With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board (public session)
Tuesday 22 July 2014 at 11:00
Conference room 3, Al-Hikmah Centre, 28 Track Road, Batley, WF17 7AA

AGENDA

1. Welcome, introduction and apologies

2. Declaration of interests

3. Chair and Chief Executive's remarks

4. Minutes and matters arising from previous Trust Board meeting held on 24 June 2014

5. Performance reports month 3 2014/15

5.1 Section 1 – Quality performance report month 3 2014/15 (to follow)

5.2 Section 2 – Customer services/patient experience report quarter 1 2014/15

5.3 Section 3 – Exception reporting and action plans

(i) Care planning
(ii) Annual serious incidents report 2013/14
(iii) Annual health and safety report and review of health and safety policy

6. Policies and strategies for approval

6.1 Review of Policy on Policies
6.2 Procurement Strategy

7. Five-year strategic plan 2014/15 to 2018/19

8. Monitor quarterly return quarter 1 2014/15

9. Assurance framework and risk register

10. Date and time of next meeting and dates for 2015

The next meeting of Trust Board will be held on Tuesday 23 September 2014 in seminar room 2, Textile Centre of Excellence, Huddersfield.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Minutes of Trust Board meeting held on 24 June 2014

Present:	Ian Black	Chair
	Peter Aspinall	Non-Executive Director
	Laurence Campbell	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:	James Drury	Deputy Director, Strategic Planning
	Bronwyn Gill	Head of Communications and Customer Services
	Diane Smith	Interim Director of Service Innovation and Health Intelligence
	Dawn Stephenson	Director of Corporate Development
	Bernie Cherriman-Sykes	Board Secretary (author)
Apologies:	Julie Fox	Non-Executive Director
Guests:	Adrian Deakin	Governor, Members' Council (staff elected, Nursing)
	Nasim Hasnie	Governor, Members' Council (publicly elected, Kirklees)
	Bob Mortimer	Governor, Members' Council (publicly elected, Kirklees)
	Kevan Riggett	Governor, Members' Council (publicly elected, Barnsley)
	Jeremy Smith	Governor, Members' Council (publicly elected, Kirklees)
	Tony Wilkinson	Governor, Members' Council (publicly elected, Calderdale)

TB/14/29 Welcome, introduction and apologies (agenda item 1)

The Chair (IB) welcomed everyone to the meeting. He welcomed Laurence Campbell (LC) to his first meeting following the approval of his appointment by the Members' Council. The apology from Julie Fox (JF) due to family illness was also noted. IB received a number of comments on agenda items, which he would raise at the appropriate point.

IB congratulated the Chief Executive, SM, who was awarded an OBE in the Queen's Birthday Honours list for services to healthcare. He has also been recognised in the Health Service Journal's 'Care Integration 50', which identifies the 50 most influential people involved in the integration of health and social care services nationally, where he was ranked in the top ten at number six. IB commented that this represents recognition for SM personally and also for the Trust. SM commented that this was a real privilege and an honour to be recognised.

IB also commented on the change to Trust Board's committee structure. He will join the Clinical Governance and Clinical Safety Committee from 1 June 2014 to the end of this calendar year; LC will join the Audit Committee from 1 June 2014 with a view to assuming the Chair from Peter Aspinall (PA) at an appropriate point; and he will review Non-Executive Director membership of Committees again once their reviews are complete. LC will also attend all committees in the next quarter as part of his induction.

TB/14/30 Declaration of interests (agenda item 2)

Name	Declaration
NON-EXECUTIVE DIRECTORS	
Peter Aspinall	Member, Disciplinary Pool, Institute and Faculty of Actuaries
Laurence Campbell	Treasurer and Trustee, Kirklees Citizens' Advice Bureau and

Name	Declaration
	Law Centre
CHIEF EXECUTIVE	
Steven Michael	Member, Academic Advisory Council, International Institute of Organisational Psychological Medicine

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. There were no other declarations made over and above those made in March 2014.

TB/14/31 Minutes of and matters arising from the Trust Board meeting held on 29 April 2014 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held on 29 April 2014 as a true and accurate record of the meeting. There were two matters arising in relation to the Equality report (TB/14/25e). Helen Wollaston (HW) reminded Trust Board of the prioritisation of people in ethnic minority communities. She also informed Trust Board of a piece of work to be undertaken jointly with Calderdale and Huddersfield NHS Foundation Trust (CHFT) aimed a widening the pool of applicants for Non-Executive Director and governor positions. A planning meeting will take place in August 2014.

TB/14/32 Chief Executive's report (agenda item 4)

IB commented on the annual visit from Monitor on 23 June 2014. The focus for him as Chair was on governance through Trust Board and the Members' Council and the level of challenge provided by Non-Executive Directors and governors. For Non-Executive Directors (PA and Jonathan Jones (JJ) were seen) the focus was on the way committees work and level and degree of challenge. SM commented the focus for the Executive was the role of Trust Board in setting the strategic direction, links to the Members' Council, and priorities for the annual plan and the role of Trust Board in shaping this agenda.

SM also covered the following.

- The support from Monitor for the Trust-developed mental health classification and clustering methodology.
- Trust Board has approved a proposal for the Trust to be a co-signatory to support the Outline Business Case for Calderdale and Greater Huddersfield in partnership with CHFT and Locala. Liaison services and integrated care of physical and mental health services are within scope but not the complete range of Trust services, which will form an additional case to be developed over the next year.
- A significant deficit has been uncovered at Barnsley Hospital NHS Foundation Trust. The Trust will work in partnership to support the recovery plan. The Trust has been assured that the position will have no negative impact on services provided by this Trust in the short-term; however, there may well be an impact on the allocation and/or division of resources in the medium-term.
- The Trust has received confirmation that it will receive its full budget allocation for forensic services in 2014/15 after the earlier concerns regarding an arbitrary reduction of £618,000.
- Local authorities in Calderdale, Kirklees and Wakefield wish to work with the Trust to understand the opportunities to develop alternative community capacity to support health and social care.
- A key issue for developments under the Better Care Fund is parity of esteem for mental health services and the Trust is working to ensure this is realised.

- Staff engagement continues on a wide range of issues currently facing the Trust.

Five-year strategic plan 2014/15 to 2018/19

James Drury (JD) took Trust Board through the development and content of the plan. A key part of the plan is a declaration of sustainability required from the Trust over one, three and five years. Alex Farrell (AF) explained that the current 'as is' model, based on the two-year operational plan agreed by Trust Board in March 2014, provides for a cost improvement programme for 2014/15 and 2015/16 of over 5% each year. This level is unsustainable in subsequent future years; therefore, the Trust has to consider a model that includes national assumptions on pay and non-pay, and tariff and internal cost pressures. At year 3, the Trust breaks even and, by years 4 and 5, it is no longer in surplus. The Trust also has to consider operational and clinical sustainability. Without doing something very different, the Trust will not be sustainable in its current organisational form in the longer-term.

SM commented that:

- a number of Trusts are beginning to struggle although this Trust is not yet in this position; therefore, there is a challenge to providers across the board;
- the priority for years 1 to 3 is to get the Trust in the best possible shape to face future challenges and this requires a re-definition of models of service and delivery on transformation;
- the Trust has to consider its organisational configuration beyond year 3 to support a sustainable organisation and platform for the future.

Work over the next two to three years will identify the partners the Trust needs to work with to meet the challenge and inform development of a sustainable organisation. IB invited comments from Trust Board.

- LC commented that he would like to see the Trust in a broader, national context making best use of its skills base forming a 'top-down' view.
- JJ asked if the Trust thought its regulators would encourage the approach the Trust will take in leading organisational reconfiguration. SM responded that there is a recognition nationally that health and social care will become closer and providers need to come together to consider and develop local solutions. He would see the Trust, therefore, 'pushing at an open door'.
- AF added that consolidation on a bigger geographical footprint would provide increased resources and the efficiencies needed would be correspondingly smaller, and a bigger organisation would be more sustainable.
- JJ asked what such a model could look like and SM responded that its basis would be on four levels.
  - Specialist services on a regional footprint.
  - Mental health and community services on a sub-regional footprint.
  - A local footprint for integrated services with social care based on district-by-district affordability.
  - Work within districts for defined communities.
- HW commented on the Trust's role in building community capacity. SM responded with the concept of the Trust as an enabler and developer of social value and that the Trust has a leadership role to support capable communities. How it is structured to do this and who funds it would need to be agreed. Tim Breedon (TB) added that this fits with the Trust's clinically-led transformation work and fit with the Trust's quality priorities with a sustainable workforce fit for the future.
- Nisreen Booya (NHB) commented that the key to the Trust's sustainability is the development of community capacity and capability, and enabling communities; however, the challenge will be how this role is defined given that the Trust is a statutory body.

- On behalf of JF, IB commented that she was supportive of the plan and sustainability declaration although concerned about its five-year nature.
- IB commented that:
  - Trusts are required to prepare the five-year plan;
  - Trusts will have to ensure fit with the NHS plan, expected in October, and this may mean that the Trust has to revise its plan;
  - there are significant changes at year 3, which will be reflected in other Trusts' plans but to different timescales, often shorter;
  - following the General Election in 2015, the plan assumes a broadly similar structure and funding nationally; however, the reality may be very different.

AF alerted Trust Board to two areas that still require adjustment in the plan, namely the decision by Trust Board at today's meeting and alignment with commissioners' views in terms of the declaration of sustainability. JJ asked if the Trust would be asked to do this each year. AF responded that it is likely that Monitor will continue to request a long-term strategic plan and detailed operational plan to a shorter time period.

In terms of the declaration of sustainability, IB asked Trust Board to support a positive response to the declaration for one year and three years. For five years, the response would be negative and will include a form of words to explain the Trust's position. IB asked that this narrative is circulated to Trust Board for comment by close of play on Thursday 25 June 2014 with delegated authority for IB, SM and AF to agree the final form of words.

Given the importance of this item IB asked for a formal vote and **it was unanimously RESOLVED to APPROVE the five-year strategic plan 2014/15 to 2018/19 for submission to Monitor by 30 June 2014 and to DELEGATE AUTHORITY to the Chair, Chief Executive and Director of Finance to approve the final narrative in relation to the declaration of sustainability.**

TB/14/33 Assurance from Trust Board Committees (agenda item 5)

Clinical Governance and Clinical Safety Committee 15 April, 13 May and 9 June 2014 (agenda item 5.1)

HW highlighted that TB is developing an action plan in response to the comments made by staff following the Francis workshop. TB added that the messages have been taken seriously and a formal response will be made to participants. SM commented that this reflects the open culture of the organisation, which reflects Trust values.

HW also commented on the planned visit to community services at Fox View. The visit was a great learning opportunity, reflecting the excellent services provided by the Trust and the level of care provided by staff; however, it also demonstrated how difficult some staff find the balance between providing a level of care and meeting the requirements of clinical record keeping. SM added that it also demonstrates how the provision of care should be seen in an holistic way.

Mental Health Act Committee 13 May 2014 (agenda item 5.2)

On behalf of JF, IB highlighted four areas:

- the High Court ruling on Deprivation of Liberty Standards, which has implications for informal patients;
- the Committee was not assured following a consent to treatment audit and asked that it is undertaken again with a report back to the Committee in November 2014;
- the cost of the Committee to ensure value for money (NB this was raised as an issue by all Committees through the self-assessment process and it has been agreed that Dawn Stephenson (DS) will undertake a review on behalf of the Chair of the Trust);

- acute trust representation has been suggested on the Committee.

Remuneration and Terms of Service Committee 1 April 2014 (agenda item 5.3)
IB commented on the increase in the appraisal target to 95%, which he was pleased to see given the improvement in achievement over the last few years and it represents an expectation that all staff will have an appraisal.

Audit Committee 8 April and 23 May 2014 (agenda item 5.4)
PA highlighted two areas in relation to the receipt by the Committee of the annual reports of Trust Board risk committees in April 2014 and approval of the annual report and accounts and Quality Report under delegated authority from Trust Board in May 2014.

TB/14/34 Annual report, accounts and Quality Report 2013/14 (agenda item 6)

It was RESOLVED to RECEIVE and ADOPT the annual report, accounts and Quality Report for 2013/14.

TB/14/35 Performance reports month 2 2014/15 (agenda item 7)

TB/14/35a Performance report (agenda item 7.1) and finance report (agenda item 7.2)
AF highlighted the following.

- The Trust is on target to meet its financial plan requirements.
- The Trust is currently meeting its cost improvement programme and action is in place to meet the £1.2 million shortfall.
- There is a forecast underspend on the capital programme, which will be addressed by the end of quarter 2. The Trust will, however, breach the 15% tolerance allowed by Monitor at the end of quarter 1 and this will be reported to Monitor in July. This was raised with Monitor at the annual visit on 23 June 2014 and is unlikely to have serious consequences.
- CQUINs will be embedded to ensure achievement.
- Data quality and maintenance of requirements for mental health currency are a priority. TB added that this area is fundamental for the development of payment by results and currency implementation. Each BDU has developed a plan to improve data quality, which is fundamental to clinical delivery, and these are monitored closely. He also confirmed that Monitor did not require the Trust to re-state its position on 7-day follow up; it does, however, require the Trust to achieve the target in quarters 1 and 2 in 2014/15.

HW commented that sickness appears to be increasing in a number of areas. Alan Davis (AGD) responded that there are no trends or themes although there is much change and pressure in the system. The wellbeing survey will highlight any underlying reasons for performance and the position will be monitored closely for underlying trends.

TB/14/35b Exception reports and action plans – Customer services annual report 2013/14 (agenda item 7.3(i))
DS introduced this item. TB commented that it is also important that the Trust captures compliments. PA added that, as a learning organisation, it is good to see instances where action has been taken and demonstrates that the organisation has learned. IB asked if there was any plan to share the report with the Members' Council and DS responded that this would be through the Members' Council Quality Group.

It was RESOLVED to NOTE the management of issues raised through Customer Services in 2013/14 and to NOTE this in the broader context of ongoing work in relation to understanding service user experience.

TB/14/35c Exception reports and action plans – Appraisal/revalidation annual report 2013/14 (agenda item 7.3(ii))

NHB introduced this item. On behalf of JF, IB commented that items such as this tend to go through alternative forums, such as Committees, prior to Trust Board. NHB responded that the requirement was to present the annual report to the organisation's board. The revalidation report has been audited by internal audit and has been used as best practice in a number of forums.

It was RESOLVED to RECEIVE the report and to APPROVE the statement of compliance confirming that the organisation is a designated body to comply with the regulations.

TB/14/35d Exception reports and action plans – Hard Truths commitments regarding the publishing of staffing data (agenda item 7.3(iii))

All Trusts are required to publish staffing data; however, there is no evidence-based tool for mental health and learning disabilities, therefore, the Trust has tried to develop a tool that can be adjusted for any tool published nationally at the end of the year. An evidence-based tool is available for community services in Barnsley (Safer Nursing Care Tool).

In the report, there are a number of areas where the actual does not meet planned. Some of these have mitigating factors; for other areas, there will be scrutiny of BDU plans to address, mitigate and resolve.

HW commented that she could also provide assurance following scrutiny by the Clinical Governance and Clinical Safety Committee. The tool can also be used to provide assurance regarding the impact on quality of the transformation programme. The Committee has also asked for the same process to be undertaken for mental health community services.

SM observed that the report does correlate with the concerns expressed by staff in the Francis workshop and does demonstrate the transparency of the organisation, which will be covered by the narrative to accompany the figures. AGD commented that staffing levels must be closely monitored both in terms of the numbers and skills mix, and understanding of the clinical needs in each in-patient area.

JJ asked if the position would be exacerbated as the Trust moves to transform its services. AGD responded that there are two considerations. Firstly, efficient use of the current configuration and, secondly, in-patient services may require investment in the future to support quality of care. There are also differences between wards providing the same or similar services, which need to be reviewed and, if necessary, addressed allowing for the availability of resources locally.

PA asked about the escalation process. AGD responded that any cause for concern would escalate through the management chain and logged on DATIX if any risk identified. This position does need further scrutiny and is most likely to result in re-investment in certain areas. SM added that it is the individual shift manager's responsibility to ensure wards are staffed and managed safely.

IB commented that he was happy that this is scrutinised through the Clinical Governance and Clinical Safety Committee and he would leave it to HW as Chair of the Committee to decide when to bring a further report back to Trust Board.

It was RESOLVED to NOTE the report.

TB/14/36 Trust Board self-certification – Corporate Governance Statement, certification on AHSCs and governance, and training of governors (agenda item 8)

It was RESOLVED to CONFIRM that Trust Board is able to make the required self-certification in relation to the Corporate Governance Statement and training for governors.

TB/14/37 Calderdale community hub – full business case (agenda item 9)

Following an introduction from AGD, HW asked if there was flexibility in the building given the uncertainty in relation to services. AGD provided assurance that the building will have opportunities for adjustment. It will also include sustainable and environmentally-friendly provisions. IB reminded Trust Board that the funding is already identified in the capital budget and the paper represents the detail of the scheme. He added that this is a good location for public transport, close to Halifax bus and rail stations, and it was the right proposal to 'knock down' the existing building and re-build in order for the Trust to have a building that is designed as fit for purpose, rather than altered to fit.

It was RESOLVED to APPROVE the construction of a hub in Halifax.

TB/14/38 Use of Trust seal (agenda item 10)

It was RESOLVED to NOTE the use of the Trust's seal since the last report in March 2014.

TB/14/39 Date and time of next meeting (agenda item 11)

The next meeting of Trust Board will be held on Tuesday 22 July 2014 in conference room 3, Al-Hikmah Centre, Batley, WF17 7AA. The meetings for 2015 were agreed as follows:

Tuesday 27 January
Tuesday 31 March
Tuesday 28 April
Tuesday 30 June
Tuesday 21 July
Tuesday 22 September
Friday 23 October
Tuesday 22 December

Signed …… Date ……

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Quality Performance Report

Quarter 1 2014/15

Table of Contents

Introduction

Improve and be outstanding

This month's report provides a stronger focus on the Trust's quality priorities and the metrics being used to underpin them. In order to understand quality, a broad view of performance, finance and the workforce needs to be analysed alongside governance, patient experience and outcomes. Accepting that quality and performance are intrinsically linked, the Trust is continuing to develop its reporting to reflect how one impacts on the other. This integrated report covers each of these aspects in a more summarised format. The report remains a "work in progress" and will continue to be improved throughout the year in line with local and national priorities.

Our approach to quality, set out in our Quality Improvement Strategy, will also be further developed and embedded during 2014/15. This approach is in line with the essence of the Francis Inquiry reports and the Care Quality Commission's (CQC) Strategy for 2013-16 Raising Standards: Putting People First.

The Trust's Quality Improvement Strategy was developed to ensure that we capture the essence of quality and translate this effectively by bringing together national policy, strategic direction and regulatory, financial and governance requirements alongside our stated imperative of providing safe, effective care for every person who accesses our services. This report aims to provide assurance to the Board that the organisation has the right focus and levels of performance to attain the highest levels of quality in the service it provides.

Our Quality Priorities

As defined in the Quality Improvement Strategy, our quality priorities are:

Priority 1: To continue to listen to our service users and carers and act on their feedback (Listen & Act)
Priority 2: Continue to improve the timeliness and ease of people accessing services when they need them (Access)
Priority 3: Continue to improve care, care planning & evaluation of care (Care & care planning)
Priority 4: Improve clinical record keeping and data quality (Recording care)
Priority 5: Continue to improve transfers of care by working in partnership across the care pathway (Care pathways)
Priority 6: Ensure that our staff are professionally, physically and mentally fit to undertake their duties (Fit and well to care)
Priority 7: To improve the safety of our service users, carers, staff and visitors (Safety)

Each priority is underpinned by measures of success. The measures are reviewed and refreshed each year to ensure we are adapting to our local and national intelligence, making sure we progress against our aim to improve quality. In 2014-15 we have set ourselves a set of challenging measures which in most cases are higher than the goals set by our commissioners.

Quality

Quality Account 2014-15

The 7 specified quality priorities for 14-15 are underpinned by a number of identified performance indicators including some current key performance measures and CQUIN targets. Note: figures/ratings used do not exactly correlate with achievement of CQUIN targets set by commissioners - this is because for the Quality Account a rounded average is taken across BDUs and care groups rather than split down into target achievement in each care group and BDU. Anticipated year end position for all key performance indicators is green. This will be assessed in Q2.

Quality Priority	Key Performance Indicators	Target	Reporting Period	Q1			Q2			Q3			Q4			Comments
				A	M	J	J	A	S	O	N	D	J	F	M	
Quality Priority 1: To continue to listen to our service users and carers and act on their feedback	% people (inpatient mental health -CKW) rating care as excellent or good	90%	Quarterly	91%												
	% of people in CAMHs service rating care as excellent or good.	Baseline position Q1. Set trajectories across Q2-4	Quarterly													
	% of people in Long Term Conditions (all teams in service line) who rate care as excellent or good	90%	Bi annually													
	Implementation of ? elements of Triangle of care across all inpatient services	100%	Annual													
	Friends & Family Test: percentage of scores recommending our services as either likely or extremely likely:	80%	Quarterly from Q3													
	ü Forensic services															
	ü Mental Health Services															
	ü Community services															
Quality Priority 2: Continue to improve the timeliness and ease of people accessing services when they need them	Improving access for people experiencing non-acute mental health problems (routine) ; face to face contact within 14 days of referral (CKW)	90%	Quarterly	73												
	Improving access for people experiencing non-acute mental health problems (routine) ; face to face contact within 14 days of referral (B)		Quarterly													**Awaiting information from team**
	Improving access to assessment & treatment for children and young people requiring assessment and diagnosis for autism / ADHD (Wakefield Services)	Awaiting confirmation	Quarterly													**Awaiting confirmation from contracts**
	Reduce the number of people on the waiting list for ASD pathway in Calderdale & Kirklees	Awaiting confirmation	Quarterly													**Awaiting information from team**
	CAMHs Barnsley: Patients seen within 5 weeks of initial referral	100%	Quarterly													**data error on system - not able to obtain Q1 data**
	Snapshot position of percentage of waits to first available appointment at month end, regardless of setting in Barnsley community services (waits greater than 3 weeks)	TBD	Quarterly													**Awaiting information from team**
Quality priority 3: Continue to improve care, care planning & evaluation of care.	% people offered a copy of their care plan.	85%	Monthly	82	82											
	Mental Health currency development: Adherence to cluster reviews –	90%	Monthly	73	73	73										
	Mental Health currency development : % of eligible cases assigned a cluster	100%	Monthly	95	96											
	Increase the number of clinical audits that have actions implemented/ demonstrate outcomes	Benchmark @ Q1 then set trajectories	Quarterly													
	Implementation of NICE clinical quality standard	Q1 Scope, Q2 Plan, Q3 Audit, Q4 implement recommendations	Quarterly													
	Identify an outcome measure (s) to be used for each service line.	Q1 Scope, Q2 Plan, Q3 Identify measures, Q4 prepare for implementation	Quarterly													
Quality priority 4: Improve clinical record keeping and data quality	Implementation of recommendations from clinical record keeping audit	Q1 Scope, Q2 Plan, Q3 Audit, Q4 implement recommendations	Quarterly													
	Mental health currency development: % mental health patients with a valid diagnosis code at discharge	99%	Monthly	91	99	82										

Quality cont….

Quality Priority	Key Performance Indicators	Target	Reporting Period		Q1 A	Q1 M	Q1 J	Q2 J	Q2 A	Q2 S	Q3 O	Q3 N	Q3 D	Q4 J	Q4 F	Q4 M	Comments
Quality priority 4: Improve clinical record keeping and data quality	% of people with ethnicity cases completed	99%	Monthly		-	-	-										**data not on system**
	Implementation of actions in BDU data quality action plans	90% of eligible actions to be completed	Quarterly	Barnsley (CS)													**data available at end of July**
				Barnsley (MH)													
				Calderdale													
				Forensics													
				Kirklees													
				Wakefield													
Continue to improve transfers of care by working in partnership across the care pathway	Delayed transfers of Care (DTOC)	<=7.5	Monthly		3.3	4	4										
	Participation in and implementation of recommendations from of intermediate care pathways	SET MILESTONES			audit complete												
	Review transition protocols for CAMH's/ Adults interface	Q1 Scope, Q2 Plan, Q3 implement, Q4 Evaluate	Quarterly														
Ensure that our staff are professionally physically and mentally fit to undertake their duties	Sickness rate	4%	Monthly		4.7	4.8	4.8										
	Development of a trustwide clinical supervision policy for nurses and implementation of audit tool	Q1 scope, Q2 Plan Q3: Tool development Q4: Audit	Quarterly														
	Staff Friends & Family Test: percentage of scores recommending: 1. Trust as a place to work	80%	Quarterly (Q1,2,4)		60%												
	2. Our services to friends and family	80%	Quarterly (Q1,2,4)		70%												
	Equality & Diversity training	80%	Quarterly		63												
To improve the safety of our service users, carers, staff and visitors	Implementation of MH safety thermometer (Establish systems and processes)		Quarterly														
	Pressure Ulcer reporting in inpatient units in Barnsley BDU	Q1- system, Q2 baseline and trajectories, Q3&Q4 TBD	Quarterly														
	Infection rates of MRSA bacteraemia	0	Quarterly		0												
	Infection rates of C Diff	<=8	Quarterly		0												
	Effective monitoring and response to medication errors	Q1 Scope, Q2 Plan, Q3 implement, Q4 Evaluate	Quarterly														

Quality Headlines

Calderdale & Kirklees Child & Adolescent Mental health services
Performance concerns remain in the Kirklees / Calderdale service and remain subject to a recovery plan. The plan has been co-produced with our Commissioners who acknowledged the significant cultural change required within the service. The District Director is holding weekly meetings with Commissioners to progress the recovery plan. Further staff engagement events are planned and the communication plan is subject to regular review.

Data Quality
While some areas of data quality have improved some remain an intermittent challenge – this is the priority of the Data Quality Steering Group and thus BDU quarterly improvement plans. Each BDU has a clear trajectory for improvement which is being monitored through the Quality Account report.

Safer Staffing
The safer staffing review and publication of staffing levels remains a priority and is subject to close internal review. The shift pattern changes proposed as part of the costs improvement programme are also subject to the final QIA. The safer staffing review is concerned with the development of an evidence based approach to determine staffing levels according to need and the shift pattern changes relate only to the efficient deployment of the unit staffing resource. Early indication from the safer staffing review and shift pattern Quality Impact Assessment shows that some action may be required to address some inconsistency of approach across the Trust. This will be reviewed in August.

OTHER
Quality Impact Assessment - Cost Improvement Programme:- In previous years the process involved conducting an assessment once the cost improvement was identified and then completing a part-year review. For 2014/15 there are cost improvements where the hypothesis requires an initial QIA and then if approved a more granular focus needs to be applied. Additional Quality Academy capacity has been utilised to support this process.
Absent Without Leave (AWOL) – Members Council raised concerns related to the number of service users who abscond, in particular those absconding from the Dales. Significant work has been undertaken to improve security at the Dales both internally and external to the building. The majority of AWOLs has been service users either not returning from planned leave or going AWOL from the smoking area. Completed work should greatly improve security in the garden area, particularly the smoking area. (Trust-wide in Q1 there were 49 reported AWOL incidents involving detained patients as compared with 56.)

Staff Friends & Family In line with national guidance the Trust has invited all our staff to give feedback on the trust as " employer of choice" and "a place care and treatment". The table reflects the results. In summary when asked "How likely are you to recommend this organisation to friends and family as a place to work" 61% of staff responded they were likely or extremely likely to recommend us. when asked "How likely are you to recommend this organisation to friends and family if they needed care or treatment" 70% of our staff responded 'likely or extremely likely'. The narrative feedback from the survey is currently being themed and will be used alongside the trusts well being at work feedback to inform us on action we need to take to respond to improving the health and well being of our staff. the feedback results will be used to determine where we need to focus our effort for a quarter 2 'deep dive'. There is no target response rate for this survey.

Compliance

SERIOUS INCIDENT – IN-PATIENT DEATH

A death occurred on the Beamshaw ward (Barnsley) in June. The service user concerned was detained under the Mental Health Act. Police are involved and the Post-Mortem findings are awaited. Immediate action has been taken to address any potential risk. An independent investigator is to be appointed to conduct the investigation

LEGAL

• The Cheshire West judgement in March 2014 clarified the threshold for assessment of people who lack capacity and are in hospital or care homes. This applies to all services (not just mental health). SWYPFT had to consider whether there were people in our in-patient units who lacked capacity and were unable to consent to the hospital admission. A briefing paper regarding the implications has been provided for the Mental Health Act Committee. A range of interventions have been implemented: internal staff training; a request to Hempsons solicitors for training for medical staff; briefing note to clinicians; clinical process guide for clinicians; CQC advice placed on trust intranet. Currently working with Local Authority partner agencies to reach an agreed interpretation of the judgement

• In Quarter 1 2014/15 there have been a total of 10 claims received, 3 clinical negligence and 7 employers liability. It is anticipated that planned changes to claims reporting and potential claims to the NHSLA will lead to a significant increase in the number of registered claims additional to the rise in number already being experienced. This matter is subject to review with a view to any mitigating action that can be initiated.

REGULATORY

• Monitor, CQC and NHS TDA are committed to developing an aligned framework for making judgements about how well-led NHS providers are. Monitor have introduced the Well-led framework for governance reviews which is intended to support the system response to Francis. Monitor expects NHS Foundation Trusts to carry out an external review of their governance every three years and the Trust is currently giving consideration as to the timescale for its first review.
• The Trust still has 2 CQC compliance actions outstanding. A recent review identified that all responsive actions bar one (relating to Trinity 2 refurbishment) had been completed by the end of May. A return CQC inspection visit to review action taken is anticipated.

• The draft Fox View CQC inspection report has been received and will be made final following completion of accuracy checking procedures. The CQC have found the Trust to be compliant against all the outcomes inspected.

• We are required to formally notify the CQC of any under 18 admissions to wards. Recent internal CQC guidance requires CQC to undertake a responsive review (within 48 hours) once notified of any such case.

Strategic Overview Dashboard

Business Strategic Performance Impact & Delivery

Section	KPI	Source	Target	Apr-14	May-14	Jun-14	Jul-14	QTD	YTD	Forecast Position
Monitor Compliance	Monitor Governance Risk Rating (FT)		Green	Green	Green	Green		Green	Green	4
	Monitor Finance Risk Rating (FT)		4	4	4	4		4	4	4
CQC	CQC Quality Regulations (compliance breach)		Green	2	Green	Green		Green	Green	4
CQUIN	CQUIN Barnsley		Green	Amber/G	Amber/G	Amber/G		Amber/G	Amber/G	3
	CQUIN Calderdale		Green	Amber/G	Amber/G	Amber/G		Amber/G	Amber/G	3
	CQUIN Kirklees		Green	Amber/G	Amber/G	Amber/G		Amber/G	Amber/G	3
	CQUIN Wakefield		Green	Amber/G	Amber/G	Amber/G		Amber/G	Amber/G	3
	CQUIN Forensic		Green	Amber/G	Amber/G	Amber/G		Amber/G	Amber/G	3
IAPT	IAPT Kirklees: % Who Moved to Recovery		52%	58.00%	52.00%	54.30%		54.77%	54.77%	4
	IAPT Outcomes - Barnsley		90%		98.43%	42.00%		70.22%	70.22%	4
	IAPT Outcomes - Calderdale		90%		97.00%	98.70%		97.85%	97.85%	4
	IAPT Outcomes - Kirklees		90%		100.00%	100.00%		100.00%	100.00%	4
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases		8	0	0	0		0	0	4
C-Diff	C Diff avoidable cases		0	0	0	0		0	0	4
PSA Outcomes	% SU on CPA in Employment		10%	7.60%	7.80%	6.60%		7.33%	7.33%	3
	% SU on CPA in Settled Accommodation		60%	70.30%	72.20%	72.20%		71.57%	71.57%	4

Customer Focus

Section	KPI	Source	Target	Apr-14	May-14	Jun-14	Jul-14	QTD	YTD	Forecast Position
Complaints	% Complaints with Staff Attitude as an Issue		< 25%	11.86%	17.39%	13% (8/61)		14.63%	14.63%	4
MAV	Physical Violence - Against Patient by Patient		14-20	Within ER	Within ER	Above ER		Above ER	Above ER	3
	Physical Violence - Against Staff by Patient		50-64	Above ER	Above ER	Above ER		Above ER	Above ER	3
FOI	% of Requests for Information Under the Act Processed in 20 Working Days		100%	100.00%	100.00%	100.00%		100.00%	100.00%	4
Media	% of Positive Media Coverage Relating to the Trust and its Services		60%	81.00%	81.00%	83.00%		81.67%	81.67%	4
Member's Council	% of Publicly Elected Council Members Actively Engaged in Trust Activity		> 50%	47.00%	47.00%	30.00%		41.33%	41.33%	4
	% of Quorate Council Meetings		100%	100.00%	100.00%	100.00%		100.00%	100.00%	4
Membership	% of Population Served Recruited as Members of the Trust		1%	1.00%	1.00%	1.00%		1.00%	1.00%	4
	% of 'Active' Members Engaged in Trust Initiatives		50%	40.00%	40.00%	40.00%		40.00%	40.00%	4
Befriending services	% of Service Users Allocated a Befriender Within 16 Weeks		70%	75.00%	75.00%	75.00%		75.00%	75.00%	4
	% of Service Users Requesting a Befriender Assessed Within 20 Working Days		80%	100.00%	100.00%	88.00%		96.00%	96.00%	4
	% of Potential Volunteer Befriender Applications Processed in 20 Working Days		90%	100.00%	100.00%	100.00%		100.00%	100.00%	4

Operational Effectiveness: Process Effectiveness

Section	KPI	Source	Target	Apr-14	May-14	Jun-14	Jul-14	QTD	YTD	Forecast Position
Monitor Risk Assessment Framework	Max time of 18 weeks from point of referral to treatment - non-admitted		95%	98.14%	99.80%	99.10%		99.01%	99.01%	4
	Max time of 18 weeks from point of referral to treatment - incomplete pathway		92%	96.66%	98.70%	98.50%		97.95%	97.95%	4
	Delayed Transfers Of Care (DTOC) (Monitor)		7.50%	3.32%	4.18%	4.18%		3.89%	3.89%	4
	% Admissions Gatekept by CRS Teams (Monitor)		95%	100.00%	100.00%	96.50%		98.83%	98.83%	4
	% SU on CPA Followed up Within 7 Days of Discharge (Monitor)		95%	97.19%	96.35%	96.84%		96.79%	96.79%	4
	% SU on CPA Having Formal Review Within 12 Months (Monitor)		95%	95.90%	94.00%	96.50%		95.47%	95.47%	4
	Meeting commitment to serve new psychosis cases by early intervention teams QTD		95%	179.49%	207.97%	186.19%		191.22%	191.22%	4
	Data completeness: comm services - Referral to treatment information		50%	100.00%	100.00%	94.00%		98.00%	98.00%	4
	Data completeness: comm services - Referral information		50%	94.00%	94.00%	100.00%		96.00%	96.00%	4
	Data completeness: comm services - Treatment activity information		50%	94.00%	94.00%	94.00%		94.00%	94.00%	4
	Data completeness: Identifiers (mental health) (Monitor)		97%	99.40%	99.40%	99.40%		99.40%	99.40%	4
	Data completeness: Outcomes for patients on CPA (Monitor)		50%	83.00%	84.70%	84.40%		84.03%	84.03%	4
	Compliance with access to health care for people with a learning disability		Compliant	Compliant	Compliant	Compliant		Compliant	Compliant	4
Data Quality	% Inpatients (All Discharged Clients) with Valid Diagnosis Code		99%	90.80%	99.10%	81.70%		90.53%	90.53%	4
	% Valid NHS Number		99%							4
	% Valid Ethnic Coding		90%							4
Mental Health PbR	% of eligible cases assigned a cluster		100%	95.30%	95.70%	95.90%		95.63%	95.63%	3
	% of eligible cases assigned a cluster within previous 12 months		100%	80.40%	80.20%	80.10%		80.23%	80.23%	3

Fit for the future Workplace

Section	KPI	Source	Target	Apr-14	May-14	Jun-14	Jul-14	QTD	YTD	Forecast Position
Appraisal	% of Staff Who Have Had an Appraisal in the Last 12 Months		90%	Data not avail	Data not avail	22.31%		22.31%	22.31%	4
Sickness	Sickness Absence Rate (YTD)		4%	4.70%	4.80%	4.80%		4.77%	4.77%	3
Vacancy	Vacancy Rate		10%	2.50%	3.50%	4.60%		3.53%	3.53%	4
Safeguarding	Adult Safeguarding Training		80%	70.11%	72.25%	72.37%		71.58%	71.58%	3
Fire	Fire Attendance		80%	74.39%	74.75%	76.74%		75.29%	75.29%	3
IG	IG Training		95%	90.47%	89.31%	89.91%		89.90%	89.90%	3

Impact and Delivery

• Ytd and forecast is green for Monitor Risk Ratings and CQC compliance

• Quarter One achievement on Quality indicators (CQUINs) will be available at the end of July and will have a detailed update in month 4 report . The risk assessment on achievement of all indicators is predicting a potential shortfall in income of £500k which is 11% of the income linked to these indicators.

• Dip in performance in achieving the recovery outcomes which is not expected to impact on overall performance on the contract

• Number of service users on CPA in employment – continues to be below 10 % . Benchmarking has been undertaken to compare achievement between BDU s and investigating data collection to demonstrate level of involvement in activities which will increase the chances of service users gaining employment eg volunteering .

Operational Effectiveness

• Data quality key performance issues which is linked to clinical record keeping, case management and the caseload allocation in teams. This can be seen in the diagnostic coding, cluster assignment and review performance.

• The trajectory compared to 2013-14 is one of improved performance. Improving clinical record keeping and clustering are key objectives in all the BDU data quality plans which are reviewed by the Data quality Steering Group chaired by the Director of Nursing.

Workforce

• Sickness remains above trajectory at quarter 1. EMT review of management action and impact on sickness scheduled for August 2014.

• Review of mandatory training KPIs to be undertaken by HR to focus on key staff groups and risk areas which can be reflected in the performance report.

Overall Financial Position

Performance Indicator		Month 3 Performance	Annual Forecast	Trend from last month	Last 3 Months - Most recent			Assurance	
Trust Targets					**2**	**1**	**-**		
1	Monitor Risk Rating equal to or ahead of plan	●	●	↑	●	●		4	-
2	£2.58m Surplus on Income & Expenditure	●	●	↑	●	●		4	-
3	Cash position equal to or ahead of plan	●	●	↑	●	●		4	-
4	Capital Expenditure within 15% of plan.	●	●	↑	●	●		4	-
5	Delivery of Recurrent CIP	●	●	↔	●	●		3	-
6	In month Better Payment Practice Code	●	●	↔	●	●		4	-

Summary Financial Performance

These Key Performance Indicators (KPI's) help the Trust to monitor progress against each element of our financial strategy.

1. The Financial Risk Rating (Risk Assessment Rating) is 4 against a plan level of 4. A score of 4 is the highest possible.

2. The year to date position, as at June 2014 is showing a net surplus of £1.6m which is £0.1m ahead of plan.
Overall the current BDU forecast positions require the utilisation of provisions (£1m) in order for the Trust to forecast a balanced surplus position. Work continues within all areas of the organisation to ensure that cost pressures are mitigated and expenditure reductions are maximised.

The largest singular forecast cost pressure identified by the Trust relates to additional Out of Area expenditure (payments made to 3rd parties for the provision of Healthcare). This is an unfunded cost pressure and the current forecast includes a pressure of £1m.

3. At June 2014 the cash position is £33.75m which is £2.13m ahead of plan.

4. Capital spend to June 2014 is £1.13m which is £0.68m (37%) behind the Trust capital plan. As triggered by the Quarter 1 Monitor return a revised capital plan has been developed to ensure that the total capital programme is delivered.

5. At Month 3 the Cost Improvement Programme is £0.22m ahead of plan of £2.59m. (8.4%) Based upon current knowledge it is forecast that there will be a £0.87m shortfall (outstanding schemes rated as red) and therefore these schemes will need to be finalised or further substitute schemes will need to be introduced. This is included within the overall Trust forecast position.

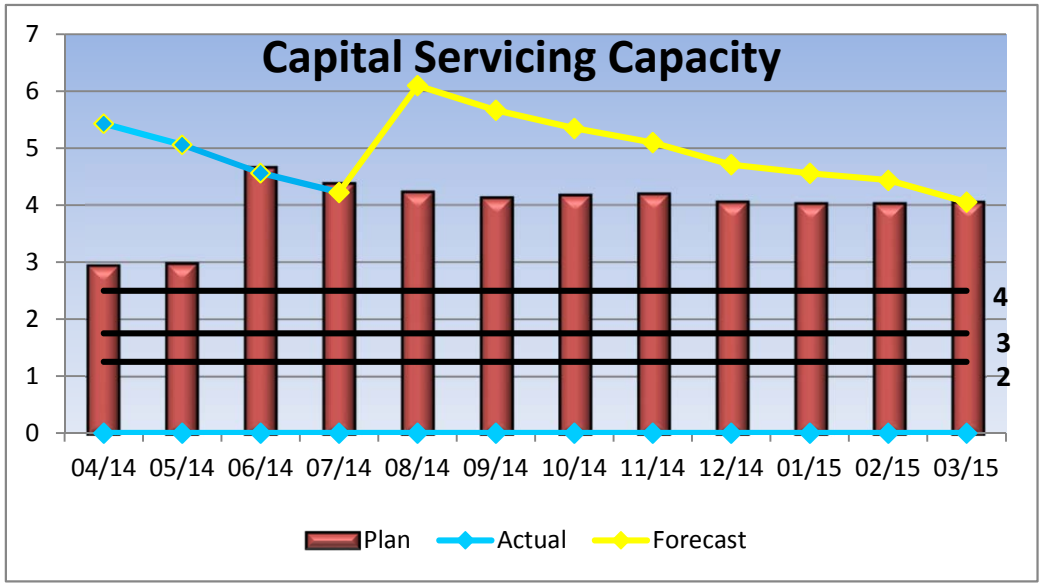
6. As at 30th June 2014 (Month 3) 91% of NHS and 95% of non NHS invoices have achieved the 30 day payment target (95%).

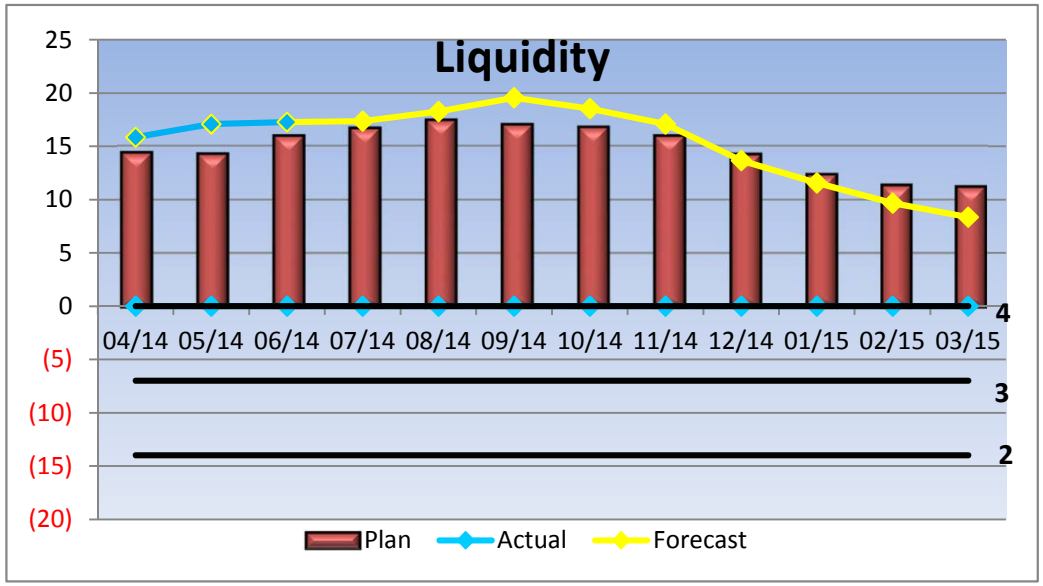
Monitor Risk Rating

Continuity of Service Risk Rating 2014 / 2015				
	Actual Performance		Annual Plan June 2014	
Metric	Score	Rating	Score	Rating
Capital Servicing Capacity	4.6	4	4.7	4
Liquidity	17.3	4	16.0	4
Weighted Average		**4**		**4**

Overall the Trust maintains a Continuity of Service Risk Rating of 4 and maintains a material level of headroom before this position is at risk. This is shown in the graphs below.

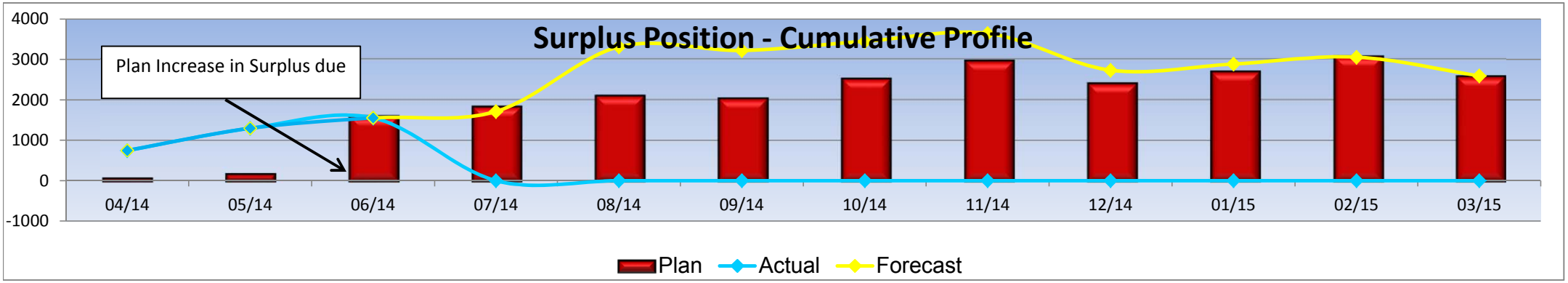
The capital Servicing Capacity ratio increases in month 5 due to the expected revaluation. This had been originally planned for month 3 as demonstrated by the increase in the plan.





Income & Expenditure Position 2014 / 2015

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**
				(18,107)	(18,106)	1	Clinical Revenue	(54,397)	(54,382)	15	(217,839)	(217,391)	448
				(18,107)	**(18,106)**	**1**	**Total Clinical Revenue**	**(54,397)**	**(54,382)**	**15**	**(217,839)**	**(217,391)**	**448**
				(1,207)	(1,243)	(36)	Other Operating Revenue	(3,271)	(3,507)	(236)	(12,937)	(13,660)	(723)
				(19,314)	**(19,349)**	**(35)**	**Total Revenue**	**(57,669)**	**(57,890)**	**(221)**	**(230,777)**	**(231,051)**	**(275)**
4,542	4,335	(207)	4.6%	14,714	14,231	(483)	BDU Expenditure - Pay	43,722	42,629	(1,092)	172,448	173,154	706
				3,903	4,080	177	BDU Expenditure - Non Pay	11,262	11,238	(23)	44,568	45,395	827
				68	103	35	Provisions	423	434	11	3,524	2,274	(1,250)
4,542	**4,335**	**(207)**	**4.6%**	**18,685**	**18,414**	**(271)**	**Total Operating Expenses**	**55,406**	**54,302**	**(1,104)**	**220,540**	**220,824**	**284**
4,542	**4,335**	**(207)**	**4.6%**	**(629)**	**(935)**	**(306)**	**EBITDA**	**(2,263)**	**(3,588)**	**(1,326)**	**(10,237)**	**(10,228)**	**9**
				433	422	(10)	Depreciation	1,298	1,267	(31)	5,191	5,191	0
				264	264	0	PDC Paid	791	791	0	3,164	3,164	0
				0	(8)	(8)	Interest Received	0	(23)	(23)	0	(89)	(89)
				(1,300)	0	1,300	Impairment of Assets	(1,300)	0	1,300	(700)	(700)	0
4,542	**4,335**	**(207)**	**4.6%**	**(1,233)**	**(257)**	**976**	**Surplus**	**(1,474)**	**(1,553)**	**(79)**	**(2,582)**	**(2,662)**	**(80)**



Income & Expenditure Position 2014 / 2015 cont….

The information above represents the plan, and phasing associated with this, as per the 2 year plan submitted to Monitor in April 2014.
This includes the planned phasing impact of the Trust Cost Improvement Programme, as shown within the CIP information.

Overall the Trust surplus position, as at June 2014 / month 3 is £1,553k. This is £79k better than planned. There are two key elements to this position:

* £1.3m planned benefit arising from the Revaluation of a Trust asset has not been finalised in Quarter 1 as planned. Until the full formal planning process is complete the benefit will not crystallise. This is forecast to be finalised within Quarter 2.

* The impact of this revaluation has been absorbed by the underspend within Operating Expenditure.

However the forecast at month 3 continues to highlight a number of risk areas / financial pressures which will need to be addressed. These include:

* Identified risks around cost reductions / savings within the Cost Improvement Programme. These continue to be the subject of management review and implementation. At this point in time plans are yet to be finalised and as such have been RAG rated as red and are reflected in the forecast. In the original plan the majority of these were designed to be delivered in Quarters 3 and 4.

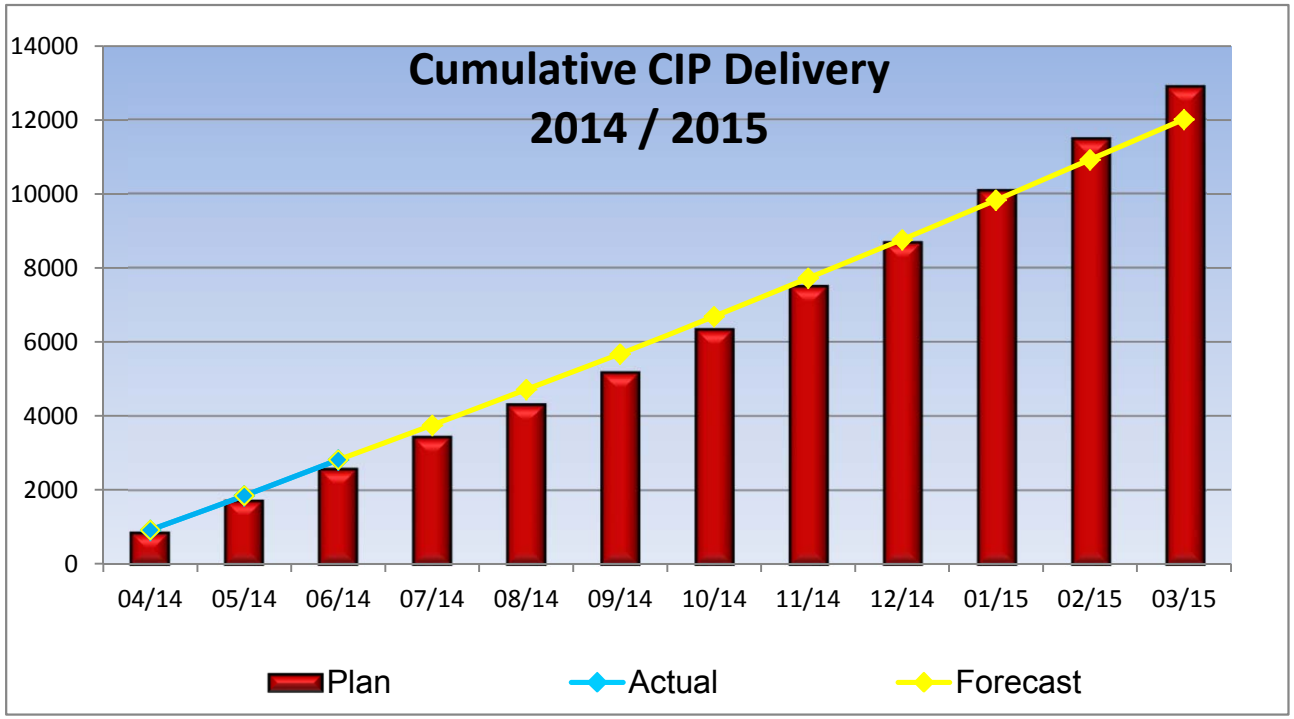
* BDU cost pressures, the largest of which relates to additional costs from Out of Areas expenditure.

Overall the current BDU forecast positions require the utilisation of provisions (£1m) in order for the Trust to forecast a balanced surplus position. Work continues within all areas of the organisation to ensure that cost pressures are mitigated and expenditure reductions are maximised.

Summary Performance of Cost Improvement Programme

Delivery of Cost Improvement Programme 2014 / 2015

	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
Target - Monitor Submission	864	864	864	868	868	868	1,159	1,159	1,182	1,400	1,400	1,400	2,591	12,898
Target - Cumulative	864	1,727	2,591	3,459	4,328	5,196	6,355	7,515	8,697	10,097	11,497	12,898	2,591	12,898
Delivery as planned	787	1,598	2,394	3,183	3,973	4,762	5,600	6,445	7,290	8,151	9,011	9,870	2,394	9,870
Mitigations - Recurrent	64	128	249	330	441	552	674	800	928	1,062	1,212	1,363	249	1,363
Mitigations - Non Recurrent	56	112	166	233	299	361	414	480	548	628	709	790	166	790
Total Delivery	**907**	**1,837**	**2,809**	**3,746**	**4,713**	**5,675**	**6,688**	**7,726**	**8,766**	**9,841**	**10,932**	**12,023**	**2,809**	**12,023**
Shortfall / Unidentified	(44)	(110)	(218)	(287)	(385)	(479)	(333)	(211)	(69)	256	565	875	(218)	875

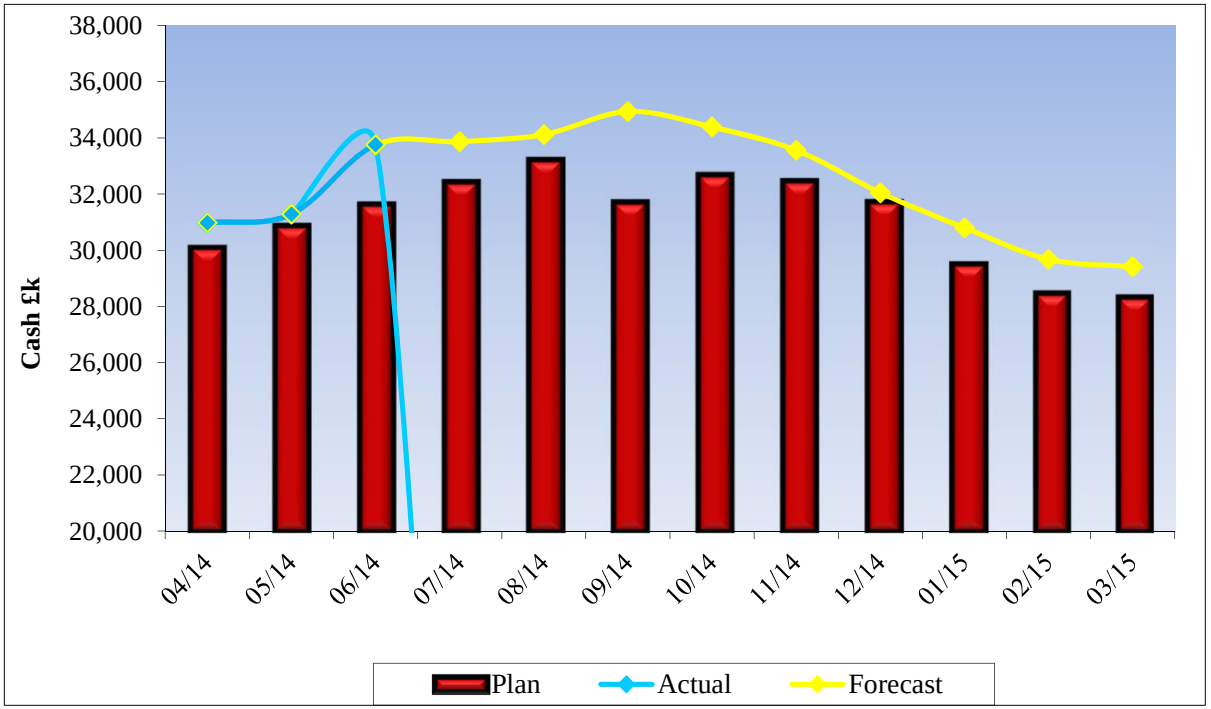


The profile of the Trust Cost Improvement Programme for 2014 / 2015 is outlined above. This profile demonstrates the Trust's plan to further expenditure reductions in Quarters 3 and 4.

The current position is a £197k shortfall against the original plan. However substitutions actioned by BDU's mean that the Trust is ahead of plan at month 3 by £218k. The overall forecast is a £875k shortfall as schemes planned for later in the year are currently not finalised.

This is based upon information available at this current time and it's a prudent assessment of delivery. This has been reflected within the overall Trust forecast position.

Cash Flow Forecast 2014 / 2015



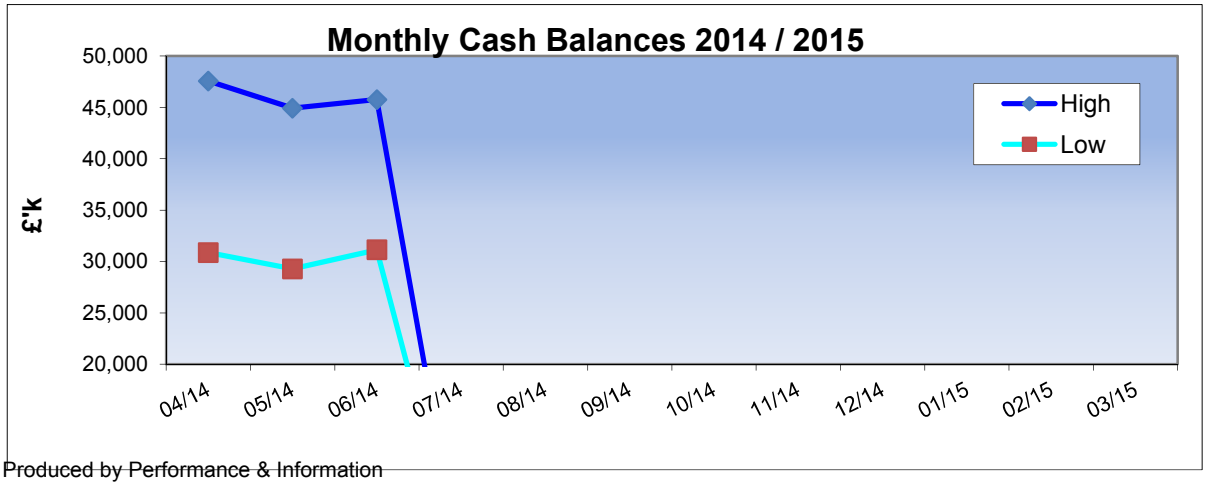
	Plan	Actual
	£k	£k
Opening Balance	33,114	33,114
Closing Balance	31,625	33,755

The Cash position provides a key element of the Continuity of Service Risk Rating. As such this is monitored and reviewed on a daily basis.

Weekly review of actions ensures that the cash position for the Trust is maximised.

Overall the cash position for June 2014 is £33.75 m which is £2.13 m ahead of plan.

In line with the current Trust expenditure profile, utilising of provisions and other balance sheet movements it is forecast that the cash position will reduce during 2014 / 2015.



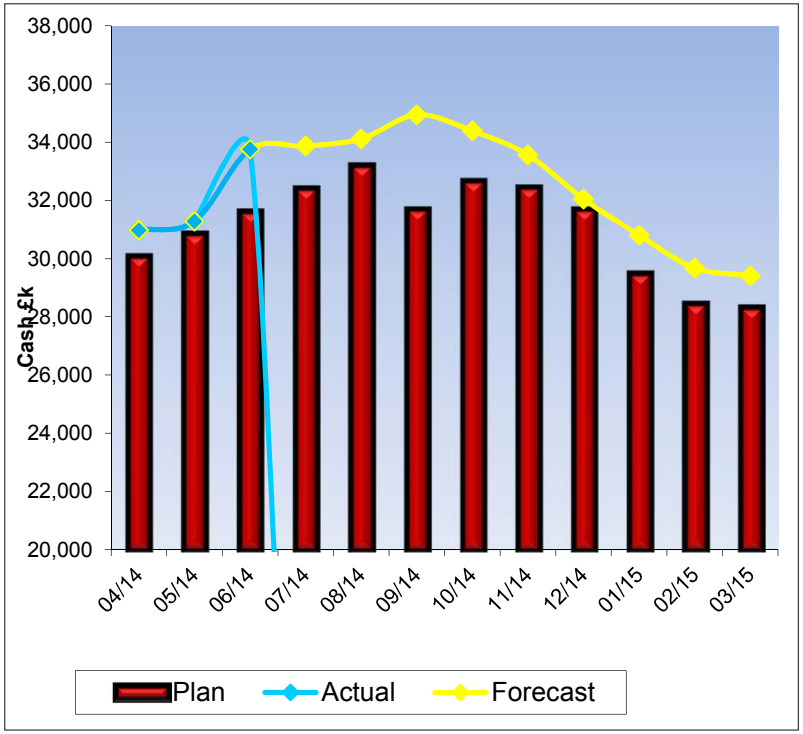
The graph to the left demonstrates the highest and lowest cash balances with each month. Maintaining an appropriate lowest balance is important to ensure that cash is available as required.

The highest balance is : £45.77m.

The lowest balance is : £31.15m.

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

Cash Flow Forecast 2014 / 2015 cont….



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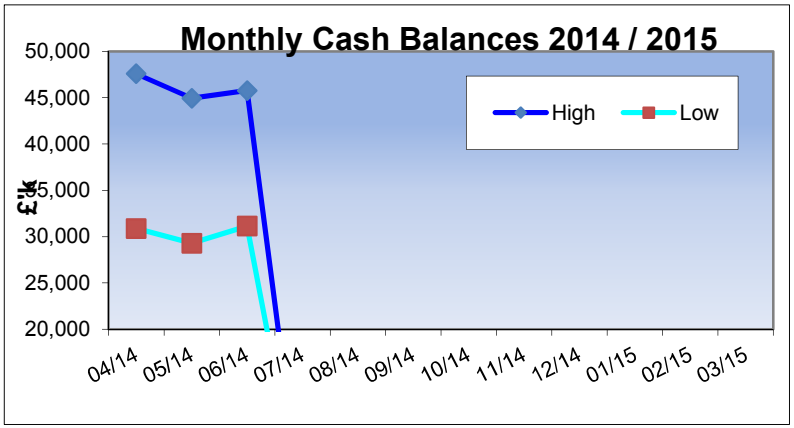

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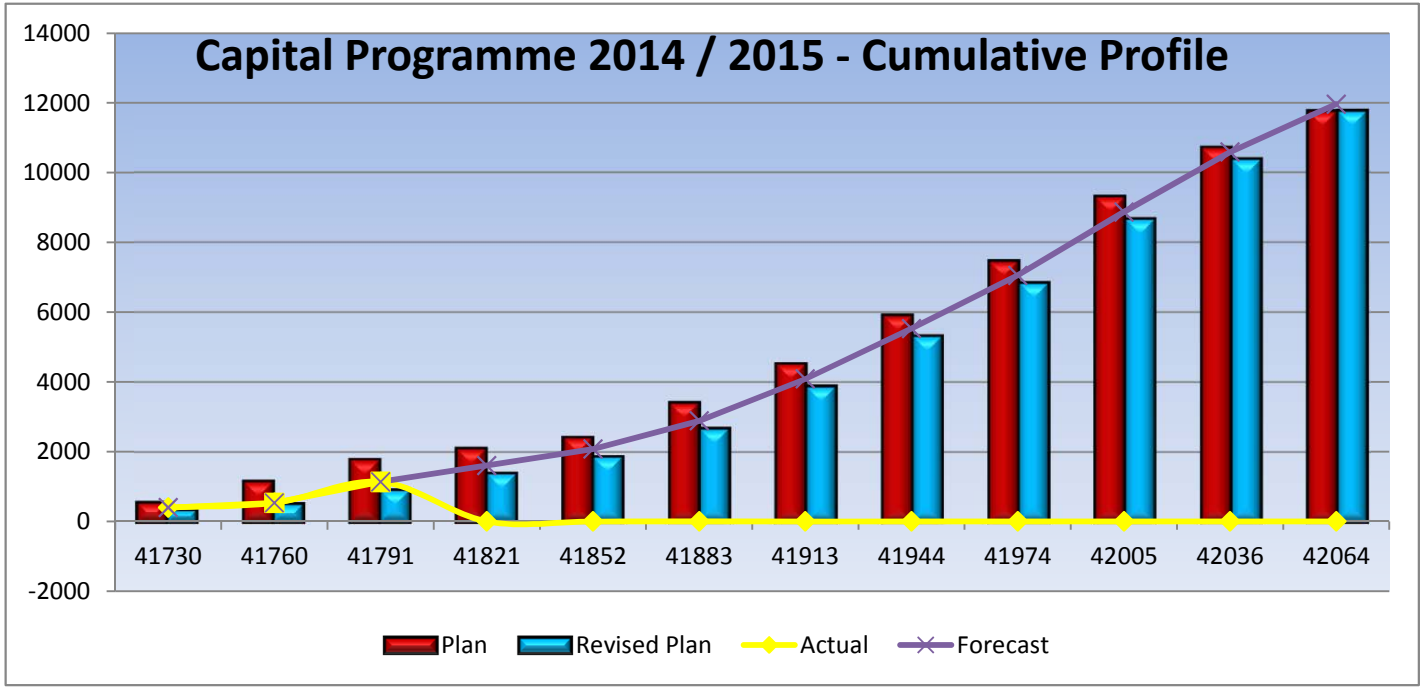
Capital Programme 2014 / 2015

Capital Expenditure Plans - Application of funds	Annual Budget £k	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Forecast Actual £k	Forecast Variance £k	Note
Maintenance (Minor) Capital							
Facilities & Small Schemes	2,294	794	380	(415)	2,267	(27)	*3*
Total Minor Capital	**2,294**	**794**	**380**	**(415)**	**2,267**	**(27)**	
Major Capital Schemes							
Hub Development / Hepworth	6,644	552	514	(38)	6,115	(529)	*4*
Fieldhead Hospital Development	2,392	346	296	(50)	3,038	646	
IM&T	450	120	33	(87)	450	0	*5*
Total Major Schemes	**9,486**	**1,018**	**843**	**(175)**	**9,603**	**117**	
VAT Refunds			(90)	(90)	(90)	(90)	
TOTALS	**11,780**	**1,812**	**1,133**	**(679)**	**11,780**	**(0)**	*1, 2*



Capital Expenditure 2014 / 2015

1. The total Capital Programme for 2014 / 2015 is £11.78m and the plan currently shown in the table represents the Monitor plan submission made in April 2014.

2. The year to date position is £679k under plan (37%) when compared to the Monitor plan for month 3. (as per the original plan submission - April 2014)

This exceeds the 15% threshold within the Monitor Quarter 1 return and as such a reforecast plan is required.

The main headlines behind this position are:

3. Underspends against Facilities (£330k) and Minor Works (£85k) have been assessed. A revised programme has been defined within the revised capital plan.

* This movement includes timing changes to Plant Room upgrades (now that issues have been resolved satisfactorily) and schemes which have been cancelled (in line with the Trust's Transformation Programme) and reallocated.

4. £247k variance to plan in relation to Forensics inpatient redevelopment. Approximately £200k of this relates to expenditure recognised in 13/14. The scheme overall is forecast to spend in line with plan. This additional funding will be utilised within the overall Capital Programme.

Elements of this underspend have been utilised in the Calderdale Hub development which is currently £168k ahead of plan.

5. IM & T has fallen behind plan due to changes in delivery timescales. This has been reflected in the revised plan.

Better Payment Practice Code

NHS		
	Number	Value
	%	%
Year to May 2014	93.7%	93.1%
Year to June 2014	91.0%	83.5%

Non NHS		
	Number	Value
	%	%
Year to May 2014	96.4%	93.0%
Year to June 2014	95.1%	91.9%

Local Suppliers - 10 days		
	Number	Value
	%	%
Year to May 2014	82.2%	63.3%
Year to June 2014	76.7%	55.0%

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.

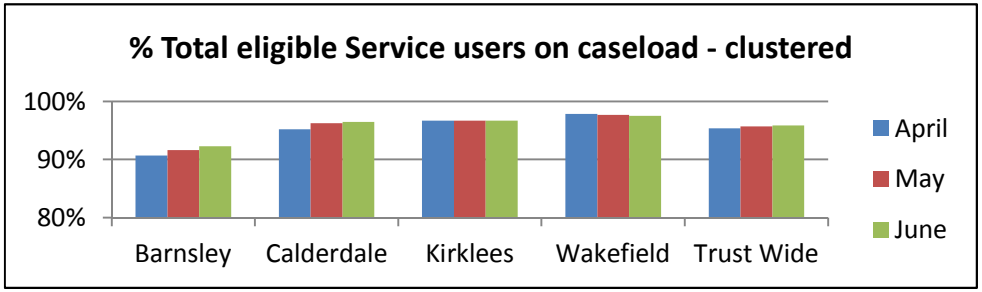
The performance against target for NHS invoices is 91% of the total number of invoices that have been paid within 30 days and 83% by the value of invoices.

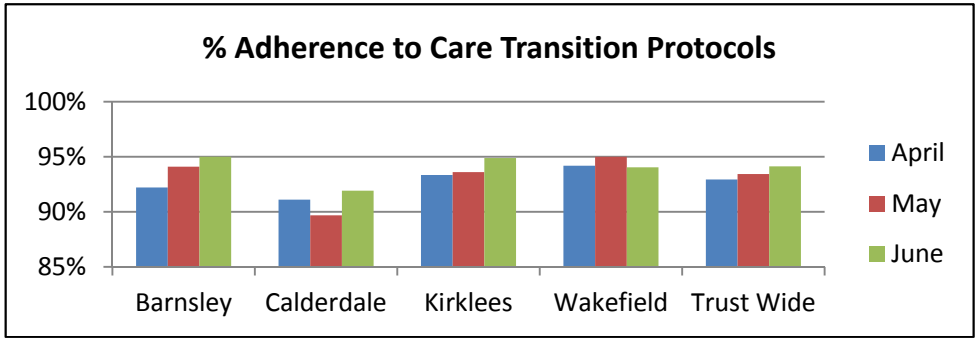
The performance against target for Non NHS invoices is 95% of the total number of invoices that have been paid within 30 days and 92% by the value of invoices.

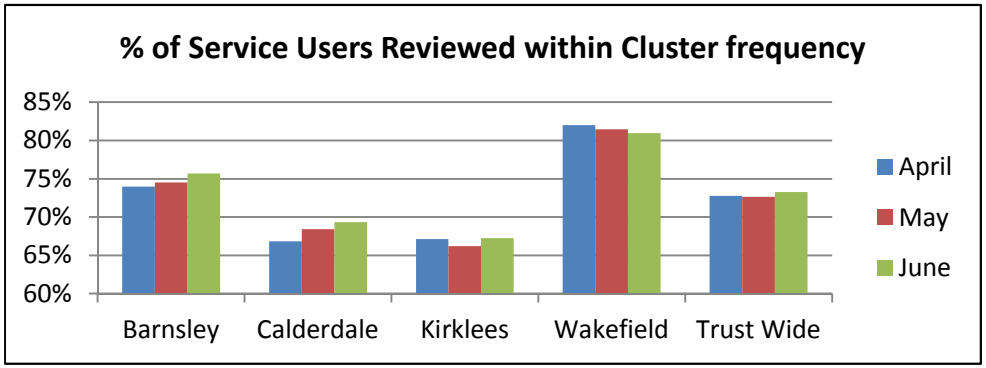
The Government has asked Public Sector bodies to try and pay Local Suppliers within 10 days, though this is not mandatory for the NHS. This was adopted by the Trust in November 2008.

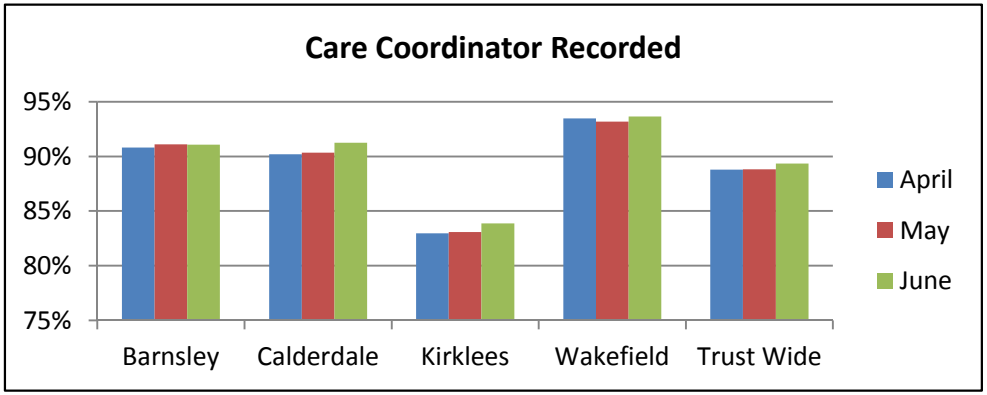
To date the Trust has paid 77% of Local Supplier invoices by volume and 55% by the value of invoices within 10 days.

Mental Health Currency Development









External
CPPP are taking forward the integrated Mental Health and LD Clusters
No other developments for June

2014/15 Cluster prices were submitted to Monitor

Internal
The Clinic list report on RIO has been updated to include the next cluster review date for each client attending the clinic. For clients never clustered or overdue the message 'has a missing or out of date MHCT Assessment' will be displayed.

Quality framework to be developed to include CROM, PROM and PREM

Data quality
There has been a slight improvement across all measures in June.

Hot Spots
Barnsley achieved 92% clustered and 76% reviewed within frequency.
South CMHT (medical caseload) and Psychology (waiting lists) are areas of concern

Calderdale and Kirklees reviewed within frequency are low at 69% & 67% respectively
Kirklees clients with a care co-ordinator recorded are low at 84% in June
77% of Kirklees clients not reviewed within frequency are within OPS.

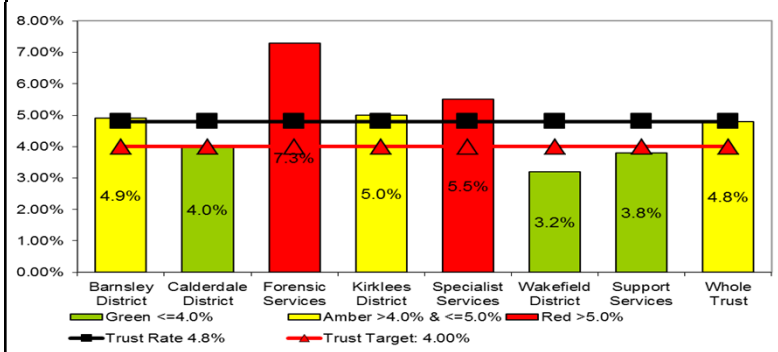
Wakefield Psychological Therapies improvement noted from last month to achieve 92.6% clustered
Wakefield inpatient areas continue to have inappropriate cluster profiles.

ADHD /ASD services trustwide overall performance regarding clustering and review needs to be improved dramatically.

Workforce

Sickness Absence

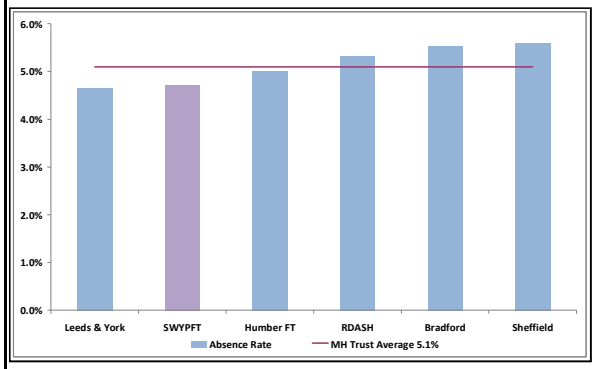
Sickness Absence by District – Year to Date



Current Absence Position – May 2014

	Barn	Cald	Fore	Kirk	Spec	Wake	Supp
Rate	5.00%	4.10%	7.40%	5.00%	6.10%	3.20%	3.50%
	↑	↓	↓	↑	↓	↓	↓

Absence Benchmark Y&H MH/LD & Care Trusts



- The Trust YTD absence levels in May 2014 are above the
- The chart above shows absence levels in MH/LD Trusts in our region for Q4 2013/14. During this time the Trust's absence was 4.7% which was below the regional average of 5.1%.

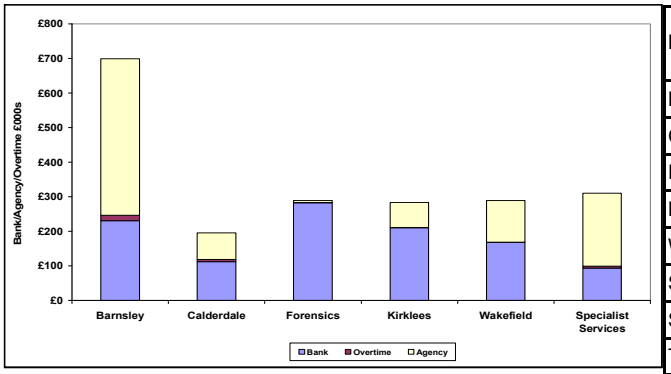
Fire Lectures

BDU	Rate
Barnsley	76.00%
Calderdale	77.60%
Forensics	84.70%
Kirklees	79.70%
Specialist	71.10%
Wakefield	75.10%
Support	75.50%
Trust	76.70%

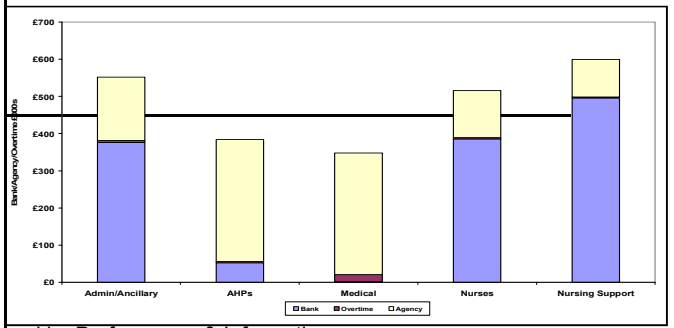
- Fire lectures rates for June 2014 is 76.7%. This is below the Trust's target of 80%.

Bank, Agency & Overtime Spend

Bank, Agency & Overtime Spend by BDU - YTD



Bank, Agency & Overtime Spend by Group - YTD



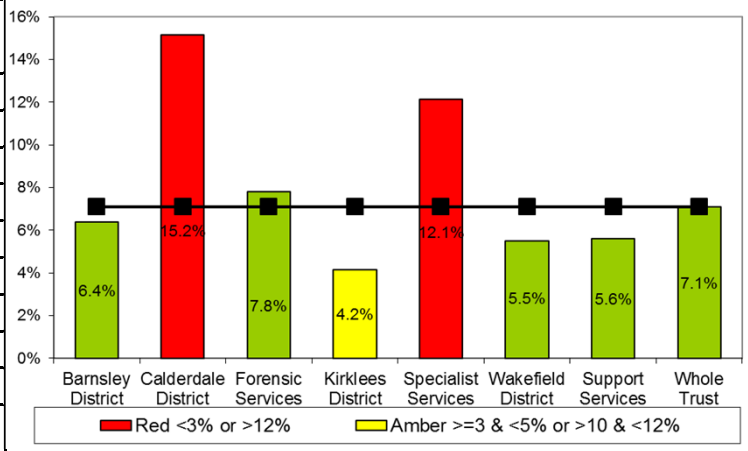
Overtime Spend by BDU - YTD - £'000s

BDU	A&C/ Ancil	AHPs	Medical	Nursing	Total
Barnsley	£2	£2	£11	£1	£16
Calderdale	£0	£0	£4	£2	£7
Forensics	£0	£0	£0	£1	£1
Kirklees	£0	£0	£1	£0	£2
Wakefield	£0	£0	£0	£0	£1
Specialist	£0	£1	£2	£2	£5
Support	£3	£0	£0	£0	£3
Total	£6	£3	£19	£7	£34

Agency Spend by BDU - YTD ('000s)

BDU	A&C/ Ancil	AHPs	Medics	Nursing	Total
Barnsley	£32	£204	£150	£67	£453
Calderdale	£0	£56	£0	£20	£76
Forensics	£6	£0	£0	£0	£6
Kirklees	£0	£0	£29	£43	£71
Wakefield	£6	£0	£115	£0	£121
Specialist	£19	£68	£27	£97	£212
Support	£108	£0	£7	£0	£115
Total	£170	£328	£328	£227	£1,053

Turnover Rates by Service – Year to Date



- Year to Date Turnover is 7.1% which is within the target range of 5-10%

Workforce cont…

Sickness

• The sickness levels for April and May show a slight increase of 0.1% compared to the same period last year.
• The Trust remains below average when benchmarked against other similar Trusts with the region.
• A particular area of concern is the CAMH Service in Calderdale and Kirklees where sickness absence for May was over 14%. A broader Service recovery plan is in place and this will include health and wellbeing support.

Fire

• The fire training figures have slightly deteriorate from the same period last year from 79.8% to 76.7%.
• Trajectory developed for each BDU and Directorate to achieve 80% target by quarter 2

Turnover

• Turnover overall is 0.5% less than the same period last year.
• There turnover in quarter 1 is a spike in Calderdale BDU, which was a result of 13 leavers, 6 of which were retirements. It is too early in the year to be able to draw any trends in one BDU.

Agency, Bank and Overtime Expenditure

• Whilst Bank and Overtime expenditure has fallen compare to the same period last year Agency spend has significantly increased.
• Highest areas of agency expenditure are the Barnsley and Specialist BDUs. The EMT is reviewing agency and bank expenditure with the development of action plans to reduce spend.

Glossary

ADHD	Attention deficit hyperactivity disorder
ASD	Autism spectrum disorder
AWA	Adults of Working Age
AWOL	Absent Without Leave
BDU	Business Delivery Unit
C. Diff	Clostridium difficile
CAMHS	Child and Adolescent Mental Health Services
CIP	Cost Improvement Programme
CPA	Care Programme Approach
CPPP	Care Packages and Pathways Project
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CROM	Clinician Rated Outcome Measure
CRS	Crisis Resolution Service
DTOC	Delayed Transfers of Care
EIA	Equality Impact Assessment
EIP/EIS	Early Intervention in Psychosis Service
FOI	Freedom of Information
FT	Foundation Trust
HONOS	Health of the Nation Outcome Scales
IAPT	Improving Access to Psychological Therapies
IG	Information Governance
IM&T	Information Management & Technology
Inf Prevent	Infection Prevention
KPIs	Key Performance Indicators
LD	Learning Disability
MAV	Management of Aggression and Violence
MH	Mental Health
MHCT	Mental Health Clustering Tool
MRSA	Methicillin-resistant Staphylococcus aureus
MT	Mandatory Training
NICE	National Institute for Clinical Excellence
NHS TDA	National Health Service Trust Development Authority
OPS	Older People's Services
PCT	Primary Care Trust
PREM	Patient Reported Experience Measures
PROM	Patient Reported Outcome Measures
PSA	Public Service Agreement
PTS	Post Traumatic Stress
QIA	Quality Impact Assessment
RAG	Red, Amber, Green
Sis	Serious Incidents
SWYFT	South West Yorkshire Foundation Trust
SYBAT	South Yorkshire and Bassetlaw local area team
SU	Service Users
TBD	To Be Decided/Determined
Y&H	Yorkshire & Humber
YTD	Year to Date

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 22 July 2014
Agenda item 5.2

Title:	**Customer services report quarter 1 2014/15**
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. Ensuring people have access and opportunity to feedback their views and experiences of care is essential to delivering the Trust's values and is part of how we ensure people have a say in public services.
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 Trust 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 quarter 3 2014/15. EMT will also ensure a customer focus through the 'Year of Values' work and will implement an 'awards' scheme to recognise teams for demonstrating the values in their work. **Customer Services Report – quarter 1 2014/15** This report provides information on feedback received, the themes indicated, lessons learned and action taken in response to feedback. In quarter 1: • 354 issues were responded to; • 61 formal complaints were received and 193 compliments; • care and treatment, waiting times, delays and cancellations, staff attitude and communication were the most common themes; • three complainants asked the Parliamentary and Health Service Ombudsman to review their complaint; • over 220 public enquiries were responded to and over 370 staff enquiries; • 53 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 1 of financial year 2014/15.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

CUSTOMER SERVICES

REPORT FOR THE PERIOD 01 APRIL 2014 – 30 JUNE 2014 (QTR. 1)

TRUST WIDE

INTRODUCTION

The report covers all feedback received by the team – comments, compliments, concerns and complaints, which are managed in accordance with policy approved by the Trust Board.

The Customer Services function provides one point of contact at the Trust for a range of enquiries and feedback and offers accessible support to encourage feedback about the experience of using Trust services.

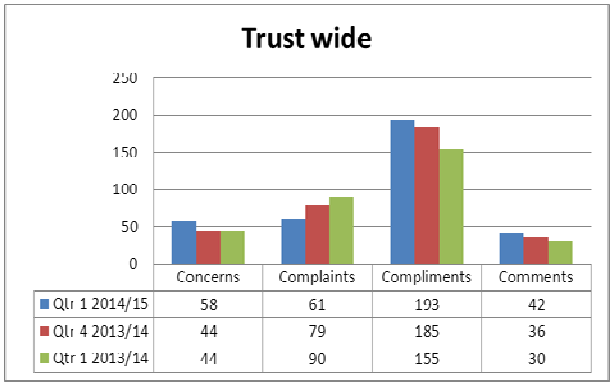
This report includes:

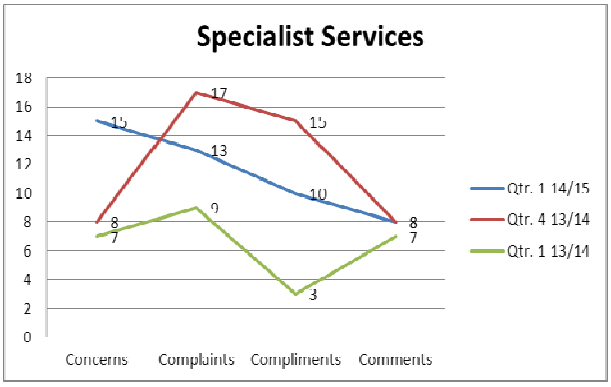
- the number of issues raised and the themes arising
- equality data
- external scrutiny and partnering
- Customer Services standards
- actions taken and changes made as a consequence of service user and carer feedback
- compliments received
- the number and type of requests processed under the Freedom of Information Act.

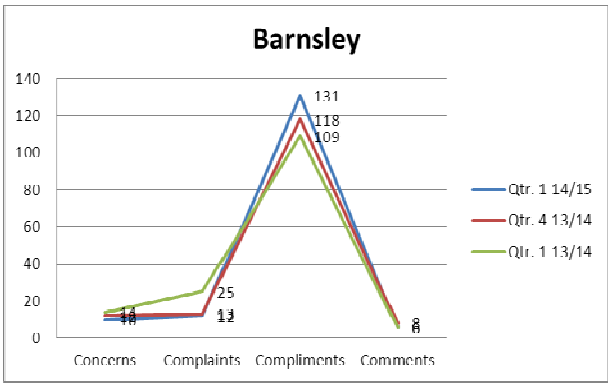
FEEDBACK RECEIVED

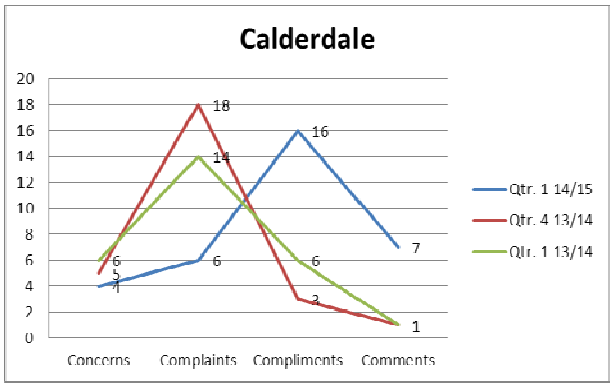
The tables below illustrate Customer Services activity in Qtr. 1. The customer services team responded to 354 issues; 61 formal complaints were received and 193 compliments. This compares to 344 issues, 79 formal complaints and 185 compliments in the previous quarter. 2013/14.

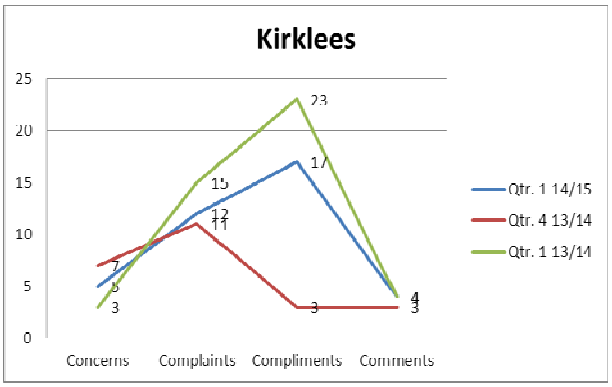
CUSTOMER SERVICES ACTIVITY QTR.1

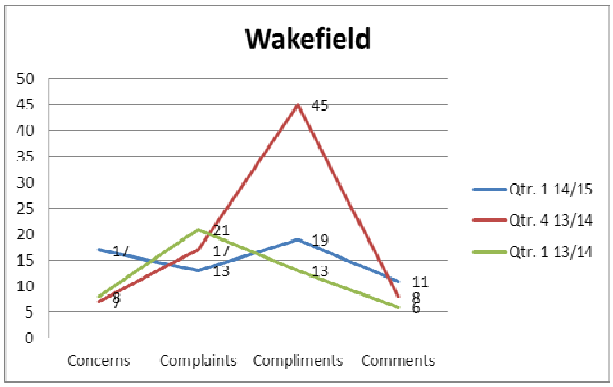


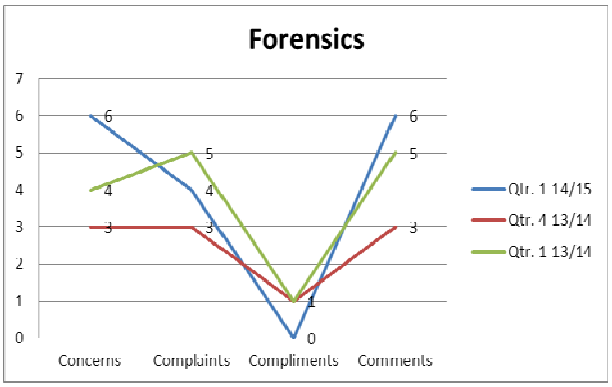


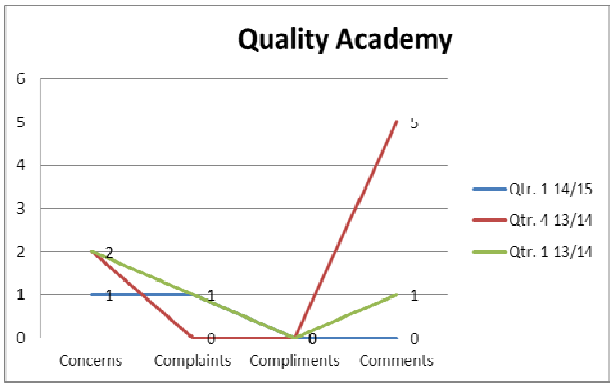












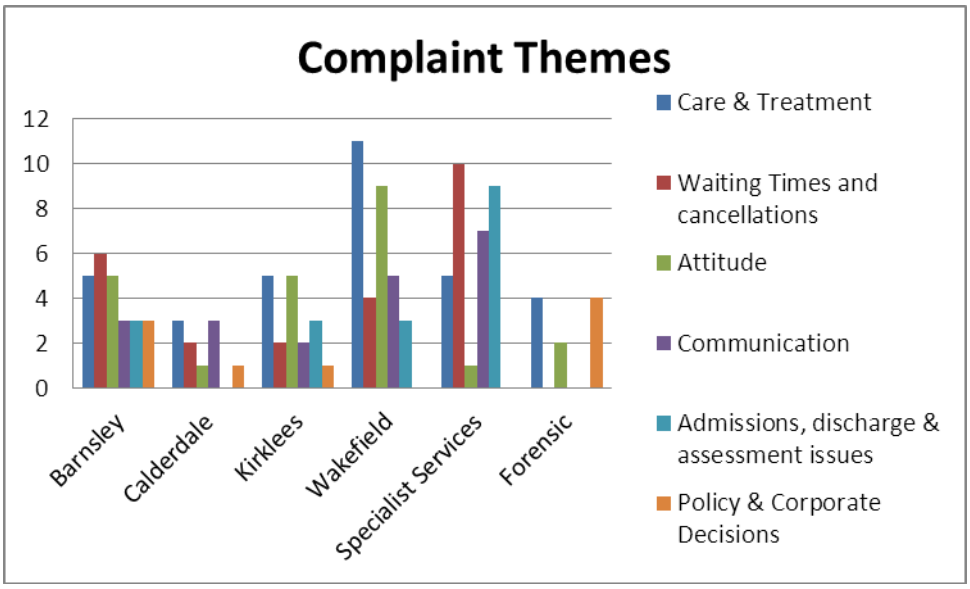
NUMBER OF ISSUES RAISED INFORMALLY

During Qtr. 1, Trust services responded to 58 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

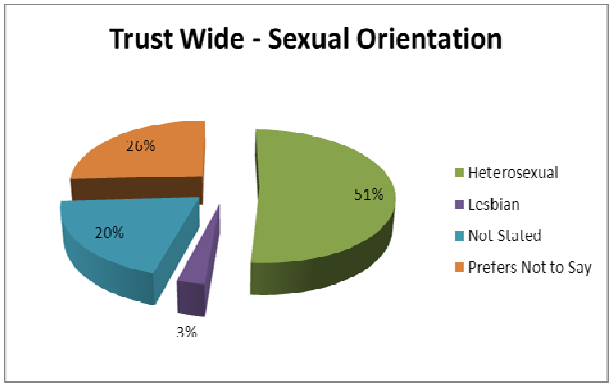
Consistent with past reporting, care and treatment was the most frequently raised negative issue (33). This was followed by waiting times, delays & cancellations (24), attitude (23), communication (21), admissions, discharge & assessment issues (18), and policy/corporate decisions (9). Most complaints contained a number of themes.

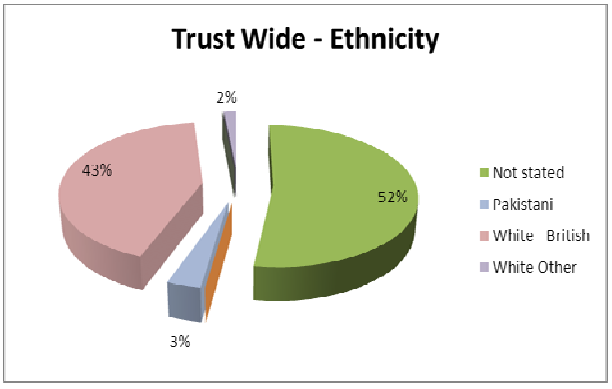
The Customer Services function connects to a weekly risk scan which brings together intelligence from the Patients Safety Support Team and the Legal Services Team to triangulate any issues of concern and assess the impact on service quality.

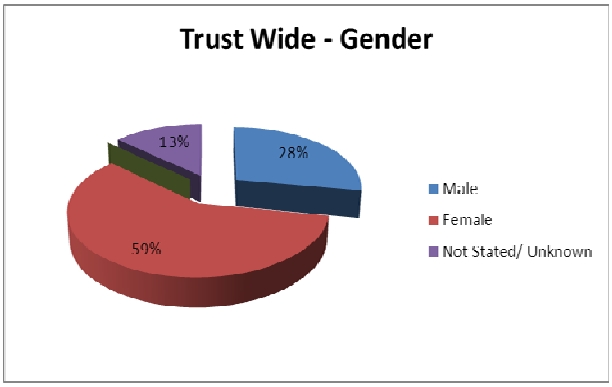


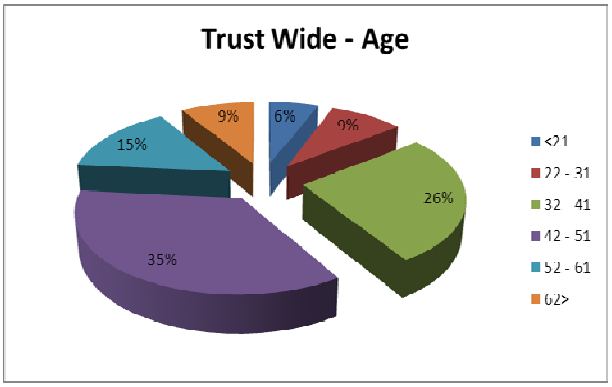
TRUST WIDE EQUALITY DATA

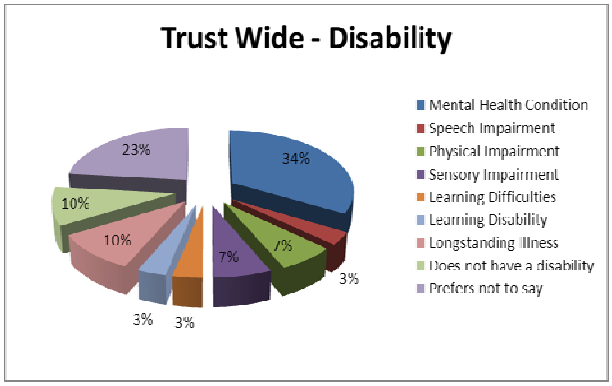
Equality data is captured, where possible, at the time a formal complaint is made. Where complaints are received by email or letter, an equality monitoring form is issued with a request to complete and return. The average response rate for forms in Qtr. 1 was 56%. The charts that follow show, where information was provided, the breakdown in respect of gender, age, disability and ethnicity trust wide. The return rate of information is shown underneath the tables.











Age 34/61 ***Gender 61/61*** ***Disability 30/61*** ***Ethnicity 61/61*** ***Sexual Orientation 35/61***

MP CONTACT

During Qtr. 1, there were 14 occasions where complaints and feedback were received via local MPs, acting on behalf of constituents. MP enquiries are processed in line with routine practice and contact made direct with individuals wherever possible.

Kirklees BDU: Jason McCartney MP (1)
Details requested regarding new legal right (wef April 14) of people accessing mental health services to choose their care provider, and how this will apply in Kirklees.

Specialist Services BDU: Barry Sheerman MP (1), Simon Reevell MP (4), Yvette Cooper MP (4), Jason McCartney MP (2), Jon Trickett (3)
All enquiries related to access to CAMHS services.

Wakefield BDU – Jon Trickett MP (1), Yvette Cooper MP (3)
Enquiries related to medication, waiting times, access to healthcare records and access to services.

PARLIAMENTARY HEALTH SERVICE OMBUDSMAN (PHSO)

During Qtr.1, 3 complainants asked the Parliamentary and Health Service Ombudsman to review their complaint (1 Kirklees, and 2 Barnsley). Such cases are subject to rigorous scrutiny by the Ombudsman, including a review of all documentation and the Trust's complaints management processes. All requested information was provided within the prescribed timeframe.

The PHSO advised the Trust that a case relating to Kirklees BDU had been reviewed in the period, a decision taken that no further investigation was required, and the case closed.

MENTAL HEALTH ACT

1 complaint was made in Qtr. 1 with regards to service user detention under the Mental Health Act. The individual elected not to specify their ethnicity. 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 Qtr. 1.

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 are in place 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.

The Customer Service function also makes connection to local Healthwatch to promote positive dialogue and respond to any requests for information. During Qtr. 1 additional detail regarding complaints was provided to Kirklees Healthwatch and an update regarding CAMHS services was provided to Barnsley Healthwatch.

Issues spanning more than one organisation in Qtr.1	Formal Concern (Over 48 Hours) (COMPLAINT)	Informal Concern (Up to 48 Hours) (CONCERN)	Service Issue (COMMENT)	Total
Barnsley Hospital NHS Foundation Trust	2	0	0	2
Barnsley Metropolitan Borough Council	1	0	0	1
Kirklees Council	0	1	0	1
NHS Bassetlaw CCG	1	0	0	1
Kirklees Healthwatch	1	0	0	1
Wakefield Metropolitan District Council	1	0	0	1
Total	6	1	0	7

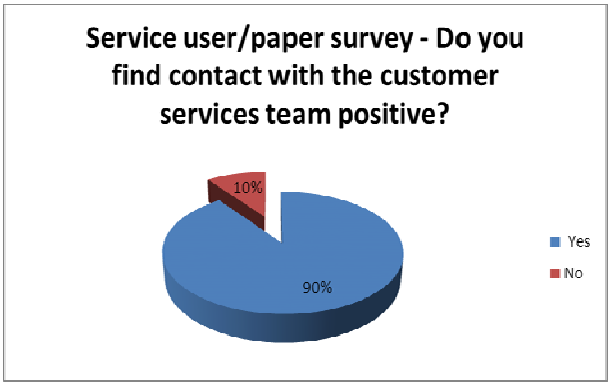
CONTACT WITH THE CUSTOMER SERVICES TEAM

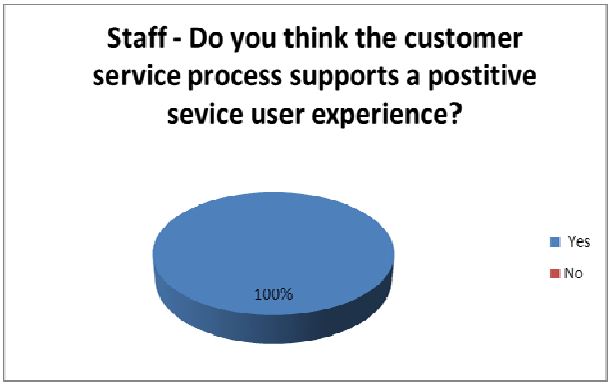
The customer services team processed 223 general enquiries in Qtr. 1, in addition to ‘4 Cs’ management. These included provision of information about Trust Services, signposting to Trust services, providing contact details for staff, signposting to involvement opportunities and Trust membership information. The team also responded to over 370 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 has recently introduced telephone surveying of service users, to support real time feedback and improved responsiveness. This will be reported on in future quarterly reports.

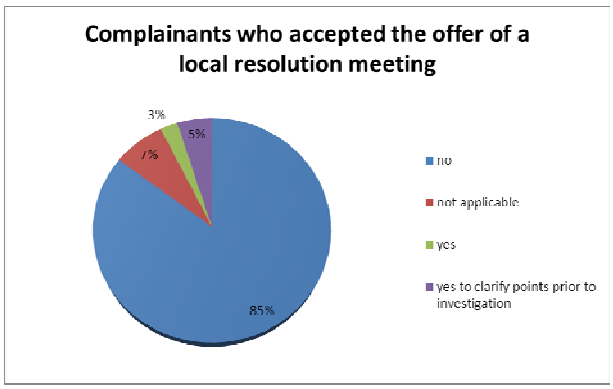


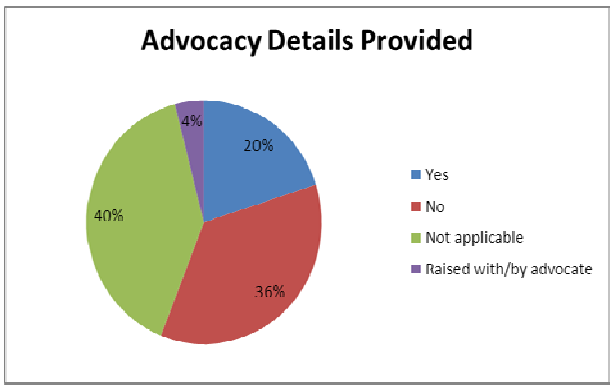


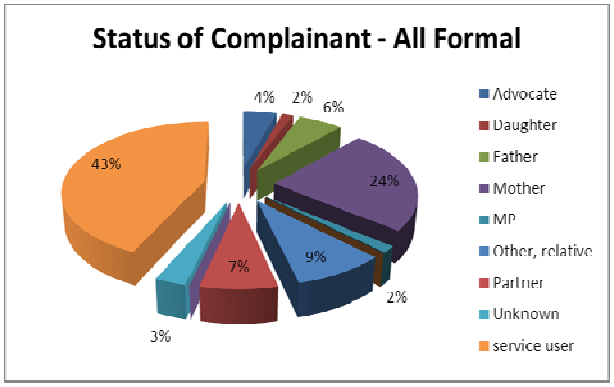
The Trust recognises that it is good practice to offer complainants the opportunity to meet staff to discuss issues. This offer is made early in the process to all complainants, but especially where complaints relate to more serious issues or complex circumstances. These meetings are ideally attended by both 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 perceive Trust services.

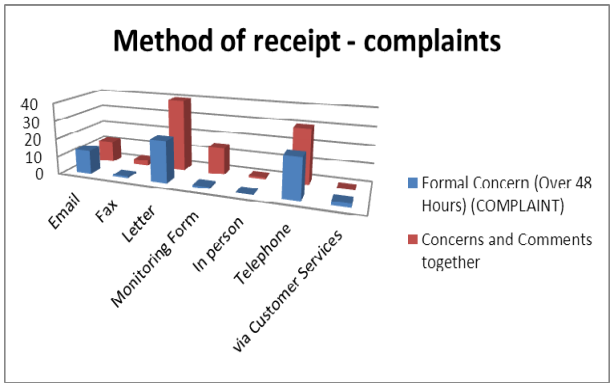
Complainants are also provided with contact details for independent advocacy services and are encouraged to use this support if helpful. A small number of service users are supported by an advocate.







Complainants may wish to communicate in writing (by letter or completion of the customer services feedback form), by 'phone, email, text message, via the website or through face to face meetings. Ensuring that people have access and opportunities to feedback their views and experiences of care is essential to delivering the Trust's values and is part of how we ensure that people 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.

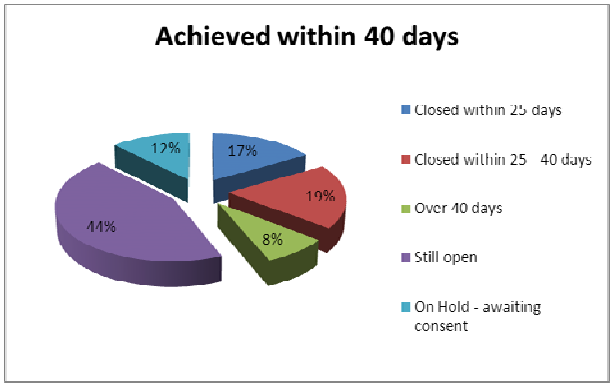


RESPONDING IN A TIMELY MANNER

The customer services standard is for complaints to be acknowledged within three days, with a named case worker 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; or 40 days for more complex cases. In Qtr 1, 61% of cases took longer than the 40 day internal service standard. This was due to:

- Further issues added to the complaint requiring additional investigation
- Capacity issues determined by responsible clinical
- Cases awaiting further information or clarification
- Cases re-opened following Trust response
- Staff absence caused delay in obtaining witness statements
- Complaint put on hold at the complainants request.

The customer services team work with service leads and heads of service to alert to issues regarding complaints investigation and timely progression.



49 formal complaints remain open, 32 which were received in the quarter. 9 of these are awaiting signed consent. 17 complaints were initially raised in the previous quarter and remain open of have been re-opened as the complainant remains dissatisfied with the Trust's response.

COMPLIMENTS

During Qtr. 1, 193 compliments were recorded. These are acknowledged by the Chief Executive and positive feedback is shared with the individual, the team and across the Trust via the intranet to support sharing of positive practice.

Example compliments received in Qtr. 1:

Thank you for everything that you have done, your support has been what I would say 'second to none'.

Barnsley substance misuse service

What a wonderfully supportive, non-judgemental team! Keep up the good work!

Calderdale psychological therapy services

Thank you for all your brilliant help and support. You have been an inspiration to me and I could not have done it without your guidance.
Barnsley Health Trainers

The group therapy has taught me ways to challenge negative thinking and turn it around. It has increased my self-confidence.

Wakefield CMHT

It has been amazing getting to know you these past few years and you getting to know my life and understanding my problems and helping me get through them. I never felt more confident than when speaking with you. I am so glad that you understood my feelings and helped me through a lot of situations. I am very grateful

Specialist Services CAMHS

Just to say a massive thank you for your time, patience and care. I don't think it's an exaggeration to say that without you and the rest of the team, I might not have been here to write this! I am so thankful for your help, you do an amazing job.

Kirklees crisis services

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. District Directors monitor the delivery of action plans and ensure that corrective action is implemented within service lines in response to trend analysis provided by Customer Services.

Some complainants meet with Trust staff to discuss their concerns. All complainants received a detailed response to the issues raised and an apology that their experience did not meet their expectations. Action taken and changes implemented in response to feedback include:

Barnsley BDU

- Staff on an inpatient ward have been reminded to provide service users with a copy of their care plan and ensure this action has been documented in healthcare records
- A community service has introduced a process to ensure family/carers have access to repeat prescriptions from GP's whilst service users are supported in inpatients settings
- An IAPT service is reviewing the process to ensure that service users on the waiting list are kept updated
- A health visiting team is reviewing the protocol for information sharing with other parties, for example, GP's. Auditing of recorded documentation has also been introduced.

Calderdale & Kirklees BDUs

- Ward staff on a Calderdale ward have been reminded about the need to protect confidentiality when discussions take place in shared/open areas.
- Crisis service staff have been reminded about the importance of using clear communication with service users/carers and families, and to ensure that the information provided has been understood.
- Details regarding discharge and the discharge policy to be provided to service users in writing, in addition to discussion
- Staff from a Kirklees service are to ensure that the carer and/or family involved in assisting the recovery of a service user are also offered assessment of their needs.

- CMHT in Kirklees are reviewing the process for patients transferring into the area to ensure all relevant information has been provided.
- Additional training is to be provided to team mangers regarding 'Deprivation of Liberty'
- Processes are being put in place to ensure correct information is provided to carers, relatives and service users regarding ward rounds, CPA's and Tribunals.
- Staff are to inform managers of any major/significant changes to a person's care package

Wakefield BDU

- Inpatient ward housekeeping staff and catering staff are reviewing the process to ensure that correct meals are delivered on a daily basis, with improved communication between the two functions.
- Duty workers have been reminded of the importance of retuning telephone calls in a timely manner
- New processes have been introduced to ensure better coordination and communication between CMHT's and crisis services.

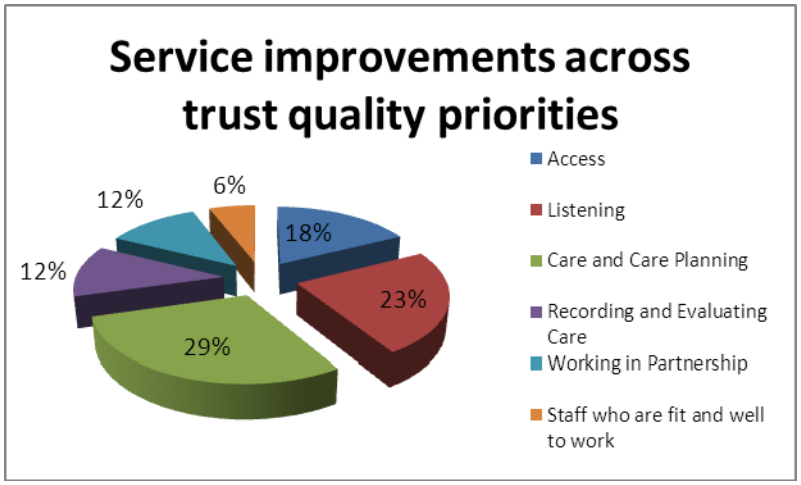
Specialist services BDU

- CAMHS services are subject to action plans to ensure issues identified are addressed and feedback responded to.

Forensic services BDU

- New process has been implemented to ensure all paperwork is sent to service users in a timely manner prior to Tribunals
- Families/carers are now provided with up to date information regarding unescorted leave conditions
- Revised processes have been implemented following a review of storage arrangements of service users' belongings

Improvements were made across the Trust's quality priorities as follows:



EXAMPLE OF SERVICE USER AND CARER EXPERIENCE

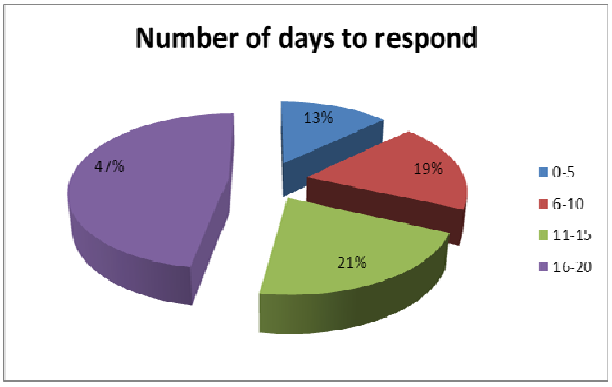
Harrison – raised concerns on a number of occasions about the standard of food offered in an inpatient unit.

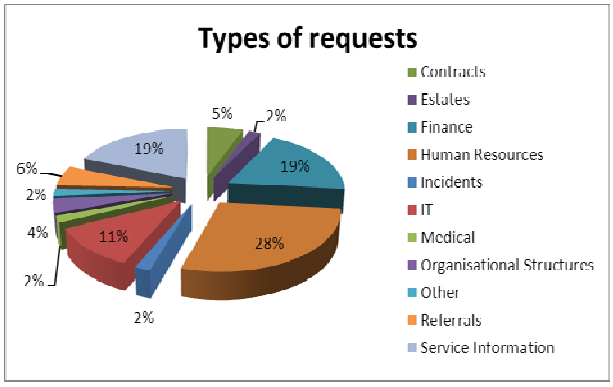
Catering/housekeeping and ward staff implemented a new process to ensure that any concerns were raised with catering staff immediately. A comments and compliments book was introduced and service users and staff were encouraged to contribute. A new form has also been introduced that service users can complete and return in the internal post to catering. Ward meetings also now include catering issues, for example menu choices and the quality of food as a standing agenda item.

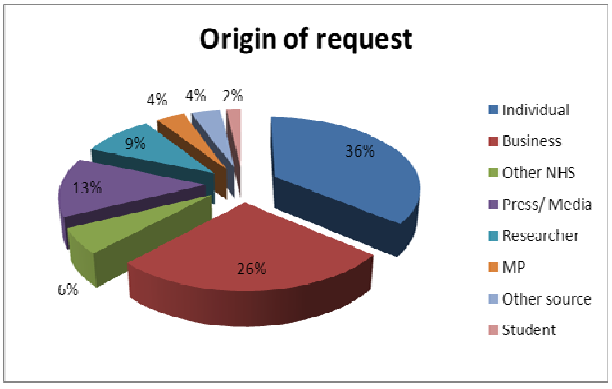
FREEDOM OF INFORMATION REQUESTS

53 requests to access information under the Freedom of Information Act were processed in Qtr. 1, a decrease on the previous quarter when of 67 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 within the 20 working day requirement.







During Qtr. 1, two requests were subject to exemption under the Act - one under section 41 - public sector contracts and one under section 43 - commercial interest.

There were no complaints or appeals against decisions made in respect of management of requests under the Act during the quarter.

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 Board now reviews reports on a quarterly basis. Quarterly reports are also shared with Extended EMT, externally with commissioners as part of the contracting and quality monitoring processes, 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 in the current financial year. Initiatives, now incorporated into the year of values programme, which support an improved service user experience are continuing, for example, the 'Right First Time, Every Time training programme.

There is also agreement for a team recognition scheme for those teams that demonstrate they 'live the values' in the delivery of their work. This will be launched in the coming weeks, will run to the end of the financial year 14/15, and be subject to evaluation.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 22 July 2014
Agenda item 5.3(i)

Title:	**Care planning update**
Paper prepared by:	Business Delivery Unit Directors/Director of Nursing/Director of Corporate Development
Purpose:	To provide an update on Care Planning setting out the actions taken to date and the further actions required to improve future performance.
Mission/values:	Delivering good quality care co-ordination, co-produced care planning and care reviews supports the Trust value of patient first and in the centre, enabling people to reach their potential and live well in their community.
Any background papers/ previously considered by:	Previous reports on national surveys
Executive summary:	**Background** At Trust Board in January 2014, the Director of Corporate Development presented a report providing an overview of Trust performance against national comparators setting out the actions being taken to improve future performance. The main areas for concern were the perception of service users regarding being offered, or given a copy of, their care plan and with regard to having had a care review meeting in the last twelve months to discuss their care. Although the scores had improved since the previous national community and in-patient surveys, the Trust was still classed as amongst the worst performing Trusts. BDU Directors were asked by Trust Board to present an update in six months' time regarding the actions taken within their respective BDUs and the improvements made. **Overview** Although there has been a big improvement for service users on CPA, due to the initial BDU focus based on risk assessment around this client group, the same has not been seen for service users on standard care. Hot spots have been identified around psychological therapies and medical workforce. In these areas there is a need for team manager support and RiO training as there is evidence that not all service users are having a care plan generated on RiO; it is actually set out within the clinic appointment letter. BDU Directors will work with team leaders to ensure that the relevant training and support is provided through the BDU and Quality Academy.
Recommendation:	**Trust Board is asked to RECEIVE the attached report and to NOTE the positive areas of good practice/improvement and the further actions being taken to improve care planning and care reviews, ensuring greater equality of care across the organisation.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Care planning
Trust Board 22 July 2014

Background

At the Business and Risk Trust Board January 2014, the Director of Corporate Development presented a report providing an overview of Trust performance against national comparators, setting out the actions being taken to improve future performance.

The main areas for concern were the perception of service users regarding being offered, or given a copy of their care plan and with regard to having had a care review meeting in the last 12 months, to discuss their care. Although the scores had improved since the previous National Community and In-patient surveys, we were still classed as being in the worst performing Trusts.

BDU Directors were asked by the Board to present an update to the Trust Board in 6 months' time, regarding the actions taken within their respective BDUs and the improvements made.

BDU actions taken to date

Care Co-ordination/care planning/reviewing care

- Circulation of the co-produced care co-ordination cards to all teams and services.
- Circulation of the co-produced standards relating to care planning and reviews of care to all teams and services.
    - Both the above discussed in governance meetings and disseminated through individual team meetings
    - Both agenda items discussed at carer and service user dialogue groups
- Promotion of co-production within care planning and care review process, with posters displaying standards in all bases.
- Team self-assessments against CQC Essential Standards including standard 1 (respecting and involving people who use services) and standard 4 (care and welfare) and action plans in place to remedy any areas of concern.
- Implementation of case management supervision in teams with a focus on professional role and responsibility, improving performance and improving service users and carers experience.
- Workshops for the care pathways (Community Therapy & Care Management) focusing on the role of the care coordinator and person centred care
- Training sessions piloted in Calderdale relating to care co-ordination competences which Kirklees staff attended. Further sessions have been arranged across the Trust over the next 12 months, these cover the competencies of:
    - Comprehensive needs assessment
    - Risk assessment and management
    - Crisis planning and management

- Assessing and responding to carers needs
- Care planning and review
- Transfer of care or discharge
    - SI action plans have promoted, through team managers, the CPA e-learning modules that cover the competencies above.

Data Quality

- Audit has been undertaken by pathway managers/clinicians to improve data quality, accurate caseloads, clusters, care reviews, risk assessments, care plans and discharge planning.
- INPAC project managers linked to BDU's have visited teams to explain the PbR dashboards and reinforce the standards.
- Use of the monthly reported PbR dashboard to understand team caseloads against standards:
    - Accurate recording of care co-ordination, monitored through case management.
    - Monitoring CPA/Standard Care registration.

Data Cleansing

- Discharging clients from Care Co-ordination when discharged from a team/service.
- Discharging episodes of care where clinical decision supports this.
- Monitoring against quality indicators and working with teams/ individuals to improve recording.

Sustaining

- Compliance is monitored through BDU performance meetings and reviewed in pathway meetings with team leaders, identifying areas of good performance and/or areas of improvement.
- Working with team leaders, doctors and medical secretaries to develop frameworks and products to sustain approaches to record keeping relating to care planning, reviews of care under CPA/ Standard Care/Mental Health Clustering and recording of outcomes to contacts.
- Promoting the use of the PbR dashboard by team leaders to support caseload management.

Indicators of Change

*Percentage of clients on **CPA** who have had a formal review within the last 12 months:*

- ❖ RiO (Dec 2013) 79%
- ❖ RiO (June 2014) 97% - Improved

*Percentage of clients on **CPA** who have been given or offered a copy of their care plan:*

- ❖ RiO (Dec 2013) 77%
- ❖ RiO (June 2014) 80% - Improving but following areas identified for focus:

- Calderdale Memory Service (East) 66.67%
- NK Community Therapies 77.08%
- SK Community Therapies 69.16%
- Barnsley Central CMHT 37.21%
- Barnsley Early Intervention 46.22%
- Barnsley North CMHT 46.41%
- Barnsley South CMHT 67.20%
- Wakefield Acute Wards OTS 75.76%
- Wakefield Day Treatment Services 57.50%

*Percentage of clients on **Standard Care** who have had a formal review within the last 12 months:*

- ❖ RiO (Dec 2013) 32%
- ❖ RiO (June 2014) 39% - Improving but needs further detailed work in all BDUs
- ❖

*Percentage of clients on **Standard Care** who have been given or offered a copy of their care plan:*

- ❖ RiO (Dec 2013) 47%
- ❖ RiO (June 2014) 40% - Deteriorating needs focused work in all BDU's

Conclusion

Although there has been a big improvement on having a care review meeting and receiving or being offered a copy of their care plan for service users on CPA, due to the initial BDU focus based on risk assessment around this client group, the same can't be said for service users on standard care.

Hot spots have been identified around psychological therapies and medical workforce. In these areas there is a need for team manager support and RiO training, as we have evidence that not all service users are having a care plan generated on RiO, it is being set out within the clinic appointment letter. This then means that the relevant box on RiO is not completed for these people, under recording against the performance indicator.

BDU Directors will work with team leaders to ensure the relevant training and support is provided through the BDU and Quality Academy.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 22 July 2014
Agenda item 5.3(ii)

Title:	**Incident Management Annual Report 2013/14**
Paper prepared by:	Director of Nursing, Clinical Governance and Safety
Purpose:	The purpose of the paper is to provide assurance to Trust Board that robust incident management arrangements are in place and to provide an overview of all incidents that take place within the Trust.
Mission/values:	The report demonstrates the Trust's commitment to delivering safe and effective services.
Any background papers/ previously considered by:	Trust Board has received quarterly Incident Management reports, which have also been considered by the Clinical Governance and Clinical Safety Committee. This report will also be reviewed in detail by the Clinical Governance & Clinical Safety Committee, and this review will inform the workplan for incident management reporting during 2014/15
Executive summary:	This report provides an overview of all incidents reported by the Trust during 2013/14, a summary of serious incidents and of recommendations from completed serious incident reports. The report, plus further detailed information at BDU and team level, will be reviewed and interpreted for the Clinical Governance and Clinical Safety Committee (CGCS). The report for the CGSC will also provide detail of action required and key areas for learning. Although the CGCS will receive assurance on the action required, and further interpretation of the data, at this stage the Board can be advised that:- ➢ Incident reporting levels remain at a similar level to the previous year. ➢ There were no 'Never Events' reported in 2013/14. ➢ There was one homicide reported during 2013/14. ➢ 101 serious incidents were reported during 2013/14 of which the largest categories were suspected suicide (23) and pressure ulcers – grade 3 and 4 (45). ➢ Analysis of suspected suicides using population size and National Confidential Enquiry data shows that a Trust of this size would expect to see between 26 to 36 potential deaths by suicide. ➢ Serious incidents are defined by NHS England and include incidents such as suspected suicide of service users, homicide by service users, never events, serious assaults and confidentiality breaches as well as attempted suicide (life threat/serious injury), and the unexpected death of an inpatient. ➢ In 2013/14 a new category of SI was introduced by NHS England relating to the reporting of grade 3 and 4 pressure ulcers, which is reflected in the overall number of SIs reported during 13/14.
Recommendation:	**Trust Board is asked to RECEIVE the report and NOTE the contents.**
Private session:	Not applicable.

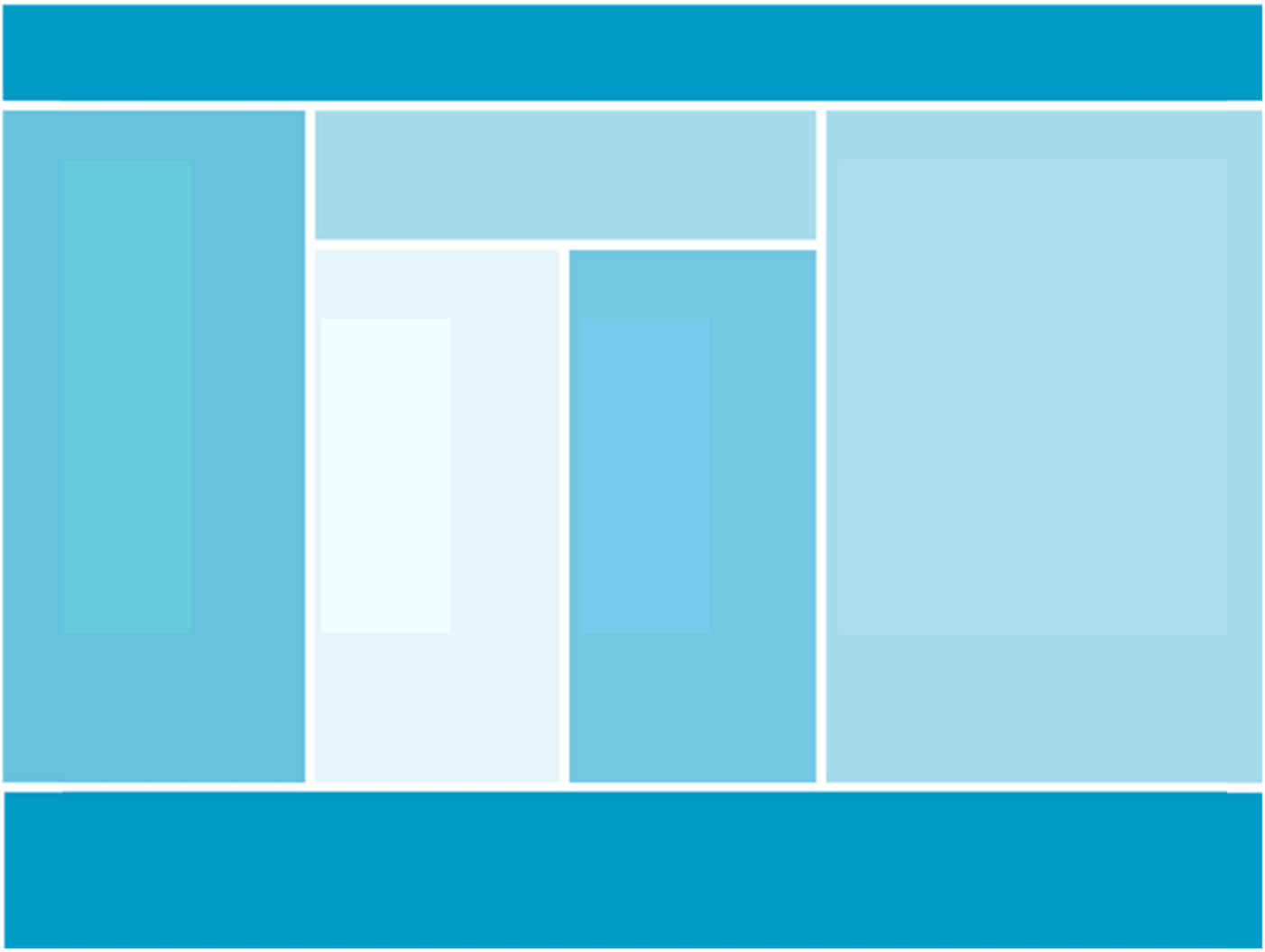
With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Incident Management

Annual Report April 2013 to March 2014

Patient Safety Support Team



Executive Summary

This report provides an overview of all the incidents reported by the Trust. It also includes further analysis of serious incidents (SIs) and analysis of recommendations of completed serious incident reports submitted to commissioners and work undertaken by the Patient Safety Support Team for the period of 1st April 2013 – 31st March 2014. This report does not cover the work of the BDUs in terms of implementing the learning arising from SIs in great detail.

The Trust over the past few years has ensured all services and teams acquired have been added to Datix and have access to reports and training made available by the Patient Safety Support Team. The team have worked with both internal and external partners to ensure the Trust has a robust system to enable reporting, investigation and analysis of incidents. Those processes have been scrutinised by and both internal and external auditors this year, an independent firm of auditors giving the Trust 'substantial assurance' as to its adherence to a national framework for managing serious incidents. Commissioners have consistently rated the quality of investigations highly. This now allows the team to support more analysis, development and learning. There has been greater support in investigating lower level incidents and BDU learning events.

The Trust reported 9970 incidents of all severity during the year; this was similar to previous years. The range within a quarter is 2327-2617 incidents. The distribution of these incidents in terms of severity is pyramid-shaped, serious incidents being fewest in number, with most incidents resulting in no harm.

Never Events

No 'Never Event' incidents were reported by SWYPFT in 2013/14. Never events are defined by the Department of Health as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Homicides: Independent Reviews

There was 1 homicide reported in 2013/14.

Serious Incidents (SI)

101 (56 when pressure ulcers removed) Serious Incidents were reported to the commissioning CCG via the Department Of Health database – STEIS/Unify. Serious Incidents are defined by NHS England and include suspected suicide of service users, homicide by service users, never events, serious assaults and confidentiality breaches as well as attempted suicide (life threat/serious injury), and the unexpected death of an inpatient. The overall data for the Trust does not suggest any trend towards deviation from the latest national picture with regard to suicides and homicides.

BDU population estimates and serious incident figures per 100,000

District	Population ONS –population estimates Mid 2012	Incident figures per 100, 000 population for 2013/4
Barnsley	231,865	5.17
Calderdale	204,170	4.4
Kirklees	422,970	3.07
Wakefield	326,433	4.29

The largest single category was suspected suicide (23). Analysis using population size and national confidential inquiry data shows that a Trust covering Barnsley, Calderdale, Kirklees and Wakefield would expect to see between 29 - 35 patient deaths by suicide per year. The report breaks this down by BDU and type and shows the previous year for comparison.

District	Population ONS – population estimates	General population suicide rate (NCI)	Patient suicide rate (28% general pop) (NCI)	Suspected suicide reported on STEIS 2013/14	Suspected suicide reported on STEIS 2012/13
Barnsley	231,865	20-24/5	6-7	5	7
Calderdale	204,170	18-21/22	5-6	7	5
Kirklees	422,970	37-45	10-13	9	8
Wakefield	326,433	29-35	8-10	2	11
Trustwide	1,185,438	104-125/127	29-35	23	31

Patient Safety Support Team

The work the team has completed over the past couple of years was validated this year through internal audit of processes for Serious Incidents. The audit received substantial assurance. The team also provided all information required for the quality account following a significant piece of work to enable local recording of severity grades to match NRLS.

Now the processes are in place the team are in a position to develop the support to the BDUs to ensure learning from incidents.

In 2014/15 more training will be available for investigating lower level incidents; the team will look at ways of providing information that helps services. The incident dashboard will begin to be available, initially to consultant medical staff.

The role of the associate medical director (AMD) for patient safety has been further developed and a new post holder has been in place since December 2013, providing support to the clinical directors and PSST, clinical leadership in terms of investigating and learning from serious incidents but also having a wider remit in terms of the Trust's approach to patient safety.

2013-14 has also seen the development of a bimonthly patient safety clinical reference group. Chaired by the AMD for patient safety, it is a forum for collecting and disseminating ideas and information between a core group of individuals directly involved in developing, implementing and monitoring systems to improve patient safety. There is a particular emphasis on investigations, recommendations and action plans arising from serious incidents and on how learning is disseminated both locally and trust-wide.

A list of co-opted experts within the Trust has been developed from a variety of specialties and disciplines to provide specialist support to SI investigators where necessary.

Learning Lessons and Safety Culture

All care providers must put patient safety at the forefront of the delivery of healthcare. The Francis report, and the government response, *Hard Truths*, among others have highlighted the need for trusts to develop a proactive and positive safety culture and robust systems and processes to monitor safety and implement change on the basis of lessons learned. There are a variety of potential opportunities for the Trust to develop networks and join initiatives towards fulfilling this aim, including the new Patient Safety Collaborative and the *Sign up to Safety* initiative. The development of an overarching Trust patient safety strategy in the forthcoming months will provide a framework to support such initiatives.

Each BDU now has a practice governance coach (or personnel with a similar role) to assist in the dissemination of learning arising from SIs. Every SI investigation is followed by a learning event for the individual team or service involved. In addition, BDUs are holding wider learning events for staff to highlight themes and trends from incidents (both serious and otherwise) along with lessons learned. Each BDU has a governance forum in which the implementation of action plans is monitored. In the great majority of cases, actions arising from recommendations in SIs have been completed or are on schedule for completion. However, the Trust still needs to develop further its processes for measuring the subsequent impact of these actions by capturing evidence of positive change, whether that be in terms of the quality of care provided, a measurable change in safety culture or a reduction in the frequency or severity of incidents.

Contents

1 Introduction

This report highlights the output from the work of the Patient Safety Support Team and the data the team produces to support the Business Delivery Units (BDUs) to undertake learning from incidents. BDUs are in the best position to demonstrate the practical application of this.

The report has 3 sections:

Section 1 Learning from Incidents

This section includes analysis of Serious Incident recommendations. The completed reports were submitted to commissioners between April 2013 to March 2014.

Section 2 Summary of all Reported Incidents

This section covers all incidents from 1st April 2013 to 31st March 2014. It should be noted that this report provides only an overview; detailed reports are produced on a quarterly basis for Business Delivery Units and many specialist advisors run/analyse incident reports within Trustwide Action Groups (TAGs) that the Patient Safety Support Team have assisted in setting up. In addition an annual audit of suspected suicides and undetermined deaths is undertaken by the Trust, the 2013/14 report is available to compliment this report.

Section 3 Work Undertaken by the Patient Safety Support Team

This section provides a summary of the work of the Patient Safety Support Team in relation to incident management and the development plans for the next year.

Section 1

2 Learning from Incident reporting

2.1 Introduction

The Trust has a moral obligation to learn from incidents, some of the lessons come at a great cost ıcluding loss of life and significant harm.

All care providers must put patient safety at the forefront of the delivery of healthcare. The Francis report, and the government response, *Hard Truths*, among others have highlighted the need for trusts to develop a proactive and positive safety culture and robust systems and processes to monitor safety and implement change on the basis of lessons learned. There are a variety of potential opportunities for the Trust to develop networks and join initiatives towards fulfilling this aim, including the new Patient Safety Collaborative and the *Sign up to Safety* initiative. The development of an overarching Trust patient safety strategy in the forthcoming months will provide a framework to support such initiatives.

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Learning from incidents occurs at many different levels in the organisation, this report can only give a few examples:-

- **Individual reflection following an incident** - when an incident takes place, clinicians reflect

on their practice, this is supported through supervision and appraisal. This reflection can result in development plans to increase skill and knowledge.

- **Team reflection and action** – teams can run reports from the Datix system to look at trends or new types of incidents and put team plans in place to increase the safety of practice. An example of this is work on low grade medication errors; the work was supported by pharmacy and practice governance to reduce the number of errors.

- **Learning events -** following a Serious Incident allows all members involved to have the findings presented and assist in turning the recommendations into actions that will make a difference.

- **BDU –** BDUs have quarterly reports on incidents which provide data to look at trends and performance information. Individual Serious Incident reports are shared at senior manager level for onward sharing through governance processes. BDUs have held learning events within the BDUs where data and cases have been discussed.

- **Trust level –** learning from incidents is reported through the BDU, TAGs, analysis of recommendations. The Incident Review Sub-Committee review wider trend and learning lessons. Annual reports from Trust wide Action Groups, report on incident information e.g. health and safety, safeguarding **and** the learning that has taken place.

- **Specialist Advisors** - receive individual incident notification to enable them to provide support if necessary. Many undertake production of quarterly reports for TAGs and wider learning. Additionally at the end of each quarter the Trust's Specialist Advisors are asked to provide information on any significant learning, identified peaks and notable advice given within the period. This is then incorporated into the Trust's quarterly incident report, produced by the Patient Safety Support Team. During 2013/14 there were a number of issues raised where learning, good practice and improvements were noted.

3. Recommendations from Completed SI reports (Trustwide)

The date range of the actual incidents these reports relate to is June 2012 and December 2013.

This section includes an analysis of the recommendations made in the Serious Incident investigation reports **completed** between 1st April 2013 and 31st March 2014 (excluding pressure ulcer and information governance incidents). There were a total of 56 investigation reports completed during this time, an increase of 8 reports from the previous 12 months, which led to 213 recommendations being made. Three reports made no recommendations. This does not include pressure ulcers which are dealt with separately later in the report.

It is important to appreciate that in undertaking an investigation of an incident the Trust takes the view that all areas for learning or improvement should be identified and lead to a recommendation being made. These are often care delivery issues, and not considered to have been either causal or contributing factors to the incident.

As shown in **Table 1** when comparing the recommendations from last year the top category is record keeping, this was also the top issue in 2011/12. The Trust has had a number of workshops during the year on record keeping so a change may be seen next year.

Table 1: Ordinal list of recommendations 2012/13 and 2013/4

Recommendation Type	2012/13	2013/14
Record keeping	1	1
Team/service roles, systems & mgt	2	4
Staff education, training, supervision	3	
Care delivery	4	5
Care pathway	5	2
Risk assessment		3

Section 2

4. Summary of incident reporting (all severity grades) in 2013/14

4.1 Introduction

This section provides an overview of all incident reporting and management (all severity grades) from 1st April 2013 to 31st March 2014.

Quarterly incident management reports provide additional 'rolling' updates and analysis and these have been sent to BDUs and Clinical Governance and Clinical Safety Committee initially, also they have been added to the Incident Management intranet page for all to view.

Patient Safety was one of the three Lord Darzi headings and this has been further enforced through the Francis report and Berwick report. In a positive safety culture we would expect to see a high level of incident reporting and clear and effective processes for learning from these. Effective incident reporting and management is a key element in a number of external agency requirements and good practice guidance, including NHS Contract, the Care Quality Commission registration requirements, and the work and publications of the NPSA. Trust processes for these are fully described in the incident management policies and procedures accessible through the Trust intranet.

All patient safety incidents of all grades are uploaded to the NHS National Reporting and Learning System (NRLS). The Trust is also required to report some incidents to external bodies and agencies e.g. CQC, information commissioner.

All reported incidents which meet the requirements for NHS Commissioning Board Serious Incident (SI) Framework are reported to the Clinical Commissioning Group via the DOH database STEIS. These incidents are also subject to an investigation using the principles of RCA, in accordance with national good practice guidance and where required an action plan to address recommendations for improvement and learning is developed.

Reported incidents with a severity grading of amber, yellow or green are subject to review by a senior member of the clinical service where the incident occurred. They identify if further investigation or action is required. In particular amber incidents may require further investigation and action by local services.

Note amber pressure ulcers graded 3/4 are STEIS reported along with some information governance incidents.

Where there is a 'cluster' of incidents which may indicate a problem a 'cluster' review may also be undertaken to identify any common themes or issues.

4.2 Incident management reports and data provided

Incident management reports and data are prepared for a range of Trust meetings, groups and managers by the Patient Safety Support Team, Specialist Advisors or Operational Managers who have access to reported incidents and report functions on Datix. Aggregated incident reports including comparative data are provided to the Trust Board, Committees, the Executive Management Team, Trust Action Groups, Business Delivery Units and Sub-Groups, from which peaks and trends can be identified and explored. The data provided can include a breakdown and analysis of incidents, which can be by type, category, sub category, severity, and date, time of day, service, team/unit, person and location of incident. Some of these reports include information about the lessons learned from Serious Incident RCA investigations.

The following are examples of the key reports that have been provided:

- Weekly summary of Serious Incidents and Investigation status to EMT
- Monthly performance data for the dashboard
- Monthly incident information for CQUIN and contracts
- A quarterly incident report including a Trust-wide report, a Serious Incident report and individual BDU reports and a non clinical services report produced at the end of each quarter
- Quarterly compliance report which is shared at the Quality Board
- The PSST and/or Specialist Advisors provide incident reports and/or incident information to Trust Action Groups – such as the Management of Aggression and Violence TAG
- Individual teams and services are now able to access incident information directly on Datix and produce their own reports locally
- One-off reports and analysis are provided on request e.g. if there is a particular concern about an issue
- Audit and service evaluation data

4.3 Total numbers of Trust-wide incidents reported in 2013/14

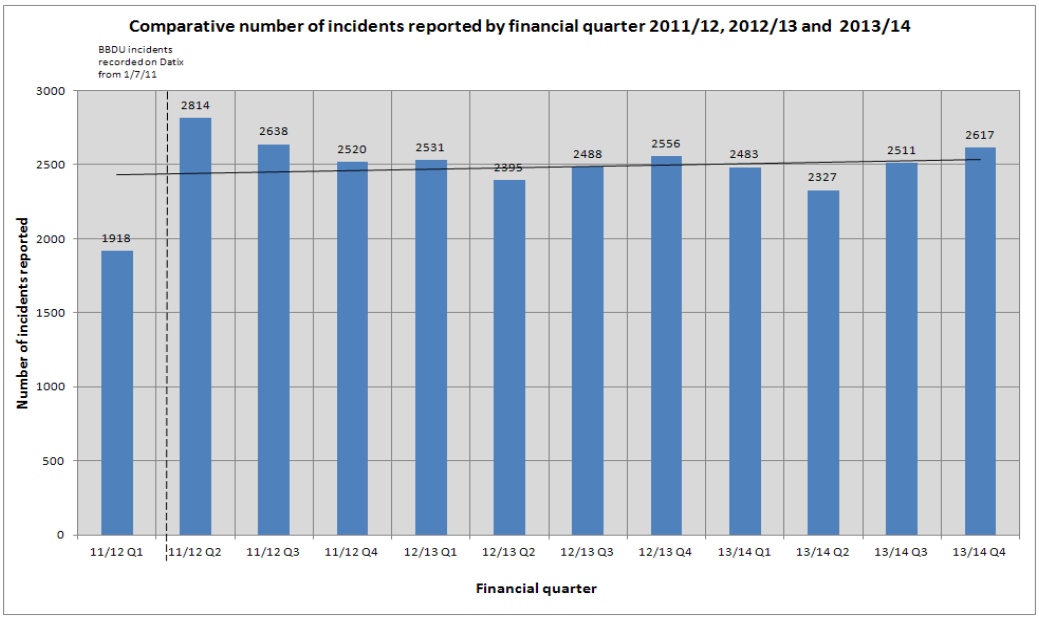
Incident reporting management and learning is a key element of an organisation's reporting and safety culture. A high level of incident reporting, particularly of less severe incidents is an indication of a strong safety culture (NPSA: Seven Steps to Patient Safety).

With the Trust changing profile of services it is difficult to make direct comparisons with previous years.

Chart 1 below shows the pattern and number of incidents reported by quarter in the Trust over the last 3 financial years.

The number of incidents reported this financial year is in line with previous years. The average number of incidents reported over the 3 years period is 9932 incidents. There were a total of 9938 incidents reported in 2013/2014. 2011/2012 was the highest reporting year where 9970 incidents reported, a difference of 32 incidents.

Chart 1 below shows the number of incidents reported by quarter from 2011/12 to 2013/14.

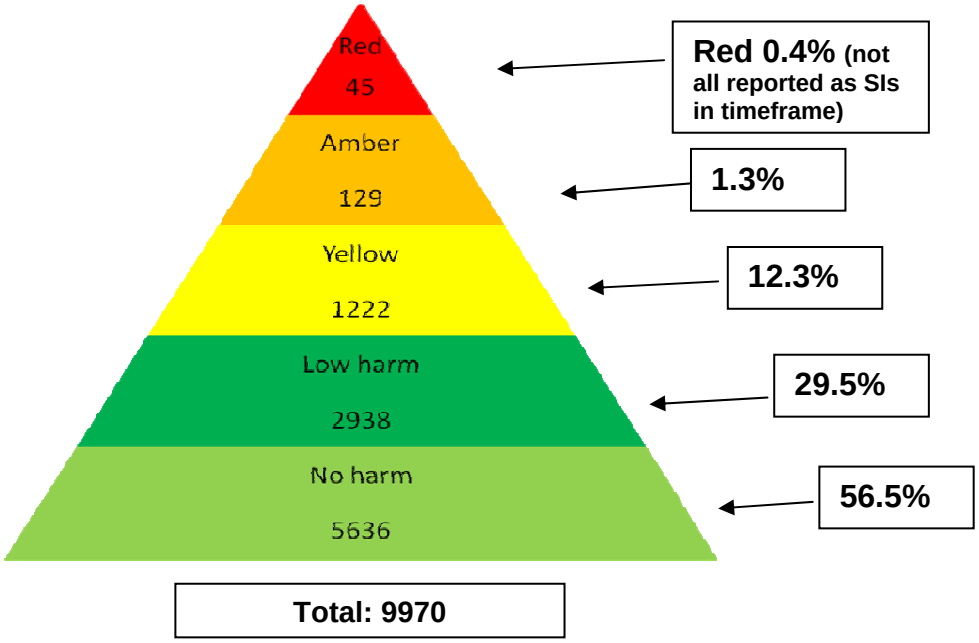


5. Severity grading of incidents

All incidents are severity graded using the Trust's risk grading matrix to give a red, amber, yellow, green grade. Red is the most serious and always classed as a Serious Incident, green is the least serious. **Charts 2 and 3** show a breakdown of all incidents reported by severity and as a percentage of the total number reported in 2012/13 and in 2013/14

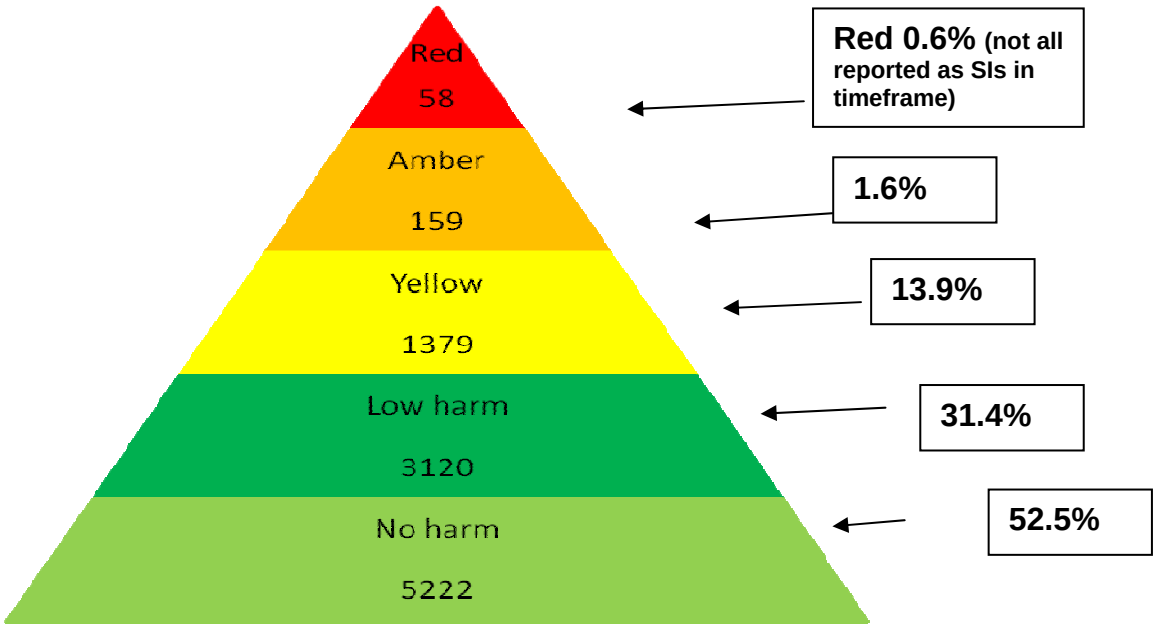
** Note The red incidents in these charts are based on different data to the SI figures, and are not exactly the same; the figures are dates of incidents. Not date reported on STEIS*

Chart 2 Incidents reported by severity 2012/13



Total: 9970

Chart 3 Incidents reported by severity 2013/14



Total: 9938

6. Results from Staff Survey 2014

A number of questions were asked within the survey which provided direct feedback on staff views with regards to the incident reporting system

The 2014 staff survey reported that the Trust had remained above the national average regarding treating staff fairly when reporting errors/near misses/incidents.

One area that requires further examination with the BDUs is the percentage of staff that saw an error, near miss or incident that could have hurt staff or patients/service users, and failed to report it. The survey highlighted that only 79% of staff had reported incidents, this is 7% below the national average. Locally this figure has decreased in comparison with last year. The Patient Safety Support Team will be undertaking awareness sessions within 2014/15 for BDU staff; this will highlight the reasons why incidents need reporting and investigating, what constitutes a reportable incident and how they are reported. An action plan has been developed which has included further examination of how sharing the learning of all incidents can be communicated to staff.

7. Internal Audit 2014

An internal audit by KPMG was undertaken of the Trust's adherence to standards set out in the *National Framework for Reporting and Learning from Serious Incidents requiring Investigation*; the overall outcome was one of 'substantial assurance'. The report highlighted a number of good practices but also made two recommendations and one suggestion about potential improvement. Both recommendations were considered 'low priority' by the auditors. The first, relating to updating the existing policy was already underway and is now complete. The second related to enhancing the processes for monitoring the impact of lessons learned. The opportunity for improvement related to the development of a single overarching policy for the management of serious incidents, acknowledging that the Trust currently has a number of policies in place that relate to serious incidents. How best to respond to these recommendations will be considered in the Incident Review Subcommittee and the Patient Safety Clinical Reference Group.

8. Quality Account

Datix was able to provide all the information required for the quality account following a piece of work to enable the trust to locally report the same data as NPSA in relation to degree of harm.

9. Serious Incidents (SIs) Analysis

9.1 Introduction

This section includes an analysis of Serious Incidents reported between 1st April 2013 and 31st March 2014.

9.2 Definition and Reporting SIs

Serious Incidents are incidents which meet the specific criteria as defined by the NHS Commissioning Board – Serious Incident Framework – March 2013 (this is based on principles set out in NPSA's 2010 National Framework for reporting and learning from serious incidents requiring investigation). There is a requirement that these incidents are reported on the DOH database, STEIS, and are subject to an internal investigation by the Trust. Some require further independent review.

The Clinical Commissioning Groups or NHS England Local Area Team for specialised commissioned services will monitor incidents and action plans. Some of this has been delegated to the Clinical Support Unit (CSU). The reporting will also include some amber incidents in relation to pressure ulcers grade 3 and 4 and serious information governance

breaches.

The SI criteria, reporting and external monitoring process means that there are potentially 3 dates associated with an SI:-

1. Actual incident date (if known)
2. Date the incident is recorded on Datix
3. Date the incident is reported on the DOH database STEIS, when it has been confirmed as an SI.

9.3 Analysis of SIs

The number of SIs reported in any given period of time can vary, and given the relatively small numbers involved and the definition of an SI, it can be difficult to identify and understand the reasons for this. However it is important that any underlying trends or concerns are identified through analysis. The Trust undertakes a range of reviews to identify any themes or underlying reasons for any peaks. This includes an annual undetermined deaths audit which reviews all suicides and undetermined deaths and compares Trust figures with the National Confidential Inquiry into Suicides and Homicides by people with Mental Illness. Investigations using the principles of root cause analysis were initiated for all incidents to identify any systems failure or other learning.

During 2013/14 a final total of 101 Serious Incidents (all graded red/amber on the Trust's severity grading matrix) were reported to the relevant Clinical Commissioning Group (CCG) via the DOH database STEIS. Some incidents are reported, investigated and later de-logged following additional information. The chart below shows all SIs with the exception of pressure ulcers. N.B. Following the production of this data, one incident of suspected suicide in Kirklees was de-logged from STEIS, since the inquest verdict was one of natural causes. Numbers and breakdown of pressure ulcers is in section e.

There were **no never events** reported. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented (DOH).

Chart 4 below total number of serious incidents (excluding pressure ulcers) by financial year 2009/10 to 2013/14

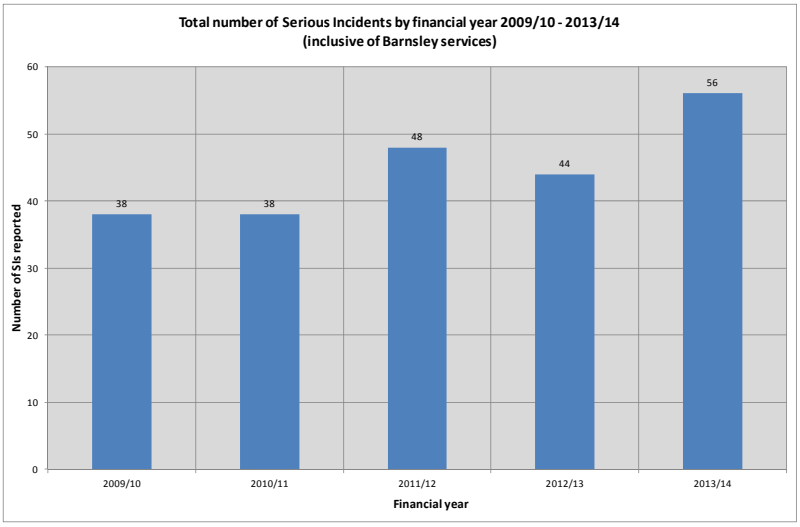


Chart 4 Above shows the total number of SIs (all categories - see chart 7 for breakdown) reported by financial year (based on date reported as an SI on STEIS) from 2009/10 to 20013/14. Barnsley BDU data is included from 2009/10 to enable comparison. This chart shows that there are fluctuations in number over the different years. The financial year 2013/14 has 56 SIs which is above average number across the 5 years which is 45.

The occurrence of SIs on a yearly and month-by-month basis, by Trust wide care group, by service and by BDU fluctuates. **Tables 1 and 2**, and **Charts 5 and 6** below show the 44 Serious Incidents reported in 2012/13 and the 56 Serious Incidents reported in 2013/14 by BDU, by month and by service. It is difficult to break down SIs in a comparative way due to the change in service; for example Barnsley adult mental health services are not organised on an age-based service structure (working aged and older age), and the Trust now has more commissioned services than previously e.g. CAMHS services.

As in previous years the majority of SIs occurred in working aged adult services which is consistent with the national picture. The Trust has had 2 Serious Incidents in Learning Disability Services, where in the last few years they have had no incidents. CAMHS and Forensic services have also reported 3 incidents, higher than previous years.

Tables 8 and 9 provide a breakdown of SI by BDU and care group or service for both 2012/13 and 2013/14 for comparison

Table 8 2012/13 - the 44 reported SIs by BDU and Service

BDU	Totals	WAA	OPS	CAMHS	Forensic	Community Healthcare (BBDU)	Mental Health & SMS (BBDU)
Barnsley	**8**						8
Calderdale	**8**	8					
Kirklees	**13**	11	2				
Wakefield	**14**	13	1				
Forensic	**1**				1		
Non clinical	**0**						
Totals	**44**	**32**	**3**	**0**	**1**	**0**	**8**

Table 9 2013/14 - the 56 reported SIs by BDU and Service

BDU	Totals	WAA	OPS	CAMHS	Forensic	Learning Disability	Community Healthcare (BBDU)	Mental Health & SMS (BBDU)
Barnsley	**12**							12
Calderdale	**9**	8	1					
Kirklees	**13**	12	1					
Wakefield	**14**	13	1					
Forensic	**3**				3			
Specialist Services	**5**			3		2		
Non clinical	**0**							
Totals	**56**	**33**	**3**	**3**	**3**	**2**	**0**	**12**

Chart 5: 2013/14 SIs by Month and Business Delivery Unit -1/4/13-31/3/14

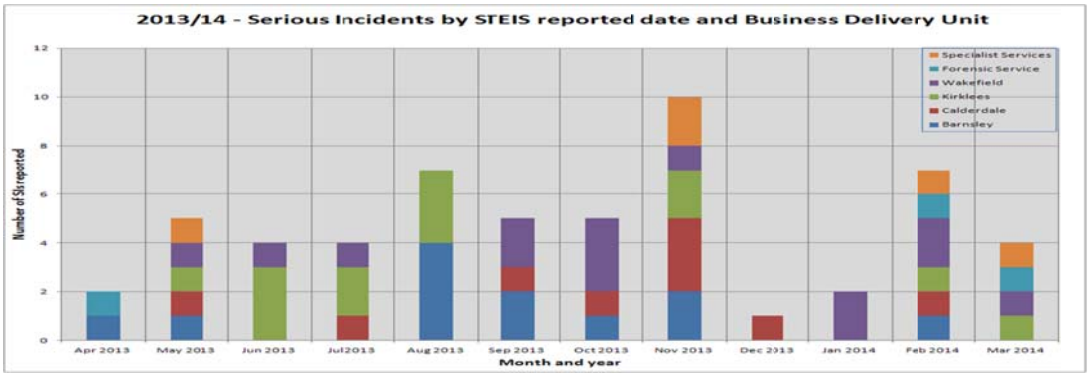
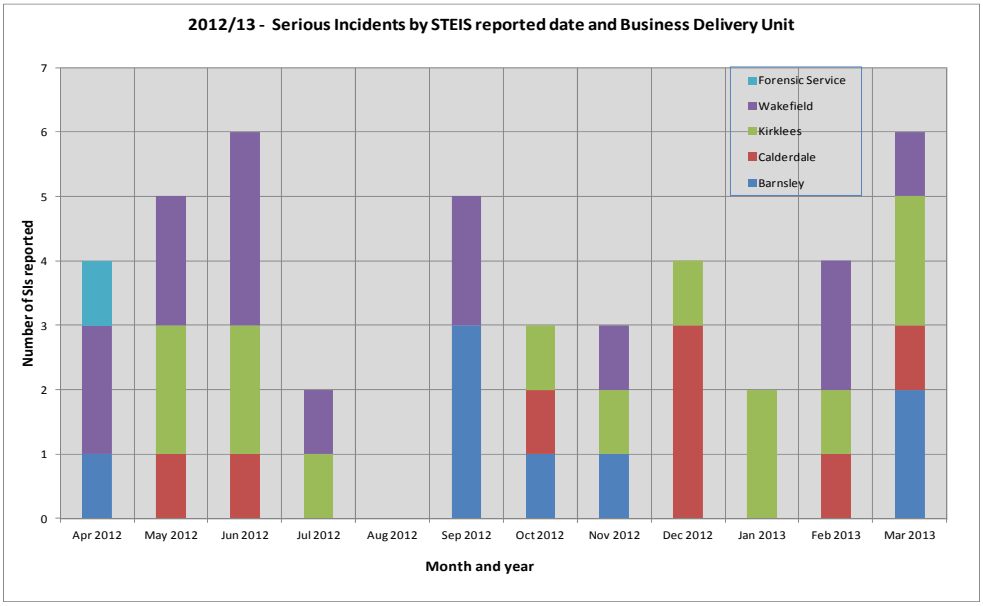


Chart 6: 2012/13 SIs by month and Business Delivery Unit - 1/4/12 to 31/03/13



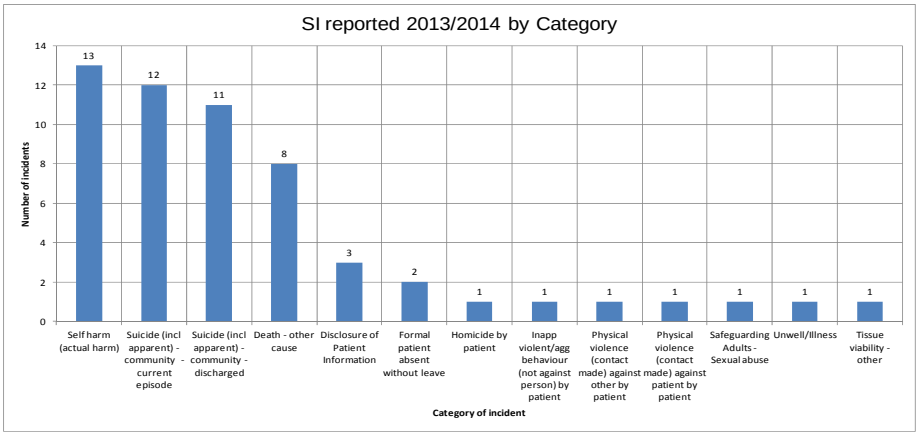
In 2012/13 the highest number were reported by Kirklees (13) and Wakefield (14) BDUs. In 2013/14 the highest were reported by Wakefield (14) Kirklees (13) Barnsley (12) BDUs. This is explained by BDU population sizes and service configuration; if the incidents are viewed on population size it shows Barnsley and Calderdale had more SIs per 100,000 population in 2013/14 but all the numbers are similar.

Table 10*:* BDU population estimates and serious incident figures per 100,000

District	Population ONS – population estimates	Incident figures per 100, 000 population for 2012/3	Population ONS –population estimates Mid 2012	Incident figures per 100, 000 population for 2013/4
Barnsley	235,976	3.4	231,865	5.17
Calderdale	202,841	3.96	204,170	4.4
Kirklees	400,920	3.2	422,970	3.07
Wakefield	337,152	4.15	326,433	4.29

Chart 7 shows the incident types as with previous years the highest single SI type is suicide or suspected suicide. These incidents are included in different 'types' because they might be suicide by service users in current contact with community services, service users discharged from mental health services with 12 months of the date of their death or an inpatient.

Chart 7- SI by type in 2013/14



The following provides further information about the main incident types as shown on **Chart 7:**

i) Suspected and actual suicide

This type of SI was most frequent in working aged adult services, and most suicides were by service users in contact with community services or discharged from services, which is consistent with national findings (NCI data). This is consistent with previous years. There has been a change from last year –patients who were in contact with community team at the time of their death have reduced (22 in 2012/13 and 12 in 2013/4). At the same time the number discharged has increased from 6 in 2012/13 to 11in 2013/14; however the criteria changed from 6 to 12 months post discharge which could account for this.

ii) Homicides

There has been 1 homicide reported in 2013/14. In the previous 2 years there had been 3 (2011/12-3 and 2012/13-0)

iii) Death /unwell– other causes

8 incidents were reported in this category, the same as last year. This has included patients that the cause of death is unclear or accidental e.g. a client recovered from a river by police, a suspected morphine overdose which was being used for pain management. It can take a significant amount of time for the cause of death to be clear but this does not prevent the investigation being completed

iv) In patient suicides

There were no inpatient suicides reported this financial year. There were 2 inpatient suicides reported the previous year.

v) Self harm/attempted suicide

During 2013/14 there were 13 very serious attempted suicides; see below for the detail. This is a significant increase from last year when 3 incidents were reported. Clearly this will be a key focus for consideration at the CGCS review stage.

Table 11: self harm/attempted suicide by BDU

	Barnsley	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Total
Contact with moving vehicle (car, train) - self injury	0	1	0	0	0	0	1
Cutting - self injury	0	0	0	3	0	0	3
Hanging - self injury	1	0	0	0	1	0	2
Jumping from height	2	0	1	0	0	0	3
Other self injury	0	0	0	1	0	0	1
Prescription medication - self poisoning	1	1	0	0	0	1	3
Total	4	2	1	4	1	1	13

9.4 Analysis of suicide and suspected suicide incidents

All suicide and suspected suicide incidents involving a service user in current contact with Trust services, and service users discharged from services within the previous 12 months (if the Trust is made aware of this), are reported as a Serious Incident. The Trust maintains close working arrangements with the Coroner's with regard to these cases.

Caution must be made against benchmarking one BDU against another because the services commissioned are not comparative e.g. not all BDUs provide IAPT services which is high volume throughput.

The National Confidential Inquiry into Suicide and Homicide by people with mental illness (NCI) undertakes an ongoing analysis of national suicide data and patient suicide data. This provides the Trust with a useful benchmark and context for comparing NCI general population and mental health 'patient' suicide data with Trust data.

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.

Table 12: 2013/14 - Incidence of suicide by Trust BDU populations and NCI suicides rates

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
Trustwide	1,185,438	104-125/127	29-35

ONS – Office of National Statistics
NCI – National Confidential Inquiry into Suicide and Homicide by people with Mental Illness

Table 13 Suspected Suicides reported on STEIS each quarter 2013/14

District	Qu1	Qu2	Qu3	Qu4	Total
Barnsley	1	2	1	1	**5**
Calderdale	1	2	3	1	**7**
Kirklees	3	3	2	1	**9(8)**
Wakefield	1	1	0	0	**2**
Total	**6**	**8**	**6**	**3**	**23(22)**

Table 12 above shows the reported expected incidence of suicide in SWYPFT by BDU based BDU populations and the NCI data. These NCI figures do not reflect any social deprivation or other factors and are simply averages of the data collected. NCI 'patient' data includes all cases where the Coroner gave a verdict of suicide or an open verdict for any person who had been in current contact with mental health services or in contact in the preceding 12 months.

Tables 13 show the suspected suicide reported on STEIS, if this is compared to the expected incidence, it shows that Barnsley, Kirklees and Wakefield are below the lowest expected figures. Calderdale is one over the expected figure. The Trust consistently is not an outlier but this does not make the Trust complacent in trying to learn and where possible prevent suicide. Note one of Kirklees incidents has been subsequently delogged as cause of death at inquest was natural causes.

Table 14 and 15 below show the Trust's actual suspected suicide SIs figures for 2012/13 and 2013/14 by BDU, by care group / service and by the team or service that the person was in contact with either at the time of death or discharge

Table 14 2013/14 - Suspected suicides by BDU and service

Service in contact with	Barnsley		Calderdale		Kirklees		Wakefield		Specialist Services		Total
	Comm	MH & SMS	WAA	OPS	WAA	OPS	WAA	OPS	LD	CAMHS	
CMHT		3	4		5		1				**13**
Crisis services			3		3		1				**7**
Rapid intervention						1					**1**
Mental Health Liaison		1									**1**
Acute Care		1									**1**
Totals	**0**	**5**	**7**	**0**	**8**	**1**	**2**	**0**	**0**	**0**	**23**

Table 15 2012/13 - Suspected suicides by BDU and service

Service in contact with	Barnsley		Calderdale		Kirklees		Wakefield		Total
	Comm	MH&SMS	WAA	OPS	WAA	OPS	WAA	OPS	
CMHT		3	1		3		4		**11**
Crisis services			3		5		3		**11**
Inpatient		1	1				1		**3**
Substance Misuse		1							**1**
Mental Health Access		1							**1**
Mental Health Liaison		1							**1**
Outpatient							1		**1**
Rapid Access								1	**1**
Day services							1		**1**
Totals	**0**	**7**	**5**	**0**	**8**	**0**	**10**	**1**	**31**

There are no inpatient deaths this year and the numbers of suspected suicides are reduced from the previous year.

These suspected suicide cases are spread across all 4 of the geographically-based BDUs, with the highest number reported in Kirklees and Wakefield BDUs, these are the BDUs with the highest population.

All of these suspected suicide incidents involved people who were in current receipt of community services or discharged within the last 12mths.

9.5 Pressure Ulcer SI's

During 2013/14 the Trust was required to report a number of grade 3 and 4 pressure ulcer incidents to the commissioning bodies via the Strategic Executive Incident System (STEIS).

The criteria that determines whether a Pressure Ulcer was reportable to the Commissioner is:

- If the Service User developed a grade 3 or 4 pressure ulcer whilst under the care of SWYPFT (72 hours after admission),
- If an existing pressure area deteriorated to a grade 3 or 4, 72 hours after admission.

Pressure ulcer SI's were reported to Commissioners **from May 2013**, therefore no comparable data is available.

An extensive amount of time and resource has been required in order to develop a process to ensure that all pressure ulcer SI's are reviewed and investigated in a timely manner and that final signed reports are submitted to Commissioners within the 45 day deadline. In addition the process ensures that action plans are completed and both lessons learned and actions for improvement are identified.

During 2014/15 it is possible that the reporting of pressure ulcer SI's may change. The Local Area Team based in Rotherham has initiated a regional group to standardise the reporting of pressure damage throughout the region. It has become apparent that within areas such as Rotherham incidents of this nature are only reported as SI's if the incident was deemed avoidable, where locally the CCG's expectation is to report prevalence as an incident.

Chart 8

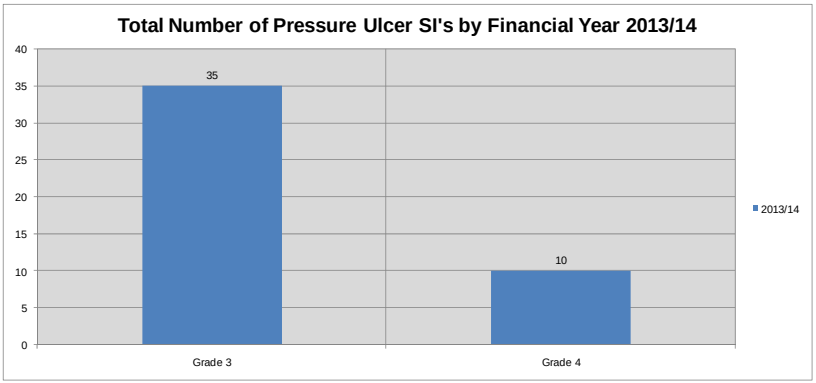


Chart 8 shows that during the year a total of 45 Pressure Ulcer incidents were reported as Serious Incidents, all of which originated from Barnsley BDU, this is where community services including District Nursing services are based.

These incidents are recorded with an amber severity (Major serious injury, impact or intervention) on the Datix System.

Chart 9

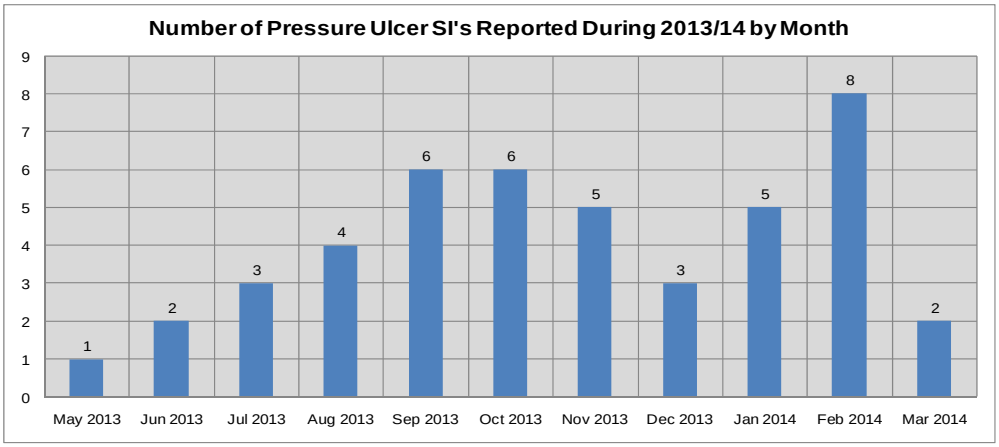
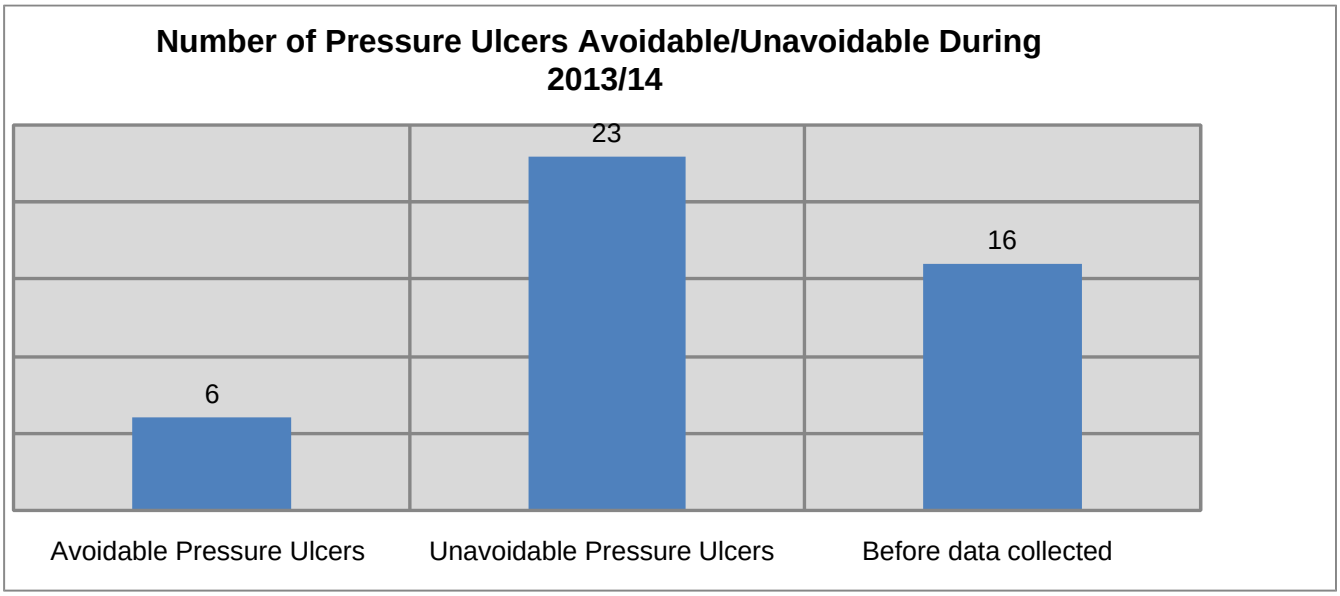


Chart 9 is based on the month when the SI was reported on STEIS not the month the incident occurred. February 2014 saw the most significant number of pressure ulcer SI's reported, however two were related to the same Service User and one Incident occurred during January 2014; however there was a delay in receiving the necessary information for the Tissue Viability Nurse to report on the attribution.

Chart 10



During the latter part of the year the Datix system was updated in order to collate information relating to whether pressure ulcers were avoidable. There were 6 that were deemed avoidable.

As a result of investigations into the "avoidable" pressure ulcers there were three specific recommendations made:

- To promote and improve communication between all agencies.
- An individual care plan must be completed for each pressure wound.
- A period of supportive leadership for District Nursing in cognitive skills.
- To share decision making at all levels and to ensure staff are aware of responsibility and accountability.

Chart 11

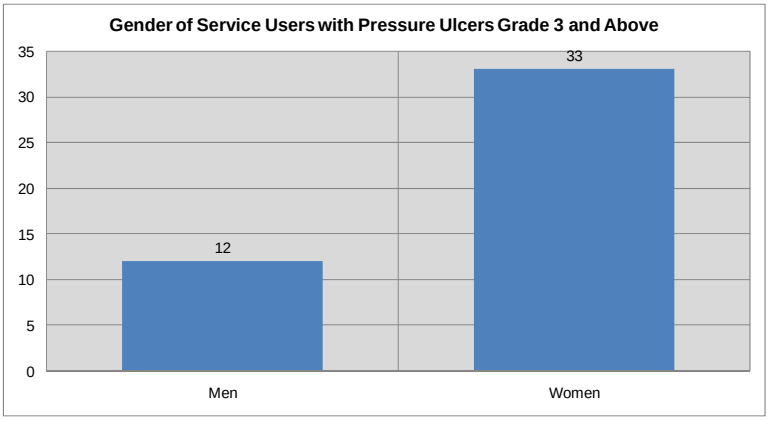


Chart 11 shows that 64% of all reportable pressure ulcer incidents involved women, in comparison with 36% of men.

Recommendations from Completed Serious Incidents

Of the 44 completed pressure ulcer SI investigations a total of 36 recommendations were produced. These were derived from 17 action plans.

The table below gives a breakdown of the recommendation themes used.

Table 16 – Breakdown of recommendation themes

Recommendations Themes	No of Recommendations
F1 Staff education, training and supervision	10
A4 Risk assessment	5
J1 Other	5
Pending coding	4
A5 Record keeping	3
F2 Policy and procedure - in place but not adhered to	3
B1 Communication	2
A1 Care pathway	1
A2 Care delivery	1
B3 Carers/family	1
G1 Organisational systems, management issues	1
Total	**36**

9.5 Information Governance SI's

Information Governance incidents which have a score of 2 or above on the Department of Health table are graded as red and managed as a Serious Incident (SIRI) by the Trust.

Chart 12

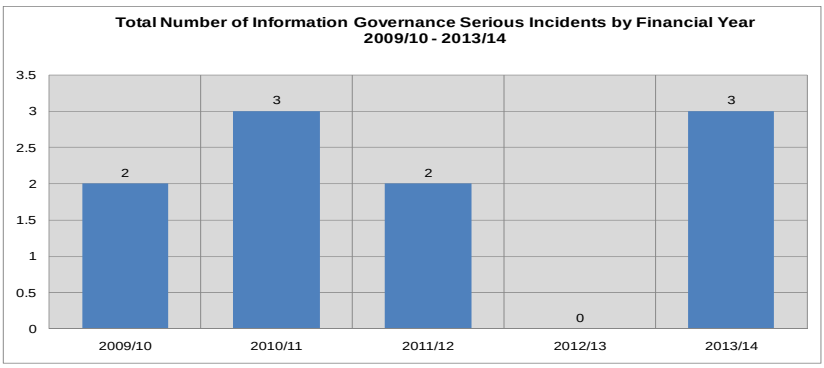


Chart 12 shows that during the year a total of 3 Information Governance incidents were reported as Serious Incidents. These incidents originated from Specialist Services and Kirklees BDU's.

Chart 13

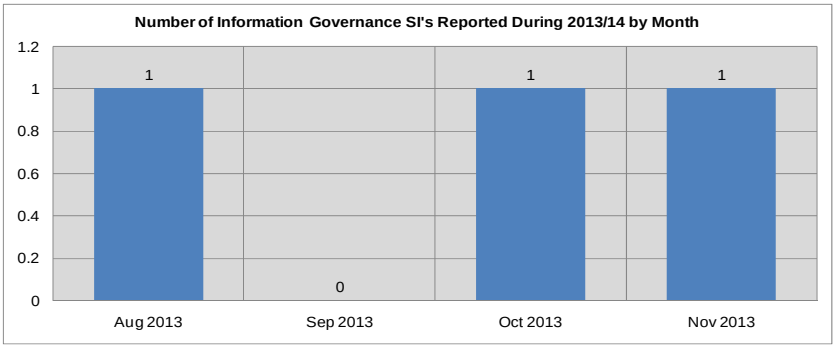


Chart 13 is based on the month when the SI was reported on STEIS not to the month the incident occurred. August, October and November 2013 were consistent with 1 incident being reported each month. October and Novembers' incidents were related to the same service. All of the incidents were relating to accidental disclosure of confidential patient information.

There were no action plans developed as a result of these reports as services immediately recognised system gaps and put processes in place, these were recorded in the reports:-

Incident	Recommendations
Service User received Discharge letter for another individual	1. Additional checking system to be put in place (to be physically checked by an additional member of staff prior to sending). This has already taken place so has not been added as an action.
Service User had received a letter and clinical report addressed to another individual.	1. Additional checking system to be put in place to include RIO and paper record (to be physically checked and re-checked by administrative member of staff prior to sending). This has already taken place so has not been added as an action. 2. Checking implemented:- Every time a patient visits the service, secretaries check that the personal contact details held are correct and update the RiO system immediately where changes are required. 3. Every paper copy of each communication is checked following typing by the secretary against the electronic record held in RiO to ensure the correct patient contact details have been inserted before sending out. 4. Secretaries also check that the letter and the envelope (if not using a window envelope) have the same address details
Service User received a letter from Doctor at their new address but on the cc list it looked like a copy had also gone to their old address. The family had a number of issues whilst living in the old property and were very concerned that someone would open the letter.	1. Regular checking system to be put in place to gather current contact information for service users/carers. This has already taken place so has not been added as an action. 2. Ensure that we have the most up to date details by systematically checking with service users or carers on every visit and updating any changes on the clinical system and in paper records immediately. (Data Quality Policy)

10. Performance reporting of SIs

During 2013/14 the Lead investigators have continued to work with the specific team of lead Medical investigators. All of these staff has undertaken additional master class training in root cause analysis with a follow up session in November 2013 and a master class session on human factors.

The investigators also have a list of identified clinical staff they can approach from a range of professional backgrounds and specialism.

The investigation process has been subjected to lean methodology and best practice guidance. This involves an initiation meeting with staff involved, a post investigation management meeting as part of the governance process to ensure the report meets the terms of reference. There is then a learning event where findings and recommendations are discussed and an action plan is drawn up. This is then sent to Director of Nursing and Medical Director for final approval before being sent to the clinical commissioning groups.

As part of the National NHS contract there is are timescales to deliver these reports (Grade 1 are 45 days and grade 2, 60 working days- ref serious incident framework 2013 NHS Commissioning Board). The Trust aims to meet the timescale but requests extension with the CCGs when this cannot be met. Commissioners are supportive that that quality of the investigations is not affected by the tighter timescale. At the end of March 2014 there were 3 overdue reports. This is the third year of improved position for completing timely investigations.

11. Serious incident investigations sent to commissioners

During the period 1 April 2013 to 31 March 2014, 91 serious incident investigation reports were submitted to the relevant commissioner (please note this is not the same data as those reported in this period). Of these 91, 45 investigations were submitted within the timescale.

Of the remaining SIs, 46 resulted in requests for extensions from the commissioner.

12. Feedback from Commissioners

Once the report is sent to the CCG it is quality assured by them to ensure it meets the required standard. Many positive comments have been received re the quality and depth of the reports.

Of the 91 serious incident investigation reports that were submitted to the relevant commissioner during the period 1 April 2013 to 31 March 2014 feedback to date has been received on 89 of these investigations.

44 investigations were submitted to Barnsley CCG who do not grade the quality of the investigations. Of these 44, Barnsley CCG asked for further clarification on 23 investigations.

Of the remaining 45 Serious incident investigations, 96% (43) resulted in a quality rating of good or excellent. 4% (2) resulted in a fair rating. No investigations were rated as poor. Of these 45, commissioners asked for further clarification on 22 investigations.

Feedback on a further 2 investigations is still awaited (a Forensic and a Wakefield SI).

Further analysis into the Serious incident investigation process will be done during 2014/15.

13. Independent reviews

13.1 Independent investigation

In line with **Single Operating Model – HSG (94) 27** requirements under DH guidance HSG (94) 27 as amended in 2005 which states that an Independent Investigation should be undertaken when a homicide has been committed by a person in receipt of specialist mental health services under the Care Programme Approach in the six months prior to the event.

This year the Trust has been involved with 3 independent investigations. The investigations commissioned through NHS England are an independent review of 3 homicide case that took place in the Trust .A fourth report will also cover the implementation of learning from 3 previous incidents which took place 2007 onwards.

All investigations should build on the Trust/provider's internal investigation, be proportional to the incident and avoid duplicating previous investigations.
This investigation will be:-"an external verification and quality assurance review of the internal investigation with limited further investigation"

These investigations involve Kirklees service users:-

During 2010/11 one homicide case (2010/9926) in Kirklees working aged adult services (homicide by a current service user) was reported and internally investigated.

During 2011/12 two further Kirklees homicide cases (2011/11370 & 2011/11502) involving current service users or service users discharged within the previous 6 months have been reported.
One of these has already been subject to Domestic Homicide Review which was reviewed as adequate by the Home Office.

The QA Panel would like to commend you on the breadth of the interviews conducted and the level of investigation into health processes in particular, which were considered thorough and comprehensive.
Home Office Quality Assurance (QA) Panel

The investigation team have been to the Trust and interviewed staff. All evidence requested has been sent to the investigators including the internal reports and action plans.
The reports are due September /October.

13.2 Pending independent review cases

The homicide that took place earlier this year may be subject to an independent inquiry, NHS England want to review the internal report before making a final decision. The internal report is almost complete.

13.3 Ongoing Investigation

The action plan from the investigation last year has been completed by the Trust. The investigation has not been signed off by the CCG due to a remaining action(not a Trust action) that needs to be completed.

Section3

14. Patient Safety Support Team / Incident Management Developments and Progress in 2013/14

14.1 Introduction

This section shows briefly the development work of the team and plans for the next year.

14.2 Strategy

Patient safety continues to be high on the political agenda. The impact following the publication of the Francis report into Mid Staffordshire Foundation Trust and the Berwick report is now translating through into practice. There is greater scrutiny from commissioners and regulators.

14.3 Datix and Datix-web developments

The Trust has continued to use and develop Datix incident management database to record, analyse and aggregate incident information. Each year as the footprint of the organisation changes, services and teams are added, this continues to enable Trust reporting and the functionality of Datix to support learning

Datix is a dynamic system and the team in collaboration with services examine ways to exploit the system.

ADHD, Learning Disabilities, Health Improvement/Wellbeing Services and CAMHS have been placed under the Specialist Services BDU. Incident information under this new heading was captured from 1 April 2013.

The Management Fact Finding Report was superseded by the SI Additional Information field which is on Datix. This is completed by Managers for all amber and red incidents. Service managers have welcomed this reduction induplication.

An additional sub category named Moisture Lesion was placed under the Tissue Viability category. This was at the request of the Tissue Viability Nurse for the Trust.

The category of Bed Management Issues (not including mixed sex accommodation) has had additional sub categories added, this was to ensure we captured improved reporting following the production of the Bed Management Protocol. This supports clinicians in reviewing and learning from these incidents.

From 1 July 2013 staff were asked if there has been a Consultant involved in the care of the patient(s) relating to the incident. If the answer is yes, staff are required to select the relevant Doctor from the list that appears. This enables all Consultants to be aware of incidents involving their patients as well as providing information for the medical revalidation process.

As of the 13 August 2013, all staff are now asked to select their Manager from a list when reporting incidents. This will send their manager an email regarding the incident that has been reported. This will ensure that managers are informed of incidents involving their staff, irrespective of whether the incident is coded correctly or not.

There are a number of BDU/Directorates where restructuring on the Datix system has taken place.

The Patient Safety Support Team carried out some work on Datix to restructure how the severity work is captured for local use and also to capture the actual degree of harm for external agencies like the NPSA.

Duty of Candour questions added to Datix along with details of why the information is required.

Questions have been simplified to ensure we capture the correct information.

Analysis and learning – all incident severity grades

Incident management reports and data have been provided regularly to Trust management groups which include information about incidents

Weekly summary of amber and red incidents and position of investigations

Monthly information into performance dashboard

Quarterly incident management report to CCCS committee

Quarterly serious incident report to board.

Many CQUIN targets are supported by information from Datix system.

The Trust has continued to contribute to national learning by liaising with NPSA (key functions transferred to NHS Commissioning Board Special Health Authority) to ensure transfer of Trust incident information to the NRLS.

The Patient Safety Support Team continued to support and monitor the SI process, particularly through the provision of information to the Incident Review sub-committee (IRSC) of the Clinical Governance and Clinical Safety Committee

Continue the analysis of recommendations from serious incident investigation reports,

by coding each recommendation. The analysis can be by category or within clinical settings e.g. all recommendations linked to an inpatient serious incident.

14.4 Policy review and update

During 2013/14 the following policies have been reviewed and are currently in the process of being agreed at board level

Incident Reporting and Management Procedures (including Serious Incidents)

Investigating and analysing incidents, feedback and claims to learn from experience

Being Open – The updated policy reflects changes to legislation with regards to Duty of Candour

14.5 Training

The Patient Safety Support Team has introduced Root Cause Analysis training during the year. This training is aimed at Managers who review and investigate amber incidents. The aim is provide a good understanding of the principles of Root Cause Analysis as well as a number of useful tools that can be utilised when completing this level of investigation.

The team continue to provide sessions at the Medical Trainee Inductions and have provided adhoc sessions for individuals requiring Datix support within BDU's. A training programme has been produced for 2014/15 this includes Datix training for new managers or those seeking refresher training.

14.6 Structure

This year has seen a change in the associate medical director for patient safety; the incident review subcommittee continues to focus on receiving assurance and ensure the performance of incident management is satisfactory. This group is chaired by the Director of Nursing, Governance and Patient Safety. With the retirement of staff the structure of the team is being reviewed. This will be completed during 2014/15.

2013-14 has also seen the development of a bimonthly patient safety clinical reference group. Chaired by the associate medical director for patient safety, it is a forum for collecting and disseminating ideas and information between a core group of individuals directly involved in developing, implementing and monitoring systems to improve patient safety. There is a particular emphasis on investigations, recommendations and action plans arising from serious incidents and on how learning is disseminated both locally and trust-wide.

The group has a strong clinical focus and is a forum in which:

- Themes or trends highlighted in serious incident investigations can be shared and broad approaches to addressing these, both trust-wide and in individual BDUs, can be formulated.
- Resource issues that inhibit or promote patient safety culture and practices within the Trust can be identified.
- Initiatives or directives on a national, regional or local commissioning basis and the impact on learning, culture and practice relating to patient safety in the Trust can be discussed.
- Evidence of activities to disseminate learning or to promote patient safety (whether or not arising from serious incident investigations) within individual business delivery units can be collated.
- Evidence of a consequent change in practice within business delivery units can be collected.
- Training needs and opportunities for individuals in relation to patient safety can be

identified.
- Legal developments that might be relevant to the group can be highlighted.
- Ideas about innovation in spreading learning or patient safety in the Trust can be generated.

14.7 Culture

The Patient Safety Support Team are focussed and constantly examining ways of effectively supporting the Trust to meet regulatory and best practice in terms of incident management. The culture within the team is to look for creative and innovative ways of delivering this work (see innovation). The cultural has begun to move from processes which are now robust towards sharing the learning in a manner that is helpful to services.

14.8 Innovation

The Patient Safety Support Team have used lean methodology to implement and then review incident reporting process and serious incident investigation process. The results have reduced duplication and increased efficiencies which have resulted in additional services being supported while at the same time delivering real cost improvement savings by reduction in staff resources.

The team have looked at innovative solutions to respond commissioning requirements to report on duty of candour without unduly increasing the demands on the service.

14.9 Modules on Datix

The Patient Safety Support Team continue to support the technical expertise for other modules on Datix that the Trust utilise

Feedback for Customer Service feedback and equality and inclusion teams
Risk register
SABs
Claims
Inquest
Request for information module for Customer services.

14.10 Working with the BDUs

Each BDU has a Lead Investigator who is responsible for working with BDU's on such subjects as learning from incidents, using Datix to assist with such learning

Audit and service evaluations

The Investigators provide the data for some cases in relation to the unexpected deaths audit.

The PSST support a number of audits and service evaluations throughout the year by providing more detailed analysis of incidents.

14.11 External partnerships

Care Quality Commission, CCGs and Commissioning Support Units in terms of reporting and performance monitoring of incidents.

14.12 Talent Management

The team are supported to develop, with two members of staff being appointed into secondments at higher bands for a period of eight months. These opportunities arose as a result of another member of the team obtaining a secondment external to the department.

14.13 Key actions and areas for development in 2014/15

2014/15 will be another challenging year for the team. The impact of the publication of the Francis report will remain high on the agenda.

The team has developed a detailed work plan for the year

This year will focus on the following areas:-

- To ensure Datix meets the requirements of the organisation and re configure to meet reporting requirements.
- Development of links with BDU's, this includes working with staff on training needs in relation to Datix and Root Cause Analysis
- Completion of the review of the Patient Safety Support Team structure
- To start the implementation of the performance dashboard module
- To develop video user guides to supplement written user guides for staff
- To continue to develop and provide training on Datix and incident reporting/reviewing.
- To support and develop SI Action Plan monitoring by BDU's
- Complete review of the Patient Safety Support Teams intranet pages
- Development of the BDU quarterly reports

Trust Board: 22 July 2014
Agenda item 5.3(iii)

Title:	**Health and safety annual report 2013/14 and objectives 2014/15**
Paper prepared by:	Director of Human Resources and Workforce Development
Purpose:	Trust Board has a duty to ensure that the health, safety and welfare of service users, staff and visitors remains a high priority within the organisation and as far as reasonably possible, risks are mitigated or reduced. This paper is devised to give assurance on the on-going management of health and safety in the Trust.
Mission/values:	Safety and effectiveness in a complex environment is vital to ensuring individuals receive care that enables them to live well in their communities.
Any background papers/ previously considered by:	The 2014/15 annual health and safety objectives have been considered and approved by the Clinical Governance and Clinical Safety Committee at its meeting on 15 April 2014.
Executive summary:	The health and safety annual report 2013/14 is designed to give an overview of the leadership and management of health and safety during the previous twelve months. The Clinical Governance and Clinical Safety Committee considered and approved the annual health and safety objectives for 2014/15. The executive summary attached gives an update on: ➢ the structure within the Trust for the management and engagement of key stakeholders in health and safety; ➢ the monitoring and auditing of health and safety in the workplace and action taken; ➢ key health and safety risks and action to mitigate them; ➢ health and safety training activity; ➢ Trust response to changes in legislation; ➢ overview of health and safety incidents during 2012/13. The 2014/2015 action plan is designed to: ➢ continue to embed a robust risked based monitoring and audit programme; ➢ develop a set of key performance indicators to help manage risk and improve health and safety arrangements in the Trust; ➢ improve access to health and safety training; ➢ develop regular communication framework for health and safety. The report also sets out a number of priorities for health and safety in the coming year in respect of: ➢ linking to occupational health to facilitate fast track staff support for absence due to injury at work; ➢ developing a flexible, risk-based inspection and audit programme; ➢ developing and using regular health and safety publicity for staff; ➢ developing a framework to ensure accurate data of staff absence due to health, safety and wellbeing is available;

	➢ reviewing and further developing the Trust's health and safety training programme reflecting the views of staff emerging from the staff survey; ➢ updating and refining reporting mechanisms for prompt and accurate reporting of incidents and near misses; ➢ implementing and completing the audit and inspection programme by the end of October 2014 and preparing for the coming year; and ➢ developing effective and robust links with a range of internal partners within the Trust.
Recommendation:	**Trust Board is asked to NOTE the health and safety annual report for and AGREE the action plan for 2014/15.**
Private session:	Not applicable.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Annual health and safety report 2013/14 (executive summary) and 2014/15 action plan

Roland Webb
Health & Safety Manager
May 2014

CONTENTS

Health and safety annual report 2013/14 (executive summary) and annual objectives 2014/15

1 Introduction

This report is designed to provide an overview of the management of Health & Safety within the organisation during 2013/2014 and key areas for developments covering 2014/2015.

A significant amount of work has been undertaken throughout 2013/2014 to ensure the Trust effectively manages health and safety risks and a number of key issues addressed over the past 12 months. It is, however, important to acknowledge the health and safety agenda continually develops with new legislation, outcomes of national reviews or enquiries and organisational learning.

The 2014/2015 Health & Safety action plan builds on the achievements of the 2013/2014 plan and addresses key risks identified in the year. A number of priorities have been identified for 2014/15.

- linking to occupational health to facilitate fast track staff support for absence due to injury at work;
- developing a flexible, risk-based inspection and audit programme;
- developing and using regular health and safety publicity for staff;
- developing a framework to ensure accurate data of staff absence due to health, safety and wellbeing is available;
- reviewing and further developing the Trust's health and safety training programme reflecting the views of staff emerging from the staff survey;
- updating and refining reporting mechanisms for prompt and accurate reporting of incidents and near misses;
- implementing and completing the audit and inspection programme by the end of October 2014 and preparing for the coming year; and
- developing effective and robust links with a range of internal partners within the Trust.

More information on these priorities and the action the Trust is taking to meet them can be found on pages 8 and 9 of the report.

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

2 Health and Safety Structure

The Trust has a well defined structure to ensure health & safety matters can be effectively discussed and where appropriate action agreed. An overarching Health TAG considers the strategic issues whilst two local Sub-Group tackle operational Health & Safety issues in the Trust and feed into the TAG.

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

3 Trust Wide Annual Health and Safety Monitoring

The Trust's Health & Safety monitoring tool continues to be the major vehicle for auditing health and safety practice and management, and it supports the proactive health & safety management at a local level. The aim of the audit is to provide a comprehensive view of health and safety issues across the Trust with the following objectives:-

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

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

The aim of the audit was to help identify any of health and safety issues across the Trust. The 2013/2014 audit tool was revised by the project team. There were two audit tools – 1. Health and Safety audit tool for managers which was disseminated to all team, unit and departmental managers; and 2. Health and Safety audit tool for buildings which was disseminated to the Health and Safety Specialists and representatives with the responsibility for managing buildings.

Report structure

The Trust wide audit of health and safety took place during December 2013. The audit tools had several sections and the results are presented within these sections. Each section provided the results for the managers and buildings surveys as tables or graphs at the beginning, followed by a summary of the results.

To assess the 'self declared' level of compliance, the results were calculated on the actual 'yes' and 'no' responses. There were a number of 'not applicable' responses which were not included in the overall percentage but the numbers included. Missing data was also not included in the overall percentage.

A section showing the Quality Health results for the health and safety questions from the 2013 national staff survey (Quality Health) was also included in the analysis.

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

Results

A total of 114 managers' surveys and 63 buildings surveys were submitted and downloaded from Survey Monkey by the Clinical Governance Support Team. Table 1 below shows the responses by each BDU and corporate and support services.

The Health & Safety Team will be undertaking audits and inspections of the teams who did not submit a return and will reporting these to their respective BDU's.

Table 1: Breakdown of responses by BDU

BDU	Managers survey	Buildings survey
Barnsley (Barnsley and Sheffield areas)	23 (20%)	16 (25%)
Calderdale (Halifax area)	15 (13%)	9 (14%)
Kirklees (Huddersfield and Dewsbury areas)	21 (18%)	8 (13%)
Wakefield (Wakefield, Pontefract and Castleford areas)	15 (13%)	11 (18%)
Forensics (Wakefield area)	12 (11%)	4 (6%)
Specialist Services (all areas)	10 (9%)	4 (6%)
Corporate and Support Services (all areas)	18 (16%)	11 (18%)
Total Trust responses	**114**	**63**

4 Safety Related Training Statistics

Safety related training during 2013/2014 revealed a 4% increase from last year compared to the previous figure of 6638 – see over the page. Information from the confidential staff opinion nevertheless seems to indicate that staff are not always aware that safety related training covers a wide spectrum of issues, giving managers the flexibility to plan their staffing needs accordingly.

Courses - 2014	Numbers
Trust Induction	422
Health and Safety Awareness	315
Fire Training	4550
Moving & Handling – People (Basic & Complex)	396
Moving & Handling – Basic Back Care	677
Conflict Resolution	207
Display Screen Equipment	151
First Aid	166
RIDDOR Training	14
Totals	6898

A series of mandatory training days, including safety related training have been agreed with the Learning & Development Department for 2014/2015 in an attempt to boost further and support access to Health & Safety learning for managers and staff.

5 RIDDOR

RIDDOR, the Reporting of Injuries, Diseases and Dangerous Occurrences requires the Trust to report over seven day injuries to the Health & Safety Executive. The Trust Health & Safety Team reported 36 such incidents during 2013/2014.

BDU	Moving and Handling / Working environment issues (e.g. office layout)	V&A	Slip Trip or Fall	Other	Total
Barnsley	1	1	4	3	9
Calderdale	0	0	1	0	1
Kirklees	0	2	1	0	3
Wakefield	0	7	1	1	8
Forensic Service	1	6	1	1	9
Specialist Services	1	0	0	1	3
Trust wide (Corporate support services)	1	0	1	1	3
Total	4	16	9	7	36

There was no follow up by the Health & Safety Executive on any RIDDOR notifications, which are used by the HSE as a basis for determining whether a formal investigation is required.

Every RIDDOR notification was investigated by the Health & Safety team, who also liaised with other colleagues and teams where appropriate, i.e. MAV, Legal, Services

Two RIDDOR notifications were made by Social Services partners (Kirklees & Barnsley Local Authorities) after incidents involving service users and hoists within joint teams that required the support and advice from SWYPFT Health & Safety.

6 Moving and Handling

Within the year 2013/14 the Moving and Handling service has recruited a band 7 adviser due to demand across the Trust for advice, support and training. This has prompted a review of the entire service including the delivery of the training agenda. In terms of training, the advisers recognised a need to consider the Trusts commitment to reduction in unnecessary travel and also the logistical and cost implications to departments for the release of large numbers of staff to attend classroom based training while remaining compliant with current legislation and guidance. With this in mind, the team has piloted a new approach to training that will meet these criteria. Following a successful pilot the new approach was implemented April 2014 and will be reviewed at six monthly intervals.

Category	Barnsley	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Trust wide (Corporate support services)	Total
Building design issues/office planning	1	0	0	0	0	0	0	1
Inappropriate for tasks to be performed by a single person (lifting large equipment/patient too large for 1	1	0	0	0	1	0	0	2

Category	Barnsley	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Trust wide (Corporate support services)	Total
person)								
Moving/Lifting Patient	2	2	1	4	1	3	0	13
Patient Moving/Lifting Object	0	0	1	1	0	1	0	3
Staff Moving/Lifting Object	3	0	0	2	1	0	4	10
Staff Stretching and/or Bending	2	0	0	0	1	0	0	3
No value	0	0	0	0	0	0	1	1
Total	9	2	2	7	4	4	5	33

6.1 Datix

Datix incident reported figures appear to have risen marginally from the previous year to 33 incidents from 25 however these incidents generally remain low to medium risk and are workplace/environmental issues which are predominantly office based issues. The team has responded to incidents with appropriate assessment, training and support to individuals and mangers as indicated. Within the year, one incident was graded as Amber and remains under investigation due to the nature of injury sustained by a client during the use of moving and handling equipment. This investigation is currently being lead by Barnsley Council representatives due to management structure within the service but the moving and handling team are providing support and input where requested in order to give staff and service managers involved in the incident assurance around the technical aspects of the use of the equipment involved. We are still awaiting the final response from the HSE.

6.2 Sickness/absence figures

Sickness/absence figures related to musculoskeletal issues show a slight increase from the previous year from 20% to 21% however the figures 2012/2013 to 2013/14 cannot be accurately compared due to additional services joining the Trust within the last year. Figures show a downward trend in the number of sickness/absence days taken due to musculoskeletal issues from 15,856 to 15,535 in 2013-14 however again this cannot be accurately compared to the previous year. The Moving and Handling team continue to work closely with Occupational Health and Wellbeing Services and Health and Safety Services in order to monitor and implement strategies to reduce these figures.

7 Slips Trips & Falls

Category	Barnsley	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Trust wide (Corporate support services)	Total
Slip, trip or fall - other/visitor	6	0	0	1	0	0	0	7
Slip, trip or fall - patient	231	145	218	272	43	26	1	936
Slip, trip or fall - staff member	29	6	8	8	11	6	5	73

A total of 1016 slips trip and falls were recorded with 9 resulting in an over 7 day absence and a RIDDOR notification. As a key safety risk, the Health & Safety team work in close partnership with the Trust's clinical Falls Group to help ensure a coordinated approach to the issues.

8 Key Health & Safety Risks

A total of 5940 of safety related incidents were recorded in 2013/2014, showing a reduction of 9.75% on the previous year's reported statistics.

4 Key risks the Trust has to manage are:-

1. **Violence & Aggression**:- The Health & Safety team work closely with MAV colleagues at both a strategic and operational level, especially in the follow up to incidents, RIDDOR notifications. There is active representation from both Health & Safety and MAV teams on the respective TAG's and Sub-Groups.

2 **Health & Wellbeing:-** The Trust is fully committed to working in partnership with all staff to help maintain and improve staff wellbeing, both in and out of work and has a well established Health & Wellbeing group with a number of initiatives in place to help support and encourage staff to maintain their mental wellbeing. Work includes cooperating with Robertson Cooper to help ensure effective strategies can be implemented to support staff

3 **Patient Slips, Trips & Falls:-** As referred to in section 7**,** the Health & Safety team work in close partnership with the Trust's clinical Falls Group to help ensure a coordinated approach to the issues in order to reduce the number of, and subsequent consequences of patient slips, trips and falls, particularly in the working clinical environment.

4 **Staff/visitor Slips Trips & Falls:-** The Health & Safety Team work closely with colleagues across the Trust, including Moving and Handling, Estates & Facilities and Capital Planning. The issue of slips, trips and falls is covered in safety training.

Additionally, the Estates Risk Assessment Officer has helped produced a winter gritting plan to reduce the risk of slips trip and falls, particularly from the consequences of heavy snow and ice.

2013/2014	Barnsley	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Trust wide (Corporate support services)	Total
Security breaches (including personal/buildings/theft and vandalism)	96	44	43	47	224	19	24	497
Health and Safety (including fire)	219	72	134	133	233	56	66	913
Slips, Trips and Falls	266	151	226	281	54	32	6	1016
Violence and Aggression	280	458	367	707	656	370	8	2846
All Other Incidents	151	84	118	116	117	69	13	668
Total	1012	809	888	1284	1284	546	117	5940

2012/2013	Barnsley	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Trust wide (Corporate support services)	Total
Security breaches (including personal/buildings/theft and vandalism)	84	50	54	69	215	7	18	497
Health and Safety (including fire)	201	68	174	169	238	33	29	912
Slips, Trips and Falls	247	136	261	293	66	11	7	1021
Violence and Aggression	248	442	424	995	1101	152	4	3366
All Other Incidents	106	99	101	206	246	23	5	786
Total	886	795	1014	1732	1866	226	63	6582

Health & Safety Action Plan – 2014/2015

Task/objective	Lead Director/ Senior Manager	Lead Officer(s)	Rationale	Target Date For Completion	Comments
1. Link in Occupational Health to RIDDOR process to facilitate fast track staff support for over seven day absences due to injuries at work.	Alan Davis/Jerry Murphy	Roland Webb/Helen Whitelam	Ensure effective cooperation between key Trust services	June 2014	Revised process and effective, open sharing of information strengthens the corporate response to RIDDOR notifications and facilitates improved review of risk assessments, support to staff and work processes
2. Develop flexible, risk based inspection/audit programme and to formally RAG rate services, wards, teams as appropriate	Alan Davis/Jerry Murphy	Roland Webb/ Steve Amos/ Richard Galliford	Ensure effective Trust wide approach to health & safety monitoring/inspections for Trust Board assurance.	June 2014	Building on the existing audit programme, the formal RAG rating of services fine tunes existing audit/inspection processes and targets resources even more effectively at high risk teams/services
3. Implement regular Health & Safety publicity in partnership with the Communications Team and using a variety of mediums to suit. To include publicity stalls "promotional week", newsletter/intranet etc	Alan Davis/Jerry Murphy	Roland Webb/ Steve Amos/ Richard Galliford	Ensure timely and relevant safety message is cascaded throughout the year	July 2014	Developing on the success of the Trust Health & Safety TAG and West/South Sub-Groups publicising the safety message on a regular, seasonal basis, including incorporation of a Trust health & safety week is a natural evolution of the safety message.
4. KPI's – Develop framework to ensure accurate data of staff absence due to health, safety and well being issues	Alan Davis/Jerry Murphy	Roland Webb	To facilitate the detection of trends and subsequent analysis of hot spots in terms of staff absence	July 2014	Objective will enable strategies to be implemented to accurately target issues leading to staff absences due to health and safety reasons.

5. Refresh, and develop Trust Health & Safety Training Programme ensuring branding of training is clear, concise and in line with the Quality Account Staff opinion survey	Alan Davis/Jerry Murphy	Roland Webb	Ensure health & safety is fit for purpose and accessible for all grades of staff.	September 2014	Effective training underpins effective delivery of Trust Safety policies and procedures and is a key element identified by the HSE in specific guidance, INDG345. Action by the Health & Safety Executive for failing to ensure staff are trained to undertake their role safely and competently is an ever present threat resulting in a constant review of Trust Health & Safety Training
6. Update and refine clear reporting mechanisms for prompt and accurate reporting of incidents and near misses, underpinning risk identification through DATIX reports	Alan Davis/Jerry Murphy	Roland Webb/Richard Galliford/Steve Amos	Ensure the Safety team have access to relevant DATIX reports	September 2014	The Health & Safety Team will be working with the Patient Safety/DATIX team to ensure pertinent reports from managers and staff are directed accurately and promptly to health & safety advisors to help underpin safe caring and working environments
7. Implement and complete audit/inspection programme by end of October and prepare for 2014/2015 monitoring programme	Alan Davis/Jerry Murphy	Roland Webb/ Richard Galliford/Steve Amos/	Ensure effective Trust wide approach to health & safety monitoring/inspections for Trust Board assurance.	November 2014	The annual health & safety monitoring programme, including the audit and inspection schedule all underpin Trust Board re-assurance of effective health & safety measures within the Trust.
8. Fully develop effective and robust links with a range of key Trust Business partners, including local CiC's CCG's, CSU's Barnsley District Council and WMDC	Alan Davis/Jerry Murphy	Roland Webb	Develop a consistent Trust wide approach with Social Services partners in line with existing model	March 2015	Recognising the evolving healthcare market, developing effective and robust links with key Trust Business partners is of paramount importance to demonstrate successful joint working.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 22 July 2014
Agenda item 6.1

Title:	**Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies)**
Paper prepared by:	Director of Corporate Development
Purpose:	To enable Trust Board to approve the Policy on Policies, a core policy for the Trust and reserved for Trust Board consideration and approval.
Mission/values:	Policies and procedures covering core Trust systems and processes are a key part of the Trust's governance arrangements, supporting the Trust to achieve its mission and adhere to its values.
Any background papers/ previously considered by:	The policy was approved by Trust Board in July 2011 and again in October 2012 as part of the changes recommended to achieve NHS LARMS level I.
Executive summary:	Background A clear, documented approach to policy approval (A policy on policies) is required as evidence to support the NHSLA Risk Management Scheme standards at level one, to support the Trust's Care Quality Commission registration and continued compliance with the conditions of the Trust's Licence. The purpose of the Policy on Policies is: ➢ to describe the approach to development and approval of policies and procedural documents; ➢ to provide a standard template for policy documents; ➢ to ensure that there are arrangements for dissemination so that staff are aware of their responsibilities in relation to the policy or procedure; ➢ to describe arrangements for ensuring such documents are regularly reviewed to reflect current guidance; ➢ to describe the process for version control to ensure people have access and are operating to the most current version; and ➢ to ensure arrangements are in place for archiving documents in line with non-clinical records management requirements. Review July 2014 The Director of Corporate Development has reviewed the Policy on Policies for relevance and compliance with guidance and considers that it remains fit for purpose. Trust Board is, therefore, asked to approve the current policy for a further two years to June 2016. Trust Board should note that the Equality Impact Assessment, which is a required part of all Trust policies, was amended in October 2013 to ensure the statements around impact on protected characteristics were evidence-based and to ensure all completed assessments were sent to the Involvement and Inclusion team. This was approved at Director-level through the Executive Management Team and the policy re-issued to staff. Future review The Director of Corporate Development has asked that a more comprehensive review is undertaken in the coming year, particularly in terms of the format outlined in the Policy on Policies, which currently follows national guidance, with the possible addition of a summary for staff of the content and articulation of any changes to policies. If appropriate, the Policy

	will come back to Trust Board during 2015 for approval.
Recommendation:	**Trust Board is asked to APPROVE the Policy for a further two-year period to June 2016 and to NOTE the minor change to the Equality Impact Assessment.**
Private session:	Not applicable.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 22 July 2014
Agenda item 6.2

Title:	**Procurement Strategy**
Paper prepared by:	Deputy Chief Executive/Director of Finance
Purpose:	Trust Board is asked to note and approve the amendments to the current Procurement Strategy (highlighted in red) which address the guidelines and recommendations from the recently published national documents on procurement.
Mission/values:	The strategy supports the Trust's legal obligations under the Public Sector Procurement Directives and its own Standing Orders/Standing Financial Instructions, national guidelines and the local procurement agenda
Any background papers/ previously considered by:	The Strategy has been formally approved by the Trust's Audit Committee 8 July 2014.
Executive summary:	The revised Strategy addresses national recommendations on procurement ensuring that the Trust is fully compliant. These include the following documents: ➢ NHS Standards of Procurement ➢ Better Procurement, Better Value, Better Care ➢ Procurement Transparency ➢ NHS eProcurement Strategy ➢ NHS Procurement Dashboard The headline areas within the new strategy are: ➢ re-emphasising the importance of clinical involvement in supply chain decisions; ➢ measuring performance against national, regional collaborative contracts; ➢ improving the business engagement of Small, Medium Enterprises (SMEs); ➢ providing greater transparency around our contracting opportunities; ➢ closer monitoring of procurement in terms of delivering CIPs; ➢ provision of eProcurement solutions which capture all non-pay expenditure; ➢ increasing the number of professionally qualified procurement staff. The method of ensuring that the objectives of the strategy are met will be through the provision of a procurement dashboard which will report of the following. a) The number of instances where patient outcome, experience or safety has been adversely affected by a lack of product or service availability. (This metric should be zero and the procurement team will measure compliance through issues reported either directly to the team or via the Datix risk management system.) b) Percentage of non-pay expenditure captured electronically through the Agresso purchase to pay system. c) The value of contribution to cost improvement as a percentage of non-pay expenditure. d) The cost to procure as a percentage of non-pay expenditure.

	e) The percentage of non-pay expenditure through national or collaborative purchasing arrangements. f) Progress against the NHS Standards of Procurement. g) Percentage of recognised procurement staff with an appropriate level of formal procurement qualification(s) h) The level of expenditure placed with Small, Medium Enterprises a. within the geographic boundary of the Trust in comparison to b. the Trust's total non-pay expenditure. c. The number of tenders placed and appropriately advertised within the respective media i.e. Trust website, contracts finder.
Recommendation:	**Trust Board is asked to APPROVE the Strategy**
Private session:	Not applicable

South West Yorkshire Partnership NHS
NHS Foundation Trust

Document name:	Procurement Strategy & Action Plan
Document type:	Policy
What does this policy replace?	The Procurement Strategy & Action Plan April 2012 – March 2015
Staff group to whom it applies:	All staff within the Trust
Distribution:	The whole of the Trust
How to access:	Intranet
Issue date:	July 2014
Next review:	June 2017
Approved by:	Executive Management Team 17 July 2014
Developed by:	Head of Procurement
Director leads:	Director of Finance / Deputy Chief Executive
Contact for advice:	Head of Procurement

PROCUREMENT STRATEGY
&
ACTION PLAN

July 2014 – June 2017

CONTENTS

1. EXECUTIVE SUMMARY

The aim of the procurement strategy is to influence and manage the entire supply chain from demand through to consumption and disposal, ensuring the lowest total cost of ownership associated with goods and services, whilst at the same time ensuring the highest standards of quality and customer satisfaction are maintained. This includes expenditure on services currently provided by sister NHS organisations under Service Level Agreements (SLA's).

Best practice purchasing will support the Trust in delivering healthcare by promoting a partnership between internal customers and external suppliers; teamwork; including users and carers in procurement decisions that affect them, effective purchasing processes and the development of staff involved in purchasing and supply.

The Trust recognises however, that benefits can only be maximised by the active participation of all concerned and the necessary processes to facilitate this are defined within.

This strategy covers a three year period and will be measured on a quarterly basis using a range of Key Performance Indicators (KPI's).

2. STRATEGIC CONTEXT

The Trust recognises that proper management of the supply chain is essential to the efficiency and effectiveness of both clinical and support services. Service User care depends on the assured and timely availability of high quality equipment, products and services. This document outlines a vision for supply management that compliments the trusts overall business objectives and will aim to:

- Work within the government guidelines and the recommendations published in the *Better Procurement, Better Value, Better Care* document published in August 2013 and to level 2 (as a minimum) of the *NHS Standards of Procurement* document published in June 2013

- Look to adopt the principles and guidance in the Procurement Transparency document published in March 2014 to ensure that expenditure data is shared to identify savings opportunities, SME's are sighted on public sector business opportunities and there is transparency about how Trust money is spent.

- Work with regional and national organisations to meet sustainability targets.

- Meet a diverse range of requirements within the organisational context by being sensitive to the needs and interests of our users, their carers, our staff and the community we serve.

- Increase the percentage level of non-pay expenditure influenced by the procurement department and captured electronically through the purchase to pay system.

- Increase the level of non-pay expenditure through national or collaborative purchasing arrangements to create leverage on achieving increased value for money by aggregating demand.

- Deliver the procurement department's contribution to the Trusts cost improvement programme.

- Empower staff enabling them to order and receive goods in a more efficient and timely manner.

- Improve purchasing performance, including the scope for supplier rationalisation and demand management to reduce the overall cost of acquisition.

- Reduce process costs by extending the use of electronic ordering, invoice matching and payment.

- Increase the level of professionally qualified procurement staff through the promotion of staff training and development within the procurement team.

- Use competition wherever appropriate ensuring that contract opportunities are published on the Trusts website via its eTendering portal.

- Reduce the clinical risks associated with the use of equipment and consumables by standardising equipment and consumables in use across the Trust, working with clinicians and other stakeholders on product selection issues to ensure that instances where patient outcome, experience or safety which could be adversely affected by a lack of product or service availability remains at zero .

The Trust is bound by statutory and mandatory public purchasing regulations and the various requirements of probity and corporate governance. It is therefore, appropriate to reaffirm that the Trust's procurement activities must be in accordance with statutory requirements and in compliance with the Trust's Standing Orders and Standing Financial Instructions.

3. SCOPE

This strategy encompasses all non-pay expenditure for goods and services, including estates/maintenance, energy, service level agreements, agency spend and IM&T. It does not include costs for permanent members of staff.

The strategy is concerned with the effective management and constant improvement of purchasing and supply activity including acquisition and full life costs, processing costs, and effective development within all areas of purchasing activity.

4. VALUES

To effectively engage and manage the purchasing function, all Trust personnel involved in, and those indirectly responsible for purchasing need to embrace the following core values:

- Maintain the highest possible standard of integrity in all their business relationships both inside and outside the organisation
- Reject any business practice that might reasonably be deemed improper and never using their authority for personal gain
- Optimise the use of resources which they influence and for which they are responsible to provide the maximum benefit to the Trust
- Ensure that all purchasing decisions reflect the needs of the Trust
- Comply with:

    - The Code of Conduct for NHS Managers
    - Trust Standing Orders and Standing Financial Instructions
    - Statutory and mandatory public purchasing regulations
    - European purchasing legislation
    - NHS policy and guidance
    - Trust Policy on Medical Devices

The continued development of the procurement team will support the Trust's strategic objectives by ensuring that the right products and services are available at the right time and offer value for money supporting clinicians in the delivery of service, contributing to improved service user care.

5. STRUCTURE AND RESPONSIBILITIES

The procurement department should be viewed as an integral part of the Trust and will be led by the Head of Procurement who will: -

- Manage the provision of a procurement service to the Trust
- Provide professional leadership to the department
- Provide professional advice in all aspects of purchasing

Responsibility for the management of the purchasing function is designated as follows:

Trust Board:	The Trust Board will monitor procurement by reviewing the procurement performance reports. The Trust Board will also ensure that the strategy is consistent with other strategies within the Trust.
Audit Committee:	The Audit Committee will monitor procurement by reviewing the procurement performance reports.
Director of Finance:	Delegated responsibility as the Trust Board lead for supply strategy, performance measurement and compliance with NHS standards/reporting requirements.
Head of Procurement:	Responsibility for the development of strategic and operational purchasing performance, ensuring compliance with relevant legislation, Trust Standing Orders/Standing Financial Instructions and NHS policy guidance, and ensuring that full engagement is achieved with the Business Development Unit (BDU) and Support Services management structure on all procurement matters.
BDU Directors/ Heads: of Support Services	Responsibility for ensuring that all BDU Managers and Senior Support Services Managers are fully aware of and signed up to the engagement process with the Procurement department ensuring compliance with all relevant legislation and the establishment of a robust business working relationship between all parties.

All Trust Managers: Responsibility for ensuring that purchasing is only carried out following consultation with the Procurement Department, complying with all appropriate policies and procedures relating to purchasing and all requirements as determined by the Capital Planning Group for all capital purchases.

As part of the Finance Directorate the Procurement Department will report directly to the Director of Finance.

6. AIMS, OBJECTIVES AND INITIATIVES

The strategy seeks to influence all non-pay activity, from demand to disposal ensuring that the lowest costs and highest levels of appropriate quality are achieved at all stages of the supply chain.

	Key Area	Objective	Strategy	Benefits	Measure (KPI)
6.1	**Sustainability** To promote equality in and through purchasing; Supporting the Trust in playing their role as a good Corporate Citizen.	Promote and develop the sustainability agenda and where practical building this into all projects undertaken by procurement.	▪ Consider the sustainability agenda in all tendering work undertaken. ▪ Discuss the development of an action plan with all key suppliers regarding sustainability. ▪ Advertise tenders locally in conjunction with wider advertising media. ▪ Work towards developing relationships with local SME's where appropriate. ▪ Monitor the impact of the Trusts purchasing sustainability policy on procurement decisions.	▪ Joint working initiatives developed between the Trust and suppliers. ▪ Development of 'Good Corporate Citizen' role. ▪ Support of local community and its economy.	▪ Sustainability policy in place. ▪ Tender documents detailing sustainability and environmental considerations with regard to the 'carbon footprint' for supply of goods and services. ▪ Sustainability / environmental policies as part of the tender evaluation process.

	Key Area	Objective	Strategy	Benefits	Measure (KPI)
6.2	**Demand Management** The overall spend on goods and services is influenced by the amount of consumables used and the way in which the equipment is utilised.	Product selection must be conducted in a planned, cohesive and constructive manner to ensure risks are minimised and that whole life costs are analysed.	▪ Monitor and increase the use of current system catalogues. ▪ Increase the volume of products managed via system catalogues. ▪ Develop and monitor a process of product standardisation / rationalisation where it is thought appropriate. ▪ Establish or work with existing Product Evaluation Groups and stakeholder groups as appropriate. ▪ Where possible increase the level of clinical engagement in product and supply chain initiatives.	▪ Reduction in processing and transactional activity. ▪ Work towards demand management analysis and strategic sourcing. ▪ Control of the product range. ▪ Reduction of risk as a result of the reduction of product ranges available and enhanced clinical involvement (particularly around medical equipment). ▪ Enhanced leverage via consolidated usage and through potential collaborative purchasing alliances. ▪ Ease of ordering for end user. ▪ Increased concentration of high volume / low value orders via catalogue.	▪ Increased spend against catalogues. ▪ Increased volume of electronic catalogues. ▪ Reduction in the volume of non catalogue requests. ▪ Measurement of savings as a result of consolidated usage/ collaborative purchasing across product ranges. ▪ Reduction in the range of like products with the identification and implementation of “best value” masking system within product catalogues.

	Key Area	Objective	Strategy	Benefits	Measure (KPI)
6.3	**Purchasing** Purchasing is about the identification of need to the point of disposal and related supply chain activity that needs to be administered in a cost effective manner that demonstrates value for money.	Purchase all goods and services in the most cost effective way giving consideration to all activity that forms part of this process.	▪ Development of a Trust Contract Portfolio. ▪ Undertake a supplier Review (Pareto) developing relationships with suppliers in accordance with their level of strategic importance to the organisation. ▪ Review all non purchase order activity and put systems in place to maximise the amount of expenditure processed via the purchase order route. ▪ Establish a process of Contract Management & Review of performance for all contracts commensurate with their strategic importance to the organisation. ▪ Drive contract compliance and uptake throughout the Trust.	▪ Increased contract coverage and control of expenditure. ▪ Increased control of contracts with contracts renewed in a timely and cost effective manner. ▪ Effective management of workload. ▪ Compliance with Trust SFI's and SO's and relevant EU legislation. ▪ Market testing to ensure VFM. ▪ Increased purchasing leverage via consolidation / collaboration of non-pay expenditure. ▪ Creation and identification of opportunities. ▪ Increased engagement with SME's. ▪ Greater savings achieved through	▪ Delivery of the department's annual CIP savings target: ▪ Annual work plan in place ▪ Reduction in the volume of invoices processed via the Non PO route ensuring increased expenditure is processed via an official order thereby increasing the value of influenceable expenditure. ▪ Increased contract coverage demonstrating increased control and influence of expenditure. ▪ Contract Review Programme in place. ▪ Capital Planning programme met and activity report produced. ▪ Reduction in the number of waivers as a result of failing to renew contracts in a timely manner.

			▪ Procure against Capital Expenditure in line with the requirements of Capital Planning. ▪ Develop a robust work plan following the development and implementation of a single contract portfolio. ▪ Develop and communicate a robust Business Continuity Plan throughout the Trust. ▪ Ensure all contract opportunities in access of £25,000 are advertised on Contracts Finder and the Trusts eTender web portal ▪ Utilisation of the DoH terms and conditions of contract ▪ Utilisation of standard PQQ forms for contracts in excess of £25K (where applicable) ▪ Adoption of NHS Procurement Dashboard.	increased competition. ▪ Greater transparency on how Trust money is spent. ▪ Fully compliant with the DoH / NHS England Procurement recommendations.	▪ Increase in the contribution to the Trusts CIP programme by Procurement.

	Key Area	Objective	Strategy	Benefits	Measure (KPI)
6.4	**Cost** Various elements contribute to the overall product cost and each one needs to be taken account of accordingly.	All goods must be ordered, received and paid for in the most cost-effective way possible.	▪ Ensure that Value for Money can be demonstrated on all purchases made via the use of Competitive Tendering in line with Trust SFI's and EU Purchasing regulations. ▪ Take account of the 'Whole Life Acquisition Costs' in all purchases made ensuring that the 'price' element is given an appropriate 'weight' in all evaluations. ▪ Ensure that wherever possible at least two options **"fit for purpose"** have been analysed and the option(s) specified are those that demonstrate	▪ Reduced revenue costs on a recurring basis. ▪ Compliance with Trust's SFI's and SO's and relevant EU Legislation. ▪ Reduction in risk re non compliance with regulations and governance arrangements. ▪ Increased contract coverage and compliance. ▪ Increased control and influence on spend.	▪ Achievement of Procurement department's £200K CIP target. ▪ Measurement of savings as a result of consolidated usage across a reduced range. ▪ Increased contract coverage demonstrating increased control and influence of expenditure. ▪ Benchmarking data to demonstrate VFM. ▪ Satisfy core standard criteria as detailed in BREEAM (BRE Environmental Assessment Method) for the purchase of equipment.

			better performance in terms of: direct/in-direct running costs, cost of disposal, spending to save, recyclability, improved manageability, energy performance, reduced harmful emissions, improved services, comfort & productivity. ▪ Ensure utilisation of the most cost effective contracts. ▪ Participate in joint contracts where realisable benefits can be achieved inclusive of a reduction in cost. ▪ Benchmarking / establish a process for determining a baseline price against which to measure offers.		

	Key Area	Objective	Strategy	Benefits	Measure (KPI)
6.5	**Relationships** Best practice can only be achieved when effective communication links have been established between all parties.	Develop relationships for effective communication to ensure customer requirement are fully met and demonstrate VFM.	▪ Continue to develop relationships with NHS Supply Chain North of England CPC and Crown Commercial Services, Shared Business Services (and any successor organisations). ▪ Develop closer working relationships with the Business Delivery Units to obtain a better understanding of how Procurement can support them in the delivery of their objectives. ▪ Produce (in-line with the Finance Directorate corporate offer) a Procurement department service offer which act as a "Quality Standard" reflecting the	▪ Greater understanding between all parties to achieve corporate objectives. ▪ The Procurement departments service offer is understood and fully communicated within the Trust and compliments the Trusts "Quality Academy" approach to its business affairs ▪ Clear lines of accountability. ▪ Enhanced Trust standing within the local communities. ▪ Contribute to sustainability agenda.	▪ Contribution to the delivery of Trust wide CIP targets. ▪ Improved prices through partnership working. ▪ Increased number of local suppliers to the Trust. ▪ Procurement department service offer produced and communicated.

			department's service offer to its customers. ▪ Develop closer working relationships with other local organisations in order to establish collaborative procurement practices and beneficial contractual agreements through economies of scale i.e. North of England CPC, SBS. WMDC, KMDC Engage with (where appropriate) local SME's, Social Enterprises etc in order to enhance the Trusts local reputation and address the sustainability agenda.		

	Key Area	Objective	Strategy	Benefits	Measure (KPI)
6.6	**Systems** Robust systems are critical for effectively managing the procurement function and for the production of timely and robust management information.	Ensure optimum use of the Purchase to Pay System fully utilise the Trusts contract management / e-tendering system to maximise benefits.	▪ Continue to work with Finance to develop existing systems to maximise their full potential. ▪ Develop a suite of purchasing specific reports for the production of robust timely information. ▪ Look to introduce further supplier catalogues (including "buyer managed" SME catalogue) onto the Trusts hosted catalogue providers system. ▪ Seek to demonstrate the full benefits of the Trusts eTendering / Contract Management system by driving out cost through competitive tendering and responsive contract	▪ Improved governance. ▪ Reduction in transactional work. ▪ Increased visibility of expenditure. ▪ Increased use of current resource on strategic sourcing. ▪ Improved demand management. ▪ Increased catalogue expenditure at agreed contracted prices. ▪ Reduction in the general paper trail associated with both tendering and the ordering of goods. ▪ Low transaction costs. ▪ Demonstrable VFM. ▪ Empowerment of staff "Trust Wide" to order and receive goods more effectively and quicker. ▪ Full audit trail providing the Trust with a robust system of ensuring probity. ▪ Increased control on non-pay expenditure	▪ Contract management system in place to enable to delivery of: ▪ Annual work plan developed. ▪ Production of purchasing reports to support supplies related activity ▪ Timely renewal of contracts. ▪ Increased contract coverage ▪ Increased numbers of competitively tendered projects ▪ Cost savings ▪ Increased catalogue coverage. ▪ Increase in eProcurement activity within the Trust and removal of process costs

			▪ management .		

	Key Area	Objective	Strategy	Benefits	Measure (KPI)
6.7	**Standards of Procurement** The adoption of the recommendations detailed in the DoH document entitled *NHS Standards of Procurement June 2013*	Monitor the departments progress against the procurement standards detailed in the June 2013 document	▪ Ensure (wherever possible the Procurement service attains and maintains the minimum of level 2 compliance under the following headings: a) Leadership b) Process c) Partnerships d) People	▪ Compliance with DoH guidelines on Procurement ▪ Executive level accountability ▪ Increased engagement ▪ Improved intelligence resulting in the reduction in expenditure ▪ Increased level of Procurement understanding within the Trust ▪ Removal of process within the P2P system	▪ Increase in purchase savings ▪ Increased efficiency ▪ Fully automated P2P systems in place ▪ Increase in Exec awareness around Procurement

	Key Area	Objective	Strategy	Benefits	Measure (KPI)
6.8	**Staff** The development of staff is integral to the success of the department in delivering a cost effective and professional service to the Trust.	All expenditure is under the influence of professionally qualified staff. The mix of skills and ability will be identified for providing an effective and efficient procurement service.	▪ All staff will have an annual PDR with clearly defined objectives and 6 monthly reviews. ▪ All staff will be provided with the opportunity to attend appropriate Purchasing Training commensurate with their role and level of responsibility. ▪ Staff will be offered the opportunity to undertake professional training commensurate with their role and level of responsibility. ▪ All staff will receive the appropriate mandatory training as determined by the trust. ▪ A training manual should be developed and maintained for all new starters who have responsible for ordering products and	▪ Improved skills. ▪ A responsive service with a greater understanding of customer requirements. ▪ Resource planning. ▪ Developed / informed staff. ▪ Increase in the number of professionally qualified staff within the procurement team	▪ Staff retention. ▪ Professional development. ▪ Number of professionally qualified staff ▪ PDP's in place and training needs identified. ▪ All mandatory training met. ▪ Departmental manual produced

			services. ▪ A departmental procedures manual should be produced to assist all procurement staff with resolving / identifying Local, Regional and National procurement issues / legislation and to act as source of reference.		

	Key Area	Objective	Strategy	Benefits	Measure (KPI)
6.9	**Governance** The Trust is bound by statutory and mandatory public purchasing regulations and the various requirements of probity and corporate governance. It is therefore, appropriate to reaffirm that the Trust's supply activities are in accordance with statutory requirements and in compliance with the Trust's Standing Orders and Standing Financial Instructions.	Work within the Trust Governance arrangements as approved by the Board.	▪ All purchasing activity is undertaken in line with pre determined thresholds. ▪ Levels of financial authority are monitored and updated in accordance with the Scheme Delegation. ▪ Liaise with internal and external audit as appropriate ensuring any recommendations made are fully implemented. ▪ All Waivers are appropriately challenged and those approved are recorded for reporting to the Audit Committee.	▪ Management of risk via pre-determined control standards. ▪ Robust processes in place. ▪ Compliance with audit requirements and recommendations. ▪ Adherence to all appropriate regulations.	▪ Audit reports. ▪ Quotation / Tender Waiver reporting. ▪ Financial hierarchy in place and regularly reviewed. ▪ Tendering documentation.

	Key Area	Objective	Strategy	Benefits	Measure (KPI)
6.10	**Miscellaneous** Those areas of Trust business which directly / indirectly influence the direction taken on both purchasing decisions made and the long term goals of the Procurement function.	To look at ways of promoting and enhancing the reputation of the Procurement function within the Trust, its service users and carers and it's outside partners.	▪ Engage with service users and carers on <u>all</u> procurement issues which directly affect them and communicate their contribution to the appropriate parties. ▪ Ensure that Trust "front line" staff are fully trained in the Agresso web requisitioning system and that all such staff have access to an appropriate training manual. ▪ Develop the Finance – Procurement Intranet page and provide <u>all</u> relevant procurement information required on the purchase of goods and services i.e. SO/SFI's, tendering	▪ Reputation of the Procurement is enhanced. ▪ Service users and carers feel that they are part of the decision making process. ▪ Trust staff are trained on the Agresso web requisitioning system, and fully aware of the Purchasing Practices and Procedures. ▪ The Procurement department is made aware of its successes and shortfalls of providing its service.	▪ Reduction in the number of Non-PO invoices due to Trust staff being more informed on Procurement Policies and the methods/rules for purchasing goods and services. ▪ Service user / carer involvement reported. ▪ Annual survey satisfaction results.

			procedure, FAQ, Contracted Agency Suppliers etc. ▪ Conduct an annual survey to test (in-line with the full Finance Directorate) the levels of satisfaction of the Procurement function within the Directorate and the Trust and to keep abreast of customer requirements.		

South West Yorkshire Partnership NHS Foundation Trust Strategic Plan 2014 – 2019 PUBLIC SUMMARY

30/06/14

1.1 Declaration of Sustainability

The Board declares that, on the basis of the plans as set out in this document, the Trust will be financially, operationally and clinically sustainable according to current regulatory standards in one, three and five years time

	One year	Three years	Five years
Financially sustainable	Confirmed	Confirmed	Not Confirmed on current configuration
Operationally sustainable	Confirmed	Confirmed	Not Confirmed on current configuration
Clinically sustainable	Confirmed	Confirmed	Not Confirmed on current configuration

Based on our scenario analysis of the “as is “ the Trust will be challenged to be able to declare a sustainable position clinically, operationally or financially at year 5 of the Strategic plan. Our assessment of the local health and social care economy is that no current NHS provider will be able to certify that they will be in a sustainable position at this point.

In our declaration of sustainability for year 3 the plan presents a strategic direction and option analysis which drives the reshaping of the cost base through efficiency in workforce, service model and infrastructure in years 1 and 2 and creates substitution activity for statutory services in year 3 at lower cost using the Recovery Model and building on the success of Creative Minds and alternative capacity models.

From year 3 onwards the Trust is predicting that sustainability will only be achieved through development of core NHS services on larger geographic footprints e.g. West Yorkshire or Yorkshire and Humber for specialist services; which reduces back office costs but maintains a local responsive delivery of community services which has a greater reliance on self directed support and self care.

Therefore the declaration of sustainability outlined above reflects the Trust position that on its current scope and configuration it is sustainable financially operationally and clinically up to the end of Year 3. Beyond this timescale in order to be sustainable the services would need to be part of a bigger entity with critical mass as a specialist mental health and community provider.

2.3.1 Capacity Analysis - Estates

The Estates Strategy previously approved by the Trust Board is focused on:

- Development of Community Infrastructure
- Development of Inpatient Estate linked to Acute Care Pathway
- Ensuring Compliance with national standards and the regulators
- Emergent agenda regarding shared premises with partners
- Disposal of Surplus Estate

Capital Plan: The capital programme is aligned to the Long Term Financial Plan and is as per the submission made to Monitor in January 2014. The approach adopted is that all new capital developments will be designed to support service transformation and will be based on agile working principles supported by greater use of IM&T. All new capital developments will be subject to the approval of business cases that clearly set out the service and financial impact. Where the planned development encompasses in patient facilities there will be an emphasis on developments increasing staff resilience whilst reducing revenue and staffing costs by adopting a site wide strategic planning approach on the two main sites at Fieldhead and Kendray through Site Development Control Plans. All developments will adhere to the principles of eliminating same sex accommodation.

Capital Receipts: In 2014/15 the Plan forecasts receipts from disposal of surplus investment property. Future capital expenditure post 2016-17 is dependent on generating capital receipts from the disposal of surplus estate. This represents a critical risk to the overall estates strategy as any slippage in disposal will create increased revenue running costs from 2016-17 and deferring of capital investment.

Transformation Focus: The major enabling schemes in our Capital Plan are set out in the table overleaf. The focus of these schemes is to support integrated team working closer to communities – in line with the transformation vision of the Trust and of our partners. Also opportunities to consolidate sites from which support services are provided enable the Trust to deliver further efficiencies, while minimising impact on front-line clinical delivery. In addition the vision for inpatient services is for high quality in-patient facilities at geographically strategic locations within the Trust area delivering single room en suite accommodation designed to support cost effective staffing models

2.3.2 IM&T Plan

The aim for the next five years is to use IM&T to facilitate the transformation of services

This includes both transformation of the services which we deliver to local populations and the support services which are provided within the Trust to our Business Delivery Units. It also encompasses joint work with partners across the health and social care spectrum to ensure safe and seamless services for the people we serve.

Specific improvements will include more agile working, improving the productivity, accessibility and responsiveness of our services. This will also improve the working lives of our colleagues by reducing unnecessary journeys. The use of clinical records 'bring forward' systems in conjunction with unobtrusive tablet style technology will support more personalised care and enhanced safety through real time updating of clinical records. This will also improve the amount of direct patient facing time of our teams. Improved integration of key clinical systems with social care systems will improve productivity through reducing the need for double-entry of notes.

More service users will be able to access our services through the use of technology. This may include booking appointments at convenient times, reviewing helpful information to better manage long term conditions, or accessing on-line or group based peer support. In addition wider use of Lync technology will support consultations and advice over video link between computers, smart phones or other devices. Our existing telehealth and telecoaching services will be rolled out further, enabling more people to take control of their health and wellbeing, using regular measurements and feedback to reduce reliance on urgent care services.

We will use data more to identify improvement opportunities and to measure benefits. This will include wider participation in benchmarking, both within the Trust and beyond. It will also include participation in local integration initiatives such as the Barnsley Integration Pioneer and Calderdale and Huddersfield locality teams initiative. Where appropriate we will consider opportunities to use data to support risk stratification in support of efficient resource deployment.

Support Services will explore the wider use of technology to drive efficiency. This may include increased automation and self service options for routine transactional requirements, allowing more emphasis on high value adding business partnering support activities which meet the needs of internal customers. This approach will also support the development of a unified support service infrastructure capable of providing both scale efficiencies and enhanced access to practical and knowledgeable support to efficiently meet the needs of a significantly larger organisation operating across a wider geographic footprint.

2.3.4 Key Workforce Trends

Changes in Skills and Roles: The movement from a professional model of service to an enabling recovery focused approach is the key driver for changes to skills and roles. This includes the development of peer support worker roles both within the Trust and in local partner organisations, supporting initiatives such as Recovery Colleges and Creative Minds. It also requires a change in emphasis for the existing clinical workforce, where more staff will spend more of their time focus on the development of partnerships e.g. with housing support providers, and on the delivery of education and enablement. Other important changes will include:

- Review of administrative support provision to enable greater use of resources, including use of technology
- Changes to the clinical support worker roles between bands 1 through to 4. The Trust envisages a stepped approach to implementation of a Healthcare Support Worker Career structure which will have greater career progression opportunity
- Increase in clinical and non clinical apprenticeship posts at both intermediate (level 2) and advanced (level 3) roles.
- Potential to develop Assistant Practitioner roles as a career development opportunity towards band 5 nursing roles
- Review of medical models across the trust to support complex case management and consultancy, and also the provision of a greater range of sub-specialties
- Greater use of volunteers – supporting customer service excellence and other important facets of high quality service provision

Impact of 7 day working: The Trust currently operates services on a 7 day basis, but there are also substantial numbers of services which are operated on a 5 day working week. The most significant impacts of a move towards 7 day access are likely to be in those clinical areas which are part of pathways directly connected to acute wards as they step up efforts to have an even flow of discharges over 7 days. This would impact on Intermediate Care teams and mental health liaison teams which already operate 7 days per week. Other services may see increases in relation to medical and nursing requirements, but this will be off-set through balancing of sessions currently delivered Monday – Friday and through enhanced use of technology to support flexible working and communications.

Impact of Safe Staffing Levels on wards: The Trust's Quality and Nursing Directorate has recently undertaken an analysis of staffing levels within the acute pathway and has supported this with internal comparisons. Steps are being taken to initiate external benchmarking arrangements. This supports the existing work that the Trust undertakes to track trends in incidents and to ensure that investment is made in skills and staff numbers where required in response. In the absence of further analysis an assumed movement would be to invest the difference in tariff deflator from 1.8% to 1.5% which was agreed with local commissioners in respect of our acute pathway related income.

2.3.4 Key Workforce Trends

South West Yorkshire Partnership NHS
NHS Foundation Trust

Flexible working: The Trust will see increased demand from its existing workforce for flexible and part-time working. The Trust is seeing a correlation between the rising age profile and an increasing 'part-time' workforce. The Trust has seen a 6% rise in staff working part-time between 2009 and 2014 (36% in 2009 rising to 42% in 2014). This rise is expected to continue over the next 5 years and potentially reach 50% by 2020. This will allow for greater flexibility of the existing workforce in terms of rostering opportunities and an ability to provide greater levels of service outside of 9-5 Mon-Fri working hours. The adverse effect of this change is expected to be pressure on pension costs and on-cost provision.

Turnover: Turnover within the Trusts workforce has seen little fluctuation over the last 5 years with rates between 9-11% and the Trust envisages that this will remain constant over the next 5 years. We anticipate increases in turnover due to retirement to be offset by a relatively slow NHS job market ultimately keeping the labour turnover rate constant.

Age Profile: Over the next 5 years the Trust must address the rising age profile of our workforce. Over this period we will see an increasing potential for staff to retire from 3% of our total staff in post in 2014 rising to 6% of our total staff in post in 2019. The Trust saw a total of 81 staff retire in 2010 and this has risen to 125 head counted staff in the last 12 months to 2014 with a total of 24 staff opting to take voluntary resignation. The number of people taking retirement within the Trust has risen year on year since 2010 and it is expected to continue to increase each year rising to approximately 182 by 2018. Roles that provide the Trust with the greatest degree of risk centre around nursing roles, HCSW roles, estates staff and admin and clerical roles over the next 5-10 years.

Figure 2: Workforce Age Profile

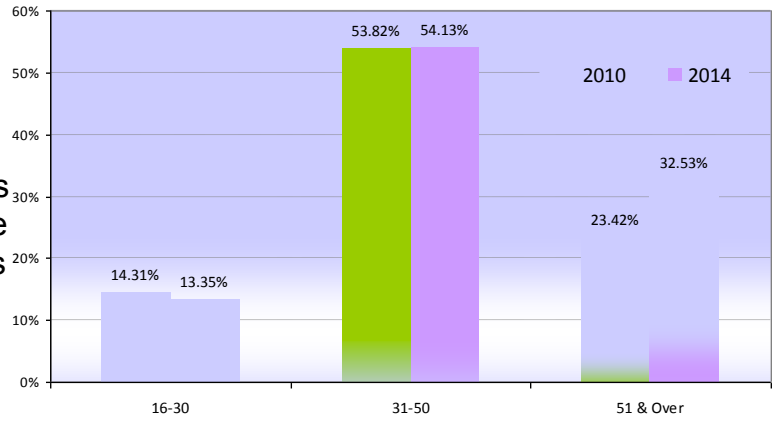
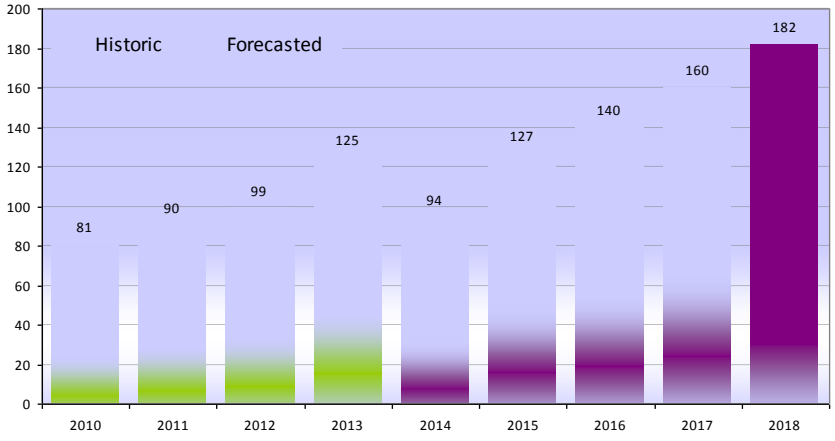


Figure 3: Workforce Retirement Potential



2.3.4 Key Workforce Trends

Hard to Recruit to posts: Allied Health professionals have traditionally been a staff group which is difficult to recruit but which is critical to delivery of holistic care and supporting recovery. It represents around 6% of the workforce with a current turnover rate of 10%. Current information on numbers of graduates indicates that in future there will be sufficient pool of staff to recruit from. The priority for AHP workforce development will be to develop workforce structure which will create better progression pathway for professional development through promotion of AHP support workers, assistant practitioners and AHP mentors and preceptorship programmes

Changes in WTE

In the last 4 years the Trust has seen an increase of 400 WTE (10.3% growth) reaching 4,594 in April 2014. This growth was driven by increases in several areas of the clinical workforce, partially as a result of the Trust's success in providing community based alternatives to hospital admission and health and wellbeing work.

In the last 12 months the increase has been just 14.4 WTE. Based on the Trust's current footprint and range of services the plan is to reduce workforce numbers during the next five years. This reflects the application of the Trust's efficiency and productivity programmes (CIP and Transformation) and also reflects the projected income and expenditure profile, which is aligned to commissioning intentions.

The scale of change indicated by the Year 1-3 CIP requirement is a reduction of 5-6% annually. The impact of these reductions is offset by the workforce predicted retirement potential of 6.17% by 2019, and the natural churn associated with posts becoming vacant. In addition the plan for sustainability (section 3) anticipates the development of a much larger platform for the services which we deliver. This means that the net effect (primarily in latter years of the Plan) is a growth in WTE numbers by the end of the 5 year period. This does not change the underlying trend which is to drive CIPs and transformation in the initial years of the Plan, driving a downward pressure on the number of WTEs in preparation for sustainable growth in the second half.

The table overleaf highlights the high level movements in WTE anticipated by this plan. It includes elements related to both continued delivery of efficiency through CIP and transformation programmes and also the development of a sustainable footprint for clinical services which involves increases in workforce as well as efficiency related downward pressure

2.4 Funding Analysis

Figure 1 highlights the relative shares of our income by source.

In summary 83% of our income is derived from CCG and NHS England contracts, 10% is from Local Authority contracts, and less than 1% related to activities undertaken for other NHS organisations. The Trust's 'other operating income' accounts for 6.5% and includes education & training and Research & Development

In terms of Service Lines our income relates to the following high-level groupings of services:

- Mental Health, including;
  - CAMHS
  - Adult Acute Mental Health
  - Adult Community Mental Health
  - Rehabilitation and Recovery
  - Older People's Mental Health (incl. Dementia)
- Forensic
- Learning Disabilities
- Community Physical Health, including:
  - Community Nursing and therapies
  - Long Term Conditions
  - Intermediate Care
  - Health and Wellbeing services

Figure 4: Share of income by source / type

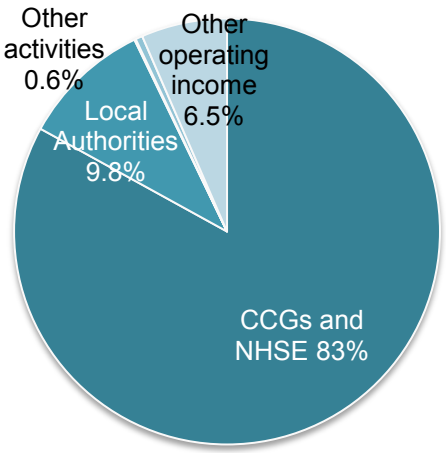
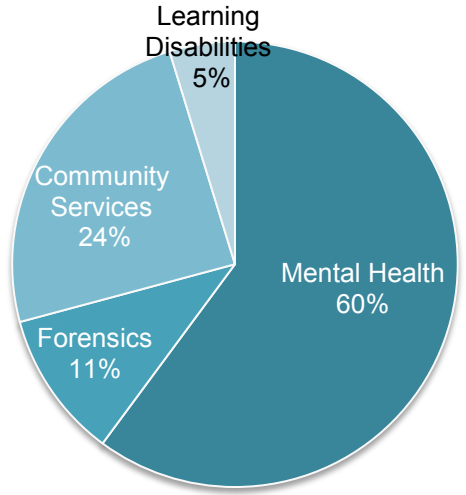


Figure 5: Share of income by grouped service line

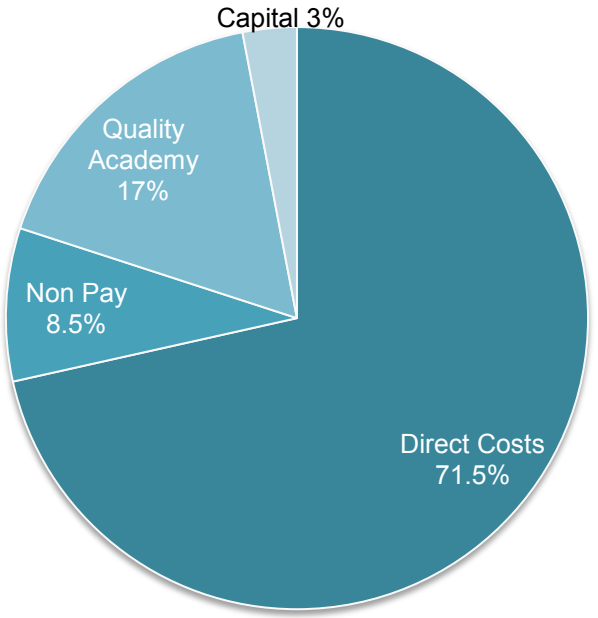


2.4 Cost Analysis

The Trust uses the income received to cover the costs of delivering and supporting services. Figure 3 highlights the breakdown of costs into

- Direct Costs, including;
  - Clinical and support staff involved in direct service provision
  - Agency and bank staff costs
  - Other pay costs
  - Redundancy costs
- Non-Pay Costs, including;
  - Drugs
  - Supplies
  - Sub-contracted services and SLAs
  - Travel and vehicle costs
  - Utilities and property costs
- Indirect costs and overheads, including;
  - Quality Academy
- Capital Charges, including:
  - Public Dividend Capital
  - Depreciation, and
  - Impairment

Figure 6: Breakdown of expenditure by cost type



2.6 PESTLE Analysis

South West Yorkshire Partnership NHS
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Political
- Austerity – particularly Local Authorities
- Parity of esteem
- Integration and personalisation
- Better Care Fund – linked to above
- Role of Health and Wellbeing Boards
- Electoral cycle – timescales for major change?
- 'Marketisation' of NHS
- Changing dynamics between DH, NHSE and Monitor + compete/collaborate dichotomy
- Fragility of partners and political dimension associated

Economic
- Declining investment/ continued austerity
- Impact of Better Care Fund
- Technological/pharma developments driving costs
- Impact of economic factors e.g. benefits reform on demand for Trust services
- Current pay and pension model sustainability?
- Continuing care costs
- Regeneration in local authorities – presents opportunities to partner
- Development of alternative/community capacity

Social/ Cultural
- Ageing population
- Ageing workforce and extension of working lives
- Changing perception of work/life balance
- Public expectations of welfare state changing
- Public expectations of customer service changing

Technological
- Improved access to information
- Social media
- Interoperability
- Increased numbers dependent on technology
- Trust capacity to digitise at the scale needed
- Telehealth/telemedicine
- Channel shift – more self serve
- Enables 'long tail' services – less geographically restricted
- Double running – those that don't want/ cant use IT

Legal / Regulatory
- Monitor / CQC / OFT – competition and collaboration
- Engagement/consultation requirements
- Partnership framework/partnership vehicles
- Framework for social enterprise

Environmental
- Carbon footprint
- Sustainability of estate
- Growth of alternative forms of provision
- Perception of what is seen as 'local' services

2.6 SWOT Analysis

South West Yorkshire Partnership NHS
NHS Foundation Trust

Strengths	• Wide range of services – offering opportunities for person centred integrated care – particularly physical/ mental health • Market leading co-production and engagement approaches – leading to Recovery focused service offers e.g. 'Creative Minds' and 'Recovery College' • Biggest Forensic contract in Yorkshire – wide range of services and estate fit for purpose • Clear understanding of service offers and service user requirements through mental health currency • Good track record – financial, risk and quality KPI performance
Weaknesses	• Need to develop more robust standardised approach to lead provider roles • Under developed commercial and marketing capability and capacity, highlighted by most service lines as a development area • Some service models increasingly considered old-fashioned by commissioners – not fully aligned to Recovery and Self Care agenda • Under developed capacity planning approaches will require co-ordination and regular review
Opportunities	• Recovery College and Creative Minds as focus for partnership – also supports offer to Health and Wellbeing market – both mental and physical health • Forensic clinical network • Development of Trust-wide specialist services (CAMHS, ADHD, PD etc)
Threats	• Loss of contracts through tenders if do not transform and engage sufficiently with commissioners • System focus on acute hospital economics plus local authority funding restrictions challenges parity of esteem • Acute overspend on specialised commissioning budget

2.7 Base Case: Sustainability

Clinical and Operational Sustainability: Within the Base Case we have assumed delivery of CIPs and transformational changes in line with our Two Year Operational Plan. We are also assuming funding for all cost pressures deemed necessary to deliver operational and clinical sustainability over the initial three years of this Plan. We have an agreed set of CIP and transformation schemes which are subject to a Quality Impact Assessment process and have been shown to be deliverable without compromising safety and service quality. In years four and five the opportunity to make internally generated efficiencies without some impact on clinical and operational sustainability is challenging.

Financial Sustainability: The Trust is aware that the forthcoming period will be more challenging. The financial climate is heightened by; an increase in the number of people requiring support, an increase in expectations from those people receiving the service in terms of availability and standard of service.

During this period we will need to maintain a downward pressure on costs at the same time as delivering significant efficiencies. These efficiencies will come from services changes, increased productivity and changes in skill mix. At the point when other parts of the social care and health sector are being squeezed we will prioritise our efforts on those people who require the service the most whilst looking for creative alternatives to support community and individual resilience.

The financial plan and execution is therefore complex but equally ambitious. It sets out to reduce the net expenditure over the Plan years 1-3 so that it's fit for purpose and ready and able to secure a sustainable platform for the services it provides. This is likely to be on a bigger footprint. It is anticipated that the growth will enable efficiencies to be realised from support service functions, provide greater resilience and have the capacity to respond to and effectively engage with our stakeholders.

the overall financial position is set out overleaf. This assumes that CIP of 5% can only be sustained for the first three years of the Plan. After that the opportunity for finding internally generated savings on the cost base is significantly reduced. The mode, also recognises relatively high proportion of cost pressures throughout the period because of the impact of 7 day working workforce configuration and investment in technology. The position at Year 5 is predicted to be an in year deficit and a Financial Risk Rating of 3. the combination of which is not sustainable.

We have used this base case position to understand the scale of the challenge and determine the remedial action required. We used this as a starting point and examined our strategic options. These are set out at Section 3

2.8 Alignment with Commissioners

The Trust operates mainly in four local health economies; Barnsley, Calderdale, Kirklees, and Wakefield, and across the whole of Yorkshire & Humber for Forensic services. This sub-section reviews commissioning intentions of both CCG and local authority commissioners in each patch, including planned use of the Better Care Fund. Where possible all of the following sources have been reviewed as part of this analysis:

- CCG 2 year and 5 year plans
- Health & Wellbeing Strategies
- Better Care Fund submissions
- Published service line commissioning intentions
- Pre Qualifying Questionnaires and Invitations to Tender
- Informal intelligence from contract management processes

Section 2.8.1 addresses the Calderdale local health economy, section 2.8.2 refers to the Kirklees area made up of both Greater Huddersfield and North Kirklees CCGs, 2.8.3 covers Wakefield, and 2.8.4 is Barnsley

Extent of Alignment of assumptions: To the extent that commissioning plans have been published they have been noted and incorporated into the assumptions used in the development of this Plan. In practice this means that commissioning intentions with regards to mental health service strategy are relatively well understood but financial assumptions regarding contract values and any specific decommissioning threat is less clear.

Engagement with commissioners and other local health economy partners is generally good, with the Trust actively participating in a wide range of strategic planning and service development activities. As such we have good relationships with our commissioners and are working together for a collectively sustainable future.

Working together with NHS provider organisations locally: The Trust continues to be an active partner in the development of provider-led responses to local health economy challenges. In Calderdale and Huddersfield a commissioner led strategic review of health and social care has led to the development of an Outline Business Case by a number of local provider organisations (CHFT, Locala and SWYPFT). This work offers a proposal to commissioners of how providers can work together to offer more effective integrated care and address the financial challenges facing the health economy. In Wakefield we are participating in the development of a similar provider led response (with Locala, Mid Yorkshire Hospitals Trust and others).

3.2 Service Line Analysis - Summary

South West Yorkshire Partnership NHS
NHS Foundation Trust

Each of the service lines at section 3.1 have been analysed in terms of the market conditions, SWOT for our own services, consideration of risks and issues and exploration of possible future scenarios. At the end of each analysis a review of strategic options has been undertaken. Table 21 summarises the Strategic Intent in each area. The full analysis for each service line is included at Appendix C. The key messages arising from the Service Line Analysis, which apply generally are;

- Consolidation of existing service portfolio
- Transformation including channel shift to self care, and
- Further development of Partnership for synergies in skills and service offerings

Table 21: Summary of Service Line Analysis

Service Line	Grow	Shrink	Partner	Transform	Comments
Acute MH	✓			✓	Growth Yr 4 onwards re sustainable service platform
Community MH	✓	(✓)	✓	✓	Growth in sub-specialisms initially
Rehab & Recovery		(✓)	✓	✓	New community model – partner re housing support
Dementia			✓	✓	Partner re post-diagnosis support
CAMHS	(✓)		✓	✓	Partner potentially re T2 T4, sub-specialism growth
Substance Misuse		(✓)	✓	✓	Integrated partnership for community. Beds viability?
Forensic	✓		✓	✓	Clinical Network, medium secure growth
Learning Disability			✓	✓	Partner around consultancy and advice – system flow
LTCs				✓	Virtual ward, care co-ordination/ referral mgt centre
Health & WB	✓			✓	Scalable multi-channel technology platform is key to grow
Intermediate Care				✓	CCG review of model and consolidation of bed base
Community Nursing & Therapies				✓	Improved access and flexibility of response - lean

(✓) = Applies to part of Service Line only

3.3 Key Opportunities & Challenges

South West Yorkshire Partnership NHS
NHS Foundation Trust

Calderdale & Kirklees BDUs	Wakefield BDU
• Hospital Liaison continues to build partnership credentials, plus Community Liaison offer into OBC Locality Teams offers growth potential for a Trust wide model • Rehabilitation: although all parties desire to improve the current pathway and to reduce the extent of OATs, the sharing of resulting efficiencies between commissioner QIPP and provider CIP will require further exploration. • The resourcing of Calderdale Crisis and Home Based Treatment continues to be an issue impacting on the effective provision of alternatives to hospital admission, and therefore will require resolution as part of the acute care pathway transformation. • The cross-subsidy of Calderdale services by Wakefield, North Kirklees and Greater Huddersfield CCGs is unsustainable. Although this is being addressed incrementally, resolution is challenging. • Trust wide sub-specialisms delivered locally highlighted by commissioners and Service Line teams in most localities	• Creative Minds funded for first time – but more to do to build commissioners association of the Trust with recovery and prevention • This perception held more widely in relation to Health and Wellbeing • IAPT opportunity – commissioners requiring more complete range of psychological therapies – potential partnership opportunity. • Review of all main adult mental health services = opportunity to realign to recovery principles but also challenge to funding and pathway stability. • Community liaison model allied to GP network locality teams – This offers potential to become a Trust wide model.

3.3 Key Opportunities & Challenges

Barnsley BDU	Other
• Intermediate Care Review – opportunities regarding Virtual Ward, but challenges regarding potential impact on bed based services – mitigated by consolidation of estate as per capital plan • Barnsley Hospital – opportunity to provide solutions – LTC models including telehealth, but requiring further pace and depth in transformation • Health and Wellbeing model – must adapt to integrated wellness service specifications, and note threat of local authority in-sourcing • Personality Disorder pathway under development offers system efficiencies and qualitative gains – potentially a model for Trust-wide services • Physical / Mental health interface – e.g. smoking cessation highlighted by CCG • Evaluation of Recovery College – opportunity to ensure share of market which is moving towards smaller 3rd sector providers • Self harm attendances at general hospital noted by commissioners – related to transitional arrangements and balance psychology/ psychiatry	• ADHD/ ASD growth potential strong – Trust wide offer • CAMHS quality and access issues being addressed but also offers good potential for niche offers e.g. HSB. • Forensic Clinical Network formation positions positively. Much riding on specific detail of national tender exercise. • Learning Disabilities transformed offer has good commissioner sign up in principle – further work on income model.

3.4 Our Plan for Sustainability

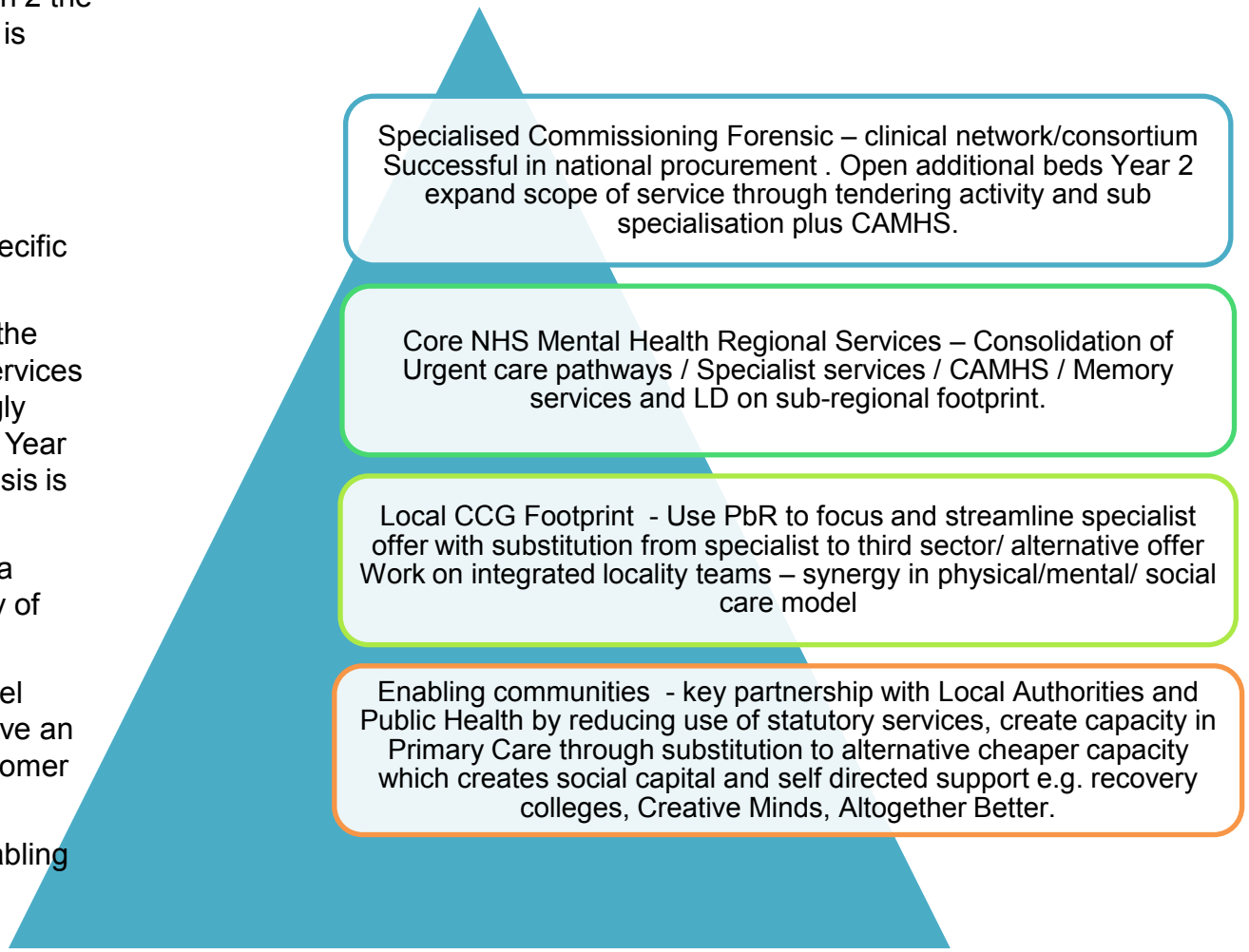
As in the base case set out at Section 2 the Trust's chosen plan for sustainability is predicated on;

- Driving hard on CIPs through transformation in Years 1-3, and
- Increasing our focus on income generation through Service Line specific plans as outlined at Section 3.4.1.

In addition this Plan recognises that the challenges of sustainability for the services which we provide become increasingly challenging at the current scale from Year three onwards. Therefore the emphasis is additionally on the following:

- Growth through partnership to find a sustainable platform for the delivery of each strata of service provision
- Achieving scale and operating model efficiency in support services to serve an increasingly dispersed internal customer base
- Continuing the journey towards enabling recovery and promoting self care.

Figure 7: Model for Sustainable Services



3.4.3 Our Plan: Sustainability

Clinical and Operational Sustainability: Within our plan for sustainability we have carried forward all of the existing mechanisms to ensure clinical and operational safety, including robust ongoing quality impact assessments of all CIP and transformation schemes prior to implementation and during roll-out. Where the base-case identified decreasing potential for internally generating efficiencies without impacting on quality in the final two years of this five year plan, our revised plan for sustainability addresses this through the establishment of a larger platform for services, which will enable more synergies to be found. This is expected to result in better access to highly specialised services, with a wider range of services being clinically and operationally viable over a wider footprint. Technology will enable access to skills and expertise over a greater number of hours per day, 7 days per week, which will enhance access for service users. Service improvement and practice governance coaching will support the spread of best practice, and oversight of quality will be maintained through current Trust Board committee structures.

Clinical sustainability is reliant upon a shift from a service to person centred delivery model. Clearly this supports the transition towards greater reliance on self directed support. In this context sustainability can only be achieved through significant redesign of clinical workforce, requiring promotion of an enabling rather than the fixing professional culture that currently prevails. In practice this will require substitution of some current roles and activities with peer support.

Financial Sustainability: In response to increasing demand and workforce related inflationary pressures, this Plan ensures that all investment requirements can be met and that efficiencies can be generated with out impacting on clinical quality. In the latter years of the Plan synergies in management administration and support services will become available, as a sustainable platform is found for the services which we provide.

In order to be ready to take advantage of such synergies it is essential that we stick to the delivery of CIPs through transformation of both clinical and support services over the first three years of the plan – building an infrastructure that is fit for the future. In addition to developing the services models and the enabling technology based delivery channels, we must focus on the accompanying work force change required to ensure we have the right skills, role types and sustainable workforce numbers to be in position to execute the Plan from Year 3 onwards.

the overall financial position is set out on the previous page. This plan would see the Trust maintain a surplus in every year and would see the FRR remain at 4 by 2019.

4.1 Key Delivery Milestones

Sustainable Platform: Our plan for Year 3 onwards requires the development of strong external partnerships and potentially new organisational forms. This takes us into relatively innovative territory, where engagement of commissioners and regulators as well as provider partners across the health and social care spectrum will be of major importance. Therefore the milestone plan below focuses on the engagement activities as well as the development of operating models which will be fit for purpose at scale.

Figure 8: Sustainable Platform – Initial Key Delivery Milestones

	Year One	Year Two	Year Three	Year Four	Year Five
CIP Delivery	Mainly driven through workforce schemes	Increasingly transformational service change	Increasingly support service efficiency	synergies	synergies
Transformation	BDU developed quick wins, plus 'ground work' for bigger change	Focus on alternative models – Recovery College, Creative Minds etc. Use technology to support growth in sub specialisms		New roles (peer support, volunteers) embedded in workforce, workforce into new organisational forms	
Commercial	Maintain net contract position, linked to transformation	Growth through bids and business cases. Development of alternative organisational vehicles to support transformation. By Y3 achieve some growth through wider service platform		Increased emphasis on wider service platform	Consolidation of benefits realisation from wider service platform
IT Investment	Focus on enablers for transformation e.g. agile, telehealth, interoperability of clinical systems. By Y2/3 enable support service scalability			Support to larger organisation plus micro orgs through Creative Minds	
Forensic	Clinical Network / partnership	Achieve growth through national procurement exercise		Consolidate and drive pathway efficiencies	
Partnership	Active contribution to integrated care initiatives in LHEs e.g. MH liaison, dementia, primary care, social care		Increasingly using joint ventures and business partnerships, plus sub-regional specialism linked to wider service platform, while maintaining core LHE presence		

4.2 Managing Risks & Resourcing the Plan

Resourcing: Our plan for Years 1 and 2 is predicated on the delivery of cost improvements through transforming services. To support this work we have created a dedicated Programme Management Office, established a fund to second clinical and operational staff, and also where required brought in external advisors to support specific developments. This is reflected in our non-recurrent expenditure plans.

Our plan from Year 3 onwards requires the addition of new skills in the Trust and will also require some highly specialist external support. In Year 1 the Trust will add a dedicated commercial manager to the team, to drive the income generation activity and support the formation of critical operational partnership arrangements. The Trust will continue to make use of legal and commercial advice to guide the process of finding a sustainable scalable platform for service provision. This is reflected with increasing transitional resource into Years 2 – 4 of the Plan.

Table 24: Strategic Risks

Risks	Controls
CIP delivery through transformation of services and change of working practices is slower than planned/ cannot achieve the planned levels of benefit in Years 1 and 2, impacting the Trust's timescale for resolution of longer term sustainable platform	Weekly CEO chaired 'ORG' meetings tracking delivery and unblocking issues. Further substitution schemes under development.
Development of Specialist Services / Forensic clinical networks and national tender exercise does not lead to maintenance/ growth of Forensic contribution in Y3	Focus on development of networks in Y1 and invest in preparation for tender exercise
Potential partner timescales not well aligned with our own. This is especially pertinent for us in view of the large number of local health economies in which we operate and the number of partners	Early conversation and adaptation of plans
Commissioner / regulator concerns – potentially re competition impact	Early conversation, expert advice, clear analysis of service user and system benefits
Any significant decommissioning of current contracts by our CCGs would challenge the delivery of sustainability (commissioning intentions indicate this is not currently planned)	Focus on demonstrating quality and value to commissioners to reduce the need to test market
Embedding Recovery principles throughout our service delivery is a significant cultural change from the former professional model requiring careful management of clinical risk	Clinical leadership roles and practice governance roles in place, plus regular review at EMT and Trust Board cttees
Management of workforce transition – recruitment and development of new roles (peer support etc) , retain skills, maintain staff side relationships.	Programme approach to workforce schemes, regular staff side engagement and clear comms.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 22 July 2014
Agenda item 8

Title:	**Trust Board self-certification – Monitor Quarter 1 return 2014/15**
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:	Compliance with Monitor's Risk Assessment Framework supports the Trust to meet the terms of its Licence and supports governance and performance management enabling the Trust to fulfil its mission and adhere to its values.
Any background papers/ previously considered by:	The exception report to Monitor highlights issues previously reported to Trust Board through performance and compliance reports. The Estates Forum has been briefed on the capital programme position.
Executive summary:	<u>Quarter 1 assessment</u> Based on the evidence received by Trust Board through performance reports and compliance reports, the Trust is reporting a governance risk rating of **green** under Monitor's Risk Assessment Framework. Based on performance information set out in reports presented to Trust Board, the Trust is reporting a continuity of services/finance risk rating of **green** with a score of **4**. <u>Self-certification</u> 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 uses an in-year quality governance metric, which is currently the same as that used for quarters 3 and 4 of 2013/14, of executive

	team turnover as this 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 1 and the in-year governance declaration on behalf of the board will be made to confirm compliance with governance and performance targets. <u>Capital plan 2014/15</u> The total capital programme for 2014/14 is £11.78 million. The year-to-date position is £679,000 (37%) below the plan submitted to Monitor in April 2014. This exceeds the threshold set by Monitor of 15%. The main reasons for the underspend are as follows. - Underspends against facilities (£330,000) and minor works (£85,000), including timing changes to plant room upgrades following resolution of water issues on the Fieldhead site and deferred schemes in line with the Trust's transformation programme. - A variance of £247,000 in relation to forensic in-patient redevelopment. Approximately £200,000 of this was spent in 2013/14. The scheme is, overall, forecast to achieve the capital plan and the additional funding will be used within the overall capital programme, for example, elements of the underspend have been used in the Calderdale hub development. - Spend on the new IT contract is behind plan due to changes in delivery timescales. Monitor was advised of the Trust's capital programme position at the annual review meeting on 23 June 2014. The revised capital programme is attached as an annex to this paper. <u>Foundation Trust sector comparison</u> As at 31 March 2014, 27 out of 147 foundation trusts were subject to enforcement action (20%) (eight more than at the same point last year). The numbers represent a gradual increase in trusts found in breach of their terms of authorisation/licence conditions due to financial issues and, increasingly, governance concerns since quarter 2 of 2013/14. Of these, 19 were subject to enforcement action in 2012/13, which was not lifted during 2013/14. Since 1 April 2014, two more trusts have been subject to enforcement action making the current total 29. Nine trusts are in special measures and there are five formal investigations for potential licence breaches. Of 147 foundation trusts, 29 carry a red rating for governance (20%); of 41 mental health trusts, there are four (10%). 80% of mental health trusts have a continuity of services risk rating of 4 at 31 March 2014 with the remainder at 3.
Recommendation:	**Trust Board is asked to APPROVE the submission and exception report to Monitor, subject to any changes/additions arising from papers discussed at the Board meeting around performance, compliance and governance. Trust Board is also asked to APPROVE the revised capital programme.**
Private session:	Not applicable

Trust Board self-certification - Monitor Quarter 1 return 2014/15
Trust Board 22 July 2014

Compliance with the Trust's Licence
The Trust continues to comply with the conditions of its Licence. There have been no changes to commissioner requested services since Quarter 4.

Trust Board
Following the successful recruitment of Laurence Campbell for the Non-Executive Director vacancy, the Members' Council approved his appointment on 30 April 2014 from 1 June 2014 for a period of three years.

The interim appointment made to the post of Director of Service Innovation and Health Intelligence has been extended for a further six months with an extension to the secondment from NHS England until mid-January 2015.

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

Following the elections to the Members' Council, which ended on 25 April 2014, the following were successfully elected.

Barnsley (two seats)
Andrew Crossley
Andrew Hill (re-elected)

Kirklees (two seats)
Michael Fenton
Nasim Hasnie (re-elected)

Wakefield (two seats)
Julie Craven
Hazel Walker (re-elected)

There remains one vacancy for the public constituency of the rest of South and West Yorkshire and one vacancy for staff seat for social care staff working in integrated teams.

Breach of capital plan tolerance
Monitor has already been alerted to the possible breach by the Trust of the 5% tolerance on delivery of capital plans. The total capital programme for 2014/14 is £11.78 million. At the end of quarter 1, the year-to-date position is £679,000 (37%) below the plan submitted to Monitor in April 2014. This exceeds the threshold set by Monitor of 15%. The main reasons for the underspend are as follows.

- Underspends against facilities (£330,000) and minor works (£85,000), including timing changes to plant room upgrades following resolution of water issues on the

Fieldhead site and deferred schemes in line with the Trust's transformation programme.

- A variance of £247,000 in relation to forensic in-patient redevelopment. Approximately £200,000 of this was spent in 2013/14. The scheme is, overall, forecast to achieve the capital plan and the additional funding will be used within the overall capital programme, for example, elements of the underspend have been used in the Calderdale hub development.
- Spend on the new IT contract is behind plan due to changes in delivery timescales.

A revised capital plan was approved by Trust Board on 22 July 2014 and is included in the quarter 1 2014/15 financial return.

Care Quality Commission (CQC)

- In the latest Quality and Risk Profile (QRP) (April 2014), thirteen (81%) risk estimates continue to fall in the 'reduced risk of non-compliance' range. There are three risk estimates within the 'increased risk of non-compliance' range relating to outcome 2 (consent), outcome 4 (care and welfare) and outcome 6 (co-operating with other providers), which are risk rated low amber, high red and low amber respectively. Across all items listed against the sixteen outcomes, the percentage of negative items remains at 5%. Risk ratings are significantly influenced by CQC compliance inspection visits and CQC Mental Health Act visits; however, both outcomes for which the Trust currently holds a CQC compliance action (outcomes 7 and 10) remain in the reduced risk of non-compliance range within the QRP.
- The Trust still has two compliance actions from the Fieldhead inspection visit (Trinity 2, Newton Lodge and Bretton) against outcomes 7 (safeguarding) and 10 (safety and suitability of premises). A recent review identified that all identified actions with one exception had been completed by the end of May 2014. The outstanding action relates to completion of refurbishment on Trinity 2. A return CQC inspection visit to review the actions taken is anticipated.
- The draft Fox View inspection report has now been received and will be made final following completion of accuracy checking procedures. The CQC has found the Trust to be compliant against all the outcomes inspected.
- 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 three CQC Mental Health Act visits in Q1 to Chantry, Enfield Down and Willowdale. Twelve MHA monitoring summary reports have been received for Priory, Hepworth, Trinity 2, Saville Park, Melton Suite, Waterton, Chippendale, Almondbury, Beechdale, Sandal, Chantry and Enfield Down. One response (Beechdale) was submitted a day late and two responses (Chantry and Enfield Down) are not due for submission until mid-July 2014 and will therefore be reported on in the Q2 report. The monitoring visits were largely positive in terms of practice and implementation of actions identified from previous visits. An improvement in the recording of Section17 leave was generally noted. Recurring issues relate to the assessment and recording of capacity, the recording of consultation with the Second Opinion Appointed Doctor by the statutory consultees and the recording of Section132 rights.

Absent without Leave (AWOL)

During quarter 1, there was one case reported to the CQC in relation to a service user in low secure services. The service user absented himself during a period of escorted leave and then returned of his own volition.

The Members' Council has asked for more information in relation to the number of service users who abscond, in particular, those absconding from the Dales unit in Halifax following coverage in the local press earlier this year. A report will be presented to the Members' Council Quality Group at the beginning of August 2014. The report will provide assurance that significant work has been undertaken to improve security at the Dales both internally and externally to the building. The majority of AWOLs involve service users either not returning from planned leave at the agreed time or going AWOL from the smoking area. Completed work should greatly improve security in the garden area, particularly the smoking area.

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 Q1, which is the same figure as Q4. All incidents have been appropriately care-managed with required levels of observation and support implemented.

Health and Safety Executive (HSE)
There were no unannounced visits received during Q1.

Infection prevention and control
In quarter 1, there have been no cases of Clostridium Difficile in Barnsley. The year-end position, therefore, is below the maximum permitted number of cases. There have been no MRSA bacteraemia cases or infection outbreaks reported.

Information Governance
The Trust currently has two 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 1.

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

Safeguarding Children
- There were 61 reported incidents Trust-wide directly relating to issues of child protection in Q1. This represents an increase on Q4 and work is ongoing to ensure improved reporting practices are sustained. All of the incidents were reviewed by the Named Nurses and were assessed to have been appropriately reported and managed.
- Work continues in Calderdale and Barnsley to address issues raised in OfSTED improvement notices with the Trust leading on some key individual pieces of work.
- Barnsley Council's children's services were inspected in June 2014 under the new month-long OfSTED inspection framework. There has been no formal announcement; however, the indications are of a positive outcome.

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

Serious Incidents
During the course of Q1 there have been 32 SIs reported to commissioners (thirteen in Barnsley which includes incidents related to pressure ulcers, four in Calderdale, six in Kirklees, seven in Wakefield, one in specialist services/CAMHS and one in forensic services). SI investigations and reports are being completed within timeframes agreed with relevant commissioners; however, reporting pressures have been increased due to a recent spike in the number of SIs. The nature of SIs has been reviewed with no theme and identifiable casual factors for the increase in SI numbers.

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. This includes the target in relation to 7-day follow up. As previously reported to Monitor, it came 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 was used for Q4 and the Trust meets its target. A retrospective review of quarters 1 to 3 2013/14 was undertaken and Monitor advised of the outcome. Monitor did not require the Trust to re-state its position for the three quarters and the Trust's Quality Accounts, therefore, receive an unqualified opinion from external audit. Monitor expects the Trust to comply with the target in quarters 1 and 2 of 2014/15. Failure to do so will lead to a reconsideration of Monitor's position.

Third party reports
There were no internal audit reports with either no or limited assurance received by the Trust during the quarter.

Strategic outline case
In June 2014, Trust Board has approved a proposal for the Trust to be a signatory for the Strategic Outline Case business case, developed in partnership with Calderdale and Huddersfield NHS Foundation Trust and Locala. The three providers will continue to work in partnership to further refine the Case to develop a position of system and organisational sustainability.

An outline business case has been submitted to CCG commissioners. They will be considering the content of the proposal in August 2014 following the agreement of the commissioner specification for integrated community services by the governing bodies. It is anticipated that the focus will be on the transformation of community services with a market testing event in August 2014 before a decision is made on the procurement option in September.

Specialist commissioning – secure mental health provision
The Trust informed Monitor of the position in relation to specialist commissioning for secure mental health provision. The issue has subsequently been resolved and the Trust awarded its full budget allocation as originally outlined for 2014/15. Negotiations continue with NHS England on the Trust's future budget allocation.

Children's and adolescents' mental health services (CAMHS)

The Calderdale and Kirklees Tier 3 CAMHS transferred to the Trust on 1 April 2013. During the past year, the service has been under review and is going through transition to new ways of working in order to deliver the required service specification. The scale of the transformation required is significantly beyond what could be considered reasonable in terms of routine transformation from one service delivery model to another within change of provider within existing resources and as set out in the Trust's original tender for the service. The review has highlighted a number of issues that need urgent attention and that originate from practices during the time of the management of the service by the previous provider. This has led to the introduction of a detailed recovery plan, which is overseen by a Partnership Executive Group consisting of commissioner and Trust quality leads.

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South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 22 July 2014
Capital programme 2014/15 revised phasing

The revised capital plan is attached. Key points are as follows.

- The programme remains at £11.78 million for 2014/15.
- The Calderdale hub reflects Trust Board approved spend with in-year spend revised to reflect the approved new build project.
- The decant project reflects the scheme proposed in the Fieldhead master plan. In-year spend has been revised to reflect anticipated progress subject to Trust Board approval.
- Minor schemes have been moved slightly and projects at Fox View moved to Quarter 4 as it is anticipated that these will not be required due to the ongoing Rehab and Recovery review (an in-year spend of approximately £150,000 is anticipated but not confirmed).
- A sum of £202,000 remains unallocated to allow for additional schemes.
- The Estate Strategy allocation has been revised down to £600,000 to reflect actual expenditure on agreed strategic schemes.

It is anticipated that the full amount of capital allocated for the year will be spent based on the current priorities and that expenditure will follow the phasing plan within reporting tolerances. All parties involved with the capital plan are aware and supportive of the revised plan, subject to Trust Board approval for schemes.

Minor / Major Capital Bids 2014 / 2015 Draft Monthly Spend Profile

Minor Capital Schemes

					1	2	3	4	5	6	7	8	9	10	11	12	C/F 2015	
Task	BDU	Asset	Scheme Type/Description	Budget Estimate	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15		
			BDU Minor Works															
																	0	0
1	Barnsley	Penistone	Internal alterations and clinical upgrades	35,000		1,000	2,500	31,500									35,000	0
2	Barnsley	Lundwood	Internal alterations and clinical upgrades	25,000					2,500	22,500							25,000	0
3	Barnsley	Mapplewell	Internal alterations and clinical upgrades	30,000								13,250	25,000	21,750			60,000	(30,000)
4	Barnsley	Oakwell	Changes to "swing area" to form secure bedrooms	80,000	5,000	0	70,000	20,000	30,000								125,000	(45,000)
5	Barnsley	SMU	Conversion of existing Bathroom into wet room	6,000			6,000										6,000	0
6	Forensic	ALL	Ensuite hinges	25,000										10,000	10,000	5,000	25,000	0
7	Forensic	Newton Lodge	Main Servery Kitchen	96,000	3,500	20,000	20,000	27,230	25,270								96,000	0
8	Forensic	Bretton	Clinic Room Lobbies	40,000								2,550	1,240	18,000	18,210		40,000	0
9	Forensic	Bretton	Ward Re-configuration	30,000										1,500	24,550	3,950	30,000	0
10	Wakefield	Castle Lodge	Bedroom Observation Windows	22,000						1,570	10,240	10,190					22,000	0
11	Wakefield	Trinity 1	Clinic Room	45,000			2,000	25,000	18,000								45,000	0
12	Wakefield	Baghill House	Clinic Room	20,000				2,500	17,500								20,000	0
13	Wakefield	Briarfields	Patient Monitor.	6,000				0									0	6,000
14	Wakefield	Trinity 1	Patient Monitor.	0				0									0	0
15	Specialist Services	Fox View	Clinic Room Upgrade	25,000	0	0										25,000	25,000	0
16	Specialist Services	Fox View	Ligature Light Bedroom	25,000	0	0	0									25,000	25,000	0
17	Kirklees	Ward 19, The Priestley Unit	Ward layout changes	170,000			3,500	3,500	52,000	75,000	36,000						170,000	0
																		0
B/F 13-14																		0
	Barnsley		Decontamination Unit	68,000	68,000												68,000	0
	Forensic		Gaskell Seclusion	160,000		0	0	65,000	50,000	45,000							160,000	0
	Calderdale		Dales Seclusion	90,000								90,000					90,000	0
			Monthly Spend Inc VAT	998,000	76,500	21,000	104,000	174,730	195,270	144,070	46,240	115,990	26,240	51,250	52,760	58,950	1,067,000	(69,000)
			Cumulative Monthly Spend Inc Va		**76,500**	**97,500**	**201,500**	**376,230**	**571,500**	**715,570**	**761,810**	**877,800**	**904,040**	**955,290**	**1,008,050**	**1,067,000**	**1,067,000**	**(69,000)**
			Facilities and IM&T Minor Works															
		Staff		204,000	16,667	16,667	16,667	16,667	16,667	16,667	16,667	16,667	16,667	16,667	16,667	16,667	200,004	3,996
		Facilities		1,025,000	0	25,000	50,000	75,000	170,000	175,000	145,000	100,000	75,000	70,000	60,000	55,000	1,000,000	25,000
		IM and T		450,000	7,703	7,703	10,000	52,000	52,208	102,500	10,000	40,000	57,459	13,000	15,000	82,427	450,000	0
			Monthly spend inc VAT		24,370	49,370	76,667	143,667	238,875	294,167	171,667	156,667	149,126	99,667	91,667	154,094	1,650,004	(1,650,004)
			Cumulative Monthly Spend Inc Va	**1,679,000**	**24,370**	**73,740**	**150,407**	**294,074**	**532,949**	**827,116**	**998,783**	**1,155,450**	**1,304,576**	**1,404,243**	**1,495,910**	**1,650,004**	**1,650,004**	**28,996**

Major Capital Works

1	Capital	Fieldhead	Fieldhead Infrastructure	300,000	130,000	0	112,000	58,000									300,000	0
2	Capital	Barnsley BDU	New St Barnsley Hub	1,500,000		7,240	12,650	14,780	11,470	150,000	327,000	250,000	244,000	290,000	205,000	88,000	1,600,140	(100,140)
3	Capital	Calderdale	Laura Mitchell House - Halifax Hub	5,400,000		15,000	16,870	14,785	15,800	212,500	212,500	310,000	440,000	600,000	525,000	360,000	2,722,455	2,677,545
4	Capital	Wakefield	Wakefield Hub	600,000								0	40,000	180,000	200,000	180,000	600,000	0
	Capital		Estate Strategy	2,000,000						0	80,000	130,000	140,000	150,000	80,000	20,000	600,000	1,400,000
5	Capital	Fieldhead	Hepworth Ward	300,000	130,000	50,000	75,000	45,000									300,000	0
6	Capital	Fieldhead	Decant Facility Fieldhead Masterplan	3,250,000	15,000	18,560	12,653	16,875	11,854	9,215	329,000	450,000	450,000	400,000	500,000	450,000	2,663,157	586,843
7	Capital	All	Stage 2 / 3 Fees for 2015/2016 schemes	75,000									0	15,000	30,000	30,000	75,000	0
			Monthly Spend Inc VAT	**13,425,000**	275,000	90,800	229,173	149,440	39,124	371,715	948,500	1,140,000	1,314,000	1,635,000	1,540,000	1,128,000	8,860,752	4,564,248
			Cumulative Monthly Spend Inc Va		**275,000**	**365,800**	**594,973**	**744,413**	**783,537**	**1,155,252**	**2,103,752**	**3,243,752**	**4,557,752**	**6,192,752**	**7,732,752**	**8,860,752**	**8,860,752**	**4,564,248**
			Total Monthly Spend Inc VAT Major / Mino	**15,898,000**	**375,870**	**161,170**	**409,840**	**467,837**	**473,269**	**809,952**	**1,166,407**	**1,412,657**	**1,489,366**	**1,785,917**	**1,684,427**	**1,341,044**	**11,577,756**	**4,495,248**
			Cumulative Monthly Spend Inc Vat Major / Mino		**375,870**	**537,040**	**946,880**	**1,414,717**	**1,887,986**	**2,697,938**	**3,864,345**	**5,277,002**	**6,766,368**	**8,552,285**	**10,236,712**	**11,577,756**	**11,577,756**	**4,524,244**
			Estate Strategy														0	
			Total Profile	**15,898,000**	**375,870**	**537,040**	**946,880**	**1,414,717**	**1,887,986**	**2,697,938**	**3,864,345**	**5,277,002**	**6,766,368**	**8,552,285**	**10,236,712**	**11,577,756**	**11,577,756**	**4,524,244**
																CHECK	202,244	

Monitor Headings	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Total
Hub Development	130,000	72,240	104,520	74,565	27,270	362,500	619,500	690,000	864,000	1,220,000	1,010,000	648,000	5,822,595
Fieldhead Hospital Development	145,000	18,560	124,653	74,875	11,854	9,215	329,000	450,000	450,000	415,000	530,000	480,000	3,038,157
Facilities & Minor Capital	93,167	62,667	170,667	266,397	381,937	335,737	207,907	232,657	117,907	137,917	129,427	130,617	2,267,004
Estates Strategy	0	0	0	0	0	0	0	0	0	0	0	0	0
IM & T	7,703	7,703	10,000	52,000	52,208	102,500	10,000	40,000	57,459	13,000	15,000	82,427	450,000
													0
Total	**375,870**	**161,170**	**409,840**	**467,837**	**473,269**	**809,952**	**1,166,407**	**1,412,657**	**1,489,366**	**1,785,917**	**1,684,427**	**1,341,044**	**11,577,756**
													0

	Monitor Headings	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total
Development of Community Infrastructure	Hub Development	306,760	464,335	2,173,500	2,878,000	5,822,595
Development of Inpatient Estate	Fieldhead Hospital Development	288,213	95,944	1,229,000	1,425,000	3,038,157
Compliance & Backlog Maintenance	Facilities & Minor Capital	326,501	984,071	558,471	397,961	2,267,004
	Estates Strategy	0	0	0	0	0
IM & T	IM & T	25,406	206,708	107,459	110,427	450,000
	Total	**946,880**	**1,751,058**	**4,068,430**	**4,811,388**	**11,577,756**

Trust Board 22 July 2014
Agenda item 9

Title:	**Assurance framework and organisational risk register Q1 2014/15**
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 mission and adhere to its values.
Any background papers/ previously considered by:	Previous quarterly reports to Trust Board.
Executive summary:	**Background** 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. Trust 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 1 covering the Assurance Framework and Organisational Risk Register. **Assurance framework 2014/15** Trust Board needs to evidence that it has systematically identified the organisation's objectives and managed the principal risks to achieving them. The Trust's Assurance Framework is designed as a tool for Trust 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 Trust 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 Trust 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 Trust 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 and the final version approved with the annual report and accounts in May 2014. The strategic corporate objectives for 2014/15 were approved by Trust Board and form the basis of the assurance Framework for 2014/15. In respect of the Assurance Framework for 2014/15, 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 has also worked with the Chairs and lead Directors of each of the sub-committees of Trust Board to identify which of the sub-committees of the Board, through their Annual Work Plans, is seeking and providing assurance to Trust 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; - children's and adolescents' mental health services.
Recommendation:	**Trust Board is asked to:** ➢ **NOTE the assurances provided for Q1 of 2014/15;** ➢ **NOTE those areas where gaps in assurance have been identified, through the Trust wide risk register and are being addressed through specific action plans as appropriate led by the lead Director;**

	➢ **NOTE the key risks for the organisation subject to any changes/additions arising from papers discussed at the Board meeting around performance, compliance and governance.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

ASSURANCE FRAMEWORK 2014/15 DRAFT Q1 2014/15

Principal delivery objective 1 Quality:

- **Create a person-centred delivery system**
- **Deliver safe services**
- **Ensure efficient and effective delivery**

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. 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			ORR ref: 267, 270, (528)
2. 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			
3. Failing to achieve devolution and local autonomy for BDUs within the new leadership and management arrangements impacting on ability to deliver safe, effective and efficient services.	▪ DDs	▪ C1, C3, C33, C52, C53, C54, C55	▪ A1, A5, A26, A33, A35,			
4. No clear lines of accountability and responsibility within Directorates and between BDUs and Quality Academy impacting on ability to deliver safe, effective and efficient services.	▪ DDs ▪ CDs	▪ C17, C23, C33, C53	▪ A12, A15, A16, A23, A35			
5. Trust plans for service transformation are not aligned to the multiplicity of stakeholder requirements leading to inability to create a person-centred delivery system.	▪ DDs ▪ QA dirs.	▪ C3, C17, C18, C30, C32, C35, C45, C52	▪ A1, A4, A5, A8, A15, A16, A26, A40, A53			ORR ref: 463
6. Failure of transformation plans to reach appropriate quality improvement thresholds leading to development of a service offer that does not meet service user/carer needs.	▪ DDs ▪ QA dirs.	▪ C3, C17, C18, C30, C32, C35, C45, C52	▪ A1, A4, A5, A8, A15, A16, A26, A40, A53			ORR ref: 463

Principal delivery objective 2 Finance:

- **Financial stability now and in the future**
- **Embed service line reporting and internal benchmarking in everyday practice**
- **Create surplus for re-investment in new models of care**

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
7. 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			ORR ref: 275, 522
8. Lack of capacity and resources not prioritised leading to non-delivery of key organisational priorities and objectives.	▪ DDs ▪ CDs	▪ C17, C18, C23, C33, C35,	▪ A1, A3, A4, A5, A42			
9. Lack of resources to support development and pump prime innovation to support delivery of plan	▪ DDs, CDs,	▪ C44, C54, C63,	▪ A5, A34, A35			
10. Failure to deliver level of transformational change required impacting on ability to deliver resources to support delivery of the annual plan.	▪ DSD ▪ DoF	▪ C17, C18, C30	▪ A1, A2, A4, A5, A35, A37			ORR ref: 463

Principal delivery objective 3 Workforce:

- **Development of workforce plan linked to service and financial objectives**
- **Development of values-based human resources management to enhance service quality**
- **Improve organisational performance through strong workforce engagement**

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
11. Staff and other key stakeholders not fully engaged in process around redesign of service offer as needed for change leading to lack of engagement and benefits not being realised through delivery of revised models and ability to deliver best possible outcome through changing clinical practice	▪ DDs	▪ C4, C7, C11, C12	▪ A1, A4, A39			
12. Lack of clear service model(s) to support a workforce plan to identify, recruit and retain suitably competent and qualified staff with relevant skills and experience	▪ DoH	▪ C1, C12, C29, C35, C67	▪ A1, A10, A20, A21, A22, A24, A47			ORR ref: 463

Principal risks (including potential risks)	Lead Director	Key controls (Systems/processes)	Assurance on controls (Planned outputs)	Board reports (inc. sub-committees, EMT)		
				Positive assurances	Gaps in control	Gaps in assurance
to deliver the service offer and meet national and local targets and standards.						
13. 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			
14. Failure to create and communicate a coherent articulation of Trust Mission, Vision and Values leading to inability to identify and deliver against strategic objectives.	▪ CE	▪ C31, C33, C44, C48, C49, C68	▪ A1, A7, A35, A42			
15. Failure to articulate leadership requirements to identify, harness and support talent to drive effective leadership and succession planning.	▪ DDs ▪ CDs ▪ AGD	▪ C26, C44, C65	▪ A3, A22, A35,			

Principal delivery objective 4 Estate

- **Development of community hubs to support service transformation and agile working in line with approved capital programme**
- **Develop, agree and implement programme for disposal of surplus estate linked to service transformation, including scoping of options for key hospital sites**
- **Development of master plan for Fieldhead underpinned by agreed capital schemes which optimise effective and efficient utilisation of the site**

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
16. Not having clearly defined service model(s) to enable estate to be reviewed and configured to support the transformation agenda.	▪ DoH ▪ DDs	▪ C1, C17, C32, C36, C37, C38	▪ A1, A4, A5, A6A18, A26, A27, A44			ORR ref: 463
17. Failure to dispose of capital assets in line with capital programme, leading to underfunding of capital programme.	▪ AGD	▪ C3, C17, C18, C36, C37, C38, C70	▪ A4, A5, A6, A8, A15, A16, A26			
18. Failure to deliver capital programme in line with timescales resulting in inability to transform and deliver services.	▪ AGD	▪ C3, C17, C18, C36, C37, C38, C70	▪ A4, A5, A6, A8, A15, A16, A26			
19. Failure of services to adopt agile working approaches, which could compromise the future estate model.	▪ AF ▪ DDs	▪ C3, C17, C18, C36, C37, C38, C70	▪ A4, A5, A6, A8, A15, A16, A26			

Principal delivery objective 5 IM&T

- **Implementation of agile working and communications technology to support efficiency and re-design of services**
- **Optimisation and integration of key clinical systems**
- **Performance framework in place, which supports service line management and reporting**

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
20. 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			ORR ref: 267, 270
21. Lack of suitable technology and infrastructure to support delivery of revised service offer leading to lack of support for services to deliver revised service offers.	▪ DoF	▪ C1, C17, C32, C39	▪ A1, A4, A5, A14, A26			
22. Failure to deliver new IT contract in line with IM&T Strategy, impacting on delivery of services.	▪ DoF	▪ C3, C39	▪ A54			

Principal delivery objective 6 Commissioning

- **Evidence 'value' to commissioners through the implementation of new currency models, which support service delivery**
- **Key partners in systems transformation programmes in all BDUs to safeguard quality in core services**
- **Commercial strategy for development of business**

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
23. Failure to understand and respond to changing market forces leading to loss of market share and possible de-commissioning of services.	▪ DSD ▪ DDs	▪ C1, C2, C3, C4, C32 ▪	▪ A4, A5, A40			
24. Failure to develop required relationships or commissioner support to develop new services/expand existing services leading to contracts being awarded to other providers.	▪ DoF ▪ DDs	▪ C1, C4, C5	▪ A1, A36, A40, A40			
25. Failure to respond to market forces and on-going development of new partnerships leading to loss of market	▪ DDs ▪ DoCD	▪ C1, C2, C3, C6, C30	▪ A26, A29, A40, A39			

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

Principal delivery objective 7 Partnerships

- **Partner with acute and community trusts within the Trust's area to increase collective ability to deliver integrated care, access Better Care Funds and enhance social and economic wellbeing**
- **Partner with the third sector to develop and deliver 'alternative service offers' increasing capacity, reducing costs and increasing quality**
- **Partner with existing and new partners to develop new business opportunities to create affordable, effective and efficient services, leveraging the resources and capabilities of all partners**

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
26. Lack of engagement and ownership to manage risk in the local economy impacting on available resources.	▪ DoC ▪ DDs	▪ C4, C5, C6, C7, C9	▪ A28, A29, A35, A39			
27. Failure to listen and respond to our service users and, as a consequence, service offer is not patient-centred, impacting on reputation and leading to loss of market share.	▪ DDs	▪ C7, C13, C15, C40, C42, C43	▪ A2, A20, A21, A29, A45, A51			
28. Risk of lack of stakeholder engagement needed to drive innovation resulting in key stakeholders not fully engaged in process around redesign of service offer.	• MD, • DoN, • DDs • DoCD,	▪ C11, C17, C18, C30, C32	• A1, A4, A35, A39			
29. Failure to deliver relationships with the third sector to delivery alternative community capacity leading to loss of market share and Trust inability to optimise business opportunities.	• DoCD	▪ C3, C6, C7, C11, C40, C59, C62	• A4, A39, A40			
30. Partners unclear of the intent and purpose of relationships leading to misunderstanding and conflict.	• DoF • DoCS • CE	▪ C4, C5, C9, C13, C28, C40, C59	• A4, A39, A40, A42			

Abbreviations:

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

Control (C...)	Key Control (systems/processes)
1.	Executive Management Team ensures alignment of developing strategies with Trust vision and strategic objectives.
2.	Production of market assessment against a number of frameworks including PESTEL/SWOT and threat of new entrants/substitution, partner/buyer power.
3.	Production of two-year operational plan and five-year strategic plan demonstrating ability to deliver agreed service specification and activity within contracted resource envelope or investment required to achieve service levels and mitigate risks.
4.	Formal contract negotiation meetings established with clinical commissioning groups and specialist commissioners underpinned by legal agreements to support strategic review of services.
5.	Development of joint QIPP plans with commissioners to improve quality and performance, reducing risk of decommissioning, change of provider
6.	Third Sector Strategy and action plan in place approved by Trust Board, promoting and developing key relationships
7.	Involving People Strategy and action plan in place approved by Trust Board, promoting and developing key relationships
8.	No longer used
9.	Care Pathways and personalisation Project Board established with CCG and Local Authority Partners
10.	No longer used
11.	Creative Minds Strategy and action plan in place approved by Trust Board, promoting different ways of working and partnership approach
12.	Partnership Boards established with staff side organisations to manage and facilitate necessary change
13.	Framework in place to ensure feedback from customers, both internal and external, including feedback loop, is collected, analysed and acted upon by through delivery of action plans through Local Action Groups
14.	No longer used
15.	Member Council engagement and involvement in working groups
16.	No longer used
17.	Director leads in place for transformation programme and key change management projects linked to corporate and personal objectives, with resources and deliverables identified.
18.	Project Boards for transformation workstreams established, with appropriate membership skills and competencies, PIDs, Project Plans, project governance, risk registers for key projects in place.
19.	Risk assessment and action plan for data quality assurance in place
20.	Risk assessment and action plan for delivery of CQUIN indicators in place.
21.	Cross-BDU performance meetings established to identify performance issues and learn from good practices in other areas
22.	Performance Management system in place, with KPI's covering national and local priorities
23.	Review of Quality Academy approach and implementation of recommendations
24.	Process in place for systematic use of benchmarking to identify areas for improvement and identifying CIP opportunities.
25.	Peer review and challenge processes in place i.e. Medium Secure Quality Network
26.	Values-based appraisal process in place and monitored through KPI
27.	Internal control processes in place to produce and review monthly budget reports and take mitigating actions as appropriate
28.	CCG/Provider performance monitoring regime of compliance with QIPP plan and CQUIN targets in place.
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
30.	Project management office in place led at Deputy Director level with competencies and skills to support the Trust to make best use of its capacity and resources and to take advantage of business opportunities
31.	Further round of Middleground developed, delivered and evaluated linked to organisational and individual resilience to support staff prepare for change and transition and to support new ways of working
32.	BDU revised service offer through the transformation programme, with workstreams and resources in place, overseen by project boards and EMT
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

Control (C...)	Key Control (systems/processes)
34.	Medical Leadership Programme in place with external facilitation.
35.	Workforce plans in place identifying staffing resources required to meet current and revised service offers and meeting statutory requirements re training, equality and diversity.
36.	Estates plan includes outcome of six facet surveys undertaken to identify possible infrastructure and services risks, linked to forward capital programme.
37.	Estates Forum in place with defined Terms of Reference chaired by a NED
38.	Estate TAG in place ensuring alignment of Trust strategic direction, with estates strategy and capital plan
39.	IM&T strategy in place
40.	Public engagement and consultation events gaining insight and feedback, including identification of themes and reporting on how feedback been used.
41.	Weekly serious incident summaries (incident reporting system) to EMT supported by quarterly and annual reports to EMT, Clinical Governance and Clinical Safety Committee and Trust Board
42.	Staff wellbeing survey conducted, with facilitated group forums to review results and produce action plans
43.	Complaints policy and complaints protocol covering integrated teams in place.
44.	OD Framework and plan in place
45.	New leadership and management arrangements established at BDU and service line level with key focus on clinical engagement and delivery of services
46.	Facilitated engagement of clinicians in TAGs
47.	No longer used
48.	Values-based Trust induction policy in place covering mission, vision, values, key policies and procedures.
49.	Communication Strategy in place
50.	Risk Management Strategy in place facilitating a culture of horizon scanning, risk mitigation and learning lessons supported through appropriate training
51.	Audit of compliance with policies and procedures co-ordinated through clinical governance team.
52.	Annual Business planning guidance issued standardising process and ensuring consistency of approach
53.	Standing Orders, Standing Financial Systems, scheme of Delegation and Trust Constitution in place and publicised re staff responsibilities
54.	Standardised process in place for producing businesses cases and benefits realisation cards.
55.	Policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval.
56.	No longer used
57.	No longer used
58.	A set of leadership competencies developed as part of Leadership and Management Development Plan supported by coherent and consistent leadership development programme
59.	Member of local partnership boards, building relationships, ensuring transparency of agenda's and risks, facilitating joint working, cohesion of policies and strategies
60.	Staff excellence award schemes in place to encourage and recognise best practice and innovation.
61.	Fostering links to Jonkoping in Sweden as part of on-going development of Quality Academy Approach and learning from best practice.
62.	Investment Appraisal framework including ensuring both a financial and social return on investment providing clarity of approach
63.	Innovation fund established to pump prime investment to deliver service change and innovation
64.	Leadership and Management Development Plan in place covering development framework, talent management and succession planning.
65.	Secondment policy and procedure in place
66.	Board strategic development sessions setting overarching strategy and strategic direction scheduled
67.	Mandatory Training Review Group in place ensuring mandatory training policy and programme linked to delivery of statutory requirements and delivery of corporate objectives.
68.	Achievement of financial targets
69.	Achieve of targets and indicators mandated by Monitor
70.	Approval by Trust Board of business cases for capital developments during 2014/15 and for planned disposals during 2014/15
71.	Continued compliance with CQC registration and Monitor Licence conditions
72.	Deliver year of values programme
73.	Review Scheme of Delegation
74.	Monthly review by EMT of stakeholder and partnership position through rich picture and risk assessment

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.	➢
2.	Production of Patient Experience quantitative and qualitative reports, triangulating themes, 'you said, we did' to Trust Board and Members' Council.	➢
3.	Annual appraisal, objective setting and PDPs to be completed in Q1 of financial year for staff in Bands 6 and above and in Q2 for all other staff, performance managed by EMT.	➢
4.	Transformation plans monitored and scrutinised through EMT ensuring co-ordination across directorates, identification of and mitigation of risks.	➢
5.	Business cases for expansion/change of services approved by EMT and/or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework.	➢
6.	Performance management of estates schemes against resources through Estates TAG, deviations identified and remedial plans requested.	➢
7.	Trust Board Strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives.	➢
8.	Quarterly quality/integrated compliance reports to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	➢
9.	Quarterly Monitor exception report to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken, which includes confirmation that the Trust complies with the conditions of its Licence and, where it does/may not, the risk and mitigating action.	➢
10.	Quarterly Assurance Framework and Risk Register report to Board providing assurances on actions being taken. Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	➢
11.	Assurance reports to Clinical Governance and Clinical Safety Committee covering key areas of risk in the organisation seeking assurance on robustness of systems and processes in place.	➢
12.	Annual Governance Statement reviewed and approved by Audit Committee and Trust Board and externally audited.	➢
13.	Monitor Risk Assessment Framework assurance group review performance before Trust Board on quarterly basis ensuring all exceptions identified and reported to Trust Board and Monitor.	➢
14.	Information Goverance Toolkit provides assurance and evidence that systems and processes in place at the applicable level, reported through IM&T TAG, deviations identified and remedial plans requested receive, performance monitored against plans.	➢
15.	Monthly review and monitoring of performance reports through Delivery EMT deviations identified and remedial plans requested.	➢
16.	Monthly review and monitoring of integrated and quality performance reports by Trust Board with exception reports requested around risk areas.	➢
17.	Annual report to Trust Board to risk assess changes in compliance requirements	➢

Assurance (A..)	Assurance on controls (Planned outputs)	Board reports received (including sub-committees, EMT)
	and achievement of performance targets.	
18.	Independent PLACE audits undertaken and results and actions to be taken reported to EMT, Members' Council and Trust Board.	➢
19.	CQC registration in place and assurance provided that Trust complies with its registration	➢
20.	Announced and unannounced inspection visits undertaken by CQC, independent reports on visits provided to the Trust Board.	➢
21.	Planned internal visits to support staff and ensure compliance with CQC standards through the delivery of supported action plans.	➢
22.	Remuneration Terms of Service Committee receive HR Performance Reports, monitor compliance against plans and receive assurance from reports around staff development, workforce resilience.	➢
23.	Audit Committee review evidence for compliance with policies, process, standing orders, standing financial instructions, scheme of delegation, mitigation of risk, best use of resources.	➢
24.	Independent CQC reports to Mental Health Act Committee providing assurance on compliance with Mental Health Act.	➢
25.	External accreditation against IIP GOLD supported by internal assessors, ensuring consistency of approach in the support of staff development and links with organisational objectives.	
26.	Annual plan and budget, two-year operational plan and five-year strategic plan approved by Trust Board, externally scrutinised and challenged by Monitor.	➢
27.	Health and Safety TAG monitor performance against plans deviations identified and remedial plans requested.	➢
28.	Staff opinion and wellbeing survey results reported to Trust Board and action plans produced as applicable.	➢
29.	Service user survey results reported annually to Trust Board and action plans produced as applicable.	➢
30.	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and director leads to provide assurance against annual plan	➢
31.	External and internal audit reports to Audit Committee setting out level of assurance received.	➢
32.	External and internal audit reports performance managed through EMT.	➢
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.	➢
34.	Innovation fund allocation approved through EMT with guidance to ensure consistency of approach and alignment with strategic priorities and corporate objectives.	➢
35.	Monitoring of organisational development plan through Chief Executive-led group, deviations identified and remedial plans requested.	➢
36.	QIPP performance monitored through delivery EMT, deviations identified and remedial plans requested.	➢
37.	Sustainability action plans monitored through Sustainability TAG, deviations identified and remedial plans requested.	➢

Assurance (A..)	Assurance on controls (Planned outputs)	Board reports received (including sub-committees, EMT)
38.	No longer applicable	
39.	Strategic overview of partnerships and growth in line with Trust vision and objectives provided through EMT and Trust Board.	➢
40.	Market analysis reviewed through EMT, market assessment to Trust Board ensuring identification of opportunities and threats.	➢
41.	Production of Corporate Governance Statement to support submission of Trust plans, setting out evidence of compliance/assurance against the statements reviewed by Trust Board	➢
42.	Rolling programme of staff, stakeholder and service user/carer engagement and consultation events	➢
43.	Data quality Improvement plan monitored through EMT deviations identified and remedial plans requested.	➢
44.	Estates Forum monitors delivery against 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.	➢
46.	Serious Incidents from across the organisation 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.	➢
47.	Mandatory training review group in place ensuring consistency of approach across Trust and compliance with legislation.	➢
48.	Assurances received by Committees of Trust Board reported quarterly to Trust Board, providing assurance on systems and controls in place and operating.	➢
49.	Medium secure quality network undertake annual peer reviews providing external assurance on systems and controls in place and operating.	
50.	Independent Hospital Managers review detentions providing external assurances of compliance with MH Act.	
51.	HealthWatch undertake unannounced visits to services providing external assurance on standards and quality of care.	➢
52.	Medical staff appraisal and revalidation in place evidenced through annual report to Trust Board and supported through Appraisers forum.	➢
53.	Chief Executive-led Operational Requirement Group established to drive delivery of two-year operational plan.	➢
54.	Operational delivery plan to ensure IM&T Strategy is implemented within timescales and within resource enveloped monitored through IM&T TAG, EMT and IM&T Forum	➢

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

ORGANISATIONAL LEVEL RISK REPORT

DATE: 22 July 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 example, 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	Forensic BDU				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

	Risk assessment	Corporate/ organisation level risk (corporate use only EMT)	Specialist services BDU	Specialist services BDU			Risk that the scale of transformation required for children's and adolescents' mental health services is significantly beyond what could be considered reasonable in terms of routine transformation from one service delivery model to another following a change of provider within existing resources and as set out in the Trust's original tender for the service. The Trust is also at risk from a reputational perspective whilst it implements a robust and detailed recovery plan.	A robust action plan is in place with a recovery Plan to address immediate concerns. A change management plan is in place to align the service to the requirements of the service specification. A longer-term transformation plan has also been developed.	4 Major	3 possible	12		➢ The implementation of the recovery has been devised in line with best practice and compliance requirements. ➢ Strict time scales are in place for delivery and it will be monitored at EMT and BDU level. ➢ External review commissioned to report by end of August 2014. ➢ Communication and briefings to be arranged for meetings with MPs. ➢ Round table meeting with local authorities and CCGs to be arranged. ➢ Workshop with staff to review progress to be organised facilitated by Ken Tooze. ➢ Communication from Chief Executive to CAMHS staff of Trust position, action Trust is taking to address issues, agreement of action and next steps. ➢ Review of action plan at EMT on 31 July 2014. ➢ P&I to review data issues and IT telecomms issues by end of July 2014. ➢ Senior staff support identified and Chief Executive visit during August programme of service visits. ➢ 'Right first time' training for front-line staff.									Trust Board July 2014