is reviewed on a regular basis to ensure it reflects the changing arrangements for commissioning set by the Government. Arrangements for managing commissioner relationships and contracts have been developed by and are the responsibility of BDU Directors.

7. Responsibility for implementation of the strategy (duties)

Executive Directors are collectively responsible, as members of Trust Board, for setting the strategic direction of the organisation and ensuring there are sound systems and processes for managing risk.

Individual directors have lead responsibility for specific areas of risk management which are detailed in appendix 4.

Managers in the Trust are responsible for effective risk management including:

- identifying risks within their own service area and ensuring these are appropriately managed or controlled and that risks which cannot be controlled or prevented are recorded on the appropriate risk register;
- ensuring adherence to Trust policies and procedures to support effective risk management;
- raising staff awareness of the key objectives in the risk management strategy;
- ensuring staff awareness of guidance relating to the identification, recording and management of hazards and incidents, including near misses;
- effective management of clinical and non-clinical risks in their area, including risks to the Trust's reputation;
- management of communications, including adherence to Trust policy;
- staff awareness (including sub contractors) of risks in the working environment;
- staff awareness of policies and procedures;
- implementation of action plans arising from investigations into complaints or incidents;
- staff training needs are identified and addressed;

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- adherence to standing orders and standing financial instructions.

All staff have responsibility for managing risk within their own sphere of responsibility, including:

- awareness of organisational and health and safety risk assessments and of any measures (e.g. policies and procedures) that are in place to mitigate risks;
- identifying and reporting hazards and risks arising out of work-related activities;
- awareness of the requirements to report adverse events and incidents;
- awareness of procedures for dealing with complaints and claims;
- awareness of their responsibilities for implementing any actions arising as a result of incidents or complaints;
- awareness of procedures for dealing with media inquiries;
- working within their area of competence and identify their own training needs;
- following Trust policies and procedures;
- contributing to identification of risks and follow up actions in the risk register.

8. Risk management processes

Risk management is recognised as being integral to good management practice and needs to be the business of everyone in the organisation. Risk management processes are designed to support better decision making by contributing to a greater understanding of risks and their potential impact.

The principal tools upon which Trust Board relies to gain assurance are described in the Chief Executive's **Annual Governance Statement** which is reviewed annually. It shows that the Trust understands its risks, is taking reasonable action to manage those risks and has action plans in place. Systems of internal control are designed to manage risk to a reasonable level rather than to eliminate all risk, through the continuous assessment of the internal and external environment to identify and mitigate risks to the achievement of the Trust's objectives and prioritisation of risk management through assessment of the likelihood and impact of identified risks if they materialise.

Effective management of risk relies on the following processes and systems.

The Trust is required by Monitor, as part of its **Licence,** to have in place a Constitution which is compliant with legislation. The Licence also requires that the organisation is financially viable and sustainable, and well governed, and that it can continue to provide commissioner requested services (as set out in previous mandatory services schedules).

The **Constitution** of the Trust sets out the legal framework in which the Trust operates. The Constitution is based on the model core constitution and defines the powers of both the Trust Board and the Members' Council. The **Standing Orders** of Trust Board and Members' Council form part of the Constitution.

As part of its Standing Orders, Trust Board has approved **Standing Financial Instructions** and a **Scheme of Delegation**, which provide the framework within which responsibility for financial decision making takes place throughout the

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organisation and is designed to ensure Trust Board has appropriate levels of control over financial decisions and is alerted to financial risks.

Trust Board assurance that its principal objectives are being achieved is summarised and evidenced in the **Assurance Framework.** Where there are gaps in control or Trust Board has received insufficient assurance, these are reflected on the risk register. The Chief Executive uses the Assurance Framework as the template for quarterly performance reviews with each Director. The Assurance Framework is reported to Trust Board on a quarterly basis and provides evidence of actions taken to manage risks.

The Assurance Framework and risk register are reviewed during the year to ensure the process, which is scrutinised by the Audit Committee on an annual basis, and format continue to provide an effective tool for summarising and monitoring assurance and risk management at Board level. The advice of internal audit is sought as part of this review.

The **Risk Register** links closely to the Assurance Framework and enables Trust Board to closely monitor any risks identified in the assurance framework where there are gaps in control (i.e. where there are external factors which the Trust cannot control or where the measures being taken by the Trust are unable to eliminate the risk.) Risk registers are held at Trust Board level, by each BDU and by support services. The Risk registers held by BDUs and support services are reviewed regularly and any risk which could have an impact across the Trust is reported to the Executive Management Team monthly to ensure risks which may have a Trust-wide impact are recorded on the Trust's risk register. Individual directors are responsible for ensuring there is a process for identifying risks relating to support services and for adding items to the Trust Board risk register (see section 9). Risk registers held at Trust Board and at service level are designed to be 'live' working documents which support the organisation to identify, assess and manage risks.

The Trust is required by its Regulator, Monitor, to produce a rolling three-year **Business Plan** for organisational and service development. The plan describes the key risks to delivery of the plan and how these would be mitigated. It maps the direction of travel, and so supports Trust Board and service managers to identify where it may be deviating from target and take remedial action.

Annual plans are developed within each locality and support directorates and co-ordinated into a Trust plan. Annual plans are agreed with commissioners and support the delivery of the business plan. The plans identify service developments and changes, and the financial and workforce implications of those plans, including any required cost improvements (CIPs). Undertaken by the Director of Nursing and the Medical Director, each cost improvement is subject to a **Quality Risk Assessment**. The assessment covers three aspects of quality (person-centred, safe, effective and efficient). The assessment tool provides a quality impact rating from 'weak' (where a cost improvement will have a detrimental impact on quality of services) to 'excellent' (where it will have a positive impact on the quality of services). The assessment is based on the Trust's seven quality priorities around access, listening to and involving service users and carers, care and care planning, recording and evaluating care, working in partnership, staff fit and well to care, and

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safeguarding. Where risks are considered to be substantive, plans may be changed or mitigating action put in place to manage the risk.

Reporting of performance against plan enables Trust Board to assess the impact and opportunities of financial decisions on clinical services and the impact of service changes on the financial position of the Trust. The reports also support Trust Board in the early identification of any risks to its strategic position, financial viability or public reputation. High level performance reports are circulated to Trust Board on a monthly basis and each quarter the Board agenda is dedicated to consideration of strategic and business risks, which includes review of performance against plan and compliance.

A range of **strategies, policies and procedures** are in place to support the effective management of risk throughout the organisation and these are located on the Trust's intranet.

The Trust aims to have a whole system approach to risk management where all staff are encouraged to take responsibility for assessing and managing risk within their own sphere of responsibility and the Trust, through its management structure, and staff have a shared responsibility for ensuring staff have the requisite skills to identify and manage risks.

A risk management process based on the Australian/New Zealand Standard (appendix 1) is used within the Trust. The whole system approach is continuously monitored by Trust Board and through the leadership and management framework to support learning and improvement.

The aim of the approach is to support an organisational culture based on prudent ambition in relation to service development and learning from experience to minimise the likelihood of risks manifesting themselves and to enable the Trust to respond positively to mitigate the impact of unavoidable risks and maximise opportunities of doing so.

Challenges in the external environment, combined with both service and structural change planned for the year ahead, offer opportunities to develop services but expose the organisation to a degree of risk. The Trust will continue to develop its risk systems in line with the changes to its structure and leadership and management arrangements, and put in place robust plans for managing risk through a period of political and financial instability externally and internally driven change.

9. Risk reporting and procedures

The Trust uses Datixweb to support the recording, management and review of risks and production of risk registers across the Trust to ensure consistency of recording. Datix allows control measures to be recorded and actions to be scheduled, with a full audit trail of changes to risk assessment. Information feeds through levels of risk register from ward to board. The system has the ability to report at different levels, look at trends across the organisation and risk areas, such as information governance, and health and safety, and record and manage actions. Identification and prioritisation of risks can be linked to other Datix modules, such as incidents and

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complaints. The Trust's has a document "Risk Management Procedure", which sets out the processes for this system and this is found on the Trust's intranet.

10. Monitoring compliance with the strategy

Compliance with the strategy will be monitored through established risk processes already in place within the organisation. These are outlined below.

11. Risk Management Training

The Trust's approach to risk management training in respect of Trust Board and the Extended Executive Management Team is set out at Appendix 7.

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Monitoring compliance with the strategy

Risk process	Purpose	Frequency	Lead	Outcome
Review of the Risk Management Strategy	To ensure it is appropriate for the Trust, reflects current priorities and the external environment, and is fit for purpose.	Annual	Director of Corporate Development	To ensure Trust Board fulfils its overall accountability and responsibility for risk management in the organisation and sets the Trust's approach to risk fits with the Trust's strategic direction.
Annual Governance Statement	Sets out the Trust's systems and processes of internal control	Annual	Chief Executive	Presented to and supported by Trust Board. Included in the Trust's annual report and accounts, scrutinised by the Audit Committee, Trust Board and Monitor
Audit Committee review of the effectiveness of risk committees	To ensure Trust Board committees are meeting their terms of reference and providing assurance to Trust Board of their effectiveness in scrutinising risk in the organisation.	Annual	Chair of Audit Committee/ Director of Corporate Governance	Presented to Audit Committee, which provides assurance to Trust Board
Ongoing work of risk committees	Scrutiny of risk and its management	Committees meet a minimum of four times per year	Non-Executive Chairs/Lead Directors/Director of Corporate Development	Quarterly feedback to Trust Board and annual reports to the Audit Committee and, through the Committee, to Trust Board.
Internal audit of risk management processes	To provide assurance that the Trust's processes are robust, appropriate (fit for purpose) and are followed.	Annual	Internal audit/ Director of Corporate Development	Presentation of report to Audit Committee
Review of the Trust's appetite for risk.	To ensure that the Trust's strategic direction, objectives and annual plan reflects its appetite for risk and that this is consistent with the Trust's mission, vision and values.	Annual (as part of annual planning)	Chair and Chief Executive	Agreement of the Trust's strategic direction and annual plan that ensures the Trust's meets its objectives and manages risk in an effective way at a level appropriate to the Trust.
Mandatory risk management training	To ensure that the Trust's approach to risk management is embedded at the highest level within the organisation.	Annual	Director of Corporate Development	Trust Board and members of the Extended Executive Management Team undertake mandatory risk management training on an annual basis.

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Appendix One

The larger process for identification, assessment and management of risk

Risk management is an iterative process consisting of well defined steps which taken in sequence, support better decision-making by contributing a greater insight into risks and their impacts. The risk management process can be applied to any situation where an undesired or unexpected outcome could be significant or where opportunities are identified.

Risk management is recognised as an integral part of good management practice. To be most effective, risk management should become part of an organisation's culture. It should be integrated into the organisation's philosophy, practices and business plans rather than be viewed or practiced as a separate activity. When this is achieved, risk management becomes the business of everyone in the organisation.

Risk Management may be applied at all stages in the life of an activity, function, project, product or asset. The maximum benefit is usually obtained by applying the risk management process from the beginning.

The Trust's whole system approach to risk assessment and management requires the organisation to have in place a systematic process for evaluating and addressing the impact of risk in a cost effective way. In order to achieve this, the Trust is committed to providing staff with the appropriate skills to identify and assess the potential for risk to arise. The system will support the use of professional judgement and decision-making.

The Trust will seek to provide an environment in which people feel comfortable about reporting incidents and risk issues and discussing them in an open, non-accusatory way. It is recognised that staff need to feel that they work in a safe and 'just culture', in which people who report risk or disclose unsafe practice are supported.

Every organisation carries some level of risk, whether associated with clinical care, financial planning, organisational reputation or the recruitment and retention of staff. Risk management is about bringing the risks from those activities together in order to allow risks to be viewed both strategically and operationally. This in turn will allow decision makers to consider the quantity and extent of risk presented and to make some choices about them.

It is important to define the relationship between the organisation and its environment, identifying strengths, weaknesses, opportunities and threats.

The context includes the financial, operational, competitive, political, social, cultural, reputation and legal aspects of the organisation's functions. This needs to be done within the context of both internal and external factors, including understanding key stakeholders and their impact on the organisation.

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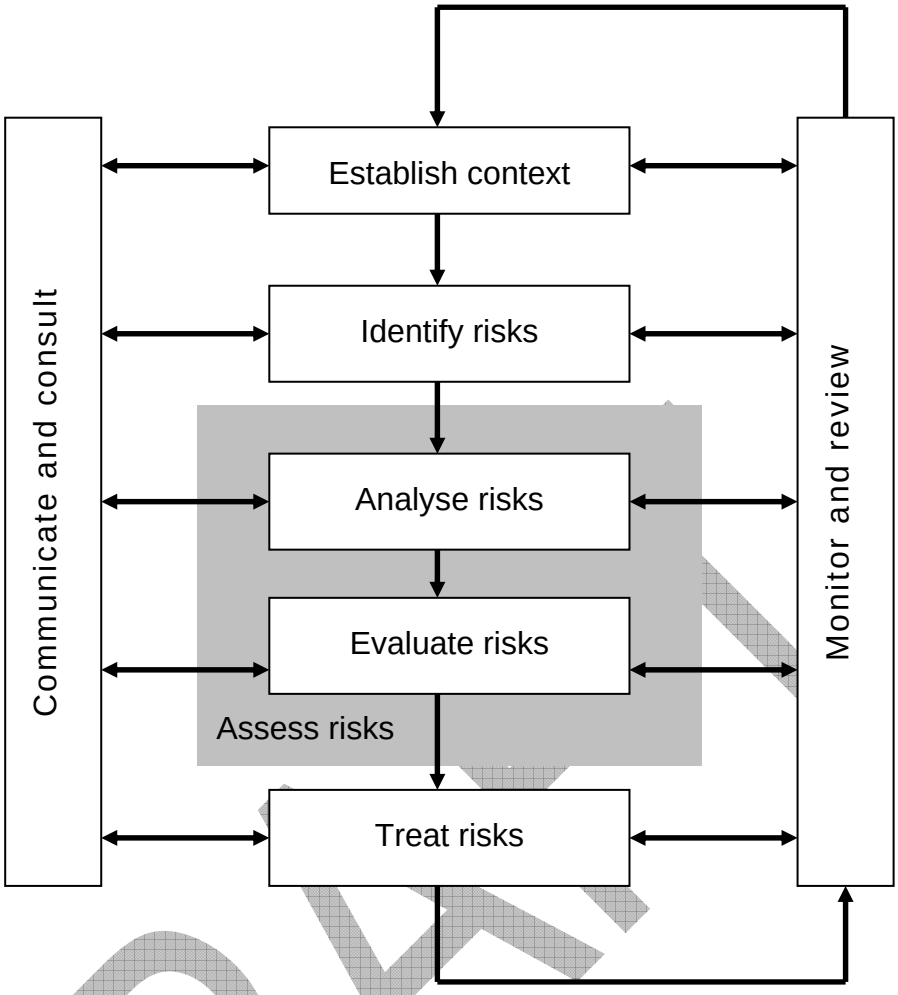

Risk Management Overview

Step One: Identification of risks

A variety of sources of information, proactive and reactive, are used to identify risks. External sources include national guidance, market analysis, financial and workforce data, benchmarking, feedback from external compliance processes, patient safety notices and communications, external inquiry reports. The Trust also relies on intelligence to identify threats to income, gained through formal processes including the Area Contracting Teams' contact with commissioners, which is fed into the Trust via the appropriate TAG and feedback from other sources such as patient surveys, complaints and compliments and direct communications with GPs.

The Trust's approach to business planning through an annual planning cycle incorporating dialogue and formal agreement with commissioners regarding the range, level and quality of services encourages the early identification of risks and enables the trust to take appropriate mitigating action where risks are identified. Planning processes are also designed to minimise the risk of the organisation incurring costs associated with the development of new services where the source of income is not identified.

Reports commissioned from internal and external audit support identification of risks and provide information about the effectiveness of controls in place to manage or mitigate risks.

Internal intelligence on risks is generated through data collection systems, including the Trust's clinical information system (RiO), which provides information about clinical activity, CQUIN targets, which provide key data relating to the quality of Trust services, and the Datix system, which provides information about adverse events and complaints.

Analysis of media coverage provides information about risks to the Trust's public reputation.

Step two: Analysis of risks
The objective of risk analysis is to separate minor acceptable risks from major risks. Risk analysis involves consideration of the sources of risk, their consequences and the likelihood of the risk manifesting itself. This information enables the Trust to plan action to reduce the likelihood of the risk occurring and to put in place contingencies to reduce the impact if the risk manifests. Sources of information may include:

- past experience;
- intelligence gained from specific sources such analysis of performance information, benchmarking, direct communications with commissioners or other stakeholders;
- published materials;
- specialist and expert judgements.

Step three: Evaluation of risks
Risk evaluation involves applying established criteria to enable the organisation, team or individual to assess the negative impact that could occur if the risk to the organisation or to service users if the risk materialises compared to the opportunity (or positive impact) that could occur as a result of taking the risk. The ability to balance the positive impact of taking risks against the potential negative impact is particularly critical in a complex environment such as the delivery of clinical services, where a no risk culture would detrimentally affect clinical decisions.

The Trust also needs to be able to assess the likely benefits of opportunities that may present to attract new sources of income against the risks, for example, where there is an opportunity to develop a new service, the Trust needs to be assured that the income will exceed the required investment in buildings or staff or that there are significant benefits in terms of partnerships, reputation or market position from developing new services which offer only a marginal financial contribution.

Evaluation should take account of the following criteria.

- Financial/value for money issues.
- Impact on service delivery and quality of services.
- Reversibility or otherwise of the risk.
- Quality or reliability of evidence surrounding the risk.
- Impact on the organisation, stakeholders of partners.

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- Impact on the trust's reputation.
- Whether, on balance, the risk is defensible.

If the resulting risk is low or acceptable, it may be accepted with minimal further treatment but should be regularly and routinely monitored to ensure that it remains acceptable.

If the risk is higher, the Trust should either take action to prevent the risk occurring or develop contingencies (risk treatment).

Step four: Risk treatment
Risk treatment involves identifying the range of options for preventing or dealing with a risk, assessing the options and preparing and implementing 'treatment' plans.

Options, which are not necessarily mutually exclusive, may include the following.

i) Avoid the risk – do not undertake the activity which is likely to generate the risk. Risk avoidance is not always appropriate and may in itself present alternative risks, such as:

- decisions being taken to avoid or ignore risks even where the potential benefits outweigh the risks;
- failure to treat or address risks;
- leaving critical choices or decisions to other parties;
- deferring decisions which the organisation cannot avoid.

ii) Reduce the likelihood of the risk – identify actions which can be taken to reduce the likelihood of the risk occurring and put in place arrangements for monitoring the implementation and effectiveness of those actions.

iii) Reduce the consequences – identify actions that can be taken to lessen the impact should the risk materialise and put in place arrangements for monitoring the implementation and effectiveness of those actions.

iv) Risk control – efforts to reduce the likelihood or consequences of a risk are risk controls. Controls may include policies, procedures or changes to the environment. Controls should be regularly reviewed to ensure they remain relevant and effective.

v) Transfer the risk – put in place arrangements to ensure other parties bear or share the risk and/or its consequences. Contracts, service level agreements, partnerships and joint ventures and insurance provision all form part of the Trust's mechanisms for transferring or sharing risks.

vi) Retain the risk – where the Trust is unable to transfer or eliminate the possibility of a risk materialising, plans should be put in place to manage the consequences of the residual risk. This may include identifying contingencies to offset the risk or to prepare for financial consequences.

A number of options for managing risk may be considered and applied either individually or in combination. Selection of the most appropriate option involves

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balancing the cost of implementing each option against the benefits derived from it. In general, the cost of managing risks needs to be commensurate with the benefits obtained. Decisions should take account of the need to carefully consider rare but severe risks, which may warrant risk reduction measures that are not justifiable on strictly economic grounds. In general the adverse impact of risks should be made as low as reasonably practicable.

Action planning to manage risks
The action plan for managing risks should identify which of the above approaches is intended. The plan should identify responsibilities, the expected outcome of treatments, budgeting, performance measures and the review process to be set in place. The plan should also include a mechanism for assessing the implementation of the options against performance criteria, individual responsibilities and other objectives, and to monitor critical implementation milestones. Actions to address significant risks are recorded on the risk register.

The Risk Register is a tool used by the Trust to enable the organisation to comprehensively understand and prioritise significant risks to the organisation requiring focus and attention. The Trust is a large and complex organisation that works within a devolved management framework. It is therefore important that the way in which the risk registers are developed reflects these management arrangements. This will ensure that risks are being assessed and managed throughout the Trust with decisions being made as near as practicable to the risk source. In addition, key risks can be monitored at the appropriate level. Risks where either the controls in place to manage the risk or the likelihood and impact score means that it is graded red will be monitored by the Board through the organisational risk register. The Trust uses the Datix system to support the recording, management and review of risks and production of risk registers across the Trust to ensure consistency of recording.

The Trust risk register is a 'living document' and as such is reviewed and revised monthly by the Executive Management Team providing a continuous scanning process. The risk register is also audited regularly for its level of accuracy and fitness for purpose and reviewed on a quarterly basis by the Trust Board. It is central to the internal control system; provides a focus to support the Trust's review of its systems of internal control and also reflects gaps in control and/or assurance in the Assurance Framework. All directors are set principle objectives linked to the organisation's strategic objectives and the Risk Register and these are reviewed quarterly by the Chief Executive. The framework for delivering each objective includes the requirement to describe any risks to achieving the objective and the controls in place to manage the risk.

All BDUs have risk registers, informed by the risks identified through clinical teams, Directors and key stakeholders. The BDU risk registers are used to inform the Trust Risk Register through the Executive Management Team. Where appropriate, individual Directors hold a register detailing risks that are managed within support services.

Risk registers should be used to inform decision-making processes. Ideally, all decisions, such as changes in policies, procedures or practices, and all resource

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commitments, should result in reductions to the organisation's highest priority risks. This means that at all levels, proposals to make changes or commit resources should include reference to the effects that this may have on the risk profile of the organisation. For significant changes all business plans, bids for funding and proposals are required to include a section which shows how they will help reduce the risks to the organisation and whether any additional risks will arise.

Risk Registers should be flexible enough to allow the organisation to respond to unforeseen risks, serious incidents, external events or changes in national policy. A dynamic, comprehensive and effectively used risk register process will not only drive risk management, but will also ensure that the Trust can justify the decisions it has made.

Guidance on completion of the Risk Register and the risk grading matrix applied in the Trust are included in appendix 2 and in the document "Risk Management Procedure".

Monitoring and Review

Risk management systems and are scrutinised by the Audit Committee, supported by internal audit and external audit, and the overall management of risk is monitored by the Trust Board, through the Assurance Framework and risk register.

The role of internal audit is to provide an independent and objective opinion to the Chief Executive and Trust Board on the system of control. The opinion considers whether effective risk management, control and governance arrangements are in place in order to achieve the Trust's objectives. The work of internal audit is undertaken in compliance with the NHS Internal Audit Standards. The audit programme is based on a risk assessment of the Trust, using the Assurance Framework and the Trust's risk register. Action plans are agreed to address any identified weaknesses. The Audit Committee relies on internal audit to support it in its role of providing assurance to the Board on the effectiveness of internal controls. Internal audit is required to identify any areas to the Audit Committee where it is felt that insufficient action is being taken to address risks.

External audit also plays a key part in identifying key risks to the organisation in relation to its work and in the monitoring and review of the Trust's systems and processes, particularly in relation to financial probity and value for money.

Communicate and consult

Effective communication is important to ensure that those responsible for managing risk and those affected understand the basis on which decisions are made and their responsibilities for managing risk. Each step of the risk management process should identify communications activity to take place with internal and external stakeholders. Communications should address issues relating to both the risk itself and the process to manage it. Communication and consultation involve a two-way dialogue between stakeholders. Since stakeholders can have a significant impact on the effectiveness of the arrangements for managing risks, it is important that their perception of risk, as well as their perception of benefits, be identified and documented and the underlying reasons for them understood and addressed.

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Documentation
Each stage of the risk management process should be documented:

- to provide those responsible for managing the risk with a clear plan for approval and subsequent implementation;
- to facilitate effective monitoring of the management plan;
- to provide a record of risks and lessons learned;
- to facilitate sharing and communication of information;
- to provide evidence of a systematic approach to risk identification and analysis.

Risk Management Database and Incident Report System
The Trust uses the Datix electronic risk management database, which has modules for managing complaints, incident, claims, Customer Services and coroners' inquests to support the retrospective review of clinical risk and facilitate learning from experience.

Trust-wide reports about incidents, complaints and claims are provided on a quarterly basis to the Clinical Governance and Clinical Safety Committee on behalf of Trust Board. Relevant information about incidents and complaints are also provided on a regular basis to BDUs, Trust-wide Action Groups, and professional groups. Specialist Advisers have direct access to the system and are able to scan the system and produce statistical incident reports.

The Trust works with the NPSA Patient Safety Manager, and patient safety incidents have been reported directly into the NRLS (National Reporting and Learning System) in line with national requirements, since December 2004.

The project to develop and implement the Datix risk module across the Trust to enable the Trust to manage the identification of risk and risk registers at all levels of the organisation has been completed. Ongoing work will focus on embedding this system at all levels, ensuring staff have the appropriate skills to identify and assess risk, the use of Datix in monitoring and managing risks, and embedding the role of risk co-ordinators with BDUs and support services, particularly the relationship with Practice Governance Coaches.

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Guidelines for Completion of Risk Register

Appendix 2

	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
3 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

Document Control	
Authors	
Version	
Circulation	
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Status	

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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

Appendix 3

Risk registers: guidance on use of the risk grading matrix

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

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	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

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Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Risk scoring = consequence x likelihood (C x L)

	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

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Instructions for use

1 Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

2 Use table 1 to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

3 Use table 2 to determine the likelihood score(s) (L) for those adverse outcomes.

4 Calculate the risk score, multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)

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Appendix 4

Directors' Responsibilities

Trust Board has overall responsibility for setting the strategic direction of the organisation, ensuring the Trust meets all external compliance duties and promoting a culture of effective risk and performance management. Individual Executive Directors have specific responsibilities in relation to risk management.

Chief Executive	As Accounting Officer, has overall accountability for risk within the organisation, in particular, internal control systems and organisational governance, Risk Management Strategy and Integrated Business Plan.
Director of Finance	Executive Director with accountability for strategic financial planning and management, demonstrating probity, including counter fraud, and value for money. Overall responsibility for coordination of the transformation programme to redesign services. Responsibility for performance management and information management and technology, including implementation of RiO, and information governance. Also holds director lead for business planning, including securing a strong market position for the organisation through integrated business and annual planning processes, and service level agreements and contracting. Holds the role of Senior Information Risk Officer.
Medical Director	Executive Director with accountability for medical leadership, including professional development and practice effectiveness, medicines management, public health, research and development, professional leadership (with the Director of Nursing), and shared accountability for clinical quality with the Director of Nursing.
Director of Human Resources and Workforce Development	Executive Director with accountability for strategic Human Resource management, workforce development, facilities and estates maintenance, catering and food hygiene, environmental management, fire safety, health and safety, security management, and waste management. Director lead for the strategic approach to the Trust's estate. Also lead director for emergency and business continuity planning.
Director of Nursing, Clinical Governance and Safety	Executive director with accountability for clinical governance and clinical safety, and compliance, including safeguarding children and vulnerable adults, system for reporting, managing, analysing and learning from incidents, including Serious Incidents, managing violence and aggression, infection prevention and control, medical devices, clinical records management, professional leadership for non-medical clinical staff, and the Mental Health Act. Has shared accountability for clinical quality with the Medical Director. Holds the role of Caldicott Guardian.
Director of Corporate Development and Constitutional Affairs	Lead Director for co-ordination of the risk agenda and with overall responsibility for the Risk Management Strategy. Director role has accountability for corporate governance, communications and public relations, public involvement, diversity and inclusion, system for managing complaints, claims and litigation, supporting the Chief Executive in maintaining the Trust Risk Register and Assurance Framework and other corporate systems. Company Secretary portfolio contained in the role.
Business Delivery Unit Directors	Directors with strategic and operational accountability for service delivery across Barnsley and Wakefield, Calderdale, Kirklees and Specialist Services, and Forensic services.

There are also a number of statutory and regulatory responsibilities across the Trust relating to risk as follows.

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Function	Lead
Accounting Officer	Chief Executive
Caldicott Guardian	Director of Nursing, Clinical Governance and Safety
Company Secretary	Director of Corporate Development
Controlled Drugs	Chief Pharmacist
Counter Fraud	Director of Finance
Director for security	Director of Human Resources and Workforce Development
Emergency planning	Director of Human Resources and Workforce Development
Fire	Director of Human Resources and Workforce Development
Health and Safety	Director of Human Resources and Workforce Development
Income from overseas	Business Delivery Unit Directors
Lead Governor	Governor
Registration Authority Manager	Director of Finance
Senior Independent Director	Non-Executive Director
Senior Information Risk Officer	Director of Finance
Whistleblowing (Non-Exec)	Deputy Chair/Senior Independent Director

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Appendix 5

Implementation plan

Action required	Action plan	Review date	Lead	Training implications
Review Board meeting cycle, agenda setting process and committee functions to ensure focus of each meeting is clear and ensure adequate focus on strategy, risk and performance.	Review agenda setting to ensure balance of focus on strategy and retrospective performance monitoring. Review terms of reference and membership of committees to ensure clarity of function and effective Board assurance.	Ongoing	Chair, Chief Executive and Director of Corporate Development	Board development sessions and strategy sessions built into cycle
Continue improved performance reporting to Trust Board to ensure information is well integrated, timely and accessible.	Review Board approach to performance monitoring to ensure the information meets Board requirements.	Ongoing	Chief Executive and Director of Finance	Individual and whole Board development to support effective governance
Each committee to undertake an annual self assessment exercise and produce an annual report to the Trust Board demonstrating how it has met its terms of reference.	Self assessment exercise to be undertaken by each committee to review performance against annual plan and interface with other committees and reported to Trust Board by the Audit Committee	April 2014	Chair of Audit Committee, other Committee Chairs and lead director for each committee	None
Work programmes to be developed annually and reviewed regularly for each Committee to ensure efforts are focused on management and monitoring of risks identified in the assurance framework, risk register and business plan.	Annual work programme to be developed for each committee and reported to Trust Board. Work programmes to be amended in the light of changes to risk register	February to April 2014 Ongoing	Committee chair and lead director	To be identified as part of work programme
Assessment of effectiveness of Board and individual directors	External facilitated assessment of Trust Board effectiveness. Chair's appraisal.	During 2014 April 2014	Chair/CE led SID	None None

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Action required	Action plan	Review date	Lead	Training implications
	Chair's quarterly reviews with Non-Executive Directors. Chief Executive's quarterly reviews with Directors. Assessment of skills and experience of Trust Board to ensure remains fit for purpose as a Foundation Trust Board.	Quarterly Quarterly As part of role of Nominations Committee	Chair Chief Executive Chair	None None Access to training as appropriate
Assessment of effectiveness of Members' Council and individual governors	Annual evaluation session Individual reviews with Chair Individual induction meetings with the Chair Trust responsibility to ensure development and maintenance of skills and knowledge of governors	September 2014 January/February 2014 On joining Ongoing	Chair Chair Chair Chair	Access to FTN GovernWell training modules and other training (both internal and external) as appropriate
Assurance provided by Committees specifically reported to Trust Board	Chairs of committees to provide specific assurance to Board where they have responsibility for scrutiny of an issue	Ongoing	Chairs and lead directors	None
Ensure effectiveness and accessibility of approaches used by Trust Board to monitor risks and receive assurance	Continued embedding of risk register management through Datix and assurance framework to support the overall system of internal control.	During 2014	Chair of Audit Committee, Chief Executive and Director of Corporate Development	
Develop internal control systems to support effective risk management in the context of devolved decision making	Develop internal governance arrangements to support service line management and to support the introduction of payment by results.	By April 2014	Chief Executive, Deputy Chief Executive & Director of Corporate Development	

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Action required	Action plan	Review date	Lead	Training implications
	Review Standing Financial Instructions and Scheme of Delegation (as part of review of Constitution and Standing Orders).	Annual	Director of Finance & Director of Corporate Development	
Risk management training relevant to individual roles to be undertaken	Trust Board to receive training in risk analysis and risk management relating to the role of a corporate board as part of Board development programme. Extended EMT to receive training on risk management. E-learning module to be developed for Trust Board, Extended EMT and risk co-ordinators.	December 2013 March 2014 During 2014	Director of Corporate development Director of Corporate Development Director of Corporate Development	
All staff to be briefed about amendments to risk management strategy	Include in weekly staff news and reference to intranet	January 2014	Director of Corporate Development	As appropriate
Key policies and procedures on the intranet to be brought up-to-date to enable document store to support information governance requirements in relation to non-clinical records.	Business critical policies identified and integrated Complete work to update the document store.	Completed during 2013 Phase II during 2014 June 2014	All directors Director of Corporate Development	Training relevant to roll out of individual policies as and when they are revised.

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Appendix 6

Risk-Related Trust Documents - Policies, Procedures, Protocols and Guidelines

All Trust policies and procedures have a role in proactively managing risk by putting in place systems and processes to effectively control and reduce identified risks.

A full list of current Trust policies, procedures and guidelines is available on the Trust intranet system. This is a constantly changing list as policies, procedures and related documents are developed and updated to ensure that they reflect current legislation, guidelines, good practice and learning.

The following documents are key to risk management.

- Trust Constitution
- Trust Board Committees' Terms of Reference
- Standing Orders, Standing Financial Instructions and Scheme of Delegation
- Business Plan
- Annual Planning Guidance
- Integrated Performance Strategy
- Emergency planning and business continuity policy
- Serious Incident management Procedures
- Incident Management Policy and Procedures
- Being Open – Policy and Guidelines
- Complaints policy and procedure (Customer Services Policy)
- Claims policy and procedure
- Communications strategy
- Media policy
- Care Programme Approach (CPA) Policy
- Health and Safety - Policies and Procedures
- Human Resources – various related policies, procedures, protocols and guidelines
- Infection Control Policies and Procedures
- Information Governance
- Medicines Management - related policies, procedures, protocols and guidelines
- Clinical and operational policies including Mental Health Act, Consent, Safeguarding Children, Vulnerable Adults and other related policies, procedures, protocols and guidelines

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Appendix 7

Risk management training arrangements

The mandatory training policy for the Trust identifies risk management training as mandatory for Trust Board and senior managers across the organisation in line with the Trust's training needs analysis. Senior managers are defined in this context as members of the Extended Executive Management Team, which comprises senior staff across the Trust in both operational and support service roles.

Risk management training is undertaken annually and, as a minimum, covers the Trust's strategic and operational approach to the identification and recording of risk.

Attendance at both the Trust Board and the Extended EMT sessions is formally recorded and non-attenders identified. In the case of Trust Board, the Director of Corporate Development ensures a separate briefing is undertaken as appropriate and that this is recorded. For members of Extended EMT who do not attend, Directors will be responsible for ensuring that these individuals are briefed appropriately. The Director of Corporate Development is responsible for ensuring that all members of the unitary Board receive risk management training and, through the Executive Management Team, is responsible for monitoring compliance by the Extended Executive Management Team.

An e-learning package will be developed by during 2014, which will be mandatory for Trust Board, members of Extended EMT and risk co-ordinators. The package will also be available for other staff.

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Appendix 8

Equality Impact Assessment Tool

Date of Assessment: December 2013

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
1	**Name of the document that you are Equality Impact Assessing**		Policy for the development, approval and dissemination of policy and procedural documents
2	**Describe the overall aim of your document and context?** **Who will benefit from this policy/procedure/strategy?**		The overall aim of the policy is to describe the Trust's approach to the development and approval of policies and procedural documents. All staff
3	**Who is the overall lead for this assessment?**		Director of Corporate Development
4	**Who else was involved in conducting this assessment?**		Integrated Governance Manager
5	**Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy?** **What did you find out and how have you used this information?**		The Executive Management Team was consulted on the original development of the policy. Feedback from the NHS LARMS assessment has also been considered in developing the policy. N/A
6	**What equality data have you used to inform this equality impact assessment?**		N/A
7	**What does this data say?**		N/A
8	**Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavourably:**	**Yes/No**	**Evidence based Answers & Actions. Where Negative impact has been identified please explain what action you will take to remove or mitigate this impact.**
8.1	**Race**	No	N/A
8.2	**Disability**	No	N/A
8.3	**Gender**	No	N/A
8.4	**Age**	No	N/A
8.5	**Sexual Orientation**	No	N/A

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	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
8.6	**Religion or Belief**	No	N/A
8.7	**Transgender**	No	N/A
8.8	**Maternity & Pregnancy**	No	N/A
8.9	**Marriage & Civil partnerships**	No	N/A
8.10	**Carers*Our Trust requirement***	No	N/A
9	**What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-**		This policy aims to standardise the approach to policy development, approval and dissemination and requires adoption of the Equality Impact Assessment throughout the organisation.
9a	**Promotes equality of opportunity for people who share the above protected characteristics;**		
9b	**Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;**		
9c	**Promotes good relations between different equality groups;**		
9d	**Public Sector Equality Duty – "Due Regard"**		
10	**Have you developed an Action Plan arising from this assessment?**		No
11	**Assessment/Action Plan approved by**		**Signed:** Dawn Stephenson **Date:** 17 December 2013 **Title:** Director of Corporate Development

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With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 17 December 2013
Agenda item 8.2

Title:	**Customer Services Policy: management of complaints, concerns, comments and compliments**
Paper prepared by:	Director of Corporate Development
Purpose:	The policy provides the framework for responding to enquiries and learning lessons from feedback through complaints, concerns, comments and compliments.
Vision/goals:	The Customer Services Policy supports the Trust's values in supporting an improved service user experience through being open honest and transparent, respectful, putting the person first and in the centre, to improve and be outstanding, be relevant today and ready for tomorrow and demonstrating that families and carers matter.
Any background papers/ previously considered by:	None
Executive summary:	The Trust has an established Customer Services function, which works across all BDUs in supporting a response to all enquiries. This includes a response to issues raised under the NHS Complaints procedures. The policy provides the framework for responding to these enquiries. It is subject to annual review and approval of the policy is reserved for Trust Board. This policy and procedure update takes account of the following. ➢ The increased emphasis on gaining insight about people's experience of using services to influence how services are organised and new services are planned. Feedback through Customer services processes is an important element of the experience framework. ➢ Recommendations arising from the Francis Report, and the Government's response, Hard Truth's, The Patients Association report on NHS Complaints and the Rt Hon Ann Clwyd's review of NHS complaints management. ➢ The policy includes revised reporting arrangements for complaints to include Quarterly reporting to Trust Board. ➢ There are potential financial implications in respect of the Parliamentary and Health Service Ombudsman's move to significantly expand the number of cases considered and to propose financial redress to resolve complaints.
Recommendation:	**Trust Board is asked to approve the policy.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Document name:	Customer Services Policy: supporting the management of complaints, concerns, comments and compliments
Document type:	Policy and Procedure
Staff group to whom it applies:	All staff within the Trust
Distribution:	The whole of the Trust
How to access:	Intranet and internet
Issue date:	December 2013
Next review:	December 2015
Approved by:	Trust Board – 17 December 2013
Developed by:	Head of Communications and Customer Services
Director leads:	Director of Corporate Development
Contact for advice:	Customer Services customer.services@swyt.nhs.uk 01924 327574

Policy Statement

The Trust's Customer Services function exists to facilitate a response to all enquiries, and to deal appropriately with feedback. The service operates as a 'one stop shop' for enquiry to the Trust, including requests under the Freedom of Information Act. This policy primarily covers feedback about Trust services and the management of complaints, concerns, comments and compliments.

To enable the Trust to provide a responsive, quality public service it is essential to actively seek the views of those people who use our services and to respond appropriately when things go wrong. The Customer Services policy responds to a number of key initiatives aimed at ensuring organisations seek out views and respond to feedback:

- Listening, Responding, Improving – A guide to better Customer Care (DOH, 2009) outlined plans to ensure a single health and adult social care approach to the handling of feedback.
- The statutory obligation to involve and consult the public about services (DOH, 2008) with organisations held to account for actions taken as a result of public participation and feedback.
- The NHS Constitution (DOH, 2009) outlines the public's rights when making a complaint.
- The Health and Social Care Act (DOH, 2008) sets out to sustain public confidence in the regulation of Health Care Professionals. This incorporates the need for effective handling of concerns about healthcare professionals
- CQC essential standards requires NHS organisations to provide evidence of good practice in relation to complaints management
- NHSLARMS requires NHS organisations as a minimum to have approved documented processes for listening, responding and improving when service users, their relatives and carers raise concerns or complaints, and those processes to be implemented and monitored.
- The report into Mid Staffordshire Hospitals Trust by Sir Robert Francis QC (2012)
- The Government's response to recommendations in the Francis report – 'Hard Truths – the Journey to Putting Patients First' (2013)
- The Patients Association report – Good Practice Standards for NHS Complaints Handling (2013)
- The review of the NHS complaints system in 2013 by the Rt Hon Ann Clwyd MP and professor Tricia Hart – Putting Patients Back in the Picture. (2013)

Experience demonstrates that the insight gained from listening to people who use services, relatives and carers promptly and openly will add considerable value to the quality of care provided. Ensuring that people have access and opportunities to feedback their views and experiences of care is an essential to delivering the Trust values and is part of how we ensure they have a say in public services. The Trust achieves this through a developing framework of activity to facilitate feedback about all aspects of services and ensuring any lessons learned are acted upon. An important element of this experience framework is feedback received as a consequence of concerns and complaints.

Dealing with feedback in a transparent and responsive way demonstrates a commitment to improving people's experience of services and to ensuring they get the best possible support, and that this is built upon mutual respect, highly effective engagement and excellent customer service. The Trust will build an evidence base to demonstrate how the insight gained from dealing appropriately with issues raised will contribute to improving the quality of the current service, and an increased level of service user satisfaction with services.

Failure to deal with complaints appropriately presents a risk to the organisation. In particular it could have an adverse effect on the Trust's public reputation either directly through people's own experience or as a result of negative media coverage. It could also lead to missed opportunities to improve services based on feedback.

Introduction

People who use Trust services have a right to have their views heard and acted upon.

NHS complaints legislation (DOH, 2009) requires a single approach for the handling of complaints across health and social care. The Trust has adopted the person centred approach outlined in The Department of Health's consultation, 'Making Experiences Count' to ensure that issues are dealt with in a way that people are empowered through the process and able to make choices about how their concerns are dealt with. This approach has been further strengthened through the Trust's response to the Francis report and to subsequent reviews arising from Francis recommendations.

Every member of staff is responsible for supporting people who wish to provide feedback or raise concerns. Staff will be alerted to customer services processes at induction and through promotional activity with services and teams, supported by publicity material and web based information. All staff should be able to advise service users, carers, relatives and visitors to the Trust on how to access the customer services process, including how to make a complaint. Staff assigned to investigate complaints should be appropriately trained and supported to take action as appropriate in accordance with Trust policy and procedures and in highlighting necessary learning.

The Trust's Customer Services function will provide a comprehensive service incorporating complaints, concerns, comments and compliments (the 4C's). The team will support service users, and others raising issues, regardless of whether feedback is handled as a complaint, concern, comment or compliment. Business Delivery Units (BDUs) will ensure that the insight gained is acted upon to improve, plan, develop and evaluate service delivery.

The Customer Services function exists to ensure this ethos is adhered to, and to contribute to improved service delivery through supporting prompt resolution of issues and providing insight into service user experience. The function provides a single point of contact for enquiries about the Trust and its services and to signpost to other sources of support, information and advice.

Customer Services will ensure that:

- Staff have access to relevant information to support service users, their relatives and carers in giving feedback. This will be achieved via access to this policy, leaflets/posters displayed in Trust facilities and via information accessible on the Trust's internet and intranet sites.
- Insight gained as a result of complaints, concerns, comments and compliments and other forms of feedback is used to improve the care provided to service users and carers.
- Investigation of complaints and concerns is performed in a thorough and timely manner, facilitating resolution in an open and conciliatory way.
- People who make complaints are treated fairly
- Information gained through feedback, forms an essential element of the Trust's approach to Governance.

The Trust takes all service user feedback seriously. Every effort must be made by staff to act on feedback at the time if possible and to try to resolve concerns promptly and locally. Care must be taken to ensure that no clinical details are disclosed without the written permission of the service user.

The Trust will assure service users that they will continue to be treated according to their clinical needs and care will not be compromised as a consequence of their feedback. Equally, relatives / carers will not be treated differently should they raise concerns. This assurance is included in Customer Services promotional literature, including leaflets, and outlined in acknowledgement letters for all complaints. Customer Services support will be offered to complainants who may be concerned that discrimination may occur and any reports of discrimination will be reported to the Customer Services Manager for investigation and corrective action. All concerns regarding actual or potential discrimination will be recorded by Customer Services on Datix web and reported in the quarterly report to Trust Board and to the Extended Executive Management Team.

The Trust will ensure the response to complaints and concerns is fair and equitable to both the complainant and the staff involved.

What is feedback?

For the purposes of this policy, feedback is defined across four categories:

Compliments
Positive feedback received regarding care received by service users, their relatives and carers.

Comments
Comments may be made either verbally or in writing to any member of staff within the Trust.

Concerns
An issue raised in writing or verbally to any member of Trust staff, identifying issues about a service or proposing ways to improve services for the people who use them, their relatives or carers.

Complaints
The NHS complaints regulations define a complaint as an expression of dissatisfaction with care, services or facilities provided by the Trust, where any of the following apply:

- Action by the Trust or someone working for the Trust has detrimentally affected the experience of the service user or carer
- The complainant believes that a mistake or error occurred and that this has detrimentally affected them
- The complainant brings to the attention of the Trust an issue about a Trust service which could detrimentally affect them or someone else which they expect the Trust to put right.

Other forms of feedback

A range of approaches are in place across the Trust to obtain feedback from people who use our services, which, taken together, provide a framework for gathering insight into service user experience.

The framework includes real time feedback, surveys, focus groups, workshops, events and dialogue groups and participation in National Patient Surveys as prescribed by the Department of Health.

Who can give feedback?

Any individual can give feedback to any Trust employee or to Customer Services. Feedback is most commonly received from service users, those affected by service provision, those acting as a representative of a service user, carers, relatives, MPs, councillors, advocates and Healthwatch.

Process for receiving feedback

The Trust promotes ways to offer feedback through:

- Leaflets and posters distributed to all areas of the Trust indicating the various ways to contact the Trust
- Members of staff and volunteers - staff are encouraged and expected to discuss any comment, concern or complaint raised and facilitate immediate action and fast resolution of any problems. In the event that the staff member cannot resolve issues immediately or answer questions, the member of staff and the person giving feedback should jointly decide to either involve a more senior member of staff or refer the matter to Customer Services.
- Web based information – including link to raise an issue or contact Customer Services. Service user feedback sent electronically is received by Customer Services and will be actioned in accordance with the nature of the feedback
- The Customer Services function – contact can be made with Customer Services by telephone, fax, e-mail, text, referral by a member of staff or in person by appointment.
- The Trust's corporate social media accounts (Facebook and Twitter) and external websites (for example Patient Opinion) are monitored to ensure feedback is captured
- In writing to the relevant ward or Department or to the Chief Executive - compliments, comments and concerns received at service level will be

responded to by the manager or service lead using the most appropriate method.

Process for Handling Feedback

Compliments

- Compliments can be provided to any member of staff by any member of the public. If a compliment is provided in writing to the relevant ward/Department the manager will respond either by telephone or in writing.
- Thank you letters/cards received by the Chief Executive will be responded to in writing if the author provides contact details. A copy will be forwarded to the appropriate Department, ward or manager or staff member with a covering note from the Chief Executive.
- Each BDU is responsible for ensuring all compliments are logged and that logs are submitted to Customer Services on a monthly basis.

Comments

- Comments can be made in writing, electronically or by telephone.
- All comments submitted by post are received by Customer Services, who will refer to the appropriate department, ward or service manager or progress using the complaints process if relevant.
- Each BDU is responsible for ensuring comments received are reviewed and actioned appropriately, including responding to the person offering the comment.
- BDUs must ensure that service areas log all comments received and that logs are submitted to Customer Services on a monthly basis.

Concerns and Complaints
Verbal

- Response to concerns and complaints should be *on the spot* wherever possible and a concern report form completed.
- If it is not possible to resolve the concern or complaint straight away, assistance should be sought from line management. If the concern or complaint is raised verbally and can be resolved within one working day the response does not need to be in writing. The issue should be documented using the concern reporting form.
- Customer Services will offer assistance as required. The Customer Services Manager will triage issues raised and assign to a customer services officer, who will negotiate with the person raising the concern to agree how the issue will be dealt with and within what timeframe.

In Writing

All written concerns and complaints will be triage assessed by the Customer Services Manager and assigned to a Customer Services officer who will work with the person raising the issue to determine a handling plan.

The complainant will be offered the choice of the complaint being dealt with through a formal route culminating in a written response or whether they wish to be supported to resolve the issue directly with the clinical team. Irrespective of the

chosen route, written concerns will be investigated, responded to either verbally or in writing and all activity will be recorded on Datix web. If a response is in writing the response should be signed by the Chief Executive.

Written complaints will always require a formal investigation and written response. The NHS Complaint Procedure encompasses complaints made by:

- A person who is in receipt of or who has received services from the Trust.
- A person who is affected, or likely to be affected, by an action, omission or decision of the Trust.
- A person who is acting on behalf of a person who has died, is a child, is unable to make the complaint themselves because of physical incapacity or lack of mental capacity (Mental Capacity Act) or has been requested to act as a service user's representative
- Complaints should be made within twelve months of the incident or becoming aware of the incident that has caused concern. However, this timescale can be extended if the Customer Services Manager is satisfied that there is good reason for any delay and that it is still possible to investigate the complaint effectively.
- When a complaint is made by a representative, the Trust's Customer Services Manager must be satisfied that there are reasonable grounds for a complaint to be made by a third party on behalf of another person. Consent should be obtained.
- All complainants will be informed about the right to access independent complaints advocacy..
- All complainants have the option to apply to the Parliamentary and Health Service Ombudsman should they remain dissatisfied following the Trust's management of their complaint, to ask for independent review of the same.

In keeping with the NHS regulations, the following are **not** covered by the Trust's Customer Services policy:

- Requests for access to records or an amendment to the clinical record (refer to Access to Records procedure).
- Requests for a change to care plan or medication (refer to clinical team).
- Reports of lost or stolen item (refer to clinical team).
- Challenges to policy decisions by the Trust Board (refer to Trust Board chair).
- Complaints made by a member of staff about their employment or about another member of staff. (refer to HR policies).
- Complaints made about volunteer activity (refer to Human Resources)
- Complaints about involvement activity (refer to Head of Equality and Inclusion)
- Complaints made by a GP about a service (refer to appropriate District Director)
- Commissioning decisions (refer to appropriate Clinical Commissioning Group).
- Complaints about services delivered by an independent provider on behalf of the Trust (the Trust is required to ensure independent providers have their own complaints procedure).
- Complaints about superannuation (refer to payroll/HR department).
- Staff who wish to voice concerns or grievances. These should be raised through appropriate line management processes in line with Trust policy.
- Complaints which have already been investigated and concluded using the NHS procedure (refer to the section of this policy covering Parliamentary and Health Service Ombudsman).

The following are not dealt with under the customer services procedure but should be brought to the attention of the Chief Executive's office to ensure a consistent approach.

- Requests for information or to visit a service by an MP or a local authority member.
- Requests for information or to visit a Trust service by a Healthwatch or Overview and Scrutiny representative.

Duties

The customer services process is supported by:-

The Customer Services Team

When concerns or complaints are received, the Customer Services Manager will ensure that the complainant is contacted by an allocated team member to discuss the handling of the concern/complaint. The complainant will be at the centre of the process and a complaint management plan will be developed taking account of the complainant's expectations for resolution and negotiated timescale for investigation. A written acknowledgement will be sent to the complainant within 3 working days. The assigned team member will liaise with the relevant clinical lead, managers or other organisations to facilitate a response within the agreed timescale. The lead investigator will keep Customer Services updated with the progression of the complaint at all times and at least weekly. The coordinator will receive information from the lead investigator to enable a response to be produced for Chief Executive sign off.

Where more than one organisation (health or social care) is involved, the Customer Services Manager or Head of Communications and Customer Services will ensure appropriate consent is obtained and that a lead person is appointed to co-ordinate the investigation and response.

Where complaints received by the Trust relate to another organisation the complaint will be referred on as appropriate without delay, following receipt of consent from the complainant.

Director of Corporate Development

The Director of Corporate Development is the lead director for customer services, including complaints management. The Director of Corporate Development will ensure appropriate arrangements are in place to respond to issues raised in ways that support people to live well in their communities and that maintain and enhance the Trust's reputation for putting people who use services at the heart of service delivery.

The Chief Executive

The Chief Executive (or nominated deputy) will sign all final responses to complainants, having received assurances that the response addresses all points raised in the complaint management plan.

District directors

District directors will ensure appropriate systems are in place to respond to feedback including the appropriate investigation of concerns and complaints and evidence of

learning. District directors will monitor the delivery of action plans and ensure that corrective action is implemented in response to complaints data and trend analysis provided by Customer Services.

Managers and service leads
Customer Services staff will advise managers as appropriate when feedback is received. In relation to complaints, managers will be responsible for:

- Carrying out an objective and thorough investigation in accordance with the procedure, either by investigating the issues in person or by appointing a suitably senior and skilled member of staff to conduct the investigation.
- Ensuring all relevant information to respond to a complaint is collated and provided to the lead investigator who will complete the complaints toolkit.
- Ensuring adherence to agreed timescales in relations to complaints investigation and management
- Advising the district director about complaints and reporting assurance to the Business Delivery Unit in respect of, for example, resolution of issues in relation to care and treatment and remedial action taken as appropriate.

Appropriate practitioners
Appropriate practitioners, as assigned, will support the investigation of complaints about clinical practice in BDUs.

Medical Director and Director of Nursing, Clinical Governance and Safety
The Medical Director and Director of Nursing, Clinical Governance and Safety are responsible for providing objective clinical advice to support the investigation of complaints either directly or through associate medical directors and lead nurses. The Trust's Medical Director will assign investigators where a complaint relates to medical staff.

Specialist advisors
Specialist advisors are responsible for reviewing the insight provided through the management of complaints, concerns, comments and compliments pertinent to their remit.

Complaints Procedure (Local Resolution)

- All complaint investigations should follow the pathway for complaint management as set out below
- All complaint responses should comply with negotiated time-scales.
- Written complaints received by the Chief Executive's office will be notified to Customer Services. Written complaints will be stamped indicating the date received. Written complaints received in other Trust locations should be forwarded to Customer Services.
- Complaints will be managed and coordinated by Customer Services in conjunction with the lead investigator.
- Complaints that span two or more organisations will be managed and coordinated by the organisation that has the majority of issues, or the highest risk issues. The lead organisation will coordinate a single comprehensive investigation and response to the complainant, in accordance with joint inter agency protocols for dealing with complaints.

- Every effort must be made to support people who wish to make a complaint. This could include language support, support in documenting the issues, signposting to advocacy services or providing mediation.
- Complaints received electronically will be coordinated by Customer Services. Contact will be made to obtain the complainants official mailing address and telephone number and an explanation provided that, due to issues of confidentially, the final response to the complaint will be sent in hard copy via the postal system.
- All complaints will be coded and logged onto Datix web. Customer Services will maintain up to date Datix web records at all times, recording all activity. Demographic data will also be captured on Datix web, including address and standard equality data.
- All records relating to complaints should be stored confidentially by the Customer Services team and should be readily accessible via the team if required. No other files relating to complaints should be held by the organisation and complaints correspondence should not be part of the clinical record. Clinical staff must be appraised of actions taken to resolve complaints to promote learning.
- Customer Services will initiate the complaint management plan; this will include contacting the complainant to identify the complainants concerns, resolution expectation and agreed timescale for the investigation.
- If the complainant requires access to medical records/patient information, Customer Services will provide appropriate contact information in accordance with the Data Protection Act / Access to Health Records Act.
- If the complaint includes a request for information under the Freedom of Information (FOI) Act, the request should be referred to the Customer Services Manager or Head of Communications and Customer Services to action.
- If a complaint makes reference to a claim for compensation this will not automatically exclude the issues from being investigated through the complaint process. However, the Customer Services Manager must be informed to ensure due consideration and collaboration with the Head of Legal Services. If there is no indication that a complaint investigation will prejudice any legal proceedings the complaint will be registered through the complaints process.
- Complaints will be acknowledged by letter outlining the agreed complaint management plan. This will be done within three working days. Complaints made by third parties will require written consent from the service user before confidential information is released. However, investigation into the issues can commence pending receipt of consent to ensure a prompt response can be offered when appropriate.
- The Customer Services Coordinator will record the progress of the complaint investigation onto Datix web and also complete a paper record, which will include copies of all correspondence to the complainant, staff, details of telephone calls, face-to-face conversations and electronic correspondence.
- The complaint management plan must be maintained in real time by Customer Services staff.
- All records relating to complaint investigation are confidential and must be kept in one master complaint file separate from any medical records. Care should be taken with accuracy, legibility and language used. In accordance with the Data Protection Act (1998) a complainant has the right to access all correspondence contained within the file.

- All complaint records must be kept by the Trust in a secure environment for 10 years.
- Customer Services must maintain contact with the complainant regarding progress and must renegotiate timescales as necessary. Any renegotiated timeframe for response will be confirmed in writing.
- Consideration must be given to the following:
    - If a complaint involves clinical issues that require urgent attention or raises issues that could potentially compromise public or patient safety the appropriate district director should be informed immediately.
    - Complaints that could fall into the Serious Untoward Incident category (SUI) must be referred for advice to the Patient Safety Support Team.
    - Where a complainant indicates they intend to take legal action, the matter should also be referred to the Head of Legal Services. The Trust will take legal advice and in some, but not all, circumstances it may be appropriate to cease action under the complaints procedure. This is consistent with national guidance.
    - Complaints about members of staff that involve accusation of misconduct should be referred to Human Resources. Staff have the right to be dealt with fairly in such cases, and complainants do not have the right to information about specific action taken against staff members.
    - Issues that could potentially attract media attention should be referred to the Head of Communications and Customer Services.
    - Issues relating to child protection should be referred to the Trust's Named Nurse for Child Protection and dealt with under joint agency protocols for child protection.
    - Issues relating to Vulnerable Adults should be referred to the Trust's Vulnerable Adults Specialist Advisor and dealt with under joint agency protocols for vulnerable adults.
    - Where a complaint alleges a criminal offence, the complainant will be advised of their right to report the matter to the police and will be supported to do so. If the complainant chooses not to report a serious matter which may be criminal, the Trust may choose to notify the police. Advice should be sought from the Caldicott Guardian where such action might be in breech of a person's confidentiality.
    - Investigators should always alert Customer Services at an early stage if a complaint is proving particularly complex or difficult to resolve. Revising the approach may prevent a complaint escalating to Ombudsman Review.

Effective inter team working between Customer Services, Patient Safety Support Team and Legal Services must be established to ensure a consistent approach and to avoid duplication and confusion to the complainant.

A conciliatory approach to issues resolution should be adopted; supported by appropriate contact with and updates for the complainant.

Investigation must be proportionate to the level and complexity of the complaint. The lead investigator will be independent of the service area to which the complaint relates. Investigation will include:

- Meeting with the complainant if appropriate
- Taking statements from the people involved

- Ensuring staff involved in complaints are aware of support mechanisms and how to access same
- Reviewing health care records, policies and procedures as appropriate (documenting evidence to support statements wherever possible)
- Taking independent expert advice if needed
- Completing the complaints toolkit and forwarding same to Customer Services
- Ensuring that the evidence in the toolkit addresses all the issues identified in the complaint management plan
- Assessing the severity grading of the complaint at the end of the investigation
- Consideration of the need to reimburse expenses or losses where fault has been identified. This might include, for example, the cost or part cost of lost property or incurred expenses.
- Developing an action plan for every complaint (even where the plan indicates no action required) and forwarding same to Customer Services
- Ensuring all relevant documents including staff statements, policy documents and file notes are collated for inclusion into the complaint file.
- Keeping contemporaneous records of the investigation within the Complaint Management Plan.

Customer Services will prepare a response to the complainant based on the information provided in the toolkit and forward to the Chief Executive for sign off.

All responses to MPs will be reviewed and prepared for Chief Executive's signature.

All response letters must inform the complainant of their right to ask the Parliamentary and Health Service Ombudsman to review their complaint if they are dissatisfied with the Trust's response.

Satisfaction surveys will be discussed with or sent to every complainant following the Trust response being offered. Survey feedback will be analysed and reported as part of the Quarterly Customer Services report to Trust Board and Extended Executive Management Team.

Business Delivery Units have lead responsibility for ensuring follow up and monitoring of action plans and demonstration of learning from complaint trends. District Directors will ensure processes are in place to provide governance and assurance in this area.

Parliamentary and Health Service Ombudsman Review

All avenues must be explored to resolve issues at local level, including further meetings and lay conciliation. However, if a complainant remains dissatisfied after local resolution they can ask the Parliamentary and Health Service Ombudsman (PHSO) to undertake a review of their case. The PHSO will assess the complaint using the Principles of Remedy, Good Administration and Good Complaint Handling. These principles provide guidance to organisations on how they should handle complaints. The overarching principles are:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right

- Seeking continuous improvement

The PHSO review will seek to demonstrate that the Trust has acted appropriately when assessing the complaint to identify if there is evidence of maladministration or service failure. The PHSO will request the Trust to provide a copy of the complaint file and health care records. After undertaking the review the PHSO will inform the Trust whether it can close the case or whether it intends to progress to formal investigation. In response to recommendations in the Francis Report and subsequent reviews of the NHS complaints procedure, the Ombudsman has indicated an intention to significantly expand the number of cases considered. The PHSO is also increasingly exercising the authority to propose financial remedy to Trusts as a mean of resolving complaints. The Head of Communication and Customer Services will Monitor the impact of this and report on the numbers of cases and financial implications on a case by case basis to the Director of Corporate Development, and reference this in the quarterly complaints reporting to Trust Board and Extended Executive Management Team.

The PHSO produces an annual review of complaints handling in the NHS and shares all investigation reports with the relevant commissioning body and strategic health authority. Learning from these reviews will be shared in the organisation via Customer Services reporting processes.

Unreasonable or persistent complaints

Most complaints are entirely reasonable; however a few are not. Some may, for example, abuse or threaten members of staff or continue to raise the same concerns when they have already been addressed. The following are examples of behaviour which might be regarded as unreasonable:

- Abusive or threatening behaviour – whether in person or in writing
- Persistent telephone calls or letters on the same issue which do not allow time for an investigation to be concluded or do not acknowledge that a response has already been offered
- Persistent verbal complaints which cannot be resolved through the informal complaints procedure.

Trust staff should acknowledge that at times people might find it difficult to express their frustration and might behave in a way that makes resolution difficult. Staff should support people to raise their issues in a constructive manner, manage expectations and work towards a satisfactory outcome. However, the Trust has a responsibility to protect its staff from people who behave in an abusive or malicious manner and to avoid inappropriate use of resources through dealing with persistent or unreasonable complaints.

If an investigation lead or Customer Services co-ordinator becomes concerned that a complainant is becoming unreasonable they must seek assistance from the Customer Services Manager. It is vital that any restrictions placed on a complainant should be as a result of a fair and consistent process. Any request to cease or limit an investigation about a complaint that is considered unreasonable or persistent,

needs to be considered in consultation with the appropriate service director and the Director of Corporate Development.

It may be necessary to request that the complainant only makes contact with a named individual, by one contact method only, for example either by telephone, email or in writing. The complainant must be advised that issues already responded to will not be re-opened or re-investigated. If appropriate the complainant should be informed that abusive correspondence or threatening behaviour will not be responded to. The complainant should be offered information regarding independent advocacy support. Where a named individual is assigned they should ensure a comprehensive record of all contact is maintained in the complaint management plan.

Letters or telephone calls received during the formal investigation stage will be acknowledged and any new issues included in the overall investigation. A meeting may be offered to clarify the issues to be investigated and confirm the process. The complainant should be advised if new issues are likely to affect the timescale for providing a final response to the complaint.

The final decision regarding ceasing all contact with a complainant lies with the Chief Executive.

Reporting Feedback

The Customer Services Team and Director of Corporate Development will monitor compliance with this procedure and report non-compliance to the Business Delivery Units and Executive Management Team.

The Customer Services Team will produce quarterly reports to Trust Board and the Extended Executive Management Team, covering the number of issues raised, complaints as a percentage of service user interventions, issues referred to the Parliamentary and Health Service Ombudsman, including financial redress, a breakdown of complaints, concerns, comments and compliments, identification of themes and evidence to demonstrate that lessons have been learned as a result of service user feedback.

This report will be shared with the Mental Health Act Committee to alert to complaints relating to application of the Mental Health Act, and with Members' Council for information.

The Report will also be shared externally with CCGs through the contract monitoring process and with Healthwatch across Trust geography.

District Directors will be responsible for ensuring systems are in place to investigate complaints and concerns, that feedback received through Customer Services processes is reviewed, that themes are identified, action plans delivered and lessons learned evidenced.

The Executive Management Team will monitor complaints and ensure lessons are learned through Business Delivery Unit performance management processes.

An annual report will be produced for consideration by the Trust Board. The Trust Board is responsible for approving Trust policy in relation to complaints handling, for ensuring compliance with national and local targets in relation to complaints and that robust systems are in place to enable feedback about services and that lessons learned lead to an improved patient experience.

Customer Services insight forms part of the Trust's evolving service user experience reporting, which is provided to the Trust Board and Members' Council on a quarterly basis in the form of 'What matters' reports. These reports include service user feedback from a range of sources and action taken on the resulting intelligence.

Process for monitoring compliance with this policy

The Director of Corporate Development is responsible for monitoring compliance with this policy. This will be achieved through:

- The ongoing monitoring role of the Customer Services team.
- The Customer Services team make data and reports available within the Trust as described above
- Routine contact with services and investigators regarding the ongoing process for complaints investigation
- feedback from Commissioners
- Contact, as appropriate with external agencies, for example neighbouring authorities, the Parliamentary and Health Service Ombudsmen and the Information Commissioner
- The NHS Litigation Authority Assessment process

Relevant concerns will be reported to the Executive Management Team, with action by the appropriate director.

	Standard	**Monitoring process - evidence:**
a	Duties	The duties of the customer services function and other staff in respect of this policy are described on pages 3,5,6,7,8,9,10,11,12 of this document Customer Services manager monitors this on a case by case basis and through reporting structure described above.
b	How the organisation listens to concerns and complaints from service users, their relatives and carers	• The Trust actively encourages and seeks feedback from people who use services and their families • People can give their feedback in a variety of ways • The Customer Services team works with individuals to resolve issues • Staff learn about the Customer Services function at induction and through promotional activity and service connection

		• Staff are encouraged to resolve issues at local level wherever possible • Investigators are supported • Customer Services manager monitors this on a case by case basis and through reporting structure described above.
c	How joint complaints are handled between organisations	• Joint agency protocols are in place to support the appropriate handling of multi-agency concerns / complaints • Customer Services manager monitors this on a case by case basis
d	How the organisation makes sure that service users, their relatives and carers are not treated differently as a result of raising a concern or complaint	• People are encouraged to raise this with the if they have concerns about this – included in contact letter • Customer Services manager monitors this on a case by case basis
e	How the organisation makes improvements as a result of a concern or complaint	• Customer Services Toolkit encourages identification of lessons learned and action planning for improvement • Quarterly reporting to BDUs indicates numbers, themes and lessons learned • Commissioner reporting evidences improvements • 'What Matters' reports to Trust Board and Members' Council and the public indicate 'lessons learned' and 'you said / we did information across the Trust's identified quality priorities

Associated documentation

There are a number of supporting procedural documents which may be subject to reference as appropriate. These include:

- Investigating and analysing incidents, complaints and claims to learn from experience Policy and Procedures
- Being Open policy
- Claims Management Policy and Procedure
- Safeguarding Children procedures
- Safeguarding adults procedures
- Health and Safety policies, procedures and processes
- Human Resources and related policies and procedural and related documents
- Information Governance (and Caldicott Guardian) related policies and procedural documents
- Media and Communications – related policies and procedural documents

Equality Impact Assessment

This policy promotes equality of access to the Trust's Customer Services function. See Appendix 1 for equality impact assessment.

The potential for people to have difficulty in accessing this procedure is mitigated by ensuring support is available through Customer Services, the availability of information in different formats on request and promoting access to interpreters and advocacy services.

Dissemination and implementation

This policy will be promoted through staff briefing and accessible via the Trust intranet and internet. Leaflets and posters publicising the ways to offer feedback will be available in all Trust clinical and public areas.

Training and support will be offered to staff to underpin the efficient and effective investigation of issues.

Implementation of the policy will be the responsibility of staff at all levels, and supported by all managers and directors.

Managers are required to monitor compliance with this policy and to ensure a systematic approach to responding to feedback from people who use services and their families / carers.

Managers are required to ensure appropriate support is in place for staff who are impacted by complaints.

BDUs are required to ensure staff who undertake complaints investigation are properly skilled and supported to do so and to develop action plans to address areas for improvement.

Review and Revision arrangements

This policy and procedure will be subject to regular review, every two years as a minimum, with review instigated in the event of policy change.

Document control and archiving

This policy will be accessible via the Trust's intranet in read only format.

A central electronic read only version will be held by the Integrated Governance Manager in a designated shared folder to which all Executive Management Team members and their administrative staff have access.

A central paper copy will be retained in the corporate library.

This policy will be retained in accordance with requirements for retention of non-clinical records.

Revisions / updates to this policy will be stored as above by the Integrated Governance Manager with previous iterations archived.

Appendix 1 - Equality Impact Assessment Tool

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	NO	
	• Ethnic origins (including gypsies and travellers)	NO	
	• Nationality	NO	
	• Gender	NO	
	• Culture	NO	
	• Religion or belief	NO	
	• Sexual orientation including lesbian, gay and bisexual people	NO	
	• Age	NO	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	NO	
2.	**Is there any evidence that some groups are affected differently?**	NO	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	NO	
4.	**Is the impact of the policy/guidance likely to be negative?**	NO	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this policy, please refer it to the Director of Corporate Development or Head of Equality and Inclusion together with any suggestions as to the action required to avoid/reduce this impact.
For advice in respect of answering the above questions, please contact the Director of Corporate Development or Head of Equality and Inclusion.

Appendix 2 - Checklist for the Review and Approval of Procedural Document

To be completed and attached to any policy document when submitted to EMT for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	YES	
	Is it clear whether the document is a guideline, policy, protocol or standard?	YES	
2.	**Rationale**		
	Are reasons for development of the document stated?	YES	
3.	**Development Process**		
	Is the method described in brief?	YES	
	Are people involved in the development identified?	YES	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	YES	
	Is there evidence of consultation with stakeholders and users?	YES	Limited to staff groups
4.	**Content**		
	Is the objective of the document clear?	YES	
	Is the target population clear and unambiguous?	YES	
	Are the intended outcomes described?	YES	
	Are the statements clear and unambiguous?	YES	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	YES	
	Are key references cited?	YES	
	Are the references cited in full?	N/A	
	Are supporting documents referenced?	YES	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	YES	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	YES	
	Does the plan include the necessary training/support	N/A	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	to ensure compliance?		
8.	**Document Control**		
	Does the document identify where it will be held?	YES	
	Have archiving arrangements for superseded documents been addressed?	N/A	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	YES	
	Is there a plan to review or audit compliance with the document?	YES	
10.	**Review Date**		
	Is the review date identified?	YES	
	Is the frequency of review identified? If so is it acceptable?	YES	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible implementation and review of the document?	YES	

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 17 December 2013
Agenda item 8.3

Title:	**Treasury Management Strategy and Policy**
Paper prepared by:	Deputy Chief Executive/Director of Finance
Purpose:	As part of its governance arrangements, the Trust is required to formally outline its approach to treasury management.
Vision/goals:	The policy links to the visions and goals of the organisation through flawless Execution (effective investment decisions) to ensure adherence to governance requirements and assurance of best use of resources.
Any background papers/ previously considered by:	This policy has been reviewed by the Executive Management Team on 21 November 2013. No amendments or revisions were suggested.
Executive summary:	The purpose of the policy is to provide a clearly defined risk management framework for those responsible for treasury operations. The approach and policy are reviewed annually. ➢ There has been one significant change since the policy was last approved by Trust Board. This covers the change in 3.1 and the methodology for calculation of Public Dividend Capital payments. This has been considered by the Audit Committee; ➢ The policy looks to minimise risks and provide a clear framework for investment decisions. ➢ Whilst minimising risk, the policy looks to maximise Trust financial performance. ➢ Trust Board should note that currently all material funds are held within the UK Government Banking System hence sovereign (minimal) risk of default.
Recommendation:	**Trust Board is asked to approve the policy to support the overall financial strategy**
Private session:	Not applicable

Document name:	Treasury Management Strategy & Policy
Document type:	Policy
Staff group to whom it applies:	All staff within the Trust who can transfer within bank Accounts
Distribution:	Executive management Team & Finance Department.
How to access:	Intranet
Issue date:	November 2009 First revision June 2010 Second Revision Nov 2013
Next review:	December 2014
Approved by:	Original - Trust Board 29 June 2010 Reviewed – Trust Board December 2013
Developed by:	Head of Finance R Adamson Accounting
Director leads:	Deputy Chief Executive / Director of Finance A. Farrell
Contact for advice:	Head of Finance – R Adamson

Contents

1 SCOPE OF THIS STRATEGY & POLICY

The Trust's mission is 'Enabling people to reach their potential and live well in their community.'

This strategy and policy exists to support this mission and provides part of the Trust's overall financial strategy which is determined by the Trust Board.

As a consequence this strategy does not determine the Trust's approach to surplus, capital expenditure or cash and working capital management, rather the cash balances available for investment under this strategy are determined by the Board's strategy on surplus, capital expenditure and cash & working capital.

2 TREASURY OBJECTIVES

2.1 Introduction

Written in conjunction with the guidance contained within 'Managing Operating Cash in NHS Foundation Trusts' (December 2005) issued by Monitor. [This document describes guidelines that are intended to ensure adequate safety (i.e. manageable risk profile) and liquidity (i.e. accessibility of funds at short notice), of such investments, while generating a competitive return]. This policy puts in place formal and comprehensive objectives, policies and practices, strategies and reporting arrangements for the effective management and control of their Treasury Management activities.

"Under Section 17 of the Health and Social Care (Community Health and Standards) Act 2003, NHS Foundation Trusts have a wide discretion to invest money (other than money held by them as Trustee) for the purposes of, or in connection with, their functions. Whilst this freedom offers greater opportunity to improve patient care, it should be managed carefully to avoid financial and/or reputational risks" (Monitor-Managing Operating Cash in NHS Foundation Trusts).

2.2 Treasury Management Strategy

The Trust's Treasury Management Strategy is to hold appropriate levels of short-term liquid investments whilst maintaining a competitive rate of interest for the Trust. The Trust will pursue best value in Treasury Management and through the use of suitable performance measures ensure that the Trust works within the context of effective risk management.

2.3 Scope of the Treasury Function

This Trust defines its Treasury Management activities as:

"the management of the organisation's cash flows, its banking, money market and capital market transactions; the effective control of the risks associated with those activities; and the pursuit of optimum performance consistent with those risks".

The objective of the treasury function is to support the Trust's development by

- ensuring a competitive rate of return on surplus funds with a minimal risk profile;
- ensuring the availability of cash to meet operational requirements; and
- ensuring the availability of flexible, competitively priced funding at all times.

This Trust acknowledges that effective Treasury Management will provide support towards the achievement of its business and service objectives. It is therefore committed to the principles of achieving best value in Treasury Management, and to employing suitable performance measurement techniques, within the context of effective risk management.

2.4 Approved Activities of the Treasury Management Operation

The Treasury Management operation will encompass all of the following techniques and procedures.

- Working capital management (including all matters relating to debtors, creditors and cash);
- Investment of surplus funds in permitted institutions and the assessment of the creditworthiness of these organisations;
- Interest rate exposure management;
- Dealing procedures (i.e. using brokers, banks);
- The interpretation and analysis of external information from various sources, including market analysts and technicians;
- The production, analysis and interpretation of internal information and reports;
- Financing of cash deficits via approved borrowing instruments.

In addition, it incorporates the formulation, monitoring and review of Treasury Management objectives, strategies, operational policies, authority limits and exception reporting criteria.

Given the nature of the activity and the size of the transactions involved, Treasury Management security controls are of paramount importance. Liaison will be required with both internal and external audit and internal controls, separation of duties, authorisation levels and responsibilities should be reviewed regularly. All banking arrangements will fall within the scope of Treasury Management (i.e. services, costs and tendering procedures). It is the responsibility of the Audit Committee to review and approve a Treasury Management Strategy and Policy (this document) on a periodic basis, which will be at least annually after the production of a revised financial plan for the Trust.

2.5 Treasury Controls

The wide range of complex financial instruments available to organisations can significantly reduce financial risk when used wisely. Equally, they can lead to financial distress when used unwisely.

The following treasury controls proposed in this document are designed to ensure the Foundation Trust treasury activities are undertaken in a controlled and properly reported manner.

The key components of the overall treasury-operating environment include

- clearly defined roles and responsibilities, as laid out in section 4;

- regular reporting of treasury activities;
- controls on who can operate bank accounts and authorisation limits; and
- segregation of duties across the treasury function.

2.6 Conclusion

Treasury Management is the efficient management of liquidity and financial risks in a business and the actions to manage these risks will vary as their nature changes over time.

This policy provides a clearly defined risk management framework for those responsible for treasury operations. In order to fully realise the benefits, it is essential that the policy is kept up to date to reflect any changes in the Trust's operation.

3 ATTITUDES TO RISK

3.1 Funding

The principal role of the Treasury Management function is to maintain liquidity and ensure a competitive return on surplus funds while maintaining a minimal risk profile.

Due to regulation changes from Monitor and the Department of Health to the calculation of Financial Risk Ratings (under the revised Risk Assessment) and the methodology of the Public Dividend Capital (PDC) interest payment calculation the Trust will conduct a monthly review on the best approach to ensuring a competitive return on surplus funds while maintaining a minimal risk profile.

The outcome of this review will be either:

- Cash remains within the Government Banking Service (GBS) and is used to offset the calculation of PDC interest payable.
- Investment, as outlined below, of surplus funds if this return is greater than the impact within the PDC calculation.

Any surplus funds to be invested will be with recognised "safe harbour" investments with a maturity date of no more than 95 days. This approach should be reviewed on an annual basis depending on the level of cash balances. Any changes in approach would require prior agreement of the Trust Board.

The key-funding objective is to ensure the Trust has sufficient liquidity to cover its business cash flows and provide reasonable flexibility for seasonal cash flow fluctuations and capital programme expenditure.

The Trust's approach to funding is that the majority of surplus funds should be available to the Trust on short notice of up to 95 days, and if the Trust holds a committed working capital facility the Trust should not aim to use it.

3.2 Safe Harbour Investments

In line with the Monitor guidance; 'Managing Operating Cash in NHS Foundation Trusts'; it is proposed that the Trust does not invest outside of safe harbour investments. This approach ensures that NHS Foundation Trust Boards do not need to undertake individual investment reviews. In addition, Monitor will not require a report on investments as part of its risk assessment process as safe harbour

investments are deemed to have sufficiently low risk and high liquidity. As an illustration of this assessment Safe Harbour Investments are treated as cash within Financial Risk Rating calculations.

There should be no circumstances for the Trust to invest surplus operating cash outside of the safe harbour.

Monitor's guidance defines a safe harbour as follows:
"Securities that are considered sufficiently safe and liquid to be in the safe harbour meet all of the following criteria:

- Meet permitted rating requirement issued by a recognised rating agency;
- Are held at a permitted institution;
- Have a defined maximum maturity date;
- Are denominated in sterling, with any payments or repayments for the investment payable in sterling;
- Pay interest at a fixed, floating or discount rate;
- Are within the preferred concentration limit.

These investments include (but are not limited to) money market deposits, money market funds, Government and Local Authority Bonds and debt obligations, certificates of deposit, and sterling commercial paper, providing they meet the following criteria. The following definitions elaborate on the criteria above and are consistent with the guidance *"Managing Operating Cash in NHS Foundation Trusts"* issued by Monitor:

Term	Advice
Recognised Rating Agency	Only the following are recognised rating agencies • Standard & Poors; • Moodys; and • FitchRatings.
Permitted Rating Requirement	The short term rating should be at least • A-1 Standard & Poors rating; or • P-1 Moodys rating; or • F1 Fitch Ratings *See note**
Permitted Institutions	Permitted institutions include: Institutions that have been granted permission, or any European institution that has been granted a passport, by the Financial Services Authority, to do business with UK institutions provided it has an investment grade credit rating of A1/A+ issued by a recognised rating agency; and The UK Government, or an executive agency of the UK Government, that is legally and constitutionally part of any department of the UK Government, including the UK Debt Management Agency Deposit Facility.

Maximum Maturity Date	• The maximum maturity date for all investments should be 95 days • The maturity date for any investment should be before or on the date when the invested funds are needed
Preferred Concentration Limit	• Cash surpluses below £750k may be invested with one institution • Cash surpluses above £750k should be invested across a number of permitted institutions to spread the investment risk • Investment limits should be set for permitted institutions based on their credit rating and net worth. These limits should be reviewed annually and reset if there is a change in either the credit rating or the net worth of the financial institution. If an institution is either downgraded or put on credit watch by a recognised rating agency, the decision to invest with them should be reviewed • Investments with permitted institutions should not exceed the set limit at any time

** Moodys, Standard & Poors and FitchRatings are the three top agencies that deal with credit ratings for the investment world.*
Due to the current financial climate, the application of long term ratings have been removed as per Monitor guidance.

3.3 Investments

In accordance with the above table, all cash balances should remain in a comparatively liquid form and all investments resulting from them should be realisable and have maturity not exceeding 12 months.

Cash deposits should only be placed with banks in line with deposit limits agreed by the Trust Board and based on the preferred recognised rating agency agreed by the Trust Board.

The Trust can invest upto one month's working capital with any one institution (currently £13.2m).

Cash deposit must be placed in Banks that are at last rated A-1, P-1 or F1 on their Short Term ratings.

These limits should be reviewed annually by the Trust Board and a review of the investment ratings must be undertaken on a quarterly basis for institutions investments are held with. See **APPENDIX 1 - Ratings Guide** for details of credit ratings.

3.4 Foreign Exchange Management

The Trust's current policy is not to cover any foreign exchange risk. This is due to the

low volume and value of the Trust's foreign exchange exposure, and will be re-evaluated if foreign trading transactions become more significant.

3.5 Bank Relationships

The Trust's approach is to develop long-term relationships with a core group of quality banks. A transactional approach, without the development of relationships, may result in the Foundation Trust being unable to rely on the support of banks in any unforeseen circumstances that may arise, such as a crisis in the banking market, or a sudden decrease in surplus funds.

The aim of the Trust is to establish a high degree of confidence and commitment between the parties so that the banks are prepared to meet funding requirements at crucial times, and at short notice.

4 SUMMARY OF KEY RESPONSIBILITIES

4.1 Trust Board

- Approve external funding arrangements;
- Approve the banking arrangements;
- Approve and monitor an appropriate Treasury Management policy and strategy.

4.2 Audit Committee

- The Committee shall review the establishment and maintenance of an effective system of internal control and risk management for its treasury function;
- The Committee shall consider external funding arrangements and recommend to the Board for approval;
- The Committee shall consider and recommend for approval the banking arrangements.

4.3 Director of Finance

- Responsible for maintaining the Trust's banking arrangements and for advising the Board on the provision of banking services and operation of accounts;
- Approve cash management/forecasting systems;
- Ensure approved bank mandates are in place for all accounts and that they are updated regularly for any changes in signatories and authority levels;
- Hold regular meetings with the Deputy Director of Finance and Head of Financial Accounting to discuss issues and consider any points that should be brought to the attention of the Audit Committee.

4.4 Deputy Director of Finance / Head of Financial Accounting

- Draft the Trust's Treasury strategy and policy for consideration by the Director of Finance;
- Report on the Treasury activities on an accurate and timely basis;
- Manage key banking relationships;
- Manage Treasury activities within agreed policies and procedures.

The Trust's Treasury procedures will be subject to periodic review by both the internal and external auditors as part of their audit undertakings and any significant deviations from agreed policies and procedures will be reported, where appropriate, to the Audit Committee.

5 BANK RELATIONSHIPS AND CASH MANAGEMENT

The development and maintenance of strong banking relationships is an important factor in the Trust's cash management policy. The provision of efficient cash management systems throughout the Trust ensures that banking requirements are serviced at optimal cost. This section details the Trust's objectives in these areas of Treasury Management.

5.1 Objectives

- To ensure the cost paid for banking services is competitive;
- To minimise the cost of borrowings and maximise the return on cash surpluses within acceptable risk parameters by maintaining efficient cash management procedures within the Trust;
- To develop and maintain strong relationships with a number of key banks;
- To monitor and ensure compliance with banking covenants.

5.2 Banking Relationships

The Deputy Director of Finance, with the support of the Head of Financial Accounting, will be responsible for managing all banking relationships across different banking services to achieve the optimum benefit to the Trust.

The Deputy Director of Finance and the Head of Financial Accounting, along with other members of the Financial Accounts Team, will meet with banks on a regular basis to discuss services provided and any new or improved products of potential interest to the Trust.

6 TREASURY REPORTING

The regular reporting of treasury activities is crucial in allowing all relevant parties to be aware of transactions undertaken, appreciate the Trust's financial position, and assess the on-going appropriateness of Treasury objectives. The following reports are produced to meet these criteria.

6.1 Daily Movement Reports

This report is completed daily by the Senior Financial Accountant for review by the Head of Financial Accounting. This details all payments to / receipts from the operational accounts (Paymaster General and the Trust nominated clearing bank) as well as the forecast closing positions.

This is used by the Head of Financial Accounting to decide on proposed appropriate levels of investments to ensure a competitive rate of return by not carrying excess funds in operational accounts.

All proposed investments are approved by the Deputy Director of Finance and / or the Head of Finance consistent with agreed delegated limits.

6.2 Monthly Reports

Monthly Reconciliation

A monthly cash flow reconciliation is produced by the Head of Financial Accounting using the daily movement report breaking down monthly payments / receipts into various headings. This is used to monitor the actual income / expenditure against the forecast, which highlights any variances, and to produce forecast cash balances.

This reconciliation includes an analysis of the interest receivable by the Trust for the month. This report is available to the Director of Finance / Deputy Director of Finance.

Monthly Board Report

Included in the monthly Board Report is a twelve month forecast of the Trust's cash balances, together with the Balance Sheet which incorporates the month's closing cash balance. This is based on the current Long Term Finance Model as submitted to Monitor.

The Income and Expenditure Account shows the interest receivable during the financial year. The monthly Board Reports also provide evidence of the calculations of Monitor's Risk Ratings and compliance with banking covenants.

Audit Committee

The Audit Committee will be provided with a Quarterly Treasury Performance Report which will include analysis of cash / borrowings and details of the performance of all cash investments and interest earned in the period together with the current risk ratings of all banking relationships.

Budget Setting for Interest Receivable

The Head of Financial Accounting will propose and agree with the Deputy Director of Finance the budgeted Interest Receivable based on projected interest rates, funds to be invested, and projected costs of investments.

7 TREASURY PERFORMANCE MANAGEMENT

Performance management is an important part of the control environment from a corporate governance perspective. A performance management framework is a mechanism for the Audit Committee and the Board to approve policy and to monitor the effectiveness of that policy. The metrics used to measure performance may be quantitative and qualitative. It is important that any quantitative measures are simple to compute and market related.

7.1 Quarterly Performance Reports

Quarterly Reports submitted to Monitor

Reports are required by Monitor to assess the financial risk of each Foundation Trust as part of the compliance framework. The report consists of a Balance Sheet, Income and Expenditure Account and Cash Flow Statement detailing planned, actual and

variance figures. A commentary is also required to explain any significant variances from plan.

Various ratios such as liquidity, return on assets, stock days, trade debtor days etc are included to ensure the Trust is maintaining its minimal risk approach and remains a going concern.

The quarterly performance reports required by Monitor will be produced by the Head of Finance and the Deputy Director of Finance. The reports will be checked and signed off by the Director of Finance and copies circulated to Trust Board.

Quarterly Treasury Performance Report

The Head of Financial Accounting will prepare a quarterly treasury performance report for circulation to Director of Finance and Audit Committee.

The report will detail:

- Analysis of cash / borrowings;
- Details of the performance of all cash investments and interest earned in the period;
- Current risk ratings of all banking relationships;
- Performance of the borrowing portfolio versus the benchmark of 3 month Libor* + 1/8th % at the start of each quarter.

*Libor = London Interbank Offered Rate

8 TREASURY CONTROLS

8.1 Summary

The overall objective of the controls set out below is to ensure treasury activities are undertaken in a controlled manner, thereby ensuring that the Trust is not exposed to undue operational risks. In particular as follows:

- Segregation of Duties is specified between those who initiate and those who authorise transactions;
- All transactions are recorded and supported by an instruction/confirmation;
- All payment instructions/confirmations will require two authorised signatories in accordance with approved bank mandates;
- Mandates will be reviewed regularly;
- The Head of Financial Accounting will ensure that there is absence cover and that current procedures are maintained in accordance with the Treasury Management Policy;
- The Trust will ensure that all the relevant people involved in Treasury Management have the relevant training required;
- This Trust is committed to the pursuit of proper corporate governance throughout its businesses and services, and to establishing the principles and practices by which this can be achieved. Accordingly, the Treasury Management function and its activities will be undertaken with openness and transparency, honesty, integrity and accountability;
- The Head of Financial Accounting will review periodically the investments to ensure that the investment Banks are appropriate.

8.2 Operational Procedures

Undertaking Transactions

- The Director of Finance will maintain schedules of those authorised to make investments where the cash is not on overnight deposit or repayable on demand, or where the amount invested is in excess of £5,000,000. In these circumstances one signatory must be drawn from each of two lists. The first list will be senior members of the finance team. The second list will be Executive Directors of the Trust, excluding the Director of Finance. The Director of Finance will ensure that all staff on these schedules are fully briefed as to their responsibilities. The Director of Finance will submit any revisions to these lists to the next Audit Committee for their information;
- Investment of less than £5,000,000 ***and*** which are either overnight deposit or are repayable on demand, may be made by two signatories from the senior finance team;
- All transfers are signed by two authorised signatories as per bank mandate, and recorded by the Chief Financial Accountant;
- Transfer initiation forms are sequentially numbered.

Verification of Transactions

All confirmations will be received and signed by the Senior Financial Accountant. Bank Mandates are maintained by the Head of Financial Accounting.

Prepared by Head of Finance
R Adamson
November 2013

APPENDIX 1 - Ratings Guide

Long-Term Debt Ratings - Measure of the borrower's ability to pay back longer term debt.

All the ratings agencies use similar classifications ranging from the very best, Aaa or AAA, downwards to the lowest rating of "Junk".

The top categories from Aaa/AAA down to Baa3/BBB are generally described as "investment grade".

Very few banks are rated higher than Aa2/AA and many fall much lower down the scale.

Moodys	**Standard & Poor's**	**Fitch Rating**
Aaa	AAA	AAA
Aa1	AA+	AA+
Aa2	AA	AA
Aa3	AA-	AA-
A1	A+	A+
A2	A	A
A3	A-	A-
Baa1	BBB+	BBB+
Baa2	BBB	BBB
Baa3	BBB-	BBB-

Short-Term Ratings - Measure of the strength of the borrower to repay short-term obligations of up to 12 months.

It is, of course easier to get a high short-term rating than a high long-term rating. Short–term ratings use a slightly different scale.

Moodys	**Standard & Poor's**	**Fitch Rating**
Prime-1 P1	A-1+	F1+
Prime-1 P1	A-1	F1
Prime-2 P2	A-2	F2
Prime-3 P3	A-3	F3
No Prime	B	B
	C	C
	D	D

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 17 December 2013
Agenda item 8.4

Title:	**Declaration of interests policy**
Paper prepared by:	Director of Corporate Development (on behalf of the Chair of the Trust)
Purpose:	To ensure the Trust continues to meet the NHS rules of Corporate Governance, the Combined Code on Corporate Governance, Monitor's Code of Governance and the Trust's own Constitution in relation to openness and transparency.
Vision/goals:	The vision and values of the Trust reflect the need for the Trust to be open and act with probity. The Declaration of Interests and independence process undertaken annually supports this.
Any background papers/ previously considered by:	None (although papers outlining the changes to the Trust's Constitution as a result of Health and Social Care Act 2012 have been presented to Trust Board for approval)
Executive summary:	In accordance with the Constitution of the Trust, the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and Monitor's Code of Governance for Foundation Trusts, and in recognition of the Codes of Conduct and Accountability issued by the Department of Health and the UK Corporate Governance Code produced by the Financial Reporting Council, the Trust is required to maintain a Register of Interests of Directors. The Trust's approach to this is set out in a policy approved by Trust Board. The Trust has had a policy in place since its inception in April 2002. This policy was replaced in May 2009 when the Trust was authorised as a Foundation Trust. The policy was subsequently revised in September 2011 to incorporate the Bribery Act 2010, which came into force on 1 July 2011 and created criminal offences of being bribed, bribing another and failing to prevent bribery for all organisations, including the NHS. The Policy has been revised to reflect the changes to the Trust's Constitution as a result of the provisions in the Health and Social Care Act 2012 relating to Directors' interests. The changes to the Trust's Constitution were approved by Trust Board in December 2012. There are no specific legal implications arising from the paper; however, the requirement for the Chair and Directors of the Trust to declare interests on an annual basis and for Non-Executive Directors to declare their independence is enshrined in the Health and Social Care Act 2012 in terms of the content of the Trust's Constitution. Directors are also subject to the provisions of the Bribery Act 2010. Trust Board should note that there is a separate policy and process for the Members' Council and staff.
Recommendation:	**Trust Board is asked to approve the revised Declaration of Interests policy.**
Private session:	Not applicable

Trust Board
Declaration and register of interests, gifts and hospitality

Introduction
In accordance with the Constitution of the Trust, the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and Monitor's Code of Governance for Foundation Trusts, and in recognition of the Codes of Conduct and Accountability issued by the Department of Health and the UK Corporate Governance Code produced by the Financial Reporting Council, the Trust is required to maintain a Register of Interests of Directors.

Policy development
The Trust has had a policy in place since its inception in April 2002. This policy was replaced in May 2009 when the Trust was authorised as a Foundation Trust. The policy was subsequently revised in September 2011 to incorporate the Bribery Act 2010, which came into force on 1 July 2011 and created criminal offences of being bribed, bribing another and failing to prevent bribery for all organisations, including the NHS. Under the Act, bribery is defined as an inducement or reward offered, promised or provided to gain personal, commercial, regulatory or contractual advantage. If a Director is offered, or any attempt is made to offer, any type of possible inducement or reward covered by the Bribery Act, details should be immediately reported to the Trust's Local Counter Fraud Specialist.

In December 2013, a further revision was made to reflect the changes to the Trust's Constitution as a result of the provisions in the Health and Social Care Act 2012 relating to Directors' interests.

Conflicts of interest
As set out in the Trust's Constitution, the duties of a Director of the Trust, whether Non-Executive or Executive, include the following.

1. A duty to avoid any situation where a Director has (or could have) a direct or indirect interest that conflicts (or may possibly conflict) with the interests of the Trust. This duty is not infringed if the situation cannot reasonably be regarded as likely to give rise to a conflict of interest or the matter has been authorised in accordance with the Constitution.

2. A duty not to accept a benefit from a third party because they are a Director or doing (or not doing) anything in this capacity. This duty is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest. (A "third party" means a person other than the Trust or a person acting on its behalf.)

If a Director of the Trust has a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to Trust Board. If a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. Any declaration must be made before the Trust enters into the transaction or arrangement.

If the Director is not aware of an interest, or where the Director is not aware of the transaction or arrangement in question, no declaration is required.

A Director need not declare an interest:

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1. if it cannot reasonably be regarded as likely to give rise to a conflict of interest;
2. if, or to the extent that, the Directors are already aware of it;
3. if, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered:

    3.1 by a meeting of the Board of Directors; or
    3.2 by a committee of the Directors appointed for the purpose under the Constitution.

In a spirit of openness and transparency, Directors are encouraged to declare all relevant and material interests. These apply to the Director as well as the husband/wife, partner, parent, child or sibling of the Director and can be defined as follows.

a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);
b) Ownership, part-ownership or directorship of private companies, business or consultancies likely or possibly seeking to do business with the NHS or which may conflict with the interests of the Trust;
c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS or which may conflict with the interests of the Trust;
d) A position of authority in a charity or voluntary organisation in the field of health and social care;
e) Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services;
f) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS Foundation Trust, including but not limited to, lenders or banks.

If Directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair.

Details of any such interests will be recorded in the register of interests of the Directors as outlined below.

Declarations of interests

Any Director who fails to disclose any interest required to be disclosed under the Constitution and as set out in this Policy may be removed from office in accordance with the process for removing a Director as set out in the Trust's Constitution.

Any Director who has an interest in a matter to be considered by Trust Board that needs to be declared should declare such interest to Trust Board and:

1. withdraw from the meeting and play no part in the relevant discussion or decision; and
2. not vote on the issue (and, if by inadvertence, they do remain and vote, their vote shall not be counted).

At the time an interest is declared, it should be recorded in Trust Board meeting minutes. Any changes in interests should be officially declared at the next Trust Board meeting following the change occurring. The Trust should be informed in writing within four weeks of becoming aware of the existence of, or a change to, an interest. The Register of Interests will be amended on receipt within seven working days and the interest notified to the next relevant meeting.

During the course of a Trust Board meeting, if a conflict of interest is established, the Director(s) concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue

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where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, a majority will resolve the issue with the Chair having the casting vote.

Register of Interests

The details of Directors' interests recorded in the Register will be kept up-to-date by means of a monthly review of the Register by the Company Secretary during which any changes of interests declared during the preceding month will be incorporated.

Subject to contrary regulations being passed, the Register will be available for inspection by the public free of charge and will be available on the Trust's website. The Company Secretary will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it. Copies or extracts of the Register must be provided to members of the Trust free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-members for copies or extracts of the Register, informed by guidance from the Information Commissioner.

Annual review

An annual review process will be undertaken (over and above the requirement for Directors to declare interests during the year) by the Company Secretary and the Register of Interests presented to Trust Board on an annual basis (usually in March each year). As part of this process, Trust Board will assess any apparent conflicts and/or any risks an interest might present to the Trust.

Determination of independence

Monitor's Code of Governance also requires the Board to identify in the Trust's annual report those Non-Executive Directors it considers to be independent in character and judgement and whether there are any relationships or circumstances likely to affect, or could appear to affect, the Director's judgement. In addition to the above declaration of interests, Non-Executive Directors are also asked to declare whether he/she:

1. has been an employee of the Trust within the last five years;
2. has, or has had within the last three years, a material business relationship with the Trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the Trust;
3. has received or receives additional remuneration from the Trust apart from the Non-Executive Directors' fee, participates in the Trust's performance related pay scheme, or is a member of the Trust's pension scheme;
4. has close family ties with any of the Trust's advisers, Directors or senior employees;
5. holds cross-directorships or has significant links with other Directors through involvement in other companies or bodies;
6. has served on the Trust Board for more than nine years from the date of their first appointment.

Gifts and hospitality

1. Directors are expected to refuse gifts, benefits, hospitality or sponsorship of any kind that might reasonably be seen to compromise their personal judgement or integrity and/or exert influence to obtain preferential consideration. All such gifts should be returned and hospitality refused other than isolated gifts of a trivial nature, such as, calendars, or conventional hospitality, such as working lunches.

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2. Directors are expected to declare and register gifts, benefits and sponsorship of any kind within two weeks of it being offered, whether refused or accepted. If an individual is unsure whether the offer constitutes hospitality, gifts or rewards as defined by the Trust's policy, then they should declare.

3. This applies to both implicit and explicit offers and whether or not linked to the awarding of contracts or a change in working practices.

4. All declarations of hospitality, gifts or rewards will be entered into the Trust's hospitality register maintained by the Company Secretary.

NB there are separate arrangements to declarations of interest, gifts and hospitality for the Members' Council and Trust staff.

Director of Corporate Development on behalf of the Chair of the Trust
December 2013
Review December 2015

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With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 17 December 2013
Agenda item 9

Title:	**Use of Trust seal**
Paper prepared by:	Chief Executive
Purpose:	The Trust's Standing Orders, which are part of the Trust's Constitution, require a report to be made to Trust Board on the use of the Trust's seal every quarter. The Trust's Constitution and its Standing Orders are pivotal for the governance of the Trust, providing the framework within which the Trust and its officers conduct its business. Effective and relevant Standing Orders provide a framework that assists the identification and management of risk. This report also enables the Trust to comply with its own Standing Orders.
Vision/goals:	The paper ensures that the Trust meets its governance and regulatory requirements.
Any background papers/ previously considered by:	Quarterly reports to Trust Board
Executive summary:	The Trust's Standing Orders require that the Seal of the Trust is not fixed to any documents unless the sealing has been authorised by a resolution of Trust Board, or a committee thereof, or where Trust Board had delegated its powers. The Trust's Scheme of Delegation implied by Standing Orders delegates such powers to the Chair, Chief Executive and Director of Finance of the Trust. The Chief Executive is required to report all sealing to Trust Board, taken from the Register of Sealing maintained by the Chief Executive. The seal has been used four times since the report to Trust Board in September 2013 in respect of: - a counterpart lease between Mark Smith and the Trust relating to the ground floor office and parking area at Britannia Works, Halifax; - a licence for occupation in respect of part of Angel Lodge, Wakefield, between Urban Housing Services LLP and the Trust; and - renewal of a lease for part of the first and second floors of The Dancer, Wakefield, between Broadsword Investments Limited, Richard Stanley and Jemma McAndrew, and the Trust; - a non-disclosure agreement with Priory Healthcare Limited.
Recommendation:	**Trust Board is asked to note the use of the Trust's seal since the last report in September 2013.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 17 December 2013
Agenda item 10

Title:	**Contract for the provision of multi-functional devices and services**
Paper prepared by:	Deputy Chief Executive/ Director of Finance
Purpose:	The proposal is presented to Trust Board for approval as the overall contract value is over the Chief Executive's delegated approval limits at £1.7 million.
Vision/goals:	The contract supports the Trust's Information Management and Technology strategy by providing a Trust-wide print solution that optimises the use of copying/printing equipment, provides 'follow me' print capabilities, demonstrates a high level of sustainability both in terms of the structure of the service being delivered and environmentally, whilst offering a reduction in costs on current expenditure of £344,000 per annum, which will form part of the cost improvement programme for 2014/15.
Any background papers/ previously considered by:	The Executive Management Team received a detailed report on the contract process and contract award decision, and supported the proposal to award the contract at its meeting on 12 December 2013. The project has also been supported by the Trust's Procurement and Sustainability TAGs and is high on both their agendas.
Executive summary:	An initial paper was submitted to the Executive Management Team (EMT) in February 2013 and work undertaken by Xerox Limited to review the current provision of multi-functional devices and services and to propose a more sustainable and cost-effective solution for the Trust's deployment and use of printers and copiers. A subsequent paper was approved by the EMT on 12 December 2013. Trust Board is asked to note the following. ➢ The total value of the five year contract is £1,722, 535. ➢ The original saving anticipated through simply exchanging like-for-like equipment was £49,000 per annum. Following the Xerox review, the implementation of a full Trust-wide document management programme will save the Trust £344,000 per annum based on current expenditure. ➢ The project covers all print devices (photocopiers, networked printers, desktop printers and all associated consumables, such as, paper, toner cartridges and utilities). ➢ Other than project management costs, there are no associated HR implications with the implementation of the initiative. ➢ The contract is fully compliant and provides the Trust with a co-terminus arrangement for all print equipment including future additions to the print fleet which is currently lacking within our present solution. ➢ All the Trust's statutory duties have been met with the award of contract and there are no issues in terms of the equality and diversity agenda.
Recommendation:	**Trust Board is asked to approve and support the five year contract award to Xerox Limited for the provision of multi-functional devices and services.**
Private session:	Not applicable