With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board Business and Risk (public session)
Tuesday 28 January 2014 at 10:45
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 17 December 2013

4. Performance reports month 9 2013/14

4.1 Section 1 – Quality performance report month 9 2013/14

4.2 Section 2 – Finance report month 9 2013/14

4.3 Section 3 – Annual planning 2014/15

4.4 Section 4 – Strategic human resources report quarter 3 2013/14

4.5 Section 5 – Patient experience report

4.6 Exception reporting and action plans

(i) Trust planned visits programme
(ii) Compliance with Care Quality Commission requirements – seclusion rooms
(iii) Service user surveys

5. Governance – review of Standing Financial Instructions

6. Monitor quarterly return and Trust Board self-certification

7. Assurance Framework and organisational risk register

8. Date and time of next meeting

The next meeting of Trust Board will be held on Tuesday 25 March 2014 in the Manor room, 5th Floor, F Mill, Dean Clough, Halifax.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Minutes of Trust Board meeting held on 17 December 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
	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:	Dawn Stephenson	Director of Corporate Development
	Robert Toole	Deputy Director of Finance
	Bernie Cherriman-Sykes	Board Secretary (author)
Apologies:	Helen Wollaston	Deputy Chair
	Steven Michael	Chief Executive
Guests:	John Haworth	Members' Council (staff, non-clinical support services)
	Bob Mortimer	Members' Council (public, Kirklees)

TB/13/63 Welcome, introduction and apologies (agenda item 1)

The Chair (IB) welcomed everyone to the meeting, particularly Robert Toole (RT), attending his first Trust Board meeting. The apologies, as above, were noted. He commented on the absence of the Chief Executive (SM) who was attending a briefing in London having been asked by the Care Quality Commission to act as a lead inspector in the first round of mental health trust inspections, which begins in January 2014. IB added that this should be seen as a significant compliment both for the Trust and SM.

TB/13/64 Declaration of interests (agenda item 2)

There were no declarations made over and above those made in March 2013 and subsequently.

TB/13/65 Minutes of and matters arising from the Trust Board meeting held on 22 October 2013 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held on 22 October 2013 as a true and accurate record of the meeting.

There was one matter arising.

TB/13/51a Supporting service users into employment Although not at the meeting, Helen Wollaston (HW) provided the Chair with some comments on items on the agenda. In relation to this item, she asked whether a timescale could be put on discussion by the Executive Management Team (EMT) followed by a report to the Clinical Governance and Clinical Safety Committee. Dawn Stephenson (DS) confirmed that there would be a discussion at EMT in January 2014 and the Committee in February 2014.

TB/13/66 Assurance from Trust Board Committees (agenda item 4)

TB/13/66a Audit Committee 18 October 2013 (agenda item 4.1)

Peter Aspinall (PA) drew Trust Board's attention to page 5 of the minutes, which referred to a 'no assurance' opinion internal audit report on procurement (non-pay purchasing). The

Committee received assurance that actions were in place closely monitored by management. The Trust has to resolve the issues raised to minimise the impact on the Head of Internal Audit Opinion at the year-end and the Annual Governance Statement. He also commented on the recommendation tracker report and the need for a relationship of mutual respect and support.

Julie Fox (JF) commented on the item in relation to Creative Minds and reminded Trust Board that, although the money for Creative Minds is channelled through charitable funds, the Audit Committee is tasked with ensuring governance and assurance arrangements are in place.

TB/13/66b Clinical Governance and Clinical Safety Committee 3 December 2013 (agenda item 4.2)
Bernard Fee (BF) provided feedback to Trust Board on behalf of HW. He particularly highlighted the Committee's consideration of children's services, and children's and adolescents' mental health services in particular. A number of issues have arisen following the transfer of services, which the Trust was not aware of at the time. Children's services in Barnsley, which transferred in October 2013, present significant clinical risk for the Trust in areas it was not involved in previously. Tim Breedon (TB) responded that the key driver for the transfer of these services to the Trust was to effect an improvement in services. The Trust needs to work with commissioners to produce improved outcomes rather than continue the traditional provider/commissioner relationship. The Trust needs to maintain strategic partnerships to enable services and outcomes to improve and flourish, and to provide added value as a result of the transfer.

BF suggested circulating a précised version of the presentation to Trust Board for information as he thought it would be helpful, particularly for Non-Executive Directors not on the Committee.

PA asked whether there were any gaps in control in relation to the transferred services. TB responded that management action is in place following a review of services but the work needed must not be underestimated. PA also asked if local authority cuts would pose any further risk to the services. TB responded that the cuts would more likely affect adult services. The local authority has a good understanding of the risks and the Trust has a robust action plan in place to mitigate risk and improve services.

The Members' Council has asked for a presentation at a future meeting to demonstrate what the Trust has done to improve the offer and services. It was also noted that this will remain as a standing item on the Clinical Governance and Clinical Safety Committee's agenda.

TB/13/66c Mental Health Act Committee 5 November 2013 (agenda item 4.3)
JF highlighted three issues in relation to bed occupancy and concerns that individuals could be sectioned to secure a bed, issues around estates and seclusion rooms (which are dealt with elsewhere on the agenda), and training for the Mental Capacity Act through development of an e-learning package.

TB/13/66d Remuneration and Terms of Service Committee 15 October 2013 (agenda item 4.4)
No issues were raised.

TB/13/67 Chief Executive's report (agenda item 5)

Alex Farrell (AF) reported on the following.

- The Trust is involved in an integrated health and social care pilot in Barnsley, which was successful in being one of the 'Pioneer' sites, as part of the Government's policy to support the implementation of integrated services. The Trust is also involved in the transformation work in Wakefield and North Kirklees, where the Clinical Commissioning Group is currently taking a business case, which includes the Mid-Yorkshire Hospitals NHS Trust reconfiguration, through governance processes. In Calderdale and Greater Huddersfield, the three NHS providers are currently working on producing a Strategic Outline Case to describe the offer for integrated health services, which is focused on reducing secondary care, integrating community services and promoting self-care. A business case will come to Trust Board in the new year.
- There are a number of concerns in relation to forensic commissioning nationally and it is intended that Chief Executives and clinical leaders in Yorkshire and the Humber, and the North East Trusts will write jointly to NHS England expressing their concerns. SM will update Trust Board in January 2014.
- NHS England's Board meets today and will agree commissioner allocations, which will have implications for commissioning of services by Clinical Commissioning Groups, which will potentially impact on the Trust.
- NHS England has published guidance on seven-day working, which is primarily focussed on acute trusts but the Trust will need to review any policy as part of annual planning. Nisreen Booya (NHB) commented that this will provide an opportunity in some services to run 'out-of-hours' clinics as part of the transformation agenda. She also mentioned that there is currently, and has been for some time, an on-call rota for consultants.
- Guidance on payment by results in mental health has been issued. Key for the Trust is the penalties for non-recording of key data and penalties linked to twelve-month CPA reviews. The challenge will be to make the changes required quickly enough to minimise loss of income due to data quality issues.
- The transformation workstreams are progressing and project management arrangements are in place. The second round of engagement events have concluded with key themes around patient-centred services, seamless services between organisations, involvement of families and carers, and use of technology in care emerging. These will be used to inform annual plans and the integrated business plan, which will come to Trust Board in January 2014.

PA asked whether the Trust was confident there is an action plan in place to address the long-standing data quality concerns. TB responded that there has been significant progress following stronger management of issues. PA asked whether failure to record data satisfactorily should not translate into management action to ensure staff record activity. TB responded that there is a continued focus to improve the level of recording.

IB suggested that the EMT might consider whether the targets for data recording in next year's annual plans should be increased to 100% and he asked management to consider what the implications of this would be. AF responded that an analysis of the risk associated with targets and performance indicators will be presented to Trust Board in April 2014 as in previous years. JF added that recording of Section 17 leave and ethnic coding are issues where the Mental Health Act Committee has asked to see improvement.

TB/13/68 Performance reports month 8 2013/14 (agenda item 6)

TB/13/68a Performance report (item 6.1)

TB highlighted issues around data recording, information governance training, the downward trend for sickness absence and safeguarding training.

TB/13/68b Finance report month 8 2013/14 (item 6.2)

RT highlighted the following.

- The stable position continues from month 7.
- The year-to-date position is showing a net surplus of £3.7 million, which is £1.2 million ahead of plan. The forecast remains consistent at £3.79 million, which is £69,000 above plan.
- The cash position is £32.7 million, which is £4.8 million ahead of plan.
- As system processes are updated, it is likely that the Trust will miss the Better Payment Practice Code (BPPC) during December. IB asked what the position would be in March 2014 and RT responded that it should return to the 95% level by the year-end. AF added that a KPMG review indicated that an 80% rate is normal and would enable the Trust to manage cash in a better way. A number of Trusts have no requirement to meet the BPPC. Although the target is no longer critical, the Trust is working to ensure robust systems and processes are in place; however, there is still a focus on paying local suppliers within 30 days.

The Chair invited comments from Trust Board.

Cost improvement programme

- BF asked why the cost improvement programme was amber. RT responded that performance is currently behind plan (£5.5 million against a plan of £5.7 million), which represents a 5% difference and is not, therefore, considered to be a major risk. BF commented that he would see this under-performance as a red risk and he would like to understand where and how the Trust has missed the target. AF responded that this was mainly relates to workforce issues in Calderdale and Kirklees (at £0.5 million). She reminded Trust Board that the risk was identified through the quality impact assessment in relation to re-profiling of the workforce on in-patient wards and reported to Trust Board. This risk has now materialised.
- The Trust-wide stated position also represents a more rigorous reporting against plan.
- BF commented that he was not confident that performance to date reflects well on next year and the ability of the Trust to realise savings from transformation.
- PA asked what management actions are in place to address this position, particularly as the EMT has incentivised objectives to achieve the forecast financial position. RT responded that Business Delivery Units (BDUs) have been tasked with finding non-recurrent or alternative savings if they find they are unable to realise the savings originally included in their plans.

JF asked whether there was a link between Barnsley BDU's sickness absence and the underspend on staffing, and whether there was any evidence from the staff survey. Alan Davis (AGD) responded that the increased sickness absence is in mental health services whilst the underspend on staffing is predominantly in community services. There has been investment in Barnsley to fill vacancies recurrently. AGD agreed to review the position and bring back to the January 2014 meeting.

Capital programme

- IB commented on the underspend on the capital programme reported to Monitor and the projected increased spend in the first three months of 2014. AGD responded that weekly monitoring of the position takes place and he is confident that the Trust can meet the re-profiled spend. There are also contingencies in place where risks have been identified.
- AF confirmed that there had been a re-statement of the capital plan at quarter 2 and discussion had taken place at the Estates Forum on plans to spend the remaining funds in line with the revised plan to be submitted to Monitor.
- BF was uncomfortable with the position as the Trust has been behind on its capital plan for the last eight months and now plans to spend a large proportion in the last three months. The Trust could be said to be adverse to spending its capital. He would like to see capital investment as a conduit for transformation. IB added that he would want to see increased scrutiny of the capital plan in the budgets for 2014/15.

- It was agreed to provide an update on the capital programme in January 2014, which will include outline plans for 2014/15. Trust Board support would then enable spending to start at the beginning of the financial year.
- BF also commented that he did not want to see the Trust spending solely to achieve the target. The Trust must spend on schemes in the capital plan to support service improvement.

AF assured Trust Board that a longer-term approach for the planning of capital spend and cost savings would be taken from 2014/15.

TB/13/68c Exception reports and action plans – Quality Governance Framework (item 6.3(i))
AF commented that this is a really important document, which underpins quality as a driving principle and demonstrates how quality is part of everything the Trust does.

It was RESOLVED 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.

TB/13/68d Exception reports and action plans – Health and safety annual report 2012/13 (item 6.3(ii))
AGD explained that the focus of the action plan is on robust, embedded, integrated health and safety systems across the Trust. Health and safety covers a number of Director-portfolios and the action plan demonstrates the strong links health and safety has with these governance arrangements. JF confirmed that the report has addressed the issues raised by the Clinical Governance and Clinical Safety Committee in September 2013.

IB asked if there is a winter plan in place. AGD responded that a plan has been developed, which focuses particularly on the weather and business continuity plans for services and main Trust sites. It was also noted how well the Trust's two main sites, at Fieldhead and Kendray, had coped in the bad weather of the last two winters.

It was RESOLVED to NOTE the annual report for 2012/13 and APPROVE the action plan for 2013/14.

TB/13/68e Exception reports and action plans – Corporate governance internal audit (item 6.3(iii))
It was RESOLVED to NOTE the findings from the corporate governance internal audit.

TB/13/69 Developing the Estates Strategy (agenda item 7)

TB/13/69a P21+ appointment of new partner organisation (agenda item 7.1)
AGD reminded Trust Board of the P21+ partnering arrangements. He presented a recommendation to appoint Interserve as the Trust's new partner. Jonathan Jones (JJ), asked to comment as Chair of the Estates Forum, commented that, although the Forum had been appraised of the position, it had not been involved in the tender process. He was not, therefore, in a position to advise Trust Board on the recommendation. He did comment that the strategic input from Willmott Dixon had been valuable to the Trust and he was keen not to lose this aspect in any new arrangements.

BF asked what Interserve had demonstrated to become the preferred supplier. In his view, the underspend on the capital programme by the Trust has affected its ability to realise capital developments.

JF asked why a Non-Executive Director had not been involved. AGD responded that this had been discussed at Trust Board previously. The changing emphasis for the capital programme from strategic development to delivery and the level of difficulty the Trust was experiencing in realising capital plans necessitated a change in P21+ partner. A speedy decision was needed and the Trust consulted the Department of Health at every stage. The point made about involvement of a Non-Executive Director was, however, noted.

AF commented that expectations had not been met on both sides and this has been a learning exercise for the Trust. Health planning distinguished Willmott Dixon from other organisations in the previous exercise and the Trust has benefitted from this. Interserve has done an excellent job on the Fieldhead site. BF questioned why Interserve was given the additional works on the Fieldhead site when Willmott Dixon was the Trust's P21+ partner. AGD explained the process and confirmed that the Department of Health had been consulted at every stage regarding the development of Newton Lodge and Willmott Dixon had been given a considerable amount of capital works to deliver.

PA asked why Willmott Dixon had withdrawn from the process given the amount of investment it had made in the Trust. AGD responded that the Estates Strategy was an excellent piece of work and Willmott Dixon had been paid for it, that it was recognised that change would result in the need for a period of transition, and an appraisal of the issues by the Trust suggested it would not be unreasonable for an amicable split to take place. As a result, Willmott Dixon decided not to tender. JJ commented that AGD had given a fair analysis of the position.

IB asked for a formal vote to take place on the appointment of Interserve as the Trust's P21+ partner. With one abstention, **it was RESOLVED to APPROVE the appointment of Interserve as the Trust's P21+ partner.**

In conclusion, JJ said it would be helpful to understand why Interserve was felt to be the best partner. AGD agreed to bring a post-tender evaluation report to the Estates Forum, which would document the full process and provide an analysis of the bids submitted. IB also agreed to write to Willmott Dixon. He commented that this also demonstrates the seeming slowness in the Trust's ability to implement its capital plans and the need for a degree of confidence that the Trust can achieve its capital plan going forward. JJ added that there is a seeming disconnect between the estates team and the Estates Forum's confidence in delivering the Strategy Trust Board has approved. He would like more assurance regarding implementation of the Estates Strategy.

TB/13/70 Strategies and policies (agenda item 8)

TB/13/70a Risk Management Strategy (agenda item 8.1)

The review of the Strategy next year will look to simplify the approach. Trust Board also noted that KPMG is reviewing the Trust's licensing arrangements and the findings will come to Trust Board as part of a wider risk analysis of the Trust's compliance with its licensing requirements.

It was RESOLVED to APPROVE the Risk Management Strategy.

TB/13/70b Customer Services Policy (agenda item 8.2)

In introducing this item, DS commented that it is intended to provide a quarterly report on trends, themes and actions from customer services to Trust Board. DS also outlined the practices in place to ensure equality and diversity issues are in place to support individuals. JF suggested a summary of the key points of a policy would assist Trust Board consideration and approval of policies. DS responded that this has been raised in various forums and will be taken on board.

JJ commented that the policy was comprehensive and asked to what extent the Trust uses technology to encourage feedback. DS responded that the Trust uses different technologies to encourage feedback but not with formal complaints currently.

IB asked for the in-depth analysis to be also available to the Members' Council. He commented that he has confidence that the investigation process is comprehensive and provides an independent view. Public engagement events also provide excellent feedback of what people really think of Trust services.

It was RESOLVED to APPROVE the Customer Services Policy.

TB/13/70c Treasury Management Strategy and Policy (agenda item 8.3)

PA confirmed that the Trust's approach is regularly reviewed by the Audit Committee.

It was RESOLVED to APPROVE the Treasury Management Strategy and Policy.

TB/13/70d Declaration of Interest Policy (agenda item 8.4)

IB commented that the Trust may be at a competitive disadvantage as a result of its approach to declaration of interests; however, he was content with the approach as it demonstrates openness and transparency, and fits with Trust values.

It was RESOLVED to APPROVE the Declaration of Interests Policy (for Trust Board only).

TB/13/71 Use of Trust seal (agenda item 9)

It was RESOLVED to NOTE the use of the Trust's seal since the last report in September 2013.

TB/13/72 Contract for the provision of multi-functional devices and services (agenda item 10)

AF confirmed that the Trust has market-tested potential suppliers through the national framework requirement for expressions of interest. She would be happy to bring the information, detail of the process and decision taken back to Trust Board. The national framework reduces the burden of tendering on NHS organisations. BF considered this a strange concept but appreciated that this is the way the NHS works.

IB asked if the Trust had considered working with other Trusts. AF responded that the Trust has looked at partnership in terms of information technology but this had not come to fruition. This is one area the Trust is exploring with acute Trust partners.

JJ asked when the savings would be achieved and AF responded from 1 April 2014. The savings were originally included in the procurement plan for 2013/14 but alternatives have been found for this year. Full achievement will be realised next year to meet the cost savings target.

It was RESOLVED to APPROVE the five-year contract award to Xerox for the provision of multi-functional devices and services.

TB/13/73 Any other business

The proposed statement with regard to the Francis Report was tabled. IB was happy to approve it but offered Trust Board the opportunity to comment by the end of this week.

TB/13/74 Date and time of next meeting (agenda item 11)

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.

Signed …… Date ……

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Quality Performance Report

Month 9 2013/14

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INTRODUCTION

Improve and be outstanding

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

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

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

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

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

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

EXTERNAL REGULATION & DIRECTION

MONITOR:

- The Trust measures for governance self-assessment against the new Risk Assessment Framework were implemented from October 2013. As at month 9 Q3 the Trust's self-assessed risk rating is green.
- Internal audit are currently reviewing Trust compliance with the new Monitor licence conditions.

CARE QUALITY COMMISSION:

- The Trust has 2 compliance actions from the inspection visit to Fieldhead (Trinity 2, Newton Lodge and Bretton) against outcomes 7 (safeguarding) and 10 (safety and suitability of premises). The CQC state that *'Overall we found patients were receiving a good level of service. However we also found some concerns regarding the design and layout of some of the hospital's seclusion rooms and the general décor and environment of Hepworth ward (within Newton Lodge). We also identified some concern regarding how some patients' seclusions had been reviewed and continued.'*A detailed action plan has been submitted in regard to the identified compliance issues to be fully completed by 31st May 2014. The plan addresses environmental improvements and increased maintenance including Hepworth ward being fully refurbished and redeveloped. The Bretton Centre has already conducted a review of seclusions taking particular account of the completeness of documentation, robustness of the rationale to 'continue' with seclusion and the frequency with which ward based staff have terminated seclusion without the presence of senior clinicians and managers
- CQC found that the following standards were met – outcome 1 (respecting and involving people who use services), outcome 4 (care & welfare of people who use services), outcome 16 (assessing & monitoring quality of service provision) and outcome 21 (records).
- CQC identified all three Dales wards (Elmdale, Beechdale, Ashdale) to be compliant in respect of all standards inspected. Staff treated service users with dignity and respect. Choices were offered to patients. A range of assessments and care plans were carried out to ensure the needs and risks of individuals were being addressed including physical health needs. Systems and processes were in place to ensure service users were safeguarded from harm.
- There were 3 CQC Mental Health Act visits in Quarter 3 – Enfield Down, Ashdale ward and a seclusion visit to Newton Lodge. CQC reported positively on treatment, care and service user participation in appropriately person-centred care planning. Concerns related to elements of record keeping. The seclusion visit identified some discrepancies between the trust policy, the code of practice and actual practice. The refurbished seclusion facilities on Bronte and Johnson were felt to address previous concerns raised but the facilities on Gaskill and Hepworth (yet to be refurbished) were still deficient.
- In the latest QRP re-fresh (December 2013):14 (87.5%) risk estimates continue to fall in the **'reduced risk of non-compliance'** range. There are 2 risk estimates within the **'increased risk of non-compliance'** range: outcome 4 (care & welfare) and outcome 6 (cooperating with other providers) which are now risk rated low red and high amber respectively. Items impacting negatively include 'intelligence from CQC staff', 'compliance reviews' and 'CQC Mental Health Act Database'. Risk ratings are significantly influenced by both CQC compliance and Mental Health Act visits.
- The CQC continue to monitor the trust closely in regard to the admission of patients to a ward when no bed is available. The CQC are also monitoring section 17 leave (MHA visits identifying instances where service users report that section 17 leave is cancelled due to non-availability of staff).

QUALITY ACCOUNT PRIORITIES 2013/14

PRIORITY	PERFORMANCE INDICATORS	STANDARD	PERFORMANCE GREEN – fully achieved AMBER – partially achieved RED – not achieved									
			Q1			Q2			Q3			*Forecast Q4*
Listen to service users and carers and act on feedback	% of people (inpatient mental health - CKW) rating care as excellent or good	90%	86%			82%			82%			*g*
	% of people (community CKW) rating care as excellent or good	90%	95%			100%			91%			*g*
	% of people (inpatient MVH) rating care as excellent or good (6 monthly report)	90%	100%						92%			
	% of people (community general) rating care as excellent or good (B)	90%	97.34%			97.09%			*Awaiting results*			*g*
	% involved as much as they wanted to be in decisions about care – LD services (CKW) – one audit reported Q3	75%							*Audit completed – awaiting analysis*			
	% complaints including staff attitude as an issue	<25	7%	21%	17%	17%	19%	17%	24%	*25%*	8%	*g*
Timely access to services	Improving access for people experiencing acute MH problems (crisis) (CKW)	95%	91%			90%			90%			*g*
	% assessments within 4 hours for people entering urgent care pathway (B)	95%	95.11%			87.3%			90%			*g*
	Non-acute mental health (routine) face-face contact within 14 days of referral (CKW)	90%	68.83%			70.6%			72.6%			*a*
	Non-acute MH (routine) treatment within 6 weeks of face-face contact (B)	90%	97.5%			92.5%			92.5%			*g*
	Psychological therapies - new referrals assessed within 14 days (CKW)	95%	98%			97.8%			93.3%			*g*
	Referrals non-urgent assessed within 14 days (B)	90%	81.2%			48.5%			50.5%			
	% of service users who have had their gate kept admission kept	95%	100%	100%	93%	99%	100%	100%	98%	99%	99%	*g*
	Referral to treatment within 18 weeks target achieved (B)	95%	100%			99.6%			98%			*g*
Improve care and care planning	% of service users on CPA with a formal review within previous 12 months	95%	96%	92%	95%	94%	94%	97%	97%	96%	98%	*g*
	% people offered copy of care plan	85%	73%	74%	74%	75%	75%	76%	77%	77%	78%	*a*
	Improving health outcomes for people in secondary MH services (exercise)	90%	100%			100%			100%			*g*
Improve recording and evaluation of care	% mental health patients with a valid diagnosis code at discharge	99%	100%	71%	98%	100	100%	95%	95%	96%	77%	*g*
	% eligible cases assigned a cluster	100%	98%	92%	92%	87%	89%	90%	91%	93%	94%	*g*
Improve transfers of care by working in partnership across the care pathway	% of people followed up within 7 days of discharge from inpatient care	95%	98%	95%	97%	97%	97%	97%	97%	96%	98%	*g*
	Delayed transfers of care	≤ 7.5	3.9	3.5	4.1	3.1	3.4	3.8	3.9	3.5	3.1	*g*
	% mental health clustering assessments completed at discharge (CROM) – from Q3	In development										*g*
Ensure our staff are professionally, physically and mentally fit to undertake their duties	Sickness rate	≤ 4.00%	5.3	4.9	4.7	*4.8*	*4.6*	4.5	4.6	4.7	4.7	*a*
	Appraisal rate	90% at Q2	71.8%			90.6% at m6			92.3% at m9			
Improve the safety of our service users, carers and visitors	% of never events	0%	0	0	0	0	0	0	0	0	0	*g*
	Achievement of NICE guidance levels of non-amber/red risk assessment s	95%	98%			97%			98%			*g*
	Effective monitoring and response to reported medication errors	100%	100%			100%			100%			*g*
	Appropriate safeguarding referrals and response	100%	100%			100%			100%			*g*

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

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

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

This remains a quality priority against which SWYPFT performs well with the focus remaining on conversion from listening to action

Q3 RAG RATING		
	A/G	

PERFORMANCE

- 5 performance indicators 4 fully met, 1 within 10% of target. (For 6th indicator data not available until Q4).
- There were 84 formal complaints in Q3 (Barnsley – 21, Wakefield – 18, Kirklees – 14, Calderdale – 13, Specialist services – 13, Forensic – 5. District Directors monitor delivery of action plans and ensure corrective action is implemented within service lines.
- In Q3 3 complainants asked for their cases to be reviewed by the Parliamentary and Health Service Ombudsman (Barnsley 1, Wakefield – 1, Kirklees – 1).
- In-Patient Survey (Quality Health) involving 20 mental health trusts covering service users between 16 and 64 who had an in-patient stay of at least 48 hours. Trust results overall are positive in regard to the service user's initial visit to the ward and benchmark well against other trusts. 80% of service users felt staff made them welcome. However one score close to the bottom 20% of all trusts related to staff knowledge of the patient and their previous care.
- Calderdale BDU community patient and carer experience survey (pilot for trust wide roll out for collection of patient experience data quarterly) – 86% of service users said they felt involved in producing their care plan; 73% of carers definitely felt happy with the opportunity they had to ask questions.

OTHER EVIDENCE OF ACHIEVEMENT

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

- Continuing to collect and review real-time feedback from the systems put in place via the patient experience project facilitating the use of technology. 'You said, we did' is a systematic collection of patient experience feedback to influence service improvement in clinical teams and enable ward to board reporting. Service improvements implemented as a result of real-time feedback from in-patient areas include: weekly patient involvement meetings and ensuring service users have the opportunity to contribute to their care plans.
- SWYPFT has successfully reached the final stages of the national patient experience network (PEN) awards for the real time patient experience project.

ORGANISATIONAL DEVELOPMENT

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

- CAMHs in Kirklees and Calderdale are to progress a 'deep dive' carers survey to gain important feedback about the service provision

Other developments

- On-going roll-out of Francis related initiatives including the development of the Carers Charter ('Families Matter' value) and monthly repeated 'right first time ' modules aiming to reach about 150 staff each time (2,000 staff over the course of the year/about a third of each trust team)
- Action being implemented following feedback from LD service users (Wakefield, Calderdale, Kirklees) at a CCG organised 'Its my Health Day' includes: standardising format and content of patient information; identifying a set of outpatient standards; developing a service user satisfaction survey programme; identifying a process for publicising outcomes of audits and action taken in a way that is relevant to the service user group.

TIMELY ACCESS TO SERVICES

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

Work continues to improve all areas related to access

Q3 RAG RATING
A

PERFORMANCE

- Fully meeting 3/8 performance indicators, within 10% of target for 2 and more than 10% away from target for 2 (Barnsley % non-urgent referrals assessed within 14 days and Calderdale/Kirklees/Wakefield face to face contact within 14 days of referral) as at month 9
- In-Patient Survey – results were positive in regard to service users feeling they had been treated fairly and not discriminated against. However, although above the benchmark level (31%) the trust score of 40% 'yes completely' responses for detained patients' rights being explained and understood is still an identified area for improvement.
- Calderdale BDU community patient and carer experience survey – Only 52% of carers (n = 26) had been offered a carer's assessment and 40% had not been made aware that the person they cared for could develop advanced decisions/statements. However 72% felt their own needs for support were responded to by mental health services. (Action by BDU).
- Following the CQC MHA visit to Ashdale ward CQC raised concerns around physical access to the Dales because of severe parking problems and the impact on visiting professionals being late for appointments with service users. (Review/action via Director of HR).

OTHER EVIDENCE OF ACHIEVEMENT

The Trust (Wakefield) is one of 10 sites across the country taking part in a national pilot to test out a new model of Liaison and Diversion services to ensure the quality of services is consistent regardless of where the person is. Mental health nurses and other mental health professionals will work in police stations and courts so that people with mental illness and substance misuse problems get the right treatment as quickly as possible which it is hoped will reduce re-offending.

ORGANISATIONAL DEVELOPMENT

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

- A workshop was held in December 2013 to agree a standard set of questions for the quarterly surveys in 2014/15. Numerous questions have been developed in a 'question bank' (including questions in relation to access to services) which can be utilised in surveys across the trust.

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

- SPA workshops completed. Evaluation findings to be reported in Q4

IMPROVE CARE AND CARE PLANNING

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

Evidence of many positive developments.
Continuing need to focus on care reviews and care planning.

Q3 RAG RATING		
	A	

PERFORMANCE

- Fully meeting 2/3 performance indicators and partially meeting another (people on CPA offered copy of care plan). In regard to the latter there is continuing review of the impact resulting from Barnsley services increasing utilisation of the electronic care record.
- In-Patient Survey – results were generally positive in regard to care, treatment and medication issues. 50% of the results show an improvement from 2012 and are above the national benchmark level. However one of the lowest scores (in line with national results) related to service users feeling they had enough access to activities, especially at weekends and evenings. Another low score related to service users having access to talking therapies on the ward.
- Calderdale BDU community patient and carer experience survey: 76% of service users (n = 141) stated they had a care plan, 79% that they had been given (or offered) a copy of the care plan, 92% that their care plan was helping them. 71% (n = 136) said they had been involved in a meeting/review to discuss their care in the last 12 months, 96% that they had been able to express their views at the meeting and 89% that the meeting/review was helpful. However 30% of respondents said they had not been told about the possible side effects of medication.

OTHER EVIDENCE OF ACHIEVEMENT

- As part of the roll out of the patient experience project systems have been established to ensure all community and in-patient services can meet the requirement to capture the friends and family test information from December 2014.

ORGANISATIONAL DEVELOPMENT

Commitment: to monitor and report on progress implementing recovery through organisational change - IMROC – Work to influence the Trust to become more recovery focused continues. Recent developments include the proposed model for recovery colleges across SWYPFT (based on information learned from a series of visits to other colleges). The model includes: collection of courses delivered in various campuses; a student charter; different faculties delivering different courses; courses co-produced by people with lived experience and people with professional experience; people attending to have a self-determined individual learning plan. There are likely to be 5 colleges (Barnsley, Calderdale, Forensic, Kirklees, Wakefield) with the first in Barnsley.

Commitment: to implement actions from clinical audits that help provide personalised recovery based care across all services - Examples of reported outcomes and service improvement as a result of audit include: In Barnsley the Preferred Priorities for Care (PPC) audit has increased professional confidence in having conversations about end of life care and the focus on an increased range of end of life care aspects; Cardiac Rehabilitation audit has led to appropriate air conditioning being set up and up to date bus timetables being provided. The trust-wide Eliminating Mixed Sex Accommodation best practice audit was followed by the production of single sex accommodation leaflets, dedicated visiting rooms at Newton Lodge and improved procedures for obtaining day and night wear when required.

Other - Review of all patient information, leaflets and other forms of communication to ensure we have clear accurate up to date information for people who use our services. A care co-ordinator card co-produced with service users to be given to all service users on both CPA and Standard Care. 12 personal standards for care planning and 12 personal standards for reviews of care agreed by a group of service users, carers and clinicians currently being disseminated into team bases as a guide/reminder for care co-ordinators and a good practice check-list. These standards will give clarity to service users about the standard of care they can expect from clinical staff and a toolkit to challenge clinical staff if they do not receive the agreed standard of care. Care co-ordinator competencies have been developed and will be implemented consistently across the trust which will be used as a framework for acceptable practice and will be audited in 2014. Work has commenced to review how RiO can be used to populate letters and appointments with the identification and contact details of the care co-ordinator.

IMPROVE THE RECORDING AND EVALUATION OF CARE

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

Record keeping remains a significant focus for improvement.

Q3 RAG RATING		
	A	

PERFORMANCE

- Not achieving 2 performance indicators - within 10% of target for 1, more than 10% away from target for 1. (% eligible cases assigned a cluster, % mental health patients with valid diagnosis code at discharge – being actioned via data quality steering group).
- There are currently 4 information governance incidents with the information commissioner (note recently introduced reduced threshold for incident reporting).
- CQC MHA visits in Q3 (Enfield Down, Ashdale, Newton Lodge) identified some deficiencies in record keeping.

OTHER EVIDENCE OF ACHIEVEMENT

The CQC compliance inspection visit to Fieldhead found the trust to be compliant with outcome 16 (assessing and monitoring the quality of care) saying that there was an effective system to regularly assess and monitor the quality of service that people receive and an effective system in place to identify, assess and manage risks. Organisational self-assessment against outcome 16 identifies improved systems and processes but still areas for attention including: greater interaction and better communication to effect full ward to board and board to ward review; strengthening of the clinical lead role; BDU 'ownership' for NICE guidance assessment and implementation; addressing deficits in Mental Capacity awareness/training

ORGANISATIONAL DEVELOPMENT

Commitments: implementation of trust-wide record keeping audit/ implementation of record keeping action plans

- Standards have been developed, consulted upon and finalised. Trust-wide record keeping audit begins w/c 20th January.
- The subject for the first Quality Forum in December 2013 was clinical record keeping and data quality.A podcast from the workshop is being developed. The presentation from the day is currently being adapted using Camtazia software and will be available in Feb/March 2014. This initiative will enable key messages to go out to staff

Other

- Concern has been raised by the mental health act committee with the lack of improvement identified from concurrent audits of the recording of patients' rights against Section 132 (MHA 1983). Changes now being implemented include utilising RiO to record that Section 132 rights have been given and ensuring that audit results are fed back more effectively to BDU operational services for action
- CQC are seeking assurances from the Trust regarding section 17 leave particularly following statements raised by service users in Bretton that leave is being cancelled. Work is being done to ensure standardisation/consistency of approach.
- Incident categorisation (DATIX) – previously information has been captured based on local definitions of severity including actual and potential harm. This information in conjunction with other fields is mapped to coding in the background that translates the information to the 6 national categories on NRLS but these do not directly map back to trust grading at all levels of degree of harm. SWYPFT was advised by our internal auditors (as part of the Quality Account process) to resolve the mapping issue to ensure severe and death incidents can be easily identified. This action has been taken.

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

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

The Trust commitment to partnership working is matched by performance but economic pressures will challenge partnership working

Q3 RAG RATING		
	A/G	

PERFORMANCE

- Achieving 2/2 performance indicators.
- In-Patient Survey – results overall were positive in regard to people leaving hospital with the majority showing an improved position from 2012 and similarly being above the benchmark level.

OTHER EVIDENCE OF ACHIEVEMENT

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

A standard procedure for minimising delayed Transfers of Care has been developed and is currently in draft format. The procedure has been developed in conjunction with clinical managers and team leaders. Implementation February 2014.

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

Multi-stakeholder engagement in transformation events trust-wide continues across all identified pathways

ORGANISATIONAL DEVELOPMENT

- Care co-ordinator competencies will be used to help focus and navigate transfer of care areas
- The ImRoc project will help staff to support people with elements of day to day living
- Following a joint review (SWYPFT/Mid-Yorks) a psychiatric liaison service has been implemented in Wakefield

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

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

Positive developments continue to be made but workforce resilience will be tested during transformation

Q3 RAG RATING		
	A/G	

PERFORMANCE

- Failing to meet the sickness rate performance indicator in Q3 (please see HR report)

OTHER EVIDENCE OF ACHIEVEMENT

The Trust's initial NHS staff survey results have been submitted to the CQC by our survey contractor Quality Health.

- *Care of patients / service users is my organisation's top priority* - 81% agree/strongly agree (benchmark average - 74%)
- *I would recommend this organisation as a place to work* - 61% agree/strongly agree (benchmark average - 55%)

ORGANISATIONAL DEVELOPMENT

- Francis related work streams – a specific task group is being established to respond to the requirements identified for staffing level reviews and reporting in the government response to the Francis recommendations ('Hard Truths')
- Leading to Quality (LTQ) – one major output of LTQ is the LTQ toolkit which consists of workbooks aimed at developing teams and team leaders so enhancing leadership, team working, staff engagement and wellbeing. In SWYPFT the intention is to utilise the developmental workbooks with teams and leaders to support service transformation. The workbooks have yet to be formally implemented with teams and it will be important to evaluate both implementation as well as impact. As part of the evaluation data will be gained to inform design improvement and findings to contribute to the literature around effective leadership and culture development in teams. The involvement of service users in the project will provide a particularly unique angle on which to promote research.

Commitment: Evaluation of Appraisal System: The evaluation of the new appraisal system (introduced from April 13) was completed in November 13. As a result of the feedback the appraisal policy is being updated and the new appraisal document will be launched in April 2014.
Commitment: Trust-wide audit of clinical supervision: in planning for March 2014 pilot in Barnsley and Wakefield with a view to roll-out trust-wide in 14/15.
Commitment: National and local staff audits: The response rate for the Trust's initial NHS staff survey results submitted to the CQC by our survey contractor Quality Health was 50%, which is very similar to last year's 51% figure. Positive results include: *'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'* - 68% agree/strongly agree (benchmark average 60%). '*In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?'* - 96%, (benchmark average 87%). Areas for development include: questions concerning uptake of training such as equality and diversity, health and safety, are lower than average. There are also a few areas relating to support by immediate managers that are slightly lower than average.
Commitment: Develop and implement the staff survey action plan for the staff survey 2013: The Quality Health staff survey findings and the final CQC results when received will be reviewed via the well-being at work partnership group.

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

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

Patient Safety remains a critical priority – CQC concerns regarding seclusion practice are being addressed

Q3 RAG RATING		
	A/G	

PERFORMANCE

- Achieving 4/4 performance indicators.
- There have been 32 Serious Incidents reported to the Commissioners in Q3 (including reportable pressure ulcer incidents many of which fall within the 'unpreventable' category). A retrospective review of all incidents in Q2 shows that 85% were rated green, 12.5% yellow, 1.5% amber and 0.5% red.
- There were 31 reported incidents directly related to issues of child protection in Q3. Reported incidents have noticeably increased but work is on-going to ensure reporting continues to improve. There were 30 adult safeguarding alerts.
- None of the 161 incidents of physical violence against staff by patients or 51 incidents of physical violence against patients by patients were amber or red rated. Due to the change to the 12 month (more frequent) re-fresher period the total percentage of staff trained in teamwork fell to 76% in October but additional courses have helped bring the figure back up to 79% by December (target – 80%).
- 290 reported incidents had a recorded action of restraint (including 2 amber incidents). 34 of which had a recorded injury. 204 (70%) related to incidents of violence and aggression and 52 (18%) to incidents of self-harm. A significant increase in the use of restraint in December related to 3 individuals – two older people with dementia where restraint was used to assist care delivery (washing/dressing) and one young person to keep them safe from self-harming.
- In calendar year 2013, prone restraint was used in 313/1310 incidents (24%).All incidents involving prone restraint in Q3 were green or yellow
- There have been no Eliminating Mixed Sex Accommodation breaches. The number of reported occurrences where a service user is placed on a corridor occupied by members of the opposite sex decreased to 8 in Q3 following a surge in numbers in Q2 (7 in Q1, 24 in Q2).
- In-Patient Survey – the results in regard to people feeling safe on the ward ('yes always' – 44%) were above the national benchmark level (41%) but reduced from 2012 (51%). 69% of respondents said the room or ward was very clean and 57% that the toilets/bathrooms were very clean.
- The trust has 2 CQC compliance actions related to seclusion environment and practice. The Trust's improvement plan has been discussed with CQC at the regular liaison meeting.

OTHER EVIDENCE OF ACHIEVEMENT

Commitment: Improve the structures to improve BDU governance:

- BDU governance group review event held December 13. The output is informing the groups' operational and reporting structures. First annual reports will be produced in March 2014.

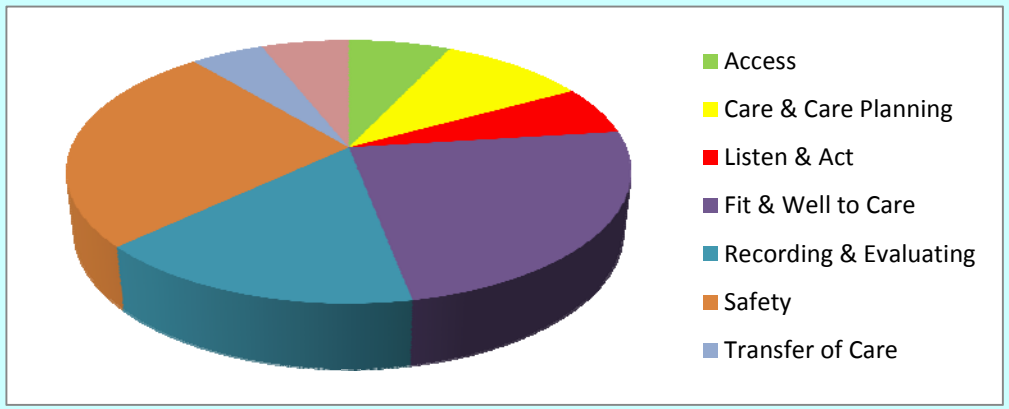
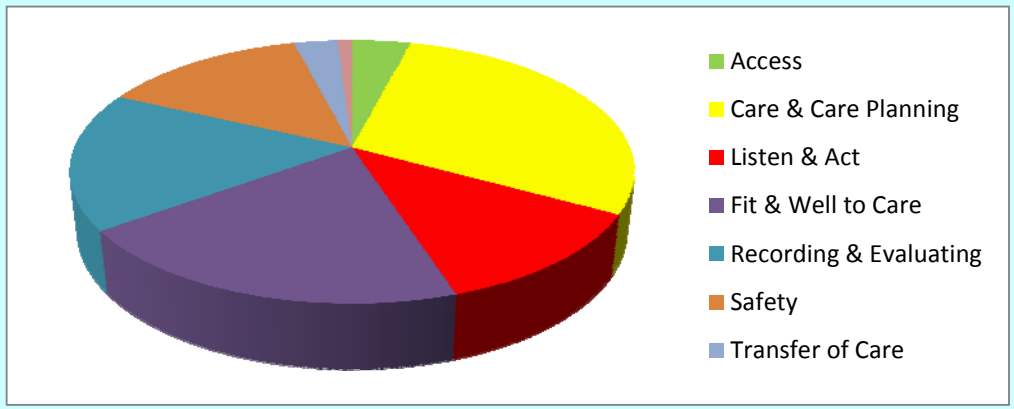
ORGANISATIONAL DEVELOPMENT

- Trust-wide bed management/patient flow event held November 13. Critical issues discussed/actions considered. BDU Director for Kirklees and Calderdale is leading on determination of actions to be facilitated via task and finish groups including potential for rolling out a trust-wide approach to patient flow.
- The next Quality Forum workshop will be on safeguarding
- A practice governance coach has been appointed to support safeguarding children in Barnsley which will enhance best practice in the children's workforce
- The trust has been a key partner in the development of the Wakefield multi-agency safeguarding Hub (MASH) due to be launched 06.01.14

EXCEPTION REPORTS

SECTION 28 – The coroner issued a Section 28 in respect of the SHARE accommodation service in Calderdale requiring that a signing in/out system be established. Whilst SWYPFT do not directly manage the service the coroner believes we have the power to effect the change via our management structures and this is indeed possible. On initial receipt we did not believe the Section 28 to be applicable to SWYPFT but having taken legal advice it now seems appropriate to accept the action.

TRUST VISIT PROGRAMME NOVEMBER 2013 - In previous years the trust has run a programme of unannounced visits to all in-patient units/wards based on the 16 CQC essential standards. However in 13/14 a different approach was initiated under the direction of the Clinical Governance & Clinical Safety Committee linked to the Trust Quality Priorities. The process was also designed to introduce the new CQC fundamental and basic standards as the basis for those undertaking visits to form a judgement. The visits continued to include discussion with service users and carers. The full information from the visits has been made available to BDUs, practice governance coaches and others with organisational leadership roles in order to facilitate understanding and promote learning. The Estates TAG will continue to monitor and implement a programme of action in response to environmental issues raised. The largest number of units visited in November 2013 were in Barnsley followed by Wakefield. Visits were not undertaken for units recently subject to a CQC inspection (e.g. all Dales units) or detailed internal review (e.g. Ward 19). 81% of the units visited were given an overall rating of 'good'. No unit visited was rated as 'inadequate'. A majority of units were assessed as fully meeting all of the 5 basic questions now being asked by the CQC – is the unit Safe?, Effective? Caring? Responsive to peoples' needs? Well-led? It is possible that there were inconsistencies between different visit teams in how they differentiated between 'YES' and 'PARTIAL' but significantly there were not any 'NO' ratings given against any of the 5 questions. There are 4 units where issues raised on previous visits have not been significantly addressed but in some cases this is because the issues relate to planned or potential building refurbishment. BDUs must ensure that the reasons for not yet addressing identified issues are understood, acceptable to the BDU and don't pose a significant risk to service users or staff. The main themes for concerns identified by visit teams were safety and staff being fit and well to care. The main theme related to identified good practice by visit teams was care and care planning.

Identified areas of concern	Identified areas of good practice
	

PUBLICATIONS/CONSULTATIONS- HARD TRUTHS

Robert Francis QC called for action across six core themes: Culture; Compassionate care; Leadership; Standards; Information; Openness, transparency and candour. On 19th November 2013 the government published its full response to Francis as *'Hard Truths – The Journey to Putting Patients First'*. The document sets out how the government expects the health and care system to prioritise and build on Francis and other independent reviews (including Keogh, Cavendish, Berwick, Clwyd) across the following vital areas:

- Transparent monthly reporting of ward-by-ward staffing levels and other safety measures.
- All hospitals will clearly set out how patients and their families can raise concerns or complain, with independent support available from local Healthwatch or alternative organisations.
- Trusts will report quarterly on complaints data and lessons learned, and the Ombudsman will significantly increase the number of cases she considers.
- A statutory duty of candour on providers, and a professional duty of candour on individuals through changes to professional guidance and codes.
- The Government will consult on proposals about whether Trusts should reimburse a proportion or all of the NHS Litigation Authority's compensation costs when they have not been open about a safety incident.
- Legislate at the earliest available opportunity on Wilful Neglect – so that those responsible for the worst failures in care are held accountable.
- A new fit and proper person's test which will act as a barring scheme.
- All arm's length bodies and the Department of Health have signed a protocol in order to minimise bureaucratic burdens on Trusts.
- A new Care Certificate to ensure that Healthcare Assistants and Social Care Support Workers have the right fundamental training and skills in order to give personal care to patients and service users.
- The Care Bill will introduce a new criminal offence applicable to care providers that supply or publish certain types of information that is false or misleading, where that information is required to comply with a statutory or other legal obligation.

The implications of *'Hard Truths'* are being considered and responses incorporated within the organisational action plan overseen by the Francis Values into Action Steering Group.

The trust has previously identified the need for clear mechanisms to ensure timely review of all expected external guidance/direction related to Francis which must be clearly linked to internal policy/procedures review and action as required. There also needs to be a clear communication strategy so staff are aware and engaged in the organisational response. Consequently further staff learning events are being organised in March 2014 to ensure that we maintain and build on the communication and feedback from the workshops originally held following publication of the second Francis report..

The Trust Board statement regarding action taken in response to Francis can be viewed on the Trust website.

PATIENT EXPERIENCE REPORT

Quality Health inpatient survey

Involving 20 mental health trusts nationally. The survey population is adults between 16 and 64 who had an inpatient stay of at least 48 hours. The trust results are generally good with 45% showing a positive increase from 2012 to 2013. From the 47 questions, 21 responses were rated in the top 20% with no Trust responses in the bottom 20% nationally. There are positive responses in relation to respect and dignity, cleanliness, keeping in touch, being listened to and involved. Areas where the findings are not as good relate to dietary requirements, some aspects of the discharge process and satisfaction with the level of activities available on wards. The results in regard to the overall experience of the service user show a positive comparison against the benchmark level but a decrease in the percentage score from 2012. However the survey results still put the Trust in the top 20% overall. Local patient experience surveys undertaken across the Trust also provide positive feedback with 97% of service users giving a good rating in terms of their experience in hospital.

QUESTION		*2012 result* *(n=166)*	2013 result *(n=151)*	National Benchmark
Overall how would you rate the care you have received during your stay?	*EXCELLENT, VERY GOOD, GOOD*	87%	**77%**	70%

Real Time Local Surveys

The Trust is using technology to conduct more real-time surveys the results of which can be contrasted with findings from national surveys. Friends and Family test results from the November 2013 Calderdale BDU community patient and carer experience survey are shown below.

Service User Survey Results		Carer Survey Results	
How likely are you to recommend our service to friends and family if they needed similar care and treatment? (n = 134)		How likely are you to recommend our service to friends and family if they needed similar care and treatment? (n = 24)	
Extremely Likely	51%	Extremely Likely	54%
Likely	34%	Likely	25%
Neither Likely nor unlikely	4%	Neither Likely nor unlikely	4%
Unlikely	3%	Unlikely	4%
Don’t Know	7%	Don’t Know	8%

Trust Board Performance Dashboard – Vital Signs (Month 9 2013/14)

Business Strategic Performance: Impact & Delivery

Month 9 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%	53%	✓	–	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%	**7.5%**	✗	↑	4
	% SU on CPA in Settled Accommodation	60%	**67.6%**	✓	↑	4

Customer Focus

Month 9 2013/14

Section	KPI	Target	Current Position	Status	Trend	Forecast Position
Complaints	% Complaints with Staff Attitude as an Issue	< 30%	8% 3/38	✓	↑	4
MAV	Physical Violence - Against Patient by Patient	19-25	Within ER	✓	–	4
	Physical Violence - Against Staff by Patient	51 - 65	Above 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%	81%	✓	–	4
Member's Council	% of Publicly Elected Council Members Actively Engaged in Trust Activity	> 50%	85%	✓	↑	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%	50%	▲	↑	3
	% of Service Users Requesting a Befriender Assessed Within 20 Working Days	> 80%	100%	✓	↑	4
	% of Potential Volunteer Befriender Applications Processed in 20 Working Days	> 90%	100%	✓	–	4

Operational Effectiveness; Process Effectiveness

Month 9 2013/14

Section	KPI	Target	Current Position	Status	Trend	Forecast Position
Inpatients	Delayed Transfers Of Care (DTOC) (Monitor)	< = 7.5%	**3.1%**	✓	↑	4
	% Admissions Gatekept by CRS Teams (Monitor)	95%	**99.3%**	✓	↑	4
Community	% SU on CPA Followed up Within 7 Days of Discharge (Monitor)	95%	97.6%	✓	↑	4
	% SU on CPA Having Formal Review Within 12 Months (Monitor)	95%	**98.3%**	✓	↑	4
Breastfeeding	Prevalence of children breastfed at 6 - 8 weeks (Barnsley)	31.5%	30%	▼	↓	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%	**80.0%**	✓	↑	4
Mental Health PbR	% of eligible cases assigned a cluster	100%	93.6%	✗	↑	3
	% of eligible cases assigned a cluster within previous 12 months	100%	77.2%	✗	↓	3
	% Inpatients (All Discharged Clients) with Valid Diagnosis Code	99%	**76.8%**	✗	↓	3

Fit for the Future; Workforce

Month 9 2013/14

Section	KPI	Target	Current Position	Status	Trend	Forecast Position	Comments
Appraisal	% of Staff Who Have Had an Appraisal in the Last 12 Months	>=90%	92.3%	✓	–	4	
Sickness	Sickness Absence Rate (YTD)	<=4%	4.7%	▼	–	3	
Vacancy	Vacancy Rate	10%	5.2%	✓	–	4	
Safeguarding	Adult Safeguarding Training	80%	80.6%	✓	↑	4	
Fire	Fire Attendance	>=80%	81.50%	✓	↑	4	
IG	IG Training	>=75%	47.40%	✗	↑	4	

Overall Financial Position

	Performance Indicator	Month 9 Performance	Annual Forecast	Trend from last month	Last 6 Months - Most recent						Assur - ance
	Trust Targets				**8**	**7**	**6**	**5**	**4**	**3**	
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 year to date position, as at December 2013, is showing a net surplus of £3.6m which is £0.9m ahead of plan. The forecast for the year remains consistent at £3.8m which is £0.04m marginally ahead of plan.
2. At December 2013 the cash position is £30.7m and is £2.6m ahead of plan.
3. Capital expenditure to December 2013 is £3.6m which is £0.2m behind revised plan. The forecast remains that the capital programme will be delivered in full.
4. At Month 9 the Cost Improvement Programme is £0.1m (approx 1%) under the target of £6.49m.
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 31st December 2013 93% of NHS and 96% of non NHS invoices have achieved the 30 day payment target. (95%)

Financial Risk Rating 2013/14				
	December 2013 Actuals		Annual Plan Quarter 3	
Metric	Score	Rating	Score	Rating
Capital Servicing Capacity	7.2 times	4	6.0 times	4
Liquidity	16.1	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				
	December 2013 Actuals		Annual Plan Quarter 3	
Metric	Score	Rating	Score	Rating
EBITDA margin	5.2%	3	5.2%	3
EBITDA, % achieved	100%	5	100%	5
ROA	6.6%	5	6.2%	5
I&E surplus margin	2.3%	4	2.6%	4
Liquid ratio	32	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.

PERFORMANCE OVERVIEW
1.0 IMPACT AND DELIVERY

1.1 CQUINs

1.1.1 Barnsley

Overall Performance Rating : Amber/Green
Key Risk Areas:

- Clinical Communication discharge communication datasets –. Failed to achieve in Quarter 3. Work on going with services to ensure achievement in Quarter 4.
- Increasing the number of people in secondary mental health in employment target not met, currently at 3.81% against a target of 7.2%. (3% month 8) 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.
- Health and wellbeing BMI CQUIN:- services are undertaking some validation work on quarter 3 submission there is a risk this CQUIN may not achieve in Quarter 3.

1.1.2 Calderdale, Kirklees & Wakefield

Overall Performance Rating: Amber/Green
Key Risk Areas:

- 2.2 (a&b) MH Access Routine 14 Days
  Both Calderdale and Kirklees continue to fail this CQUIN at month 9 and QTD (76.7%/66.7% and 68.8%/67.3% respectively against a target of 80%).
  Wakefield continue to maintain performance and have achieved at Quarter end.
  Both Calderdale and Kirklees BDU CQUIN Leads are reviewing the cases under target.

- 2.2 (c&d) CAMHS Access Routine (4 Weeks) (Wakefield Only)
  RiO reporting is showing an underperformance in this CQUIN. Work is on-going with the Service to validate RiO figures with those that are manually extracted by the Service. An exception report will be provided to Commissioners highlighting the discrepancy in figures and will offer assurance about the internal work that is taking place.

Areas to Note:

- 5.1 IP/Community Surveys : At Q3 8 out of the 9 IP questions achieved over 75% response rate. All of the Community questions achieved over 75% response rate. In total, for Q3, 87.5% achievement has been made.

1.1.3 Forensic

- 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. Commissioners have approved CQUIN achievement for all 6 CQUINs for Q2.
- Payment for Q1 achievement for all 6 CQUINs was received 22nd November 2013.

1.2 INFECTION PREVENTION

Hospital Acquired Infections: Achieving target for avoidable infections. No further cases Quarter 3. 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.

1.3 PSA OUTCOMES

Underperformance against national Department of Health outcome measures % on CPA in employment current position 7.5% (6.9% month 8) Target >10%
Position all BDUs improved in Month 9,
Wakefield 6.8%, Kirklees 9.4%, Calderdale 8.1%, Barnsley 3.81%

Barnsley have a local target of 7.2%

2.0 CUSTOMER FOCUS

2.1 PHYSICAL VIOLENCE - AGAINST STAFF BY PATIENT

The number of incidents reported of physical violence against staff by patient rose above the expected levels. The increase is due to incidents involving 3 specific individuals.

2.2 MEMBERSHIP/BEFRIENDING SERVICES

% of members actively engaged – efforts to engage members continue with an increase in active engagement since the previous quarter. The Trust's vision for volunteering may also have a positive impact on member involvement in future months

Befriending service – the befriender recruitment drive has had a positive impact on the number of service users allocated a befriender within 16 weeks and efforts in this area are continuing

3.0 OPERATIONAL EFFECTIVENESS

3.1 BREASTFEEDING

The project leads are about to undergo training to support the altogether better health champions. The team are actively working together with both health and children centres to ensure good engagement to promote breast feeding. The effects of the project are not reflected in statistics due to its infancy.
A meeting is booked for 29th Jan with the all together better team and partners to gain support for the program and promote/ improve uptake of breast feeding.

3.2 MEALTH CURRENCY DEVELOPMENT (December month 9)

External

- Cluster service specifications and contract discussions continue in January with Contracts due to be finalised by the end of February.

Internal

- A Quality Forum focussing on clinical record keeping and accountability was held in Barnsley in December. Feedback and suggested actions to improve processes will be documented in an Action plan and circulated to all BDUs for consultation and feedback in February.
- The MH Currencies project group is working with LD and Forensic services to develop cluster recording and reporting to ensure readiness for 2015/16 when mandatory collection is expected.

3.2.1 Mental Health Clustering

- The project group have focused on improving the following metrics with services. The % of eligible clients clustered and % Care Coordinator recorded have improved month on month. The % of eligible clients reviewed within frequency has slowly fallen since September and will be the focus of work with services in the last quarter of 2013/14.

2013	% of eligible clients clustered	% reviewed within frequency	% Care Coordinator recorded
Target	100%	100%	100%
August	↑ 89%	↓ 73%	↑ 70%
September	↑ 90%	↓ 74%	↑ 70%
October	↑ 91%	↓ 71%	↑ 76%
November	↑ 93%	↓ 71%	↑ 80%
December	↑ 94%	↓ 70%	↑ 81%

FIT FOR FUTURE : WORKFORCE

4.1 Appraisal

Current Position (End of November) – 92.3% Overall. 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 November Position) – 4.71% Overall.

The current year to date absence rate for the whole of SWYPFT is 4.71%. This shows a slight increase from last month's figure of 4.68%, but shows a significant reduction from last year's YTD rate of 5.09% in November 2012.

The current 2013-14 (end of March 2014) 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 slight month on month increases between the end of August through to November, 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 November Position)

Barnsley BDU

- **Current YTD absence rate = 4.90%; Current projection by March 2014 = 4.80%; Projection Trend = Reducing** ***(-0.22%)***
- Short term absence has been much reduced through winter months thus far in Barnsley BDU giving rise to revised projection of 4.80%.
- Hot spots include: Children's Services, Inpatient Rehabilitation, Long Term Conditions. The higher rates seen in these areas are due to long term absence which is being proactively managed (District Nursing currently accounting for 15% of ALL absence in the BDU).

Calderdale BDU

- **Current YTD absence rate = 3.63%; Current projection by March 2014 = 3.55%; Projection Trend = Increasing** ***(+0.15%)***
- Calderdale continues to see the lowest rates across the Trust as a BDU, however the past 2 months have seen a spike in absence (4.66% in October and 5.45% in November). This is due to increased LTS in Adult Services and Substance Misuse.
- BDU is still projecting a much lower rate than last year when it was 5.38%

Forensics BDU

- **Current YTD absence rate = 6.55%; 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 reductions from this time last year (7.16% cumulative in November 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 (5.54% cumulative).
- Long term absence is still being experienced in both Low Secure and Newhaven and this is causing high rates of 8.51% and 7.68% respectively, though both rates have decreased between October and November.

Kirklees BDU

- **Current YTD absence rate = 5.17%; Current projection by March 2014 = 5.24%; Projection Trend = Increasing *(+0.10%)***
- Adult Services in-month absence rate has risen from 3.09% in July to 5.32% in November. Long term absence has risen in the past 3 months to largely contribute to this rise.
- Older Peoples Services remains above target and has been rising since June 2013. The rate has been above 5.70% for the past 4 months. This is mainly due to long term absence in specific areas which is being closely managed by both service leads and HR services.
- The current absence rates in this report do not include the recent outbreak of viral gastroenteritis currently being experienced within Ward 19.

Specialist Services

- **Current YTD absence rate = 3.92%; Current projection by March 2014 = 3.94%; Projection Trend = Reducing *(-0.04%)***
- The BDU is seeing consistent absence rates around 4% since April. BDU overall cumulative absence is 2.28% lower than for the same period last year and is on target to see a rate under 4% by March 2014.
- 3 specific hot-spot areas within the Service account for over 40% of the total absence burden and these are being targeted.

Support Services

- **Current YTD absence rate = 3.74% - Current projection by March 2014= 3.45%; Projection Trend = Reducing *(-0.05%)***
- 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), however this rate is significantly lower than previous years where Estates staff had absence rates of 11-12%.

Wakefield BDU

- **Current YTD absence rate = 4.44%; Current projection by March 2014 = 4.40%; Projection Trend = Unchanged**
- Cumulative absence rate has been slowly rising since May through to November. The BDU is still significantly reducing its absence rate from last year at the same point of the year (5.32% in November 2012 - 0.88% higher than current YTD rate). Current rate still sees the BDU experiencing its lowest BDU rate in the last 6 years.

4.4.2 Summary:

- Whilst SWYT overall rate has risen for 3rd 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 2 from October).
- 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 overall rise in November is due to expected increases in short term seasonal absence in specific areas (Kirklees, Calderdale). Short term absence in Barnsley and Wakefield has been lower than forecasted so far.
- 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 (End of November Position) – 75.7%

- Trust overall position remains below target at 75.7% (target = 80%). This shows an improvement from 75.7% last month.
- At present all BDU's have uptake levels between 71% and 83%. *(Barnsley 79.8%, Calderdale 83.4%, Forensics 85.0%, Kirklees 74.5%, Specialist Services 87.4%, Support Services 80.9%, Wakefield 87.2%).* All BDU's have improved their position from October.

4.4 Information Governance

- 477 staff completed the training in December against a target of 750, only a small amount more than the previous month.
- Less than half of the Trust staff (47.4%) have completed the training in the first 9 months of the year. The information has been available to managers and staff throughout the year to help manage the smoothing out of the large number of staff completing this training in the last quarter of the year putting pressure on services, systems and other staff.
- 2% of staff are recorded on the system as either never having completed the training or not having completed last year or this year so far. These will be separately targeted via the Directors, they pose a significant risk to the organisation, in the event of an incident.

The monthly target is now 820 per month and if it is not achieved in January it will have to increase again.

GLOSSARY

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

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Finance Report

Month 9 2013 / 2014

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Overall Financial Position

Performance Indicator		Month 9 Performance	Annual Forecast	Trend from last month	Last 3 Months - Most recent			Assurance	Page
Trust Targets					8	7	6		
1	£3.7m Surplus on Income & Expenditure	●	●	⇧	●	●	●	4	4 to 6
2	Cash position equal to or ahead of plan	●	●	⇧	●	●	●	4	15
3	Capital Expenditure within 15% of plan.	●	●	⇩	●	●	●	4	17
4	In month delivery of recurrent CIPs	●	●	⇔	●	●	●	4	7 to 10
5	Monitor Risk Rating equal to or ahead of plan	●	●	⇔	●	●	●	4	13
6	In month Better Payment Practice Code	●	●	⇩	●	●	●	4	19

Summary Financial Performance

1. The year to date position, as at December 2013 is showing a net surplus of £3.6m which is £0.9m ahead of plan. The Forecast for the year remains consistent at £3.76m which is £0.043m marginally above plan.
2. At December 2013 the cash position is £30.7m which is £2.6m ahead of plan.
3. Capital spend to December 2013 is £3.58m which is £0.22m (6%) behind the revised capital plan.
4. At Month 9 the Cost Improvement Programme is £0.1m (approx 1%) under the target of £6.49m.
5. The previous financial risk rating methodology at December 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 December 2013 93% of NHS and 96% of non NHS invoices have achieved the 30 day payment target (95%).
N.B. Better Payment Practice performance has continued to drop during December 2013. This is expected to continue 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)	(3,595)	42	Wakefield Commissioners	(32,729)	(32,345)	384	(43,639)	(43,560)	79
				(3,560)	(3,433)	127	Kirklees Commissioners	(31,271)	(30,843)	428	(41,951)	(41,466)	485
				(1,796)	(1,797)	(1)	Calderdale Commissioners	(16,160)	(16,145)	14	(21,546)	(21,501)	45
				(7,390)	(7,307)	83	Barnsley Commissioners	(65,840)	(65,434)	406	(87,705)	(87,055)	651
				(2,178)	(1,988)	190	Secure Services Comm's	(18,464)	(17,895)	569	(24,998)	(23,721)	1,277
				(33)	(67)	(33)	Non Contract Income	(279)	(484)	(205)	(359)	(559)	(200)
				(18,594)	**(18,187)**	**407**	**Total Income**	**(164,742)**	**(163,147)**	**1,596**	**(220,198)**	**(217,861)**	**2,337**
524	494	(30)	5.8%	1,823	1,820	(3)	Wakefield	16,420	16,590	170	21,889	22,153	264
589	571	(18)	3.0%	2,078	2,086	8	Kirklees	18,096	18,620	524	24,473	24,978	505
341	317	(24)	7.0%	1,183	1,176	(7)	Calderdale	10,049	10,215	166	13,604	13,713	109
1,717	1,586	(131)	7.6%	6,218	6,159	(59)	Barnsley	53,436	51,896	(1,540)	71,233	69,696	(1,537)
429	430	1	-0.2%	1,366	1,370	4	Secure Services	12,162	12,283	121	16,263	16,460	196
309	293	(16)	5.2%	1,200	1,178	(22)	LD & Specialist	10,789	10,463	(326)	14,375	13,936	(439)
700	682	(17)	2.5%	3,788	3,736	(52)	Support	31,698	30,966	(732)	42,808	42,415	(392)
0	0	0		130	200	69	Provisions	3,724	3,026	(697)	4,384	3,507	(877)
4,608	**4,373**	**(235)**	**5.1%**	**17,786**	**17,725**	**(62)**	**Total Operating Expenses**	**156,375**	**154,059**	**(2,316)**	**209,031**	**206,858**	**(2,172)**
4,608	**4,373**	**(235)**		**(808)**	**(463)**	**345**	**EBITDA**	**(8,368)**	**(9,088)**	**(720)**	**(11,168)**	**(11,003)**	**165**
				446	435	(11)	Depreciation	4,016	3,916	(99)	5,354	5,222	(132)
				142	141	(0)	PDC Paid	1,273	1,273	(0)	1,698	1,698	0
				0	(7)	(7)	Interest Received	0	(65)	(65)	0	(75)	(75)
				0	0	0	Impairment of Assets	396	396	0	396	396	0
4,608	**4,373**	**(235)**	**5.1%**	**(220)**	**107**	**327**	**Surplus**	**(2,682)**	**(3,567)**	**(885)**	**(3,719)**	**(3,762)**	**(43)**

Income and Expenditure Summary

Forecast

The Trust annual plan surplus is £3.72m.

The forecast for the year end position, as at month 9, is that this target will be marginally exceeded by £43k and the key components of this are:

		£k	
*	Operational Budgets Position	1,296	Gain - Actual vs plan
*	Provisions	877	Provisions held to offset specific income risks
*	Depreciation	132	Gain - Actual vs plan
*	Interest better than planned	75	Gain - Increased cash balances
		2,380	
	Less:		
*	CQUIN Risk	600	
*	Activity Income Risk	1,737	
		2,337	
		43	Favourable

Forecast Risk and Mitigation

Whilst risk has been minimised in the Trust forecast, two principal risks remain:

* Estates Revaluation - This exercise had a planned I&E impact of £(800)k as at the end of Quarter 3. Actual is £(1.0)m an expected adverse impact of c.£(200)k which is offset by other related impacts e.g PDC & depreciation. For information the revaluation detail was received during M9 closedown and has been subject to ongoing validation. Notwithstanding this the assumed impact is consistent with plan and out-turn positions.

  It should be noted that within this valuation there is a £1.3m positive impact from the assumed revaluation of Aberford Field which will crystallise once planning permission is given. The estates team now expects this in February 2014. should this timescale slip into 14/15 (next year) there would be a corresponding £1.3M adjustment required impacting on the I&E. The year end position would be a surplus of £2.4m that is £1.3m lower than planned.

  This would effectively be a technical adjustment as opposed to operational impact.
* Restructuring Costs - Funding has been identified to cover the revised (+c.£300k) 2013/2014 MARS/redundancy requirements. An updated estimate has been made in respect of the expected requirements for the 2014/2015 Provision. The funding has been found from in-year budget underspends and review of existing provisions. This adjusted provision allows for an additional £0.7m initial estimate for future costs of restructuring for 2014/15.The total provision for 2014/15 stands at c.£2.2m. HR business partners are reviewing the position as part of annual planning.

Month 9

The year to date position, as at month 9, reflects a £3.567m surplus which is £0.885m (33%) 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%) The Quarter 3 assessment on CQUIN is currently not finalised but will be included within the overall financial position as soon as possible.

* Barnsley BDU is not able to recover planned (budgeted) income arising from available PICU beds and Substance Misuse. These are under plan by £0.23m 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 £170k overspent. This is a £3k reduction in overspend from Month 8. The forecast overspend position is £264k which is a £56k reduction from Month 8. The headline forecast movement is due an update of the recruitment position with some posts not appointed to or offered internally leading to further vacancies.

* Kirklees BDU - The year to date position is £524k overspent. This is a £8k marginally increased overspend from Month 8. 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 £540k to £505k.

* Calderdale BDU - The year to date position is £166k overspent. This is a £7k reduction in the overspend position from Month 8 and relates to updated assumptions on recruitment plans. The forecast overspend position is £109k which is line with previous forecasts.

* Barnsley BDU - The year to date position is £1540K underspent. This is a £59k increased underspend from Month 8. This reflects the impact of recent recruitment leading to increased expenditure on pay but has been offset by savings within non pay. The forecast underspend has remained broadly static at £1537k.

* LD & Specialist - The year to date position is £326k underspend. This is a £22k increase in the underspend position from Month 8. A high level of vacancies remain within these areas.The forecast underspend is £439k which is a reduction of £65k due to additional agency medical costs to provide maternity / sickness cover.

* Secure Services - The year to date position is £121k overspent. This is a £4k increased overspend position from Month 8. This is due to pay cost pressures arising from the usage of bank staff and client acuity needs. The forecast has reduced from £203k in Month 8 to £196k overspend in Month 9 due to reviewed recruitment assumptions.

* Support - The underspends are principally staff related, primarily within the Human Resources and Estates & Facilities (some non-pay) teams. The forecast reflects additional expenditure expected in Quarter 4 for items to include seasonal estates expenditure (gritting, utilities etc) and forecast expenditure on Consultancy.

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	414	552
	Actual	36	36	36	36	27	25	25	25	33				278	383
	Variance	(10)	(10)	(10)	(10)	(19)	(21)	(21)	(21)	(13)				(136)	(169)
LD & Specialist BDU	Target	24	24	24	24	24	24	24	24	24	24	24	24	216	288
	Actual	24	24	24	24	24	22	17	17	17				192	242
	Variance	0	0	0	0	0	(3)	(7)	(7)	(7)				(24)	(46)
Kirklees BDU	Target	25	25	25	55	55	55	55	55	55	55	55	55	405	570
	Actual	25	25	25	25	25	25	25	25	25				226	301
	Variance	0	0	0	(30)	(30)	(30)	(30)	(30)	(30)				(179)	(269)
Calderdale BDU	Target	20	20	20	37	37	37	37	37	37	37	37	37	282	393
	Actual	20	20	20	19	19	19	19	19	19				173	229
	Variance	0	0	0	(18)	(18)	(18)	(18)	(18)	(18)				(109)	(164)
Secure Services	Target	38	38	38	38	38	39	39	39	39	39	39	39	346	463
	Actual	27	27	27	27	27	28	28	28	28				249	333
	Variance	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)				(98)	(130)
Barnsley BDU	Target	156	156	157	157	157	157	157	157	157	157	157	157	1,411	1,882
	Actual	134	134	135	135	135	135	135	135	135				1,210	1,615
	Variance	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)				(201)	(267)
Support	Target	126	126	126	126	126	126	126	126	126	126	126	126	1,134	1,512
	Actual	115	115	115	104	109	114	111	111	111				1,006	1,274
	Variance	(11)	(11)	(11)	(22)	(17)	(12)	(15)	(15)	(15)				(128)	(238)
Trustwide	Target	253	253	253	253	253	253	253	253	253	253	253	252	2,277	3,035
	Actual	253	253	253	253	253	253	253	253	253				2,277	2,535
	Variance	0	0	0	0	0	0	0	0	0				0	(500)
Total	Target	688	688	689	736	736	737	737	737	737	737	737	736	6,485	8,695
	Actual	634	634	635	623	620	620	612	612	620				5,610	6,911
	Variance	(54)	(54)	(54)	(113)	(116)	(117)	(125)	(125)	(117)				(875)	(1,784)

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	7				84	91
	Variance	9	9	9	9	9	11	10	10	7				84	91
LD & Specialist BDU	Target													0	0
	Actual	0	0	0	1	1	6	6	6	6				27	46
	Variance	0	0	0	1	1	6	6	6	6				27	46
Kirklees BDU	Target													0	0
	Actual	0	0	0	0	0	23	57	103	75				257	269
	Variance	0	0	0	0	0	23	57	103	75				257	269
Calderdale BDU	Target													0	0
	Actual	0	0	0	1	1	36	16	22	22				98	164
	Variance	0	0	0	1	1	36	16	22	22				98	164
Secure Services	Target													0	0
	Actual	0	0	0	0	0	0	0	0	0				0	23
	Variance	0	0	0	0	0	0	0	0	0				0	23
Barnsley BDU	Target													0	0
	Actual	22	22	22	22	22	22	22	22	22				201	267
	Variance	22	22	22	22	22	22	22	22	22				201	267
Support	Target													0	0
	Actual	9	9	9	20	15	9	15	15	15				113	159
	Variance	9	9	9	20	15	9	15	15	15				113	159
Trustwide	Target													0	0
	Actual	0	0	0	0	0	0	0	0	0				0	500
	Variance	0	0	0	0	0	0	0	0	0				0	500
Total	Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	40	40	40	53	48	107	127	178	147				780	1,520
	Variance	40	40	40	53	48	107	127	178	147				780	1,520

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	414	552
	Actual	45	45	45	45	36	36	35	35	40	0	0	0	361	475
	Variance	(1)	(1)	(1)	(1)	(10)	(10)	(11)	(11)	(6)				(53)	(77)
LD & Specialist BDU	Target	24	24	24	24	24	24	24	24	24	24	24	24	216	288
	Actual	24	24	24	25	25	27	23	23	23	0	0	0	219	288
	Variance	0	0	0	1	1	3	(1)	(1)	(1)				3	(0)
Kirklees BDU	Target	25	25	25	55	55	55	55	55	55	55	55	55	405	570
	Actual	25	25	25	25	25	48	82	128	100	0	0	0	483	570
	Variance	0	0	0	(30)	(30)	(7)	27	73	45				78	(0)
Calderdale BDU	Target	20	20	20	37	37	37	37	37	37	37	37	37	282	393
	Actual	20	20	20	20	20	54	35	41	41	0	0	0	270	393
	Variance	0	0	0	(17)	(17)	17	(2)	4	4				(12)	(0)
Secure Services	Target	38	38	38	38	38	39	39	39	39	39	39	39	346	463
	Actual	27	27	27	27	27	28	28	28	28	0	0	0	249	356
	Variance	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)				(98)	(107)
Barnsley BDU	Target	156	156	157	157	157	157	157	157	157	157	157	157	1,411	1,882
	Actual	156	156	157	157	157	157	157	157	157	0	0	0	1,411	1,882
	Variance	0	0	0	0	0	0	0	0	0				0	0
Support	Target	126	126	126	126	126	126	126	126	126	126	126	126	1,134	1,512
	Actual	124	124	124	124	124	123	125	125	125	0	0	0	1,119	1,433
	Variance	(2)	(2)	(2)	(2)	(2)	(3)	(1)	(1)	(1)				(15)	(79)
Trustwide	Target	253	253	253	253	253	253	253	253	253	253	253	252	2,277	3,035
	Actual	253	253	253	253	253	253	253	253	253	0	0	0	2,277	3,035
	Variance	0	0	0	0	0	0	0	0	0				0	0
Total	**Target**	**688**	**688**	**689**	**736**	**736**	**737**	**737**	**737**	**737**	**737**	**737**	**736**	**6,485**	**8,695**
	Actual	**674**	**674**	**675**	**676**	**668**	**727**	**739**	**790**	**767**				**6,389**	**8,431**
	Variance	(14)	(14)	(14)	(60)	(68)	(10)	2	53	30				(96)	(264)

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 overall Trust target is £8.7m. The latest forecast is achievement of £6.91m recurrently, a shortfall of £1.78m. A total of £1.52m is expected to be managed by recurrent and non-recurrent measures in year.

The main elements of the recurrent shortfall are:	£k
* Rehab & Recovery (Trustwide)	500
* E-Rostering (Kirklees & Calderdale)	433
* Additional target (Barnsley BDU)	267

Month 9 Position

The year to date target is £6.49m and to date BDU's have allocated £6.39m. This leaves a shortfall of £96k.

* Wakefield BDU - the year to date position reflects slippage of 1 scheme, this is £53k. Overall the total forecast shortfall is £77k 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 £98k 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 £201k 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 £128k due to delays in realising procurement CIP's and expected delays in recruitment. The forecast position is a shortfall of £238k and with the exception of the procurement CIP non recurrent substitutions are being found.

* Trustwide - The annual plan contained an assumption around the delivery of a Trustwide Rehab & Recovery CIP. It is now forecast that this will not be achieved. As part of the Transformation programme it needs to be validated if this can be delivered in 2014 / 2015. This is mitigated through provisions.

Utilisation of Provisions

	Original Plan £000's	Adjustment £000's	Revised Plan £000's	Spend Year to Date £000's	Total Forecast Expendiuture £000's	Variance £000's	Notes
Innovation Fund	1,000	0	1,000	557	1,012	12	
TOTAL - Innovation Fund	**1,000**	**0**	**1,000**	**557**	**1,012**	**12**	
Recurrent Contingency	500	(288)	212	212	212	0	
CQUIN Contingency	500	0	500	0	0	(500)	2
TOTAL - Recurrent Contingency	**1,000**	**(288)**	**712**	**212**	**212**	**(500)**	
Non Recurrent CIP	(500)	0	(500)	(500)	(500)	0	
Rehab & Recovery CIP	(500)	0	(500)	0	0	500	3
Losses / Negligence	250	228	478	378	478	0	
Cap to Rev Transfer	250	(250)	0	0	0	0	
Inflation (Pay Awards)	1,634	0	1,634	1,634	1,634	0	
Clinical Excellence Awards	95	0	95	51	95	0	
Non Recurrent Contingency	0	977	977	942	977	0	
Expenditure Funding for Service Development	363	2,554	2,917	205	1,399	(1,518)	1
St Lukes Provision	0	380	380	0	380	0	
Estates Revaluation	0	782	782	0	1,004	222	
Restructuring Provision	0	643	643	0	1,050	407	4
TOTAL - Other Provisions	**1,592**	**5,313**	**6,906**	**2,711**	**6,517**	**(388)**	
TOTAL - Provisions held centrally	**3,592**	**5,025**	**8,618**	**3,479**	**7,741**	**(877)**	

The £3.6m original provision,included £1.6M funding for pay awards which was allocated to BDUs in month 1. Balance therefore totals £2.0m representing <1% (0.7%) of Trust budgets. A further £5m has been sourced £2.5m from non recurrent funds/flexibility and £2.5m expenditure provisions held against planned service developments with an income risk.

1. These expenditure budgets are for pay and non pay budgets relating to expected income streams within the annual plan which will either not crystallise or have been delayed. As such the budgets have not been devolved to BDU's until income has been finalised with commissioners.

		£k
*	Forensics additional capacity	1,138
*	RAID delayed start	381

2. CQUIN risk contingency is being released to offset the income pressure arising from the shortfall in CQUIN delivery.

3. Pressure arising from the outstanding Rehab & Recovery transformation project efficiency savings/CIP.

4. Additional funding has been identified to cover the revised (+c.£300k) 2013 / 2014 redundancy requirements. An updated estimate has been assessed for the 2014 / 2015 Provision. The funding has been found from in-year budget underspends and review of existing provisions.

The 13/14 I&E surplus plan/forecast remains as targeted.

Utilisation of Provisions

Innovation Fund	Original Plan £000's	Spend Year to Date £000's	Total Forecast Expendiuture £000's	Variance £000's	Notes
Wakefield	40	11	40	0	
Kirklees	40	33	40	0	
Calderdale	40	30	40	0	
Barnsley	40	40	40	0	
Secure Services	40	11	40	0	
LD & Specialist			0	0	
Support	80	24	80	0	
Creative Minds	120	49	120	0	
Change Management	600	358	612	12	
TOTAL - Innovation Fund	**1,000**	**557**	**1,012**	**12**	

The Trust forecast position is predicated upon the £1m Innovation Fund being fully utilised.

The allocation was undertaken as part of the Trust Annual Planning process.

The majority of the fund was allocated to support the Trust Transformation agenda.

All BDU's are forecasting that their allocation will be used.

BDU's have been tasked with chasing up expenditure, and associated benefits realisation, of this funding.

Monitor Risk Rating

Financial Risk Rating 2013/ 2014

	December 2013 Actuals		Annual Plan Quarter 3	
Metric	Score	Rating	Score	Rating
Capital Servicing Capacity	8.0	4	6.0	4
Liquidity	18.0	4	15.1	4
Weighted Average		**4**		**4**

Financial Risk Rating 2013/ 2014

	December 2013 Actuals		Annual Plan Quarter 3	
Metric	Score	Rating	Score	Rating
EBITDA margin	5.84%	3	5.20%	3
EBITDA, % achieved	100%	5	100%	5
ROA	6.98%	5	6.20%	5
I&E surplus margin	2.89%	4	2.60%	4
Liquid ratio	31.5	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	(7.43)	(5.72)	(5.99)	(0.27)	
	Recharges	(5.08)	(4.04)	(4.19)	(0.15)	
Non-healthcare Income Total		(12.50)	(9.76)	(10.18)	(0.42)	
	Admin & Clerical	27.53	20.53	19.81	(0.72)	1
	Agency	2.64	1.95	2.34	0.39	2
	Ancillary	7.17	5.38	5.27	(0.11)	
	Medical	19.52	14.61	14.09	(0.52)	1
	Nursing	82.55	61.98	60.05	(1.92)	1
	Other Healthcare Staff	32.93	24.77	22.80	(1.97)	1
	Other Pay Costs	(4.48)	(3.73)	0.00	3.73	3
	Senior Management	1.42	1.07	0.94	(0.12)	
	Social Care Staff	2.39	1.81	1.76	(0.05)	
Pay- Expenditure Total		171.67	128.36	127.06	(1.30)	
	Clinical Supplies	2.69	1.99	1.91	(0.08)	
	Drugs	3.90	2.93	2.87	(0.06)	
	Healthcare subcontracting	2.71	2.03	3.06	1.02	
	Hotel Services	2.43	1.86	1.96	0.09	
	Office Supplies	4.17	3.08	2.93	(0.14)	
	Other Costs	6.44	4.71	4.34	(0.37)	
	Property Costs	6.67	5.14	5.40	0.26	
	Service Level Agreements	5.90	4.41	4.45	0.04	
	Training & Education	1.18	0.89	0.61	(0.28)	
	Travel & Subsistence	5.68	4.35	3.76	(0.59)	
	Utilities	2.00	1.34	1.34	0.00	
	Vehicle Costs	1.71	1.33	1.54	0.20	
Non-pay Expenditure Total		45.48	34.05	34.15	0.10	
	Provisions	4.38	3.72	3.03	(0.70)	
Grand Total		**209.03**	**156.37**	**154.06**	**(2.32)**	

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 £5.42m underspend on pay. This is being offset by the £3.73m staff vacancy factor and £0.39m agency overspend.

* Non pay shows relatively small variances over a number of categories. The most significant is Healthcare Subcontracting which includes the out of area spending relating to PICU and acute beds.

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

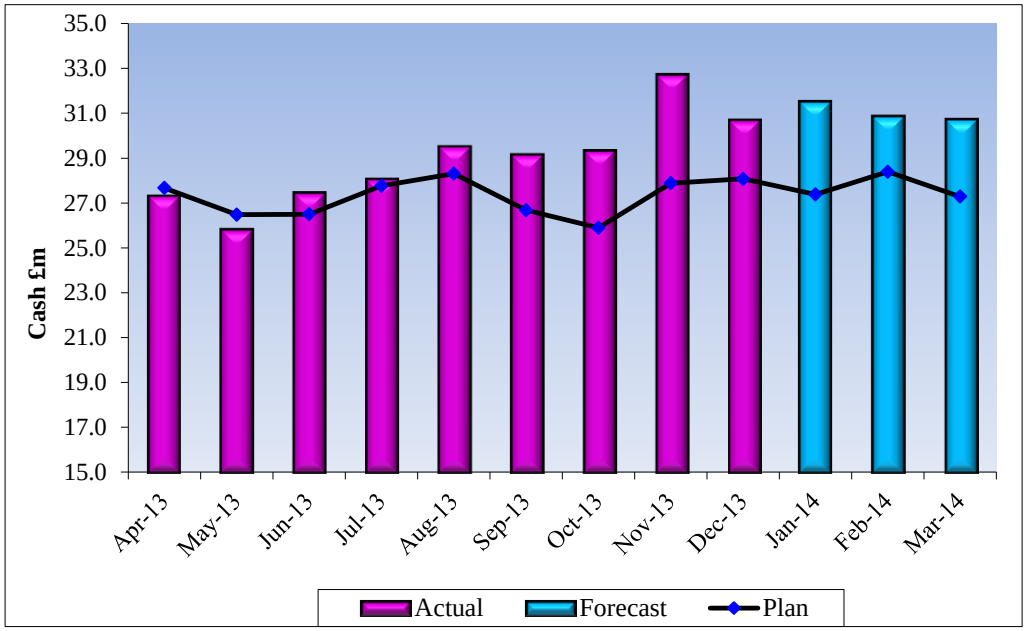
2. Agency costs are higher than planned. Spend is:

* Medical £780k
* Nursing £507k
* Social Workers £364k
* Admin & Clerical £686k

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.

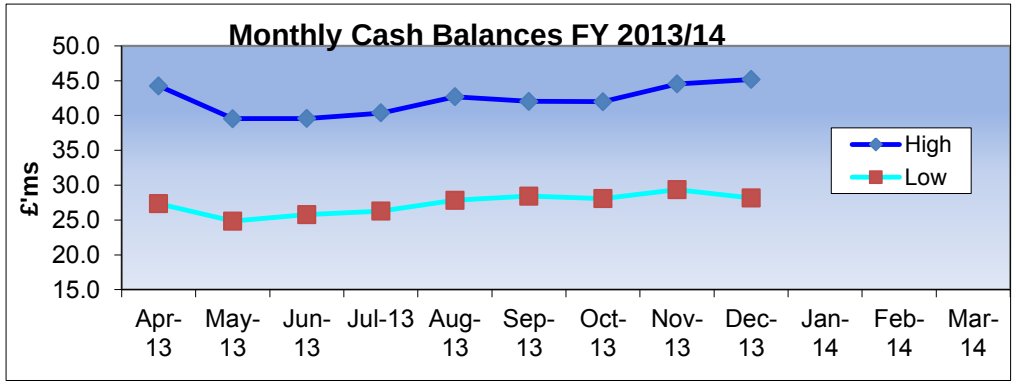
The plan is based upon the Annual Plan submitted to Monitor in May 2013.

The actual cash position for the month is £30.69m. This is £2.62m ahead of the planned cash value of £28.07m.

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

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

	Plan	Actual
	£m	£m
Opening Balance	27.88	32.72
Closing Balance	28.07	30.69



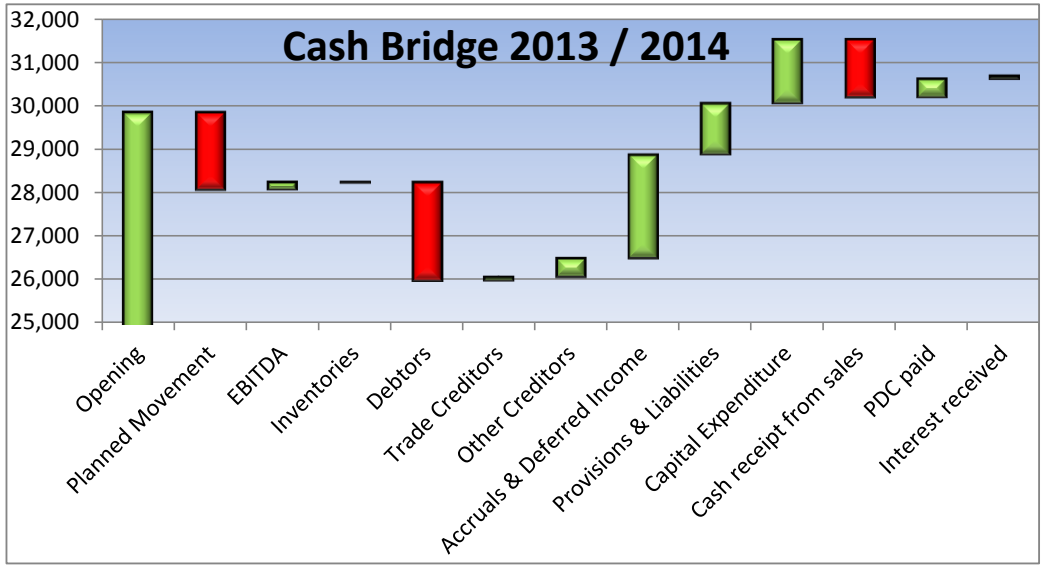
The graph to the left demonstrates the highest and lowest cash balances with each month. This is important to ensure that cash is available as required.

The highest balance is : £45.17m.
The lowest balance is : £28.15m.

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)	8.91	9.09	**0.17**	*1*
Movement in working capital:				
Inventories & Work in Progress	0.00	0.00	**0.00**	
Receivables (Debtors)	(1.68)	(3.94)	**(2.26)**	*4*
Trade Payables (Creditors)	0.37	0.45	**0.08**	
Other Payables (Creditors)	(2.64)	(2.22)	**0.42**	
Accruals & Deferred income	0.72	3.11	**2.39**	*2*
Provisions & Liabilities	(2.73)	(1.55)	**1.17**	
Movement in LT Receivables				
Capital expenditure	(4.92)	(3.46)	**1.47**	*3*
Cash receipts from asset sales	1.33	0.00	**(1.33)**	
PDC Dividends paid	(1.13)	(0.70)	**0.43**	
PDC Received	0.00	0.00	**0.00**	
Interest (paid)/ received	0.00	0.07	**0.07**	
Closing Balances	**28.07**	**30.69**	**2.62**	



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. The value of accruals continue to be higher than planned. As per previous quarter ends accruals are at their highest peak and it would be expected for these to drop as charges are received in January 2014. (£1.5m - expected LIFT invoices from NHS England)

3. Due to changes in the capital programme there has been a positive impact on the cash position.

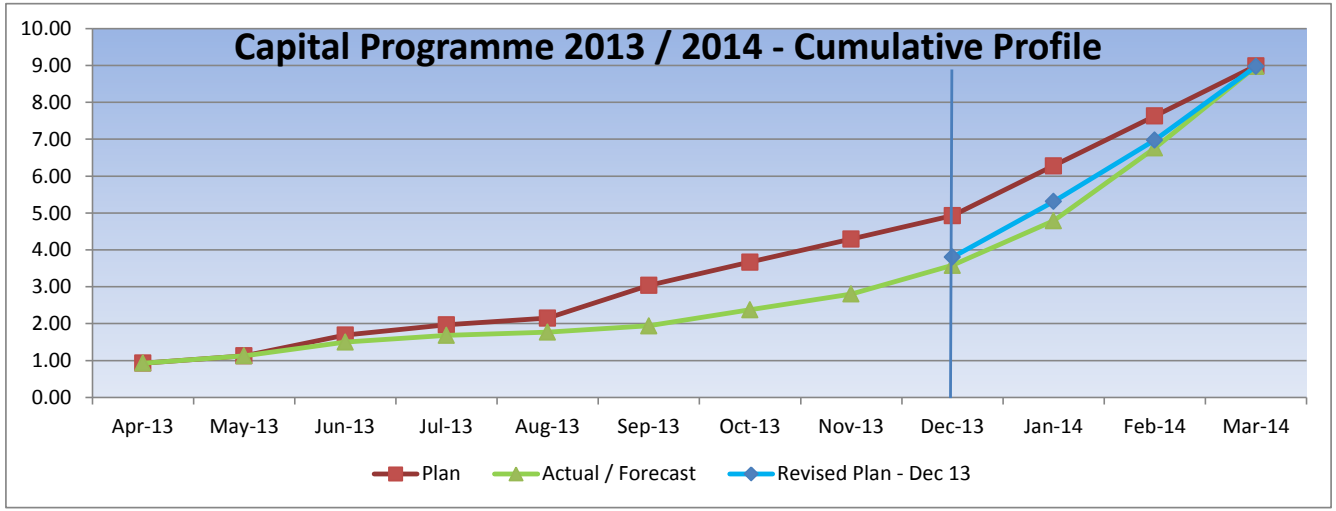
Factors which decrease the cash position against the plan:

4. Debtors are higher than planned, predominatly non NHS. The key headlines are noted within the Balance Sheet information on page 18.

The cash bridge to the left depicts , by heading, the positive and negative impacts on the cash position throughout the course of the year. This has been updated and now reflects the movement as compared to plan.

Capital Programme 2013 / 2014

Capital Expenditure Plans - Application of funds	Scheme Total £m	REVISED Annual Budget £m	REVISED 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	4.12	1.66	1.53	(0.13)	4.28	0.15	
Total Minor Capital		**4.12**	**1.66**	**1.53**	**(0.13)**	**4.28**	**0.15**	*2*
Major Capital Schemes								
Newton Lodge	11.80	1.31	1.31	1.32	0.00	1.32	0.00	
IM&T	1.60	0.85	0.31	0.21	(0.10)	0.85	0.00	
Estate Strategy	19.90	2.84	0.59	0.53	(0.06)	2.66	(0.18)	
Total Major Schemes		**5.00**	**2.21**	**2.05**	**(0.16)**	**4.82**	**(0.18)**	*3*
VAT Refunds		(0.13)	(0.07)	(0.00)	0.06	(0.13)	0.01	
TOTALS		**8.99**	**3.81**	**3.58**	**(0.22)**	**8.97**	**(0.02)**	*1*



Capital Expenditure 2013 / 2014

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

2. The year to date position is £0.22m under plan (6%) when compared to the resubmitted plan of December 2013.
This is due to delays on commencement of the major utilities upgrade, Laura Mitchell (Halifax) purchase now forecast to complete in January 2014 as opposed to December 2013 and Forensics ward slightly behind plan although this has already been caught up.

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. The main schemes spend in Qtr 4 relate to:

Forensic Ward Refurbishment	£1.55m
Seclusion Facilities	£0.55m
Major Utilities Upgrade	£0.83m
Calderdale Hub	£0.35m
Total	**£3.28m**

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 31/12/13	Actual at 31/12/13	Note
	£m	£m	£m	
Non-Current (Fixed) Assets	**69.20**	**110.14**	**105.78**	*1*
Current Assets				
Inventories & Work in Progress	0.56	0.56	0.56	
NHS Trade Receivables (Debtors)	1.43	1.04	1.25	*2*
Other Receivables (Debtors)	3.15	5.36	7.27	*3*
Cash and Cash Equivalents	29.85	28.07	30.69	*9*
Total Current Assets	**34.99**	**35.04**	**39.77**	
Current Liabilities				
NHS Trade Payables (Creditors)	(2.48)	(2.85)	(2.94)	*4*
Non NHS Trade Payables (Creditors)	(3.88)	(1.89)	(1.90)	*4*
Other Payables (Creditors)	(3.36)	(3.50)	(3.69)	
Capital Payables (Creditors)	(1.25)	(0.60)	(1.38)	*5*
Accruals	(9.03)	(10.09)	(12.18)	*6*
Deferred Income	(0.79)	(1.01)	(0.74)	
Total Current Liabilities	**(20.79)**	**(19.94)**	**(22.83)**	
Net Current Assets/Liabilities	**14.20**	**15.10**	**16.95**	
Total Assets less Current Liabilities	**83.40**	**125.24**	**122.73**	
Provisions for Liabilities	(8.07)	(5.34)	(6.52)	*7*
Total Net Assets/(Liabilities)	**75.33**	**119.90**	**116.21**	
Taxpayers' Equity				
Public Dividend Capital	(41.99)	(41.99)	(41.99)	
Revaluation Reserve	(7.26)	(22.54)	(18.17)	
Other Reserves	(5.22)	(5.22)	(5.22)	
Income & Expenditure Reserve	(20.86)	(50.15)	(50.84)	*8*
Total Taxpayers' Equity	**(75.33)**	**(119.90)**	**(116.21)**	

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 £1.25m - broadly in line with plan. Of this £0.18m are older than 60 days. The Trust is engaged in the Month 9 Agreement of Balances exercise to resolve these.

3. Other debtors are £1.91m higher than planned. Late payments from Council commissioners continue to present the significant element of this value.

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 are higher than planned due to the changes made to 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 November 2013	93.3%	94.3%
Year to December 2013	93.3%	93.8%

Non NHS		
	Number	Value
	%	%
Year to November 2013	96.2%	94.4%
Year to December 2013	95.6%	93.5%

Local Suppliers - 10 days		
	Number	Value
	%	%
Year to November 2013	79.0%	73.5%
Year to December 2013	75.3%	68.7%

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 93% 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 75% of Local Supplier invoices by volume and 69% 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 Quarter 4 (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 government expenditure over £25,000.

This is for non-pay expenditure; however, organisations can exclude any information that would not be disclosed under a Freedom of Information request as being Commercial in Confidence.

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

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

Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
31/10/2013	Fleet Vehicle Insurance	Trustwide	Zurich Insurance Company	8101249	973,301
25/11/2013	Availability Charge SLA	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	8101912	196,254
05/11/2013	Rent	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	2149900	168,522
19/11/2013	Drugs	Trustwide	Mid Yorkshire Hospitals NHS Trust	2150748	121,058
23/10/2013	Computer Network Costs	Trustwide	Calderdale and Huddersfield NHS Foundation Trust	2149265	43,213
10/12/2013	FP10´S	Trustwide	NHSBSA	2151783	43,117
18/12/2013	Drugs	Barnsley	Sheffield City Council	2152505	39,722
17/12/2013	CNST contributions	Trustwide	NHS Litigation Authority	8103429	28,302
04/12/2013	Staff benefits expenses	Trustwide	Childcare Vouchers Ltd	2151327	25,891
21/11/2013	Computer Network Costs	Trustwide	Calderdale and Huddersfield NHS Foundation Trust	2150827	25,722

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 implemented half way through a financial year, the Trust would only see six months benefit from that action in that financial year

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

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 28 January 2014
Agenda item 4.3

Title:	**Annual planning 2014/15**
Paper prepared by:	Deputy Chief Executive Director of Finance
Purpose:	For Trust Board to note the annual planning process for 2014/15
Vision/goals:	This paper contributes to the Trust having a clear strategy and plans for implementation.
Any background papers/ previously considered by:	Monitor planning guidance.
Executive summary:	This report: ➢ sets out the context and assumptions underlying the 2014/15 plan; ➢ informs Trust Board of the intended internal process, timetable and delivery arrangements for the development of the Annual Plan; ➢ informs Trust Board of the requirements of Monitor for the 2014/15 Annual Planning Review process; ➢ highlights to Trust Board the likely issues and implications of the above.
Recommendation:	Trust Board is asked to note the contents of the paper.
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Annual Planning Process 2014/15
Trust Board 28 January 2014

1. Purpose of Report

- To set out the context and assumptions underlying the 2014/15 Plan
- To inform Trust Board of the intended internal process, timetable and delivery arrangements for the development of the Annual Plan
- To inform Trust Board of the requirements of Monitor for the 2014/15 Annual Planning Review process.
- To highlight to Trust Board the likely issues and implications of the above.

2. Context and Assumptions

2.1 Monitor's review of Foundation Trust planning in the 2013/14 cycle highlighted that in many cases Trust's struggle with longer term planning (beyond 2 years). In the context of an increasingly challenging combination of factors facing the NHS over the next 5 years, Monitor and other NHS and social care regulatory bodies are strengthening the business planning requirements placed on Foundation Trusts and other bodies, including CCGs, to drive greater alignment and enhanced longer term planning (5 years).

2.2 The above analysis fits with the position recognised by the Board that

- the situation over the next 5 years is the most challenging yet
- single organisation solutions will be insufficient
- Local Health Economy (LHE) alignment and partnership working is required
- transformation is required

2.3 The affordability challenge for NHS over next 5 years is unprecedented (e.g. 6.6% in 15/16). Key drivers of this include changes to the NHS Pension Scheme in 15/16 and 16/17, and the impact of the Better Care Fund. To address this challenge it is considered that there is an efficiency opportunity within individual FTs of 2% per annum for 5 years. However, historically the Service has delivered annual productivity gains of between 0.4% and 1.4%. In addition there is believed to be a further efficiency opportunity through working across LHEs of between 1%-2% per annum.

2.4 Our plan makes the following assumptions.

	2014/15	2015/16	2016/17	2017/18	2018/19
Deflation	(2.00)%	(2.00)%	(2.00)%	(2.00)%	(2.00)%
Pay Award	1.00%	1.00%	1.00%	1.00%	1.00%
Incremental Drift	1.50%	1.50%	1.50%	1.50%	1.50%
Pension Changes	0.00%	0.70%	0.70%	0.00%	0.00%
Non-Pay Inflation	2.70%	2.70%	2.70%	2.70%	2.70%

2.5 To address these assumptions, and to cover internal cost pressures and service development investment requirements, the following level of efficiency savings / CIP are planned.

	2014/15	2015/16	2016/17	2017/18	2018/19
CIP	5.5%	5.5%	5.0%	5.0%	5.0%

3. Annual Planning Process 2014/15

3.1 The Annual Planning returns to Monitor will be in two phases this year. Firstly a detailed 2 year operational plan is required to be submitted by 4th April. Secondly a 5 year strategic plan is required to be submitted by the 30th June. Subsequent to both stages will be a review by Monitor with feedback to the Trust. The assessment of our plan will be concluded by October 2014.

3.2 To meet these requirements the following timetable is proposed.

	2 Year Operational	5 Year Strategic
Submit Plan to Monitor	4th April 2014	30th June 2014
Trust Board	25th March 2014	24th June 2014
EMT	13th March 2014	12th June 2014

3.3 There is much cross over in the requirements for both plans, and so a key principle of the approach to delivery will be that both documents are kept in mind at all times, with some initial work on the strategic plan being required in order to draft the 2 year operational plan.

3.4 A series of workshops are proposed in which Directors (and others) will contribute to the formulation of the plan and the underpinning analyses. A detailed project plan is to be drafted in w/c 20/1/14 which will identify the specific details of the workshops required, and will allow diarising of key planning sessions. The principle will be to ensure that details are understood and key issues debated in advance of the proposed sign off dates at section 3.2.

3.5 Lead Directors will be agreed for all sections of the Plan. Where currently known these arrangements are set out at section 4. EMT will act as a steering group for the production of the Plan. The Chief Executive will act as sponsor to the project. The Deputy Chief Executive / Director of Finance will chair an assurance group that will meet bi-weekly to coordinate the delivery and report to EMT on progress. The Deputy Director of Strategic Planning will act as project manager and will produce bi-weekly highlight reports against the project plan. A project team of subject matter experts from the Quality Academy and BDUs has been convened and will support the delivery of the plan.

4. Annual Planning Requirements 2014/15

A detailed section by section breakdown of requirements is included in Monitor's planning guidance on its website at Monitor annual plan guidance. A summary of the sections of both the 2 year and 5 year plans, including the details of lead directors for each is set out below:

2 Year Operational Plan		5 Year Strategic Plan	
Section	**Lead Director**	**Section**	**Lead Director**
Short Term Challenge	BDU Directors	Declaration of Sustainability	CEO
Quality Plans	Director of Nursing and Quality	Market Analysis and Context	Interim Director of Service Innovation & Health Intelligence
Operational	BDU Directors	Risk to Sustainability	CEO

2 Year Operational Plan		5 Year Strategic Plan	
Section	**Lead Director**	**Section**	**Lead Director**
Requirements and Capacity		and Strategic Options	
Productivity, Efficiency, and CIPs	Director of Finance	Strategic Plans	CEO
Supporting Financial Information	Director of Finance	Supporting Financial Information	Director of Finance

5. Issues and Implications

5.1 The Declaration of Sustainability requires a statement that the organisation will be sustainable over the next 5 years on a clinical, operational, and financial basis. In view of the wider context and scale of the challenge facing all health and social care economies, this statement will require detailed supporting analysis and a considered response, including reference to the major assumptions underpinning any such statement.

5.2 All provider plans will be triangulated with those of local commissioners and where relevant other providers. Therefore it is necessary to develop a shared view of the scale of the challenge facing each local health economy in which we operate, and to ensure that demand, activity and income assumptions broadly correlate. To begin this process we will engage with commissioners to agree the Units of Planning to which we will contribute. A further key consideration in this process of engagement with local partners will be understanding the challenges and responses of Local Authority partners, and proposals for the use of The Better Care Fund.

5.3 Much of the analysis required for the Annual Plan will be undertaken at the level of 'key service lines'. This analysis will be required in addition to an understanding at a BDU level. We will build upon existing team based planning processes and the use of Service Line Reporting to assist this development.

6. Recommendations

Trust Board is requested to note the content of the report.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board: 28th January 2014

Human Resources Performance Report

October – December 2013

Section 1: Executive Summary

Section 2: HR Performance Dashboard

Section 3: Sickness Absence Trajectories by BDU

Section 4: Value Based Human Resource Management: Update

Section 1: Executive Summary

1.1 HR Dashboard

1.1.1 Sickness Absence Rate

A more detailed sickness absence report is provided in Section 3. Overall, the Trust remains above the 4.0% with a total absence rate of 4.71% at the end of November 2013. In comparison to the same period last year, the Trust's sickness rate is consistently lower. The Trust does, however, remain below average for Yorkshire and Humber MH/LD Trusts for quarter 2 with a rate of 4.5% compared to 4.9%.

Overall absence is being managed with audits of this taking place by HR. Regular case conferences and reviews undertaken in partnership with Occupational Health.

Where significant organisational change is being undertaken, HR working proactively with Occupational Health to manage any potential stress issues before they become a problem.

BDU Update

Forensic BDU

All staff are being proactively managed within the process with a number being at stage 3. Whilst absence levels remain high, they are significantly less than this time last year.

Kirklees

This is increasing. The main absence is down to Older Peoples Services predominantly Ward 19 and the North Kirklees CMHT most of which is long term absences. HR has recently undertaken an audit of these two areas and all staff are now being managed within the process. A major piece of work has been undertaken to develop the leadership particularly on the Ward which includes proactively managing the sickness absence.

Calderdale

Absence is low, however a small increase recently. This has been targeted and measures implemented to manage it.

Specialist Services
Absence is low. However Foxview (LD) is a hotspot at15%. Targeted absence management is taking place with additional input from OH regarding a piece of work on stress and resilience.

Barnsley BDU

Barnsley BDU have undertaken a review to see if there is any correlation between the levels of sickness and current staff underspend.

It is their view that there is no link to the sickness absence levels in Barnsley BDU with an underspend on staffing. Absence levels throughout the year have been between 4.69% and 5.35% and whilst the absence was slightly higher than expected in the opening 4 months of the financial year the increase in absence has been as a result of prolonged long term absence seen in both Health Visiting and District Nursing – neither of which have been subject to any staffing underspend. Health Visiting absence is now reducing, but District Nursing in particular is responsible for 15% of ALL absence experienced within the BDU at this time and has been for the past 4 months with a rate of around 10%. There are currently an exceptional number of sustained long term absence cases (12) which are being stringently managed through the Sickness Absence Policy and the majority of these are due to genuine 'poorly' absence reasons. Mental Health absence rates have been lower than expected projections this year other than small identified hotspots within MH administration.

Over the past 4 months the absence rates for the BDU as a whole have been lower than expected as short term sickness due to expected 'seasonal' absence has been minimised This has led to the BDU being back on track with expected absence levels and on current trend they will potentially lower their absence rate from that of 4.77% last year. The current projection for March 2014 is 4.80%.

1.1.2 **Staff Appraisal Rates**

Appraisal rates remain above the 90% target at 92.3%.

1.1.3 **Turnover Rates**

Staff turnover remains within normal target rate of 5-10% overall. Support Services were higher due to redundancies and MARS programme focused on protecting frontline services by reducing overheads.

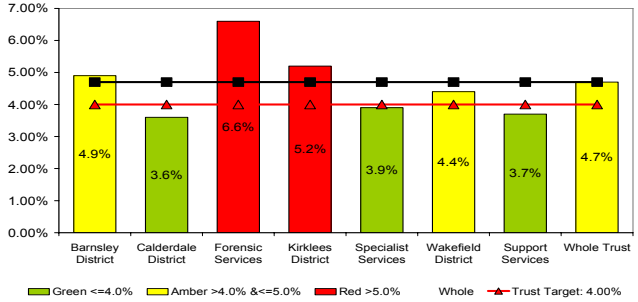
1.1.4 **Bank, Agency and Overtime Spend**

The total expenditure on Bank, Agency and Overtime continues to be below the spend for the same period in 12/13 with 13/14 quarter 1 to quarter 3 expenditure being £628k less than last year.

Section 2: Human Resources Performance Dashboard (October to December 2013)

Sickness Absence

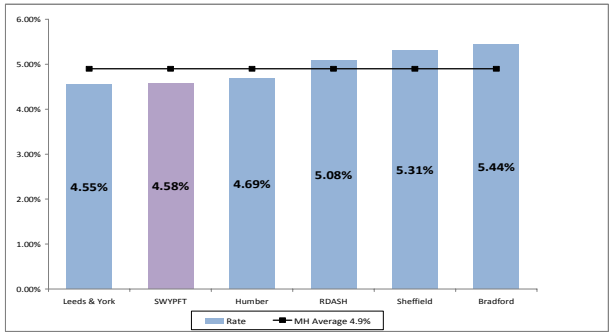
Sickness Absence by District – Year to Date



Current Absence Position – November 2013

	Barn	Cald	Fore	Kirk	Spec	Wake	Supp
Rate	4.9%	5.5%	6.4%	5.3%	3.9%	4.7%	4.2%
Trend	↑	↓	↓	↑	↑	↓	↑

Absence Benchmark Y&H MH/LD & Care Trusts



- The Trust YTD absence levels in November 2013 are above the 4.0% target at 4.7%.
- The chart above shows absence levels in MH/LD Trusts in our region for Q2 2013/14. During this time the Trust's absence was 4.58% which was below the regional average of 4.9%.

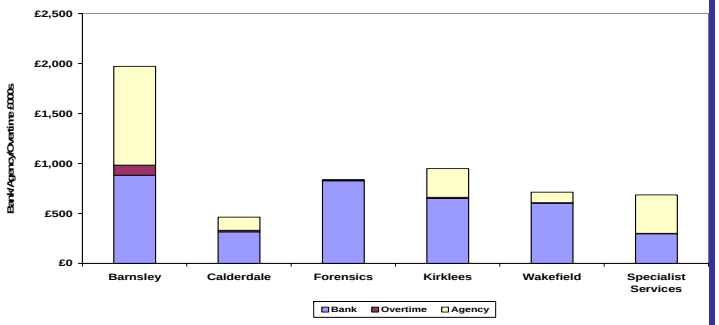
Staff Appraisal

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

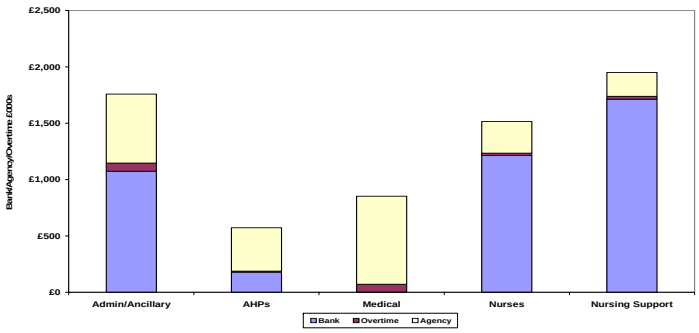
- Appraisal rates for the month ending December 2013 was 92.3%. This is above the Trust's target of 90%.

Bank, Agency & Overtime Spend

Bank, Agency & Overtime Spend by BDU - YTD



Bank, Agency & Overtime Spend by Group - YTD



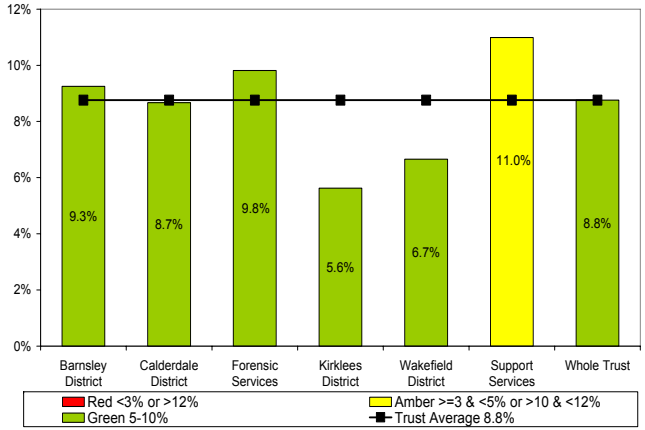
Overtime Spend by BDU - YTD ('000s)

BDU	A&C/ Ancil	AHPs	Medical	Nursing	Total
Barnsley	£13	£3	£52	£33	£101
Calderdale	£1	£2	£1	£12	£16
Forensics	£1	£0	£5	£0	£6
Kirklees	£0	£1	£8	£1	£10
Wakefield	£0	£0	£3	£0	£4
Specialist	£2	£1	£0	£1	£4
Support	£54	£0	£0	£1	£54
Total	£71	£7	£70	£48	£196

Agency Spend by BDU - YTD ('000s)

BDU	A&C/ Ancil	AHPs	Medics	Nursing	Total
Barnsley	£143	£298	£390	£158	£988
Calderdale	£36	£37	£40	£19	£131
Forensics	£5	-£3	£0	£0	£2
Kirklees	£0	£4	£104	£178	£286
Wakefield	£10	£0	£74	£21	£105
Specialist	£16	£76	£161	£132	£385
Support	£405	-£26	£10	-£14	£375
Total	£614	£386	£780	£494	£2,273

Turnover Rates by Service – Year to Date



- Year to Date Turnover is 8.8% which is within the target range of 5-10%

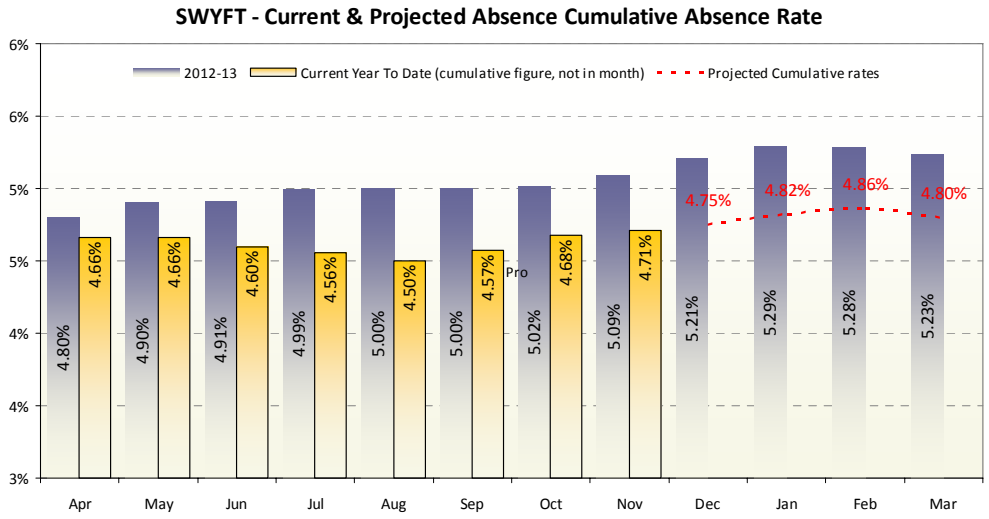
Section 3: Sickness Absence Trajectories – Month 8 – April to November 2013

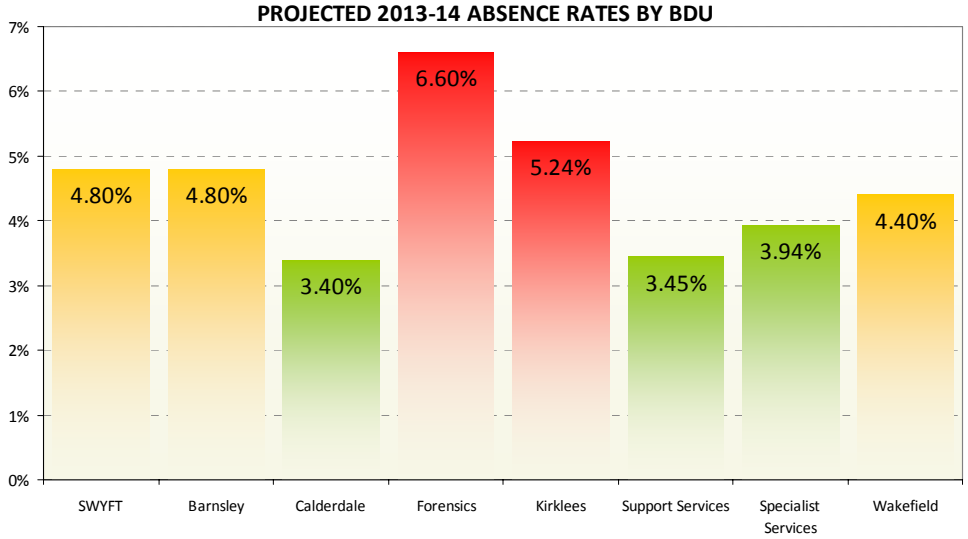
Rates correct at the time of publication. Absence rates are liable to change following amended or late submission of absence returns from departments

The Trustwide absence rate for November was 4.95% (in-month rate). This is a 0.10% reduction from 5.05% experienced in October. A higher Trustwide absence rate over the winter period was forecasted and expected due to instances of short term seasonal absence. The current year to date (YTD) absence rate for the whole of SWYFT is now at 4.71% as a result. The cumulative absence rate has now seen month on month increases since August when it was a year low of 4.50%. Despite the steady rise through the last 4 months the overall rate of 4.95% is still 0.19% lower than this time last year in November (5.09% cumulative). The seasonal trend for the overall absence rate this year is very similar to last year as the rate continued to rise from August 2012 through until February 2013.

The 2013-14 absence rate projection based on current trend remains at 4.80% as recent increases were projected and factored into end of March projections. This figure would be a 0.43% reduction from last year but still above the 4.0% Trust Board target.

The graph below shows the cumulative absence rate for SWYFT overall (red columns) against the cumulative rolling absence rate from last year (blue columns) with the projected cumulative rate for the coming year (red dotted line). SWYFT is projected to reduced it's absence rate by 0.43% from last year, down to 4.80%





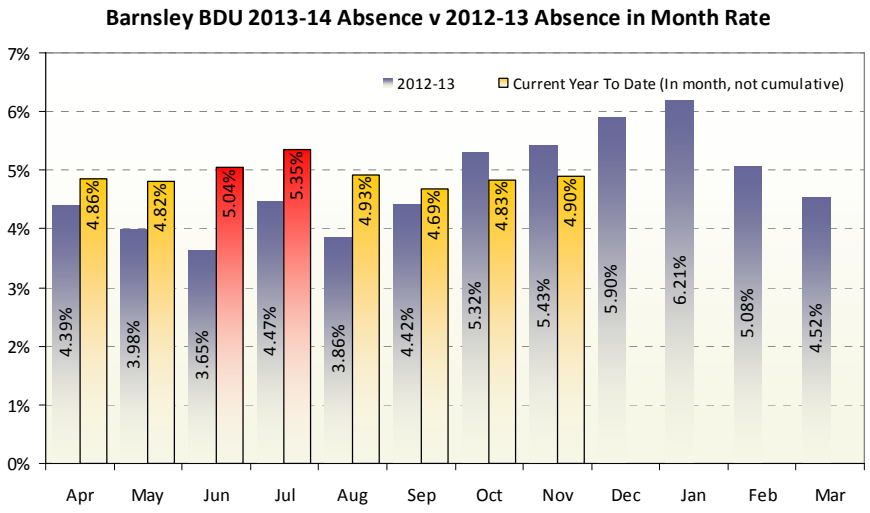
Barnsley BDU - Current YTD absence rate 4.90% - *Current projection by March 2014 – **4.80%*** **YTD Projection Trend = REDUCING**
Last year: 4.77%

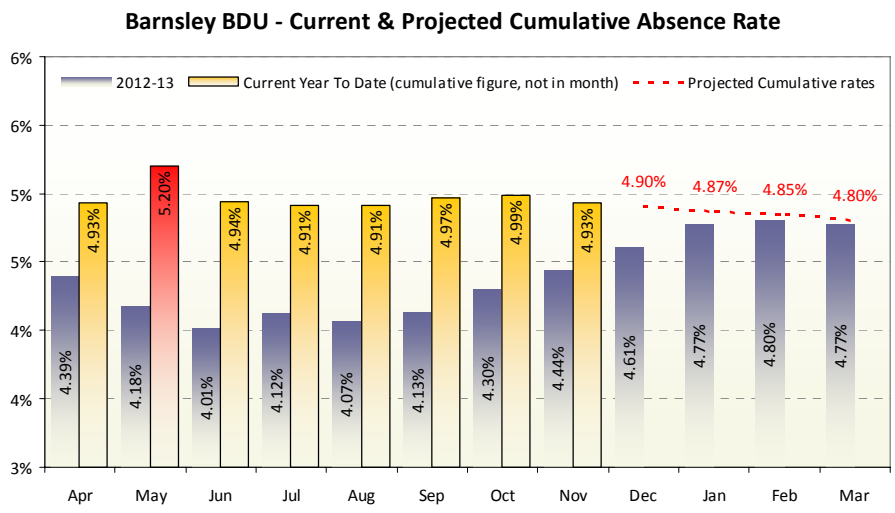
The BDU has now seen a stabilising of absence rates underneath 5% for the past 4 months at a time when historically the BDU has experienced rising absence rates between August and January. This stabilising has led to a reducing YTD projection toward March 2014 of 4.80% which brings the BDU back toward last years overall rate of 4.77%. The BDU has seen its projected absence rate reduce from 5.05% to 4.80% in the last 3 months.

The BDU as a whole is seeing higher than expected absence within Children's Services (6.90%) and Long Term Conditions (6.03%). Both areas have higher instances of long term absence currently which are being managed and Children's Services has been reduced in the past 2 months. Long Term Conditions absence within the month of November stands at 6.03% and has remained above 6% for the last 6 months and this is due to long term absence within District Nursing at this time (9.76%). As Long Term Conditions is a large establishment in the Barnsley BDU area this service gives a weighted influence to overall rates. Extensive HR support and long term absence management via the Trusts Sickness Absence Policy is being undertaken at this time in this area as there are currently 12 members of staff on long term absence.

Current Barnsley Hotspots:

Children's Services: Health Visiting overall (6.90%)
Inpatient Rehab: MVH Ward 4 (7.77%)
Long Term Conditions: District Nursing (9.76% - an average of 30.7 days lost per absence episode since April 2013. 556 calendar days lost in November which is rising. 15% of all calendar days lost within Barnsley BDU are currently in District Nursing), Palliative Care (6.97% - rising absence which has been above 8% (in-month) for last 4 months)



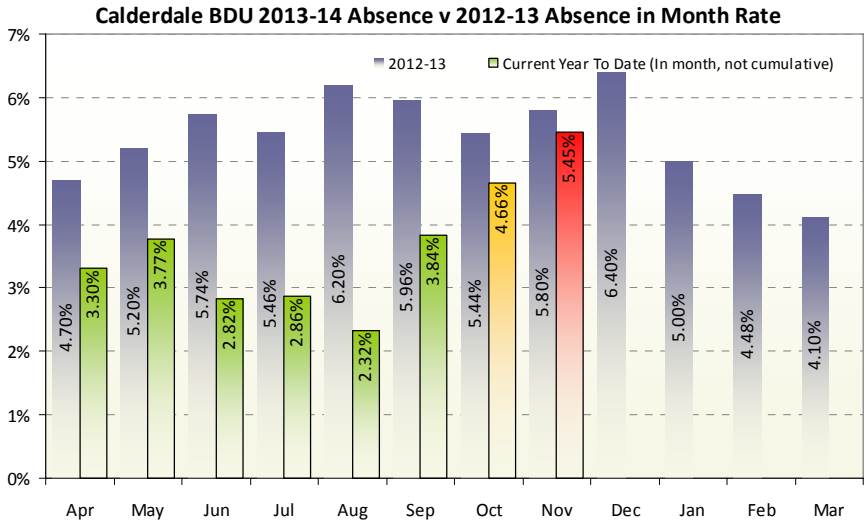


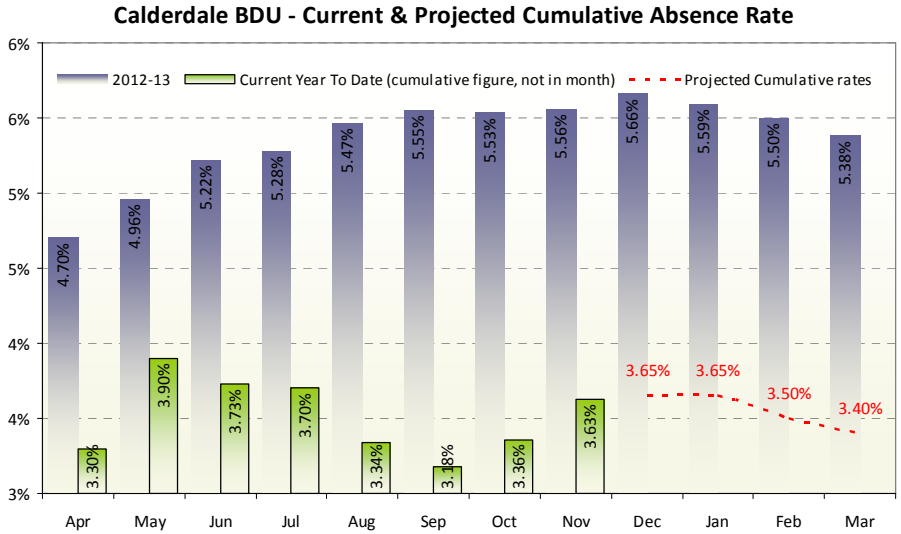
Community Mental Health – MH Administration (23.51% - in-month absence rate for November at 8.88% which is significantly reduced from 30% at the beginning of the year. Long term absence has caused there to be an average of 46 days lost per episode this year in MH Admin).
Primary Care & Preventative – CASH (8.98% - 19.39% absence rate for month of November with 113 days lost across 5 absence episodes). Elderly MH Psychology (9.29% - a quarter of all available working days were lost to absence in November).

Calderdale BDU - Current YTD rate 3.63% - *Current projection by March 2014 – **3.55%*** **YTD Projection Trend = INCREASING**
Last year: 5.38%

Calderdale has seen incredibly low absence rates between April and September which remained below 4%, but the last two months have seen a sharp rise in absence; predominantly due to increases experienced within Adult Services and Substance Misuse units. The cumulative rate for the BDU in November of 3.63% is an increase, but it is still a significant reduction from last year where the cumulative rate by November 2012 was 5.56% and rising month on month, peaking by December at 5.70%.

Both AWA and OPS service lines are currently enjoying low absence rates with Older Peoples Services having the lower rate of 1.81% cumulative. OPS currently has the lowest cumulative rate of all SWYFT service lines at the present time with a rate of only 1.81% from April and this rate has remained constantly low since April. Long term absence within Adult Services has been the main contributory factor in the sharp rise in absence. In September the BDU had NO-ONE on long term sick, but this has now increased. The BDU is projecting an overall reduction of nearly 2% from last year's rate of 5.38% down to 3.55% by the end of March 2014.



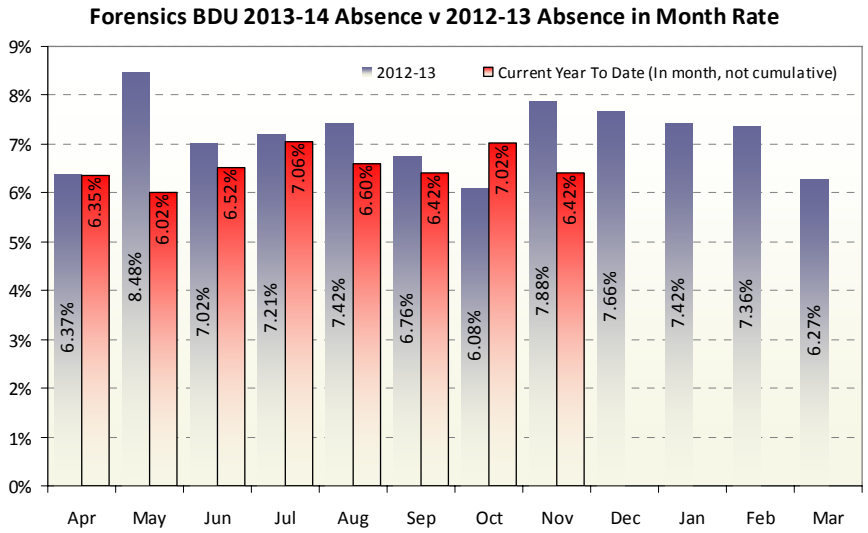


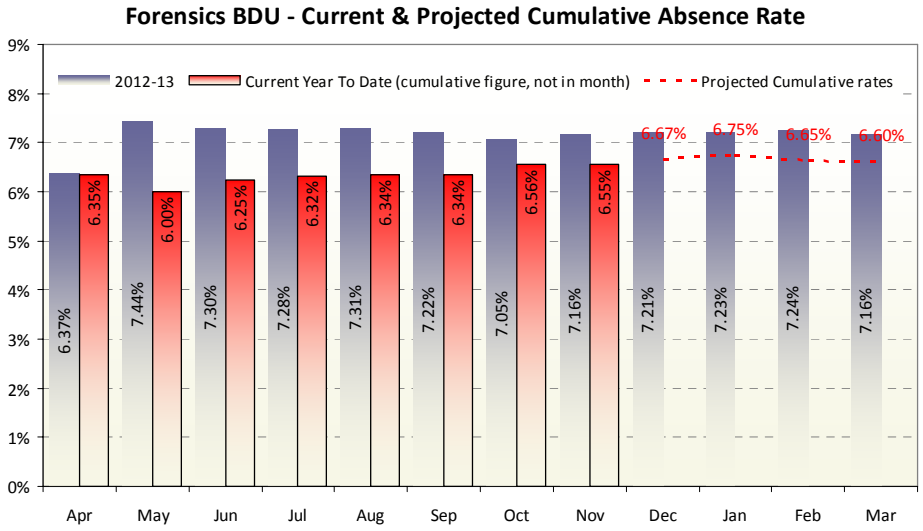
Current Calderdale Hotspots:

Adult Services: Elmdale (4.51%) – Whilst the cumulative rate is low, in-month absence has risen to 8.34% and has been rising for the past 4 months - 87 days lost through 10 episodes in November.
Older Peoples Services – CMHT Older Peoples East (3.35% - Whilst cumulative rate is low, in-month absence in November stands at 12.19% with 54 days lost across 6 episodes.)
Substance Misuse: Alcohol Tier 3 Team (6.26%), Criminal Justice Team (11.82% - absence rate for November was 27.32%. This is a small team, however significant absence in November with a quarter of all working days lost. Currently an average of 30 days lost per episode within the team)

Forensics BDU - Current YTD absence rate 6.55% - *Current projection by March 2014 – **6.60%*** **YTD Projection Trend = UNCHANGED**
Last year: 7.16%

Forensics continues to see higher absence rates than the rest of the Trust, though the BDU has made reductions from this time last year when cumulative absence by November 2012 was 7.16% and rising. The reduction overall is as a result of significant absence rate reductions in Medium Secure Services which sees the service enjoying their lowest rates for the past 3 years. The current YTD rate for Medium Secure is 5.54%. The overall rate has been slowly rising between August and October, but November saw an in-month rate of 5.97% which is a significant reduction from November 2012. The cause for the rise in previous months has been an increase in short term seasonal absence. Long term absence is still being experienced in Low Secure and this is causing a current YTD rate of 8.51%. Newhaven saw a YTD rate of 7.68% through to November. The BDU is projected to reduce its cumulative absence by March 2014 to 6.60% - largely due to the reductions within Medium Secure. This projection remains unchanged from last month but shows a reduction overall of 0.56% from last year. The BDU does remain well above the 4% target and is 1.5% higher than the nearest projected absence rate of all other BDU's.





Current Forensics Hotspots:

Low Secure: Admissions & Assessment Unit – Sandal (11.64%), Continuing Treatment – Thornhill (7.53% - Absence within November in-month has now been reduced to under 2%), Almondbury Rehab & Recovery (11.13% cumulative – absence rate within November has increased to 13.75% with 86 days lost across 11 episodes.
Medium Secure: Security Porters (13.64% - average of 31 days lost per episode), RSU Chippendale (7.83%), RSU Priestley (7.91% cumulative – this rate has been significantly reducing for the past 4 months after high absence between April and July. Reduced from 11.40% in April to 4.69% in November), Appleton (9.28%). Gaskell Unit (6.95% cumulative – in-month November 14.53%. A total of 129 days lost across 11 episodes in November).
Newhaven: Low Secure (10.07% cumulative - After an initial rate of 17.13% in April this area has seen month on month absence reductions to a rate of just 4.97% in November. The reason for the reduction has been due to focused management of long term absence.

Kirklees BDU **- Current YTD absence rate 5.17% -** *Current projection by March 2014 – **5.24%*** **YTD Projection Trend = INCREASING**
Last year: 4.95%

November's in-month absence rate has reduced slightly from October to 5.29%, but the last 4 months have seen significantly higher absence rates than those experienced in the first 4 months. This has caused the projected absence rate to rise month on month and now stands at 5.24%. This would be higher than the overall rate for last year of 4.95%. Whilst short term absence due to seasonality is a factor, long term absence has increased over the last 4 months. Long term absence is being managed and recently staff have been dismissed through the Management of Ill Health Policy and there are further to follow.

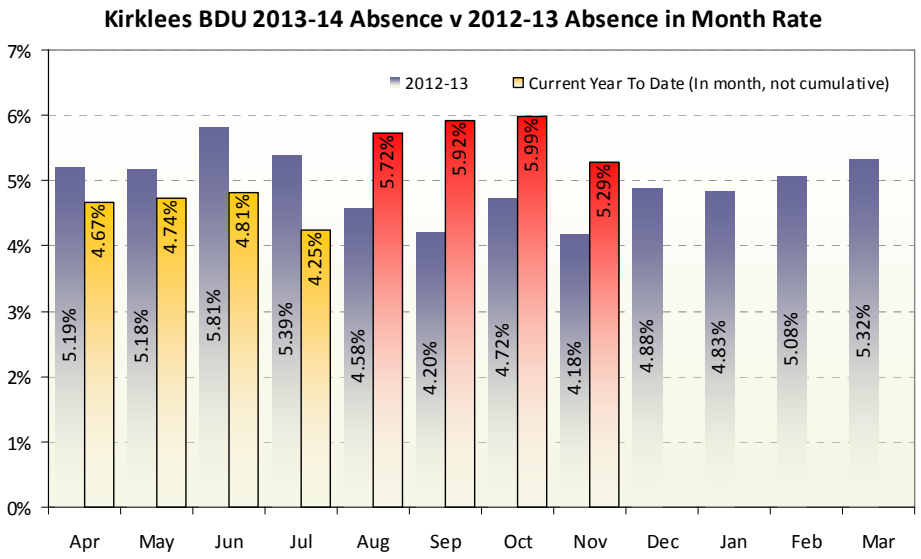
The reason for higher absence rates is due to Older Peoples Services predominantly. The rate has been rising since June 2013 and has been above 7.70% for the past 4 months. November has seen the highest rate this year for OPS at 8.0%. OPS currently have the highest rate of days lost per episode than any other service line within SWYFT with an average of 21 days lost per episode. . Older Peoples Services are currently accounting for 42% of the total sickness burden within the BDU, but has only 28% of the total workforce. Ward 19 has historically had high absence all year and has been above 13% all year. At the time of this publication (January) Ward 19 have been subject to further short term absence due to an onset of Viral Gastroenteritis which is being dealt with by the IPC team on a daily basis to minimise contamination through deep clean prevention measures, prevention of cross contamination between male and female ward areas and the unit has been closed to new admissions. At the time of writing 6/20 service users and 2/40 staff members have been affected. It is expected that absence rates in this area over the next few months in this report will increase further. The IPC team are giving daily progress reports.

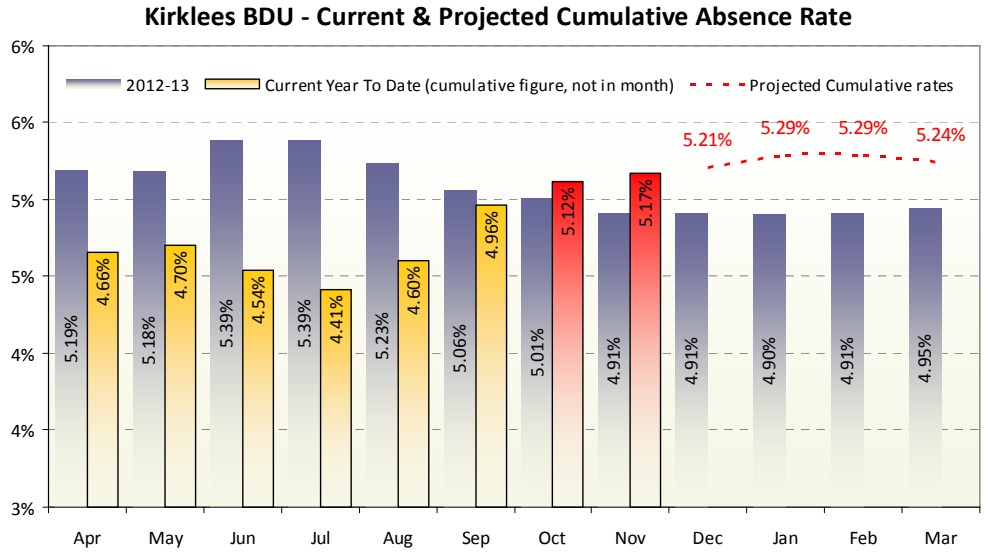
Adult Services in-month absence has risen from 3.09% in July to 5.32% in November. The average length of each absence has risen from 8.22 days in July to 13.7 in November intimating that long term absence is the reason for the rise.

The BDU is currently projected to return a revised rate of 5.24% by the end of March 2013 which will be a 0.29% increase on last year's return of 4.95%. Two targeted pieces of work are currently underway regarding both Enfield Down and Ward 19 regarding their current absence in the form a detailed workforce review with Quality Academy support.

Current Kirklees Hotspots:

Adult Services: Ashdale (9.24%), Care Management North Kirklees (6.86%), Enfield Down (6.74% - average of 21.2 days lost per episode since April 2013. Targeted work has already seen a reduction in this area), Kirklees IHBT (3.15% cumulative – Low overall, but 9.37% in November with 79 days lost across 6 episodes).
Older Peoples Services: Ward 19 (13.10% cumulative – 42% of all absence in OPS is experienced in Ward 19, but has only 28% of the total staff of the department. In-month absence rate since June has been over 13%. Average of 28.7 days lost per episode), South Kirklees CMHT (7.11%)





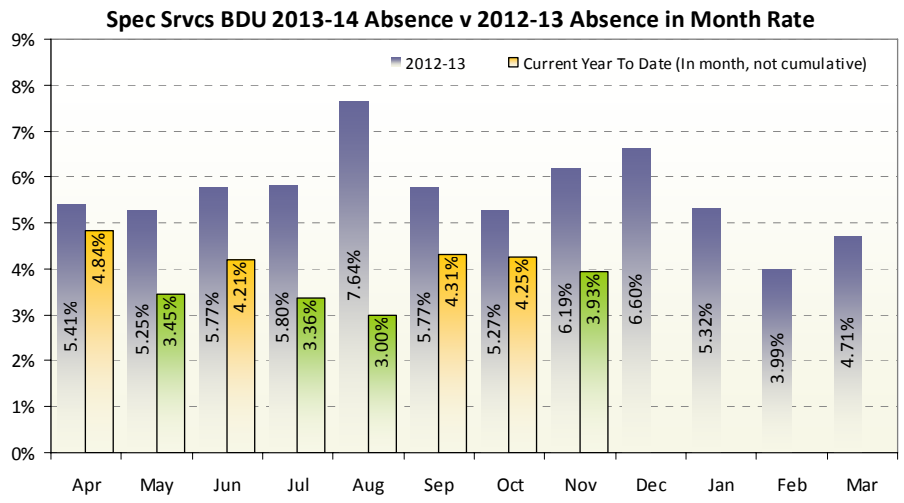
Specialist Services BDU **Current YTD absence rate 3.92% -** *Current projection by March 2014 – **3.94%*** **YTD Projection Trend = REDUCING**
Last year: 5.63%

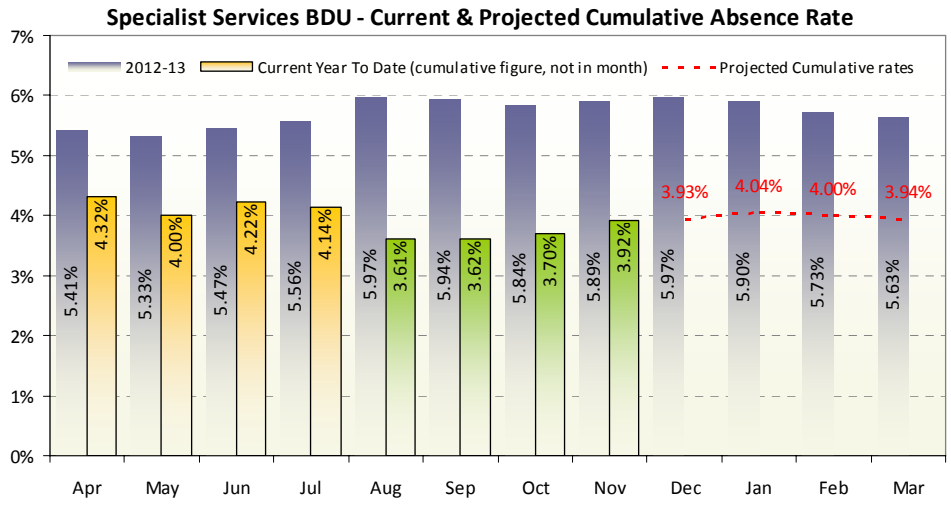
Specialist Services are seeing consistent absence rates around 4%. The projected absence rate for the end of March 2014 has continued to see a downward trend for the last 7 months to the current projection of 3.94%. The stability in absence rates is a positive sign as historically the area has experienced high absence rates in the varying services and the area is undergoing constant additions in terms of services being added to the management structure. Despite this however Specialist Services has two specific areas of high absence that need targeted absence management and they are Fox View and Calderdale CDLT. The 1st 6 months of 2012 saw a cumulative absence rate of 5.94% and no month saw a rate underneath 5%. This is compared against 2013 where rates have not been above 4.30%. The BDU is projected to significantly reduce its cumulative absence by 1.71% by the end of March 2014 to 3.94%.

Current Specialist Services Hotspots:

Specialist Services: CAMHS Barnsley (6.26%), Calderdale CDLT (20.04% - Currently have 6 staff on LTS and November saw almost 50% available working days lost to absence), Fox View Respite Care (12.66% - absence been above 9.9% all year and continues to rise – November at 8.74%. Average of 30.4 days lost per episode since April 2013), HUD Day Services – PLD (13.12% – in-month absence has risen from 10.14% to 16.17% in November).

Calderdale CDLT, Fox View and HUD Day Services account for 40% of the total absence burden within the BDU at present, but only have 9% of the total staff within the BDU.



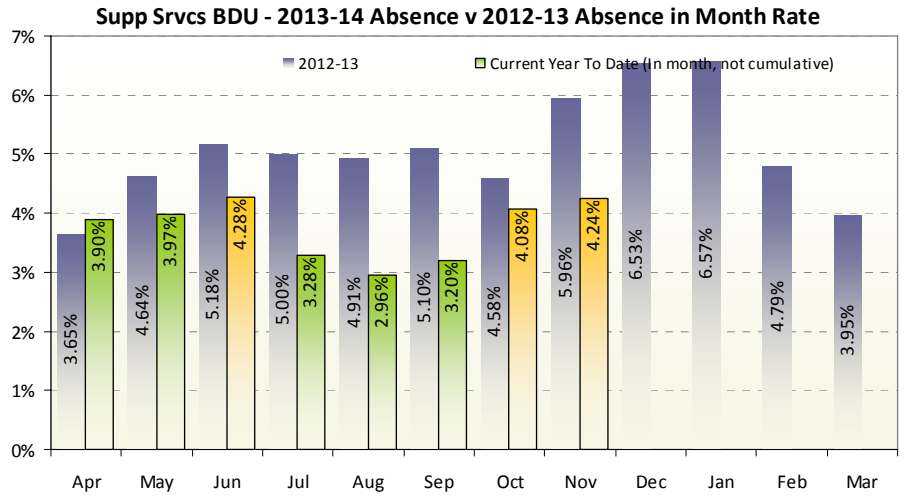


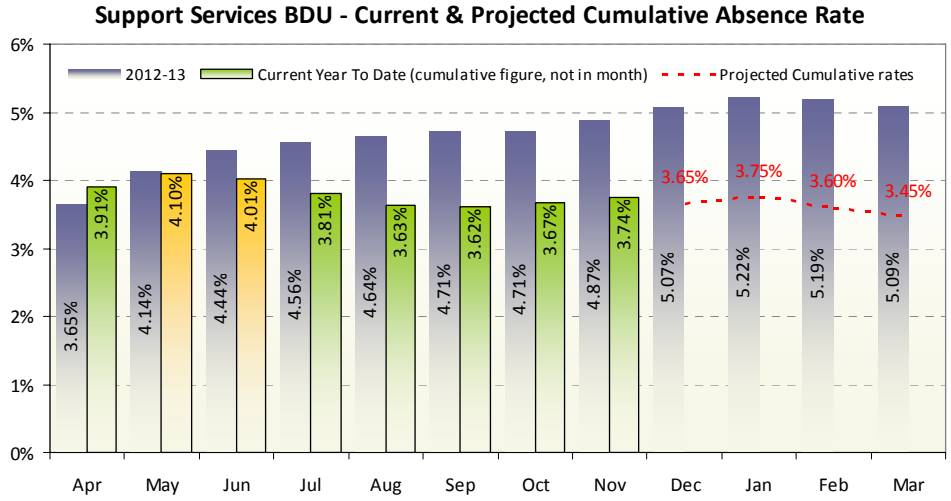
Support Services BDU **Current YTD absence rate 3.74% -** *Current projection by March 2014 – **3.45%*** **YTD Projection Trend = UNCHANGED**
Last year: 5.09%

Support Services have seen stable cumulative absence returns since April 2013 which have fluctuated only slightly between 3.8% and 4.1% all year. November saw no change to the cumulative absence rate at 3.62%. The reduction of long term absence within Estates continues to be the main reason for sustained low absence in this area. Estates & Facilities staff account for over 50% of all calendar days lost per month within all support services areas and currently stands at 5.08%. Support Services is historically a stable absence rate area which was influenced last year by individual long term absences which are now no longer current. Support Services are projected to reduce their absence rate this year to 3.45%: below the Trustwide target of 4%.

Current Support Services Hotspots:

Estates & Facilities: Domestics (7.95% - West side of the Trust – Currently seeing an average of 30.2 days lost per episode this year), Estates Management Engineering (22.25% cumulative - long term sickness has been effectively managed and reduced now – in-month rate at just 4.97% now).
IM&T: Performance & Information (3.71% cumulative – 3 people off long term in November accounting for 90 days and 12.82% rate.)





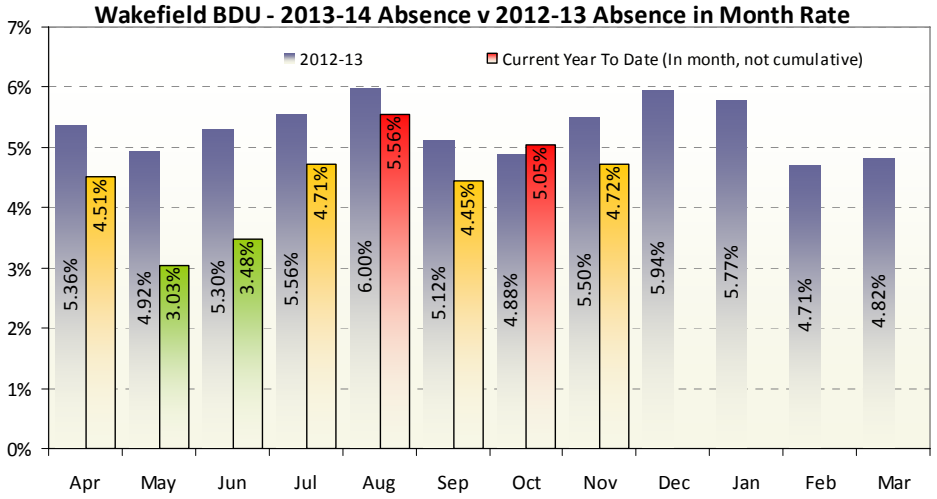
Wakefield BDU **- Current YTD absence rate 4.44% -** *Current projection by March 2014 – **4.40%*** **YTD Projection Trend = UNCHANGED**
Last year: 5.32%

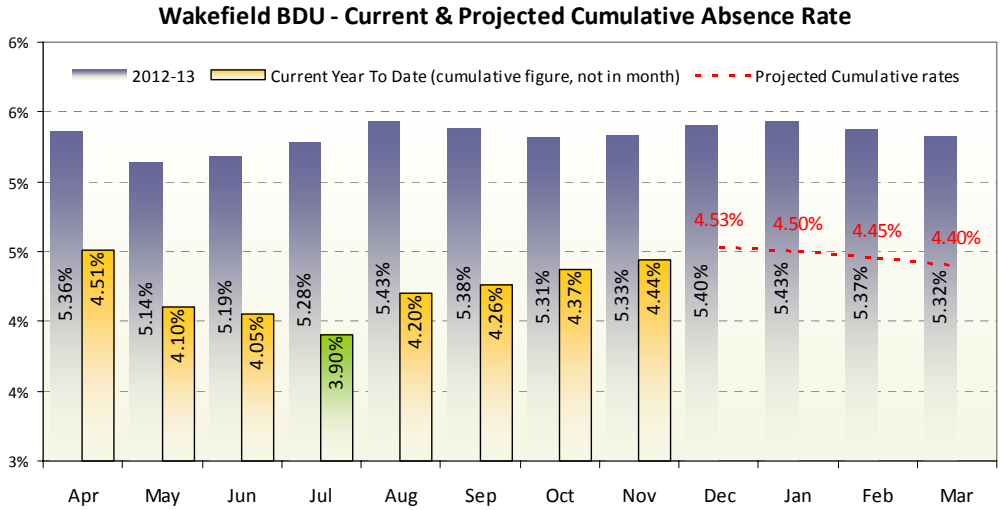
November has since seen a reduction back to 4.77% in-month despite a predicted rise due to short term absence. The overall projected absence rate remains unchanged however at 4.40%. This would be a significant reduction on last years rate of 5.32%. The cumulative absence rate has been slowly rising since July's low of 3.90% however and now stands at 4.44% to the end of November. Both Adult Services and Older Peoples Services have reduced their absence rate in September from highs in August.

Adult Services has seen a reduction in long term absence within November. The service experienced the same amount of absence instances, but saw 76 fewer calendars lost. Older Peoples Services saw a 30% reduction in absence instances in November compared to August and have now returned a rate below 4% in 6 of the first 8 months of this financial year. The November rate was reduced to 3.57% and the current YTD rate is 3.42%. The BDU overall is still experiencing in-month absence rates lower than like-for-like months last year. Cumulative absence by November 2012 stood at 5.33%, so the current rate of 4.44% is a significant reduction.

Current Wakefield Hotspots:

Adult Services: Crisis Team (8.48% - average of 26.1 days lost per episode this year), Castle Lodge (9.30% – average of 32.4 days lost per absence episode since April 2013), CMHT Horbury (28.72% - 3 people long term sick in November),
Older Peoples Services: The Poplars (6.36%)





Summary – November 2013

Overall, 3 BDU's absence projections remain unchanged (*Forensics, Support Services and Wakefield*), 2 BDU's show reduced projections (*Barnsley and Specialist Services*) and 2 BDU's have seen increased projections (*Calderdale and Kirklees*) at the end of November 2013. The Kirklees projection has now seen month on month revised projection increases since July and Calderdale sees its second successive increase. The overall absence projection for the whole of SWYFT remains unchanged in November however and has either remained unchanged or been reduced since the month 4 report.

- All BDU's are projecting a LOWER absence rate by March 2104 compared to the previous year apart from Barnsley BDU and Kirklees BDU.
- Of the 34 services lines (Department level) across the whole of SWYFT, 17 are currently experiencing absence rates beneath 4%. This shows a reduction from 19 in October.
- Stress related absence continues to be the main reason for absence across the Trust accounting for approximately 1 in every 4/5 days lost.
- Long term absence will continue to be a focus for reduction going forward. The Trust sees an average of around 77% of its absence attributed to long term at this time. This and the reduction of stress related absence will be the main focus regarding action plans going forward for individual BDU's.
- On current projections, Calderdale BDU, Specialist Services and Support Services are projected to achieve the SWYFT target rate of 4% by the end of March 2014 financial year.
- On current projections the Trust is on target to reduce the absence rate by 0.43% to 4.80%, but will not meet the 4% target.

Section 4: Value Based Human Resource Management (HRM): Update

The Trust undertook an extensive engagement programme with internal and external stakeholders to develop its organisational mission and the underpinning values. This engagement programme resulted in the development of a set of Trust values. In order to ensure that the Trust embed these values within the organisations culture the key HR processes have started to be re-designed through Value Based HRM. This section is designed to provide a brief update on where we are on 3 key areas of Value Based HRM on future developments.

4.1 Value Based Appraisal

The Trust introduced a new appraisal scheme from the 1st April 2013. This new appraisal scheme was developed following consultation with managers, staff and staff side and was designed to look at both behaviours linked to our values and performance linked to organisational objectives. As part of the implementation was a formal evaluation process to help us learn and continuously improve the scheme. This evaluation has taken place and a series of key issues have been identified which include:

- Streamlining the documentation
- Timing of the appraisal
- Development of e-appraisal system

The Trust is in consultation with the Staff Side on updating the appraisal policy and developing a report to the EMT. It has been recognised overall the scheme has been well received but naturally there are areas where it has identified the importance of good leadership and management to progress the development and transformation of services.

4.2 Value Based Recruitment

The Trust has piloted a number of value based recruitment processes with a view to this being embedded across all areas from 1st April 2014. All senior posts have used the value based recruitment with an assessment centre approach and a number of clinical areas have used it for both qualified nursing and healthcare support worker posts.

A key development for 14/15 is developing value based recruitment for medical appointments.

4.3 Value Based Induction

The Trust set up a working group with managers and staff side to look at and develop a value based induction. This approach looks at induction as a supportive framework for the first 12 months of someone joining the Trust. It builds on value based recruitment which is the gateway into the organisation. The proposal is to have a 9 month probationary period as part of the induction process. The induction policy is being finalised with staff side with a view for implementation in 14/15.

4.4 Future Developments in Value Based HRM

There are 3 major developments planned for 14/15 to extend further valued based HRM:

- Value Based Leadership and Management Development Strategy
- Value Based Contract of Employment
- Value Based approach to Bullying and Harassment

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 28 January 2014
Agenda item 4.5

Title:	**Service User Experience Report**
Paper prepared by:	Director of Corporate Development
Purpose:	To note the process underway to further develop What Matters reporting and to note service user contact with Customer Services during quarter 3, the themes arising, learning, and action taken in response to feedback
Vision/goals:	Listening to and responding to service user feedback is fundamental to demonstrating an honest, open and transparent approach, that is respectful, puts the person first and in the centre and evidences that families and carers matter. Evidencing a good service user experience underpins delivery of the Trust's strategic vision and all value statements.
Any background papers/ previously considered by:	The Board approved a revised Customer Services policy and procedure in December 2013. Included in this is the requirement for the Board to formally review, on a quarterly basis, the feedback received through the Trust's Customer Services function in relation to comments, concerns, complaints and compliments. EMT will undertake work to agree key indicators for incremental reporting on service user experience The Trust wide Service User Experience Group (a sub group of the EISTAG) will work with BDUs to ensure collection of relevant information in support of revised What Matters reporting.
Executive summary:	**What Matters reporting** The What Matters report was introduced at the start of 2012. Six issues have been published, both in printed and web versions. This publication has been public facing, providing external assurance for CCGs and Healthwatch, as well as service users and carers and the public, that the Trust is responding to feedback and driving service improvement. However, the report only ever provided a standalone snapshot of activity each quarter, without demonstrating on-going performance and improvement. Following discussions at Trust Board and Non-Executive Director experience in other business environments, it is proposed to enhance What Matters reporting by developing a range of key performance indicators to evidence patient experience, and to use reporting on these KPIs as a tool to change behaviours and influence improvement. A small range of key indicators will be developed by the Executive Management Team, which will evidence improved customer care. The agreed indicators will be measured in the same way each quarter to ensure consistency. Reporting on these indicators will begin in 2014/15. EMT will also consider how to build customer focussed KPIs into the 'Year of Values' work and will consider how to recognise teams and individuals for great service, for example a potential link to annual staff awards process (Excellence 14).

	Customer Services Report – Qtr 3 2013/14 The Trust Board approved revised policy in December 2013. This policy responds to a number of key initiatives aimed at ensuring organisations seek out views and respond to feedback, including the Francis Report, the Government's response, 'Hard Truths – the Journey to Putting Patients First' (2013), and 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). The policy sets out revised reporting arrangements for the Board to formally receive Customer Services reports on a quarterly basis (previously shared for information and update) as well as an annual report. This report provides information on the number of complaints, the themes indicated, lessons learned and action taken in response to feedback. In quarter 3: • 385 issues were responded to • 84 formal complaints received and 226 compliments • Care and treatment, staff attitude and admission, discharge and referral were the most common themes • 3 complainants asked the Parliamentary and Health Service Ombudsman to review their complaint • The team responded to almost 600 telephone contacts from staff.
Recommendation:	**Trust Board is asked to note the revised arrangements for reporting What Matters and for formal review of customer services feedback on a quarterly basis.**
Private session:	Not applicable.

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South West Yorkshire Partnership NHS
NHS Foundation Trust

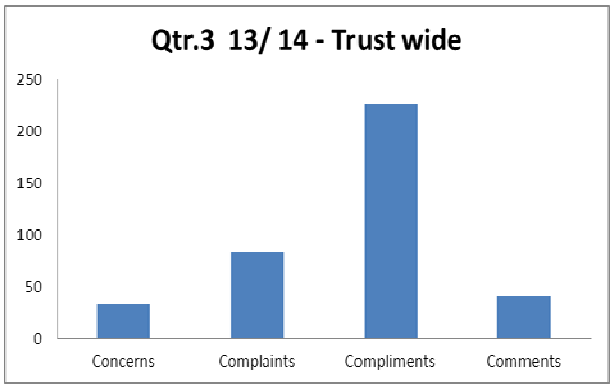
CUSTOMER SERVICES

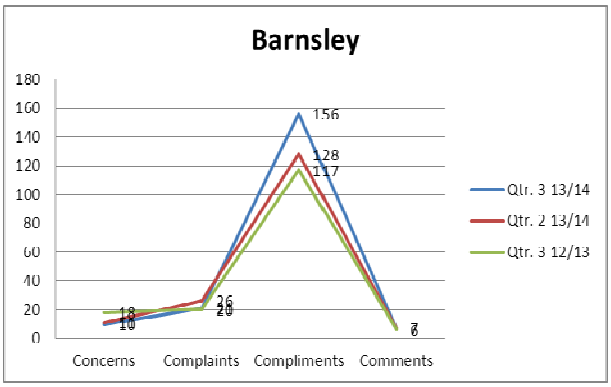
QUARTERLY REPORT FOR THE PERIOD 01 OCTOBER 2013 - 31 DECEMBER 2013 (QTR. 3)

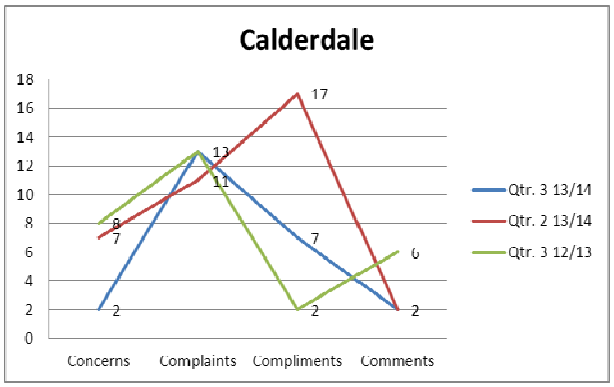
CUSTOMER SERVICES ACTIVITY QTR 3 2013/ 2014

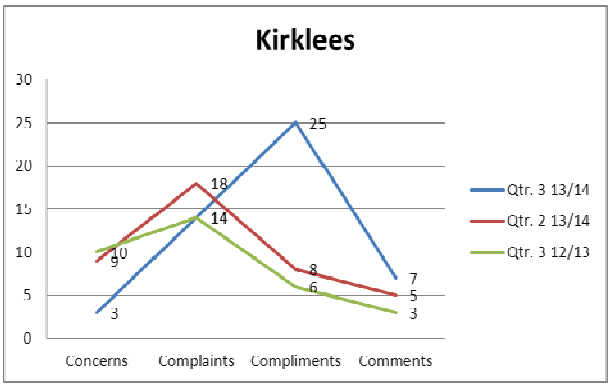
The customer services team responded to 385 issues under the Customer Services Policy: supporting the management of complaints, concerns, comments and compliments in qtr. 3, 13/14. 84 formal complaints were received and 226 compliments. This compares to 362 issues, 86 formal complaints and 196 compliments in qtr. 2. A breakdown of the issues across the Business Delivery Units and the Quality Academy are indicated in the tables below.

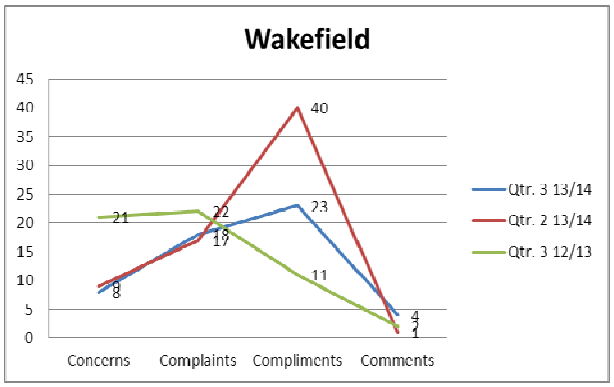
FEEDBACK RECEIVED

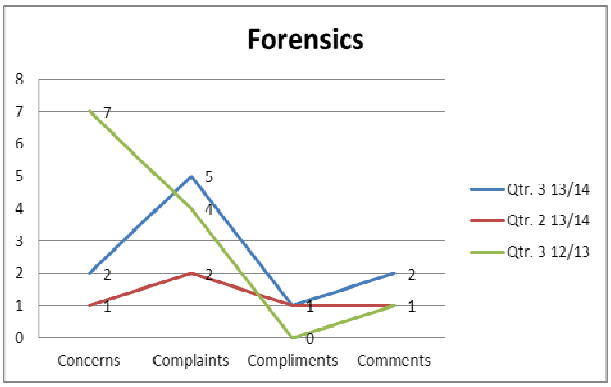


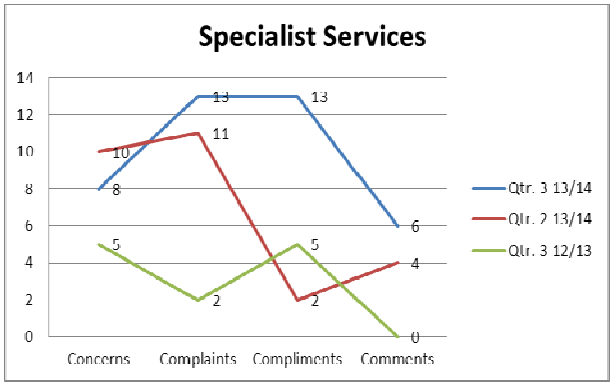


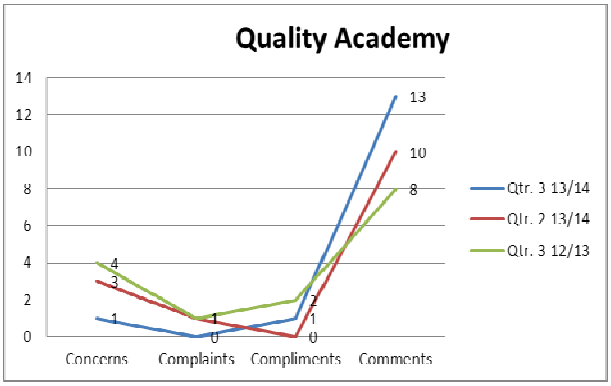












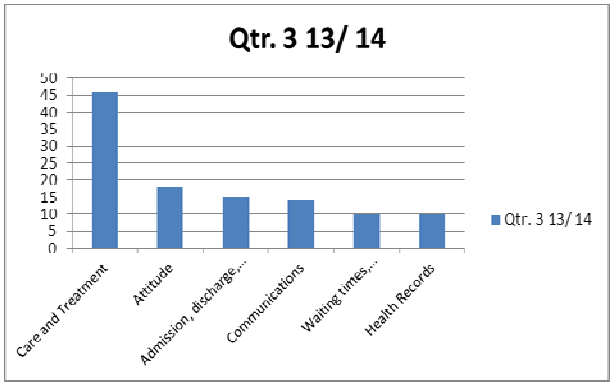
NUMBERS OF ISSUES RAISED INFORMALLY

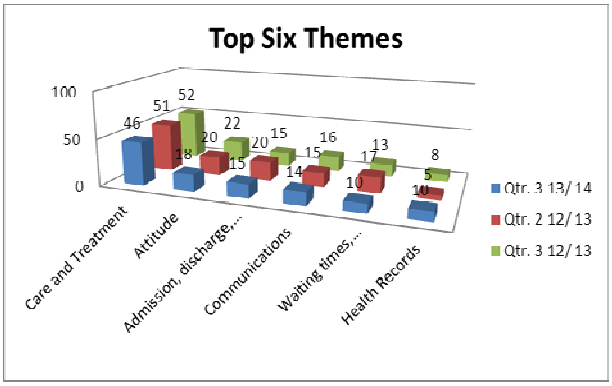
During the period, Trust services responded to 34 issues of concern at local level. The customer services team worked with service lines to ensure the recording of issues raised informally and to capture action taken in response to this feedback. This promotes a default position of putting things right as and when they happen wherever possible and supports shared learning about service user and carer experience.

THEMES

The primary themes for comments, concerns and complaints during qtr. 3 were: care and treatment (46) staff attitude (18), admission, discharge and referrals (15), communication (14), waiting times, appointments, cancellations (10) and health records (10)

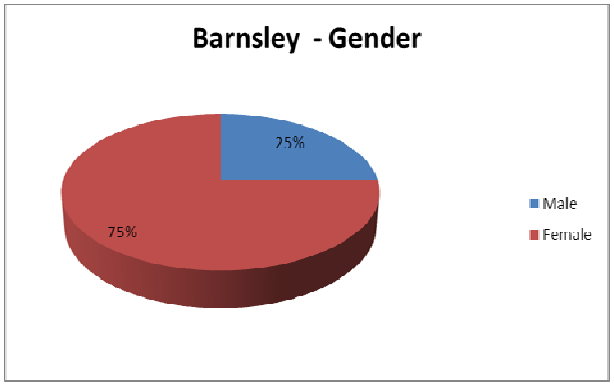
The Customer Services function contributes to a weekly risk scan which brings together intelligence from the Patient Safety Support Team and the Legal Services Team to triangulate any issues of concern and assess the impact on service quality. The team also input as appropriate to the monthly clinical / professional meeting.

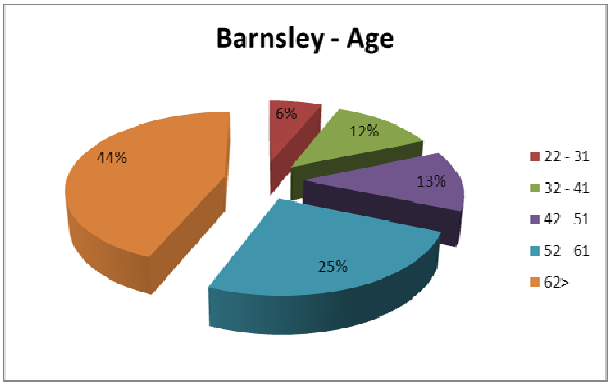


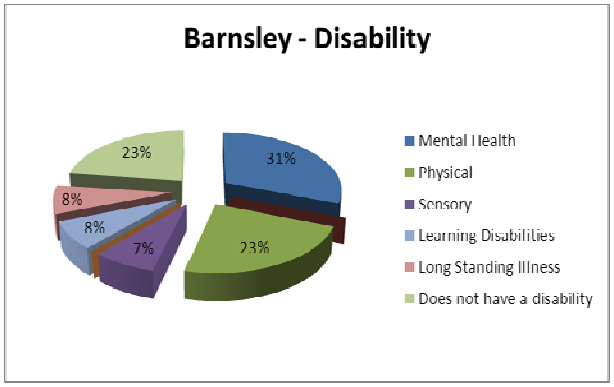


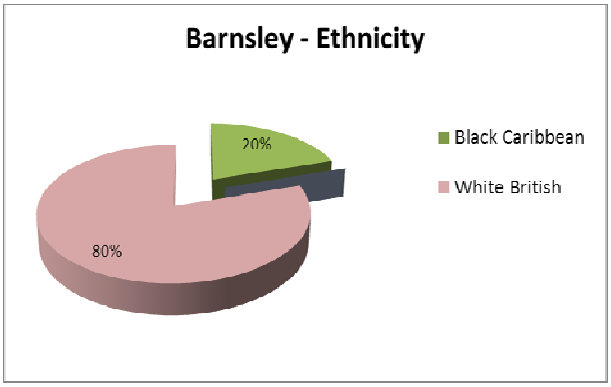
EQUALITY DATA – FORMAL COMPLAINTS

Equality data is captured, where possible, at the time a formal complaint is made. Where complaints are received by email or letter, an equality monitoring form is issued with a request to complete and return. The current average response rate for forms is 68%. The charts that follow show where information was provided, the breakdown in respect of gender, age, disability and ethnicity. The total number of complaints received and information provided across the characteristics is shown beneath the 4 tables for each BDU.

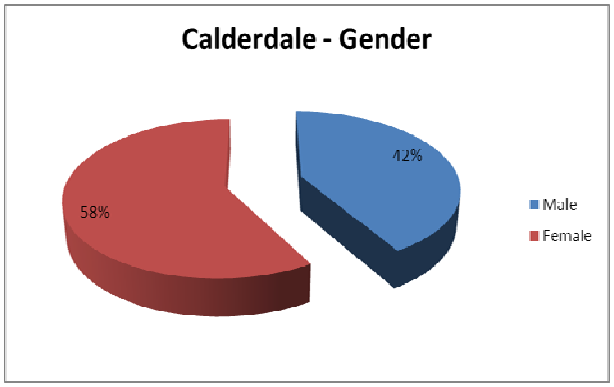


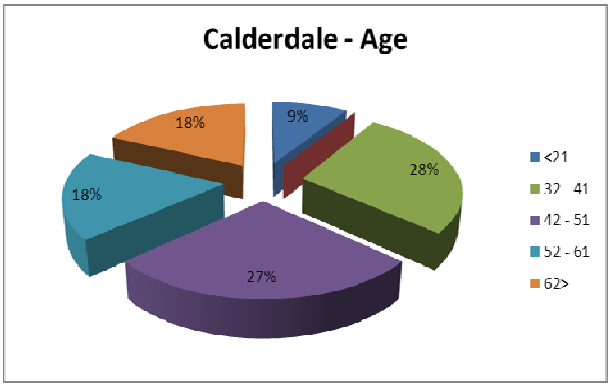


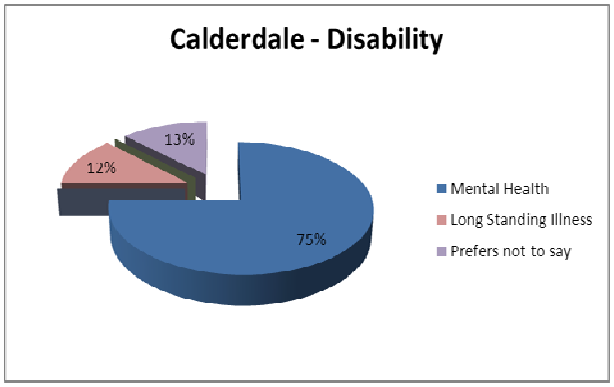


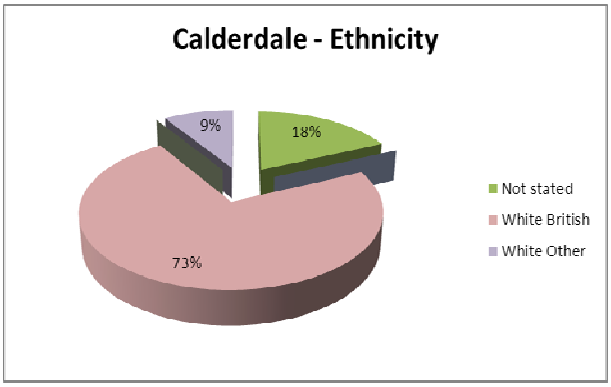


Gender 20/ 21 *Age 16/ 21* *Disability 11/ 21* *Ethnicity 15/ 21*

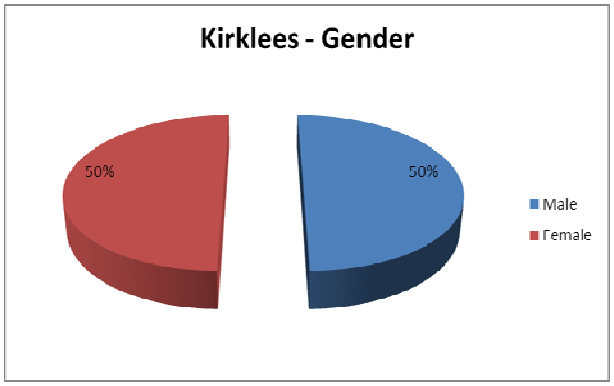


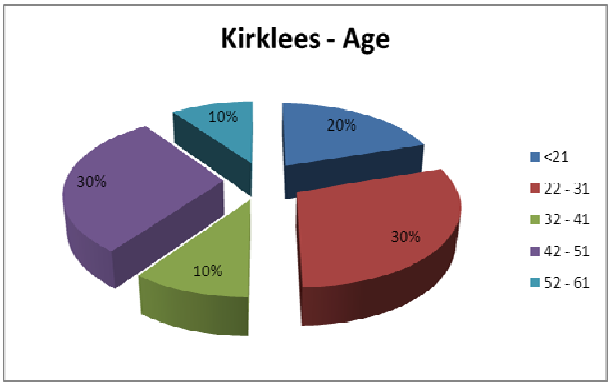


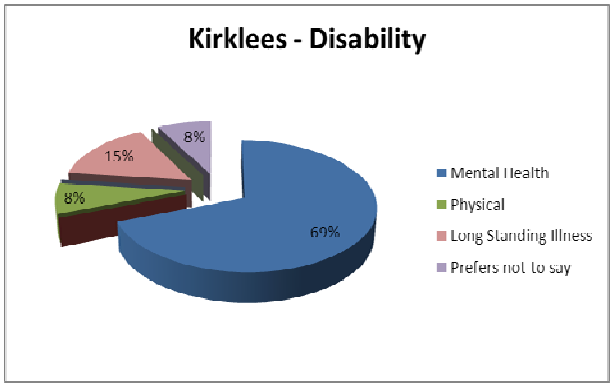


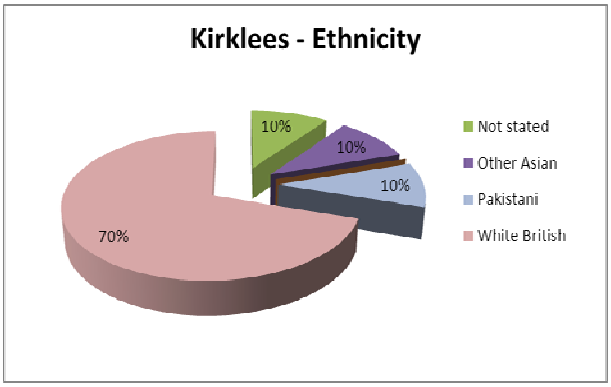


Gender 12/ 13 *Age 11/ 13* *Disability 7/ 13* *Ethnicity 11/ 13*

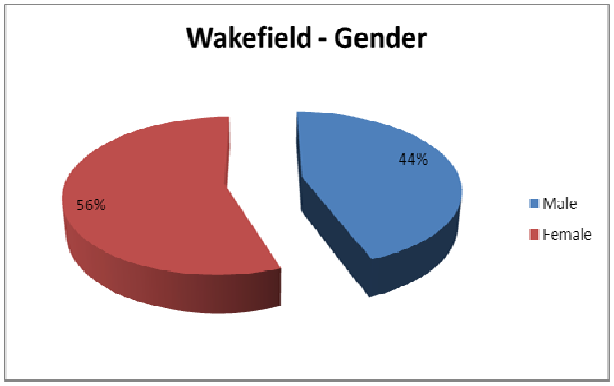


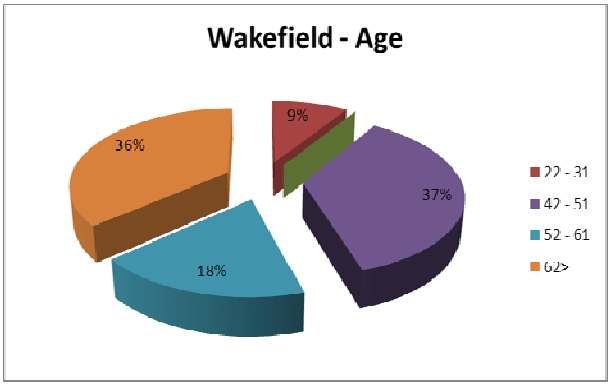


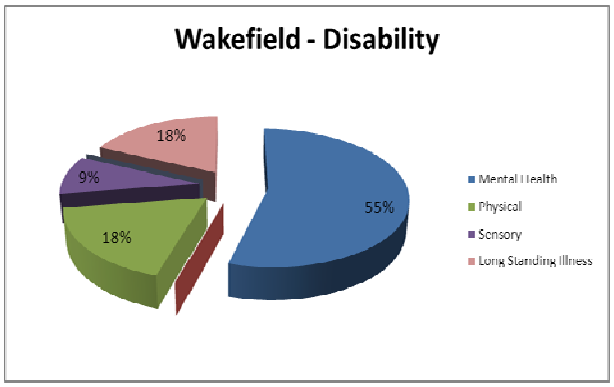


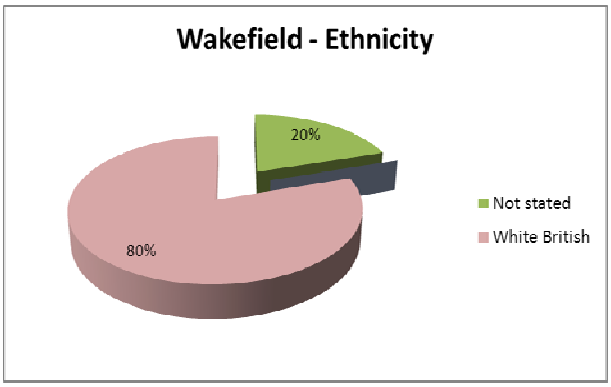


Gender 14/ 14 *Age 10/ 14* *Disability 10/ 14* *Ethnicity 10/ 14*

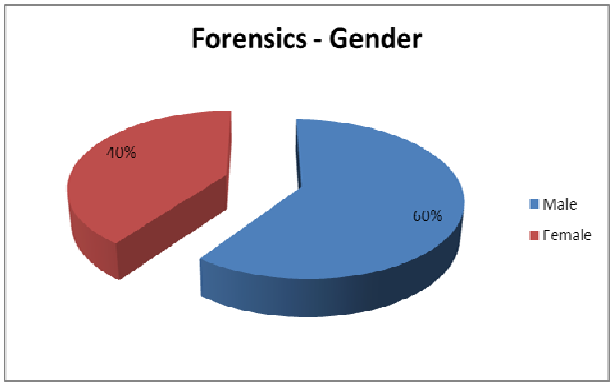


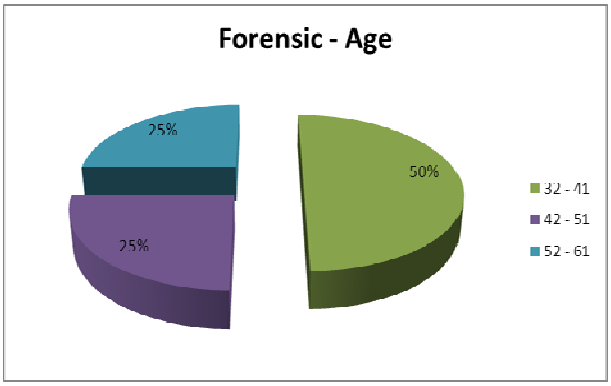


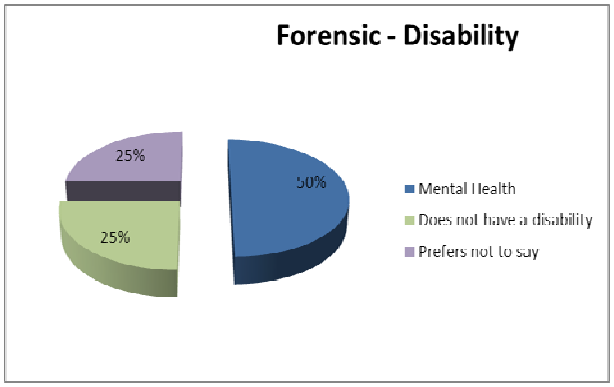


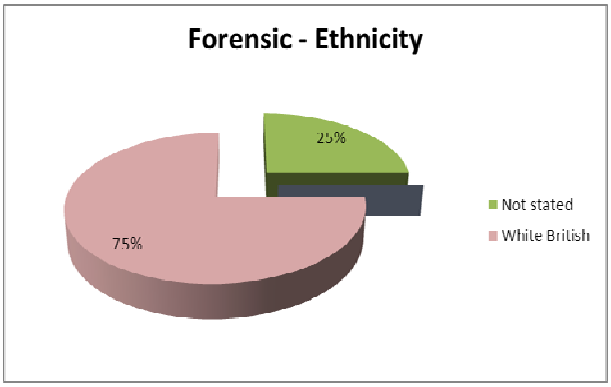


Gender 18/ 18 *Age 11/ 18* *Disability 8/ 18* *Ethnicity 10/ 18*

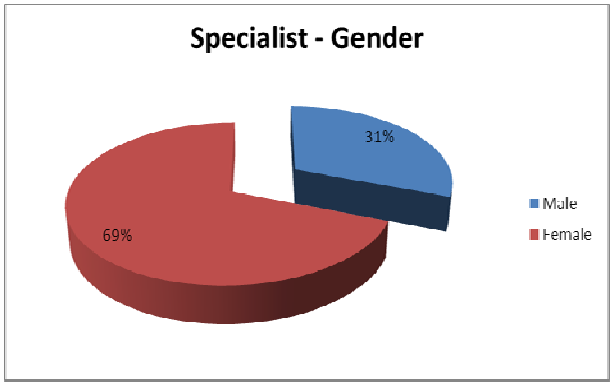


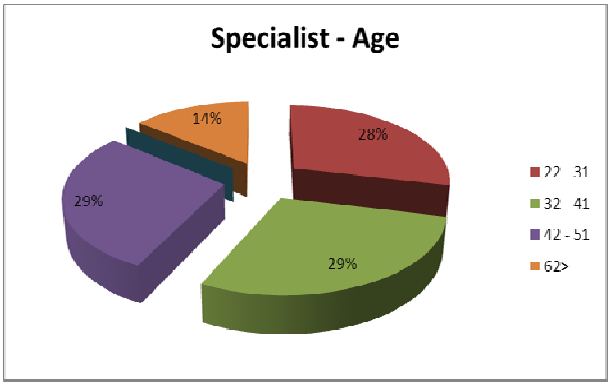


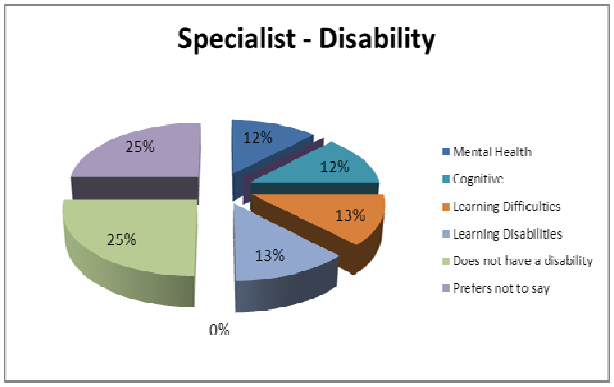


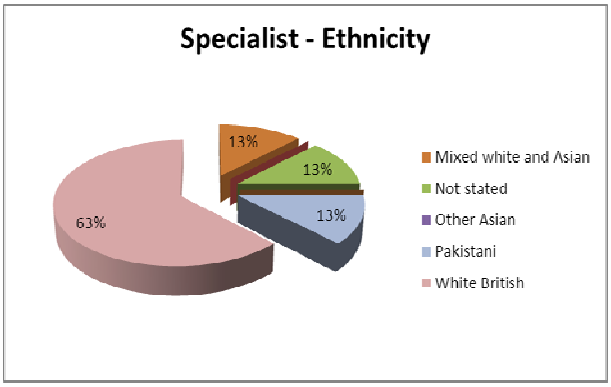


Gender 5/ 5 *Age 4/ 5* *Disability 4/ 5* *Ethnicity 4/ 5*









Gender 13/ 13 *Age 7/ 13* *Disability 6/ 13* *Ethnicity 8/ 13*

MEMBERS OF PARLIAMENT - MP

During quarter 3, there were 8 occasions where complaints and feedback were received via local MPs, acting on behalf of constituents. The issues included:

- Forensic BDU - carer/ relative issues regarding visiting hours, health records, and leave arrangements under the Mental Health Act.
- Specialist services (CAMHS) – follow up care after out of area placement
- Barnsley BDU – 2 separate issues raised regarding care and treatment
- Kirklees BDU - removal from a waiting list
- Calderdale BDU - current care and treatment
- Wakefield BDU – medication query
- I contact related to local authority services provided by York Council and the enquiry was redirected.

MP enquiries are processed in line with routine practice and contact made direct with individuals wherever possible.

PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN (PHSO)

During Quarter 3, 3 complainants asked the Parliamentary and Health Service Ombudsman to review their complaint (1 – Kirklees, 1 Wakefield and 1 Barnsley – this case being an appeal against the PHSO's original decision to not investigate). Such cases are subject to rigorous scrutiny by the Ombudsman, including a review of all documentation and the Trust's complaints management processes. All requested information has been provided.

The Barnsley case (referred to above) was reviewed on appeal, and a further decision made by the PHSO requesting the Trust to resolve by means of apology and financial redress.

During the period, the LGO & PHSO reported on a joint investigation, with recommendations for both the Trust and the Local Authority on a Kirklees case, dating back to 2011. The Trust is working with Kirklees LA to complete an action plan, including a review of the joint working protocol and to agree payment of financial redress with the complainant.

The PHSO advised that another case relating to Kirklees BDU was reviewed in the period, a decision made that no further investigation is required, and the case is closed.

One case relating to Calderdale BDU, referred by a complainant to the PHSO, did not follow usual process in that the complaint had not previously been raised directly with our organisation. The Trust had therefore had no opportunity to investigate through local resolution. The Ombudsman acknowledged that the case had not followed the standard path, but concluded it was more customer focussed to widen their remit of investigation to include Trust input, rather than refer the complainant to the Trust to seek local resolution. The Ombudsman did helpfully correct aspects of the report before final publication which inferred we had had prior input to the case, and the Trust explained to the complainant the partnership work underway with Calderdale and Huddersfield NHS Foundation Trust to implement RAID, which will offer improved support to people presenting in acute settings with a mental health problem. Financial redress was also provided paid as directed by the Ombudsman.

MENTAL HEALTH ACT

3 complaints were made in this quarter with regard to service user detention under the Mental Health Act. All 3 specified their ethnicity as white British. Information on the numbers of complaints regarding application of

the Act is routinely reported to the Mental Health Act Sub Committee of the Trust Board.

CARE QUALITY COMMISIONER (CQC)

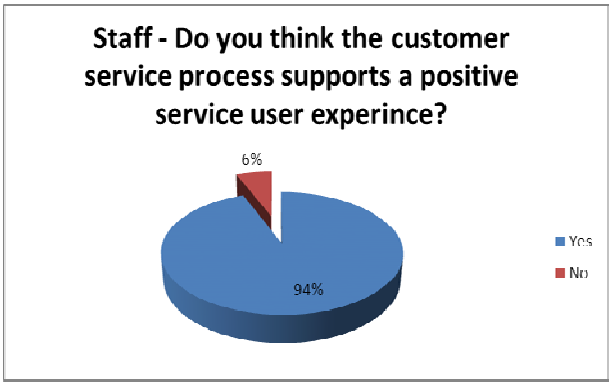
During the quarter the CQC referred a complainant to the Trust who had approached them directly. The complaint related to Wakefield BDU and was in relation to restraint and medication issues. The Trust responded directly to the complainant, advising the CQC of the response.

CUSTOMER SERVICES TEAM PERFORMANCE / CUSTOMER SATISFACTION

The customer services team processed 230 enquiries in this quarter, in addition to '4 Cs' management. These included provision of information about Trust Services, signposting to Trust services, providing contact details for staff and signposting to involvement activities and dialogue groups. The team also responded to 589 telephone enquiries from staff, and offered support and advice in resolving concerns at local level.

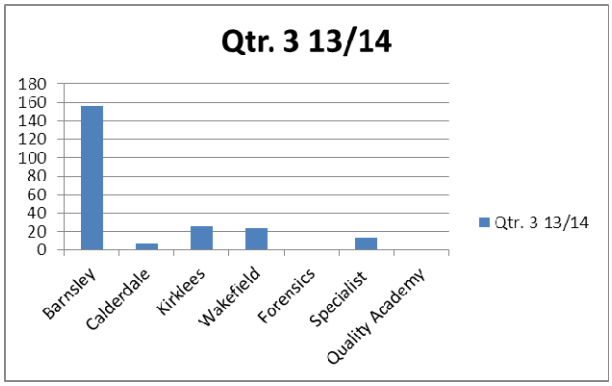
In responding to contact of any kind, the team negotiates with individuals regarding the timescales for responding to issues and regular contact is maintained until issues are resolved to the individual's satisfaction. This connection results in positive feedback to the service regarding complaints management.

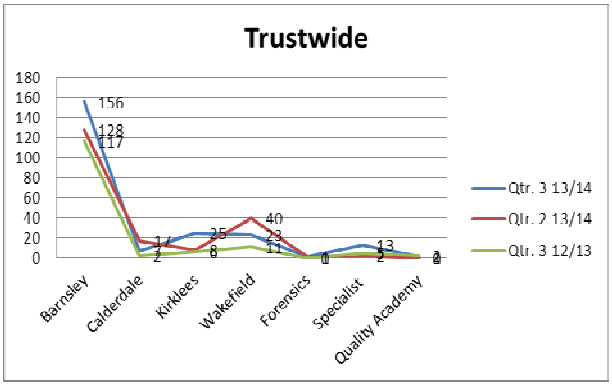
A range of survey material has been introduced to evaluate the customer services offer and improvements have been made to processes in response to feedback. The way in which the customer services team is collecting feedback from service users is being reviewed in order to capture real time feedback and improve responsiveness. This will be done through, for example, telephone survey.



COMPLIMENTS

Compliments are acknowledged by the Chief Executive and positive feedback is shared with teams. A breakdown of the compliments across the Business Delivery Units and the Quality Academy is shown in the tables below. There were 224 compliments recorded in the period regarding care and treatment.





Some compliments received in the period:

A great big thank you for helping me on the road to recovery I've appreciated everything you have done for me. Hope I can stay on the road to recovery. I would like to say a great big thank you to each and every one of you for everything you have been done for me while I've been staying with you. You made me feel really welcome when I arrived. The food has been lovely; in fact everything about the unit has been fantastic.

To all the staff concerned with the care of our mother. Thank you so much for all the care and concern shown to our mother and ourselves during the illness and final days. We very much appreciate your professional and compassionate approach.

There aren't enough words to say thank you for all you did for me and my family. His last few months were the best they could have been and that's all down to your staff. Fantastic team work.

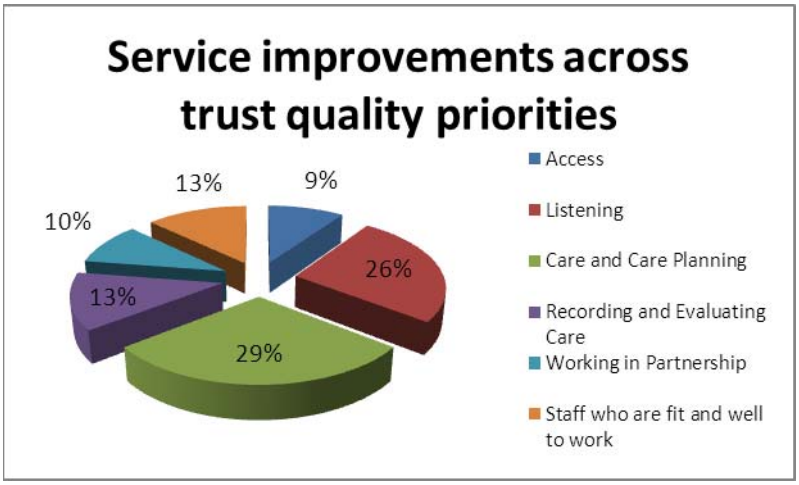
Word cloud shows the key words quoted in compliments received in the period:

ACTION TAKEN IN RESPONSE TO FEEDBACK / CHANGES MADE AS A CONSEQUENCE OF FEEDBACK

Not all complaints require action plans to remedy issues, but all provide helpful feedback which is used in services to support service improvement. The delivery of action plans is monitored to ensure corrective action is implemented in service. Most complainants meet with Trust staff to discuss their concerns. All complainants received a detailed response to the issues raised and an apology where appropriate. Examples of changes made in the period in response to feedback include:

- The Physiotherapy team in Barnsley is currently reviewing the process of self-referral into services to ensure it meets service user needs and is responsive to feedback

- An inpatient ward in Wakefield has reviewed the process for communicating with service users about the ward environment
- A district nursing team in Barnsley has improved record keeping following a review, for example no 'copy and paste' entries to avoid incorrect data entry / wrong record entry.
- Kirklees inpatient staff have been instructed to ensure that next of kin and other family members contact details are stored on Rio and subject to regular update. This follows a review of the admission procedure and checklist.
- A Kirklees ward is to introduce a comprehensive education programme to improve the level of understanding for carers of people living with dementia. The ward is also putting in place improved levels and management of observations, and an engagement plan to improve the ward environment. This will focus on all aspects of risk associated with a service user's care, including mobility.
- A Kirklees inpatient ward has improved communication to ensure carers and family members fully understand the reasons behind bed availability and the Trust's bed management protocol.



SERVICE USER AND CARER STORIES

Tina – contacted the customer services team to raise concerns regarding the length of time she had waited to be seen by the podiatry team in Barnsley. Tina also raised concerns regarding cancellation of clinic appointments and how referrals to the clinic were reviewed

As a result of Tina's feedback, the service has now put in place a system for receiving and actioning referrals, alongside implementing methods for addressing the increasing demand placed on the service.

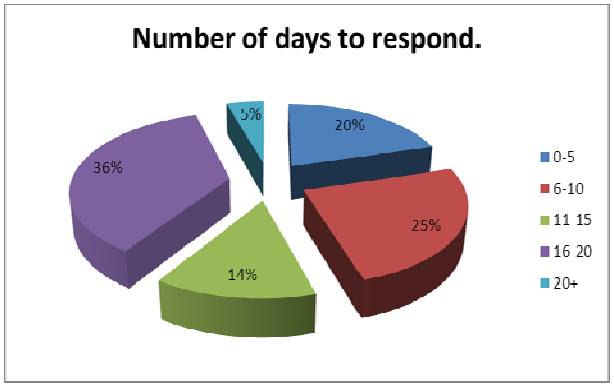
Colin raised concerns that he felt all aspects of his care has not been shared with him and that he had not received a copy of his care plan.

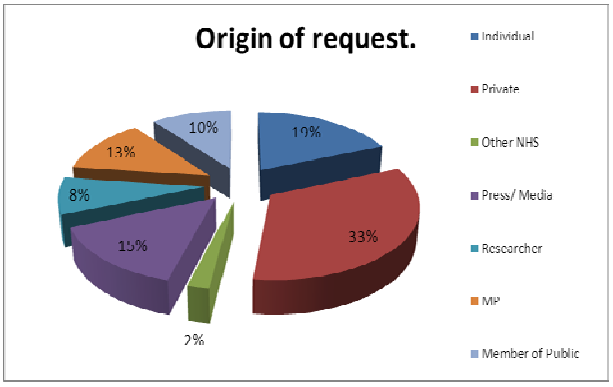
Staff in a Kirklees BDU community mental health team now ensure service users are provided with a copy of their care plan and that this is clearly documented within health care records.

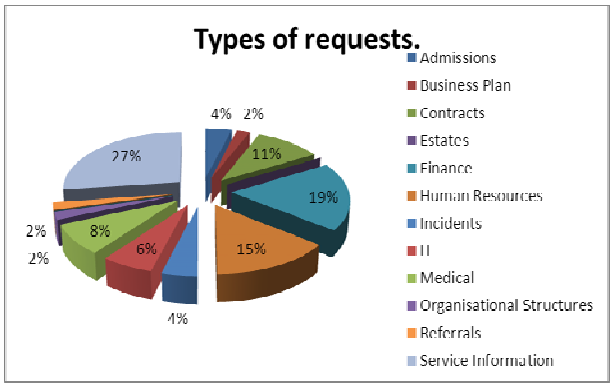
FREEDOM OF INFORMATION REQUESTS

53 requests to access information under the Freedom of Information Act were processed in quarter 3, an increase on the previous quarter when 39 requests were processed. Many requests were detailed and complex in nature and required significant time to collate an appropriate response working with services and quality academy functions.

The customer services team works with information owners in the Trust to respond to requests as promptly as possible, but wherever possible within the 20 working day requirement.







During quarter 3 there were no exemptions applied to any requests, and there were no complaints or appeals against decisions made in respect of management of requests under the Act.

LOOKING FORWARD

Customer Services efforts continue to focus on gathering insight on service user experience and to support teams to develop action plans to change and improve services as a consequence of feedback.

The Trust's Customer Services Policy: management of complaints, concerns, comments and compliments ensures compliance with national standards in respect of NHS complaints handling and takes account of other relevant publications. The policy was revised in December 2013 to take account of:

- the increased emphasis on gaining insight into people's experience of using services to influence how services are organised and new services are planned.
- 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 reference to the Parliamentary & Health Service Ombudsman's evolving stance on redress

The policy includes revised reporting arrangements for complaints to include formal quarterly reporting to Trust Board. Quarterly reports are also shared with Extended EMT, externally with commissioners as part of the contracting process, and with Healthwatch across our geography. Monthly reporting on complaints regarding staff attitude continues as part of the Trust's performance report.

The Trust is reviewing its quarterly reporting on 'What Matters'. The current What Matters report was introduced at the start of 2012. Six issues have been published, both in printed and web based formats. This publication has been public facing, providing external assurance for CCGs and Healthwatch, as well as service users and carers and the public, that the Trust is responding to feedback and driving service improvement.

However, the report only ever provided a standalone snapshot of activity each quarter, without demonstrating on-going performance and improvement.

Following discussions at Trust Board and Non-Executive Director experience in other business environments, it is proposed to enhance What Matters reporting by developing a range of key performance indicators to evidence patient experience, and to use reporting on these KPIs as a tool to change behaviours and influence improvement. A small range of key indicators to evidence improved customer care will be developed in draft form by the Patient Experience Sub Group of the EISTAG. These will be subject to approval by Executive Management Team. The agreed indicators will be measured in the same way each quarter to ensure consistency. Reporting on these indicators will begin in 2014/15.

EMT will also consider how to build customer focussed KPIs into the 'Year of Values' work and will consider how to recognise teams and individuals for great service, for example a potential link to annual staff awards process (Excellence 14).

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 28 January 2014
Agenda item 4.6(i)

Title:	**Trust planned visit programme**
Paper prepared by:	Director of Nursing, Clinical Governance and Safety
Purpose:	The purpose of the paper is to inform Trust Board of the findings and actions following completion of the Trust planned visit programme to in-patient areas November 2013 and to inform Trust Board of the 2014/15 visit programme proposal.
Vision/goals:	Strive to improve and be outstanding
Any background papers/ previously considered by:	Papers have been received by Trust Board and Clinical Governance and Clinical Safety Committee with regard to previous unannounced visit programmes.
Executive summary:	The paper describes the approach taken for the Trust's planned programme of visits to in-patient units in 2013/14, some key findings and proposals for future visits. A more detailed thematic analysis has been completed and will be reviewed by the Clinical Governance and Clinical Safety Committee in February 2014. BDU Directors will briefly update Trust Board on the actions to be taken as a result of the visits. The visits are one part of the methodology the Trust uses to self-assess compliance against Care Quality Commission standards.
Recommendation:	**Trust Board is asked to NOTE the report and to SUPPORT the future visits proposal.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Planned Visit Programme

Background

For 3 years the trust has run a programme of unannounced visits to all in-patient units/wards based on the 16 Care Quality Commission (CQC) essential standards. These visits have had two purposes; firstly an opportunity to provide some level of external assessment as part of the trust assurance process; secondly to expose wards/units in some degree to the kind of experience they might have when inspected by the CQC and help them prepare for such an eventuality. The planned programme has covered ALL units regardless of any level of concern previously expressed. However in 2013/14 there has been a move towards a more intensive risk based approach with units/wards where there is an identified concern.

The Trust is also introducing the 15 steps programme (piloted in Barnsley) as a more open and less intensive approach to conducting unit visits, which will involve service users, carers, the Members' Council and staff. Unannounced visits would remain as an assurance tool for Trust Board.

In addition, over the last few months we have piloted processes around community team visits which we will be putting into effect in 2014/15.

Planned Visits November 2013

Under the direction of the Clinical Governance & Clinical Safety Committee modifications were made to the planned ward/unit visit programme with more focused links to the Trust Quality Priorities. The actual number of visits undertaken was reduced as none were scheduled for units that had recently undergone a CQC inspection (e.g. all Dales units) or been subject to a detailed internal review (e.g. Ward 19).

An important change to the process was to give units a pre-warning of the visit the day before in order that clinical, risk and training records were ready/available to the visit team and, service users/carers were alerted that people would be on the unit the next day that they could speak to (in confidence) should they wish to do so.

Visit teams provided units with verbal feedback at the end of the visit. Visit teams then completed written feedback, copies of which were sent to the ward/unit manager, relevant service/general manager and Business Delivery Unit (BDU) Director. BDUs are responsible for ensuring any required follow up action is identified, implemented and monitored.[1] The same information was provided to link Quality Academy personnel (such as Practice Governance Coaches and Specialist Advisors). All environmental/facility issues raised have been captured on estates and facility plans with action to be monitored by the Estates Trust Action Group.

An evaluation of the modified process will be completed in January 2014 involving questionnaires completed by visit team members and a ward manager focus group. The findings will influence the approach taken on any future planned visits.

Thematic analysis against the visit team findings was completed in December 2013. This information has been disseminated to BDUs (specifically BDU governance groups) and Quality Academy personnel with the intention that it is appropriately placed, reviewed and opportunities for learning facilitated.

[1] BDU governance reports completed March 14 should reference action taken in response to visits

81% of units were given an overall rating of 'good' on a four point scale ranging from inadequate to outstanding. 4 units visited (19%) were rated as 'requires improvement'. No unit visited was rated as 'inadequate'.

A majority of units were assessed as meeting all 5 basic questions now being asked by the CQC – is the unit safe? effective? caring? responsive to peoples' needs? well-led? There are inconsistencies between visit teams in terms of how they differentiated between 'YES' and 'PARTIAL' ratings but significantly there were not any 'NO' ratings given against any of the 5 questions.

There were a number of units where issues raised on previous visits had not been fully addressed. In 12 units (63%) the issues had generally been well addressed but minor issues were outstanding. In 4 cases (21%) issues had been poorly addressed with most issues outstanding but often this related to the building being fit for purpose. For example on one unit issues specified on the previous visit can only be addressed if the unit is identified for substantial refurbishment – these areas being:

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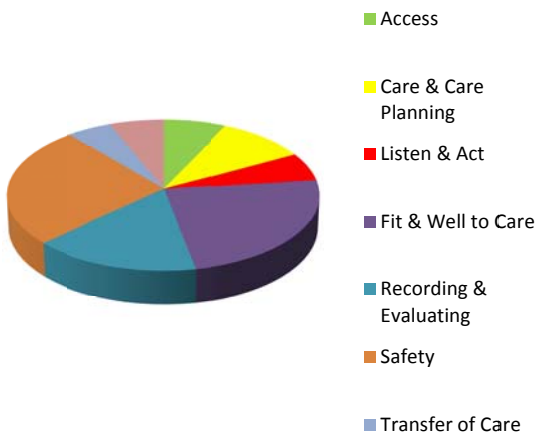
- Lack of en-suite facilities which is challenging for staff in terms of managing dignity and privacy
- The identified clinic room (converted bedroom) still has some deficiencies and is used for multiple functions

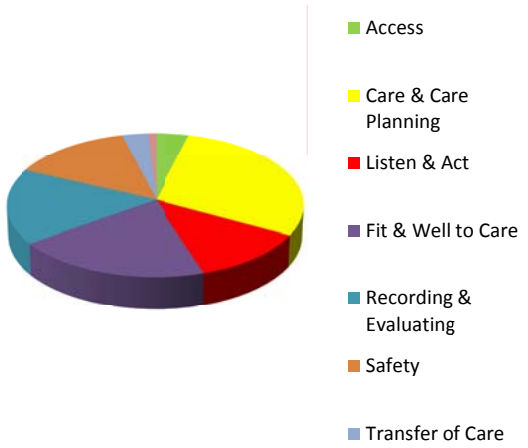
BDUs must ensure that reasons for not addressing identified issues are understood, acceptable to the BDU and do not pose a significant risk to service users or staff.

The main themes for concerns identified by visit teams were safety and staff being fit and well to care. An outline of the themes for concerns is shown in the table overleaf. The main theme related to identified good practice by visit teams was care and care planning.

CONCERNS



GOOD PRACTICE



QUALITY PRIORITY AREA	THEMES IDENTIFIED AS CONCERNS	
As well as specific action taken by BDUs to address identified deficits in wards/units within the BDU there will be action by the Quality Academy to respond to issues raised.		
SAFETY *Information regarding safeguarding concerns has been reviewed by the safeguarding team to ensure appropriate advice and support is being provided to the unit concerned.*	***Safeguarding*** -privacy & dignity (6); confidentiality (1); capacity/consent (1) ***Medication –*** Storage (1); Records (1); Incidents (1) ***Mixed Sex Accommodation*** ***Visitor ID Checking*** ***Risk assessment/management*** ***Other: Maintenance checking; Environmental security***	***8*** ***3*** ***2*** ***2*** ***2*** ***2***
FIT & WELL TO CARE *Practice Governance Coaches are working with units to ensure staff are accessing, learning from and applying skills developed from training and supervision*	***Training*** ***Supervision*** ***Meetings/meeting protocols*** ***Other: Time to Care; Induction; Health & Wellbeing; Observation awareness; Integrated Management***	***10*** ***3*** ***2*** ***5***
RECORDING & EVALUATING CARE *There are a range of trust actions to improve care recording. Compliance team facilitating improved awareness/response to NICE guidance via BDU governance groups.*	***Care Records/Care Plans*** ***NICE awareness/review*** ***Training Records***	***10*** ***3*** ***1***
CARE & CARE PLANNING *Focus for trust-wide action with the development of standards for care reviews and care co-ordinators*	***Service user/relative involvement*** ***Other: Personalisation of care; Structured activities; Handover length; Resource utilisation***	***5*** ***4***
ACCESS *Links to care pathway development and transformation*	***To Psychology; To a Medic; To Beds; To LA records; To timely patient information***	***5***
LISTEN & ACT *Links to trust-wide initiatives on obtaining and responding to real-time service user feedback*	***Obtaining service user feedback during stay; Information on therapy sessions; Food choices; Signage***	***4***
TRANSFER OF CARE *Links to work re: system flow (bed management)*	***Admissions/discharges; GP registration***	***2***
OTHER *All environmental/facility issues raised have been captured on estates and facility plans with action to be monitored by the Estates Trust Action Group.*	***Environmental Issues***	***8***

Learning from Care Quality Commission Processes

In June 2013 the CQC published 'A new start' – a consultation on changes to the way CQC regulates, inspects and monitors care. Changed inspection processes are currently being implemented in Acute Trusts. In October 2013 CQC published a list of eight mental health and community services provider organisations that they will inspect between January and March 2014 using the new CQC model. The Trust's Chief Executive has been asked to chair one of the pilot inspection groups and the Medical Director to participate in another. This provides SWYPFT with a valuable learning opportunity from which to design our future visits so that they more closely align with CQC inspection processes.

Future Programme 2014/15

The following proposal is made.

- A planned programme of visits throughout the year to all wards (approximately two per month). This will reduce the current pressures inherent with undertaking all visits within a fixed 2 week timescale.
- Visit team membership to continue to include directors and clinicians, but not the Members' Council who will be participating in the 15 steps programme. Involvement of ward managers is a suggestion under consideration as a means to promote greater learning across different units. Greater consistency in governance personnel will support consistency of the visit approach and how ratings are applied.
- A community team visit programme will be organised in a similar way covering a sample of teams in each BDU (it will not be possible to include all teams). Team selection criteria is currently being defined but may (as happened for the pilot) be determined by the BDU.
- Risk-based visits (generally longer and more specifically focused) will occur throughout the year when prompted by triangulated evidence of concern.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board: 28 January 2014
Agenda item 4.6(ii)

Title:	Update on Seclusion Rooms Upgrade Programme
Paper prepared by:	Director of Human Resources and Workforce Development
Purpose:	The CQC has raised a number of concerns regarding the Trust's seclusion facilities resulting in a moderate concern identified at Fieldhead.
Vision/goals:	The Trust is committed to ensuring people are cared for in an environment that is respectful and provides privacy and dignity.
Any background papers/ previously considered by:	This paper provides an update on the progress of the seclusion upgrade programme which has been previously discussed by the Trust Board
Executive summary:	The Trust undertook a review of all its seclusion facilities following a number of issues raised by the CQC. The review was led by Dr Berry who reported the working group's findings to the EMT in November 2012. The group developed a set of local standards based on the national guidance and made recommendations on a series of upgrades ranging from minor works to significant capital schemes. The overall conclusions were as follows: 1. Pilot areas for adoption of full standards ▪ Bronte Ward ▪ Johnson Ward 2. Areas requiring minimal input to achieve standards ▪ Newhaven ▪ Thornhill ▪ Ward 18 ▪ Appleton 3. Areas requiring significant expenditure and disruption to achieve standards ▪ Trinity ▪ Gaskell 4. Areas requiring major design but able to achieve critical standards ▪ Elmdale ▪ Sandal ▪ Melton 5. Areas requiring major redesign or construction of the ward environments before all standards can be made ▪ Hepworth A capital programme was developed in partnership with clinical staff and service managers to ensure the seclusion facilities can be upgraded whilst maintaining clinical safety. An update of the programme is detailed below. The programme as agreed is on schedule. The upgrades have been agreed with the clinical staff and reflect the review work led by Dr Berry and CQC comments.

The Trust has met with CQC who are happy with the timescales given and the work to be undertaken. The CQC has asked if there are any significant delays from the planned dates that they are notified immediately. Arrangements are being made for the CQC to have site visits to look at the upgraded facilities.

Seclusion Facility	Background	Due for Completion	Progress
Johnson Ward	New seclusion built as part of scheme	Complete	Complete
Bronte	Meets agreed standard	Complete	Complete
Newhaven	Scheme starts on 3/2/14	17/3/14	On target
Thornhill	Starts 18/3/14	11/4/14	On target
Ward 18, Priestley Unit	Scheme commenced	31/1/14	On target
Appleton/ Chippendale	Scheme complete	Complete	Complete
Trinity (New)	A new additional seclusion was required to ensure it meets the privacy and dignity standards	14/2/14	On target
Trinity (Existing)	The existing facility will be upgraded on completion of the new seclusion room. Due to start 3/3/14	9/4/14	On target
Gaskell	Gaskell for clinical safety cannot commence until Hepworth scheme complete. Due to start May 2014	13/6/14	On target
Emdale	The Dales upgrade to start Mid-April following consultation with PFI provider	Final date to be agreed	On target
Sandal	Scheme commenced on 18/3/13	Due to handover on 31/1/14	On target
Melton	Complete	Complete	Complete
Hepworth	Major capital schemes approved by the Trust Board	Due to complete in April 2014	On schedule

Recommendation:	**Trust Board is asked to note progress**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 28 January 2014
Agenda item 4.6(iii)

Title:	**National service user surveys 2013**
Paper prepared by:	Director of Corporate Development
Purpose:	To provide an overview of performance against national comparators and to set out the actions being taken to improve future performance.
Vision/goals:	Supports the Trust value of patient first and in the centre
Any background papers/ previously considered by:	Previous reports on National Surveys
Executive summary:	**Background** The Trust participates in two national mental health surveys each year, which enables year-on-year comparisons, the opportunity to benchmark against other mental health providers and identification of areas to prioritise for improvement. **Overview** Inpatient summary - 21% of responses classed as in the best performing Trusts. - The remainder about the same as other Trusts in the survey. - No scores classed as in the worst performing Trusts. Community summary - 5% of responses classed as in the best performing Trusts. - 90% classed as being about the same as other Trusts in the survey. - 5% of responses classed as in the worst performing Trusts (2 areas). The CQC results show a poor response with regard to community service users being offered or given a copy of their care plan and with regard to having had a care review meeting to discuss their care. Although the scores have improved over 2012, the current situation is still unacceptable. Having a care plan and a care review should be a fundamental requirement that the Trust meets for all service users who are on a Care Programme Approach or on Standard Care. Following receipt of the survey results the Trust has undertaken a deep dive into the two areas highlighted above through analysis of the data on the clinical system RiO. The review highlighted that a larger % of service users on standard care, as opposed to those on CPA, are not receiving copies of their care plans or a timely care review, the majority being on medical or psychology case loads. BDU Directors have been provided with an analysis by BDU and by team to allow targeted action in the underperforming areas. The improvement of these two key indicators will be performance managed through Performance EMT.
Recommendation:	**Trust Board is asked to receive the attached report, note the positive areas of good practice and the actions being taken to improve care planning and care reviews, ensuring greater equality of care across the organisation.**
Private session:	Not applicable

Trust Board 28 January 2014
NATIONAL SERVICE USER SURVEYS 2013

The Trust participates in two national mental health surveys each year which enables year on year comparisons, the opportunity to benchmark against other mental health providers, and identification of areas to prioritise for service improvement.

Quality Health Inpatient Survey 2013

- Quality Health inpatient survey involving a number of mental health trusts (20) nationally. The survey population is adults between 16 and 64 who had an inpatient stay of at least 48 hours between July and December 2012.
- The inpatient report shows that for 45% of the results there has been a positive increase from 2012 to 2013.
- Out of 47 questions, 21% of responses were classed as being in the best performing Trusts, the remainder about the same as other Trusts in the survey, no scores classed as being in the worst performing Trusts.
- Areas such as respect and dignity, cleanliness, keeping in touch, being listened to and involved, rated well.
- Areas where we are in the middle range related to dietary requirements, some aspects of the discharge process and the rating of the overall experience. Satisfaction with the level of activities available on wards continues to be an area of concern.

Action: Practice governance coaches will be working with BDU leads on how the patient experience can be improved in the areas noted above. [CHECK PRIORITIES KB/TB]

Care Quality Commission National Survey 2013

- The Care Quality Commission national community survey involved all mental health services in England (Trust's commissioned through Quality Health). The survey population is people 18 and over who received a service between July and September 2012.
- The CQC report was published at the end of September and was based on a scoring system rather than response percentages, showing the Trust position (top 20%, middle 60% or bottom 20%) for each survey question across all mental health trusts nationally.
- 5% of responses were classed as in the best performing Trusts, 90% classed as being about the same as other Trusts in the survey, and 5% of responses classed as in the worst performing Trusts.
- From the CQC report the more positive responses relate to key Trust values around people being treated with respect and dignity, having the purpose of their medication explained to them and receiving support with accommodation needs.
- Overall rating, ranging from 0 (I had a poor experience) to 10 (I had a very good experience) for the Trust was 7.4, which compares favourably with the highest score achieved of 7.6 and the lowest of 6.6.
- Responses where the Trust benchmarks poorly are around being given/offered a copy of their care plan and having a care review in the last 12 months.

The following tables show the results from the CQC and Quality Health, and focus on the two poorly performing areas of the community survey, showing a comparison with the previous year and the Quality Health benchmarking results:

Key

SWYT CQC RAG RATING	QUALITY HEALTH BENCHMARK RATING
Top 20%	↑ Better than average score of Trusts in QH survey
Mid	⇔ same score as Trusts in QH survey
Bottom 20%	↓ worse than the average score of Trusts in QH survey

Table 5 CARE PLAN

QUESTION	*SWYT CQC 2012*	*All trusts top score*	SWYT CQC 2013	All trusts top score	*QH 2012 (n=273)*	QH 2013 *(n=251)*	QH Benchmark (BM)
CARE PLAN							
Have you been given (or offered) a written or printed copy of your NHS care plan? In last year, more than one year ago.	3.4	8.7	**4.0**	8.2	21% 10%	**21%**↔ **21%**↑	41%↓ 15%↑
Do you understand what is in your NHS care plan?	6.1	7.8	**6.5**	7.8	35%	**36%**↑	41%↓
Do you think your views were taken into account when deciding what was in your care plan?	6.9	7.9	**7.1**	7.8	53%	**49%**↓	53%↓
Does your NHS care plan set out your goals?	5.9	7.0	**6.3**	7.1	42%	**42%**↔	41%↓
Has the NHS mental health services helped you start achieving these goals?	6.5	7.7	**6.6**	7.6	47%	**43%**↓	44%↓
Does your NHS care plan cover what you should do if you have a crisis?	7.1	7.9	**6.7**	7.8	61%	**53%**↓	54%↓
Section score	***6.0***	***7.5***	***6.2***	***7.3***			

Table 6 CARE REVIEW

QUESTION	*SWYT CQC 2012*	*All trusts top score*	SWYT CQC 2013	All trusts top score	*QH 2012 (n=273)*	QH 2013 *(n=251)*	QH Benchmark (BM)
CARE REVIEW							
In the last 12 months have you had a care review meeting to discuss your care?	5.2	8.6	**5.2**	7.8	20%	**28%**↑	29%↓
Were you told that you could bring a friend, relative or advocate to your care review meeting?	7.5	8.9	**8.2**	9.2	69%	**71%**↑	72%↓
Before the review meeting were you given a chance to talk to your care co-ordinator about what would happen?	5.8	8.4	**6.8**	8.3	50%	**50%**↔	59%↓
Were you given a chance to	8.0	8.7	**7.8**	9.1	69%	**62%**↓	69%↓

QUESTION	*SWYT CQC 2012*	*All trusts top score*	SWYT CQC 2013	All trusts top score	*QH 2012 (n=273)*	QH 2013 *(n=251)*	QH Benchmark (BM)
express your views at the (care review) meeting?							
Did you find the care review helpful?	6.6	7.7	**6.7**	7.9	42%	**44%↑**	48%↓
Did you discuss whether you needed to continue using NHS mental health services? *YES*	6.4	8.2	**7.2**	8.1	55%	**60%↑**	57%↑
Section score	***6.6***	***7.9***	***7.0***	***8.0***			

Overview

The CQC results show a poor response with regard to community service users being offered or given a copy of their care plan, and with regard to having a care review meeting. Although the scores have improved over 2012, the current situation is still not acceptable; having a care plan and a care review meeting should be a fundamental requirement, which we meet for all service users who are on CPA or standard care.

Following the community survey results the Trust has undertaken a deep dive into the 2 specific areas of concern, through an analysis of the data on RiO. The national survey covers both service users on CPA and standard care. An analysis at BDU level shows that according to the data recorded on RiO as at December 2013:

- 77% on CPA had been given or offered a care plan, and 79% on CPA had had a care review meeting in the last 12 months
- 47% of the users on standard care had been given or offered a care plan and 32% had had a care review meeting in the last 12 months.

The above comparison shows that a larger percentage of individuals on standard care, as opposed to those on CPA care, are not receiving copies of their care plans or a timely care review. A large majority of these individuals are on medical and psychology caseloads.

BDU Directors have been provided with an analysis by BDU and by team to allow targeted action in the underperforming areas.

- To ensure all service users have access to a current written or printed copy of their care plan.
- To ensure all service users have a care review meeting.
- To ensure all service users are told who their care coordinator is and how to contact them when necessary.

Following a poor score in the same areas in 2012/13, the following actions, which we have worked on this year through co-production with service users, carers and clinicians, should assist with the issues highlighted in this section, but the bottom line is that clinicians need to take responsibility for under taking care planning and care review in line with Trust policy.

- **12 Personal standards for care planning and 12 personal standards for reviews** of care have been agreed by a group of service users, carers and clinicians following a project which included:
  - Workshops to look at care planning and reviews of care
  - Visits to two other Trusts who were perceived as doing well with care planning and reviews of care
  - A task and finish group to co-produce this work.

- These standards are currently being circulated around the Trust and into team bases as a guide/reminder for care co-ordinators and will be used as a good practice check list

These standards will give clarity to service users about the standard of care they can **expec**t from our clinical staff and give them a toolkit to challenge clinical staff if they do not receive the agreed standard of care.

- **A Care Coordinator card** has been co-produced with service users. The card will be given to all service users on both CPA and standard care and will contain the following information: Name of care co-ordinator, Profession of care co-ordinator, Contact details of care co-ordinator, Urgent and non-urgent contact details of support/professionals, Preferred contact of the service user.
- Work has commenced to review how RiO can be used to populate letters and appointments etc. with the identification of the care co-ordinator and contact details.

- **Data Quality** – There are a number of individuals who are not recorded as being on CPA or Standard Care and not having a named care co-ordinator, as care co-ordination is directly linked to CPA/Standard Care. Examples of these are:
  - Individuals who have not been discharged from the electronic record although discharged from a clinician/team
  - Individuals who have been screened for a service and are waiting for the service/treatment to begin
  - Individuals not having had CPA registration details completed by the clinician involved
  - Historical caseloads migrated over to RiO

Action: To be addressed through the Data Quality Steering Group, chaired by the Director of Nursing.

- **Care Coordinator Competencies** have been developed in SWYPFT and will be implemented consistently across the Trust. Training in the six core competences is being run over the next 3 months. These competencies will be used as a framework for acceptable standard of practice and will be audited in 2014.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 28 January 2014
Agenda item 5

Title:	**Review of Standing Financial Instructions**
Paper prepared by:	Director of Corporate Development
Purpose:	To advise Trust Board of changes to the Trust's Standing Financial Instructions, which are part of the Trust's governance arrangements ensuring it remains legally constituted, financially viable and sustainable as a Foundation Trust and to continue to meet its obligations under its Constitution.
Vision/goals:	Links to all corporate objectives as robust governance arrangements support the Trust in achieving its objectives.
Any background papers/ previously considered by:	Paper to the Audit Committee 21 January 2014. A copy of the full Standing Financial Instructions is available should any Director wish to see the detail of the document.
Executive summary:	NHS Foundation Trusts are required to have Standing Financial Instructions in place for the regulation of their proceedings and business. The Instructions are part of the Trust's Standing Orders, which, in turn, are part of the Trust's Constitution. Standing Orders and delegated powers provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly. All members of Trust Board and all members of staff, including staff seconded to the Trust and contractors working for the Trust, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions. All are required to adhere to the Instructions. The Trust Standing Financial Instructions have been reviewed, compared to a number of other NHS organisations, circulated for comments internally and with key external partners, and updated accordingly. In summary, this review has resulted in a number of format changes and update of external guidance references, such as bank names and reference to NHS Protect. No material changes have been made to the content. The Audit Committee considered and endorsed the changes at its meeting on 21 January 2014 and will recommend approval to Trust Board. No changes are required to the Trust's Standing Orders as a result of the review. Trust Board should also note that the Chief Executive intends to review the Scheme of Delegation in consultation with the Chair of the Trust and the Deputy Chief Executive, and a revised Scheme will be presented to Trust Board in March 2014. This may require changes to the SFIs to reflect any changes in approval thresholds, which Trust Board will also be asked to approve.
Recommendation:	**Trust Board is asked to approve the revised Standing Financial Instructions.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 28 January 2014
Agenda item 6

Title:	**Trust Board self-certification – Monitor Quarter 3 return 2013/14**
Paper prepared by:	Director of Corporate Development
Purpose:	To enable Trust Board to be assured that sound systems of control are in place including mechanisms to identify potential risks to delivery of key objectives.
Vision/goals:	Links to all corporate objectives as compliance with Monitor's Risk Assessment Framework supports the Trust to meet the terms of its Licence and supports governance and performance management.
Any background papers/ previously considered by:	The exception report to Monitor highlights issues previously reported to Trust Board through performance and compliance reports.
Executive summary:	<u>Background</u> Trust Board will recall that the basis of Monitor's risk ratings change from quarter 3 with the introduction from 1 October 2013 of the Risk Assessment Framework and a paper assessing risk as a result of these changes was presented to Trust Board in October 2013. The new framework has two main aims: - to show when there is a significant risk to the financial sustainability of a provider of key NHS services, which endangers the continuity of those services through the continuity of services risk rating; and/or - to show where there is poor governance at an NHS Foundation Trust through the governance rating. The governance risk rating is generated by considering the following information regarding a Trust and whether it is indicative of a potential breach of the governance condition: - performance against selected national access and outcomes standards; - CQC judgments on the quality of care provided; - relevant information from third parties; - a selection of information chosen to reflect quality governance at the organisation (Quality Governance Indicators); - the degree of risk to continuity of services and other aspects of risk relating to financial governance; - any other relevant information. The focus of the finance rating has changed from generation of surplus to Continuity of Service and early identification of financial risks. Five Financial Risk Ratings (rated 1 – 5) are replaced by two Financial Risk Ratings (rated 1 – 4), which cover, in layman's terms: - liquidity – days of costs the Trust can cover based on cash readily available; - Capital Servicing Capacity – to what degree does Trust income cover any debts/financial obligations it may have. The metrics are based on debt minimisation and cash maximisation and have been monitored in shadow format since the Risk Assessment Framework consultation. In terms of risk and implications, both metrics are favourable for the Trust.

	Quarter 3 assessment Based on the evidence received by Trust Board through performance reports and compliance reports, the Trust is reporting a governance risk rating of **green** after applying the new Framework. Based on performance information set out in the performance report, the Trust is reporting a continuity of services/finance risk rating of **green** with a score of **4**. Information on Monitor's benchmarking figures for Q2 can be found in the finance report under item 4.2. Self-certification Monitor authorises NHS foundation trusts on the basis that they are well-governed, financially robust, legally constituted and meet the required quality threshold. Monitor's Risk Assessment Framework is designed to: - show when there is a significant risk to the financial sustainability of a provider of key NHS services, which endangers the continuity of those services through the continuity of services risk rating; and/or - show where there is poor governance at an NHS Foundation Trust through the governance rating. Trust Board is required to provide board statements certifying ongoing compliance with its Licence and other legal requirements to enable Monitor to operate a compliance regime that combines the principles of self-regulation and limited information requirements. The statements are as follows. - For continuity of services, that the Trust will continue to maintain a risk rating of at least 3 over the next twelve months. - For governance, that the board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the Framework and a commitment to comply with all known targets going forward. - And that Trust Board can confirm there are no matters arising in the quarter requiring an exception report to Monitor, which have not already been reported. The Framework also introduces in-year quality governance metrics for the first time. The metric used for Q3 is executive team turnover as it is seen as one of the potential indicators of quality governance concerns. The Trust is required to provide information on the total number of executive (voting) posts on the Board, the number of these posts that are vacant, the number of these posts that are filled on an interim basis, and the number of resignations and appointments from and to these posts in the quarter. The Trust is required to report retrospectively from Q1. Subject to any changes required by Trust Board as a result of earlier board papers and the resultant discussion, the attached report will be submitted to Monitor in respect of Quarter 3 and the in-year governance declaration on behalf of the board will be made to confirm compliance with governance and performance targets.
Recommendation:	**Trust Board is asked to approve the exception report to Monitor, subject to any changes/additions arising from papers discussed at the Board meeting around performance, compliance and governance.**
Private session:	Not applicable

Trust Board self-certification - Monitor Quarter 3 return 2013/14
Trust Board 28 January 2014

Commissioner requested services
There have been no changes to commissioner requested (mandatory) services since Quarter 2.

Trust Board
As previously reported, the interviews to appoint to the vacant post of Director of Service Improvement and Health Intelligence were held on 1 October 2013 and no appointment was made. The Chief Executive re-evaluated the position and has made an interim appointment to the post. Diane Smith, Head of Emergency Preparedness, Resilience and Response at NHS England (South Yorkshire and Bassetlaw), has joined the Trust on secondment from NHS England for a period of six months on a part-time basis.

A Non-Executive Director vacancy remains on the Board following the appointment of Ian Black as Chair and the decision by the Nominations Committee not to appoint to this vacancy immediately. The balance of the Board remains with six Non-Executive Directors (including the Chair) and five Executive Directors (including the Chief Executive). The process to recruit to fill the Non-Executive Director vacancy from the end of May 2014 when Bernard Fee's term of office ends has begun. The post will be advertised nationally on 26 January 2014.

Members' Council
Renewed approaches have been made to Kirklees Metropolitan Council to identify a representative to fill the allocated seat but there has been no response so far. The Leader of Council has recently resigned and, when a new appointment is made, the Trust will approach the Council again. There has also been a change of representative from Calderdale Council. The Members' Council still carries two public vacancies (one in Calderdale and one in Wakefield) and two staff vacancies for psychological therapies and social care staff working in integrated teams.

Elections for vacant seats and to fill those seats where governors will be retiring by rotation will begin in February 2014. The seats are as follows.

Barnsley
Two seats – Shaun Adam and Andrew Hill are both retiring by rotation and both are eligible for re-election
Calderdale
One vacant seat
Kirklees
Two seats – Nasim Hasnie and Dave Rigby are retiring by rotation and both are eligible for re-election
Wakefield
Two seats – Hazel Walker is retiring by rotation and is eligible for re-election. There is also one vacancy
Rest of South and West Yorkshire
One seat – newly created in 2013
Staff
One vacant seat – psychological therapies
One vacant seat – social care staff working in integrated teams

Care Quality Commission (CQC)

- No formal response to the whistleblowing concerns received by the CQC has yet been received although the Trust did receive a written response on 19 August 2013 thanking the Trust for the constructive discussion and the honest and genuine attempts being made to resolve the issue. The CQC confirmed that no regulatory action would be taken but the matter would be kept under review.
- In the latest QRP re-fresh (December 2013) fourteen risk estimates (87.5%) fall in the 'reduced risk of non-compliance' range. There are two risk estimates within the 'increased risk of non-compliance' range relating to outcome 4 (care and welfare) and outcome 6 (co-operating with other providers), which are now rated 'low red' and 'high amber' respectively.
- The Trust has two compliance actions from the inspection visit to the Fieldhead site in July 2013. Locations visited were Trinity 2, Newton Lodge and Bretton). The CQC found that overall patients were receiving a good level of service; however, there were some concerns regarding the design and layout of some of the hospital's seclusion rooms and the general décor and environment of Hepworth ward (within Newton Lodge). The CQC also identified some concern regarding how some patients' seclusions had been reviewed and continued. A detailed action plan has been submitted to address the compliance issues, which will be fully completed by 31 May 2014.

  The CQC found that the following standards were met:
  - outcome 1 (respecting and involving people who use services);
  - outcome 4 (care and welfare of people who use services);
  - outcome 16 (assessing & monitoring quality of service provision); and
  - outcome 21 (records).
- The CQC identified the three Dales wards (Elmdale, Beechdale and Ashdale) as compliant in respect of all standards inspected.
  - Staff were found to be treating service users with both dignity and respect.
  - Choices were being offered to patients.
  - A range of assessments and care plans had been carried out to help ensure the needs and risks of individuals were being addressed, including physical health needs.
  - Systems and processes were in place to ensure service users were safeguarded from harm.
- There were three CQC Mental Health Act visits in Q3 to Enfield Down, Ashdale ward at the Dales, and a seclusion visit at Newton Lodge. The CQC reported positively on treatment, care and service user participation in appropriately person-centred care planning. Concerns related to elements of record keeping. The seclusion unit visit identified some discrepancies between Trust policy, the Code of Practice and actual practice. The refurbished seclusion facilities on Bronte and Johnson were felt to address previous concerns raised although the facilities on Gaskell and Hepworth, which are yet to be refurbished, remain deficient. A plan is in place, closely monitored by Trust Board, to refurbish all of the Trust's seclusion units either within this financial year or by the end of Q1 2014/15.

Children's and adolescents mental health services

The Trust informed Monitor and other relevant stakeholders of a whistleblowing concern brought to the Trust's attention by a member of staff who transferred to the Trust from Calderdale and Huddersfield NHS Foundation Trust (CHFT) when CAMH services transferred. This related to an issue of data recording. The matter is now the subject of an internal, independent investigation.

Local Government Ombudsman's report
Monitor has been notified that the Trust received a report on 20 November 2013 into a complaint from the Local Government Ombudsman in relation to the assessment and care of an elderly couple by the Trust and Kirklees Council. The Council and the Trust have written to the complainant apologising for the distress caused and explaining what changes had already been made and what further actions the Council and Trust intends to take. For the Trust, the issues related to communication with a relative (son), the involvement in decisions about care and a delay in reviewing medication.

Civil claim
Monitor has been made aware that a civil claim against the Trust has been taken out, which is being handled by the NHSLA. The proceedings are at an early stage and the Trust will update Monitor on the outcome.

Rule 28 Letter (previously Rule 43)
Following an inquest in December 2013 into the death of a lady in Calderdale early in 2013, the Trust received a Rule 28 Letter from the Coroner following a narrative verdict. This required the Trust to ensure that there was a signing in/signing out facility for the unit where the deceased was living. The Trust has access to four crisis beds within the accommodation, which are owned and managed by Share. The Trust is currently preparing a response jointly with the Calderdale Council, which will be sent by the required deadline of 5 February 2014. This includes the Trust seeking legal advice as the Trust has no control over the premises.

Absent without Leave (AWOL)
During quarter 3, there were no CQC notifiable AWOL incidents.

Eliminating Mixed Sex Accommodation (EMSA)
There have been no breaches reported on Datix in Q3. The Trust continues to monitor where service users are placed in an individual room on a corridor occupied by members of the opposite sex. There have been eight such instances reported on Datix in Q3, which represents a decrease over Q2. All incidents have been appropriately care-managed with required levels of observation and support implemented.

Health and Safety Executive (HSE)
No unannounced visits received during Q3.

Infection prevention and control
In Q3, there have been no cases of Clostridium Difficile reported. There is a cumulative total of six cases in Barnsley at the end of Q3 against a full-year trajectory of eight (local target agreed with commissioners as agreed with Monitor). There is a risk that this trajectory will be exceeded. There have been no MRSA bacteraemia cases reported and four infection outbreaks (suspected viral gastroenteritis) have been reported. There were no laboratory confirmed causative micro-organisms in any of the outbreaks.

Information Governance
The Trust currently has four incidents with the Information Commissioner, three of which are awaiting a response and one of which was reported during Q3. This is a reflection of the

reduced threshold now applied for external reporting (from July 2013 all category 2 incidents will be reportable where previously this was category 3 and above).

National Specialised Services Specification Compliance
Following publication by NHS England of clinical commissioning policies and service specifications for directly commissioned services, which covers Trust forensic services, the Trust undertook a self-assessment exercise during the summer. The Trust was found to be compliant in all areas except one. This relates to seven beds in the Ryburn building, which is outside of the perimeter fence and not directly attached to the remaining secure element of the service. This was specifically designed in order to have seven rehabilitation beds which would facilitate easier discharge to the community. It was agreed that the Trust would submit notification to NHS England of this area of non-compliance. An action plan to bring the low secure service into compliance was submitted and accepted by NHS England. This involves enhancements to the physical security of the reception area of the rehabilitation ward within the low secure service. The timescale for completion has been agreed and a temporary derogation put in place by commissioners to facilitate full compliance with the service description by end of the financial year 2013/14.

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

Safeguarding Children
- There were 31 reported incidents Trust-wide directly relating to issues of child protection in Q3. This represents an increase on Q2 and work is ongoing to ensure reporting practices continue to improve. All of the incidents were reviewed by the Named Nurses and were assessed to have been appropriately reported and managed.
- There are two Serious Case Reviews involving Trust services in Barnsley and Kirklees with which the Trust is fully co-operating.
- The Trust continues to work closely with partners to support the actions to address the OfSTED Improvement Notices in Barnsley and Calderdale children's services and is leading on some key pieces of work. Part of this work is the appointment of a Practice Governance Coach to support the safeguarding children agenda and implementing best practice across children's services in Barnsley.

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

Serious Incidents
During the course of Q3 there have been 32 SIs reported to commissioners (18 in Barnsley which includes incidents related to pressure ulcers, five in Calderdale, two in Kirklees, four in Wakefield, and two in specialist services/CAMHS). SI investigations and reports are being completed within timeframes agreed with the relevant commissioners. No 'Never Events' occurred in the Trust during this quarter.

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

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

- Service level agreements management (non-healthcare) – limited assurance
  The recommendations from internal audit focus on a review of all SLA with NHS bodies to ensure their remit is clear, establishing and maintaining a database for SLAs, ensuring all SLAs are signed by both parties and developing a standard template.
  An action plan in respect of the issues raised and recommendations made within the reports has been developed, approved through the Executive Management Team.

- Procurement (non-pay purchasing) – no assurance
  KPMG was asked by the Trust to undertake a follow up review into a potential breach of standing financial instructions (SFIs). The audit concluded that a breach of Standing Orders had occurred whereby invoices were being approved for payment without **sufficient** evidence of budget holder approval or of appropriate receipting of goods. There was no evidence to suggest that there was at any time intent to deceive or defraud the Trust; however, given this is a key control in the process for the procurement and payment of goods, the conclusion of the report was that this merited an audit opinion of 'no assurance'. The report was received by the Audit Committee in July 2013. The report findings included four high and two medium priority recommendations in relation to processes and procedures, communications and culture. The financial systems have been re- audited by Internal Audit in December 2013, including a follow up to the original no assurance report. The Audit Committee has taken a robust approach to seeking assurance in relation to the report on procurement and will consider the Trust's progress at its meeting on 21 January 2014. This matter is not expected to impact adversely on the Annual Governance Statement for 2013/14.

The Audit Committee will also receive the following internal audit reports at its meeting on 21 January 2014.

- Risk management and Board assurance framework – moderate
- Information Governance (Toolkit) – moderate
- Infection prevention and control arrangements – moderate

The Trust was selected for the national NHS Protect counter fraud assessment process, which took place on 29 October 2013. The area assessed related to informing and involving. The Trust had self-assessed its position as amber and provided a workplan that indicated continued and planned action in relation to compliance with the standard. A number of red standards were identified during the assessment by NHS Protect (for standards 2.3 working with other organisations, and 2.4 code of conduct). The Trust has responded to the recommendations made in the report and all action will be completed by the end of March 2014. The Audit Committee will consider the report at its meeting on 21 January 2014.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 28 January 2014
Agenda item 7

Title:	**Assurance framework and organisational risk register Q3 2013/14**
Paper prepared by:	Director of Corporate Development
Purpose:	Trust Board to be assured that a sound system of control is in place with appropriate mechanisms to identify potential risks to delivery of key objectives.
Vision/goals:	The Assurance Framework and risk register are part of the Trust's governance arrangements and integral elements of the Trust's system of internal control, supporting the Trust in meeting its goal of flawless execution and in meeting its constitutional, legal and equality and diversity obligations.
Any background papers/ previously considered by:	Previous quarterly reports to Trust Board.
Executive summary:	**Background** The Trust Board has a duty to ensure that the organisation delivers healthcare and health improvements, promotes good health within a system of effective controls, and within the Governments objectives for the NHS. The Board needs to be confident that the systems, policies and people in place are operating in a way that is effective in driving the delivery of objectives by focusing on minimising risk. This paper and supporting appendix set out the systems and processes in place and the assurances derived. This report provides an update as at Quarter 3 covering the Assurance Framework and Organisational Risk Register. **Assurance framework 2013/14** The Board needs to evidence that it has systematically identified its objectives and managed the principal risks to achieving them. The Trust's Assurance Framework is designed as a tool for the Board to fulfil this objective. Trust Board provides leadership, sets values and standards, sets the organisations strategic objectives, monitors and reviews management performance and ensures that obligations to stakeholders are met. To ensure that these obligations are met there must be a sound system of internal controls, and the Board is required at least annually, to conduct a review of these internal controls. Whilst the risks to achieving the organisation's strategic objectives should be reduced through these internal controls, they can rarely be eliminated. The Assurance Framework provides Trust Board with a simple but comprehensive method for the effective and focused management of the principal risks to meeting their objectives. It simplifies Board reporting and the prioritisation of action plans allowing more effective performance management. It sketches an outline of the controls and where assurances can be sought. Lead Directors are responsible for identifying the controls that are in place or need to be in place for managing the principle risks, and providing assurance to the Board. An Annual Governance Statement (AGS) has to be signed by the Chief Executive every year and is based on the systems in place, particularly the

	Assurance Framework. The AGS forms part of the annual accounts and, without this, the annual accounts cannot be approved. The Assurance Framework informs the appropriate declarations to be made in the AGS, including any significant control issues in line with current guidance where appropriate. The strategic corporate objectives for 2013/14 were approved by the January Trust Board and form the basis of the assurance Framework for 2013/14. In respect of the Assurance Framework for 2013/14, the Director of Corporate Development has worked with each lead Director to identify the principle high level risks to delivery of our principle objectives. For each of these risks the key controls in place and the sources of assurances have been identified and any material gaps are identified through the performance and risk management process. The Chief Executive uses the Assurance Framework at each Director's quarterly review meeting to ensure Directors are delivering against agreed objectives and action plans are in place to address any areas of risk identified. The Director of Corporate Development will also work with the Chairs and lead Directors of each of the sub-committees of the Board to identify which of the sub-committees of the Board, through their Annual Work Plans, is seeking and providing assurance to the Board, that the key controls are in place and operating satisfactorily. (This does not reduce individual Director's accountability in respect of their identified areas of responsibility.) **External Assurance** The Trust's internal auditor (KPMG) undertook a review of the Board assurance framework and risk register in July 2013 to assess the risk management arrangements and assurance framework in place within the Trust. The Trust asked KPMG to focus on how the recently introduced process for identifying and recording risk though the DATIX system had been implemented and embedded within Business Delivery Units (BDUs). KPMG reviewed arrangements in Calderdale and Kirklees BDUs. An opinion of moderate assurance has been given and accepted by the Trust. The Director of Corporate Development is co-ordinating the Trust's response to the recommendations, which are, in the main, best practice improvement points rather than significant control weakness. KPMG also found that the assurance framework provides a good level of accuracy and the information needed to make decisions and compares favourably to standard practice across peers. **Organisational risk register** The organisational risk register records high level risks in the organisation and the controls in place to manage and mitigate the risks. The risk register has been reviewed by the Executive Management Team during the last quarter, risks are re-assessed based on current knowledge and proposals made in relation to this assessment, including the addition of any high level risks from BDUs, Corporate or Project specific risks and the removal of risks from the register. The risk register contains the following risks:

	- issues around data and information; - the Care Packages and Pathways project for mental health; - impact on services as a result of local authority spending cuts and changes to the benefits system; - expectations of emerging Clinical Commissioning Groups; - transformational service change programme; - changes to national funding arrangements; - contract renewal for intermediate care and memory services in Barnsley. Three additional risks have been added in relation to bed pressures, children's and adolescents' mental health services and an internal audit report on procurement.
Recommendation:	**Trust Board is asked to:** ➢ **note the assurances provided for Q3 of 2013/14;** ➢ **note those areas where gaps in assurance have been identified, through the Trust wide risk register and are being addressed through specific action plans as appropriate led by the lead Director;** ➢ **note the key risks for the organisation subject to any changes/additions arising from papers discussed at the Board meeting around performance, compliance and governance.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

ASSURANCE FRAMEWORK 2013/14 – as at Q3 2013/14

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

Principal risks (including potential risks)	Lead Direct	Key controls * (Systems/processes)	Assurance on controls * (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurance	Gaps in control	Gaps in assurance
1. Failure to understand and respond to changing market forces leading to loss of market share.	▪ DSD ▪ DDs	▪ C1, C2, C3, C4, C8, C32 ▪	▪ A4, A5, A40	A4, A5, A40		ORR 462
2. Lack of engagement and ownership with key stakeholders to manage risk in the local economy impacting on available resources.	▪ DoC ▪ DDs	▪ C4, C5, C6, C7, C8, C9, C10	▪ A28, A29, A35, A39	A28, A29, A35, A39		ORR 275
3. Failure to develop required relationships or commissioner support to develop new services/ expand existing services, contracts awarded to other providers.	▪ DoF ▪ DDs	▪ C1, C4, C5, C8, C10	▪ A1, A36, A40, A40	A1, A36, A40, A40		ORR 462 ORR 463 ORR 523
4. Staff and other key stakeholders not fully engaged in process around redesign of service offer, resulting in inertia and lack of progress.	▪ DDs	▪ C4, C7, C8, C10, C11, C12, C16	▪ A1, A4, A39	A1, A4, A39		ORR 463
5. Failure to listen and respond to our service users, service offer not being patient centred, impacting on reputation and leading to loss of market share.	▪ DDs	▪ C7, C13, C15, C16, C40, C42, C43	▪ A2, A20, A21, A29, A45, A51	A2, A20, A21, A29, A45, A51		ORR 463

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

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

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurance	Gaps in control	Gaps in assurance
1. Inadequate capture of data resulting in poor data quality impacting on ability to deliver against care pathways and packages and evidence delivery against performance targets and potential failure regarding Monitor Compliance Framework.	▪ DoF	▪ C17, C19, C20, C21, C22	▪ A1, A9, A10, A11,A13, A15, A16, A17, A43	A1, A9, A10, A11,A13, A15, A16, A17, A43		ORR 267 ORR 270

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurance	Gaps in control	Gaps in assurance
2. Unexplainable variation in clinical practice resulting in differential patient experience and outcomes and impact on Trust reputation.	▪ MD ▪ DN ▪ DDs	▪ C4, C23, C24, C25, C26, C43	▪ A1, A8, A33, A36, A46, A52	A1, A8, A33, A36, A46, A52		
3. Changing service demands and external financial pressures in local health and social care economies have an adverse impact on achieving local and national performance targets and ability to manage within available resources.	▪ DDs	▪ C4, C5, C20, C22, C27, C28	▪ A1, A8, A9, A10, A11, A15, A16, A23, A30	A1, A8, A9, A10, A11, A15, A16, A23, A30		ORR 275 ORR 462
4. Failure to deliver level of transformational change required impacting on ability to deliver required change management programme.	▪ DSD ▪ DoF	▪ C17, C18, C30	▪ A1, A2, A4, A5, A35, A37	A1, A2, A4, A5, A35, A37		ORR 463
5. Lack of sign up from staff in recognising the need for change leading to lack of engagement and benefits not being realised through delivery of revised models.	▪ DDs	▪ C31, C32, C33, C34	▪ A3, A35, A52	A3, A35, A52		ORR 463
6. Workforce plan doesn't support identification and recruitment of suitably competent and qualified staff to deliver the service offer.	▪ DoH	▪ C1, C12, C29, C35, C67	▪ A1, A10, A20, A21, A22, A24, A47	A1, A10, A20, A21, A22, A24, A47		
7. Not having a clearly defined Estates Strategy to support the revised service offer.	▪ DoH ▪ DDs	▪ C1, C17, C32, C36, C37, C38	▪ A1, A4, A5, A6A18, A26, A27, A44	A1, A4, A5, A6A18, A26, A27, A44		
8. Lack of suitable technology and infrastructure to support delivery of revised service offer.	▪ DoF	▪ C1, C17, C32, C39	▪ A1, A4, A5, A14, A26	A1, A4, A5, A14, A26		

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

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurances	Gaps in control	Gaps in assurance
1. Failure to motivate and engage clinical staff through culture of quality improvement, benchmarking and changing clinical practice, impacting on ability to deliver best possible outcomes.	▪ MD ▪ DoN	▪ C31, C32, C34, C44, C45, C46	▪ A1, A11,A21, A29, A35, A49, A52	A1, A11,A21, A29, A35, A52	A49	ORR 463
2. Failure to create and communicate	▪ CE	▪ C31, C33, C44, C48, C49, C68	▪ A1, A7, A35, A42	A1, A7, A35,		

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurances	Gaps in control	Gaps in assurance
a coherent articulation of Trust Mission, Vision and Values leading to inability to identify and deliver against strategic objectives.				A42		
3. Failure to create a learning environment leading to repeat incidents impacting on service delivery and reputation.	▪ ▪ DoN	▪ C23, C41, C50, C51	▪ A15, A19, A24, A27, A46, A48	A15, A19, A24, A27, A46, A48		
4. Failing to achieve the right balance of devolution and local autonomy for BDU's versus corporate cohesion.	▪ DDs	▪ C1, C3, C33, C52, C53, C54, C55	▪ A1, A5, A26, A33, A35,	A1, A5, A26, A33, A35,		
5. Failure to develop a culture of tackling poor performance at all levels.	▪ DDs ▪ CDs	▪ C12, C26, C33, C56	▪ A15, A16, A22, A31, A32	A15, A16, A22, A31, A32		ORR 267 ORR 268

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

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

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

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurances	Gaps in control	Gaps in assurance

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurances	Gaps in control	Gaps in assurance
1. Failure to respond to market forces and on-going development of new partnerships.	▪ DDs ▪ DoCD	▪ C1, C2, C3, C6, C16, C30	▪ A26, A29, A40, A39	A26, A29, A40, A39		ORR 463 ORR 522
2. Risk of sustainability of partnerships and relationships in a resource constrained environment causing internal not system-wide focus.	▪ DDs ▪ DoCD	▪ C4, C6, C10, C59	▪ A1, A10, A35, A39	A1, A10, A35, A39		ORR 463 ORR 522 ORR 523
3. Lack of investment in capacity and skills required to build and deliver on partnerships.	▪ DoF	▪ C23, C26, C30, C33, C35, C44, C57	▪ A1, A3, A5, A35	A1, A3, A5, A35		ORR 463

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

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurances	Gaps in control	Gaps in assurance
1. Risk of lack of stake holder engagement needed to drive innovation, key stakeholders not fully engaged in process around redesign of service offer.	• MD, • DoN, • DDs • DoCD ,	▪ C10, C11, C16, C17, C18, C30, C32	• A1, A4, A35, A39	A1, A4, A35, A39		ORR 463
2. Lack of commitment to make necessary changes across the organisation	▪ DDs	▪ C11, C12, C13, C16, C31, C60, C61, C63,	• A2, A5, A7	A2, A5, A7		ORR 463
3. Lack of clarity on tools and processes required to enable a quick, effective approach.	▪ DoSD	▪ C30, C62, C63	• A4, A5	A4, A5		
4. Lack of availability of resources to pump prime innovation.	▪ DoF	▪ C30, C62, C63	• A5, A7, A34, A35	A5, A7, A34, A35		ORR 463

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

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

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurances	Gaps in control	Gaps in assurance
3. Failure to identify, harness and support talent through personal development to maximise potential.	▪ DDs ▪ CDs	▪ C26, C44, C65	▪ A3, A22, A35,	A3, A22, A35,		

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

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurances	Gaps in control	Gaps in assurance
1. Failure to articulate leadership requirements, Inability to develop effective leadership and succession planning	▪ DDs ▪ CDs	▪ C26, C34, C44, C64	▪ A3, A25, A35	A3, A25, A35		
2. Failure to develop leadership culture, managers fails to support and prioritise development programmes.	▪ DDs, CDs,	▪ C26, C31, C33, C44	▪ A3, A15, A22	A3, A15, A22		
3. Lack of resources to support development and delivery of programmes.	▪ DDs ▪ CDs	▪ C31, C34, C54, C63	▪ A5, A34, A35, A47	A5, A34, A35, A47		ORR 463

Abbreviations:

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

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

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

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

Assurance (A..)	Assurance on controls (Planned outputs)	Board reports received (including sub-committees, EMT)
		2013) ➢ Quality Impact Assessment of CIPs (April, June, September and December 2013) ➢ Serious incidents quarterly reports during 2013/14 and annual report June 2013 ➢ CQUIN achievement and forecast (June 2013) ➢ Clinical audit and effectiveness plan 2013/14 (June 2013) ➢ Health and safety annual report 2012/13 and plan 2013/14 (September 2013) ➢ Self-assessment against MIND report on prone restraint (September and December 2013) ➢ Children's services December 2013 ➢ Bed pressures December 2013
12.	Annual Governance Statement (SIC) reviewed by Audit Committee and Board and Externally audited. 4.1	➢ Approval of annual report and accounts at Audit Committee May 2013 and Trust Board June 2013
13.	Monitor Compliance Assurance group review performance before Trust Board B&R meeting ensuring all exceptions identified and reported to Trust Board and Monitor. 2.1	➢ Process in place to review compliance with Monitor targets on quarterly basis ➢ Progress reviewed monthly at EMT evidenced through EMT minutes
14.	IG Toolkit provides assurance and evidence that systems and processes in place at the applicable level, reported through IG TAG, deviations identified and remedial plans requested receive, performance monitored against plans. 2.8,	➢ Information Governance TAG papers and minutes ➢ Performance EMT meetings and papers ➢ Monthly performance reports ➢ Reports to Clinical Governance and Clinical Safety Committee
15.	Monthly review and monitoring of performance reports through Performance EMT deviations identified and remedial plans requested. 2.1, 2.3, 3.3, 3.5, 4.1, 8.2.	➢ Performance reports to EMT (which include 'hotspots' and areas for concern) ➢ Minutes from performance EMT meetings ➢ Transformational service change progress reports to EMT (monthly) ➢ Sickness absence (currently standing item) ➢ Risk assessment of target, CQUINs, etc. EMT May 2013 and Trust Board April 2013 ➢ Cost improvement programme (July 2013)
16.	Monthly review and monitoring of Integrated Performance Report by Trust Board with exception reports requested around risk areas. 2.1, 2.3, 3.5, 4.1,	➢ Performance reports to Trust Board ➢ Minutes from Trust Board meetings ➢ Risk assessment of performance targets 2013/14 to Trust Board April 2013 ➢ CQUIN performance and risk assessment Clinical Governance and Clinical Safety Committee June 2013 ➢ Quality Impact Assessment Audit Committee April 2013, Clinical Governance and Clinical Safety Committee April, June, July and December 2013
17.	Annual report to Business and Risk Board to risk assess changes in compliance requirements. 2.1,	➢ Risk assessment of performance targets 2013/14 to Trust Board April 2013 ➢ Monitor risk assessment framework risk analysis Trust Board October 2013
18.	Independent PEAT Audits undertaken and results and actions to be taken reported to EMT Members Council and Board. 2.7,	➢ PLACE results to EMT August 2013 and Trust Board October 2013
19.	CQC registration certificate in place. 2.3,	➢ Care Quality Commission registration certificates ➢ Application for addition Trust Board June 2013
20.	Announced and unannounced inspection visits undertaken by CQC, independent reports on visits provided to the Trust Board. 1.5, 2.6,	➢ Updates provided to Trust Board on unannounced visits to Newton Lodge and the Dales ➢ Trust Board and Members' Council informed of CQC investigation into whistleblowing regarding bed pressures
21.	Unannounced internal visits to support staff and ensure compliance with CQC standards through the delivery of supported action plans.1.5, 2.6, 3.1,	➢ Clinical Governance and Clinical Safety Committee April, June, July and December 2013
22.	Remuneration Terms of Service Committee receive HR Performance Reports and monitor compliance against plans and receive assurance from reports around staff development, workforce resilience. 2.6, 3.5, 4.2, 4.4, 7.3, 8.2,	➢ Sickness absence R&TSC April, July and October 2013 ➢ Exception report R&TSC April, July and October 2013 ➢ Interim results of staff wellbeing survey July 2013 ➢ Update on achievement of appraisal target July 2013

Assurance (A..)	Assurance on controls (Planned outputs)	Board reports received (including sub-committees, EMT)
23.	Audit Committee review evidence for compliance with policies, process, SO's, SFI's, SofD, mitigation of risk, best use of resources. 2.3, 4.1,	➢ Annual report and accounts ➢ Standing item on service line reporting and currency development ➢ Standing item on procurement and review of procurement strategy ➢ Standing item on progress against counter fraud plan ➢ Standing item on progress against internal audit plan ➢ Head of Internal Audit Opinion May 2013
24.	Independent CQC Reports to MHA Committee providing assurance on compliance with MH ACT2.6, 3.3, 4.2,	➢ All Mental Health Act Committee meetings
25.	External accreditation IIP, supported by internal assessors, ensuring consistency of approach in the support of staff development and links with organisational objectives. 7.1, 8.1,	
26.	Annual Plan approved by Board, externally scrutinised and challenged by Monitor. 2.7, 2.8, 3.4, 5.1,	➢ Monitor commentary on annual plan ➢ Annual plans, budgets and minor capital programme 2012/13 approved by Trust Board March 2013 ➢ Monitor annual plan approved by Trust Board May 2013 ➢ Monitor quarterly returns
27.	Health and Safety TAG monitor performance against plans deviations identified and remedial plans requested. 2.7, 3.3,	➢ Health and Safety TAG minutes ➢ Health and safety arrangements peer review outcome to Clinical Governance and Clinical Safety Committee April 2013 ➢ Health and Safety annual report and plan to Clinical Governance and Clinical Safety Committee September and December 2013
28.	Staff Opinion Survey results reported annually to board and action plans produced as applicable. 1.2,	
29.	Service user survey results reported annually to board and action plans produced as applicable. 1.2, 1.5, 3.1, 5.1,	➢ Quarterly quality and compliance reports to Trust Board ➢ CQC registration quarterly reports to EMT
30.	Annual Reports of sub-committees of the Board to Audit Committee, attendance by Chairs of sub-committees and director leads to provide assurance against annual plan	➢ Audit Committee annual report to Trust Board 2012/13 April 2013 ➢ Review of other risk Committees' effectiveness and integration Audit Committee April 2013
31.	External and Internal Audit Reports to Audit Committee setting out level of assurance received. 3.5 ,	➢ Internal audit update reports to Audit Committee ➢ External audit update reports to Audit Committee ➢ Annual report and accounts to Audit Committee May 2013 ➢ Quality Accounts progress standing item on Clinical Governance and Clinical Safety Committee agenda ➢ Quality Accounts final report to Clinical Governance and Clinical Safety Committee Committee May 2013
32.	External and internal Audit reports performance managed through approvals EMT. 3.5,	➢ Internal audit follow up reports to EMT and consideration of internal audit reports with limited assurance throughout 2013/14 ➢ Quality Accounts external assurance Audit Committee May 2013 and Trust Board June 2013
33.	Audit of compliance with policies and procedures in line with approved plan co-ordinated through clinical governance team in line with Trust agreed priorities. 2.2, 3.4,	➢ Reports to Clinical Governance and Clinical Safety Committee ➢ Monitoring of action plan following medicines management audit CG&CS Committee April and June 2013, and update July 2013 ➢ Limited assurance reports considered by EMT ➢ Internal audit reports on clinical governance (substantial), compliance CQC standards (moderate), quality governance (substantial), change management programme (moderate), health record (SystmOne) (moderate), adult safeguarding (limited), IG toolkit (substantial), facilities (moderate), revalidation (substantial) and financial affairs – community patients (limited progress), data quality (limited), clinical

Assurance (A..)	Assurance on controls (Planned outputs)	Board reports received (including sub-committees, EMT)
		leadership (advisory), self-directed support (advisory), local authority partners (substantial), corporate governance (substantial), payroll (substantial), estates strategy management (substantial), service level agreement management (non-healthcare) (limited), procurement (non-pay purchasing) (none)
34.	Innovation bids approved through approvals EMT ensuring consistency of approach and alignment with strategic priorities and corporate objectives. 6.4, 7.2, 8.3,	➢ Innovation Funds bids forms and benefits realisation and minutes EMT throughout 2013/14
35.	Monitoring of OD Plan through EMT group deviations identified and remedial plans requested. 1.2, 2.4, 3.1, 3.2, 3.4, 4.1, 4.4, 5.2, 5.3, 6.1, 6.4, 7.2, 7.3, 8.1, 8.3.	➢ OD group led by CE established to review OD plan.
36.	QIPP performance monitored through Performance EMT deviations identified and remedial plans requested. 2.2, 2.4,	➢ Performance reports to EMT ➢ Performance EMT minutes
37.	Sustainability action plans monitored through Sustainability TAG deviations identified and remedial plans requested. 1.3, 2.4,	➢ Sustainability TAG minutes
38.	Annual Report and feedback on undergraduate medical training 4.2,	
39.	Strategic overview of partnerships and growth in line with Trust vision and objectives provided through Strategic EMT. 1.2, 1.3, 1.4, 5.1, 5.2, 6.1	➢ Stakeholder updates at Strategic EMT ➢ Chief Executive's reports to Trust Board (formal and informal) – standing item from December 2012
40.	Marketing analysis reviewed through Strategic EMT, Market Assessment to Business and Risk Trust Board ensuring identification of opportunities and threats. 1.1, 1.3, 5.1,	➢ Market analysis at Strategic EMT and time out sessions ➢ Trust Board April 2013 ➢ Chief Executive's reports to Trust Board (formal and informal)
41.	Production of Monitor B12 setting out evidence of compliance/assurance against the statements reviewed by Trust Board	➢ Monitor annual plan, including Trust Board self-certification, approved by Trust Board April 2013 ➢ Approval by Trust Board of Monitor annual plan May 2013 ➢ Monitor Compliance Framework to Trust Board April 2013 ➢ Monitor Code of Governance to Trust Board April 2013 ➢ Monitor Quality Governance Framework Clinical Governance and Clinical Safety Committee April 2013 and Trust Board December 2013 ➢ Monitor risk assessment framework Trust Board October 2013
42.	Results from appraisal monitoring process reported to EMT and Trust Board ensuring communication of MVV through the Trust.3.2, 4.3,	➢ Performance reports to Trust Board and EMT ➢ Transformational service change consultation and engagement events June/July and October/November 2013 ➢ Revised appraisal process rolled-out to all staff from 1 April 2013 following positive feedback from pilot of values-based system.
43.	Data quality Improvement plan monitored through EMT deviations identified and remedial plans requested. 2.1,	
44.	Estates Forum monitors delivery against Estates Strategy. 2.7,	➢ Estates forum minutes and papers outlining development of Estates Strategy
45.	Equality and Involvement Strategy into Action Group established monitoring delivery of equality, involvement and inclusion action plans, reporting into CG&CS Committee. 1.5	➢ Equality and Involvement Strategy into Action Group terms of reference and minutes
46.	Serious Incidents from across the organisation are reviewed through the Incident Review Panel including the undertaking of root cause analysis and dissemination of lessons learnt and good clinical practice across the organisation. 2.2, 3.3,	➢ Incident Review Sub-Committee minutes and reports to Clinical Governance and Clinical Safety Committee ➢ Serious incidents quarterly reports to Clinical Governance and Clinical Safety Committee and Trust Board
47.	Mandatory training review group in place ensuring consistency of approach across Trust and compliance with legislation. 2.6, 4.2, 8.3, 7.2,	➢ Review group terms of reference ➢ Revised mandatory training policy approved by EMT October 2012
48.	Assurances received by sub-committees of the Board reported quarterly to Trust Board, providing Board assurance on systems and controls in place and	➢ Assurance from Trust Board Committees to Trust Board (June, September and December 2013)

Assurance (A..)	Assurance on controls (Planned outputs)	Board reports received (including sub-committees, EMT)
	operating. 3.3	
49.	Medium secure quality network undertake annual peer reviews providing external assurance on systems and controls in place and operating. 3.1,	
50.	Independent Hospital Managers review detentions providing external assurances of compliance with MH Act.4.2, 1.5,	All detained but non-restricted patients have their renewal of section examined at a formal meeting with independent hospital managers who examine legality and appropriateness of detention. Also able to identify any concerns voiced by patients/advocates about care given. Feedback given to Mental Health Act Committee through standing item on the agenda (feedback from Hospital Managers' Forum).
51.	LINKs undertake unannounced visits to services providing external assurance on standards and quality of care.	➢ Draft reports provided to services, final report agreed and action plans developed
52.	Appraisal and revalidation in place evidenced through ORSA and supported through Appraisers forum. 2.2, 2.5, 3.1, 4.2,	➢ Medical Appraisers' Forum minutes

South West Yorkshire Partnership NHS
NHS Foundation Trust

ORGANISATIONAL LEVEL RISK REPORT

Date: Trust Board 28 January 2014

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

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

Risk ID	Hist. Ref	Source	Risk Responsibility	BDU/Directorate	Service	Specialty	Description of risk	Current control measures	Consequence (Current)	Likelihood (Current)	Rating (current)	Risk level (current)	Summary of risk action plan	Fin cost (£)	Risk Owner	Expected date of completion	Monitoring & Reporting Requirements		Risk level (Target)	Is this rating acceptable?	Comments	Risk Review Date
267	Risk Assessment	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)				Data quality and capture of clinical information on RiO will be insufficient to meet future compliance and operational requirements to support service line reporting and the implementation of the mental health currency leading to reputational and financial risk in negotiation of contracts with commissioners.	Data quality Strategy approved by Board Oct 2011. Annual report produced for Business and Risk Board to identify risks and actions required in order to comply with regulatory and contract requirements. >Data quality framework is monitored by the Data quality Steering group which is chaired by the Director of Nursing > Key issues in relation to data quality and clinical practice to support mental health currency implementation are included in the Data quality action plan which is reviewed by the Steering group. > All BDUs have individual data quality action plan which is reviewed internally. > Accountability for data quality is held jointly by Director of Nursing and Director of Finance. >Responsibility for data quality is delivered by BDU directors, BDU nominated quality leads and clinical governance. >Key metrics for Data quality are produced monthly in BDU and trust dashboards and reviewed by Performance EMT . >Annual clinical audit programme is planned to reflect data quality priorities.	5 Catastrophic	4 Likely	20	Red/extreme /SUI risk (15-25)	[25/04/2013 09:19:14 Ros Taylor] >Specific project arrangements for implementation of mental health currency - Project Board and Project team in place. Director lead Director of Finance. > Engagement plan for 2013-14 in place for commissioners and implementation plan reflected in contract monitoring agreed. >Engagement plan and resource plan in place to support implementation of currency internally through project team and practice governance coach >Baseline reports produced to communicate where teams are not meeting standards and need to focus efforts. >Project arrangements designed to identify key issues - clarity on services offer;clarity of clinical process; improve configeration of clinical system; link to transformation; benchmarking use of resources. >Changes to clinical systems to support mental health currency implementation and to improve data quality is managed by the RiO Development Board which is chaired by the DoF and includes DoN and Medical Director and BDU Director. This is supported by network of clinicians and managers - RiO Clinical Reference Group. Trust data quality action plan reviewed & approved Oct 2011. Progress updates against data quality action plan to to EMT in November 2011 and January 2012. BDU data quality improvement plans developed June 2012. Trust data quality improvement plan to be developed June/July 2012. Progress against action plans monitored by BDUs and reviewed quarterly by Data Quality Steering Group and EMT. Monthly monitoring and performance management of data quality by BDUs.Ongoing review of achievement of data quality targets at performance EMT. Phase 1 RiO Optimisation Project with SHA completed to plan April 2012. Ongoing work to increase % coded episodes & to address issues with coding procedures. State of readiness report for InPAC and cluster coding commissioned for October 2011. Monthly monitoring of clustering data quality and KPIs via PbR data quality and finance workstream & reports into PbR steering group.	100K est additional capacity	DoF Lead and Medical Director	Implementation of national guidance during 2013-14.	EMT and Trust Board monthly review for data quality indicators.Steering group review for > Data quality Board > PbR Project Board > RiO system development Board.	16	Red/extreme /SUI risk (15-25)	Yes	[25/04/2013 09:19:14 Ros Taylor] 2013-14 objectives to identify variances from currency model at team level. Understand variances and take corrective action to show demonstrable improvement by end of year.	29/01/2013
270	Risk Assessment	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)				The Care Packages and Pathways project will not deliver an improvement in service quality and outcomes through the roll out of clustering and mental health currency.	>Accountability arrangements in place for delivery of mental health currency Project-lead Director of Finance. Key project Board members DoN and Medical Director. >Progress reviewed by Audit Committee and Board. >Key issues / risks and progress monitored by EMT through Performance EMT. > Key representation at national level for development of costing by CEO and DoF through CPPP programme.	5 Catastrophic	4 Likely	20	Red/extreme /SUI risk (15-25)	[25/04/2013 09:56:15 Ros Taylor] >Project management arrangements established to include EMT, co-ordinating group and BDU specific working groups links to commissioners in Calderdale/Kirklees/Wakefield formalised.(see Risk 267) >Work on currency and benchmarking included in the Mental Health "Big ticket " transformation programme to evidence benefits. > Input and participation in CPPP programme to share best practice and benchmark progress, > Revised Project plan Sept 2013 shared with external audit . > Trajectory developed to meet data quality requirements for March 2014.	included in 267	Mental Health Big ticket leads BDU director kirklees and calderdale and medical director/ DoF	Big ticket vision and Findings from Pbr implementation reported to Performance EMT and to be incorporated into benchmarking for trasnformation work.	>EMT Progress reports >Report on progress to every Audit Committee >Regular Board updates	16	Red/extreme /SUI risk (15-25)	Yes	[25/04/2013 09:56:15 Ros Taylor] 2013-14 objectives to identify variances from currency model at team level. Understand variances and take corrective action to show demonstrable improvement by end of year.	29/01/2013
275	Risk Assessment	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)				Reduction in Local authority funding and changes in benefits system will result in increased demand of health services - due to potential increase in demand for services and reduced capacity in integrated teams- which will create risk of a negative impact on the ability of integrated teams to meet performance targets.	>District integrated governance boards established to manage integrated working with good track record of cooperation. >Maintenance of good operational links though BDU teams and leadership. >Monthly review through Performance EMT of key indicators which would indicate if issues re delivery i.e. Delayed transfers of care and service users in settled accomodation.	4 Major	4 Likely	16	Red/extreme /SUI risk (15-25)	[25/04/2013 10:03:36 Ros Taylor] > Using mental health transformation programme to engage local authority in solutions which maintain quality and enable statutory organisations to live within resources. >Participation in transformation programmes at system level to deliver improvements - for example Greater Huddersfield and Calderdale transformation programme has developed financial baseline which recognises commissioner and provider financial pressures and targets for the system including the local authorities. > Creating opportunities to reduce reliance on statutory sector through support to third sector providers e.g.through Creative Minds Strategy and Innovation Fund investment. > Development of ImROC implementation plan in parternship with service users to promote recovery e.g. Moorland Court development in Barnsley. [23/10/2012 10:36:51 Ros Taylor] Joint assessment of potential impact of LA partners through governance boards. Support to third sector providers through Creative Minds Strategy and Innovation Fund investment. BDU review of governance board position. Regular review with LA leads to monitor impact of changes. Annual plans and CIPs have been developed and agreed in context of CSR for 2012/13. Senior level dialogue with key local authority leaders to gather intelligence on likely impact in 2013/14 with development of a negotiated plan for 2013/14 by December 2012. Impact assessment for Barnsley BDU to evaluate notified changes in funding. Joint assessment of potential impact of LA partners through governance boards. Support to third sector providers through Creative Minds Strategy. BDU review of governance board position. Regular review with LA leads to monitor impact of changes. Annual plans and CIPs have been developed and agreed in context of CSR.		District Service Directors	Big ticket vision and plan in place by end of August 2013. System transformation programmes milestones in 2013-14	EMT (monthly) and Trust Board (monthly)	12	Amber/ high (8-12)	Yes		29/01/2013
462	Risk Assessment	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)				Risk that the expectations of emerging CCGs for mental health and community services will create a potential reputational and financial risk for the Trust.	> Clear accountability at BDU level for managing stakeholder relationships with support from Quality academy Directors through professional networks. >Agreed joint governance arrangements for management of service contracts > Review of contract and stakeholder issues monthly through EMT > Regular review by Board of effectiveness of stakeholder management.	5 Catastrophic	4 Likely	20	Red/extreme /SUI risk (15-25)	> Contract terms agreed for 5 out of 8 commissioners. Three outstaning issues which there are proposals being considered for resolution. > Using contract and quality Board meetings to forge relationships and better understanding with commissioners > Development of team to team meetings to strengthen partnership working >Development of marketing strategy to ensure good communication and understanding of service offer.		District Service Directors supported by CEO and quality academy directors		EMT (monthly) and Trust Board (quarterly)	16	Red/extreme /SUI risk (15-25)	Yes	[25/04/2013 11:00:58 Ros Taylor] Contracts signed before May 2013.	

Risk ID	Hist. Ref	Source	Risk Responsibility	BDU/Directorate	Service	Specialty	Description of risk	Current control measures	Consequence (Current)	Likelihood (Current)	Rating (current)	Risk level (current)	Summary of risk action plan	Fin cost (£)	Risk Owner	Expected date of completion	Monitoring & Reporting Requirements		Risk level (Target)	Is this rating acceptable?	Comments	Risk Review Date
463	Risk Assessment	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)				Risk that the planning and implementation of transformational change through the Big Ticket programmes will increase clincial and reputational risk in in year delivery by imbalance of staff skills and capacity between the "day job" and the "change job". Areas rated as red (Trust Board July 2013) currently are identified as adult mental health services, community mental health services and older people's services under the mental health strand; and the general community services strand. Mitigating action is in place to ensure the first key milestone of the end of August for an outline of the vision, implementation plan, timescales and key milestones.	> Scrutiny of performance dashboards and weekly risk reports by BDU s and EMT to ensure performance issues are picked up early. >Weekly risk review by Director of Nursing and Medical Director to ensure any emerging clinical risks are identified and mitigated. >Monthly performance review by Board > Clear accountability arrangements for leadership and milestones for the transformation programme which are monitored by Director of Service Development and EMT. >Engagement of extended EMT in managing and shaping transformational change and delivering in year performance.	5 Catastrophic	4 Likely	20	Red/extreme /SUI risk (15-25)	> Additional resouces and external consultancy recruited to support the transformation programme. > Key deliverables reviewed and monitored by EMT.	£500,000	Leads for Big ticket programmes Director of Service Improvement/ EMT - in year performance	Big ticket vision and plan in place by end of August 2013. System transformation programmes milestones in 2013-14	EMT (monthly) and Trust Board (quarterly)	16	Red/extreme /SUI risk (15-25)	Yes		
464	Risk Assessment	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)				Risk that the Trust does not have a clear marketing approach to enable it to maximise opportunities and mitigate threats in an increasingly competitive market.	>Develop a clear marketing and commercial approach within the organisation, building on existing arrangements. > Marketing approach reviewed and approved by Board and EMT	5 Catastrophic	3 Possible	15	Red/extreme /SUI risk (15-25)	> Enagement of specialist resource to shape marketing strategy > Report to Board April 2013 >Implementation plan in 2013-14 >Key intelligence and actions reflected in Monitor Plan (May 2013) IBP (October 2013). Branding policy agreed by EMT October 2013. CRM system specification and procurement November 2013 to March 2014	£100,000	CEO lead & EMT	First draft Monitor Plan May 2013 Implementation plan qtr one 2013 Final version stategy in IBP Oct 2013	Monthly strategic and business and risk EMT meetings. Trust Board reports as appropriate.	12	Amber/ high (8-12)	Yes		
520	Risk Assessment	Corporate/ organisation level risk (corporate use only EMT)	Specialist Services	Child and Adolescent Mental Health Services (CAMHS)	Child and Adolescent Mental Health Services - Calderdale and Kirklees		Children are potentially at serious risk due to lack of robust systems and processes to support safe pracice. These include timely access and responses, appropriate clinical interventions . The organisation is at risk from a reputational perspective whilst dealing and addressing issues of a historical nature	A number of plans have been put in place A recovery Plan to address the immediate concerns A chsnge managemnent plan to align the service to the requirements of the serive specification A longer term transformation plan	4 Major	3 Possible	12	Amber/ high (8-12)	THe implementation of thje recovery has beend devised in line with best prtactice and compliance requirements. Strict time scales are in place for delivery and it will be monitored at EMt and BDu level		Karen Taylor, BDU Director		Risks to be reviewed monthly at performance EMT. Ongoing review of frequency will be reviewed at performance EMT on 23 January 2014.			Yes		23/01/2014
522	Risk Assessment	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)				Changes to national funding arrangements i.e. CCG allocation, creation of integration fund and local initiatives e.g. revenue consequences of the Mid Yorks reconfiguration and local re tendering will increase the risk that in 2014-15 contracting round the monies prioritised by commissioners for SWYPFT services will increase the level of savings required to > 5.5% to maintain financial viability.	> Develop a clear service strategy through the internal Transformation Programmes to engage commissioners and service users on the value of services delivered. > Ensure appropriate SWYPFT participation in system transformation programmes. > Robust process of stakeholder engagement and management in place through EMT >Progress on Transformation reviewed by Board and EMT	5 Catastrophic	3 Possible	15	Red/extreme /SUI risk (15-25)	> Engagement of specialist resources to ensure Transformation work capacity in place. > EMT review of commissioner intentions and contract management > Key intelligence and actions reflected in Monitor plan (May 2013) IBP (October 2013)	£100,000	Deputy DCE lead & Directors	First draft Monitor plan February/March 2014. Implementation plan qtr one 2013. Updated version strategy in IBP Oct 2013	Monthly strategic and business and risk EMT meetings. Trust Board reports as appropriate. Business case for RAID approved by C&K commissioner. Wakedfield case submitted. Monthly at EMT and Trust Board 22 October 2013	12	Amber/ high (8-12)	Yes		28/01/2014
523	Risk Assessment	Corporate/ organisation level risk (corporate use only EMT)	Barnsley				Commissioning intentions of Barnsley CCG may lead to loss of contract for intermediate care and memory services representing a risk to the Trust's reputation, provision of a full pathway to service users and income / contribution.	Trust is working with commissioners to review the service specification. Trust is reviewing organisational arrangements for intermediate care to more closely align to district nurses and community matrons to ensure integration in pathways. Trust is working with Barnsley CCG to develop transformation programmes jointly.	4 Major	3 Possible	12	Amber/ high (8-12)	Agreement reached with commissioners to roll-over contract at end of March 2014. Trust will continue to work with commissioners on a revised service specification. As part of its transformation of general community services, intermediate care will be more closely aligned to district nurses and commununity matrons to ensure integration in service pathways. The Trust will continue to work with Barnsley CCG both to develop transformation programmes jointly and to ensure the Trust's own transformation programme meets commissioner needs and specification.	£5 / 6 million	District Service Director, Barnsley and Wakefield	September 2014	Monthly strategic and business and risk EMT meetings. Trust Board reports as appropriate. Monitoring of transformation programme progress.	12	Amber/ high (8-12)			28/01/2014
527	Risk Assessment	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)				Bed management pressures identified via whistle blowing to CQC with particular concerns raised re: admitting people to wards when no bed immediately available. Pressures across all bed based Mental Health areas across the Trust.	Revised bed management protocol. Review of above protocol underway. Patient flow system established in two BDU's with rest to follow. Linked to Acture Care Transformation Programme.	4 Major	4 Likely	16	Red/extreme /SUI risk (15-25)	Bed Management Protocol. Escalation process clear. Clinical Leadership involvement. Robust monitoring.		District Service Director	Reviewed Protocol February 2014	Monthly at EMT	12	Amber/ high (8-12)	Yes		27/02/2014
528	Risk Assessment	Finance	Trust wide (Corporate support services)	Finance	Receipt and payment of invoices	Finance and Procurement	Lack of assurance on operation of key controls for the ordering , receipting and payment of non-pay invoices increases the risk of inappropirate use of Trust resources with a consequent negative impact on the Trust final accoutns and Head on internal audit opinion for 2013-14	Procedures have been designed to ensure invoices only paid when goods receipted on the system . Investigation has suggested that these are being over ridden in some circumstances	4	5	20	Red/extreme /SUI risk (15-25)	Management action to identify those areas where controls had been over ridden and clear instructions given to staff on appropirate action - immediate on finding anomaly Independent investigation commisioned from internal audit to independently validate control issues and make recommendations. Internal audit report presented to Audit Committee July 2013 Management report to Audit Committee on action taken to date and action plan for future months - July 2013 Internal Audt review of finance function December 2013 including review of remedial action . All recommendations on target Jan 2014 - final report to Audit Committee April 2014	Cost within internal audit contract. No evidence of fraud or misuse of trust resources	Director of Finance	Audit report signed off Feb 2014.	Update to Performance EMT March on follow up actions and audit opinion. Weekly departmental review of progress against plan	12	Amber/ high (8-12)	Yes		20/02/2014