With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board Business and Risk (public session)
Tuesday 29 April 2014 at 9:30
Shibden room, 5th floor, F Mill, Dean Clough, Halifax

AGENDA

1. **Welcome, introduction and apologies**

2. **Declaration of interests**

3. **Minutes and matters arising from previous Trust Board meeting held on 25 March 2014**

4. **Audit Committee annual report to Trust Board**

5. **Stakeholder analysis**

6. **Delivery of the two-year operational plan 2014/15 to 2015/16** (verbal item)

7. **Performance reports month 12 2013/14**
   7.1 Section 1 – Quality performance report month 12 2013/14 (to follow)

   7.2 Section 2 – Finance report month 12 2013/14

   7.3 Section 3 – Strategic human resources report Q4 2013/14

   7.4 Exception reporting and action plans
   - (i) Risk assessment of performance targets, CQUINs and Monitor Risk Assessment Framework (to follow)
   - (ii) Equality report
   - (iii) Quarterly serious incidents report
   - (iv) Customer services quarterly report

8. **Monitor quarterly return and Trust Board self-certification**

9. Assurance Framework and organisational risk register

10. Date and time of next meeting

The next meeting of Trust Board will be held on Tuesday 24 June 2014 in Rooms 49/50, Folly Hall, Huddersfield.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Minutes of Trust Board meeting held on 25 March 2014

Present:	Ian Black	Chair
	Peter Aspinall	Non-Executive Director
	Bernard Fee	Non-Executive Director
	Julie Fox	Non-Executive Director
	Jonathan Jones	Non-Executive Director
	Helen Wollaston	Deputy Chair
	Steven Michael	Chief Executive
	Nisreen Booya	Medical Director
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Alan Davis	Director of Human Resources and Workforce Development
	Alex Farrell	Deputy Chief Executive/Director of Finance
In attendance:	Adrian Berry	Director, Forensic Services (from item 8.1)
	James Drury	Deputy Director, Strategic Planning (for item 8.1)
	Bronwyn Gill	Head of Communications
	Sean Rayner	District Director, Barnsley and Wakefield (from item 8.1)
	Diane Smith	Interim Director of Service Innovation and Health Intelligence
	Dawn Stephenson	Director of Corporate Development
	Karen Taylor	District Director, Calderdale and Kirklees (from item 8.1)
	Robert Toole	Deputy Director of Finance (to item 8.2)
	Bernie Cherriman-Sykes	Board Secretary (author)
Apologies:	None	

TB/14/09 Welcome, introduction and apologies (agenda item 1)

The Chair (IB) welcomed everyone to the meeting. He particularly welcomed Diane Smith (DSm), Interim Director of Service Innovation and Health Intelligence, attending her first meeting of Trust Board. Although a public Trust Board meeting, IB commented that no members of the public were present. He assured Trust Board that there had been the usual notification of the meeting in advance.

TB/14/10 Declaration of interests (agenda item 2)

The following declarations of interests were considered by Trust Board.

Name	Declaration
CHAIR	
Ian Black	Non-Executive Director, Benenden Healthcare (mutual) Non-Executive Director, Seedrs (with small shareholding) Private shareholding in Lloyds Banking Group PLC (retired member of staff) Chair, Family Fund (UK charity) Member, Advisory Group for the Point of Care Foundation's development of a report on health service leadership and management Member, Whiteknights, a charity delivering blood and organs on behalf of hospitals in West and North Yorkshire
NON-EXECUTIVE DIRECTORS	
Peter Aspinall	Director, Honley Show Society Ltd.
Bernard Fee	No interests declared
Julie Fox	No interests declared; however, does work with the Care Quality Commission in work and inspection with children and young people who offend and child protection issues. This is

Name	Declaration
	not likely to conflict with the non-executive director role.
Jonathan Jones	Member, Squire Sanders (UK) LLP Member, Squire Sanders MENA LLP Spouse, shareholder in Barcelona Hold Co (holding company of Zenith Vehicle Contract Limited)
Helen Wollaston	Director, Equal to the Occasion (consultancy) Director, WISE (Women in Science and Engineering) Partner is Fitness to Practice Panellist with the Medical Practitioners' Tribunal Service
CHIEF EXECUTIVE	
Steven Michael	Member of Huddersfield University Business School Advisory Board Member, Leeds University International Fellowship Scheme Partner, NHS Interim Management and Support Trustee, Spectrum People NHS Confederation selected Chief Executive representative, Mental Health Network Board Health and Wellbeing Boards, Wakefield and Barnsley Involvement in Care Quality Commission mental health inspection arrangements
EXECUTIVE DIRECTORS	
Nisreen Booya	Honorary President of the Support to Recovery (Kirklees mental health charity) Appointed member, Yorkshire and Humber clinical senate, providing independent source of clinical advice for Yorkshire and the Humber Involvement in Care Quality Commission mental health inspection arrangements
Tim Breedon	No interests declared
Alan Davis	No interests declared
Alex Farrell	Spouse is General Practitioner based in Beeston, Leeds
OTHER DIRECTORS	
Adrian Berry	No interests declared
Sean Rayner	Member, Independent Monitoring Board for HMP Wealstun Trustee, Barnsley Premier Leisure
Diane Smith	No interests declared
Dawn Stephenson	Voluntary Trustee for Kirklees Active Leisure
Karen Taylor	Trustee, Barnsley Hospice

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

TB/14/11 Minutes of and matters arising from the Trust Board meeting held on 28 January 2014 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held on 28 January 2014 as a true and accurate record of the meeting.

There was one matter arising.

TB/13/67 Specialist services commissioning The Chief Executive (SM) informed Trust Board that a letter has been sent on behalf of clinical leads and Chief Executives from forensic providers in northern England to NHS England. Contact has been made by Richard Barker,

Head of Commissioning at NHS England in the north; however, NHS England appears to be keeping to its position on differential commissioning. Bernard Fee (BF) asked that the Trust agrees a contingency plan, particularly given the amount of investment in and development of forensic services, if the commissioning position changes significantly from the current, public plans.

TB/14/12 Assurance from Trust Board Committees (agenda item 4)

TB/14/12a Audit Committee 21 January 2014 (agenda item 4.1)

Peter Aspinall (PA) drew Trust Board's attention to page 6 of the minutes, which referred to an audit of financial management arrangements, including a review of the Trust's progress against the recommendations from the internal audit report on procurement (non-pay purchasing). This was likely to provide a substantial assurance opinion with no significant risks to report. As a result, KPMG has confirmed that a substantial opinion for core controls of financial management would support a clean Head of Internal Audit Opinion.

He also commented on an early stage internal audit report on data quality, which shows some progress with other areas requiring attention. The Committee will consider the report at its meeting on 8 April 2014.

TB/14/12b Clinical Governance and Clinical Safety Committee 11 February 2014 (agenda item 4.2)

Helen Wollaston (HW) raised two issues. The last meeting demonstrated the need for operational input to items on the agenda. BDU Directors will be invited to attend meetings in future. She also commented on the item on page 7 of the minutes in relation to service users into employment. The paper presented resulted in a lengthy discussion at the meeting and is an issue of concern for the Committee. The Trust's approach will be picked up through the transformation programme and development of the recovery college approach.

TB/14/12c Mental Health Act Committee 25 February 2014 (agenda item 4.3)

Julie Fox (JF) commented on four issues in relation to the e-learning package for the Mental Health and Mental Capacity Acts, which has potential for income generation, the progress on refurbishment of seclusion rooms, the Care Quality Commission's (CQC) focus on community services, and the review of the capacity of Section 136 suites, which has arisen as a result of the Crisis Concordat issued by the Department of Health.

IB asked if the attendance of local authority representatives gave cause for concern. JF responded that there had been changes to local authority representation and it has been suggested that, if a representative cannot attend, they should send a brief report to the meeting.

TB/14/12d Remuneration and Terms of Service Committee 4 February 2014 (agenda item 4.4)

SM updated on a key item for the Committee in relation to performance against the gateway objectives for Directors. BF commented that Trust Board should consider the Government's position on pay in the NHS in general when determining Director and senior level pay.

TB/14/13 Chief Executive's report (agenda item 5)

SM reported on the following.

- The Strategic Outline Case in Calderdale and Greater Huddersfield is currently with clinical commissioning groups for public engagement and consultation. Regular updates will be provided to Trust Board within the project framework. The Secretary of State has

responded to the proposed transformation work in Wakefield and North Kirklees, 'Meeting the Challenge', and given conditional approval with a number of reservations regarding the provision of community services as alternatives to hospital provision. The Trust is a joint signatory and is involved in different parts of the project, including mental health, which is linked to the Trust's transformation programme, and care closer to home. SM commented that clarity on who is leading the programme is needed to ensure it covers the health economy in Wakefield and North Kirklees. The Trust also remains involved in the integrated health and social care pilot in Barnsley, which is one of the 'Pioneer' sites as part of the Government's policy to support the implementation of integrated services. Joint work has also been agreed with Barnsley Hospital NHS Foundation Trust on provider contribution to the Better Care Fund.

- Both he and Nisreen Booya (NHB) have been involved in the CQC's first wave inspections. Trust Board were interested in and would welcome further information and discussion time on the Trust's approach and how it can learn from others' experience.
- SM also commented on the review of the Trust's rehabilitation and recovery services by Mental Health Concern, mental health currency and parity of esteem for mental health.

TB/14/14 Strategic delivery framework and corporate objectives 2014/15 (agenda item 6)

SM commented that development of the strategic framework builds on the work done at the strategy session in February 2014 and clearly sets out the mission, values, high level objectives (both delivery and organisational development) and key performance indicators (both delivery and organisational development). The key performance indicators will be further reviewed and refined to ensure they are measurable. JF commented that she thought this was a good, clear framework but would like to see the Trust aspire to do the 'day job' excellently not just well and for the strategic objectives to focus more on outcomes.

It was RESOLVED to APPROVE the strategic framework and underpinning delivery and organisational development objectives. There will be a further refinement to form the basis of the Board assurance framework for Trust Board in July 2014.

TB/14/15 Performance reports month 11 2013/14 (agenda item 7)

TB/14/15a Performance report (item 7.1)

Alex Farrell (AF) highlighted the following.

- There is a trajectory of improvement for data quality issues around clinical recording, care programme approach and CQUINs in relation to routine access and gatekept admissions; however, this needs to continue in 2014/15 as it will have an impact on the Trust's income position.
- The pressure on beds continues as evidenced by the level of out-of-area placements; however, the introduction of patient flow co-ordination has reduced the need to outsource beds. Again, this will have an impact next year on the Trust's financial position if not managed closely.

JF asked why the indicator for service users into employment was reported as green with an assurance level of 4 given the underperformance and concerns raised at the Clinical Governance and Clinical Safety Committee. It was agreed the indicator should be rated red. SM asked when performance triggers an in-depth report to a Committee or Trust Board. Tim Breedon (TB) responded that, following the concerns expressed at the Clinical Governance and Clinical Safety Committee, a further review of what action the Trust can take to support and facilitate service users into employment should be taken to the Committee in June 2014 and, if necessary, escalated to Trust Board in July 2014. A session was suggested at the

May strategy meeting on the recovery model, the shift in emphasis to self-care and the shift to the Trust being a recovery-based organisation. This should include an understanding of the labour market, which does present difficulties for service users seeking employment.

TB/14/15b Finance report month 11 2013/14 (item 7.2)
AF highlighted the following.

- Confirmation that planning permission for Aberford Field will not be realised in this financial year has resulted in a surplus reduction of £1.3 million. To balance this, a sum of £1 million has been released from the provision for ongoing re-structuring costs in 2013/14. The positive impact of the revaluation of the land is expected to materialise in 2014/15 and is reflected in the revised financial plan.
- The Trust is £1.7 million adrift on its cost improvement programme; however, non-recurrent mitigation has been identified by BDUs, which will be reflected recurrently in 2014/15.
- The report contains information on Monitor benchmarking. BF asked if the worsening position of acute trusts would affect the nature of the partnerships the Trust enters into. AF responded that the Trust is very aware of the position and will seek to protect the services it provides when considering or entering into any partnership. IB also pointed out that the worsening position is across the sector, not just acute trusts.
- The Trust is on target to achieve the revised capital plan.
- Robert Toole (RT) commented that the Trust is incurring considerable costs in relation to out-of-area placements, which is presenting a cost pressure for 2014/15. Effective bed management internally will become increasingly important in the coming year.

TB/14/15c Exception reports and action plans – Information Governance 2013/14 (item 7.3(i))
AF confirmed that the Trust has achieved level 2 for the Information Governance Toolkit, which is supported by internal audit and will be presented to the Audit Committee in April 2014, and has achieved the 95% training target. HW asked if more effort will be put into 'phasing' the training in 2014. AF responded that BDUs are actively trying to manage this and it is hoped to implement a phased performance next year.

It was RESOLVED to NOTE the position in relation to information governance and APPROVE the submission of the Toolkit outcome for 2013/14.

TB/14/15d Exception reports and action plans – Eliminating mixed sex accommodation – Trust compliance statement (item 7.3(ii))
It was RESOLVED to APPROVE the compliance declaration.

TB/14/16 Governance issues (agenda item 8)

TB/14/16a Annual planning and budget setting 2014/15 to 2015/16 (item 8.1)
Trust Board received an update on the development and content of the two-year operational plan, including:

- annual planning requirements;
- six key aspects for future delivery;
- key points in the plan for 2014/15 to 2015/16 around doing the 'day job' well, delivering transformation and managing partnerships;
- timescales;
- workforce;
- capital expenditure;
- financial position;
- service developments and cost pressures; and
- quality improvements and efficiency savings.

It was agreed that there would be a session for Trust Board in advance of the meeting in June 2014 to consider the detail of the five-year strategic plan and subsequent submission to Monitor.

IB referred to the rigorous process undertaken prior to Trust Board, particularly the session held the previous week, led by AF. Trust Board provided robust challenge in a number of areas focussing on:

- the cost improvement programme, the timescales for achievement and the feasibility of achieving such as challenging programme;
- the Quality Impact Assessments undertaken to assess risk to services and the assurance this process provides to Trust Board;
- the Trust's transformation programme and how and when it would produce the service changes and efficiencies needed for future years;
- workforce efficiencies and changes required to support transformation;
- the Trust's proposed capital programme to support service transformation;
- how Trust Board would receive assurance that the plan was deliverable.

BDU Directors provided assurance on delivery of the plan and it was agreed that there would be robust and close monitoring by Trust Board of delivery in 2014/15 through the performance and finance reports.

The Chair asked for a formal vote on this item and **it was unanimously RESOLVED to:**

- **APPROVE the annual budget for the two-year submission to Monitor for 2014/15 to 2015/16;**
- **DELEGATE authority to agree any refinement needed in relation to workforce numbers and additional costs of impairments prior to the submission date of 4 April 2014 to the Chair and Chief Executive;**
- **APPROVE the annual budget for 2014/15;**
- **APPROVE the summary annual plan submission to Monitor;**
- **APPROVE the allocation of capital funding for 2014/15; and**
- **RECEIVE the outcome of an independent review of the Trust's plans for implementation at April's meeting.**

TB/14/16b Annual Governance Statement (item 8.2)

It was RESOLVED to APPROVE the Annual Governance Statement for 2013/14 and to DELEGATE authority to the Audit Committee to approve the final version as part of its approval of the annual report and accounts for 2013/14 on 23 May 2014.

TB/14/16c Monitor Code of Governance (item 8.3)

It was RESOLVED to RECEIVE the self-assessment and CONFIRM that it provides assurance that processes are in place to ensure the Trust complies with the Monitor Code of Governance.

TB/14/16d Monitor Licence (item 8.4)

It was RESOLVED to CONFIRM that the report provides assurance that the Trust is complying with its Licence conditions. The implications for the Trust as being a Licence holder were noted.

TB/14/17 Use of Trust seal (agenda item 9)

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

TB/14/18 Date and time of next meeting (agenda item 10)

The next meeting of Trust Board will be held on Tuesday 29 April 2014 in the Shibden room, 5th floor, F Mill, Dean Clough, Halifax. He also highlighted the Members' Council meeting on 30 April 2014 at 13:00 in the legends suite, Barnsley Football Club, and the role of Non-Executive Directors in the discussion item.

Signed …… Date ……

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 29 April 2014
Agenda item 4

Title:	**Audit Committee annual report to Trust Board 2013/14**
Paper prepared by:	Chair of Audit Committee
Purpose:	The purpose of this paper is to provide assurance to Trust Board that its Committees operate effectively and meet the requirements of the terms of reference.
Mission/values:	A strong and effective Board and Committee structure enables the Trust to achieve its vision and goals, and maintain a sustainable and viable organisation.
Any background papers/ previously considered by:	The Audit Committee received annual reports from Trust Board Committees as well as considering its own report at its meeting on 8 April 2014.
Executive summary:	The Audit Committee is required under its terms of reference to review other risk Committees' effectiveness and integration to provide assurance to Trust Board that risk is effectively managed and mitigated within the organisation, that Committees are fulfilling their terms of reference, and that integration between Committees avoids duplication. The Committee agreed to combine this process with the production of the Annual Governance Statement (AGS). Trust Board Committees are responsible for scrutiny and providing assurance to Trust Board on key issues within their terms of reference. Agendas are set to enable Trust Board to be assured that scrutiny processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk. As part of this process of assurance to Trust Board and as part of development of the AGS annually, Trust Board Committees are required to produce an annual report and an annual workplan, undertake an annual self-assessment, and review their terms of reference for relevance and appropriateness. The Audit Committee received the annual report from each Committee and its forward work programme at its meeting on 8 April 2014, supported by a short presentation from each Committee Chair and Lead Director to provide assurance to the Committee on the assurance each Committee has provided to Trust Board in terms of meeting its terms of reference, in identifying and mitigating risk, and in integrating with other Committees. A summary is contained in the Audit Committee annual report. There were no changes to the terms of reference for the Committees; however, references under counter fraud were changed to refer to NHS Protect. The individual Committee annual reports and work programmes have been approved by the relevant Committee and were presented to the Audit Committee. These are available for Trust Board if required. Overall the review of the documents and presentation of the work of the Committees was sufficient to enable the Chair of the Audit Committee to support an assurance to Trust Board that the integrated governance

	arrangements in the Trust were operating effectively and that Committees: ➢ had met the requirements of the Terms of Reference; ➢ had followed a workplan aligned to the risks and objectives of the organisation, within the scope of its remit; and ➢ could demonstrate added value to the organisation.
Recommendation:	**Trust Board is asked to RECEIVE the annual report from the Audit Committee and to SUPPORT the view that the Committee can provide assurance that, in terms of the effectiveness and integration of risk Committees, risk is effectively managed and mitigated through assurance that Committees meet the requirements of their Terms of Reference, that Committee workplans are aligned to the risks and objectives of the organisation, which would be in the scope of their remit, and that Committees can demonstrate added value to the organisation.**
Private session:	Not applicable

Audit Committee Annual Report 2013/14
Trust Board 29 April 2014

1. Purpose of Report

The purpose of the report is to provide a summary of the Committee's activities during the financial year 2013/14 in order to evidence the effectiveness and impact of the Committee by demonstrating compliance with its Terms of Reference.

2. Background

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

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

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

The Committee is made up of Non-Executive Directors and members from April 2013 to March 2014 were Peter Aspinall (Chair), Bernard Fee and Jonathan Jones. During a three-month sabbatical period from June to September, Jonathan Jones's place on the Committee was taken by Ian Black given his previous experience on the Committee.

3. Review of Committee Activities

The activities during the year have been cross referenced to the purpose of the group as outlined in the Terms of Reference below.

3.1 Internal Audit

The Committee shall ensure that there is an effective internal audit function, established by management, that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board as follows.

	Progress
Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.	Following a robust tendering process, KPMG was awarded the internal audit service contract from 1 July 2012 for a period of three years.
Review and approval of the Internal Audit strategy, programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.	A draft Internal Audit Annual Plan for 2013/14 was presented to and agreed by the Audit Committee in April 2013. Final approval of the plan was given in May 2013. The plan provides a risk-based analysis of the Trust's operations, utilising the Trust Board assurance framework, reflecting the Trust's corporate objectives, priorities and areas identified for improvement. Progress against the plan is reviewed at every meeting and this includes reports on the Trust's progress against actions identified to address recommendations made by KPMG. Regular meetings are held with the Director of Finance to monitor progress against the work plan.
Consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources.	The Committee receives audit reports and audit findings in line with the audit plan. The recommendations are followed up to ensure actions are taken in line with the action plans agreed. To January 2014, 19 internal audit reports were presented to the Committee. Of these, there were: - no full assurance opinions; - eight substantial assurance opinions; - seven moderate assurance opinions; - three limited assurance reports (adult safeguarding, clinical record keeping (data quality) and service level agreement management (non-healthcare); and - one no assurance opinion in relation to procurement (non-pay) purchasing (see below). A limited assurance opinion was also given to a follow up report on the stewardship of financial affairs of patients. Three reports were advisory in relation to commercial strategy, clinical leadership and self-directed support. One report was the result of an investigation into a possible breach of Standing Orders (see below). Management action has been agreed for all recommended actions, reported to the Committee and, where appropriate, progressed by KPMG. In the main, there are no significant outstanding actions although the Director of Finance has agreed to review the recommendations in relation to the change management programme for continued relevance. The Audit Committee reviewed and received the Head of Internal Audit Opinion as part of the final accounts process for 2012/13.
Ensure the Internal Audit function is adequately resourced and has appropriate standing in the organisation.	The ongoing adequacy of resources is assessed through review of the internal audit plan and monitoring rate of achievement. No significant issues have been raised in-year although some issues have been raised by the Director of Finance in relation to the planning of audit work

	Progress
	by KPMG.
An annual review of the effectiveness of internal audit.	KPMG has identified a number of performance areas against which the Committee can assess its performance and the timing of this assessment will be agreed with the Chair of the Committee.

3.2 Counter Fraud

The Committee shall ensure that there is an effective counter fraud service, established by management, that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.

	Progress
Consideration of the provision of the Counter Fraud service, the cost of the audit and any questions of resignation and dismissal.	Following a robust tendering process, KPMG was awarded the internal audit service contract from 1 July 2012 for a period of three years. This includes the provision for counter fraud services.
Review and approval of the Counter Fraud strategy, programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.	KPMG presented a programme of work to the Committee in April 2013, which was approved. Progress against plan is reviewed at every meeting. The Committee received an annual report for 2012/13 in July 2013.
Consideration of the major findings of Counter Fraud (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources.	The Committee receives the Counter Fraud update report at each meeting to identify progress and any significant issues for action. The work of Counter Fraud is summarised in the annual report. A report on a risk assessment of the Trust's response to the Bribery Act 2010 was presented to the Committee in October 2013. The assessment concluded that the Trust has comprehensive and up-to-date policies and procedures in place to govern appropriate business behaviour. Ten recommendations were made, of which three are high priority, and these will be taken forward by the appropriate Director lead. The Trust was also one of a number of Trusts chosen by NHS Protect for a focussed counter fraud assessment and the assessment focussed on the area of 'Inform and Involve'. The findings of this assessment were reported to the Committee in January 2014. The Trust received an amber rating with the overall quality assessment rating red. The Trust was found to partially meet two standards and to not meet two others. A number of recommendations were made, including reviewing and publicising the anti-fraud, bribery and corruption policy, obtaining staff feedback from induction and awareness training, structured liaison with other agencies and updating the organisations Code of Conduct ensuring that fraud and corruption issues are covered. These recommendations have now been addressed and the Local Counter Fraud Specialist will work with the Trust to continue to improve the quality assessment rating.
An annual review of the effectiveness of Counter	Based on the self-review toolkit, the Trust is rated

	Progress
Fraud Services.	overall as green with one area, inform and involve, where further work can be done to improve against the standard, rated as amber (see above).

3.3 External Audit

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

	Progress
Consideration of the appointment and performance of the External Auditor, as far as Monitor's rules permit.	Deloitte was awarded a three-year contract in October 2010. At its meeting in April 2013, the Audit Committee considered the appointment of the Trust's external auditor given the expiry of the current contract on 30 September 2013. The Director of Finance proposed that the Committee considered re-appointing Deloitte as the overall service levels received and client management were considered to be very good. Based on a recent tender evaluation for professional services, its audit fee represented good value for money. The Head of Procurement confirmed that there was an option in the original tender to re-appoint Deloitte for up to two years and the Committee agreed to propose to the Members' Council an extension for two years. This was subject to a positive response from Deloitte in relation to its fees over this period, which was received. The Members' Council approved the proposal at its meeting in July 2013.
Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy.	The Audit Committee has received and approved the Annual Audit Plan (January 2014). Progress against plan is monitored at each meeting.
Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.	The Audit Plan and fee for Deloitte was approved as part of the re-appointment process during 2013. As part of the negotiation of the fee during this process, the Trust received a reduction in the fee level to reflect that there was no requirement for Deloitte to incur tending or marketing expenditure for retention of the Trust's contract. A formal plan and fee proposal was presented to and approved by the Committee in January 2014.
Review all External Audit reports, including agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.	The Audit Committee received and approved: ➢ the statement for those with responsibility for governance in relation to 2012/13 accounts; ➢ final reports and recommendations as scheduled in the annual plan.

<u>External audit key performance indicators</u>

The lead director has considered a number of measures that could be used as indicators to review the performance of the external audit function.

- Evidence of Professional capacity and relevant experience
  Very good

Deloitte has provided evidence of its professional standing and experience in providing external audit to foundation trusts.

- Evidence of quality assurance in undertaking the duties of external audit.
  Very good
  Deloitte has provided evidence of the quality assurance process it undertakes to ensure consistency and quality in documents and advice prepared for clients.
- Client Relationship
  Very good
  Deloitte has been proactive in client management and impartial and professional in the advice it has given. Final accounts have been completed on time in challenging timescales through continued good working relationships at team level.
- Innovative Practice and development
  Very good
  The Trust has commissioned Deloitte for work outside the external audit brief, for example, due diligence for iThinksmarter and Altogether Better, vehicle structure and accounting advice for Creative Minds, strategy and market analysis support for forensics, and advice and support in letting the Trust's IT contract.
- Added value to the organisation
  Very good
  As well as the above additional work, Deloitte has worked closely with the Trust to improve the format, presentation and content of its Quality Accounts and Deloitte's work in this area and on the annual accounts has identified a number of areas for improvement. Deloitte has also worked with the finance team to improve the efficiency of year-end reporting processes and proactively engaged with the Trust around emerging technical issues, such as consolidation of charitable funds, estates revaluation and the St. Luke's site agreement.

The Members' Council approved a recommendation to re-appoint Deloitte as the Trust's external auditors for a further two years from 1 October 2013. As part of the negotiation of the fee during the re-appointment process, the Trust received a reduction in the fee level to reflect that there was no requirement for Deloitte to incur tending or marketing expenditure for retention of the Trust's contract.

4. Other Governance Duties

4.1 Standing Items for each Meeting

The Committee has reported on the following as standing items at each meeting to provide assurance to the Board that the Trust has complied with Trust regulations and Standing Orders.

- Review of internal audit progress reports.
- Review of losses and special payments.
- Review of counter fraud progress report.
- Review of external audit activity.
- Treasury management report.
- Procurement report, which monitors non-pay spend and progress on tenders.
- Triangulation report of risk, performance and governance.
- Review of progress towards implementation of service line reporting and currency development.

The Committee is also required to receive a report on any waiver of Standing Orders. Any waivers in relation to procurement are reported at each meeting through the procurement report and considered by the Committee. During 2013/14, there have been no other waivers of the Standing Orders.

As part of its regular review of Treasury Management, the Committee reviewed the Treasury Management Strategy and Policy and recommended its approval to Trust Board in December 2013. It also considered the Trust's working capital facility and, following a change in the methodology to assess financial risk within foundation trusts by Monitor, it recommended to Trust Board that the Trust ends its facility from October 2013. This was also approved by Trust Board.

4.2 Ad-hoc items

KPMG was asked to review an investigation previously undertaken by West Yorkshire Audit Consortium and reported to the Audit Committee in October 2012 to establish if a breach of Standing Orders had occurred as the previous report was inconclusive. KPMG reported its findings to the Committee in July 2013. KPMG found that there was no definitive evidence that Standing Orders and procurement procedures had been breached; however, it was apparent that they had been misinterpreted by senior staff who, if they had checked and clarified their assumptions, should have taken different actions. A further, independent review was commissioned by the Director of Corporate Development in her role as Company Secretary and presented to the Committee in October 2013. This resulted in the no assurance opinion on the Trust's procurement (non-pay) purchasing. The Committee sought robust assurance in relation to management's response to the findings and noted that the no assurance opinion could affect the Head of Internal Audit Opinion at the year-end. KPMG would also expect to see reference in the Chief Executive's Annual Governance Statement.

An audit of financial management undertaken in late 2013/early 2014 provided a preliminary substantial assurance audit opinion. This audit included a robust review of the Trust's implementation of the recommendations arising from the procurement (non-pay) purchasing audit. Subject to confirmation that this audit has produced a substantial opinion, KPMG would expect to be able to provide a clean Head of Audit Opinion for 2013/14.

5. Annual Items

In discharging its duties in relation to financial reporting the Committee has received the following reports as part of its remit.

- Received and approved annual report, annual accounts and Quality Accounts for 2012/13 and received and approved the annual accounts and annual report for Charitable Funds for 2012/13.
- Received the report from External Audit for those charged with governance, which outlines findings of external audit.
- Reviewed the external audit report on the production of Quality Accounts for 2012/13. The scrutiny of the Quality Accounts themselves is a responsibility of the Clinical Governance and Clinical Safety Committee.
- Reviewed the Use of Resources Assessment for 2012/13.
- Reviewed and approved changes to the Trust's Accounting Policies.
- Reviewed the process for the development of the Assurance Framework.
- Reviewed the Procurement Strategy, priorities and progress against achievement of cost savings.
- Received a report on the Transforming Community Services process in terms of realization of benefits and lessons to be learned for the Trust's future strategic approach.
- Considered the external agencies annual report for 2013/13 for assurance that the Trust acts on reports, etc. received.
- Reviewed the governance and assurance arrangements for the Trust's Creative Minds activity.

- Received a report on an audit of mental health joint working arrangements undertaken by Wakefield Council.

6. Governance Assurance

Effectiveness of Trust Board Committees

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

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

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

Each Committee has Terms of Reference and is required to produce an annual report outlining the achievements against objectives and compliance with Terms of Reference. The Committee reviewed its own annual report, work programme and terms of reference at its meeting in January 2014. No changes were made to the terms of reference as a result of the review.

Consideration has also been given whether the Charitable Funds Committee should be included in this assessment particularly as charitable funds now incorporates exchequer funds in addition to donations, which is reflected in the heightened interest of the Audit Committee. On balance, it was generally agreed that the Committee already has a robust process in place in terms of a review of its activities through presentation of its annual report and accounts annually to both the Audit Committee and Trust Board, and the quarterly meeting of the Corporate Trustee for the charitable funds. Any changes to the Committee's terms of reference require the approval of Trust Board and it has been agreed that the Director of Finance will review the delegated limits for the Committee for approval by Trust Board.

The Audit Committee reviewed Committee annual reports, annual work programmes and the outcome of self-assessments on 8 April 2014 for 2013/14. The purpose of the review is for the Audit Committee to provide assurance to Trust Board that:

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

The review was undertaken as part of formal Audit Committee business with Committee Chairs and key Committee members invited to present. The Audit Committee received the annual report from each Committee and forward work programmes.

Audit Committee

Chair – Peter Aspinall; Lead Director – Alex Farrell

The Committee met its Terms of Reference and developed a work plan to reflect the risks and objectives of the organisation. Any action required as a result of the self-assessment will be reviewed by the Committee in July 2014. A proposal from the Chair in relation to Committee training will be taken forward by Deloitte and KPMG. It was agreed to amend the terms of reference under counter fraud to refer to NHS Protect.

Clinical Governance and Clinical Safety Committee

Chair – Helen Wollaston; Lead Director – Tim Breedon

The Committee met its Terms of Reference and continued to develop its work programme throughout the year to reflect the risks and objectives of the organisation. A revised format covering four specific areas (standing items, assurance, key clinical risks and quality improvement) will be introduced for 2014/15. This reflects the wide scope of work within the Committee's remit and the need to balance scrutiny of improvement activity and monitoring of risk. There has been good attendance at the Committee throughout the year and, from April 2014, BDU Directors will be invited to attend to provide an operational perspective to issues on the Committee's agenda. The Quality Impact Assessment arrangements have been a key area for Committee scrutiny and monitoring throughout the year to provide assurance on the process and the impact on Trust services.

Mental Health Act Committee

Chair – Julie Fox; Lead Director – Tim Breedon

The Committee fulfilled its Terms of Reference and met its work programme over the year.

- Following feedback from the Hospital Managers' reviews, the Hospital Managers' Forum has been strengthened during the year and its role, remit and representation on the Committee clarified.
- The Committee commissioned and received reports on the outcome of Section 17 and Section 132 audits. Action in relation to both is monitored through the Committee.
- Clinically-led presentations at the start of each meeting bring the Mental Health Act to life for the Committee through clinicians explaining how the Act works in practice.
- There has been significant improvement in the way the Trust implements actions arising from Care Quality Commission Mental Health Act visits as a result of the Committee's challenge and scrutiny.
- Further work will be undertaken in 2014/15 on interpretation and analysis of data to build on progress during the year.

Remuneration and Terms of Service Committee

Chair – Ian Black; Lead Director – Alan Davis

The Committee met its terms of reference and fulfilled its work programme for the year. The programme is reviewed regularly by the Chair of the Committee to ensure it reflects the risks and objectives of the organisation and that the Committee adds value. One member of the Committee took a sabbatical during the year. Although the Committee did meet during this time, the meeting was quorate and the Non-Executive Director concerned was given the opportunity to provide comments on the items considered at the meeting.

In relation to training for members of this Committee, it was felt that there was no requirement for current members; however, this would change should the membership of the Committee change. Papers were now circulated in a timely way.

All Committees will review the outcomes of their self-assessments at some point in the coming year and it was agreed that these would be scheduled into forthcoming agendas.

Summary

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

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

- could demonstrate added value to the organisation.

The review by the Committee also informs the Accounting Officer's Annual Governance Statement, which provides assurance that risk is managed within the organisation.

Internal audit of corporate governance arrangements

An internal audit of corporate governance arrangements was undertaken by KPMG in autumn 2013 and reported to the Committee in October 2013 and Trust Board in December 2013. The audit focussed on progress against recommendations in the previous year and on the Mental Health Act Committee. An opinion of substantial assurance was given. The following were noted in relation to the Mental Health Act Committee.

- The recommendation to review and rationalise the membership had been undertaken by the Chair. This had improved the contributions of all attendees and discussions and decisions were more focused as a result.
- The Committee was found to be acting fully within the requirements of its terms of reference.
- The review of the Committee's annual report and work programme showed that agenda items and planned discussions were in line with its terms of reference.

Three low priority recommendations were made. The audit provides further assurance for Trust Board of the effectiveness and impact of its Committees in meeting their terms of reference.

1. Approval of a change to the Committee's terms of reference by Trust Board was not formally minuted. The Trust has accepted the observation and will ensure in future that approval (or otherwise) of changes is recorded in Trust Board minutes.
2. In relation to quoracy of meetings, the Trust accepted the observation that one meeting was not quorate. Whilst every effort is made to ensure meetings are organised to enable all Committee members to attend and that sufficient notice is given of Committee meeting dates, priorities can and do change and, on rare occasions, this will happen too close to a meeting to enable deferment. The Chair makes the decision whether to continue with the meeting or not. The suggestion of identifying deputies was noted and again considered. The specialist knowledge to understand a Committee's work and the span of Executive Director portfolios makes it difficult to identify deputies to cover the business of the Committee effectively. The observation regarding decisions being taken whilst the Committee was inquorate was also noted.
3. KPMG also recommended consideration of a Trust Board-type cover sheet for Committees. It has been agreed with the Director of Corporate Development that this is not a practical solution for Committees. However, both the Audit and Clinical Governance and Clinical Safety Committees have a cover sheet for each item, clearly indicating the agenda item number, the title of the item and what the Committee is asked to do. This will be replicated for the Mental Health Act Committee from February 2014. Where an item is not covered by a paper, it will be made clear on the agenda that it is a verbal item. Advice will also be given to authors of papers to ensure a clear purpose is set out at the beginning of any paper and a clear indication given of what is required of the Committee.

7. Review of Committee administrative arrangements

The Committee meets the minimum requirement for the number of meetings in the year and has been quorate at each meeting. The requirement to send papers out six clear days in advance of the meeting has been met throughout the year. There have been some

instances where individual papers have, with agreement, been sent out after this requirement.

8. Self Assessment

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

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

From the feedback received the majority of areas were assessed as compliant. The key comments/findings were as follows.

Composition, establishment and duties

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

Whilst some training is available none yet has been specific to the Audit Committee. The Committee has discussed this issue and KPMG and Deloitte have agreed to provide appropriate training.

Compliance with the law and regulations governing the NHS

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

A comment was made regarding awareness of whether this had been discussed or not. This was a matter for consideration for Trust Board during the application for Foundation Trust status and the decision taken that, given the experience and knowledge within the Trust, the Company Secretary role would be included in the Director of Corporate Development's portfolio.

Internal audit

Has the Committee established a process whereby it reviews any material objection to the plans and associated assignments that cannot be resolved through negotiation?

A negative response was given to this question by one Committee member. Further collaborative work has been undertaken to develop a definition of robust mutual expectations, including protocols, scoping, performance measurement and tracking.

Other issues

Has the Committee considered the costs that it incurs and are the costs appropriate to the perceived risks and benefits?

A negative response was given to this question by one Committee member.

Does the Committee assess its own effectiveness periodically?

A comment was made that, although this is done, the Committee could probably do this better.

9. Conclusion

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

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

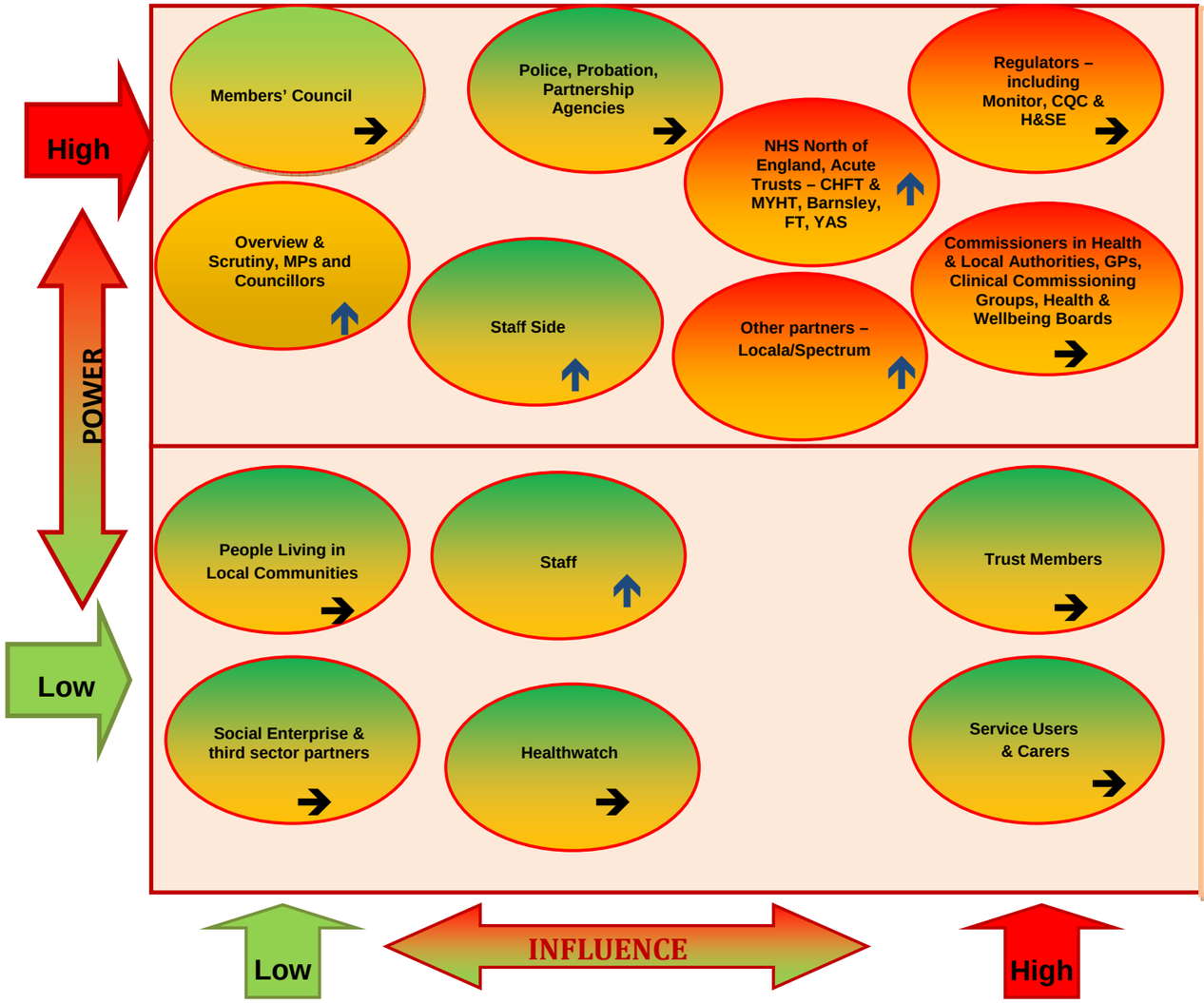
Trust Board 30 April 2013
Agenda item 5

Title:	**Stakeholder Analysis**
Paper prepared by:	Director of Corporate Development
Purpose:	To update Trust Board on the current stakeholder position
Mission/values:	Identifies potential risks around key stakeholder relationships that may impact on delivery of corporate objectives and delivery of Trusts Mission.
Any background papers/ previously considered by:	Previous stakeholder analysis presented to Trust Board.
Executive summary:	The Executive Management Team undertakes a routine review of key internal and external stakeholders in terms of power and influence, and potential risk to delivery of corporate objectives, identifying potential risks and where relationships need further attention and focused engagement. Key issues ➢ Impact of delivery of transformation plans on staff morale and potential impact on delivery of services mitigated by BDU staff road shows led by BDU Directors and the Chief Executive planned during May 2014 and regular monthly meetings with Staff Side. ➢ Ongoing compliance and regulatory scrutiny Monitor/Care Quality Commission mitigated by operational delivery of two-year operational plan, whilst maintaining safe services driven through weekly Operational Requirement Group meetings chaired by Chief Executive. ➢ Impact of specialist commissioning review on income streams mitigated by ongoing meetings with commissioners highlighting potential impact on services. ➢ Relationship management mitigated by ongoing dialogue with local authority Overview and Scrutiny Committees regarding service transformation and Strategic Outline Case. ➢ Team-to-team meetings held with other providers to discuss key issues and risks and joint working opportunities.
Recommendation:	**Trust Board is asked to note the update, issues arising and mitigating action being taken.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Stakeholder Analysis – Power/Influence Matrix (April 2014)



- **Key**

Rag Rating
Red – needs further attention/engagement
Amber – Relationships reasonable, develop engagement.
Green – Relationships working well, keep engaged.
Review
Review at Business and Risk Executive Management Team Meeting
Link to transformation plan, communication and engagement.

Note – Impact:
➔staying about the same
🡅increasing
🡇 decreasing

Key Issues - External

- On-going compliance - Monitor and CQC.
- Relationship management across all stakeholder groups.
- Clinical Commissioning Groups, disparate commissioning arrangements.
- BDU links to CCG's and GP's.
- Other party service reviews.
- Potential loss of funding from commissioners.
- Impact of AQP, new entrants, predatory nature social enterprises.
- Impact of recent court cases, safeguarding on reputation.

Key Issues - Internal

- Service transformation, emerging service models linked to workforce, use of IT and use of estate.
- Embedding new mission and values across the organisation.
- Delivery of CIP 14/15 and ability to maintain safe service delivery.
- On-going communication and engagement through staff briefing, team meetings, chief executive Road shows, weekly update intranet and internet.
- Staff side engagement.
- Leadership and development strategy and development opportunities.
- Impact of new Health and Social Care Bill on Members' Council over next 6 to 12 months
- Weak performance National Survey Care Planning/Care Reviews.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Finance Report

Month 12 2013 / 2014

TABLE OF CONTENTS

Strategic Overview

Key Financial Indicators 3

Income & Expenditure 4

Cost Improvement Programme 7

Monitor Risk Rating 11

Analysis of Expenditure by Type 12

Run Rate Information 13

Cash and Working Capital 14

Reconciliation of Actual Cash Flow to plan 15

Capital Programme 16

Balance Sheet 17

Better Payment Practice Code 18

Transparency Disclosure 19

Glossary of Terms & Definitions 20

Overall Financial Position

	Performance Indicator	Month 12 Performance	Annual Forecast	Trend from last month	Last 3 Months - Most recent			Assurance	Page
Trust Targets					**11**	**10**	**9**		
1	£3.7m Surplus on Income & Expenditure	●	●	⇔	●	●	●	4	*4 to 6*
2	Cash position equal to or ahead of plan	●	●	⇔	●	●	●	4	*14*
3	Capital Expenditure within 15% of plan.	●	●	⇔	●	●	●	4	*16*
4	In month delivery of recurrent CIPs	●	●	⇔	●	●	●	4	*7 to 10*
5	Monitor Risk Rating equal to or ahead of plan	●	●	⇔	●	●	●	4	*11*
6	In month Better Payment Practice Code	●	●	⇔	●	●	●	4	*18*

Summary Financial Performance

1. The year end position, as at March 2014, is showing a net surplus of £3.8m which is £33k better than plan.
2. At March 2014 the cash position is £33.1m which is £5.8m ahead of plan.
3. Capital spend to March 2014 is £8.77m which is £0.23m (2.5%) behind the revised capital plan.
4. At Month 12 the Cost Improvement Programme is £0.26m (approx 3%) under the target of £8.7m.
5. The Financial Risk Rating (Risk Assessment Rating) is 4 against a plan level of 4. A score of 4 is the highest possible.
6. As at 31st March 2014 (Month 12) 92% of NHS and 95% of non NHS invoices have achieved the 30 day target (95%).

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**
				(3,239)	(3,543)	(304)	Wakefield Commissioners	(43,241)	(43,058)	183	(43,241)	(43,058)	183
				(3,582)	(3,595)	(13)	Kirklees Commissioners	(41,655)	(41,481)	174	(41,655)	(41,481)	174
				(1,844)	(1,947)	(102)	Calderdale Commissioners	(21,912)	(21,871)	41	(21,912)	(21,871)	41
				(7,254)	(7,438)	(184)	Barnsley Commissioners	(88,117)	(87,603)	513	(88,117)	(87,603)	513
				(2,178)	(1,901)	277	Secure Services Comm's	(24,998)	(23,773)	1,225	(24,998)	(23,773)	1,225
				(54)	(106)	(52)	Non Contract Income	(411)	(691)	(280)	(411)	(691)	(280)
				(18,150)	**(18,529)**	**(379)**	**Total Income**	**(220,334)**	**(218,477)**	**1,857**	**(220,334)**	**(218,477)**	**1,857**
525	512	(13)	2.5%	1,832	2,026	194	Wakefield	21,914	22,370	456	21,914	22,370	456
609	581	(28)	4.6%	2,196	2,151	(45)	Kirklees	24,656	24,963	307	24,656	24,963	307
342	319	(23)	6.8%	1,193	1,239	46	Calderdale	13,617	13,836	219	13,617	13,836	219
1,630	1,524	(106)	6.5%	5,585	5,936	351	Barnsley	67,275	65,910	(1,364)	67,275	65,910	(1,364)
428	444	16	3.7%	1,373	1,344	(29)	Secure Services	16,270	16,365	95	16,270	16,365	95
410	382	(28)	6.8%	1,566	1,587	21	LD & Specialist	18,708	18,220	(488)	18,708	18,220	(488)
704	688	(16)	2.3%	4,014	3,866	(148)	Support	42,933	41,796	(1,138)	42,933	41,796	(1,138)
0	0	0		(264)	(226)	37	Provisions	3,012	1,848	(1,165)	3,012	1,848	(1,165)
4,647	**4,448**	**(199)**	**4.3%**	**17,495**	**17,923**	**428**	**Total Operating Expenses**	**208,385**	**205,307**	**(3,078)**	**208,385**	**205,307**	**(3,078)**
4,647	**4,448**	**(199)**		**(655)**	**(606)**	**49**	**EBITDA**	**(11,949)**	**(13,170)**	**(1,221)**	**(11,949)**	**(13,170)**	**(1,221)**
				446	376	(70)	Depreciation	5,354	5,144	(210)	5,354	5,144	(210)
				141	130	(12)	PDC Paid	1,698	1,529	(169)	1,698	1,529	(169)
				0	(8)	(8)	Interest Received	0	(88)	(88)	0	(88)	(88)
				0	74	74	Impairment of Assets	1,178	2,833	1,655	1,178	2,833	1,655
4,647	**4,448**	**(199)**	**4.3%**	**(68)**	**(35)**	**33**	**Surplus**	**(3,719)**	**(3,752)**	**(33)**	**(3,719)**	**(3,752)**	**(33)**

Income and Expenditure Summary

Forecast

The Trust annual plan surplus is £3.72m.

The year end position is that this target will be marginally exceeded by £33k.Whilst this is broadly in line with plan there are a number of components which make up this position and the main headlines are outlined below:

		£k	
*	Operational Budgets Position	1,914	Gain - Actual vs plan
*	Provisions	1,165	Provisions held to offset specific income risks
*	Depreciation	210	Gain - Actual vs plan
*	PDC	169	Gain - Actual vs plan
*	Interest better than planned	88	Gain - Increased cash balances
		3,545	
	Less:		
*	CQUIN Risk	572	
*	Activity Income Risk	1,285	
*	Revaluation Exercise	1,655	Includes Aberford Field timing delay
		3,512	
		33	Favourable

Month 12

For the financial year 2013 / 2014 the Trust overall surplus position is £3.752m. This is £0.033m (1%) ahead of plan.

Whilst overall this position is broadly in line with plan there are specific material variances within this position. Throughout the course of the year risks have been identified and action taken to mitigate against these.

These include:

* Cost pressures arising from BDU operational issues such as expenditure on Inpatient staffing and Out of Area placements.
* Timing issues arising from actions such as the revaluation of Trust Estate (now expected in 2014 / 2015)

It is important to ensure that this process continues during 2014 / 2015 to ensure that risks are identified and addressed.

Income and Expenditure Detail

Healthcare Contract Income

Income is behind plan. This is due to:

* Overall the CQUIN income target for 2013 / 2014 is £4.7m. Shortfall against this target is forecast as £572k. Whilst Quarter 4 shortfall has yet to be finalised with Commissioners a forecast position as at the end of March 2014 has been included in the year end position.

* Barnsley BDU is not able to recover planned (budgeted) income arising from available PICU beds and Substance Misuse. These are under plan by £0.26m year to date.

* Non recurrent support from Wakefield CCG (originally planned as £500k) has been received. Part is reflected into the income position and part has been received directly into the Trust Charitable Funds to support Creative Minds.

BDU Operational Income & Expenditure

Whilst there are numerous factors in the expenditure position the most significant issues for 2013 / 2014 are highlighted below:

* Wakefield BDU - The year end position is £456k overspent. Mitigations undertaken within the BDU have meant that the Out of Area overspend pressure of £677k has been partially offset by underspends in other areas.

* Kirklees BDU - The year end position is £307k overspent. The BDU has partially mitigated against two material pressures arising from the staffing requirements of an inpatient area(for which additional funding has been provided as part of the Trust Annual Plan) and Out of Area placements (£241k).

* Calderdale BDU - The year end position is £219k overspent. As per other BDU's mitigation has been undertaken to reduce the impact arising from overspends on Out of Area placements (£424k).

* Barnsley BDU - The year end position is £1364K underspent. This is driven by underspending across all service areas primarily on vacancies and non pay savings relating to prescribing and travel budgets. As part of the Transformation of Community Services, all vacant posts have been under review to ensure any posts recruited to are in line with plans for future service provision and to achieve efficiency savings within the BDU.

* LD & Specialist - The year end position is £488k underspend. This is predominately on pay expenditure and these areas have experienced high levels of staffing turnover during 2013/14. Additionally work is continuing to review the requirements arising from the Transformation programme.

* Secure Services - The year end position is £95k overspent. Pay pressures arising from the need to cover higher than average sickness rates have been offset by savings from within the BDU. Work is ongoing to address these pressures.

* Support - The year end position is £1,138k underspent. Of this £612k has arisen due to underspends on pay. The main issues for the Support areas going forwards is ensuring minimisation of non pay expenditure and delivering efficiency savings.

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	552	552
	Actual	36	36	36	36	27	25	25	25	33	35	35	35	383	383
	Variance	(10)	(10)	(10)	(10)	(19)	(21)	(21)	(21)	(13)	(11)	(11)	(11)	(169)	(169)
LD & Specialist BDU	Target	24	24	24	24	24	24	24	24	24	24	24	24	288	288
	Actual	24	24	24	24	24	22	17	17	17	17	17	17	242	242
	Variance	0	0	0	0	0	(3)	(7)	(7)	(7)	(7)	(7)	(7)	(46)	(46)
Kirklees BDU	Target	25	25	25	55	55	55	55	55	55	55	55	55	570	570
	Actual	25	25	25	25	25	25	25	25	25	25	25	25	301	301
	Variance	0	0	0	(30)	(30)	(30)	(30)	(30)	(30)	(30)	(30)	(30)	(269)	(269)
Calderdale BDU	Target	20	20	20	37	37	37	37	37	37	37	37	37	393	393
	Actual	20	20	20	19	19	19	19	19	19	19	19	19	229	229
	Variance	0	0	0	(18)	(18)	(18)	(18)	(18)	(18)	(18)	(18)	(18)	(164)	(164)
Secure Services	Target	38	38	38	38	38	39	39	39	39	39	39	39	463	463
	Actual	27	27	27	27	27	28	28	28	28	28	28	28	333	333
	Variance	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(130)	(130)
Barnsley BDU	Target	156	156	157	157	157	157	157	157	157	157	157	157	1,882	1,882
	Actual	134	134	135	135	135	135	135	135	135	135	135	135	1,615	1,615
	Variance	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(267)	(267)
Support	Target	126	126	126	126	126	126	126	126	126	126	126	126	1,512	1,512
	Actual	115	115	115	104	109	114	111	111	111	89	89	89	1,274	1,274
	Variance	(11)	(11)	(11)	(22)	(17)	(12)	(15)	(15)	(15)	(37)	(37)	(37)	(238)	(238)
Trustwide	Target	253	253	253	253	253	253	253	253	253	253	253	252	3,035	3,035
	Actual	253	253	253	253	253	253	253	253	253	253	253	(248)	2,535	2,535
	Variance	0	0	0	0	0	0	0	0	0	0	0	(500)	(500)	(500)
Total	Target	688	688	689	736	736	737	737	737	737	737	737	736	8,695	8,695
	Actual	634	634	635	623	620	620	612	612	620	601	601	100	6,911	6,911
	Variance	(54)	(54)	(54)	(113)	(116)	(117)	(125)	(125)	(117)	(136)	(136)	(636)	(1,784)	(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	3	3	3	91	91
	Variance	9	9	9	9	9	11	10	10	7	3	3	3	91	91
LD & Specialist BDU	Target													0	0
	Actual	0	0	0	1	1	6	6	6	6	6	6	6	46	46
	Variance	0	0	0	1	1	6	6	6	6	6	6	6	46	46
Kirklees BDU	Target													0	0
	Actual	0	0	0	0	0	23	57	103	75	4	4	4	269	269
	Variance	0	0	0	0	0	23	57	103	75	4	4	4	269	269
Calderdale BDU	Target													0	0
	Actual	0	0	0	1	1	36	16	22	22	22	22	22	164	164
	Variance	0	0	0	1	1	36	16	22	22	22	22	22	164	164
Secure Services	Target													0	0
	Actual	0	0	0	0	0	0	0	0	0	8	8	8	23	23
	Variance	0	0	0	0	0	0	0	0	0	8	8	8	23	23
Barnsley BDU	Target													0	0
	Actual	22	22	22	22	22	22	22	22	22	22	22	22	267	267
	Variance	22	22	22	22	22	22	22	22	22	22	22	22	267	267
Support	Target													0	0
	Actual	9	9	9	20	15	9	15	15	15	15	15	15	159	159
	Variance	9	9	9	20	15	9	15	15	15	15	15	15	159	159
Trustwide	Target													0	0
	Actual	0	0	0	0	0	0	0	0	0	0	0	500	500	500
	Variance	0	0	0	0	0	0	0	0	0	0	0	500	500	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	80	80	580	1,520	1,520
	Variance	40	40	40	53	48	107	127	178	147	80	80	580	1,520	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	552	552
	Actual	45	45	45	45	36	36	35	35	40	38	38	38	475	475
	Variance	(1)	(1)	(1)	(1)	(10)	(10)	(11)	(11)	(6)	(8)	(8)	(8)	(77)	(77)
LD & Specialist BDU	Target	24	24	24	24	24	24	24	24	24	24	24	24	288	288
	Actual	24	24	24	25	25	27	23	23	23	23	23	23	288	288
	Variance	0	0	0	1	1	3	(1)	(1)	(1)	(1)	(1)	(1)	(0)	(0)
Kirklees BDU	Target	25	25	25	55	55	55	55	55	55	55	55	55	570	570
	Actual	25	25	25	25	25	48	82	128	100	29	29	29	570	570
	Variance	0	0	0	(30)	(30)	(7)	27	73	45	(26)	(26)	(26)	(0)	(0)
Calderdale BDU	Target	20	20	20	37	37	37	37	37	37	37	37	37	393	393
	Actual	20	20	20	20	20	54	35	41	41	41	41	41	393	393
	Variance	0	0	0	(17)	(17)	17	(2)	4	4	4	4	4	(0)	(0)
Secure Services	Target	38	38	38	38	38	39	39	39	39	39	39	39	463	463
	Actual	27	27	27	27	27	28	28	28	28	36	36	36	356	356
	Variance	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(11)	(3)	(3)	(3)	(107)	(107)
Barnsley BDU	Target	156	156	157	157	157	157	157	157	157	157	157	157	1,882	1,882
	Actual	156	156	157	157	157	157	157	157	157	157	157	157	1,882	1,882
	Variance	0	0	0	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	1,512	1,512
	Actual	124	124	124	124	124	123	125	125	125	105	105	105	1,433	1,433
	Variance	(2)	(2)	(2)	(2)	(2)	(3)	(1)	(1)	(1)	(21)	(21)	(21)	(79)	(79)
Trustwide	Target	253	253	253	253	253	253	253	253	253	253	253	252	3,035	3,035
	Actual	253	253	253	253	253	253	253	253	253	253	253	252	3,035	3,035
	Variance	0	0	0	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**	**8,695**	**8,695**
	Actual	**674**	**674**	**675**	**676**	**668**	**727**	**739**	**790**	**767**	**681**	**681**	**680**	**8,431**	**8,431**
	Variance	(14)	(14)	(14)	(60)	(68)	(10)	2	53	30	(56)	(56)	(56)	(264)	(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 against the original plan, 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 shortfall against the original plan are:	£k
* Rehab & Recovery (Trustwide)	500
* E-Rostering (Kirklees & Calderdale)	433
* Additional target (Barnsley BDU)	267

Month 12 Position

The year to date target is £8.7m and to date BDU's have allocated £8.43m. This leaves a shortfall of £264k.

* Wakefield BDU - An overall shortfall against the original CIP schemes of £77k was identified relating to timing delays on staffing changes and the Transport contract. These same schemes are forecast to be recurrently achieved in 2014 / 2015.

* LD & Specialist - Schemes totalling £46k have experienced timing delays in 2013 / 2014 and have been met by non recurrent substitutions. These will be delivered in 2014 / 2015.

* Kirklees BDU - The shortfall against the original e-rostering scheme (£269k) has been met through non recurrent substitutions in year. £46k has been met by recurrent substitutions and the remainer is being recurrently addressed as part of the 2014/2015 CIP process and will include assessment against changes including handover times and shift arrangements.

* Calderdale BDU - The position reflects the amendment of the original e-rostering scheme (£164k) to a number of different recurrent mitigations. This includes review of allowances and enhancements paid to staff and savings on drugs expenditure.

* Secure Services - The outturn position is £130k under the original plan. £23k has been identified non recurrently. A recurrent substitution, savings arising from changes to shift patterns, has been identified for 2014 / 2015.

* Barnsley BDU - In year a shortfall against the original plan of £267k had been identified. This had been met by non recurrent actions during 2013 / 2014. As part of the Annual Planning process for 2014 / 2015 alternative recurrent schemes have been identified and are forecast to deliver.

* Support - During 2013 / 2014 a £238k shortfall against the original plan had been identified due to delays in realising procurement CIP's and expected delays in staffing changes. Non recurent schemes had offset some of this leaving a shortfall of £79k in year. Staffing changes have now happended and schemes such as the Multi Functional Devices are forecast to deliver in full for 2014 / 2015.

* Trustwide - The annual plan contained an assumption around the delivery of a Trustwide Rehab & Recovery CIP (£500k). This has not been delivered in 2013 / 2014 and has been mitigated through utilisation of the overall provisions position. This has been assessed as part of Annual Planning.

Monitor Risk Rating

Financial Risk Rating 2013/ 2014

	March 2014 Actuals		Annual Plan Quarter 4	
Metric	Score	Rating	Score	Rating
Capital Servicing Capacity	9.8	4	5.8	4
Liquidity	17.2	4	12.8	4
Weighted Average		**4**		**4**

Financial Risk Rating 2013/ 2014

	March 2014 Actuals		Annual Plan Quarter 4	
Metric	Score	Rating	Score	Rating
EBITDA margin	5.73%	3	5.20%	3
EBITDA, % achieved	100%	5	100%	5
ROA	6.74%	5	5.70%	5
I&E surplus margin	2.79%	4	2.40%	4
Liquid ratio	32.6	4	27.9	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.

The Monitor Financial Risk Rating is 4.1 against a planned position at the end of Quarter 4 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	(8.16)	(8.16)	(8.60)	(0.44)	
	Recharges	(5.56)	(5.56)	(5.73)	(0.16)	
Non-healthcare Income Total		(13.73)	(13.73)	(14.33)	(0.60)	
	Admin & Clerical	27.43	27.43	26.48	(0.94)	1
	Agency	2.70	2.70	3.69	0.99	2
	Ancillary	7.17	7.17	7.02	(0.15)	
	Medical	19.60	19.60	18.82	(0.78)	1
	Nursing	83.12	83.12	80.33	(2.78)	1
	Other Healthcare Staff	33.04	33.04	30.33	(2.71)	1
	Other Pay Costs	(4.47)	(4.47)	0.00	4.47	3
	Senior Management	1.42	1.42	1.29	(0.14)	
	Social Care Staff	2.48	2.48	2.43	(0.06)	
Pay- Expenditure Total		172.49	172.49	170.39	(2.10)	
	Clinical Supplies	2.82	2.82	2.70	(0.12)	
	Drugs	4.33	4.33	4.11	(0.21)	
	Healthcare subcontracting	2.95	2.95	4.42	1.47	
	Hotel Services	2.47	2.47	2.51	0.03	
	Office Supplies	4.25	4.25	4.26	0.01	
	Other Costs	5.92	5.92	6.21	0.29	
	Property Costs	6.90	6.90	7.26	0.36	
	Service Level Agreements	5.90	5.90	5.89	(0.01)	
	Training & Education	1.41	1.41	0.97	(0.44)	
	Travel & Subsistence	5.84	5.84	5.03	(0.81)	
	Utilities	2.03	2.03	1.93	(0.10)	
	Vehicle Costs	1.79	1.79	2.11	0.33	
Non-pay Expenditure Total		46.61	46.61	47.40	0.79	
	Provisions	3.01	3.01	1.85	(1.16)	
Grand Total		**208.38**	**208.38**	**205.31**	**(3.08)**	

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 £7.56m underspend on pay. This is being offset by the £4.47m staff vacancy factor and £0.99m agency overspend.

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:

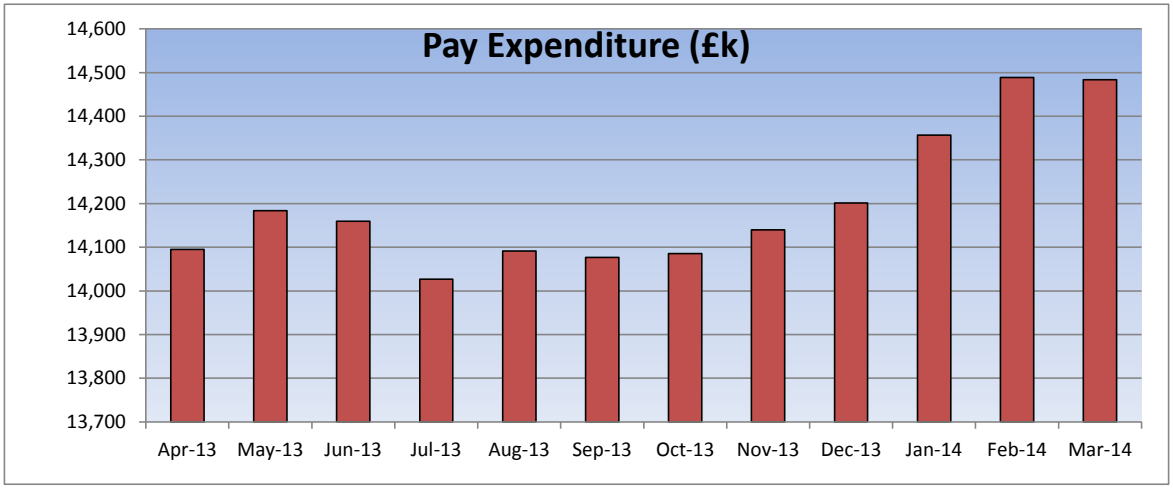
* Medical £1210k
* Nursing £764k
* Scientific & PAMs £693k
* Admin & Clerical £1018k

This is external agency costs only

3. This represents the recurrent staff vacancy factor. The savings requirement is £4.47m across the Trust and is planned to be achieved as part of achievement of the Trust overall financial

4. The most significant non pay cost pressure is in relation to Healthcare Subcontracting. This includes expenditure on Out of Area placements for both PICU and acute beds.

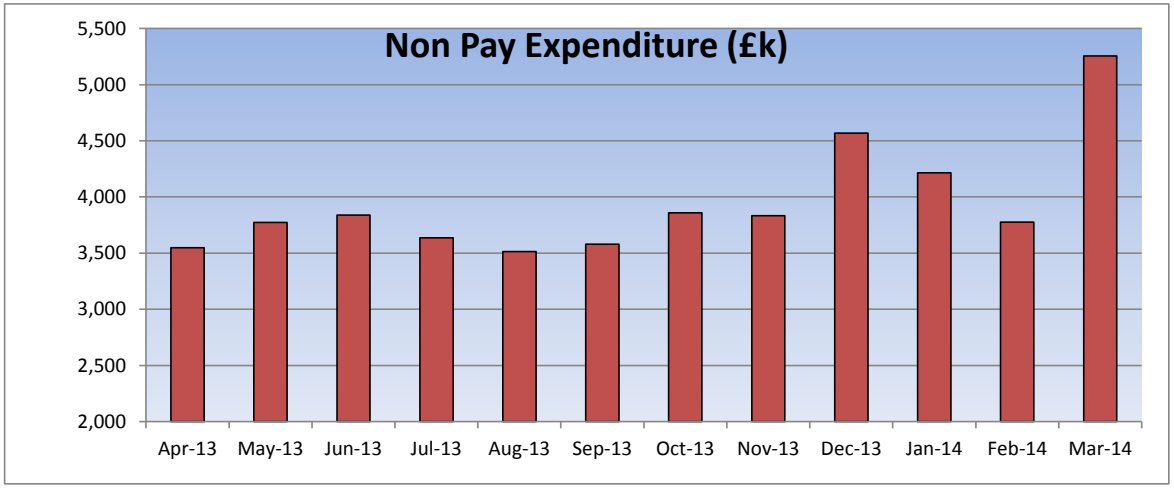
Run Rate Analysis 2013 / 2014



The value of all pay expenditure (substantive and other pay) has marginally increased from £14.1m over the course of the year with a peak in February 2014 of £14.5m. This movement is a 2.8% increase from April 2013 to March 2014.

This information has been normalised to the extent that this covers BDU operational pay expenditure only, as highlighted above, and excludes adjustments actioned centrally. Therefore payments such as redundancies have been excluded from this value.

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	TOTAL
Pay (£k)	14,095	14,184	14,160	14,027	14,091	14,077	14,085	14,140	14,201	14,357	14,489	14,483	**170,389**
Movement %		0.6%	-0.2%	-0.9%	0.5%	-0.1%	0.1%	0.4%	0.4%	1.1%	0.9%	0.0%	**2.8%**



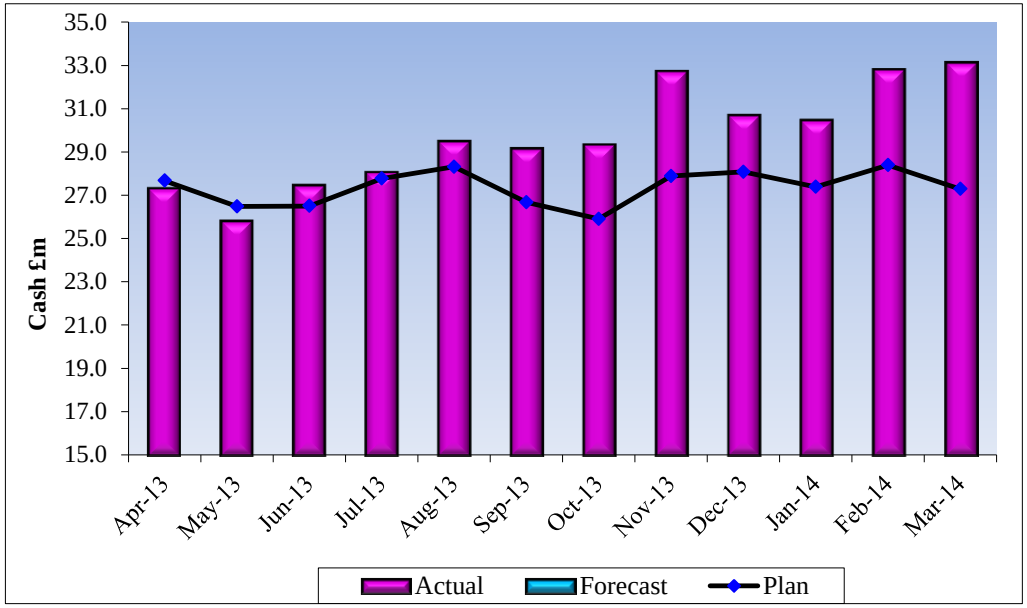
The non pay expenditure run rate has been normalised to exclude the impact of exceptional adjustments in year. Therefore items such as capital charges (Depreciation, PDC) and the I & E impact of the Estates Revaluation exercise have been excluded.

Whilst the level of Trust non pay expenditure is less than pay, there has been greater variation by month in the rate of expenditure. For instance March 2014 is 48% higher than April 2013.

An element of this is due to one off annual adjustments such as the impact of the Trust stock adjustment (c.£300k)

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	TOTAL
Non Pay (£k)	3,549	3,773	3,838	3,636	3,513	3,580	3,859	3,833	4,570	4,216	3,776	5,255	**47,398**
Movement %		6.3%	1.7%	-5.3%	-3.4%	1.9%	7.8%	-0.7%	19.2%	-7.7%	-10.4%	39.2%	**48.1%**

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.

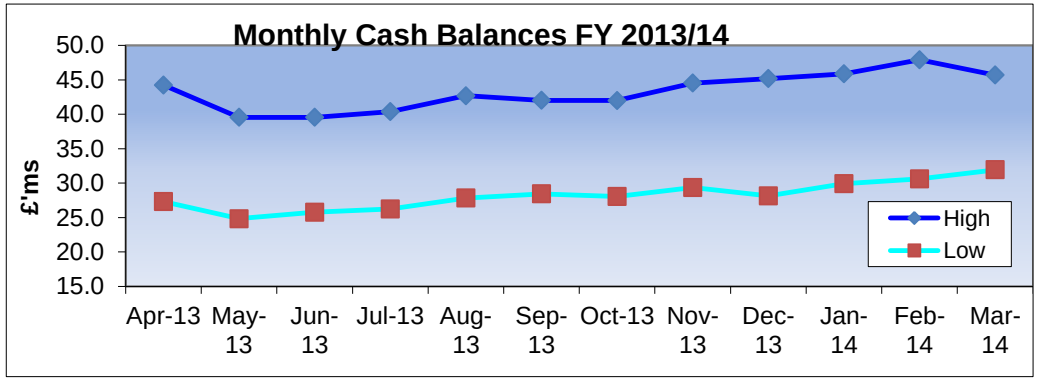
The actual cash position for the month is £33.11m. This is £5.83m ahead of the planned cash value of £27.29m.

A breakdown of this movement is provided on page 15 as the Reconciliation of Actual Cash Flow to Plan. It is important to note that a number of these key movements are due to timing differences to those planned and as such the cash position is forecast to return closer to that orignally anticipated.

The two main components of this are:

* Creditor (c.£1.9m) expected to be paid Qtr 1 2014/15
* Increased provisions expected to be paid during 2014/15

	Plan	Actual
	£m	£m
Opening Balance	28.39	32.81
Closing Balance	27.29	33.11



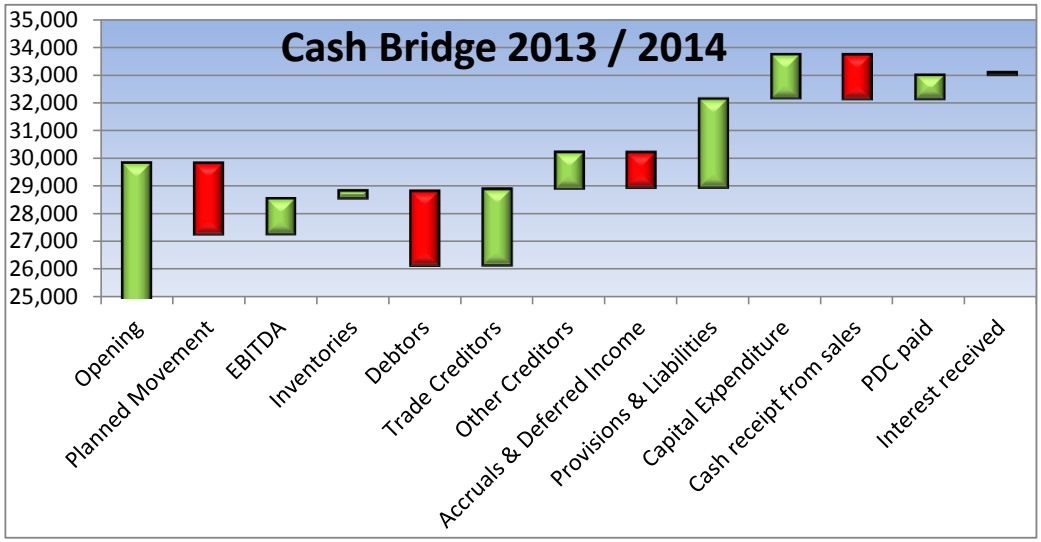
The graph to the left demonstrates the highest and lowest cash balances with each month. This is important to ensure that cash is available as required.

The highest balance is : £45.68m.
The lowest balance is : £31.93m.

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)	11.88	13.17	**1.29**	*1*
Movement in working capital:				
Inventories & Work in Progress	0.00	0.28	**0.28**	
Receivables (Debtors)	0.50	(2.19)	**(2.69)**	*4*
Trade Payables (Creditors)	0.12	2.87	**2.76**	*3*
Other Payables (Creditors)	(0.99)	0.33	**1.33**	*3*
Accruals & Deferred income	(0.40)	(1.68)	**(1.28)**	
Provisions & Liabilities	(4.04)	(0.83)	**3.21**	*2*
Movement in LT Receivables				
Capital expenditure	(8.99)	(7.39)	**1.59**	*5*
Cash receipts from asset sales	1.61	0.00	**(1.61)**	*5*
PDC Dividends paid	(2.26)	(1.38)	**0.88**	
PDC Received	0.00	0.00	**0.00**	
Interest (paid)/ received	0.00	0.09	**0.09**	
Closing Balances	**27.29**	**33.11**	**5.83**	



The Annual Plan reflects the May 2013 submission to Monitor.

Factors which increase the cash position against plan:

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

2. The value of Provisions has a positive impact on cash, over and above these shown within the underlying EBITDA position. The cash impact of these will be when the Provision is physically paid.

3. Creditors are higher than planned. The largest element relates to 1 invoice (c.£1.9m) which is awaiting suitable supporting documentation to enable payment. It is planned that this will be paid in Qtr 1 2014/15.

Factors which decrease the cash position against the plan:

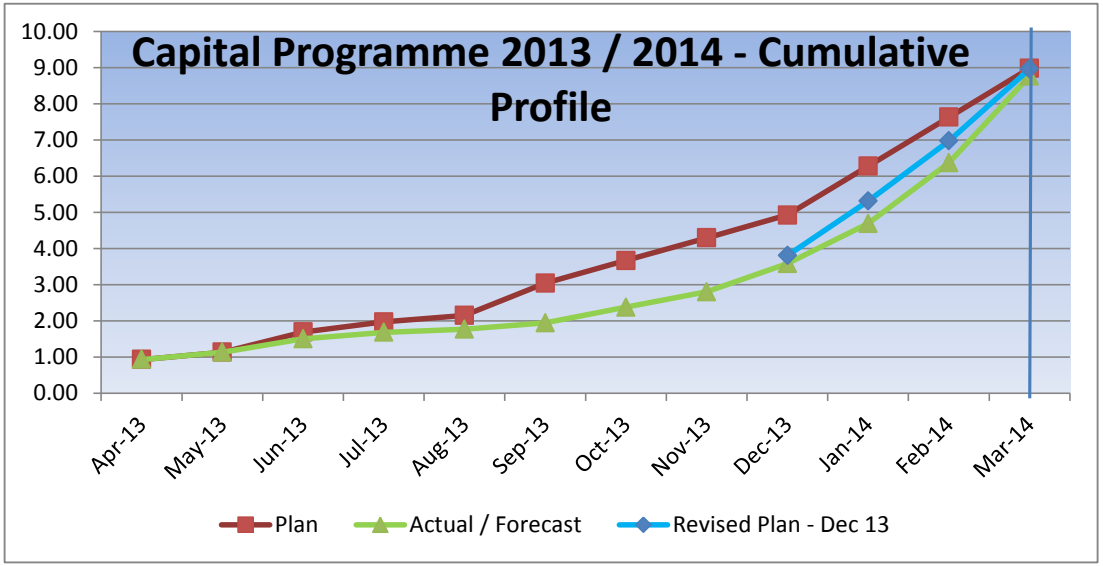
4. Debtors are higher than planned. These have been reviewed and no specific issues have been identified. For some payments have already been received in April 2014.

5. The Capital Programme has both a positive and negative impact on cash. Positive as physical expenditure is lower than planned as invoices have not yet been received and negative as the cash sale arising from Aberford Field has not been realised as planned.

The cash bridge to the left depicts , by heading, the positive and negative impacts on the cash position throughout the course of the year.

Capital Programme 2013 / 2014

Capital Expenditure Plans - Application of funds	Scheme Total £m	REVISED Annual Budget £m	Year End Actual £m	Variance £m	Note
Maintenance (Minor) Capital					
Small Schemes	4.89	4.12	4.29	0.17	
Total Minor Capital		**4.12**	**4.29**	**0.17**	*2*
Major Capital Schemes					
Newton Lodge	11.80	1.31	1.24	(0.08)	
IM&T	1.60	0.85	0.60	(0.25)	
Estate Strategy	19.90	2.84	2.72	(0.12)	
Total Major Schemes		**5.00**	**4.55**	**(0.45)**	*3*
VAT Refunds		(0.13)	(0.07)	0.05	
TOTALS		**8.99**	**8.77**	**(0.23)**	*1*



Capital Expenditure 2013 / 2014

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

2. The year end out turn position is £8.77m which is £0.23m under plan. This represents a variance of 2.5%.

Notable projects in year have included:

* Commencement of the Fieldhead infrastructure scheme which is vital to the future of the Fieldhead site. This will ensure that any future changes to the site can be safely met.

* Commencement of the Hepworth Ward renewal which is a significant step forward in upgrading the Trust inpatient facilities.

* Comprehensive scheme of boiler and lighting renewals finished in year to ensure the Trust meets its sustainability targets.

* The Trust has continued to reduce its backlog maintenance liability ensuring staff work in the best accommodation.

* The purchase of Laura Mitchell House (Halifax) enabling development of the Calderdale hub.

Balance Sheet

	Actual at 31/03/13	Plan at 28/02/14	Actual at 28/02/14	Note
	£m	£m	£m	
Non-Current (Fixed) Assets	**69.20**	**112.59**	**103.79**	*1*
Current Assets				
Inventories & Work in Progress	0.56	0.56	0.28	*2*
NHS Trade Receivables (Debtors)	1.43	1.04	1.91	*3*
Other Receivables (Debtors)	3.15	3.18	4.86	*4*
Cash and Cash Equivalents	29.85	27.29	33.11	*9*
Total Current Assets	**34.99**	**32.07**	**40.17**	
Current Liabilities				
NHS Trade Payables (Creditors)	(2.48)	(2.60)	(5.36)	*5*
Non NHS Trade Payables (Creditors)	(3.88)	(3.14)	(4.30)	*5*
Other Payables (Creditors)	(3.36)	(3.50)	(3.42)	
Capital Payables (Creditors)	(1.25)	(1.00)	(2.80)	*6*
Accruals	(9.03)	(8.53)	(7.29)	*7*
Deferred Income	(0.79)	(0.89)	(0.84)	
Total Current Liabilities	**(20.79)**	**(19.65)**	**(24.01)**	
Net Current Assets/Liabilities	**14.20**	**12.41**	**16.16**	
Total Assets less Current Liabilities	**83.40**	**125.00**	**119.95**	
Provisions for Liabilities	(8.07)	(4.03)	(7.24)	*8*
Total Net Assets/(Liabilities)	**75.33**	**120.97**	**112.71**	
Taxpayers' Equity				
Public Dividend Capital	(41.99)	(41.99)	(43.40)	
Revaluation Reserve	(7.26)	(22.54)	(14.78)	
Other Reserves	(5.22)	(5.22)	(5.22)	
Income & Expenditure Reserve	(20.86)	(51.22)	(49.31)	
Total Taxpayers' Equity	**(75.33)**	**(120.97)**	**(112.71)**	

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). The plan value is reflective of the original capital programme.

2. Due to stock rationalisation there has been a reduction in the Trust Inventories value. (Community Equipment) A further review of stock management is being conducted.

3. NHS debtors are higher than planned. This is due to all invoices (including estimates) being raised prior to the year end. Issues, such as CQUIN, remain to be finalised. The Agreement of Balances exercise will facilitate payment of these.

4. Other debtors are higher than planned with the largest values being in relation to Council payments. Payments have been received in April 2014.

5. Creditors continue to be managed in year. The biggest elements are Superannuation, income tax and National Insurance which are all paid monthly in arrears. NHS Creditors are exceptionally high due to a payment of c.£1.9m for which suitable supporting information is being obtained.

6. Capital payables are higher than planned due to the changes made to the Capital programme.

7. Accruals are lower than planned. These continue to be reviewed on a monthly basis.

8. Due to addtional provisions made in year, this has increased the value of provisions above those originally planned.

9. The movement in Cash Flows is reconciled on page 15.

Better Payment Practice Code

NHS		
	Number	Value
	%	%
Year to February 2014	92.3%	92.9%
Year to March 2014	92.3%	92.9%

Non NHS		
	Number	Value
	%	%
Year to February 2014	95.0%	92.6%
Year to March 2014	95.0%	92.6%

Local Suppliers - 10 days		
	Number	Value
	%	%
Year to February 2014	74.8%	67.5%
Year to March 2014	74.6%	68.5%

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

The performance against target for NHS invoices is 92% of the total number of invoices that have been paid within 30 days and 93% by the value of invoices.

The performance against target for Non NHS invoices is 95% 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 68% by the value of invoices within 10 days.

Throughout the system and process changes made during 2013/2014 performance against these targets have been maintained at a higher level than originally forecast. The team continue to review identified specific issues, for example process issues in relation to catering invoices. This is shown within the Local Suppliers reduced performance figures.

Transparency Disclosure

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

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 (£)
14/03/2014	Availability Charge SLA	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	8109535	196,254
21/03/2014	Rendered by PCT	Barnsley	Barnsley Metropolitan Borough Council	2157961	103,184
19/03/2014	Drugs	Trustwide	Mid Yorkshire Hospitals NHS Trust	2157797	100,712
21/03/2014	FP10´S	Trustwide	NHSBSA Prescription Pricing Division	2157991	92,831
18/02/2014	FP10´S	Trustwide	NHSBSA Prescription Pricing Division	2156027	86,584
20/03/2014	Local Authority Social Workers	Barnsley	Barnsley Metropolitan Borough Council	2157873	73,580
24/03/2014	FP10´S	Trustwide	NHSBSA Prescription Pricing Division	2158120	50,648
28/02/2014	Local Authority Social Workers	Wakefield	Wakefield MDC	2156533	43,461
10/03/2014	Local Authority - Other Staff	Calderdale	Calderdale Metropolitan Borough Council	2157170	34,540
10/03/2014	Local Authority - Other Staff	Calderdale	Calderdale Metropolitan Borough Council	2157137	34,540
18/02/2014	Non - Healthcare - NHS Trusts	Trustwide	Leeds and York Partnership NHS FT	2155991	32,055

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: 29 APRIL 2014

Strategic Human Resources Performance Report (July 2014-March 2014)

Content/Executive Summary

Section 1: HR Performance Dashboard

- The Trust's sickness levels of 4.7% was above the 4% target although below 12/13 levels which was 5.3%. A more detailed breakdown of sickness by service line is provided in Section 2.

- Appraisal rates are still above target.

- Bank and overtime total expenditure is lower than the previous year, although agency spend has increased but does include Calderdale and Kirklees CAMHs which were not part of the Trust in 12/13.

Section 2: Sickness By BDU Service Line

- The chart shows the sickness levels broken down by service lines across the BDUs.
- 2 BDUs Calderdale and Specialist Services are both below the target level of 4%.
- Forensic BDU sickness fell by 0.5% compared to 12/13.
- Barnsley BDU sickness remained the same as the previous year.
- Kirklees BDU sickness was the only one to see an increase from the previous year.

Section 3: NHS Staff Survey 2013: Review of findings in relation to key issues identified in the Francis report

- The Trust has used the key results of the NHS staff survey to benchmark itself across the organisation against other similar Trusts in the Yorkshire and Humber Region. The key questions used to benchmark are those identified by NHS Employers as indicators to review the Trust's position against the Francis report. Overall the findings were positive, particularly around the willingness to recommend the Trust as an employer or a place to receive treatment which will be used nationally as a key indicator. However, there are areas around support from immediate managers and incident reports which will be followed up.

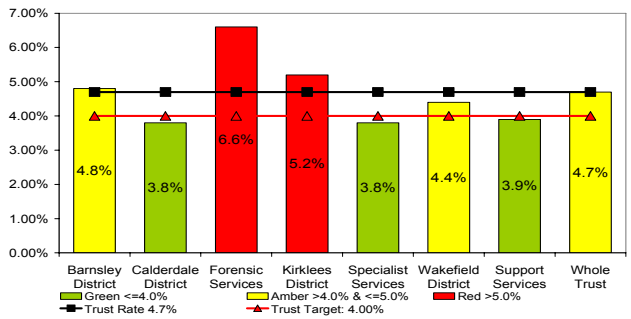
Section 4: 6 Month Staff Well-Being Survey

- The Trust completed its second 6 month staff survey in January 2014. The results of the survey are broken down by BDU. A series of engagement workshops have been arranged for each BDU to develop its action plan.
- The Trust is planning to develop the 6 month survey in 2014/15 to include the staff friend and family test which all Trusts will have to undertake quarterly.

Section 1: Human Resources Performance Dashboard (March 2013/2014)

Sickness Absence

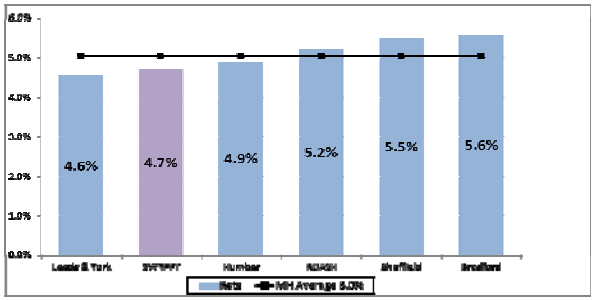
Sickness Absence by District – Year to Date



Current Absence Position – March 2014

	Barn	Cald	Fore	Kirk	Spec	Wake	Supp
Rate	4.4%	3.2%	6.2%	4.8%	3.5%	2.9%	3.4%
Trend	↑	↓	↓	↑	↓	↓	↓

Absence Benchmark Y&H MH/LD & Care Trusts



- The Trust YTD absence levels in March 2014 are above the 4.0% target at 4.7%.
- The chart above shows absence levels in MH/LD Trusts in our region for Q3 2013/14. During this time the Trust's absence was 4.7% which was below the regional average of 5%.

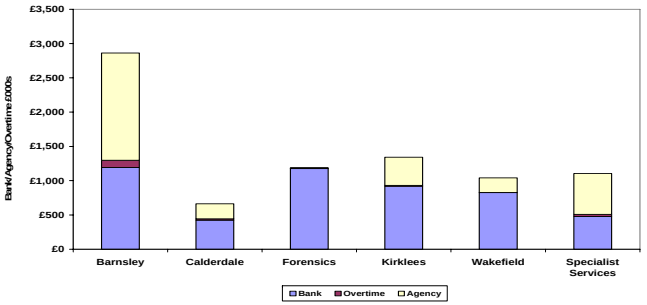
Staff Appraisal

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%

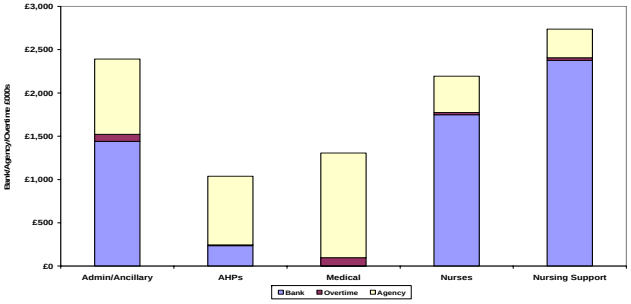
- Appraisal rates for 2013/2014 is 92.3%. This is above the Trust's target of 90%.

Bank, Agency & Overtime Spend

Bank, Agency & Overtime Spend by BDU - YTD



Bank, Agency & Overtime Spend by Group - YTD



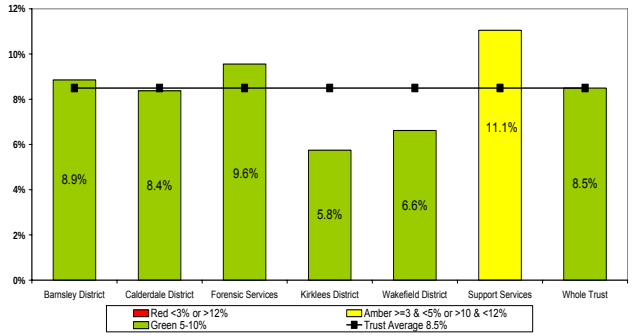
Overtime Spend by BDU - YTD ('000s)

BDU	A&C/ Ancil	AHPs	Medical	Nursing	Total
Barnsley	£12	£5	£68	£19	£105
Calderdale	£2	£2	£4	£13	£20
Forensics	£1	£0	£5	£0	£6
Kirklees	£0	£1	£9	£1	£12
Wakefield	£0	£0	£3	£0	£4
Specialist	£4	£1	£3	£21	£28
Support	£62	£0	£0	£1	£63
Total	£81	£9	£93	£55	£238

Agency Spend by BDU - YTD ('000s)

BDU	A&C/ Ancil	AHPs	Medics	Nursing	Total
Barnsley	£183	£526	£586	£270	£1,565
Calderdale	£6	£115	£69	£29	£219
Forensics	£10	-£4	£0	£0	£6
Kirklees	£0	£4	£150	£256	£411
Wakefield	£13	£0	£177	£21	£212
Specialist	£21	£178	£209	£188	£596
Support	£634	-£25	£18	-£14	£613
Total	£868	£794	£1,210	£751	£3,623

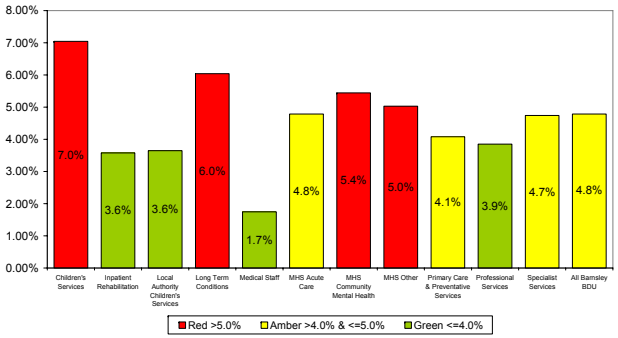
Turnover Rates by Service – Year to Date



- Year to Date Turnover is 8.5% which is within the target range of 5-10%

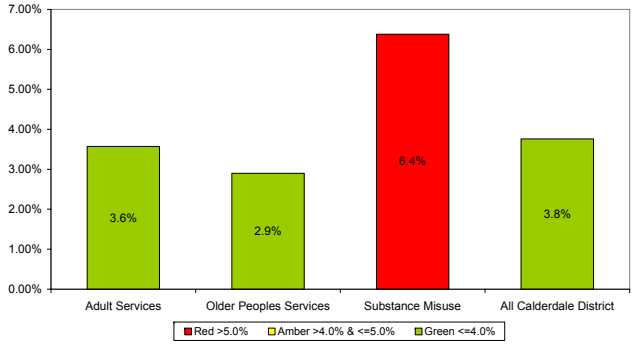
Section 2: Sickness By BDU Service Line

Barnsley BDU



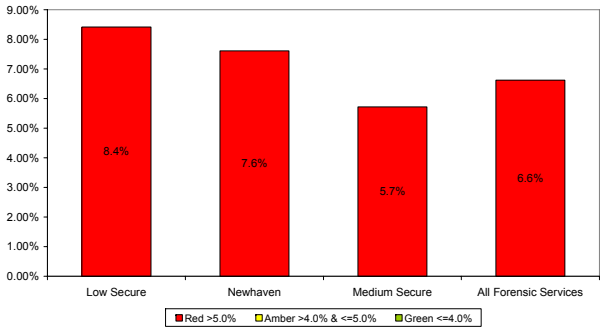
- The overall BDU sickness rate for 13/14 is the same as the previous.
- Childrens Services has increased from 5.1% to 7% and the highest in the BDU.

Calderdale BDU



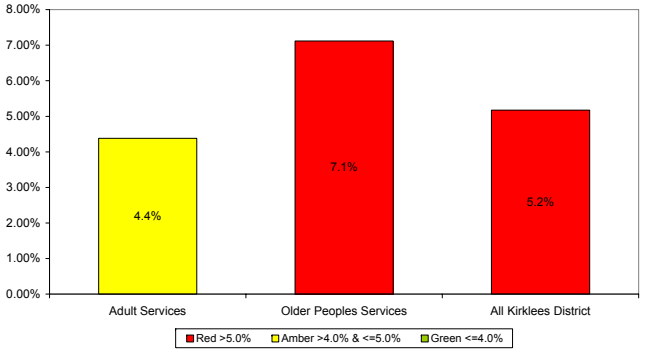
- Calderdale BDU overall sickness has fallen from 5.4% in 12/13 to 3.8% in 13/14.
- Calderdale BDU is below the Trust's target of 4%.

Forensic BDU



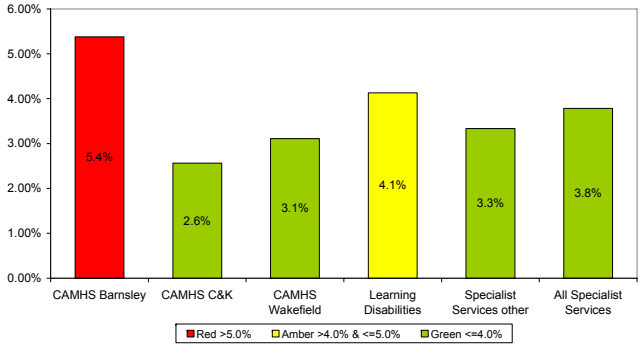
- Forensic sickness has fallen from 7.1% in 12/13 to 6.6% in 13/14.
- Newhaven and Low Secure sickness has fallen dramatically in March 2014 to 4.8% and 4.7% respectively.

Kirklees BDU



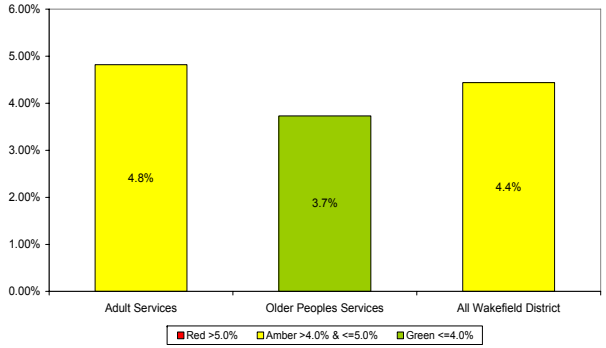
- Kirklees BDU sickness has increased slightly from 5.0% to 5.2% from last year to this year.

Specialist Services BDU



- Specialist Services BDU is below the Trust's target.
- There is not a comparison from last year given CAMHs from Calderdale and Kirklees were part of CHFT in 12/13.

Wakefield BDU



- Wakefield BDU sickness fell from 5.1% in 12/13 to 4.4% in 13/14.

Section 3: NHS Staff Survey 2013: Review of findings in relation to key issues identified in the Francis report

Introduction

Between October and December 2013 the annual National NHS Survey was undertaken, which is designed to collect the views of staff across the NHS. The overall aim of the survey is to gather information that will enable NHS organisations to improve the working lives of staff with the aim of consequently providing high quality care for service users and their carers. The Trust achieved a 51% response rate with over 400 staff completing the questionnaire.

NHS Employers have encouraged Trusts to use the national staff survey data when reviewing the findings of the Francis report. This brief paper analyses the survey findings and compares the Trust's key scores with those of other local community, learning disability and mental health NHS provider organisations. The report also provides information on BDU results, although the number of respondents in each BDU varies and so this needs to be considered when interpreting these results.

The following key scores are highlighted:

Culture

Francis calls for organisations to ensure they have a shared common culture of care. Question 4 in the staff survey considers the extent of effective working in the organisation with team working as a potential indicator around the culture of an organisation. Areas that have poor levels of team working will be a challenge in development of a culture of care. The Trust had a scale summary score of 3.85 for effective team working, this is above the national average of 3.83 (i.e. positive finding).

Staffing Levels

The Francis report stresses the importance of ensuring staffing levels are set at a safe level. Key finding 3 provides a summary of questions around the extent of work pressure felt by staff. The Trust's score is in the lowest 20% of Trusts (i.e. a positive finding), with a scale summary score of 2.93, the national average being 3.07.

Leadership

The Francis report stresses the importance of line managers supporting staff to provide high quality care. Staff perception of line managers is covered in key finding 9 and these can be used to identify issues around support from managers.

The Trust's had a 3.73 summary scale score, which is at the same level as 2012, the national average was 3.82. The Trust's score was in the bottom 20% of Trusts (i.e. negative finding).

Staff engagement

The Francis report has highlighted how staff disengagement can lead to downward spiral into poor care. The various staff engagement questions and the composite staff engagement score should also be looked at in light of Francis. For example, if there has been a significant year on year worsening or there are pockets of disengagement within an organisation.

The Trust's overall staff engagement score was summary scale 3.77, this has increased from 3.72 in 2012, the national average is 3.71 (i.e. positive finding).

The willingness to recommend

Staff willingness to recommend the organisation they work for as a place to be treated is increasingly being seen as a "litmus test" of standards of care. The answers to key question 24 in the survey *"staff recommendation of the Trust as a place to work or receive treatment"* will therefore be seen as especially important.

The Trust had a scale summary score of 3.75, this has improved from 3.69 in 2012, national average is 3.55.The Trust's score is in the top 20% of Trusts (i.e. positive finding).

Providing safe care

The way the organisation deals with incidents and near misses is covered extensively in key finding 18, fairness and effectiveness of incident reporting procedures. The Trust's scale summary score is 3.57, above the national average of 3.52 (i.e. positive finding).

Views on incident reporting

The increasing willingness of staff to report incidents can be an indicator of confidence in procedures. Key finding 14, reports the percentage of staff reporting errors, near misses or incidents witnessed in the last month. The Trust's overall score was 87%, this is in the worst 20% of Trusts, the national average being 92%, (i.e. negative finding).

The following table shows the Trust's scores compared to scores from other local NHS organisations.
(HSB) = Higher Score Better - (LSB) = Lower Score Better

	SWYPFT	National Average	Leeds & York PFT	Bradford DCT	Humber	RDASH	Sheffield	Leeds Comm
Culture Team Working (HSB)	**3.85**	3.83	3.79	3.83	3.71	3.88	3.75	3.75
Staffing Levels (LSB)	**2.93**	3.07	2.96	3.05	3.14	2.96	2.96	3.13
Leadership (HSB)	**3.73**	3.82	3.86	3.74	3.74	3.84	3.81	3.53
Staff Engagement (HSB)	**3.77**	3.71	3.68	3.77	3.64	3.77	3.81	3.61
Willingness to recommend (HSB)	**3.75**	3.55	3.50	3.58	3.46	3.68	3.80	3.54
Providing Safe Care (HSB)	**3.57**	3.52	3.54	3.66	3.51	3.58	3.60	3.70
Views on Incident Reporting (HSB)	**87%**	92%	93%	94%	94%	93%	91%	97%

The following table shows the Trust's scores broken down into each BDU.
(HSB) = Higher Score Better - (LSB) = Lower Score Better – (NRR) Not enough response to report

	SWY PFT	Nat Ave	B'sley	C'dale	F'sic	K'lees	Spec S'vice	Supp S'vice	W'field
Culture Team Working (HSB)	**3.85**	3.83	3.96	3.97	3.65	3.67	3.70	3.83	3.95
Staffing Levels (LSB)	**2.93**	3.07	2.93	2.92	2.88	3.24	3.09	2.65	2.86
Leadership (HSB)	**3.73**	3.82	3.70	3.80	3.80	3.63	3.59	3.89	3.86
Staff Engagement (HSB)	**3.77**	3.71	3.80	3.89	3.88	3.67	3.67	3.84	3.70
Willingness to recommend (HSB)	**3.75**	3.55	3.76	3.79	4.05	3.46	3.66	3.95	3.60
Providing Safe Care (HSB)	**3.57**	3.52	3.61	3.60	3.59	3.45	3.50	3.59	3.45
Views on Incident Reporting (HSB)	**87%**	92%	89%	(NRR)	87%	70%	(NRR)	(NRR)	(NRR)

Conclusion

Overall the majority of staff survey findings are positive for the Trust particularly around staff willingness to recommend the organisation as a place to work or receive treatment. There are two areas of concern levels of incident reporting and immediate support from managers. At the end of the financial year the level of incident reporting can be reviewed, it is not felt levels of incident reporting have reduced using data from quarterly reviews. Secondly, the level of support provided to staff from immediate managers, this will considered as part of a wider review of leadership and management development activity.

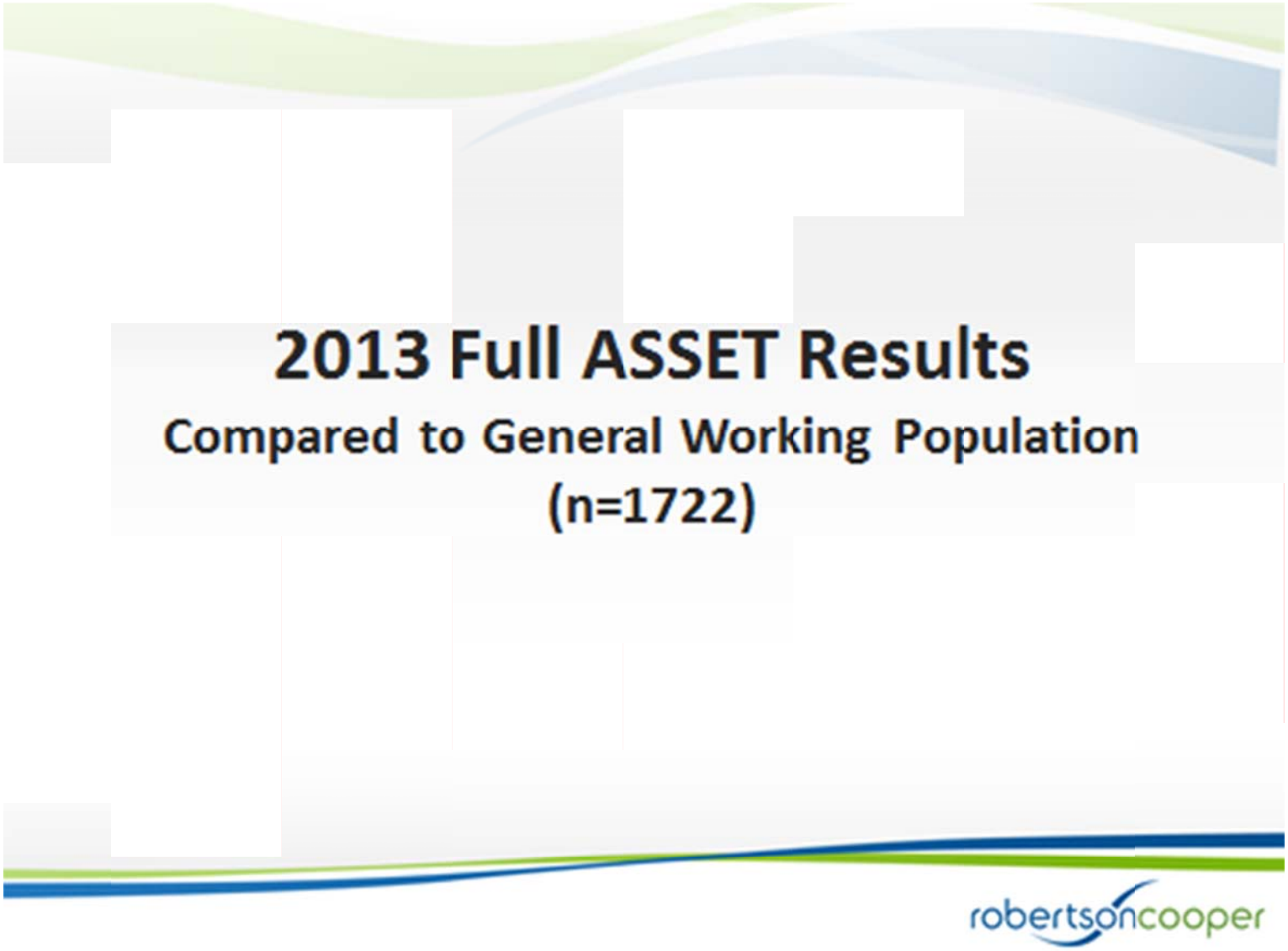
nt

ɔut

is kind,
king
ıe NHS

ɔrk

-being.

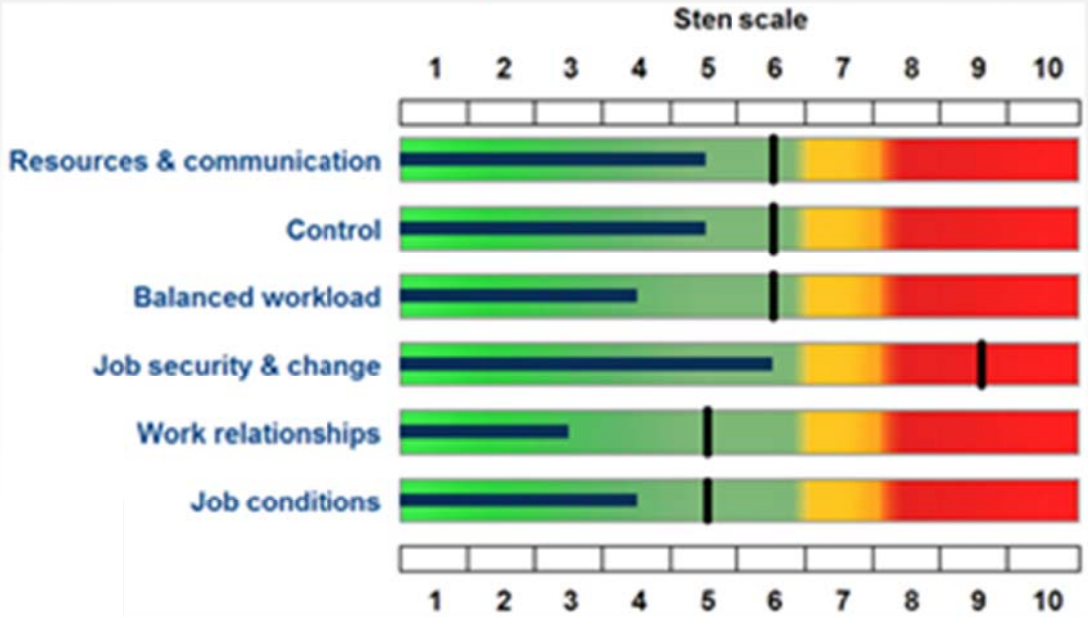


The following slides show an initial results breakdown, based on all the online responses received to the survey (1,722 in total).

6 Essentials

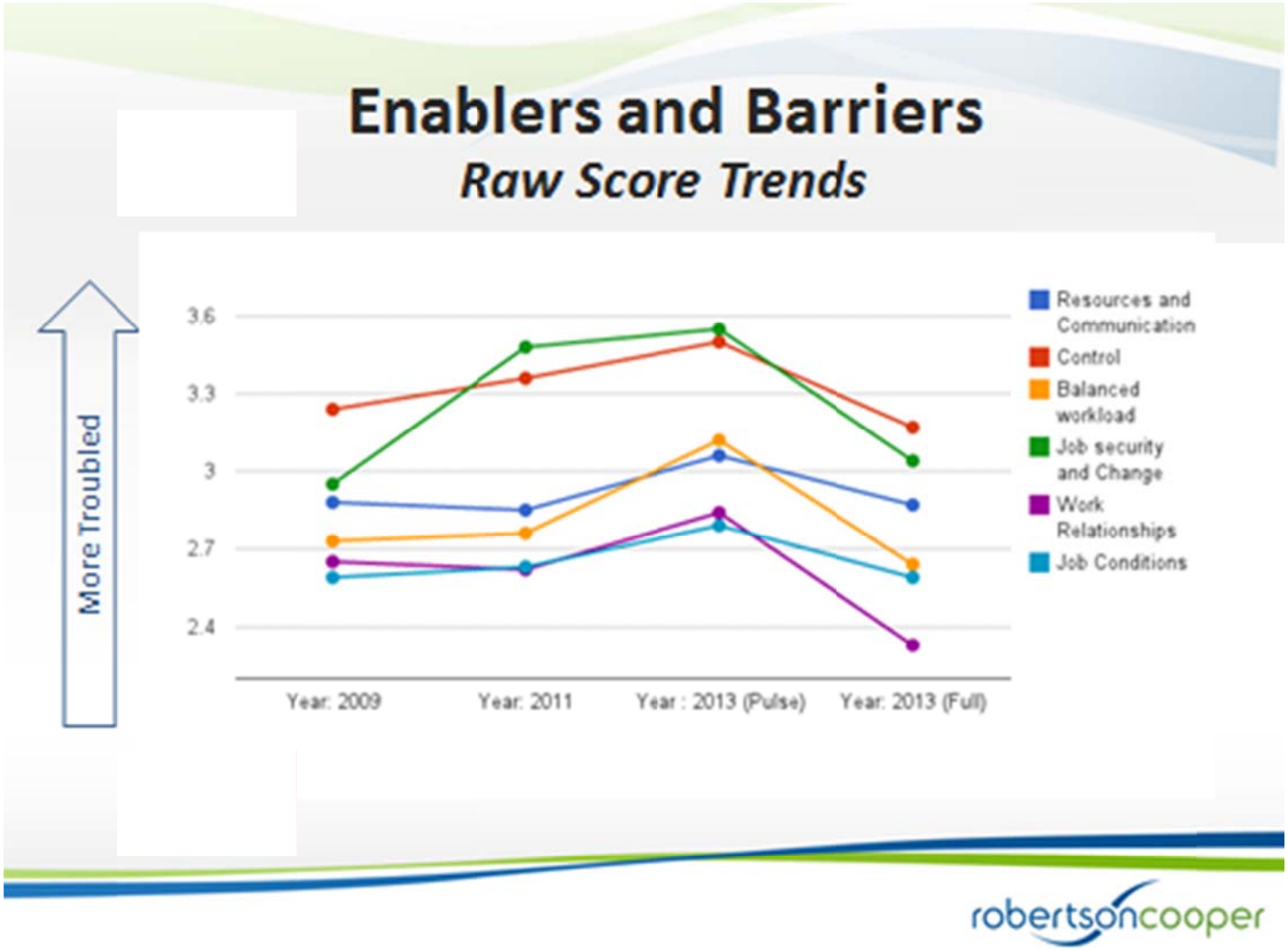
(compared to general working population)

All online respondents (n=1722)



Note: the higher the score the greater the extent to which the area is considered a stressor

t



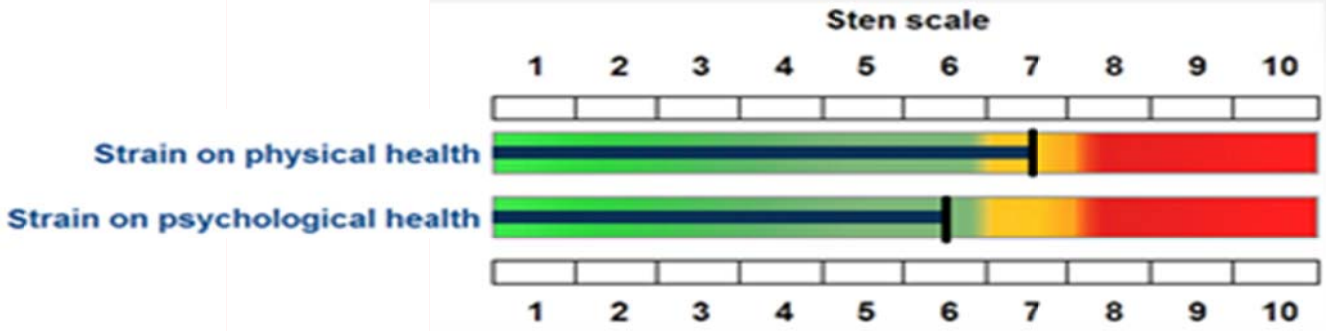
ıe last

Vork
than

Your Health

(compared to general working population)

All online respondents (n=1722)



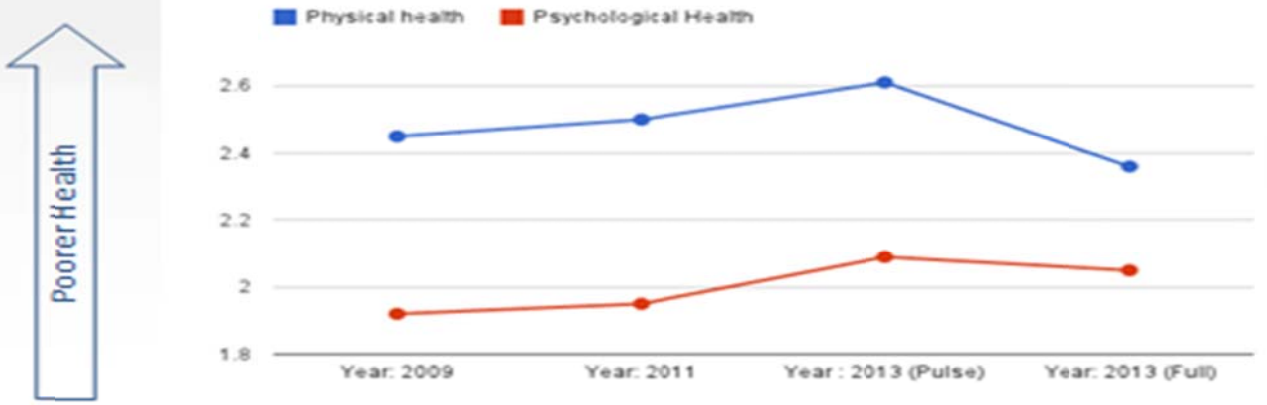
Note: the higher the score the greater the extent to which the area is considered a stressor

robertsoncooper

/er

Your Health

Raw Score Trends

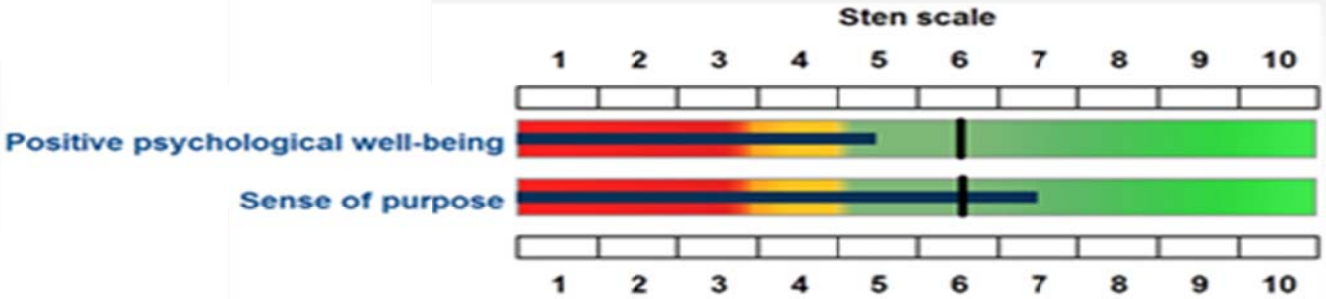


robertsoncooper

Psychological Well-Being

(compared to general working population)

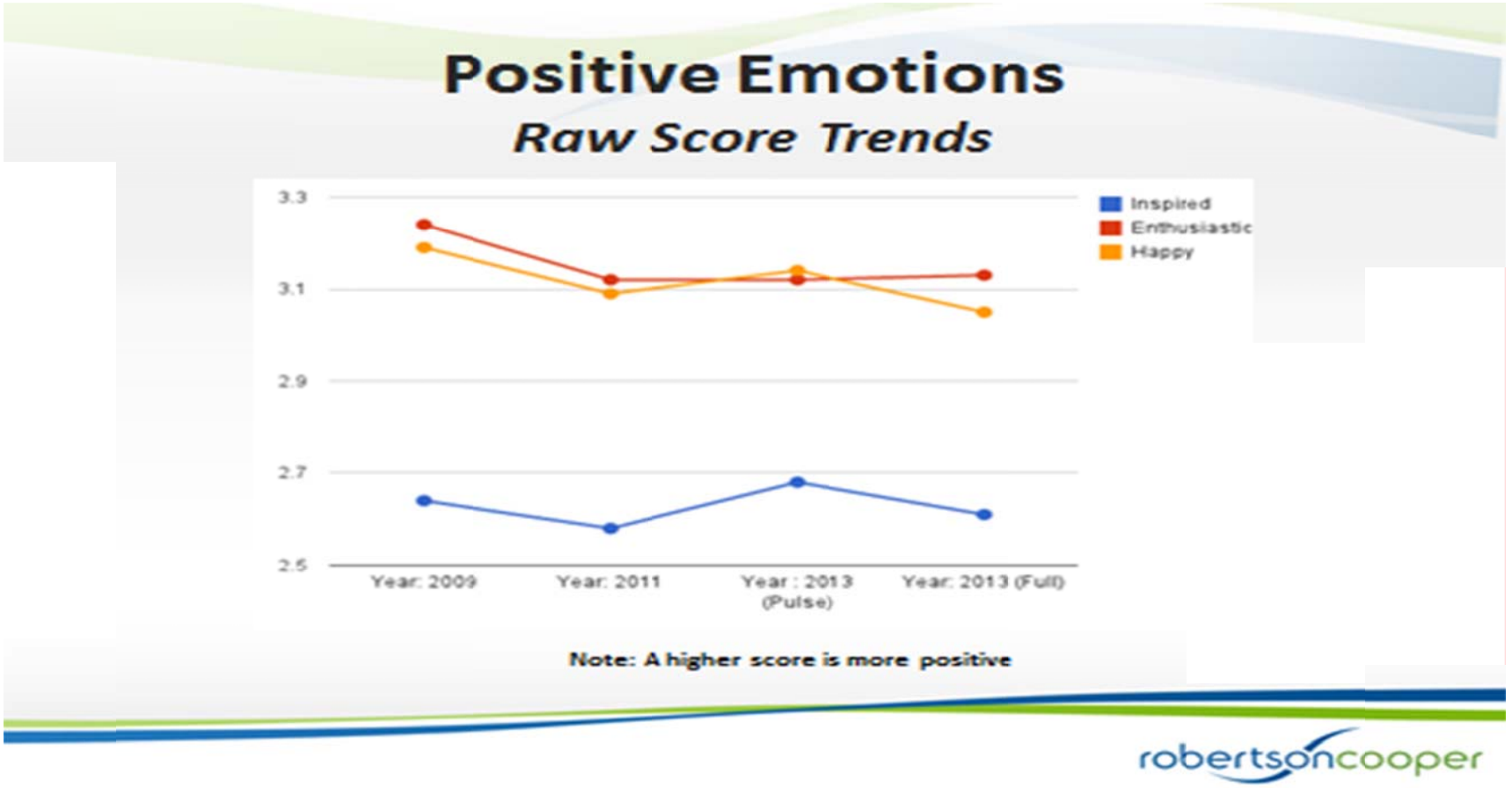
All online respondents (n=1722)



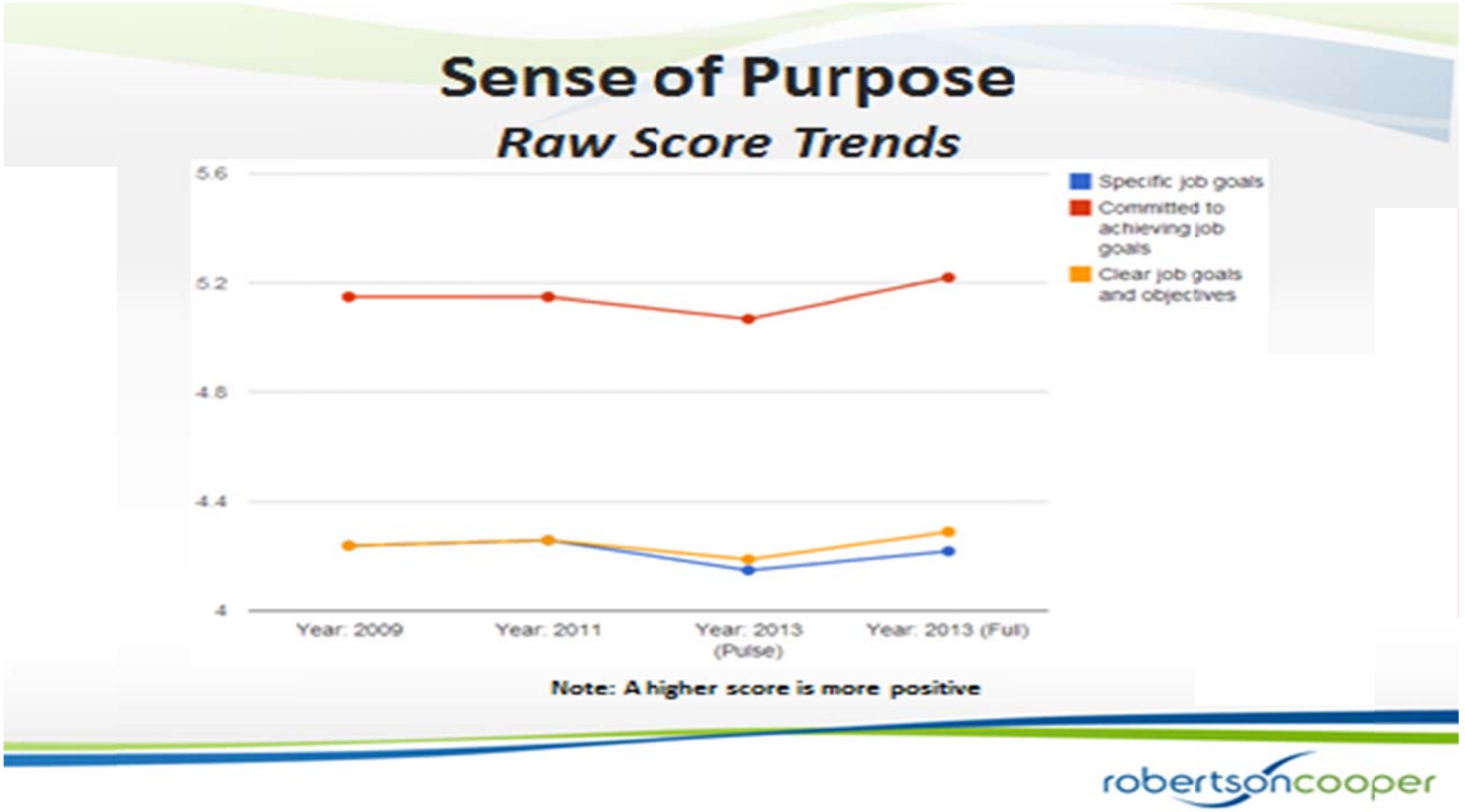
Note: the higher the score the more positive the area

robertsoncooper

ut at the


Positive Emotions
Raw Score Trends
3.3
3.1
2.9
2.7
2.5
Year: 2009
Year: 2011
Year : 2013 (Pulse)
Year: 2013 (Full)
Inspired
Enthusiastic
Happy
Note: A higher score is more positive
robertsoncooper

y

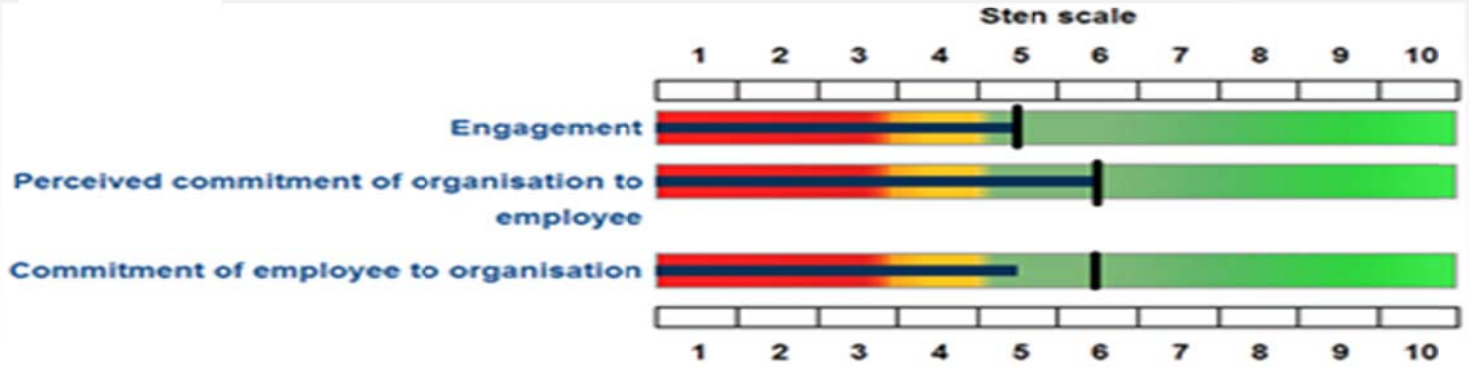

Sense of Purpose
Raw Score Trends
5.6
5.2
4.8
4.4
4
Year: 2009
Year: 2011
Year: 2013 (Pulse)
Year: 2013 (Full)
Specific job goals
Committed to achieving job goals
Clear job goals and objectives
Note: A higher score is more positive
robertsoncooper

ing in the

Engagement & Related Scales

(compered to general working population)

All online respondents (n=1722)



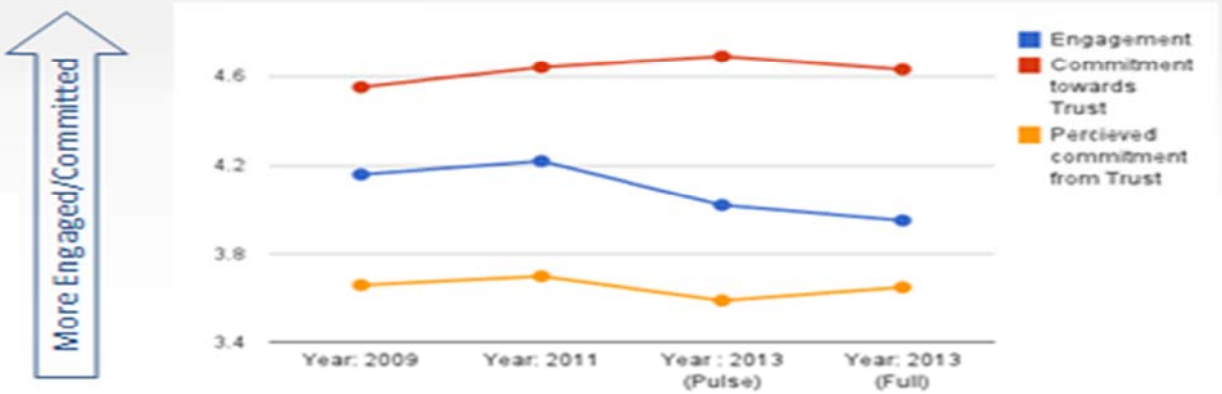
Note: the higher the score the more positive the area

robertsoncooper

e

Engagement & Related Scales

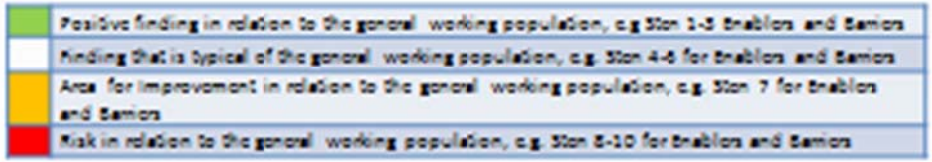
Raw Score Trends



robertsoncooper

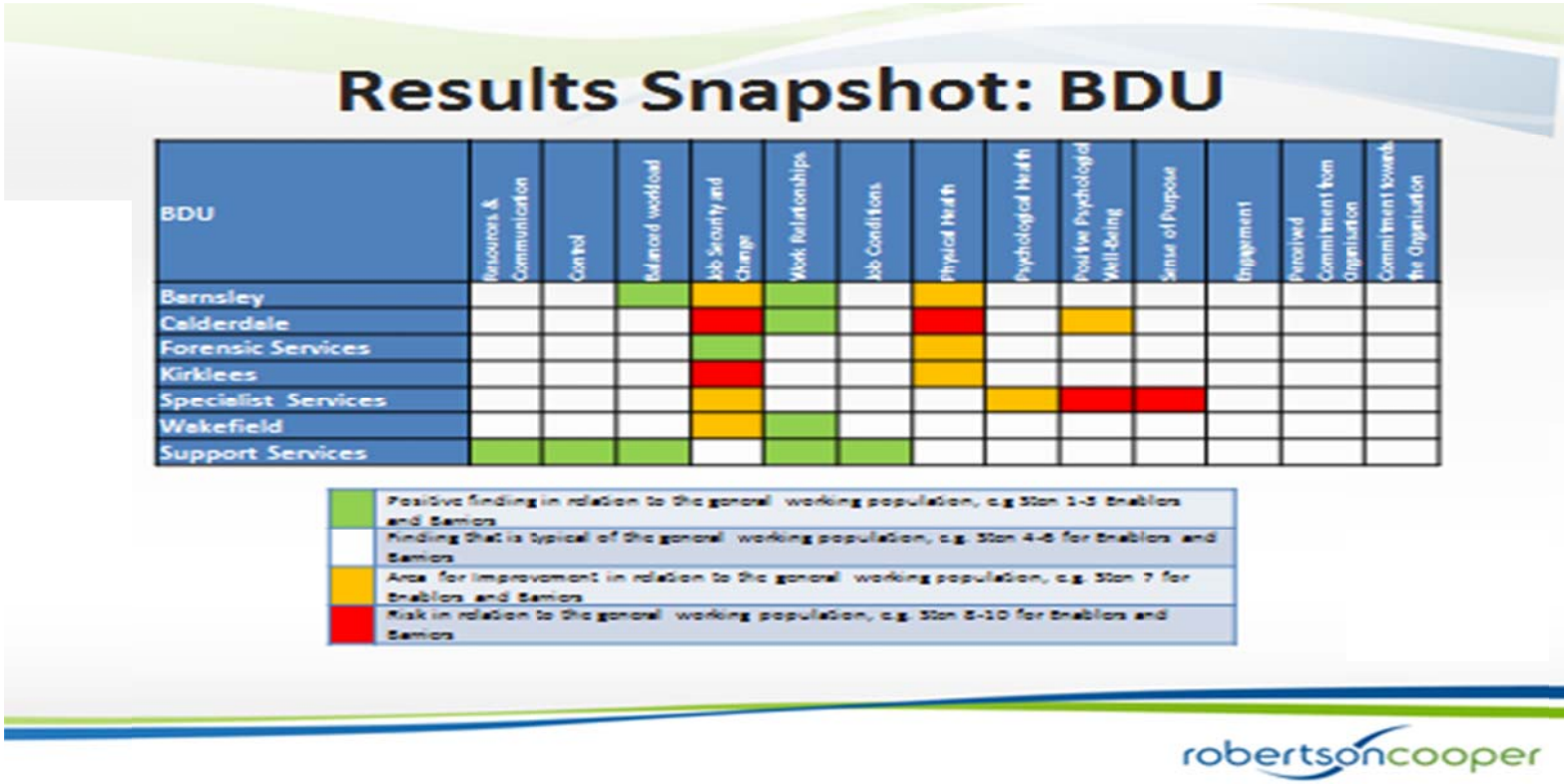
Snapshot Results

- The following slide shows the ASSET results for each BDU.
- There are two ways to read the results:
  - From left to right: see the results for a specific group across all ASSET measures
  - From top to bottom: see how each ASSET measure differs between the groups
- Use the key below to see how each group scored:



- All results are in comparison to the General Working Population.
- The number of respondents for each group is shown in brackets. Minimum group size = 8

robertsoncooper

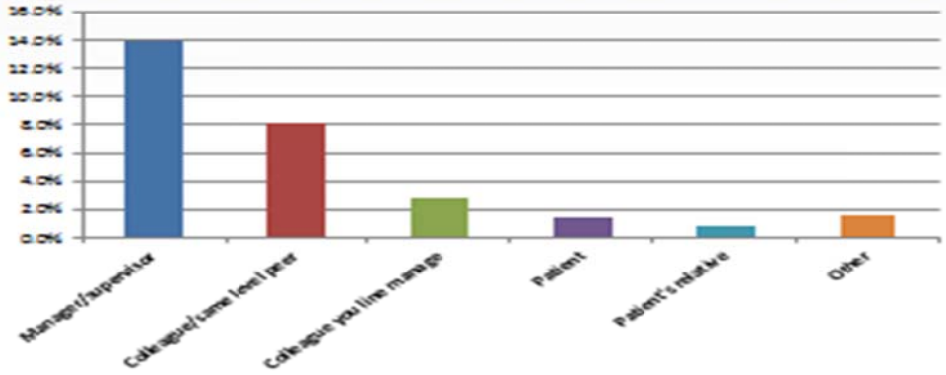


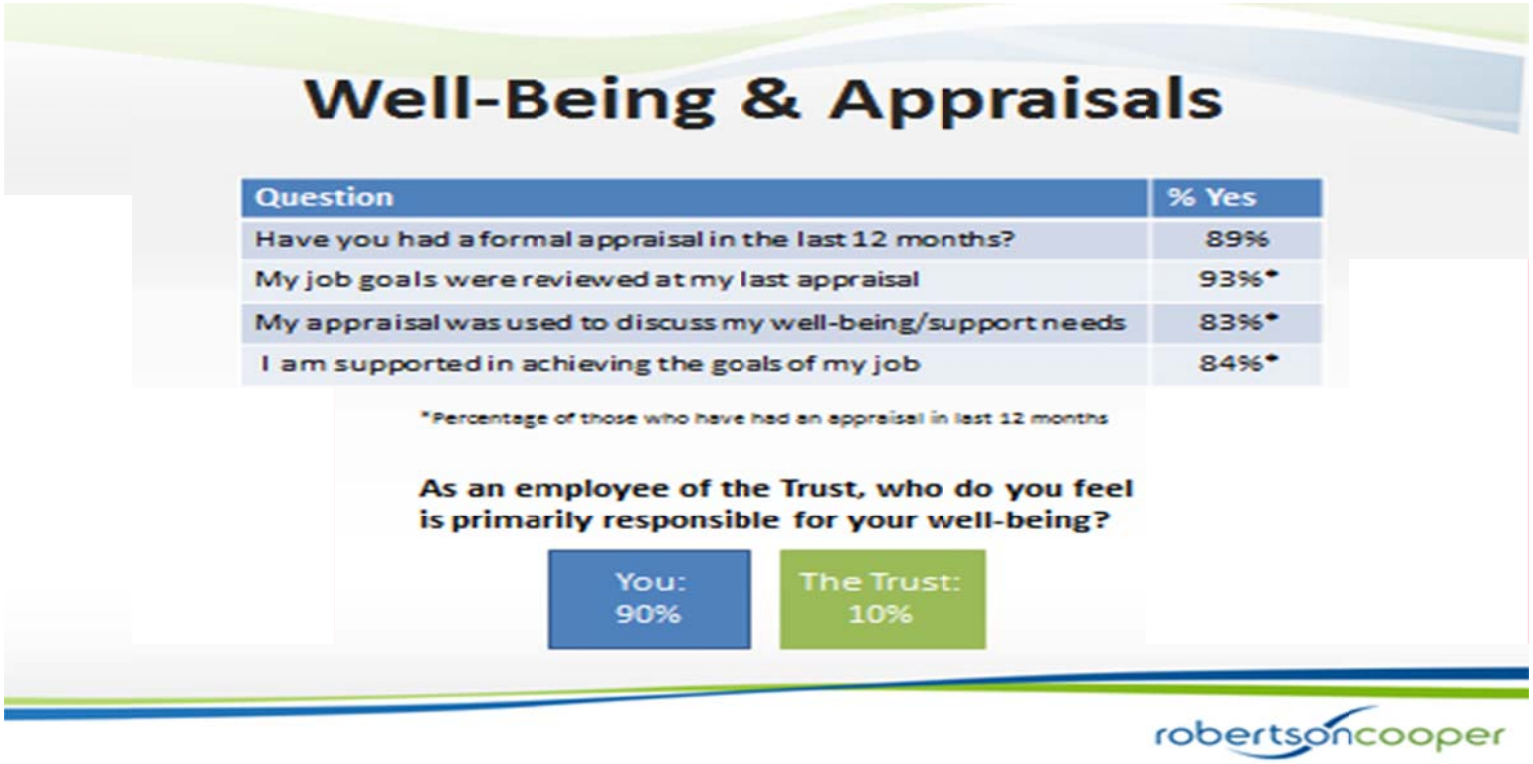
l BDU's.
al

sults in full.

Workplace Bullying

	2009	2011	2013 (Pulse)	2013
Bullied at work	23.4%	19.8%	23.1%	23.3%
Bullied in last 6 months	40.1%	31.9%	36.9%	38%
Reported bullying	34.7%	39.1%	39.9%	37.2%
Bullying resolved	39.3%	42.3%	34.5%	34.9%



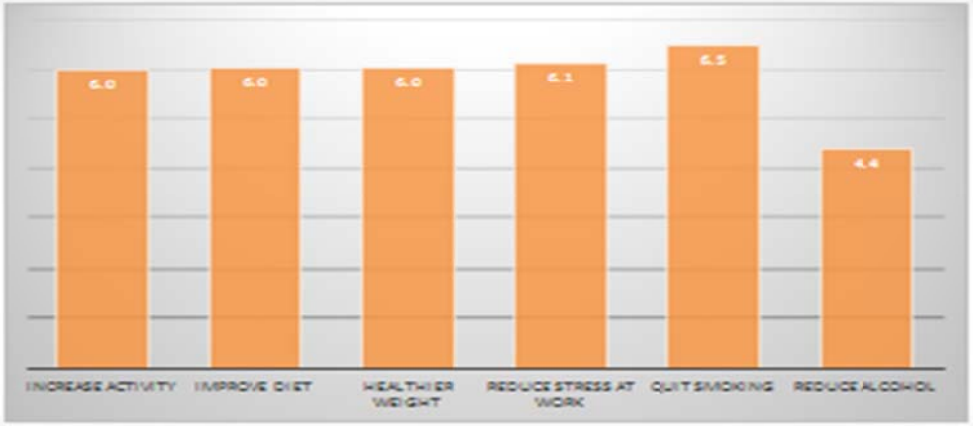


s – and
highest

sibility for
heir own

Health Behaviour Change

On a scale of 0 - 10, where 0 = no importance, 5 = somewhat important and 10 = extremely important, how important is it to you right now to:



robertsoncooper

n
e to take


Change Management
n=587
The Trust will be undertaking a significant period of service transfomation. Do you have any suggestions about how this change process can be managed effectively?
Better communication
Listening to staff
Resources
Inclusive approach
Affirming staff value
Constant change/Pace of change
Role of management
Effective support structure/services
robertsoncooper


Next steps...
Detailed results analysis
Staff engagement groups
Tailored interventions
Open & honest communication
robertsoncooper

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 29 April 2014
Agenda item 7.4(ii)

Title:	**Equality Report 2013/14**
Paper prepared by:	Director of Corporate Development
Purpose:	The purpose of this paper is to two-fold: - to demonstrate how the Trust meets its public sector duties; and - more importantly, to show how the Trust is embedding this through the organisation and showing the differences it is making to service users, carers and staff.
Mission/values:	Equality and diversity considerations are intrinsic to improving the service user and carer experience and the workplace culture, supporting the delivery of the Trust's mission, underpinned by the trust values.
Any background papers/ previously considered by:	Supports the delivery of the Trust's Equality First Strategy
Executive summary:	The Trust is committed to promoting the equality and diversity agenda, aiming to provide services which promote recovery, challenge stigma, enable social inclusion and promote an inclusive and fair working environment for our staff. Its aim is to ensure that everyone that needs to can access our services and that the Trust has a workforce that is free from discrimination and harassment. The Trust has adopted the NHS Equality Delivery System Framework (EDS), which has recently been reviewed and simplified, to assess equality performance and to provide assurance that the Trust meets its public sector equality duties. The Trust has chosen, based on using the original version of the EDS and recent engagement activity, inclusion and involvement work to focus on one outcome from each of the four EDS Goals: • better health care outcomes; • improved patient access and experience; • a representative and supported workforce; • inclusive leadership. The Trust has set out the rational for the choice, links to national policies and how it will evidence and measure performance. The Trust will undertake an annual review with its stakeholders to evaluate progress and determine priorities for future years.
Recommendation:	**Trust Board is asked to receive the Equality Report for 2013/14, to note the work the Trust has done to date and the further development required.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 29 April 2014
Agenda item 7.4(iii)

Title:	**Serious incident report Q4 2013/214**
Paper prepared by:	Director of Nursing, Clinical Governance & Safety
Purpose:	This report is providing information in relation to serious incidents in Quarter 4. The Board need to be aware of the year end position.
Vision/goals:	• Honest, Open and Transparent • Person First and in the Centre
Any background papers/ previously considered by:	A more detailed report is sent quarterly to the CGCSC. Previous quarterly reports which have been submitted to Trust Board. The annual report which is submitted to CGCSC.
Executive summary:	➢ This is the SI quarter 4 position. The annual report will be produced during quarter 1 2014/15, this report will include detailed data on trends and details on learning lessons. ➢ There have been no 'Never Events' reported in the Trust during 2013/14. ➢ There have been 29 SIs during quarter 4. This brings the annual total to 101 which is more than double the number last year, however as reported previously the reporting criteria has changed this year. Pressure ulcers which would not have been reported account for 45 incidents and the tightening of information governance reporting has resulted in 3 incidents. ➢ The Trust has reported a homicide this quarter where both the perpetrator and victim where in current contact or had been with the last 12 months. ➢ The apparent suspected suicide numbers have all year been below the number identified using benchmarking from NCI and population size. ➢ The position in relation to timely completion of report has continued to improve this year. ➢ The independent review process has just started in relation to the Kirklees Homicide cases 2010.9926, 2011.113700 and 2011.11502. The review is level C which is mainly desktop with some interviews. The aim is to get the investigation reports to Trust Board in October/ November 2014. NHS England has also requested the investigations covers the learning outcomes from 3 previous Kirklees homicides that took place in 2007/8. ➢ The Quarterly reports are being produced and will be shared with the CGCSC and BDUs.
Recommendation:	**Trust Board is asked to receive the report and note the contents**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trustwide Serious Incident (SI) Report for Quarter 4 2013/14 (1 January 2014 to 31 March 2014) data as 1.4.14

The SI figures given in different reports can vary slightly. This report is based on the date the SIs were reported to the PCT via the DOH database, STEIS.

1. Never Events

Never Events is a list (DOH) of serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There have been no 'Never Events' during 2013/14.

2. Serious Incidents reported to the Commissioners

During Quarter 4 there have been 29 serious incidents reported on STEIS. This brings the annual total to 101, which is more than double the number last year; however, as reported previously, the reporting criteria has changed this year. Pressure ulcers, which would not have been reported, account for 45 incidents over the year and the tightening of information governance reporting has resulted in three incidents (included in the 56 figure).

Table 1: Total SIs reported to the Commissioner by financial year and quarter up to the date of this report (2009/10 - 2013/14)

Financial quarter	10/11		11/12	12/13	13/14	
	SWYPFT	Barnsley	SWYPFT	SWYPFT	SIs	Pressure ulcers
Quarter 1	9	5	12	15	11	3
Quarter 2	4	2	12	7	14	13
Quarter 3	6	4	18	10	18	13
Quarter 4	7	1	6	12	13	16
Totals	**26**	**12**	**48**	**44**	**56**	**45**

Table 2: SI reported by teams and BDU	Barnsley	Calderdale	Kirklees	Wakefield	Specialist Services	Forensic Services	Total
District Nursing	16						16
CMHT	1	1		2			4
Crisis Resolution/IHBTT				1			1
Rapid Access				1			1
Assertive Outreach Team			1				1
Rehabilitation			1				1
Learning Disabilities Inpatient					2		2
Forensic In patients						2	2
Psychotherapy services				1			1
Total	17	1	2	5	2	2	29

The impact of reporting pressure ulcers grade 3/4 has significantly impacted the number of SI reported in Barnsley. This is a new requirement this year.

Table 3: Type of incident and BDU for Qu 4	Barnsley	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Total
Death - other cause	0	0	0	2	0	1	3
Formal patient absent without leave	0	0	0	0	1	0	1
Homicide by patient	0	0	0	1	0	0	1
Physical violence (contact made) against patient by patient	0	0	0	1	0	0	1
Safeguarding Adults - Sexual abuse	0	0	0	0	0	1	1
Self harm (actual harm)	0	0	0	1	1	0	2
Suicide (incl apparent) - community team care - current episode	1	1	1	0	0	0	3
Unwell/Illness	0	0	1	0	0	0	1
Pressure Ulcer - grade 3	12	0	0	0	0	0	12
Pressure Ulcer - grade 4	4	0	0	0	0	0	4
Total	17	1	2	5	2	2	29

Pressure ulcers continue to be the highest category of incident (16). This is followed by apparent suicides –current service users and discharged with 12 months (3) and death other (3)

3. Suspected Suicide reported to the Commissioners

The National Confidential Inquiry figures **July 2013** indicate that:

- Based on an average of the suicides recorded in the general population over the 10 years 2001 to 2011 there are approximately 10.86 suicides per 100,000 general populations each year. (range 8.8-10.6)
- On average during 2001-2011 patient suicides accounted for 28% of the general population suicide figures

The table below shows the populations of the BDUs and some average suicide rates which would be consistent with the figures produced by the NCI.

District	Population ONS – population estimates Mid 2012	General population suicide rate (NCI)	Patient suicide rate (28% general pop) (NCI)
Barnsley	231,865	20-24/5	6-7
Calderdale	204,170	18-21/22	5-6
Kirklees	422,970	37-45	10-13
Wakefield	326,433	29-35	8-10

Table 4: Suspected Suicides reported on STEIS

District	Qu1	Qu2	Qu3	Qu4	Total
Barnsley	1	2	1	1	5
Calderdale	1	1	3	1	6
Kirklees	3	3	3	1	10
Wakefield	1	1	0	0	2
Forensic	0	0	0	0	0
Specialist Services	0	0	0	0	0
Total	**6**	**7**	**7**	**3**	**23**

Although not complacent and all serious incidents are subject to investigations the Trust is just inside the figures expected to be seen. It must be noted that these figures are apparent suicides and not confirmed by Coroner. The total for year is 23 which is lower than the expected figure of between 29-36 based on the population size.
This figure must be viewed with caution as the national figures above are 2 years out of date when produced so can only be indicative but we are at the lower end of what we would expect to see.

4. Performance Management of Serious incidents

- **21** SI reports have been completed this quarter and sent to the Commissioners
- **30** SI reports have been closed by the Commissioners
- There are currently **27** open SI investigations taking place across the Trust data run on 1.4.14

	Barnsley	Calderdale	Wakefield	Kirklees	Forensic Service	Specialist Services	Total
Within timescales	11	6	4	3	0	2	**26**
Overdue - extension agreed* see breakdown below	1	1	0	1	0	0	**3**
Overdue - no extension agreed*	0	0	0	0	0	0	**0**
Total	**12**	**7**	**4**	**4**	**0**	**2**	**29**

Overdue breakdown:	Barnsley	Calderdale	Wakefield	Kirklees	Forensic Service	Specialist Services	Total
4-6 months since reported on STEIS	1	1	0	1	0	0	**3**
7-9 months since reported on STEIS	0	0	0	0	0	0	0
Total	**1**	**1**	**0**	**1**	**0**	**0**	**3**

There is nationally an agreement to aim to complete report in 45 working days, while the Trust tries to achieve this it has the support of commissioners to complete a quality report above a timely report. The performance in completing reports within the target 60 days has significantly improved throughout the year. There are less overdue reports, and the length of

time for overdue reports has decreased. The delays are often due to complexity of the case including a number of organisations along with staff availability for interviewing. At the end of March last year (2011/12) there were 18 overdue reports, currently there are 3 reports overdue, in the case of 2 the delay is in receiving information from a 3rd party .

5. SI Action plans

Each BDU monitors the implementation of action plans. The Patient Safety Support Team send out position status based on information completed on Datix with the quarterly report. On the Datix system there are currently **49** action plans being implemented, work is taking place within the BDU to improve the completion of action plans, last quarter there was **78**. Some action plans are partially completed; there are currently **30** action plans that still have some action to complete that is past the agreed timescale. The remaining **19** are within timescales.
More detail is available in individual BDU quarterly reports. The Clinical Support Unit is randomly reviewing completed action plans.

6. Updates on other SIs

Independent Reviews (DOH guidance HSG (94)27)
The independent review process has just started in relation to the Kirklees cases listed below. The review is level C which is mainly desktop with some interviews. The aim is to get the investigation reports to Trust Board in October/ November 2014. NHS England has also requested the investigations covers the learning outcomes from 3 previous Kirklees homicides that took place in 2007/8.

- **Kirklees BDU: 2010/9926** –A Kirklees CMHT service user being convicted of the murder of a neighbour and sent to prison. An internal investigation was completed in Feb 2011, and the action plan to address the recommendations has been implemented by the BDU and has evidence to demonstrate this.

- **Kirklees BDU: 2011/11370 and 2011/11502 -** 2 recent alleged homicides by ex-service users have been confirmed as homicide cases The internal Trust investigations into these cases are completed and action plans are being implemented. 2011/11370 has been subjected to a domestic homicide review which is a multi-agency review and overseen by the Home Office.

- **Barnsley BDU:** an internal investigation into an incident in which a service user killed a member of his family was completed earlier in 2011; an action plan was developed to address the report recommendations have been implemented. This incident occurred before Barnsley services joined SWYPFT. An independent inquiry has taken place and a further action plan has been produced. The action plan is being monitored by the CCG.

7. Serious Incident Learning

This is covered in six monthly and annual reports. The patient safety support team continue to support business delivery units in providing information to support them learning from incidents.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 29 April 2014
Agenda item 7.4(iv)

Title:	**Customer services report Q 4 2013/14**
Paper prepared by:	Director of Corporate Development
Purpose:	To note the service user experience feedback received via the Trust's Customer Services function, the themes arising, learning and action taken in response to feedback.
Mission/values:	A positive service user experience underpins the Trust's mission and all values; in particular: honest, open and transparent, person first and in the centre, improve and be outstanding, families and carers matter.
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. The Trust wide Service User Experience Group (a sub group of the EISTAG) is working to develop a dashboard of KPIs. EMT will agree key indicators for incremental reporting on service user experience.
Executive summary:	Following discussions at Trust Board and Non-Executive Director experience in other business environments, it has been agreed to develop 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 Qtr 3 2014/15. EMT will also consider how to build customer focussed KPIs into the 'Year of Values' work and will implement an 'awards' scheme to recognise teams for demonstrating the values in their work. **Customer Services Report – Qtr 4 2013/14** This report provides information on the number of complaints, the themes indicated, lessons learned and action taken in response to feedback. In quarter 4: • 344 issues were responded to • 79 formal complaints were received and 185 compliments • Care and treatment, admission, discharge and referral, staff attitude and waiting times were the most common themes. • 1 complainant asked the Parliamentary and Health Service Ombudsman to review their complaint • Over 150 public enquiries were responded and over 550 staff enquiries • 67 requests for information under the Freedom of Information Act were actioned.
Recommendation:	**Trust Board is asked to review and note the feedback received through customer services in quarter 4 of financial year 2013/14.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

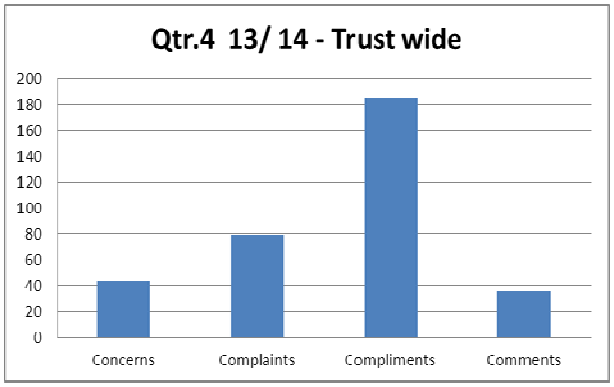
CUSTOMER SERVICES

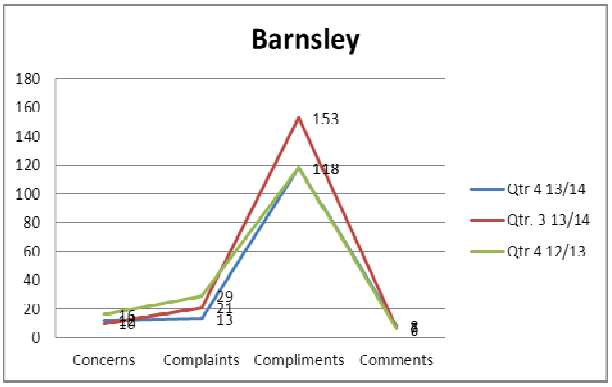
QUARTERLY REPORT FOR THE PERIOD 01 JANUARY 2014 - 31 MARCH 2014 (QTR. 4)

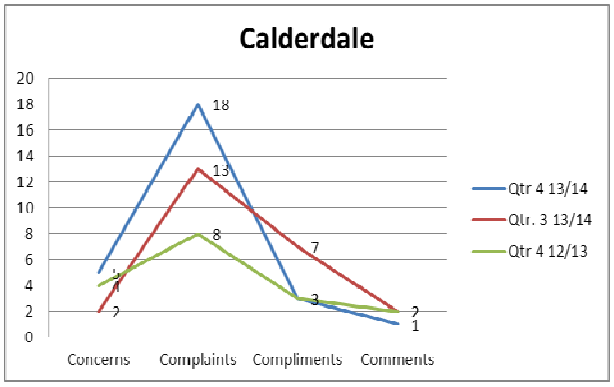
CUSTOMER SERVICES ACTIVITY QTR 4 2013/ 2014

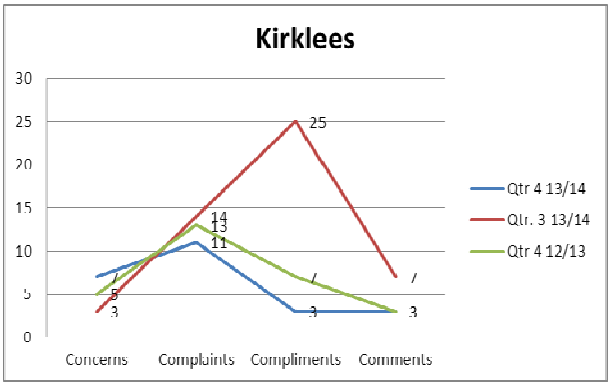
The customer services team responded to 344 issues under the Customer Services Policy: supporting the management of complaints, concerns, comments and compliments in qtr. 4. 79 formal complaints were received and 185 compliments. This compares to 384 issues, 85 formal complaints and 223 compliments in qtr. 3. A breakdown of the issues across the Business Delivery Units and the Quality Academy are indicated in the tables below.

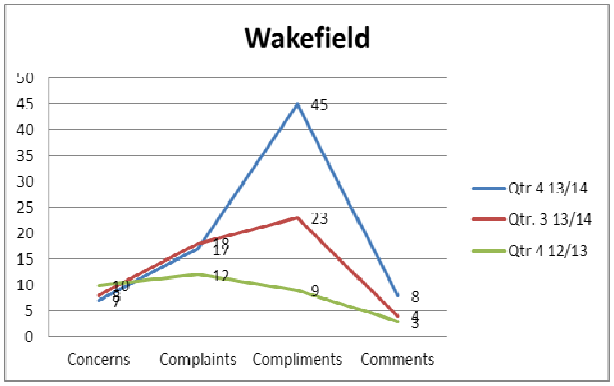
FEEDBACK RECEIVED

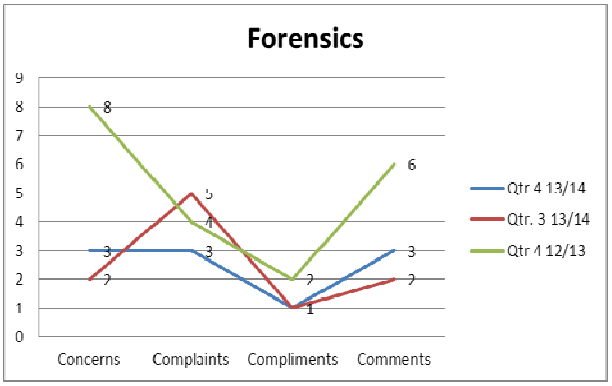


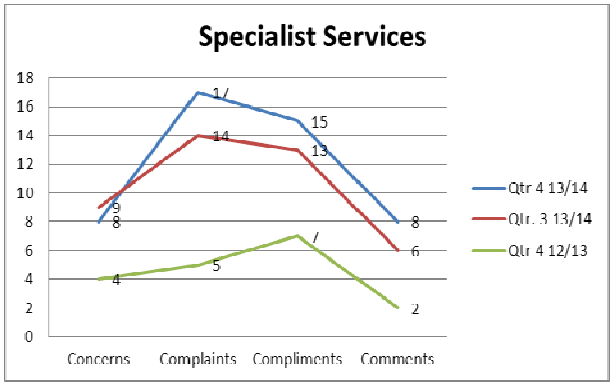


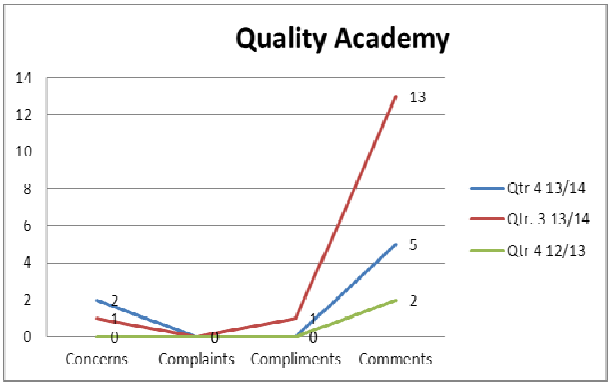












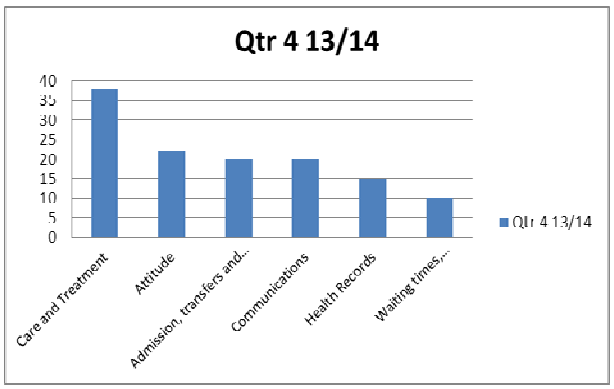
NUMBERS OF ISSUES RAISED INFORMALLY

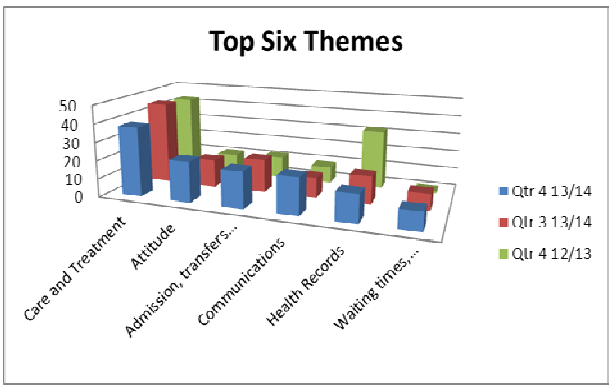
During the period, Trust services responded to 44 issues of concern at local level. The customer services team worked with service lines to ensure the recording of issues raised informally and to capture action taken in response to this feedback. This promotes a default position of putting things right 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. 4 were: care and treatment (38) admission, discharge and referrals (22), staff attitude (20), waiting times, appointments and cancellations (20), communications (15) and policy, corporate decisions (10)

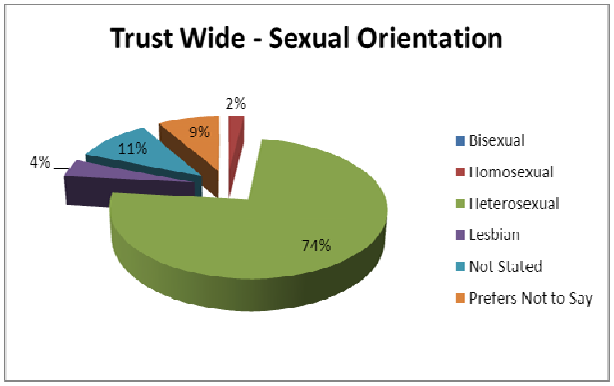
The Customer Services function links to a weekly risk scan which brings together intelligence from the Patient Safety Support Team and the Legal Services Team to triangulate any issues of concern and assess the impact on service quality. The team also input as appropriate to the monthly clinical / professional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

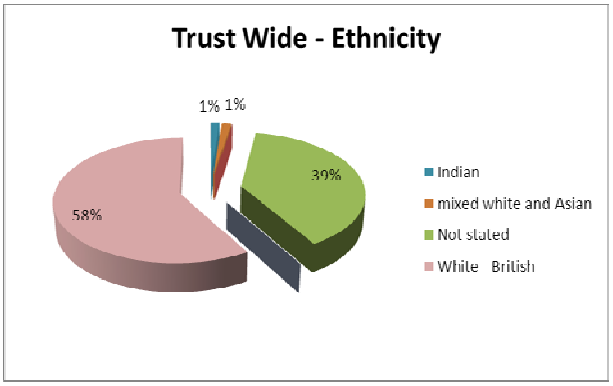


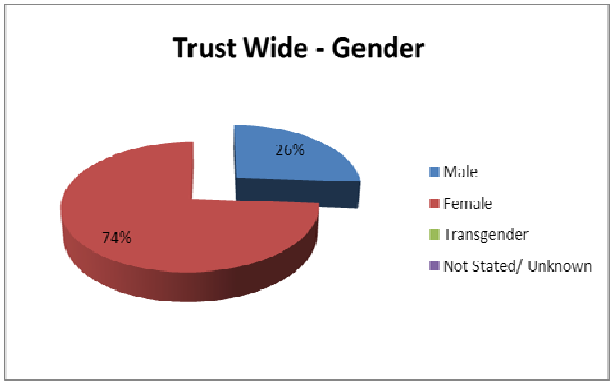


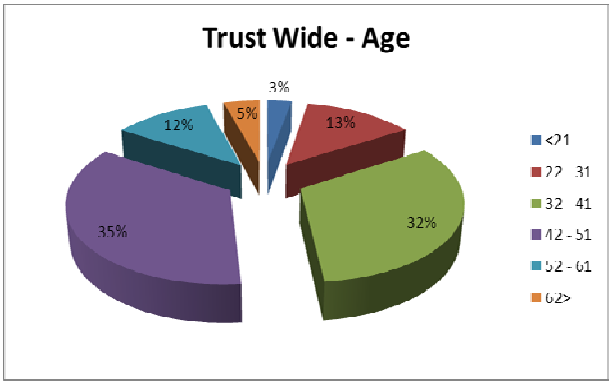
TRUST WIDE EQUALITY DATA

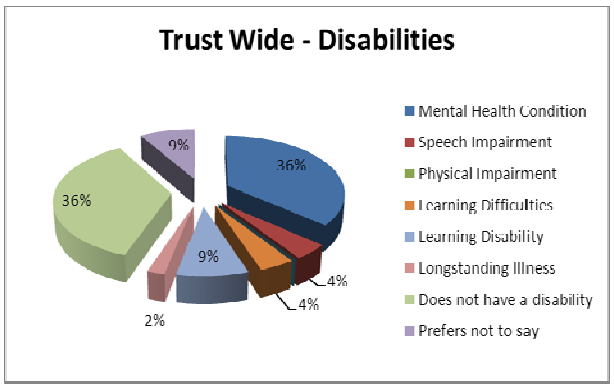
Equality data is captured, where possible, at the time a formal complaint is made. Where complaints are received by email or letter, an equality monitoring form is issued with a request to complete and return. The current average response rate for forms is 59%. The charts that follow show where information 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 underneath the tables.











Age 68/79 *Gender 77/79* *Disabilities 47/79* *Ethnicity 77/79* *Sexual Orientation 47/79*

MP CONTACT

During quarter 4, there were 7 occasions where complaints and feedback were received via local MPs, acting on behalf of constituents. The issues included:

- Specialist services (CAMHS) – two enquiries regarding appointment waiting times and one regarding access to services
- Barnsley BDU – enquiry about alternative therapy options
- Wakefield BDU – three enquiries – a medication query, issues regarding a consultant report to DVLA and concern regarding assumed lack of support and late diagnosis.

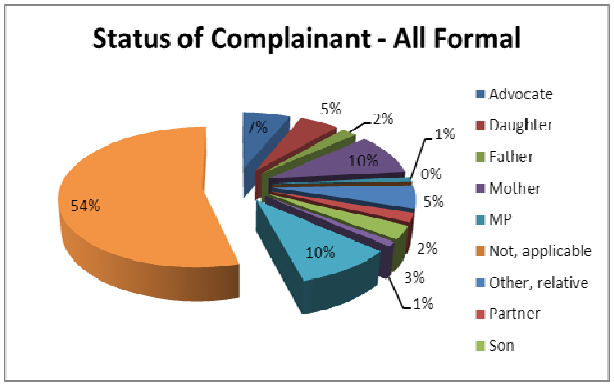
MP enquiries are processed in line with routine practice and contact made direct with individuals wherever possible.

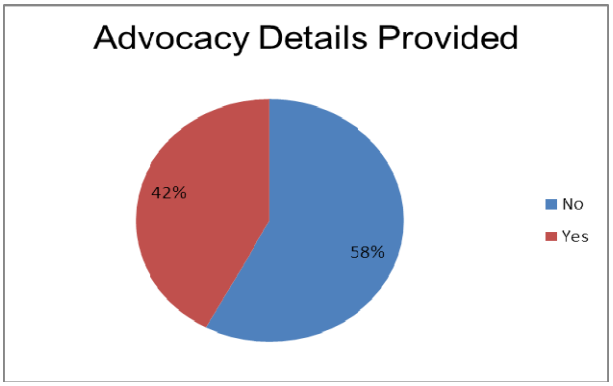
ADVOCACY SERVICES AND ASSISTANCE WITH PROVIDING FEEDBACK

Some service users find it helpful to have the support of a relative or other person to speak on their behalf or raise issues for them. Independent assistance can also be provided by Independent Advocacy. This service

operates outside the NHS, and supports people making a complaint, or thinking of making a complaint. The way in which NHS complaints advocacy services are commissioned was changed in April 2013. These services are now determined and provided by each local authority.

All complainants are advised by the Customer Services Team that independent advocacy is available.





PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN (PHSO)

Cases which are reviewed by the PHSO are subject to rigorous scrutiny by the Ombudsman, including a review of all documentation and the Trust's complaints management processes.

During Quarter 4, 1 complainant asked the Parliamentary and Health Service Ombudsman to review their complaint. All requested information was provided within the specified timeframe. During Quarter 3, the PHSO reported on a joint investigation, with recommendations for both the Trust and Kirklees Council, dating back to 2011. The Trust is working with the Council to ensure that the completed action plan and the revised joint working protocol are provided to both the LGO and PHSO. The recommended response and financial redress to the complainant have been actioned.

MENTAL HEALTH ACT

4 complaints were made in the quarter with regard to service user detention under the Mental Health Act. 2 specified their ethnicity as white British and 2 chose not to disclose. 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 COMMISSION (CQC)

No issues were referred to the Trust by the CQC in the period.

JOINT WORKING

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

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

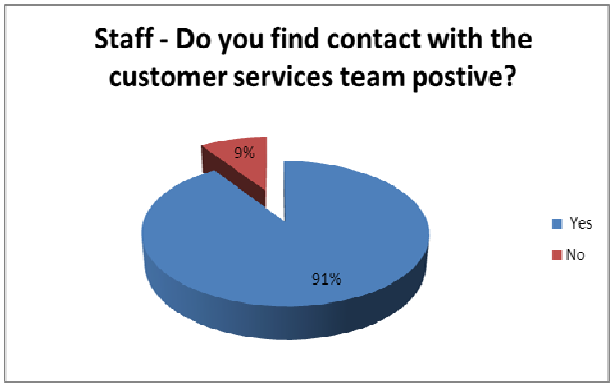
Issued raised spanning more than one organisation in Qtr 4	Formal Concern (Over 48 Hours) (COMPLAINT)	Informal Concern (Up to 48 Hours) (CONCERN)	Service Issue (COMMENT)	Total
Barnsley Hospital NHS Foundation Trust	1	0	0	1
Barnsley Metropolitan Borough Council	1	0	0	1
Calderdale and Huddersfield NHS Foundation NHS Trust	1	0	0	1
Member of Parliament	2	2	3	7
Mid Yorkshire Hospital NHS Trust	1	0	0	1
NHS Barnsley CCG	0	1	0	1
Other	0	0	1	1
Total	6	3	4	13

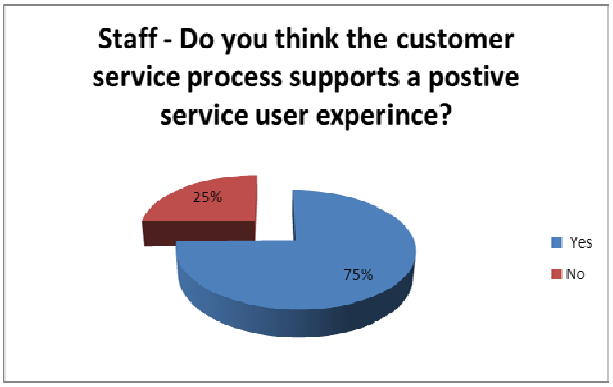
CONTACT WITH THE CUSTOMER SERVICES TEAM

The customer services team processed 151 general 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 568 telephone enquiries from staff, and offered support and advice in resolving concerns at local level.

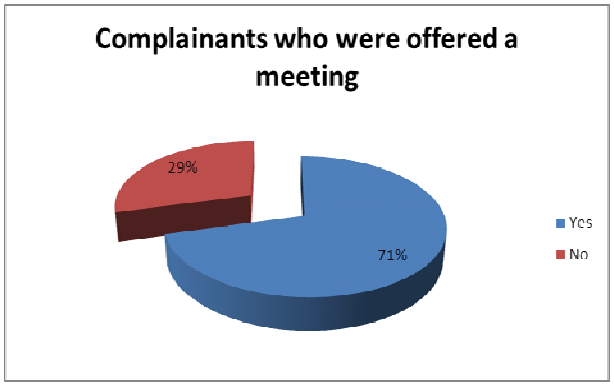
In responding to contact of any kind, the team negotiates with individuals regarding the timescales for responding to issues and regular contact is maintained until issues are resolved to the individual's satisfaction. This connection results in positive feedback to the service regarding complaints management.

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 Customer Services Team increasingly collects feedback from service users via telephone survey which supports real time feedback and improved responsiveness.

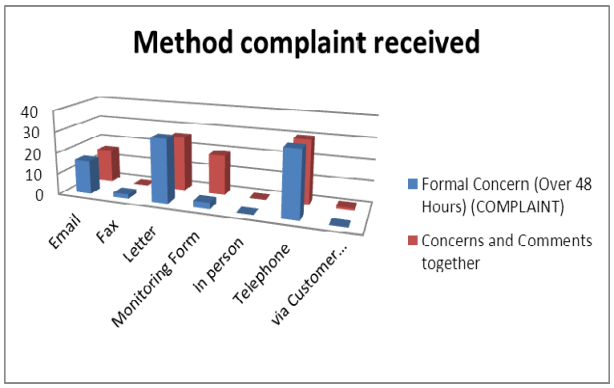




The Trust recognises that it is good practice to offer complainants the opportunity to meet staff to discuss issues. This offer is made early in the process, especially when complaints relate to more serious issues or complex circumstances. These meetings are ideally attended by Customer Services and service staff and provide an opportunity for staff to reflect on the experience from the service user's perspective. Feedback from staff shows that this improves overall understanding of how people who use services and their families are affected by the contact. Most complainants agree to meet with Trust staff to discuss their concerns.

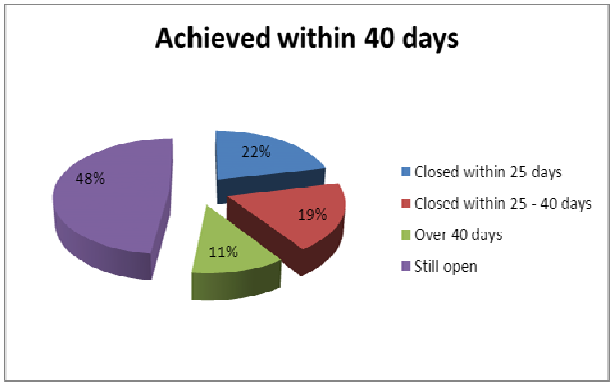


Complainants may wish to communicate in writing, over the phone, by email or through face to face meetings. Ensuring that people have access and opportunities to feedback their views and experiences of care is an essential to delivering the Trust values and is part of how we ensure they have a say in public services. The Customer Services function is part of a developing framework of activity to facilitate feedback about all aspects of services and ensuring any lessons learned are acted upon.



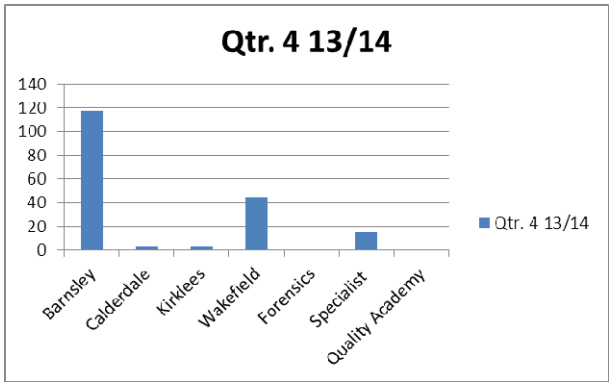
RESPONDING IN A TIMELY MANNER

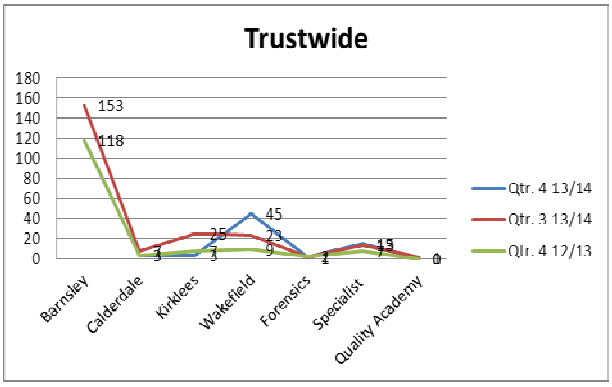
The customer services standard is for complaints to be acknowledged within three days, with a named case manager assigned. Timescales are negotiated on an individual basis, with each complainant offered regular updates on progress until issues are resolved to their satisfaction or a full explanation has been provided. All complaints are dealt with as speedily as possible. The standard is for every complaint to be responded to within 25 days; exceptionally within 40 days for the most complex cases.



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 185 compliments recorded in the period regarding care and treatment.





Some compliments received in the period:

We would like to thank you for all your dedicated time you have given to our daughter. You have been a big part of our lives, helping us to understand and deal with her illness. We wish you all the best in your career path, you will be hugely missed. Best Wishes.

Once i accessed treatment, the experienced has been very positive. Appointments that fitted around work were especially important, and this has helped me to maintain treatment without breaks. I feel that i have been lucky to have seen the member of staff who has helped me in so many ways.

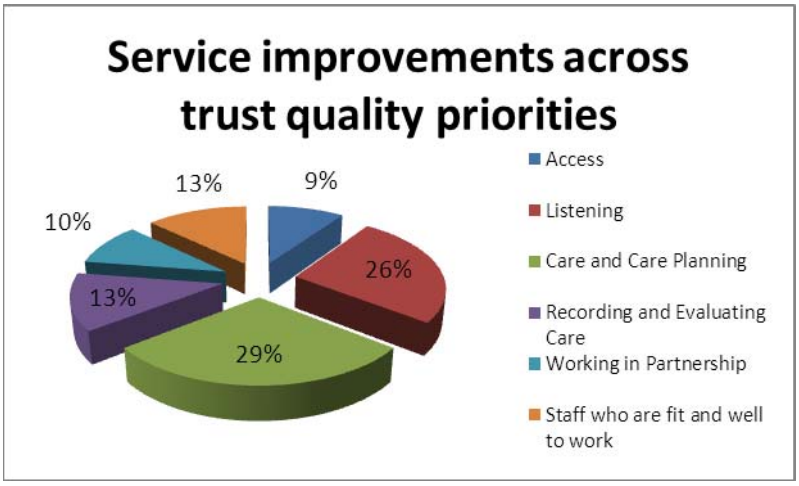
The health trainer has been very supportive and listened to my issues in a sensitive manner. Her genuine concern, care and trusting manner has made discussing my problems via my GP service more bearable with such a trusting individual. Andrea is a valuable resource to have and I thank her for being there to listen and help me gain some inner strength and confidence back.

Word cloud illustrates 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 Kirklees CAHMS service is currently reviewing staff attendance at Children and Family meetings to ensure a full overview is provided.
- Kirklees IAPT services have increased capacity to enable thorough signposting to appropriate services to best suit the needs of individual service users
- Barnsley district nursing services have implemented new procedures to ensure family members/carers are provided with updates and action plans where appropriate.
- Barnsley continence service now ensures all service user manual records are checked against electronic records to ensure consistency
- A Kirklees inpatient ward will ensure full explanations are provided to service users/family members/carers regarding bed management and out of area placements.
- A Barnsley CMHT is working collaboratively to ensure effective joint crisis contingency plans are in place



SERVICE USER AND CARER STORIES

Ian contacted the customer services team to raise concerns regarding his father's recent admission. He was upset that his father's fluid intake had not been monitored, health care records were not completed, senior staff had took leave at the same time and that there was no cover in their absence. Some of his father's personal belongings were lost. Ian also raised concerns that the responsible named clinician did not visit his father during his stay.

As a result of Ian's feedback, the service has now put in place systems for supporting staff in caseload management, improve record keeping, and to ensure that the named clinician meets with the patient. All annual leave is centrally recorded, cover arranged and always in place. A full explanation was provided to Ian to ensure all concerns raised were answered in full

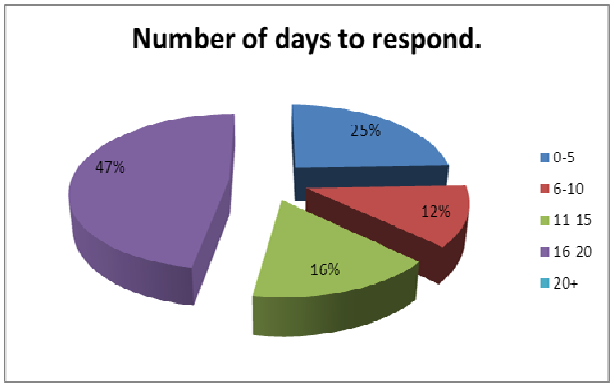
Amy raised concerns that three of her appointments showed in her records as DNAs, where in fact, 2 appointments had been cancelled by the CAMHS service and she never received a further appointment. The investigation showed that Amy and her family experienced poor communications as a result of poor administration.

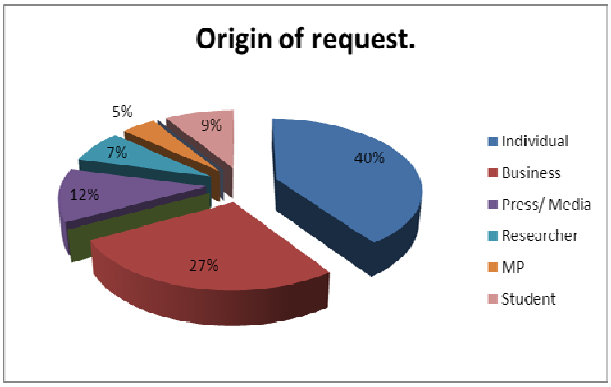
An apology was offered along with an explanation of the improved administrative procedures put in place to minimise future errors. Records were amended to reflect that missed appointments were the fault of the service.

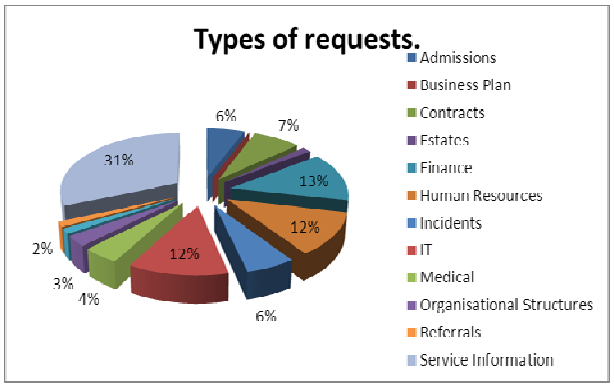
FREEDOM OF INFORMATION REQUESTS

67 requests to access information under the Freedom of Information Act were processed in quarter 4, an increase on the previous quarter when 53 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 4 there was one exemption applied under section 22 of the Act, as the information requested was intended for future publication and will be incorporated into the Trust's annual report and accounts. 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 into 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 include reference to the Parliamentary & Health Service Ombudsman's evolving stance on redress
- Policy and procedures in relation to response to feedback and complaints

management are currently being reviewed in light of the introduction of the duty of candor

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 has ceased production of the quarterly report 'What Matters', which promoted positive practice across quality priorities. Reporting is being developed from that of snapshot reporting of positive experience to a dashboard of agreed KPIs, incrementally reported to influence and change behaviours and ensure an optimum service user experience. This work is being progressed as part of the service user experience sub group of the Equality & Inclusion Trust Action Group.

EMT will also consider how to build customer focussed KPIs into the 'Year of Values' work and to recognise teams and individuals for demonstrating they 'live the values' in the delivery of their work.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 29 April 2014
Agenda item 8

Title:	**Trust Board self-certification – Monitor Quarter 4 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.
Mission/values:	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:	Quarter 4 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 was included in the finance report for month 11. 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 Q4 is, again, 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. 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 4 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 4 return 2013/14
Trust Board 29 April 2014

Commissioner requested services
There have been no changes to commissioner requested (mandatory) services since Quarter 3.

Trust Board
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. Similarly, the Chief Executive has agreed to maintain a voting cohort of five Executive Directors to ensure appropriate balance on Trust Board. 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 the Non-Executive Director vacancy when Bernard Fee's term of office ends in May ended on 7 April 2014 with formal interviews. The successful candidate, Laurence Campbell, will take up post on 1 June 2014, subject to satisfactory references and approval of the appointment by the Members' Council on 30 April 2014.

Members' Council
A renewed approach will be made to Kirklees Metropolitan Council to identify a representative to fill the allocated seat now a new appointment has been made to the Leader of the Council.

The nominations process for elections to the Members' Council ended on 14 March 2014. The current position is as follows. Ballot papers have been sent to eligible members and voting ends on 25 April 2014.

- In Barnsley, there were three candidates for two seats and an election is currently in progress. The closing date of the election is 25 April 2014 and an update on the successful candidates will be given at the meeting. The candidates are:

  Shaun Adam (seeking re-election);
  Andrew Crossley;
  Andrew Hill (seeking re-election).

- In Calderdale, there was one candidate for one seat and the following was elected unopposed from 1 May 2014 for a three-year term.

  Daniel Redmond

- In Kirklees, there were eight candidates for two seats and an election is currently in progress. The closing date of the election is 25 April 2014 and an update on the successful candidates will be given at the meeting. The candidates are:

  Peter Adu;
  Katerina Dalli;
  Michael Fenton;
  David Gill;

Nasim Hasnie (seeking re-election);
Graham Lamming;
Gordon Morrison;
Geoff Smith.

- In Wakefield, there were four candidates for two seats and an election is currently in progress. The closing date of the election is 25 April 2014 and an update on the successful candidates will be given at the meeting. The candidates are:

  Julie Craven;
  Tony Fitzpatrick;
  Roger Grainger;
  Hazel Walker (seeking re-election).

There remains one vacancy for the public constituency of the rest of South and West Yorkshire.

- For the staff psychological therapies vacancy, there was one candidate for one seat and the following was elected unopposed from 1 May 2014 for a three-year term.

  Garry Brownbridge

There was no candidate for the social care staff working in integrated teams seat; therefore the vacancy remains.

Care Quality Commission (CQC)

- In the latest QRP re-fresh (February 2014) 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 still has two 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 submitted action plan addressing environmental improvements is to be fully completed by 31 May 2014.
- The Trust has still not received the CQC report following the inspection visit to Fox View made in January 2014 where the outcomes inspected were 4 (care/welfare), 6 (co-operating with other providers), 7 (safeguarding), 13 (staffing), and 21 (records). It is known that the inspector was given very good feedback from relatives and carers who spoke consistently of the high levels of care they felt were provided by the service. There was also evidence that safeguarding concerns were picked up and acted on. The inspector did identify some gaps in records and was giving consideration as to whether these would require a compliance action to be issued in respect of outcome 21.
- The CQC continues to monitor the trust in regard to admission of patients to wards when no beds are available, environmental standards relating to seclusion rooms and the level of cancellation of section 17 leave
- There were ten CQC Mental Health Act visits in Quarter 4 to the Horizon Centre, Appleton, Fox View, Elmdale, Priory, Hepworth, Trinity 2, Savile Park, Melton Suite and Waterton. Four reports have been received (Appleton, Elmdale, Fox View and the Horizon Centre), which are largely positive in terms of practice and implementation of actions identified from previous visits. It is noted that there has been improvement across Trust units in terms of section 17 leave forms being appropriately authorised on the Trust's approved form. Evidence of physical health checks and physical health plans

were deficient at the Horizon Centre. A continuing lack of evidence of meaningful patient involvement in care planning was identified in the report on Elmdale.

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 was the subject of an internal, independent investigation, which has now concluded that there was no evidence of deliberate data manipulation but there have been examples of poor practice and poor leadership, which have been addressed through a robust action plan.

Absent without Leave (AWOL)
During quarter 4, there was one case reported to the CQC relating to a service user in medium secure services who absented themselves from hospital and was returned by police.

Eliminating Mixed Sex Accommodation (EMSA)
There have been no breaches reported on Datix in Q4. 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 six such instances reported on Datix in Q4, which represents a decrease over Q3. 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 Q4.

Infection prevention and control
In quarter 4, there has been one case of Clostridium Difficile in Barnsley, which resulted in a cumulative total of seven cases at the year-end against a full year trajectory of eight. The year-end position, therefore, is below the maximum permitted number of cases. 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 three incidents with the Information Commissioner and has provided responses to all enquiries from the Information Commissioner's Office. No further incidents have been reported in quarter 4.

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

Safeguarding Children
- There were 37 reported incidents Trust-wide directly relating to issues of child protection in Q4. This represents an increase on Q3 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 Q4 there have been 29 SIs reported to commissioners (17 in Barnsley which includes incidents related to pressure ulcers, one in Calderdale, five in Kirklees, two in Wakefield, two in specialist services/CAMHS and two in forensic services). 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
There were no internal audit reports with either no assurance or limited assurance received by the Trust during the quarter. The Audit Committee received a substantial assurance audit report on financial management, which included a review/follow up of the recommendations from the procurement (non-pay purchasing) audit that provided a no assurance opinion. The follow up found that:

- there had been timely and effective progress in relation to the action agreed with management;
- the interim arrangements where permanent solutions have not yet been implemented were effective; and
- there was no indication of breaches in control during the period.

As a result, the Audit Committee received a draft Head of Internal Audit Opinion, which provided a substantial assurance opinion.

The Trust also received substantial assurance for the internal audit of the Trust's compliance with the terms of its Licence and for its response to the Francis II report.

Strategic outline case
Work in partnership with Calderdale and Huddersfield NHS Foundation Trust and Locala continues to progress. The strategic outline case is being discussed by a wide range of stakeholders and is currently under consideration by commissioners. It is the intention of the three providers to continue to work in partnership to develop a position of system and organisational sustainability and development of an outline business case by the end of May 2014.

Monitor targets – 7-day follow up

It has come to light through data quality monitoring that the definition used for the denominator for the 7-day follow up target was not in line with Monitor's Risk Assessment Framework. The correct definition has been used for Q4 and the Trust meets its target. A retrospective review of quarters 1 to 3 2013/14 is underway and Monitor will be advised of the outcome.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 29 April 2014
Agenda item 9

Title:	**Assurance framework and organisational risk register Q4 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.
Mission/values:	The Assurance Framework and risk register are part of the Trust's governance arrangements and integral elements of the Trust's system of internal control, supporting the Trust in meeting its 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 4 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. Trust Board approved a first draft of the AGS at its meeting in March 2014. The strategic corporate objectives for 2013/14 were approved by 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.) **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; - transformational service change programme; - arrangements for specialist commissioning of forensic services; - the local health economy position; - bed pressures. The risk in relation to an internal audit report on procurement has been removed following presentation to the Audit Committee of an internal audit report on financial management, which provided a substantial assurance opinion, and receipt by the Committee of the draft Head of Internal Audit Opinion for 2013/14, which provided a substantial assurance opinion.
Recommendation:	**Trust Board is asked to:** ➢ **note the assurances provided for Q4 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

ASSURANCE FRAMEWORK 2013/14 – as at Q4 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

Appendix 1

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

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

Assurance (A..)	Assurance on controls (Planned outputs)	Board reports received (including sub-committees, EMT)
1.	Quarterly documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems. 1.2, 1.4,2.1, 2.2, 2.3, 2.4, 2.6, 2.7, 2.8, 3.1, 3.2, 3.4, 4.3, 4.4, 5.2, 5.3, 6.1, 7.1	➢ CE summary letters to Directors following each quarterly review. ➢ Update reports to each 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 ➢ Paper to Trust Board on revised reporting January 2014
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. ➢ Review of values-based appraisal process undertaken and revised policy and supporting documentation approved by EMT March 2014
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 and January 2014
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 and January 2014 ➢ 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 and January 2014
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 and February 2014 ➢ Achieving service transformation and marketing and strategic planning papers to Trust Board April 2013 ➢ In support, business and risk strategic analysis to Trust Board January 2014 ➢ In support, transformation programme visions to Trust Board March 2014 ➢ Two-year operational plan briefing for Trust Board March 2014
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 and January 2014 ➢ 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 and January 2014)
10.	Quarterly Assurance Framework, Risk Register and Risk Triangulation report to	➢ Assurance Framework and risk register to Trust Board (April, July and October 2013

Assurance (A..)	Assurance on controls (Planned outputs)	Board reports received (including sub-committees, EMT)
	Board providing assurances on actions being taken. 2.1, 2.3, 5.3,	and January 2014) ➢ 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 2013 and February 2014) ➢ 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 and February 2014 ➢ Trust approach to supporting service users into employment February 2014
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 ➢ First draft 2013/14 approved by Trust Board January 2014
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 ➢ Approval of annual submission Trust Board March 2014
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 and February 2014
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 ➢ Monitor licence compliance March 2014
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

Assurance (A..)	Assurance on controls (Planned outputs)	Board reports received (including sub-committees, EMT)
		➢ 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 ➢ Will form standing item on CG&CS Committee agenda to reflect rolling programme from 1 April 2014
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 and February 2014 ➢ Interim results of staff wellbeing survey July 2013 and full results February 2014 ➢ Update on achievement of appraisal target July 2013
23.	Audit Committee review evidence for compliance with policies, process, SO's, SFI's, SofD, mitigation of risk, best use of resources. 2.3, 4.1,	➢ Annual report and accounts ➢ Standing item on service line reporting and currency development ➢ Standing item on procurement and review of procurement strategy ➢ Standing item on progress against counter fraud plan ➢ Standing item on progress against internal audit plan ➢ Head of Internal Audit Opinion May 2013 ➢ Review of Standing Financial Instructions January 2014 ➢ Review of declaration of interests process January 2014
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,	The Trust was accredited against the IiP standard in 2009 and re-assessed in 2012, and is working towards achieving GOLD standard in 2014/15.
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,	➢ Interim results of staff wellbeing survey July 2013 and full results February 2014 with NHS national survey ➢ HR performance report Trust Board January 2014
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

Assurance (A..)	Assurance on controls (Planned outputs)	Board reports received (including sub-committees, EMT)
		Committee agenda ➢ Quality Accounts final report to Clinical Governance and Clinical Safety Committee May 2013
32.	External and internal Audit reports performance managed through approvals EMT. 3.5,	➢ Internal audit follow up reports to EMT and consideration of internal audit reports with limited assurance throughout 2013/14 ➢ Quality Accounts external assurance Audit Committee May 2013 and Trust Board June 2013
33.	Audit of compliance with policies and procedures in line with approved plan co-ordinated through clinical governance team in line with Trust agreed priorities. 2.2, 3.4,	➢ Reports to Clinical Governance and Clinical Safety Committee ➢ Monitoring of action plan following medicines management audit CG&CS Committee April and June 2013, and update July 2013 ➢ Limited assurance reports considered by EMT ➢ Internal audit reports on clinical governance (substantial), compliance CQC standards (moderate), quality governance (substantial), change management programme (moderate), health record (SystmOne) (moderate), adult safeguarding (limited), IG toolkit (substantial), facilities (moderate), revalidation (substantial) and financial affairs – community patients (limited progress), data quality (limited), clinical leadership (advisory), self-directed support (advisory), local authority partners (substantial), corporate governance (substantial), payroll (substantial), estates strategy management (substantial), service level agreement management (non-healthcare) (limited), procurement (non-pay purchasing) (none), risk management and board assurance framework (moderate), Information Governance Toolkit, (moderate) and infection prevention and control (moderate).
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,	Currently no annual report produced; however, evidence provided as follows. <u>Leeds</u> Annual MPET contract review meeting notes (7 August 2013) Feedback report covering September 2012 to June 2013 <u>Sheffield</u> Rotations 2-5 feedback reports from February 2013 to October 2013
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) ➢ Business and risk strategic analysis January 2014
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

Assurance (A..)	Assurance on controls (Planned outputs)	Board reports received (including sub-committees, EMT)
		➢ Monitor Compliance Framework to Trust Board April 2013 ➢ Monitor Code of Governance to Trust Board April 2013 and March 2014 ➢ 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 ➢ Monitor licence risk assessment Trust Board January 2014 ➢ Approval by Trust Board of two-year operational plan 2014/15 to 2015/16 March 2014
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,	➢ Quality improvement plan currently under development for presentation to CG&CS Committee April 2014
44.	Estates Forum monitors delivery against Estates Strategy. 2.7,	➢ Estates forum minutes and papers outlining development of Estates Strategy
45.	Equality and Involvement Strategy into Action Group established monitoring delivery of equality, involvement and inclusion action plans, reporting into CG&CS Committee. 1.5	➢ Equality and Involvement Strategy into Action Group terms of reference and minutes
46.	Serious Incidents from across the organisation are reviewed through the Incident Review Panel including the undertaking of root cause analysis and dissemination of lessons learnt and good clinical practice across the organisation. 2.2, 3.3,	➢ Incident Review Sub-Committee minutes and reports to Clinical Governance and Clinical Safety Committee ➢ Serious incidents quarterly reports to Clinical Governance and Clinical Safety Committee and Trust Board
47.	Mandatory training review group in place ensuring consistency of approach across Trust and compliance with legislation. 2.6, 4.2, 8.3, 7.2,	➢ Review group terms of reference ➢ Revised mandatory training policy approved by EMT October 2012
48.	Assurances received by sub-committees of the Board reported quarterly to Trust Board, providing Board assurance on systems and controls in place and operating. 3.3	➢ Assurance from Trust Board Committees to Trust Board (June, September and December 2013 and March 2014)
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

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

ORGANISATIONAL LEVEL RISK REPORT

DATE: 29 April 2014 (Trust Board)

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

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

Risk ID	Hist Ref.	Source	Risk Responsibility	BDU / Directorate	Service	Speciality	Description of risk	Current control measures	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Summary of risk action plan	Fin cost (£)	Risk owner	Expected date of completion	Monitoring & reporting requirements		Risk level (target)	Is this rating acceptable?	Comments	Risk review date
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)	➢ Progress against Data quality action reviewed at Performance EMT on ongoing basis. ➢ Communication via Team Brief and Extended EMT re key messages. ➢ Action plan for each BDU monitored through PBR project team and Board 1. RiO Optimisation – re- focused and linked to PBR roll out with engagement of clinical staff 2. Roll out plan reviewed by RiO development Board. 3. Wider system development network established with clinicians and managers. First set of quick wins to be implemented Qtr 1 2014 ➢ Data quality metrics included in monthly performance reports.	100K est. additional capacity	DoF Lead and Director of Nursing	Implementation of national guidance during 2014/15.	EMT and Trust Board monthly review for data quality indicators. Steering group review for Data quality Board, PbR Project Board and RiO system development Board.	15		Yes		Trust Board July 2014
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)	➢ Re-launch of Project Jan 2013 with Director Finance lead. Project Board in place with Medical Director and BDU Director representation ➢ Steering group arrangements in place with Commissioners to manage implementation. ➢ Project plan in place for 2014-15 contracts proposal to roll over Memorandum of Agreement with Commissioners ➢ PBR communications and information plan to roll out from April 2014 ➢ Standing item on Performance EMT	Included in 267	DoF	As above and included in transformation programme and two-year operational plan	EMT Progress reports Report on progress to every Audit Committee Regular Board updates	15		Yes	2014/15 objectives to identify variances from currency model at team level. Understand variances and take corrective action to show demonstrable improvement by end of year.	Trust Board July 2014

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 arose regarding delivery i.e. delayed transfers of care and service users in settled accommodation.	4 Major	4 Likely	16	Red/extreme /SUI risk (15-25)	Continues to be monitored through BDU / commissioner forums. Some evidence in For e.g. recruitment in Kirklees of budgetary pressures in LA impacting on speed of recruitment.		District Service Directors	Included in two-year operational plan	EMT (monthly) and Trust Board (monthly)	12	Amber/ high (8-12)	Yes		Trust Board July 2014
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 clinical and reputational risk in in year delivery by imbalance of staff skills and capacity between the "day job" and the "change job".	➢ Scrutiny of performance dashboards and bi-weekly risk reports by BDUs 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 Trust Board. ➢ Clear accountability arrangements for leadership and milestones for the transformation programme which are monitored by EMT. ➢ Engagement of extended EMT in managing and shaping transformational change and delivering in year performance.	5 Catastrophic	4 Likely	20	Red/extreme /SUI risk (15-25)	➢ Engagement events being held in June/July on transformation. ➢ Business Case for RAID completed and being implemented qtr 4 2013-14. ➢ Director objectives linked to deliverables in the transformation programme.	£500,000	Leads for Big ticket programmes Director of Service Improvement/ EMT - in year performance	Two-year operational plan	EMT (monthly) and Trust Board (quarterly)	15	Red/extreme /SUI risk (15-25)	Yes		Trust Board July 2014
511		Forensic					Specialist commissioning arrangements have significantly altered since the business plan to expand the women's service was approved. There remains uncertainty as to the basis on which contracting of the new beds can take place and despite numerous meetings with commissioners, no clear process has been identified. There is the potential for the expanded bed base to be ready for commissioning without either an agreed commissioning model or financial envelope which could potentially have a significant negative revenue impact within the Forensic contract value.	➢ Negotiations are underway with the specialist commissioners. ➢ A range of alternative workstreams which would provide subspecialisation areas to support further commissioning work are underway. ➢ Internal financial modelling, particularly with regard to capacity generation is underway. ➢ Future meetings with the commissioning team and head of specialist commissioning within the region are due to take place in early December. ➢ The opening of the beds has been postponed until June 2014 to allow refurbishment works and this has provided a further window of opportunity for contract negotiation.	4 Major	4 Likely	16	Red/extreme /SUI risk (15-25)	➢ Internal service offer developments underway. Financial modelling being undertaken internally. ➢ Ongoing negotiations with commissioners and the head of specialist commissioning have been arranged. ➢ Paper to Trust Board 29 April 2014		Director of Forensic Services			9	Amber/ high (8-12)			Trust Board July 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 Trust 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)	➢ SWYPFT proactive in involvement in system transformation programmes which are led by commissioners. ➢ Internal SWYPFT transformation programme linked to CCG commissioning by including schemes within the QIPP element as part of the service development plan in the 2014-15 contract ➢ RAID scheme being implemented in Calderdale and Huddersfield ➢ Psychiatric Liaison scheme approved in Wakefield.	£100,000	Deputy DCE lead & Directors	Two-year operational plan	Monthly strategic and business and risk EMT meetings. Trust Board reports as appropriate. Business case for RAID approved by C&K commissioner. Wakefield case submitted. Monthly at EMT and Trust Board 22 October 2013	12	Amber/ high (8-12)	Yes		Trust Board July 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 completed and action plan developed. ➢ Patient flow system established in two BDU's with rest to follow. ➢ Linked to Acute Care Transformation Programme.	4 Major	4 Likely	16	Red/extreme /SUI risk (15-25)	➢ Actions in place to manage patient flow have had positive impact on numbers of bed days out of area and the level of cost incurred in qtr 4. ➢ Trajectory monitored at EMT performance	`	District Service Director	Reviewed Protocol February 2014	Monthly at EMT	12	Amber/ high (8-12)	Yes		Trust Board July 2014