With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board (business and risk – public session)
Tuesday 21 October 2014 at 9:00
Small conference room, Learning and Development Centre, Fieldhead, Wakefield, WF1 3SP

AGENDA

1. Welcome, introduction and apologies

2. Declaration of interests

3. Minutes and matters arising from previous Trust Board meeting held on 23 September 2014

4. Chair and Chief Executive's remarks (verbal item)

5. Performance reports month 6 2014/15

5.1 Quality performance report month 6 2014/15 (to follow)

5.2 Assurance on financial reporting

5.3 Customer services/patient experience report quarter 2 2014/15

5.4 Exception reporting and action plans

(i) Equality Delivery System

(ii) Quality Academy review and action plan

6. Governance

6.1 Members' Council evaluation

6.2 Changes to the Trust's Constitution

6.3 Audit Committee assurance on staff register of interests

7. Implementing the Estates Strategy

8. Monitor quarterly return quarter 2 2014/15

9. Assurance framework and risk register

10. Date and time of next meeting

The next meeting of Trust Board will be held on Tuesday 16 December 2014 in the Boardroom, Kendray, Doncaster Road, Barnsley.

Minutes of Trust Board meeting held on 23 September 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
Apologies:	Julie Fox	Non-Executive Director
In attendance:	Adrian Berry	Director of Forensic Services
	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)
Guests:	Bob Mortimer	Governor, publicly elected, Kirklees

TB/14/50 Welcome, introduction and apologies (agenda item 1)

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

IB began by noting that this was Nisreen Booya's (NHB) last Trust Board meeting. He thanked NHB for her significant contribution during a time of considerable challenge and change. He went on to say that there had been a robust interview process for the post of Medical Director involving service users, directors and staff over two days. The involvement of both a service user and the Chief Executive of another Trust at the final interview for all five candidates was especially useful and he was pleased to confirm the appointment of Adrian Berry (ABe) as Medical Director from 1 October 2014.

TB/14/51 Declaration of interests (agenda item 2)

There were no declarations over and above those made in March 2014 and at subsequent meetings.

TB/14/52 Minutes of and matters arising from the Trust Board meeting held on 22 July 2014 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held on 22 July 2014 as a true and accurate record of the meeting. There were no matters arising.

Nisreen Booya joined the meeting

TB/14/53 Assurance from Trust Board Committees (agenda item 4)

TB/14/53a Audit Committee 8 July 2014 (agenda item 4.1)

Peter Aspinall (PA) commented that the item on staff declarations of interests had been deferred to the October meeting. He also commented on the 'training' item, which arose from the Committee self-assessment earlier in the year. KPMG and Deloitte, as the Trust's

internal and external auditors, have been asked to put together a series of sessions around Audit Committee effectiveness, transformation, key issues and priorities in relation to the Committee's responsibilities, and triangulation between financial numbers and activity. Piers Ricketts from KPMG will facilitate a session on characteristics of a successful transformation at the next meeting on 7 October 2014 and there is an open invitation to Trust Board members to attend.

PA also commented on the IM&T Forum the previous day. The Forum received a paper on ongoing investment plans to support transformation and change. The Forum continues to seek assurance that IT is a partnership eliminating the view that IT is developed in isolation, takes note of user feedback and provides added value for patients and service users and service development. Steven Michael (SM) commented that identifying capital that can be invested linked to transformation represents a prudent approach, which meets the Trust's needs. Jonathan Jones (JJ) added that this is as much a cultural journey as an IT journey, particularly around winning hearts and minds to ensure the benefits of technology are harnessed. Alan Davis (AGD) added that the IT plan links strongly to the Estates Strategy and the development of agile working.

TB/14/53b Clinical Governance and Clinical Safety Committee 17 September 2014 (agenda item 4.2)

Helen Wollaston (HW) highlighted the following.

- A key item for the Committee was the recovery plan for child and adolescent mental health services (CAMHS).
- A detailed response to staff following the Francis workshops was presented to the Committee. It was agreed that IB and HW would sign-off a concise summary letter on behalf of Trust Board, including a reminder of how to raise concerns and signposting the detailed response.
- The Committee received an update on unplanned visits, which very much take the middle ground in terms of assessment. The Committee was keen to see examples of excellent and outstanding services where appropriate, whilst accepting there will always be areas for development even when excellent practice is identified. She also encouraged Trust Board members to participate in the visits. SM commented that the Care Quality Commission (CQC) will come to a view on a rating and, therefore, the Trust needs to be prepared for this. Current ratings represent a cautious approach but there are areas of excellent and outstanding services within the Trust.

SM also commented on CAMHS and the following points were made.

- There is active dialogue with commissioners in Calderdale and Kirklees on the position and the recovery plan. Commissioners acknowledge that the recovery plan is having an effect.
- SM attended an engagement and listening event with staff the previous day, which was much in line with Trust values with an open and candid discussion.
- The report from the independent review was excellent and has produced a set of recommendations and observations that will be shared with staff. The Trust has asked the reviewers to return in six months to assess the action taken.
- IB encouraged Trust Board to attend the Insight evening events on CAMHS in each BDU area.
- AGD also commented on the correlation between areas with service issues and levels of sickness absence, which is demonstrated in CAMHS in Calderdale and Kirklees. Addressing underlying issues are a key part of the recovery plan.
- SM has asked for areas that can be fast-tracked in the recovery plan to be expedited as a matter of urgency.

- He also commented that, in terms of commissioning, there are gaps in the service and, as a Board, Directors need to be aware of where these are. The independent review was to have compared the service in Calderdale and Kirklees with that in Wakefield; however, a comparison was difficult due to the differences in the level of investment.
- He added that the Trust must learn from the due diligence experience. Alex Farrell (AF) concurred and added that a key area for due diligence in the future would be to seek the views of the people who use services.
- Tim Breedon (TB) reminded Trust Board why the Trust bid for the services in the first place. A Trust-wide footprint minimises the risk in the transition between child and adult services and enables the Trust to demonstrate to commissioners where investment is needed to strengthen services.

TB/14/53c Mental Health Act Committee 5 August 2014 (agenda item 4.3)
On behalf of Julie Fox, TB raised the following.

- The impact of the Cheshire West judgement regarding the admission of informal patients may increase the numbers of individuals detained, which will be monitored closely.
- There has been an improvement in data quality and the information presented to the Committee.
- There will be a detailed summary of local approaches to the Mental Health Crisis Concordat and use of Section 136 suites at the next meeting of the Committee. SM commented that the Better Care Fund is charged with reducing emergency admissions by 3.5%. There could be an emerging crisis with the emergency mental health pathway and there is, therefore, a need for parity of esteem in national and local plans.

TB/14/53d Remuneration and Terms of Service Committee 14 July 2014 (agenda item 4.4)
IB commented on:

- the appointment of an interim Commercial Manager for a three-month period prior to a full recruitment exercise commencing September 2014;
- the continued detailed scrutiny of the human resources performance report by the Committee; and
- approval of Directors' performance related pay scheme for 2014/15.

In relation to the off-payroll item, PA asked whether there was a risk of which Trust Board should be aware. Dawn Stephenson (DS) responded that the Trust is required to report in its annual report and accounts on off-payroll arrangements. The report to the Committee provided assurance that the Trust is adhering to HM Treasury requirements and action is in place to address any gaps or areas of weakness.

TB/14/54 Chief Executive's remarks (agenda item 5)

Under his remarks, SM raised the following.

- The meeting with Monitor on the Trust's quarter 1 return and five-year strategic plan was positive and Monitor was supportive of the Trust's plans given the current uncertainty and challenge. Feedback confirmed level 4 and a green governance rating.
- The Dalton review (Hospital Change Review) provides a focus on potential provider configurations and models. The work to date confirms that the Trust approach represents a good response to future sustainability.
- The Health Service Journal (HSJ) commissioning summit.
- The different approaches locally towards the Better Care Fund, which represents a potential risk in terms of Trust services included in local bids and uncertainty of the detail of some plans.
- Trust and staff recognition is a priority for the Chair and Chief Executive this year to celebrate and recognise the Trust and its staff. SM highlighted a number of areas where

staff have been recognised. This included the Trust's inclusion in the HSJ top NHS organisations in which to work. The Trust appears in the top 100 (out of 371 organisations) and it is clear from the list that the Trusts in the 'top ten' publicise, promote and market themselves. The Trust needs to do more of this.

AGD was asked to update on potential industrial action by health unions, which have announced the intention to ballot members on industrial action in response to the national pay agreement (with the exception of the BMA and Royal College of Nursing). UNISON members have voted in favour of strike action; however, it was noted that the turnout was very low at 14%. The impact on Trust services is not clear. Other unions are currently balloting members. No date has yet been set for the action and the Trust will receive a minimum seven days' notice. Contingency plans will be in place for services and risk assessments undertaken. Dialogue with staff side continues and the priority is to protect patient care. SM commented that the Trust could be faced with the scenario that services are left unsafe. AGD responded that the Trust will work with staff side locally to ensure services would not be left in an unsafe position. AGD was asked to inform Trust Board if any urgent risks emerge and provide an update to the Remuneration and Terms of Service Committee on 14 October 2014.

TB/14/55 Appointment of Responsible Officer (agenda item 6)

It was RESOLVED to APPROVE the change in Responsible Officer for the Trust from 1 October 2014 and for Barnsley Hospice until 15 January 2015 from Nisreen Booya to Adrian Berry.

JJ asked about the plans to replace ABe as Director of Forensic Services. ABe responded that the detail has to be agreed. The Medical Director role precludes operational responsibility for a service. He will still maintain an externally focussed strategic involvement role in forensic services to utilise knowledge and expertise; however, operational responsibility has still to be agreed. Additional capacity is in place in the interim to ensure BDU Director level management and clinical lead responsibilities are covered. An update will be provided to Trust Board in October 2014 and in SM's report to the Remuneration and Terms of Service Committee. SM confirmed that ABe would retain responsibility until arrangements are confirmed. NHB added that very few organisations have such a seamless transfer from one Medical Director to another. She commented that it is essential that ABe retains his national and regional portfolio at a strategic level.

TB/14/56 Performance reports month 5 2014/15 (agenda item 7)

TB/14/56a Performance report (agenda item 7.1)

Three areas were highlighted.

1. Data quality and mental health currency

TB commented that there is an improving trajectory in this area due to two key developments, namely the establishment of a Director-led data quality group with a clinical focus, and payment by results data. There are also a number of areas for close monitoring in terms of training and he assured Trust Board that action is in place to address these.

2. Movement in the financial position

AF commented that, in month 4, the year-to-date position was a slight overspend as the re-valuation of land at Aberford Field had not materialised, which masked the £1.4 million underspend on pay. The month 5 year-to-date position is a £2.1 million underspend as the re-valuation has occurred and the full underspend on pay is visible. There is a £1.8 million underspend in pay (against an underspend of £1.4 million in month 4). The Executive

Management Team (EMT) has agreed it needs be assured that vacancies have no adverse impact on services and will feedback to Trust Board in October 2014.

The forecast is improving within operational BDU budgets and less provision is required to manage this position moving from £1.5 million in month 4 to £637,000 in month 5. The net surplus position, which is £1.8 million above plan, will reduce to the forecast position due to phasing of cost improvements and the erosion of the current underspend.

The overall forecast on the cost improvement programme is a shortfall of £782,000 as schemes planned for later in the year are not yet finalised, particularly for management of pay (mandatory training headroom), medical staffing and shift patterns. Substitutions of £2.1 million, both recurrent and non-recurrent, have been identified and a final position will be presented to Trust Board at the month 6 point in October 2014.

SM commented that the operational requirement group and EMT continue to review the 'RAG' rating of the cost savings and there will be a review of the position by Deloitte in October 2014.

AGD confirmed that revised shift patterns 'go live' on 13 October 2014. Consultation with staff is complete although there is a small number of staff in a formal process for re-deployment.

The following comments were made in the subsequent discussion.

- JJ commented that the position appears to be broadly on plan. For the review in October, he would like to see that EMT is broadly confident and comfortable with the plan to March 2015 and beyond. SM responded that the transformation of services plays a key role in the Trust's sustainability and the mental health summit on 16 October 2014 will translate the vision to operational implementation taking the programme through to 2015/16. Provision has also been made for safer staffing pressures, particularly around Calderdale crisis services, Bretton Centre and a peripatetic nursing team.
- JJ commented that he would like to see examples of what has been achieved in terms of efficiency and transformational savings in October's report.
- PA commented on the complexity of the task for this year, which the Trust will need to do again next year. Deloitte will report on the Trust's position and the implications.
- In relation the vacancy factor, HW asked whether the Trust is just not recruiting to vacant posts without the quality impact assessment other cost savings have been subjected to. AF responded that the movement in forecast is due to a detailed analysis of the vacancy position to provide a realistic assessment of vacancies and the impact on pay. She also commented that there is a weekly review of vacancies, chaired by Karen Taylor, to ensure essential posts are filled quickly.
- Laurence Campbell (LC) commented that the change in shift patterns represents a big move for the Trust, particularly if done all at once, and asked whether this will form a 'big bang' or be piloted in one or two areas. AGD confirmed that the majority of staff will move to twelve-hour shifts. Issues for staff were identified in the quality impact assessment and the impact on staff of twelve-hour shifts already operational in other parts of the Trust reviewed. The ongoing impact on staff will be monitored closely. TB commented that part of the quality impact assessment looked at areas where twelve-hour shifts had already been implemented. There are conflicting views nationally on the impact on staff and this will be monitored both in the short- and longer-term in terms of the impact on staff and services.
- IB asked how Trust Board can seek assurance that controls and governance are in place to ensure 'surprises' such as those making headlines do not happen at this Trust. He would like to see an explicit explanation of how Trust Board receives such assurance and suggested that the Audit Committee looks at this. JJ commented that he is happy

that structures are in place and he would expect internal and external audit to identify any concerns or risks. SM commented that the original due diligence in the Foundation Trust application required the Trust to improve its financial and non-financial reporting, which has led to detailed and transparent reporting to Trust Board. He suggested that the Company Secretary undertakes an historical review of the consistency of financial reporting linked to operational reporting to Trust Board. Trust Board agreed this should be taken through the Audit Committee in October with feedback to Trust Board later in the month. IB suggested that one outcome may be to bring the Trust's governance review forward. HW commented that a review of governance in charitable funds may also be useful to give Trust Board assurance on the checks and balances, and governance processes in place.

3. Workforce metrics

AGD commented on sickness and highlighted two areas of concern, Calderdale and Kirklees CAMHS, which is part of the recovery plan, and low secure services. Performance against the appraisal target is not meeting the original target set of 90% of staff in bands 6 and above to have appraisals in quarter 1 and 90% of staff in bands 5 and below in quarter 2. However, the Trust is meeting the national benchmark and a further report will be presented to the Remuneration and Terms of Service Committee.

TB/14/56b Exception reports and action plans – Quarterly serious incidents report (agenda item 7.2(i))

TB commented on the following.

- There is a slightly increasing trend, which is indicative of a positive reporting culture.
- The Clinical Governance and Clinical Safety Committee received a detailed report on the tissue viability service in Barnsley at its September meeting, including high and local level action plans in place to address issues.
- There has been an increase in the number of suspected suicides; however, no trend has been identified following review and analysis by the AMD for Patient Safety. The Clinical Reference Group will examine trends and broader issues regarding patient safety and the outcome will be presented to the Committee in November 2014. The AMD for Patient Safety will also make a presentation to the Committee.
- A draft report on the outcome of the independent investigation has been received for a factual accuracy check. A date for receipt of the final report for presentation to Trust Board is awaited from Veritas.

It was RESOLVED to NOTE the report.

TB/14/56c Exception reports and action plans – Francis workshops – Trust Board response (agenda item 7.2(ii))

This item was covered under agenda item 4.2.

TB/14/56d Exception reports and action plans – NHS Constitution (agenda item 7.2(iii))

DS introduced this item and commented that it might be useful in future to include detail on the Trust's website both in terms of how the Trust meets its responsibilities but also to highlight the rights and responsibilities of staff and service users.

In response to a query from LC, TB commented that there are certain criteria the Trust has to meet in terms of mixed sex accommodation. A declaration is made by Trust Board each year that it meets the requirements and he assured LC that the Trust meets these currently.

It was RESOLVED to APPROVE the paper, which demonstrates how the Trust is meeting the requirements of the NHS Constitution.

TB/14/56e Exception reports and action plans – Care Quality Commission fit and proper person's test (agenda item 7.2(iv))
Trust Board noted that this will form part of the annual declaration of interests exercise in future. **It was RESOLVED to NOTE the CQC's fit and proper person's requirement and to APPROVE the proposal to undertake a retrospective declaration for Trust Board, agreeing this should be part of the annual exercise for reporting to Trust Board in March 2015.**

TB/14/56f Exception reports and action plans – Building a Trust health intelligence resource to support transformation and decision-making (agenda item 7.2(v))
Diane Smith (DSm) introduced this paper. PA asked how the Trust will measure 'success'. DSm responded that this would involve triangulation of information the Trust already has and ensuring the information is applied to support BDUs provide and improve services to the benefit of patients.

IB asked for a follow up report in six months to Trust Board to demonstrate how this has been developed and to demonstrate the benefits to the Trust.

LC asked if resource was available and DSm responded that this has still to be clarified with the Chief Executive. SM added that key is to harness talent that already exists within the organisation through matrix working. He also commented that the Trust spends a deal of time satisfying policy, commissioning and regulatory requirements; however, it needs to also apply intelligence for its own benefit and to improve services.

It was RESOLVED to NOTE the report and to RECEIVE an update report in six months.

TB/14/57 Implementing the Estates Strategy (agenda item 8)

TB/14/57a Barnsley hub – New Street business case (agenda item 8.1)
AGD introduced this item. LC asked whether there is a risk that the transformation agenda will threaten hub development. AGD responded that the community hub structure supports transformation to move delivery of services closer to the communities the Trust serves and improve the productivity of staff, which is vital to transformation. IB suggested a review of how hubs are working in twelve months. AGD responded that there is a formal process of review for each capital development at the twelve-month point and IB suggested that this could inform a review of hubs collectively for Trust Board in October 2015.

AF commented on three areas that require further work before implementation in relation to the disposal of Queen's Road, the movement of staff and agile working assumptions.

AGD confirmed that the refurbishment would take place in this financial year.

It was RESOLVED to APPROVE the business case to refurbish the New Street Health Centre.

TB/14/58 Charitable funds annual report and accounts 2013/14 (agenda item 9)

It was RESOLVED to APPROVE the annual report and accounts for charitable funds 2013/14.

TB/14/59 Use of Trust seal (agenda item 10)

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

TB/14/60 Date and time of next meeting (agenda item 11)

The next meeting of Trust Board will be held on Tuesday 21 October 2014 in the small conference room, Learning and Development Centre, Fieldhead, Wakefield.

Signed …… Date ……

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Quality Performance Report

Strategic Overview

September 2014

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Introduction

Dear Board Member/Reader

Welcome to the Trust's Quality Performance Report: Strategic Overview for September 2014/Quarter 2 information unless stated.

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.

The quality performance strategic overview report is a key tool to provide assurance to the Board that the strategic objectives are being delivered and to direct the Board's attention to significant risks, issues and exceptions.

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

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

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

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

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

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.

Quality Priority	Key Performance Indicators	Target	Reporting Period	Q1			Q2			Q3			Q4			Year End Position
				A	M	J	J	A	S	O	N	D	J	F	M	@ Q4/ Month 12
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%			87%									
	% of people in CAMHs service rating care as excellent or good.	70%	Quarterly commencing Q3													
	% of people in Long Term Conditions who are extremely likely/likely to recommend the service to their Friends & Family	90%	Bi annually	97%												
	Implementation of elements of Triangle of care across inpatient services	100%	Annual													
	ü Mental Health Services	80%	From Q3													
	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	83.70%			81.52%									
	Improving access for people experiencing non-acute mental health problems (routine) ; face to face contact within 14 days of referral (B)		Quarterly	57.94%			63.57%									
	Improving access to assessment & treatment for children and young people requiring assessment and diagnosis for autism / ADHD (Wakefield Services)		Quarterly													
	Reduce the number of people on the waiting list for ASD pathway in Calderdale & Kirklees		Quarterly				116									
	CAMHs Barnsley: Patients seen within 5 weeks of initial referral	100%	Quarterly	14%			4%									
	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													
Quality priority 3: Continue to improve care, care planning & evaluation of care.	% people offered a copy of their care plan	85%	Monthly	81.71%	81.98%	82.29%	82.49%	82.25%	82.20%							
	Mental Health currency development: Adherence to cluster reviews	90%	Monthly	72.76%	72.63%	73.26%	72.58%	71.68%	71.68%							
	Mental Health currency development: % of eligible cases assigned a cluster	100%	Monthly	95.34%	95.69%	95.87%	95.98%	95.99%	95.92%							
	Increase the number of clinical audits that have actions implemented/ demonstrate outcomes	From Q3 5% increase Q$ further 5% increase	Quarterly				Benchmark 28%									
	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 quality forum	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	90.8%	99.1%	81.7%	99.5%	100.0%	100%							
	% of people with ethnicity cases completed	99%	Monthly	-	-	-	93.7%	84.9%	94.8%							
	Implementation of actions in BDU data quality action plans	Evidence of activity against data quality action plan	Quarterly – Barnsley (CS)				Due 27.10.14									
			Barnsley (MH)				Due 27.10.14									
			Calderdale													
			Forensics				Due 27.10.14									
			Kirklees				Due 27.10.14									
			Wakefield				Due 27.10.14									
Continue to improve transfers of care by working in partnership across the care pathway	Delayed transfers of Care (DTOC)	<=7.5	Monthly	3.32%	4.18%	4.49%	3.82%	3.66%								
	Participation in and implementation of recommendations from of intermediate care pathways	Audit to remain on track	Quarterly	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	4.7	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:	80%	Quarterly (Q1,2,4)	62%			56%									
	2. Our services to friends and family	80%	Quarterly (Q1,2,4)	70%			65%									
	Monitor of mandatory training figures for Equality & Diversity training	80%	Quarterly	63%			70>2%									
To improve the safety of our service users, carers, staff and visitors	Implementation of MH safety thermometer (Establish systems and processes)		Monthly													
	Pressure Ulcer reporting in inpatient units in Barnsley BDU	Q1- system, Q2 baseline and trajectories, Q3&Q4 TBD	Quarterly				Due 7.11.14									
	Infection rates of MRSA bacteraemia	0	Quarterly	0			0									
	Infection rates of C Diff	<=8	Quarterly	0			2									
	Effective response to incidents – adherence to policy timescales (5% increase in people responding within timescales by end of Q4)	Q1 Scope, Q2 Plan, Q3 implement, Q4 Evaluate	Quarterly				58%									
	Reduction in the number of medication errors entered in the 'other' category. (5% reduction by end of Q4)															

Quality Headlines

CAMHS external review

The commissioned external review of CAMHs services has been completed. The process occurred during one week in August and a return visit is planned in 6 months time. The review has provided assurance that SWYPFT has identified the critical issues and put in place effective remediation action. There was positive feedback in respect of the Wakefield CAMHs services which are being used as the model for other CAMHS services going forward. The review has provided some helpful suggestions to incorporate within the action plan as well as recommendations for commissioners.

The Clinical Governance and Clinical Safety Committee continue to monitor progress against the action plan.

Safer staffing

From June 2014 all Trusts have had to publish detailed information about nurse staffing levels and specifically where there is a shortfall between planned and actual staffing levels. In addition, all wards must display the information publically on a shift by shift basis so service users and carers can see them. SWYPFT is committed to using the best available evidence to support setting safe and effective staffing levels. Where levels drop below planned levels there is escalation via management reporting systems and DATIX web incident reporting. Work continues to improve our understanding of how we have arrived at the current staffing levels as well as seeking to confirm that they continue to be safe and effective. In order to ensure that we are able to respond sufficiently to the outcome of our internal staffing level reviews the trust has made a financial provision of £250,000 to support work in this area.

12 hour shifts and headroom

The Trust is introducing changes to in-patient shift patterns across all BDU areas. There have been several joint BDU and Quality Academy Quality Impact Assessment review meetings to explore critical issues and identify mitigating action prior to implementation. Issues addressed include: clarity between 'handover' and 'overlap' with protection of vital quality and safety functions identified within both; maintaining an appropriate balance of non-qualified to qualified staff; ensuring that level of acuity pressures on staffing does not leave service users vulnerable in terms of their safety and welfare; recognising and addressing physical and emotional demands on staff. The changes take effect during October and the impact will be monitored.

Service user survey results

The 2014 national (CQC) community mental health survey results have now been received. The survey questionnaire was substantially redeveloped and updated in order to reflect changes in policy, best practice and patterns of service. Therefore the results are not directly comparable with those from previous surveys. The response rate for the Trust was 28% similar to the national response rate of 29%. Across all 9 survey sections SWYPFT scores were 'about the same' as other Trusts with a rating closest to the top 20% in the 'overall' section. The SWYPFT score for the section 'reviewing your care' fell closest to a bottom 20% rating. Results triangulate well with CQUIN survey findings particularly relating to higher scores around engagement, being listened to and treated with respect and dignity. The survey findings were discussed at the Trust-wide Patient Experience Group on 3rd September. Recommendations for continued action include: continued progress of work being led by the MH PbR team in ensuring good practice on annual reviews in line with clusters with focus on people on standard care; organisational agreement on the medical care plan ensuring service users are provided with a copy; measuring changes in care reviewing via record keeping audit; each BDU to review their offer in regard to 'other areas of life' to see if there is improvement to be made for people getting the help and support they would like.

T**he NHS Staff Family and Friends Test** data for quarter 1 has been published on the NHS England and NHS Choices websites.

Nationally an average of 62% of staff would recommend their organisation as a place to work, 76% would recommend their organisation as a place to receive care and treatment. The Trust's quarter one results were 62% recommend as place to work, 70% recommend as a place to receive care and treatment. These results were obtained through the Trust's Wellbeing at Work Survey. Local NHS Trust's results:Bradford District Care Trust, 48% average recommend as place to work, 62% recommend for care and treatment,Humber NHS FT, 50% average recommend as place to work, 71% recommend for care and treatment,Leeds Community Health Care, 47% average recommend as place to work, 81% recommend for care and treatment,Leeds and York Partnership FT, 49% average recommend as place to work, 62% recommend for care and treatment,RDASH, 62% average recommend as place to work, 71% recommend for care and treatment, Sheffield Health and Social Care, 69% average recommend as place to work, 74% recommend for care and treatment.

The narrative comments will be thematically analysed for the Well- Being at Work Group, who will lead and over see necessary improvement activity.

Quality Headlines cont….

Quality Impact Assessment in transformation programme

Quality Academy personnel are working with the transformation programme leads to ensure that Quality Impact Assessment is an integral component of the transformation work. The revised format ensures that each programme board completes a Quality Impact Assessment as part of the design phase which is then subject to the ususual challenge process. The Quality Impact assessment remains focussed on impact against our seven quality priorities.

Independent Investigation Reports

Three investigations were commissioned through NHS England which are an independent review of homicide cases that took place in the Trust during 2010/11 The investigation will also produce a thematic analysis of these incidents and 3 previous incidents which took place 2007 onwards. These investigations have built on the Trusts' internal investigation. The draft reports have been accuracy checked within the Trust and the draft action plan is being developed in preparation for NHS England publication of the reports which will be in early November. The recommendations were consistent with our expectations.

Incident management and undetermined death annual reports

Both the Trust annual Incident Management and annual undetermined deaths reports have been published in Q2. Both reports were presented at the Clinical Governance & Clincal Safety Committee (GCCSC) and are being shared with the BDUs.

The incident report covers all incidents reported in the Trust with a more detailed section on serious incidents. The report provides data broken down for each BDU along with examples of learning that have taken place. There is also a section on the work of the patient safety support team. The Trust reported 9938 incidents of all severity during the year, similar to previous years. The three most frequent recommendation types arising from serious incident investigations related to record keeping, care pathways and risk assessment. In 2013/14 a review of outstanding serious incident action plans was completed resulting in a significantly improved position in regard to all actions being implemented.

The Undetermined deaths audit examines more closely the details of deaths that were reported that took place from April 2013 to March 2014. The data captures many of the questions asked in the National Confidential Inquiries (NCI). Findings from the undetermined deaths audit show that the largest proportion of deaths occurred in the service user's home and a high proportion of the service users were living alone at the time of their death. 46% of deaths occurred within 7 days of last contact with services (4 people died within less than 24 hours of contact). Last contacts were primarily with a community mental health team or crisis. Investigator views on areas which could possibly have had some preventative impact prevention in regard to undetermined deaths included access to psychological treatment and better communication between teams.

Plans for 2014-15 include the development of an overarching patient safety strategy and action in support of the new national Sign up to Safety' initiative. The Trust will commit to turning pledges into a safety improvement plan to reduce deaths and harm for patients over the next 3 years.

Compliance

Increased admissions when no bed immediately available
After a period of no such incidents between July and September 2014 there have been 6 admissions to wards when no bed has been immediately available (4 of which related to Elmdale). This is something the Trust continues to have to report against to the CQC. The matter has been raised for review by the Deputy District Directors in order to understand if there are any particular reasons for the increase and whether any specific intervention is required. The matter has also been raised at EMT. Clinical Leads been asked to look at any trends. District Director – Wakefield and Barnsley Business Delivery Units is leading work to review and consider any necessary protocol revision.

Care Quality Commission (CQC)
The Trust still has 2 compliance actions from the Fieldhead inspection visit (Trinity 2, Newton Lodge and Bretton) against outcomes 7 (safeguarding) and 10 (safety and suitability of premises). The CQC have been informed that the trust has completed all specified actions and a return CQC inspection visit is expected.
The CQC continue 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.

OFSTED Barnsley
Ofsted inspected Barnsley Borough Council 3rd June-25th June 2014-09-22 There is a continuous improvement plan in place of which SWYPFT are fully engaged as Partners. The arrangements for health assessment and needs of Children in Care (LAC) was seen as improved since the last inspection with a high proportion of Children and Young People receiving assessments (95% 2013-14).

From September 2014 Wakefield BDU moved to **single sex accommodation** for acute services. Trinity 2 and Priory now serve as separate gender wards. Options are currently being reviewed in regard to single sex accommodation in Kirklees and Calderdale.

Monitor - Push on patient safety/response to Berwick
In 2013 Professor Don Berwick led a review of patient safety in the NHS, culminating in the report "A promise to learn – a commitment to act". This report set out principles and recommendations for a whole-system approach to continually reduce harm throughout the NHS in England. Monitor, in partnership with the Health Foundation is identifying the support and development trusts may need in moving forward with patient safety via a survey and interviews with patient safety leads. This work complements work on the "Sign up to Safety" initiative which is supported by the Trust.

Parliamentary and Health Service Ombudsman
During Qtr.2, 6 complainants asked the Parliamentary and Health Service Ombudsman to review their complaint (1 Specialist Services - Barnsley CAMHS), 1 Wakefield, 1 Calderdale, 1 Forensics and 2 Kirklees). 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

Gate-kept admissions
A review of our reporting methods for 'gate keeping' admissions to inpatient services is being undertaken to ensure compliance with the Monitor Risk Assessment Framework. A report on the findings of the audit will be taken to the Data Quality Steering Group on 27th October 2014 and reported in the compliance report for Q3.

Prone Restraint
There has been a reducing trend in the use of prone restraint within the Trust. Prone Restraint accounted for 19% of restraints in the past 12 months and 14% of all restraints in Quarter 2 2014/15. There was 1 Amber incident of prone restraint recorded in Q2 related to Trinity 2 (Wakefield). The service user caused injury to 2 staff members who required treatment at A & E. A strategy meeting to discuss further care was called.

Strategic Overview Dashboard

Business Strategic Performance Impact & Delivery

Section	KPI	Source	Target	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Q1	Q2	YTD	Year End Forecast Position
Monitor Compliance	Monitor Governance Risk Rating (FT)	M	Green	Green	Green	Green	Green	Green		Green		Green	4
	Monitor Finance Risk Rating (FT)	M	4	4	4	4	4	4	4	4	4	4	4
CQC	CQC Quality Regulations (compliance breach)	CQC	Green	2	Green	Green	Green	Green	Not Avail	Green		Green	4
CQUIN	CQUIN Barnsley	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Not Avail	Amber/G	Not Avail	Amber/G	3
	CQUIN Calderdale	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Not Avail	Amber/G	Not Avail	Amber/G	3
	CQUIN Kirklees	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Not Avail	Amber/G	Not Avail	Amber/G	3
	CQUIN Wakefield	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Not Avail	Amber/G	Not Avail	Amber/G	3
	CQUIN Forensic	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Not Avail	Amber/G	Not Avail	Amber/G	3
IAPT	IAPT Kirklees: % Who Moved to Recovery	C	52%	57.62%	51.67%	41.48%	54.10%	50.97%	49.21%	Not Avail	51.34%	51.01%	4
	IAPT Outcomes - Barnsley	C (FP)	90%	Not Avail	98.43%	97.42%	99.45%	97.39%	Not Avail	Not Avail	Not Avail	98.17%	4
	IAPT Outcomes - Calderdale	C (FP)	90%	97.00%	100%	96.00%	82.76%	91.67%	Not Avail	Not Avail	Not Avail	93.49%	4
	IAPT Outcomes - Kirklees	C (FP)	90%	100%	98.00%	95.81%	96.12%	98.65%	Not Avail	Not Avail	Not Avail	97.72%	4
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	C	8	0	0	0	1	1	0	0	2	2	4
C-Diff	C Diff avoidable cases	C	0	0	0	0	0	0	Not Avail	0	Not Avail	0	4
PSA Outcomes	% SU on CPA in Employment		10%	7.60%	7.80%	6.60%	7.47%	7.36%	7.50%	Not Avail	7.50%	7.37%	3
	% SU on CPA in Settled Accommodation		60%	70.30%	72.20%	72.20%	71.28%	71.52%	70.70%	Not Avail	70.70%	71.50%	4

Customer Focus

Section	KPI	Source	Target	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Q1	Q2	YTD	Year End Forecast Position
Complaints	% Complaints with Staff Attitude as an Issue	L	< 25%	11.86%	17.39%	13%(8/61)	10%(7/69)	15%(8/53)	14% (8/58)		13% (23/180)	Not avail	4
MAV	Physical Violence - Against Patient by Patient	L	14-20	Within ER	Within ER	Above ER	Above ER	Above ER	Above ER	Not avail	Not avail	Not avail	4
	Physical Violence - Against Staff by Patient	L	50-64	Above ER	Above ER	Above ER	Within ER	Above ER	Within ER	Not avail	Not avail	Not avail	4
FOI	% of Requests for Information Under the Act Processed in 20 Working Days	L	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	4
Media	% of Positive Media Coverage Relating to the Trust and its Services	L	60%	81.00%	81.00%	83.00%	83.00%	83.00%	73.00%	83.00%	73.00%	82.00%	4
Member's Council	% of Publicly Elected Council Members Actively Engaged in Trust Activity	L	> 50%	47.00%	47.00%	30.00%	30.00%	30.00%	56.00%	30.00%	56.00%	36.80%	4
	% of Quorate Council Meetings	L	100%	100%	100%	100%	100%	100%	100%	100.00%	100%	100%	4
Membership	% of Population Served Recruited as Members of the Trust	M	1%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	4
	% of 'Active' Members Engaged in Trust Initiatives	M	50%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	4
Befriending services	% of Service Users Allocated a Befriender Within 16 Weeks	L	70%	75.00%	75.00%	75.00%	75.00%	75.00%	80.00%	75.00%	80.00%	75.00%	4
	% of Service Users Requesting a Befriender Assessed Within 20 Working Days	L	80%	100%	100%	88.00%	88.00%	88.00%	80.00%	88.00%	80.00%	92.80%	4
	% of Potential Volunteer Befriender Applications Processed in 20 Working Days	L	90%	100%	100%	100%	100%	100%	100%	100.00%	100%	100%	4

Operational Effectiveness: Process Effectiveness

Section	KPI	Source	Target	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Q1	Q2	YTD	Year End Forecast Position
Monitor Risk Assessment Framework	Max time of 18 weeks from point of referral to treatment - non-admitted	M	95%	98.14%	99.80%	99.10%	99.00%	98.53%	98.92%	98.98%	98.53%	98.91%	4
	Max time of 18 weeks from point of referral to treatment - incomplete pathway	M	92%	96.66%	98.70%	98.50%	97.34%	97.47%	97.31%	98.50%	97.31%	97.47%	4
	Delayed Transfers Of Care (DTOC) (Monitor)	M	7.50%	3.32%	4.18%	4.18%	3.82%	3.66%	4.97%	4.00%	4.13%	3.95%	4
	% Admissions Gatekept by CRS Teams (Monitor)	M	95%	100%	100%	96.50%	100%	99.06%	95.06%	99.54%	98.55%	99.11%	4
	% SU on CPA Followed up Within 7 Days of Discharge (Monitor)	M	95%	97.19%	96.35%	96.84%	97.31%	95.59%	95.36%	96.78%	96.19%	96.71%	4
	% SU on CPA Having Formal Review Within 12 Months (Monitor)	M	95%	95.90%	94.00%	96.50%	94.02%	94.58%	98.06%	96.46%	98.64%	96.46%	4
	Meeting commitment to serve new psychosis cases by early intervention teams QTD	M	95%	179.49%	207.97%	186.19%	166.67%	166.67%	179.49%	186.29%	179.49%	181.39%	4
	Data completeness: comm services - Referral to treatment information	M	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%	4
	Data completeness: comm services - Referral information	M	50%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	4
	Data completeness: comm services - Treatment activity information	M	50%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	4
	Data completeness: Identifiers (mental health) (Monitor)	M	97%	99.40%	99.40%	99.40%	99.52%	99.56%	99.54%	99.41%	99.54%	84.22%	4
	Data completeness: Outcomes for patients on CPA (Monitor)	M	50%	83.00%	84.70%	84.40%	84.77%	83.80%	83.20%	84.35%	83.20%	84.03%	4
	Compliance with access to health care for people with a learning disability	M	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	*Compliant*	Compliant	*Compliant*	Compliant	4
Data Quality	% Inpatients (All Discharged Clients) with Valid Diagnosis Code	L	99%	90.80%	99.10%	81.70%	99.50%	100.00%	100.00%	81.71%	100.00%	94.22%	4
	% Valid NHS Number	C (FP)	99%	Not Avail	Not Avail	Not Avail	99.97%	99.93%	99.60%	Not Avail	99.60%	99.60%	4
	% Valid Ethnic Coding	C (FP)	90%	Not Avail	Not Avail	Not Avail	94.50%	94.84%	86.15%	Not Avail	86.15%	86.15%	4
Mental Health PbR	% of eligible cases assigned a cluster	L	100%	95.30%	95.70%	95.90%	86.72%	95.99%	95.90%	Not Avail	95.90%	93.92%	3
	% of eligible cases assigned a cluster within previous 12 months	L	100%	80.40%	80.20%	80.10%	73.72%	79.49%	79.10%	Not Avail	79.10%	78.78%	3

Fit for the future Workplace

Section	KPI	Source	Target	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Q1	Q2	YTD	Year End Forecast Position
Sickness	Sickness Absence Rate (YTD)	L	<=4%	4.70%	4.70%	4.50%	4.60%	4.60%	4.60%	4.50%	4.60%	4.60%	3
Vacancy	Vacancy Rate	L	10%	2.50%	3.50%	4.60%	Not Avail	4.50%	4.50%	Not Avail	4.50%	3.78%	4
Appraisal	Appraisal Rate Band 6 and above	L	>=95%	12.90%	29.00%	54.10%	58.90%	74.60%	88.50%	54.10%	88.50%	74.60%	4
	Appraisal Rate Band 5 and below	L	>=95%	3.40%	8.20%	17.00%	23.80%	40.20%	78.30%	17.00%	78.30%	40.20%	4
Mandatory Training	Aggression Management	L	>=80%	56.00%	56.90%	56.60%	59.10%	61.20%	62.60%	56.60%	62.60%	62.60%	2
	Equality, Diversity & Inclusion	L	>=80%	55.50%	58.60%	62.30%	64.80%	66.70%	70.20%	62.30%	70.20%	70.20%	3
	Fire Safety	L	>=80%	74.39%	74.75%	76.74%	77.71%	80.50%	82.70%	76.74%	82.70%	82.70%	4
	Infection, Prevention & Control & Hand Hygiene	L	>=80%	56.90%	59.40%	63.00%	64.80%	68.40%	71.30%	63.00%	71.30%	71.30%	3
	Information Governance	M	>=95%	90.47%	89.31%	89.91%	89.68%	89.24%	89.80%	89.91%	89.80%	89.80%	4
	Safeguarding Adults	L	>=80%	71.10%	72.30%	74.20%	75.50%	77.30%	78.60%	74.20%	78.60%	78.60%	3
	Safeguarding Children	L	>=80%	64.50%	66.90%	69.70%	73.20%	75.00%	77.30%	69.70%	77.30%	77.30%	3
	Food Safety	L	>=80%	40.80%	40.20%	41.80%	44.10%	45.30%	48.40%	41.80%	48.40%	48.40%	2
	Moving & Handling	L	>=80%	23.80%	30.90%	36.10%	42.00%	47.50%	52.40%	36.10%	52.40%	52.40%	2

Impact and Delivery

• Compliance - The Trust still has 2 CQC compliance actions outstanding and these will remain in place until CQC re-inspect. The action plan related to the compliance actions has been fully implemented.
• Year to date and forecast is green for Monitor Risk Ratings and CQC compliance
• Quarter Two Quality indicators (CQUINs) are due to be submitted at the end of October. Work is currently being undertaken to collate performance. The risk assessment on achievement of all indicators for 2014/15 is predicting a potential shortfall in income of £500k which is 11% of the income linked to these indicators and the forecast remains at Amber/Green.
• Number of service users on CPA in employment – continues to be below 10% and has increased slightly compared to previous months. Benchmarking has been undertaken to compare achievement between BDUs. Investigations regarding data collection have taken place to demonstrate level of involvement in activities which will increase the chances of service users gaining employment e.g. volunteering.

Operational Effectiveness

• There has been an increase in delayed transfers of care from inpatient settings during the month. The cases are being reviewed on an individual basis and are mostly associated within the Kirklees and Specialist Services BDU's. The overall performance remains under the Monitor threshold at the end of quarter 2 and will be closely monitored within the Trust. External issues impacting on the delays will be discussed with appropriate parties.
• Issues in performance associated with Data quality (DQ) indicators continue and are mostly associated with clinical record keeping, case management and the caseload allocation in teams. This can be seen in the cluster assignment and recording of ethnicity. A specific focus over the last month has been on data quality affecting the CPA review KPI and as a result this is now reporting above trajectory. Work continues within BDU's to maintain this level of performance going forward and to align with routine operational practice.
• 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 end of September 14 and remains at 4.6% for the third month running. Work continues to focus on reducing sickness related absence within the Trust.
• Review of mandatory training KPIs are being undertaken by HR to focus on key staff groups and risk areas – performance for September 14 evidences a further increase in performance against all mandatory training areas which shows a positive impact of the work being undertaken.
• BDUs and Support services continue to review compliance with mandatory training to ensure completion. This is supported by the staff appraisal and objective setting process.

KEY	
4	Forecast met, no plan required/plan in place likely to deliver
3	Forecast risk not met, plan in place but unlikely to deliver
2	Forecast high risk not met, plan in place but vey unlikely to deliver
1	Forecast Not met, no plan / plan will not deliver
CQC	Care Quality Commission
M	Monitor
C	Contract
C (FP)	Contract (Financial Penalty)
L	Local (Internal Target)
ER	Expected Range
N/A	Not Applicable

Overall Financial Position

	Performance Indicator	Month 6 Performance	Annual Forecast	Trend from last month	Last 3 Months - Most recent			Assurance	
Trust Targets					5	4	3		
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 (as per the Trust Monitor return) is 4 against a plan level of 4. A score of 4 is the highest possible. It is forecast that a rating of 4 will be maintained for the remainder of 2014 / 2015.

2. The year to date position, as at September 2014 shows a net surplus of £4.3m which is £2.2m ahead of plan.
This underspend position is driven by underspends on pay. However this is not maintained because from October 2014 there is a significant level of CIP linked to workforce and the current level of underspend will be used to offset the underperformance on these CIPs

The Trust forecast position remains in line with plan. Month 6 has seen a further improvement in the forecast position within Operational BDU budgets but the utilisation of provisions remains at broadly the same level as month 5.

3. At September 2014 the cash position is £32.1m which is £0.4m ahead of plan.

4. Capital spend to September 2014 is £2.35m which is £0.34m (13%) behind the revised Trust capital plan. The revised plan was

5. At Month 6 the Cost Improvement Programme is £0.66m ahead of plan of £5.2m. (12.7%) Based upon current knowledge it is forecast that there will be a £0.55m shortfall (outstanding schemes rated as red) and therefore these schemes will need to be fi

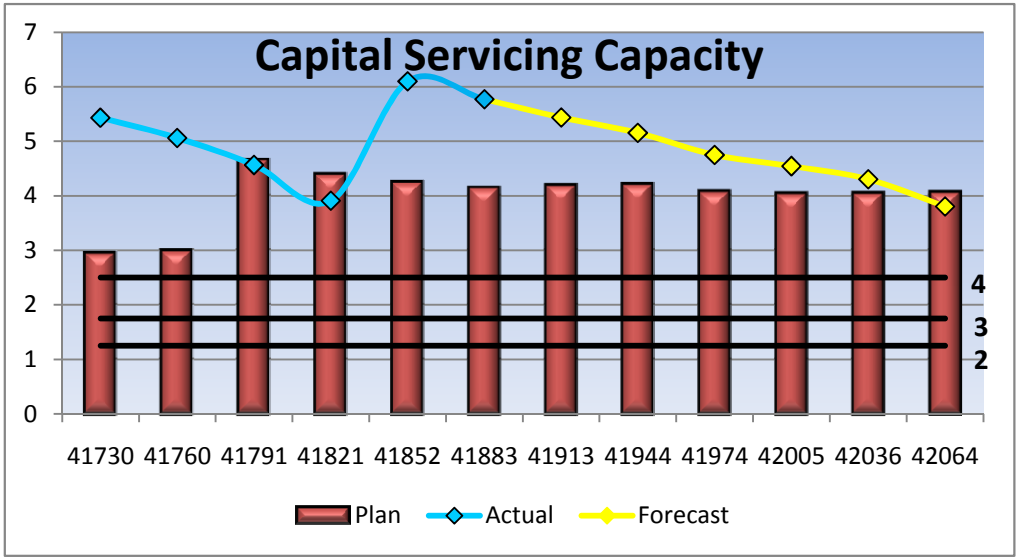
6. As at 30th September 2014 (Month 6) 88% of NHS and 93% of non NHS invoices have achieved the 30 day payment target (95%).

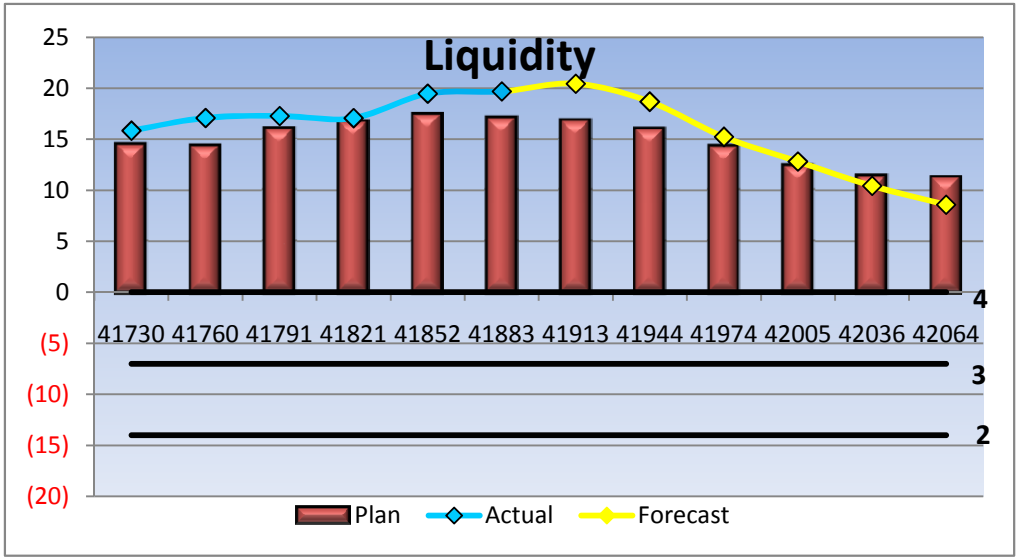
Monitor Risk Rating

Continuity of Service Risk Rating 2014 / 2015				
	Actual Performance		Annual Plan September 2014	
Metric	Score	Rating	Score	Rating
Capital Servicing Capacity	5.8	4	4.1	4
Liquidity	19.7	4	17.1	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.

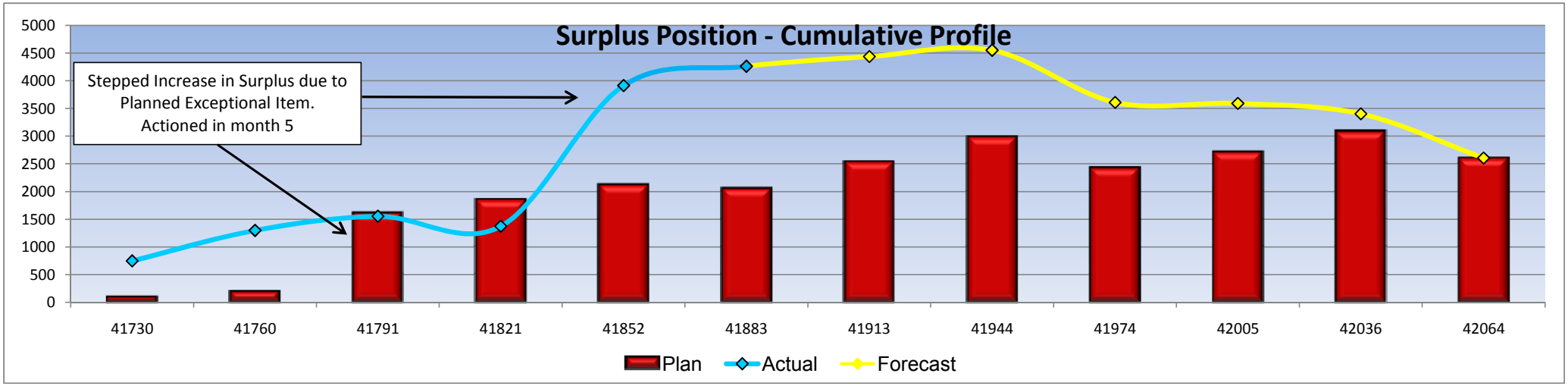
The movement in the Capital Servicing Capacity ratio in month 5 is primarily due to the Trust Asset revaluation undertaken. This had been planned for month 3.





Income & Expenditure Position 2014 / 2015

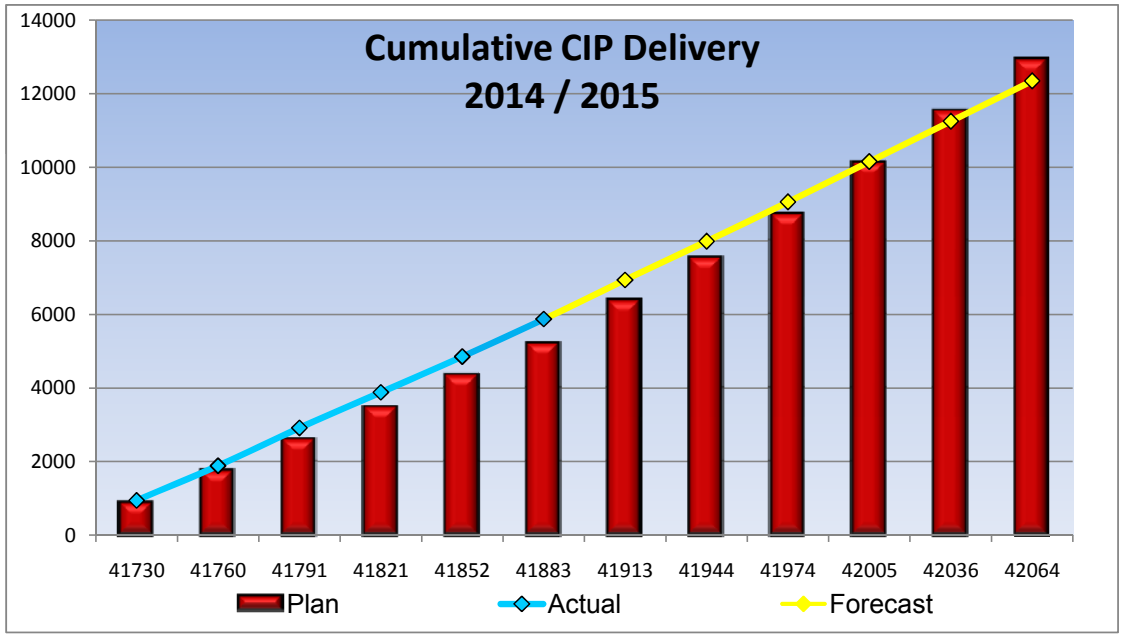
Budget Staff in Post	Actual Staff in Post	Variance		This Month Budget	This Month Actual	This Month Variance	Description	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Forecast Outturn	Forecast Variance
WTE	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**		**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
				(18,351)	(18,131)	220	Clinical Revenue	(109,012)	(108,696)	316	(218,371)	(217,813)	558
				(18,351)	**(18,131)**	**220**	**Total Clinical Revenue**	**(109,012)**	**(108,696)**	**316**	**(218,371)**	**(217,813)**	**558**
				(1,687)	(1,567)	121	Other Operating Revenue	(7,862)	(7,932)	(69)	(14,896)	(15,556)	(660)
				(20,038)	**(19,698)**	**340**	**Total Revenue**	**(116,874)**	**(116,627)**	**247**	**(233,267)**	**(233,369)**	**(103)**
4,563	4,348	(215)	4.7%	14,892	14,301	(591)	BDU Expenditure - Pay	87,965	85,504	(2,461)	174,034	172,905	(1,129)
				4,006	3,961	(44)	BDU Expenditure - Non Pay	23,038	23,395	357	46,196	48,145	1,949
				494	425	(68)	Provisions	954	816	(138)	2,799	2,507	(293)
4,563	**4,348**	**(215)**	**4.7%**	**19,391**	**18,687**	**(704)**	**Total Operating Expenses**	**111,957**	**109,715**	**(2,242)**	**223,030**	**223,556**	**527**
4,563	**4,348**	**(215)**	**4.7%**	**(647)**	**(1,011)**	**(364)**	**EBITDA**	**(4,917)**	**(6,913)**	**(1,996)**	**(10,237)**	**(9,813)**	**424**
				433	429	(4)	Depreciation	2,596	2,554	(42)	5,191	5,159	(32)
				264	244	(20)	PDC Paid	1,582	1,428	(154)	3,164	2,842	(322)
				0	(8)	(8)	Interest Received	0	(49)	(49)	0	(94)	(94)
				0	0	0	Revaluation of Assets	(1,300)	(1,280)	20	(700)	(700)	0
4,563	**4,348**	**(215)**	**4.7%**	**49**	**(346)**	**(396)**	**Surplus**	**(2,040)**	**(4,260)**	**(2,220)**	**(2,582)**	**(2,606)**	**(24)**



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	5,196	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	5,196	12,898
Delivery as planned	820	1,641	2,461	3,275	4,088	4,904	5,807	6,699	7,613	8,548	9,483	10,420	4,904	10,420
Mitigations - Recurrent	61	122	240	319	405	517	606	695	787	881	975	1,069	517	1,069
Mitigations - Non Recurrent	62	123	214	289	362	455	525	592	659	725	792	859	455	859
Total Delivery	**943**	**1,886**	**2,915**	**3,883**	**4,855**	**5,876**	**6,939**	**7,987**	**9,059**	**10,153**	**11,250**	**12,348**	**5,876**	**12,348**
Shortfall / Unidentified	(79)	(158)	(324)	(423)	(527)	(680)	(584)	(472)	(362)	(56)	247	550	(680)	550



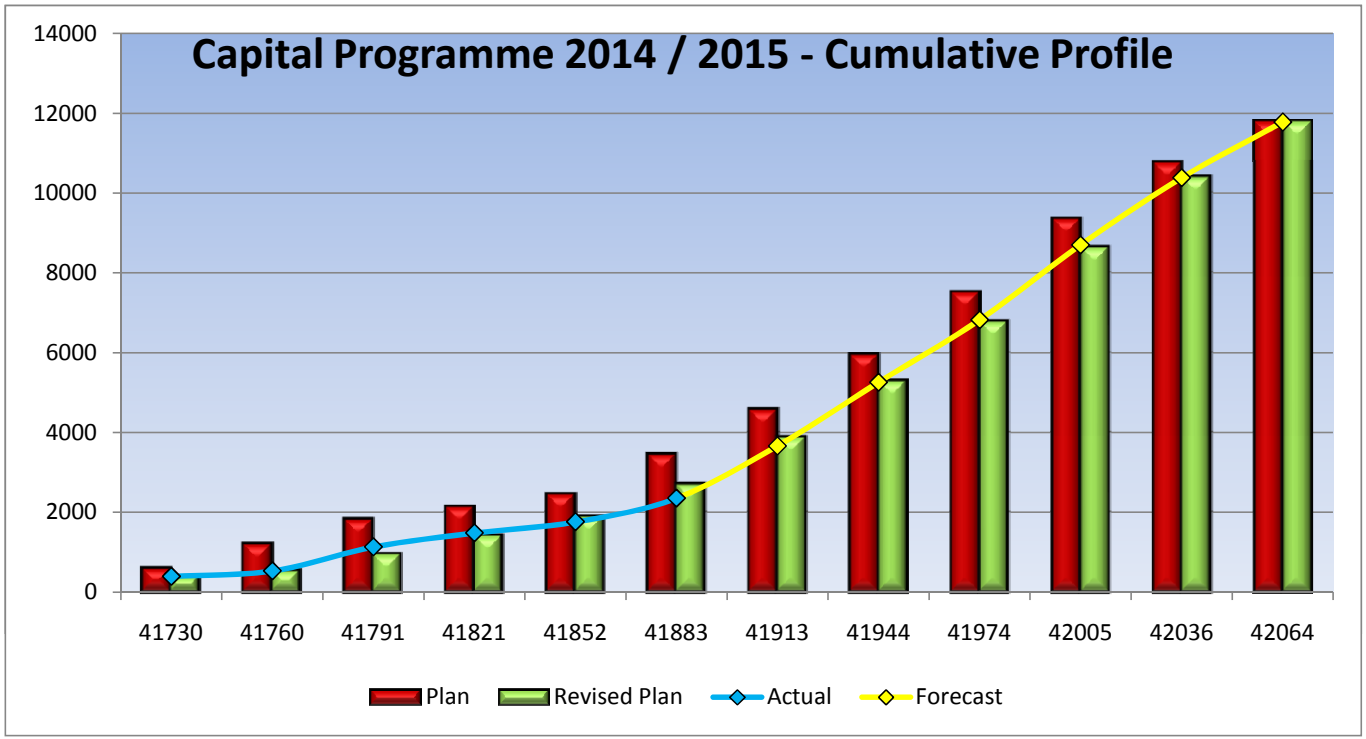
The profile of the Trust Cost Improvement Programme for 2014 / 2015 is outlined above. This profile demonstrates the Trust's plan to further expenditure reductions in Quarters 3 and 4.

The current position is a £292k shortfall against the original plan. However substitutions actioned by BDU's mean that the Trust is ahead of plan at month 6 by £680k. The overall forecast is a £550k 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.

Capital Programme 2014 / 2015

Capital Expenditure Plans - Application of funds	REVISED Annual Budget £k	REVISED 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	2,267	1,311	899	(412)	2,609	342	*3*
Total Minor Capital	**2,267**	**1,311**	**899**	**(412)**	**2,609**	**342**	
Major Capital Schemes							
Hub Development / Forensics	6,025	771	829	58	5,721	(304)	*4*
Fieldhead Hospital Development	3,038	384	516	132	2,993	(45)	
IM&T	450	232	101	(131)	448	(2)	
Total Major Schemes	**9,513**	**1,387**	**1,446**	**58**	**9,162**	**(351)**	
VAT Refunds			9	9	9	9	
TOTALS	**11,780**	**2,698**	**2,354**	**(344)**	**11,780**	**(0)**	*1, 2*



Capital Expenditure 2014 / 2015

1. The total Capital Programme for 2014 / 2015 is £11.78m. As part of the Quarter 1 Monitor return, there was a requirement to issue a revised capital plan and these revised figures are shown.

The overall capital programme remains unchanged as £11.78m but the profile has been revised.

2. The year to date position is £344k under the revised plan (13%). The forecast is that the Capital Programme will be delivered in full.

The main headlines behind this position are:

3. Minor works are significantly under spent as at month 6. All orders, bringing spend back to profile for maintenance spend, are now in place and being actioned. The schemes are all planned to spend in full.

4. Major schemes are now reaching the construction phase and will deliver within the forecast phasing.

The Wakefield Hub scheme is currently flagged at high risk of not being delivered. This is partly due to issues in acquiring a suitable site and partly due to further review of the clinical model for the hub.

Better Payment Practice Code

NHS		
	Number	Value
	%	%
Year to August 2014	88.6%	91.4%
Year to September 2014	88.3%	91.3%

Non NHS		
	Number	Value
	%	%
Year to August 2014	93.8%	89.9%
Year to September 2014	93.4%	89.4%

Local Suppliers - 10 days		
	Number	Value
	%	%
Year to August 2014	76.6%	60.7%
Year to September 2014	78.3%	66.8%

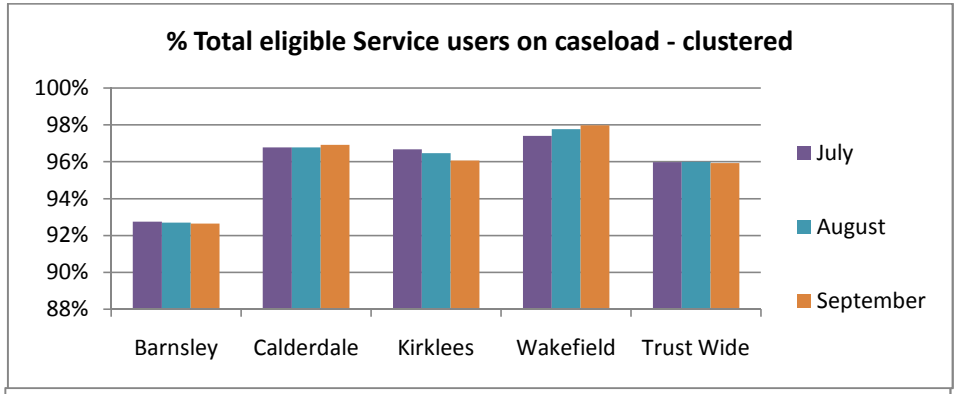
The Better Payment Practice Code requires the Trust to pay 95% of valid invoices by the due date or within 30 days of receipt of goods or a valid invoice whichever is later.

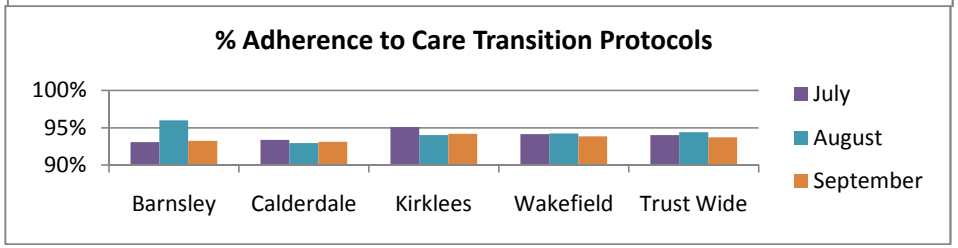
The performance against target for NHS invoices is 88% of the total number of invoices that have been paid within 30 days and 91% by the value of invoices.

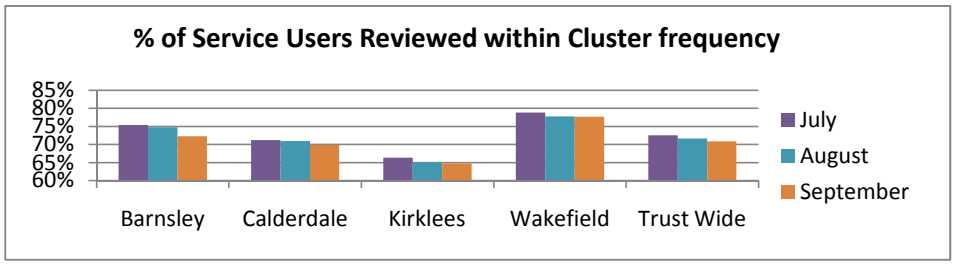
The performance against target for Non NHS invoices is 93% of the total number of invoices that have been paid within 30 days and 89% by the value of invoices.

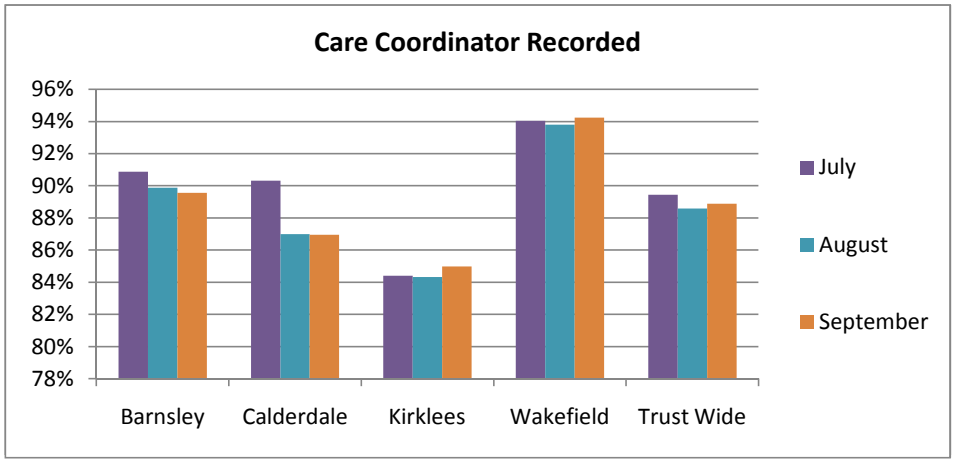
The Government has asked Public Sector bodies to try and pay Local Suppliers within 10 days, though this is not mandatory for the NHS. This was adopted by the Trust in November 2008.
To date the Trust has paid 78% of Local Supplier invoices by volume and 67% by the value of invoices within 10 days.

Mental Health Currency Development









External

An alternative Patient Reported Outcome Measures (PROM) tool is being reviewed and this is being backed by NHS England in conjunction with Sheffield University.

Internal

MH currency clinical advisors for Barnsley and Wakefield have been working on the transformation agenda and the turnaround plan for CAMHS

The Trust have a small working group established to develop initial internal CROM reporting.

A meeting was held on the 9th October to discuss MH Currencies and PBR in practice to get a understanding of the pathways , the data requirements, usability of the clinical system and the data quality issues currently being faced and how processes can be streamlined / improved etc

Data Quality

The Health & Social Care Information Centre (HSCIC) have published an interactive indicator tool to assist with data quality.

September Position and Hot Spots

Barnsley - achieved 93% clustered but reviews have dropped to 72% within frequency.

Hot Spot - Dementia Consultant Team are 40% clustered and ADHD team also have 50% clustered.

Kirklees clustered remains at 96% and reviewed within frequency is still low at 65% mainly due to older peoples services.

Hot Spots - SK Treatment team 21%, SK Memory Monitoring 41%, NK Treatment tea 46% SK East CMHT OPS 51%.

Calderdale clustered remains at 97% and reviewed within frequency is still 70% .

Hot Spots - Community Treatment 19% clustered, Memory Service East 53% clustered, Psychology 65%.

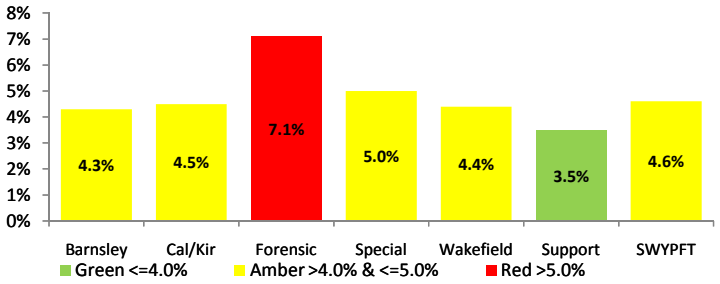
Wakefield clustered remain at 98% clustered and 78% reviewed within frequency.

Hot Spots - Memory Service 87% clustered, ADHD teams 63%

Workforce

Human Resources Performance Dashboard - September 2014

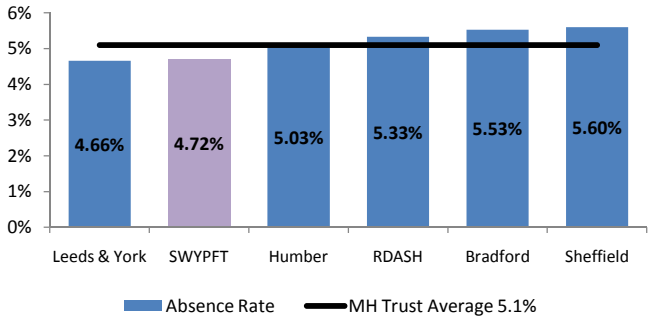
Sickness Absence



Current Absence Position - August 2014

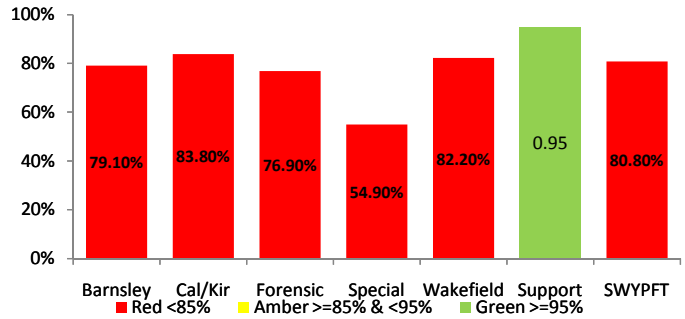
	Barn	Cal/Kir	Fore	Spec	Wake	Supp	SWYPFT
Rate	4.4%	4.5%	6.4%	3.7%	4.3%	3.2%	4.5%
Trend	↓	↓	↑	↓	↓	↓	↓

The Trust YTD absence levels in August 2014 (chart above) were above the 4% target at 4.6%



The above chart shows absence levels in MH/LD Trusts in our region for 2013/14. During this time the Trust's absence rate was 4.5% which is below the regional average of 5.1%.

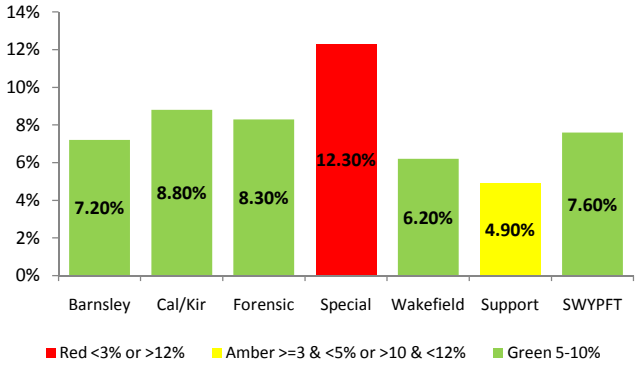
Appraisals



The above chart shows appraisals rates for all staff.

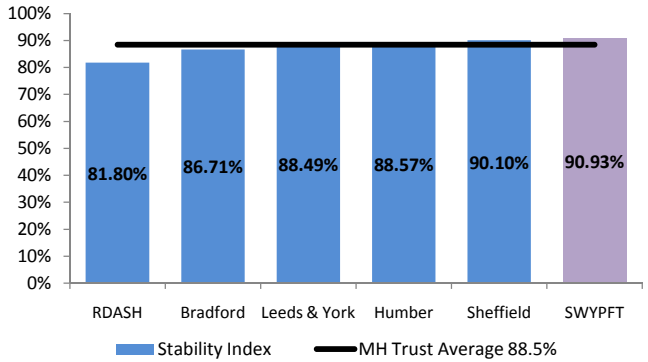
The Trust is below the 95% target, all staff should have been appraised by the end of September 2014.

Turnover and Stability Rate Benchmark



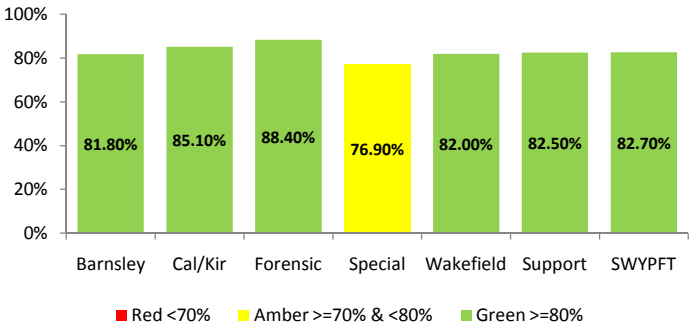
This chart shows Turnover levels up to the end of September 2014.

Overall turnover is within the target range of 5% to 10%. However, in Specialist Services turnover is above this level. Turnover in Specialist Services will continue to be monitored over the next few months.



This chart shows stability levels in MH Trusts in the region for the 12 months ending in June 2014. The stability rate shows the percentage of staff employed with over a years' service. It shows that the Trust has the best stability rate compared with other MH/LD Trusts in our region.

Fire Lecture Attendance



The Trust has now achieved its 80% target for fire lecture training. Specialist Services are not currently achieving the target, however, fire training levels again improved in September

Workforce - Performance Wall

Trust Performance Wall

Month		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Sickness (YTD)	<=4%	4.70%	4.50%	4.60%	4.60%	4.60%	4.50%
Sickness (Monthly)	<=4%	4.10%	4.50%	4.60%	4.50%	4.60%	4.50%
Appraisals (Band 6 and above)	>=95%	12.90%	29.00%	54.10%	58.80%	74.60%	88.50%
Appraisals (Band 5 and below)	>=95%	3.40%	8.20%	17.00%	23.80%	40.20%	78.30%
Aggression Management	>=80%	56.00%	56.90%	56.60%	59.10%	61.20%	62.60%
Equality and Diversity	>=80%	55.50%	58.60%	62.30%	64.80%	66.70%	70.20%
Fire Safety	>=80%	76.70%	74.70%	76.70%	77.70%	80.50%	82.70%
Food Safety	>=80%	40.80%	40.20%	41.80%	44.10%	45.30%	48.40%
Infection Control and Hand Hygiene	>=80%	56.90%	59.40%	63.00%	64.80%	68.40%	71.30%
Information Governance	>=95%	93.70%	89.30%	89.90%	89.70%	89.20%	89.80%
Moving and Handling	>=80%	23.80%	30.90%	36.10%	42.00%	47.50%	52.40%
Safeguarding Adults	>=80%	71.10%	72.30%	74.20%	75.50%	77.30%	78.60%
Safeguarding Children	>=80%	65.50%	66.90%	69.70%	73.20%	75.00%	77.30%
Bank Cost		£340k	£425k	£333k	£440k	£367k	£365k
Agency Cost		£301k	£341k	£411k	£360k	£430k	£337k
Overtime Cost		£10k	£12k	£12k	£8k	£23k	£19k
Additional Hours Cost		£77k	£72k	£64k	£81k	£74k	£73k
Sickness Cost (Monthly)		£449k	£460k	£479k	£465k	£487k	£472k
Vacancies (Non-Medical) (WTE)		347.68	356.66	352.31	372.66	355.23	347.12
Business Miles		317k	321k	332k	309k	308k	317k

Barnsley District

Month		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Sickness (YTD)	<=4%	4.80%	4.50%	4.40%	4.30%	4.30%	4.30%
Sickness (Monthly)	<=4%	4.40%	4.50%	4.40%	4.20%	4.20%	4.40%
Appraisals (Band 6 and above)	>=95%	14.80%	32.40%	56.50%	61.10%	76.70%	89.10%
Appraisals (Band 5 and below)	>=95%	6.50%	13.40%	22.30%	28.60%	44.40%	75.30%
Aggression Management	>=80%	68.70%	68.20%	59.90%	60.30%	65.40%	67.70%
Equality and Diversity	>=80%	69.90%	72.50%	74.30%	75.00%	76.70%	77.70%
Fire Safety	>=80%	75.70%	74.30%	76.00%	77.80%	78.60%	81.80%
Food Safety	>=80%	45.50%	44.60%	48.70%	48.10%	53.50%	54.90%
Infection Control and Hand Hygiene	>=80%	66.80%	67.50%	70.40%	70.00%	72.90%	75.10%
Information Governance	>=95%	94.40%	88.10%	88.80%	89.00%	88.90%	89.30%
Moving and Handling	>=80%	25.40%	30.70%	38.40%	46.60%	52.50%	57.60%
Safeguarding Adults	>=80%	76.80%	77.40%	79.40%	80.50%	81.30%	83.40%
Safeguarding Children	>=80%	73.30%	74.50%	75.60%	76.40%	77.20%	78.50%
Bank Cost		£44k	£49k	£43k	£55k	£53k	£50k
Agency Cost		£115k	£148k	£190k	£168k	£157k	£129k
Overtime Cost		£4k	£4k	£8k	£4k	£12k	£11k
Additional Hours Cost		£30k	£31k	£32k	£34k	£39k	£38k
Sickness Cost (Monthly)		£176k	£164k	£168k	£165k	£164k	£170k
Vacancies (Non-Medical) (WTE)		125.69	135.08	122.25	117.96	124.61	124.54
Business Miles		130k	125k	139k	127k	131k	137k

Calderdale and Kirklees District

Month		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Sickness (Monthly)	<=4%	4.20%	4.60%	4.60%	4.10%	4.50%	4.50%
Appraisals (Band 6 and above)	>=95%	12.60%	32.60%	60.90%	67.50%	83.10%	96.20%
Appraisals (Band 5 and below)	>=95%	1.60%	7.10%	19.70%	25.80%	37.70%	76.70%
Aggression Management	>=80%	56.70%	57.10%	56.40%	59.80%	60.60%	60.80%
Equality and Diversity	>=80%	48.20%	51.10%	56.60%	60.80%	63.10%	69.00%
Fire Safety	>=80%	71.90%	72.70%	79.00%	78.90%	82.50%	85.10%
Food Safety	>=80%	24.60%	22.00%	21.40%	22.70%	23.30%	28.90%
Infection Control and Hand Hygiene	>=80%	45.60%	47.10%	52.30%	55.80%	60.10%	65.00%
Information Governance	>=95%	91.30%	89.40%	90.80%	91.60%	92.90%	93.20%
Moving and Handling	>=80%	11.40%	27.40%	32.50%	38.30%	43.80%	49.80%
Safeguarding Adults	>=80%	72.70%	72.60%	74.00%	76.90%	78.40%	78.40%
Safeguarding Children	>=80%	48.80%	49.80%	54.00%	62.40%	65.80%	70.70%
Bank Cost		£96k	£118k	£98k	£117k	£83k	£94k
Agency Cost		£66k	£45k	£36k	£54k	£107k	£43k
Overtime Cost		£3k	£5k	£0k	£2k	£7k	£3k
Additional Hours Cost		£3k	£3k	£3k	£2k	£3k	£2k
Sickness Cost (Monthly)		£98k	£106k	£106k	£85k	£98k	£104k
Vacancies (Non-Medical) (WTE)		84.45	81.65	78.89	79.48	76.91	62.76
Business Miles		60k	77k	75k	62k	64k	73k

Forensic Services

Month		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Sickness (YTD)	<=4%	6.60%	6.90%	7.10%	7.30%	7.30%	7.10%
Sickness (Monthly)	<=4%	6.20%	6.90%	7.40%	7.50%	7.30%	6.40%
Appraisals (Band 6 and above)	>=95%	0.00%	3.20%	44.40%	46.40%	58.50%	86.50%
Appraisals (Band 5 and below)	>=95%	1.40%	1.80%	3.50%	10.70%	27.00%	75.50%
Aggression Management	>=80%	70.50%	69.50%	69.20%	72.80%	73.50%	72.80%
Equality and Diversity	>=80%	46.10%	51.20%	55.10%	60.30%	61.70%	67.60%
Fire Safety	>=80%	82.60%	83.40%	84.70%	87.80%	88.20%	88.40%
Food Safety	>=80%	31.40%	31.70%	33.10%	39.40%	38.10%	41.50%
Infection Control and Hand Hygiene	>=80%	47.30%	52.50%	54.90%	58.80%	64.10%	70.00%
Information Governance	>=95%	93.30%	88.80%	89.40%	90.90%	92.40%	92.50%
Moving and Handling	>=80%		40.60%	44.60%	49.10%	53.90%	60.40%
Safeguarding Adults	>=80%	72.80%	73.00%	74.20%	76.90%	78.00%	77.30%
Safeguarding Children	>=80%	56.90%	59.70%	64.70%	70.60%	71.50%	75.00%
Bank Cost		£65k	£115k	£96k	£129k	£97k	£90k
Agency Cost		£2k	£2k	£2k	£3k	£2k	£3k
Additional Hours Cost		£0k	£3k	£3k	£0k	£1k	£0k
Sickness Cost (Monthly)		£64k	£59k	£66k	£66k	£69k	£64k
Vacancies (Non-Medical) (WTE)		24.99	30.69	36.6	41.91	38.91	43.15
Business Miles		5k	4k	7k	4k	2k	7k

Specialist Services							
Month		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Sickness (YTD)	<=4%	3.80%	4.80%	5.50%	5.50%	5.40%	5.00%
Sickness (Monthly)	<=4%	3.50%	4.80%	6.10%	5.60%	5.10%	3.70%
Appraisals (Band 6 and above)	>=95%	11.50%	19.60%	32.20%	35.00%	48.80%	66.20%
Appraisals (Band 5 and below)	>=95%	3.40%	4.00%	11.20%	19.20%	24.40%	45.00%
Aggression Management	>=80%	42.90%	48.50%	53.10%	54.10%	55.80%	56.80%
Equality and Diversity	>=80%	48.00%	52.50%	58.40%	60.80%	62.40%	66.80%
Fire Safety	>=80%	75.30%	69.90%	71.20%	70.90%	73.60%	76.90%
Food Safety	>=80%	72.40%	73.70%	74.10%	74.60%	74.60%	76.20%
Infection Control and Hand Hygiene	>=80%	49.30%	51.80%	58.10%	59.70%	62.30%	64.00%
Information Governance	>=95%	89.60%	86.40%	86.90%	86.30%	85.70%	86.00%
Moving and Handling	>=80%	20.30%	29.40%	31.40%	37.30%	42.40%	46.10%
Safeguarding Adults	>=80%	49.00%	52.80%	57.30%	59.10%	63.50%	63.50%
Safeguarding Children	>=80%	55.80%	55.70%	62.60%	64.30%	67.80%	71.60%
Bank Cost		£43k	£27k	£5k	£34k	£28k	£34k
Agency Cost		£39k	£70k	£102k	£46k	£100k	£103k
Overtime Cost		£2k	£2k	£1k	£2k	£3k	£3k
Additional Hours Cost		£9k	£5k	£4k	£3k	£5k	£3k
Sickness Cost (Monthly)		£28k	£42k	£61k	£54k	£50k	£32k
Vacancies (Non-Medical) (WTE)		33.12	30.97	32.94	42.1	31.4	34.08
Business Miles		35k	37k	35k	36k	32k	30k

Wakefield District							
Month		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Sickness (YTD)	<=4%	4.40%	3.10%	3.10%	3.60%	4.10%	4.40%
Sickness (Monthly)	<=4%	2.90%	3.10%	3.10%	4.60%	5.60%	5.60%
Appraisals (Band 6 and above)	>=95%	13.60%	28.70%	44.30%	46.60%	69.20%	89.00%
Appraisals (Band 5 and below)	>=95%	1.70%	8.70%	16.90%	26.00%	53.20%	81.60%
Aggression Management	>=80%	67.20%	66.80%	67.70%	70.20%	69.00%	69.80%
Equality and Diversity	>=80%	62.30%	64.20%	66.50%	71.40%	73.20%	74.80%
Fire Safety	>=80%	79.70%	73.70%	75.10%	77.90%	82.30%	82.00%
Food Safety	>=80%	37.70%	39.00%	40.10%	45.40%	45.20%	47.40%
Infection Control and Hand Hygiene	>=80%	64.20%	68.20%	69.50%	69.90%	74.30%	75.30%
Information Governance	>=95%	97.70%	94.60%	94.00%	93.50%	94.90%	93.90%
Moving and Handling	>=80%	37.20%	36.70%	39.30%	43.40%	49.10%	52.10%
Safeguarding Adults	>=80%	76.20%	77.80%	79.40%	80.10%	83.00%	84.80%
Safeguarding Children	>=80%	67.50%	69.70%	71.50%	77.80%	79.60%	80.40%
Bank Cost		£43k	£63k	£43k	£65k	£56k	£61k
Agency Cost		£45k	£38k	£37k	£62k	£42k	£38k
Additional Hours Cost		£9k	£4k	£5k	£7k	£9k	£9k
Sickness Cost (Monthly)		£35k	£41k	£36k	£53k	£67k	£63k
Vacancies (Non-Medical) (WTE)		33.1	31.79	35.5	33.92	37.51	37.19
Business Miles		37k	38k	37k	39k	37k	39k

Support Services							
Month		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Sickness (YTD)	<=4%	3.90%	4.10%	3.90%	3.70%	3.60%	3.50%
Sickness (Monthly)	<=4%	3.40%	4.10%	3.60%	3.40%	3.40%	3.30%
Appraisals (Band 6 and above)	>=95%	13.60%	36.30%	72.60%	75.60%	88.70%	95.50%
Appraisals (Band 5 and below)	>=95%	1.80%	4.30%	13.90%	20.40%	39.80%	95.00%
Aggression Management	>=80%	35.50%	37.40%	41.00%	44.90%	49.00%	52.80%
Equality and Diversity	>=80%	38.90%	42.50%	47.40%	48.70%	51.20%	55.90%
Fire Safety	>=80%	80.40%	77.00%	75.50%	74.60%	80.70%	82.50%
Food Safety	>=80%	95.10%	95.10%	96.10%	96.20%	89.30%	87.80%
Infection Control and Hand Hygiene	>=80%	54.90%	59.60%	63.10%	67.50%	70.90%	73.30%
Information Governance	>=95%	92.10%	89.80%	90.10%	87.30%	82.00%	84.60%
Moving and Handling	>=80%		27.50%	32.00%	34.90%	40.10%	44.40%
Safeguarding Adults	>=80%	65.10%	67.80%	69.10%	68.50%	71.00%	73.20%
Safeguarding Children	>=80%	78.40%	80.50%	82.10%	83.10%	84.20%	85.50%
Bank Cost		£49k	£54k	£47k	£40k	£51k	£36k
Agency Cost		£33k	£38k	£44k	£28k	£22k	£22k
Overtime Cost		£1k	£1k	£1k	£1k	£0k	£1k
Additional Hours Cost		£25k	£26k	£17k	£35k	£17k	£20k
Sickness Cost (Monthly)		£48k	£50k	£43k	£42k	£39k	£40k
Vacancies (Non-Medical) (WTE)		46.33	46.48	46.13	52.79	40.99	40.5
Business Miles		49k	40k	40k	41k	42k	31k

Glossary

ADHD	Attention deficit hyperactivity disorder
ASD	Autism spectrum disorder
AWA	Adults of Working Age
AWOL	Absent Without Leave
B/C/K/W	Barnsley, Calderdale, Kirklees, Wakefield
BDU	Business Delivery Unit
C. Diff	Clostridium difficile
CAMHS	Child and Adolescent Mental Health Services
CAPA	Choice and Partnership Approach
CCG	Clinical Commissioning Group
CGCSC	Clinical Governance Clinical Safety Committee
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
CTLD	Community Team Learning Disability
DTOC	Delayed Transfers of Care
DQ	Data Quality
EIA	Equality Impact Assessment
EIP/EIS	Early Intervention in Psychosis Service
EMT	Executive Management Team
FOI	Freedom of Information
FT	Foundation Trust
HONOS	Health of the Nation Outcome Scales
HSCIC	Health and Social Care Information Centre
HV	Health Visiting
IAPT	Improving Access to Psychological Therapies
IG	Information Governance
IM&T	Information Management & Technology
Inf Prevent	Infection Prevention
IWMS	Integrated Weight Management Service
KPIs	Key Performance Indicators
LD	Learning Disability

MAV	Management of Aggression and Violence
MBC	Metropolitan Borough Council
MH	Mental Health
MHCT	Mental Health Clustering Tool
MRSA	Methicillin-resistant Staphylococcus aureus
MSK	Musculoskeletal
MT	Mandatory Training
NCI	National Confidential Inquiries
NICE	National Institute for Clinical Excellence
NHSE	National Health Service England
NHS TDA	National Health Service Trust Development Authority
NK	North Kirklees
OPS	Older People's Services
OOA	Out of Area
PCT	Primary Care Trust
PICU	Psychiatric Intensive Care Unit
PREM	Patient Reported Experience Measures
PROM	Patient Reported Outcome Measures
PSA	Public Service Agreement
PTS	Post Traumatic Stress
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
RAG	Red, Amber, Green
Sis	Serious Incidents
SK	South Kirklees
SMU	Substance Misuse Unit
SWYFT	South West Yorkshire Foundation Trust
SYBAT	South Yorkshire and Bassetlaw local area team
SU	Service Users
TBD	To Be Decided/Determined
WTE	Whole Time Equivalent
Y&H	Yorkshire & Humber
YTD	Year to Date

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 21 October 2014
Agenda item 5.2

Title:	**Assurance on financial reporting**
Paper prepared by:	Chair of Audit Committee
Purpose:	To inform Trust Board of the outcome of the discussion at the Audit Committee in relation to financial reporting
Mission/values:	Robust governance arrangements are essential for the Trust to remain legally constituted, financially viable and sustainable as a Foundation Trust. This item also demonstrates openness and transparency.
Any background papers/ previously considered by:	None
Executive summary:	Background At the Trust Board meeting on 22 September 2014, the Chair requested that Trust Board considers how it could assure itself that the transparency of financial reporting and disclosure was sufficient to avoid a situation whereby a material misstatement of financial information could occur without being identified through the relevant governance process and Trust Board being appropriately sighted on the issue. This was in reference to the recently disclosed overstatement of Tesco profit projections, which was reported in the national press where the governance processes had failed to identify the error and the Board was consequently made aware of this matter through a whistleblower. Trust Board agreed the Audit Committee should be asked to consider the matter at its meeting on 7 October 2014 with feedback to Trust Board at this meeting. It was agreed to pose the following question for discussion: *"Given the recently reported irregularities in financial reporting at Tesco PLC where the Board and Audit Committee were not sighted on the issue or risk, what safeguards and controls does this organisation have in place to mitigate the risk of a material misstatement in financial reporting occurring?"* Audit Committee 7 October 2014 In considering the question, it is relevant to consider the development of financial reporting and disclosure through the Foundation Trust application process. During the process, the Trust was challenged on the transparency and content of its performance and financial reporting. This resulted in the revision of the financial reporting pack to include: - consideration of the income expenditure position, including EBITDA; - cash; - balance sheet; - capital spend; and - Monitor risk rating. Since 2009, the scope of the report has widened to include: - review and reporting of any central held reserves; - a more detailed routine analysis of significant variances, which includes a link to performance metrics; - focus on developing forecasting skills so that, by month 6, the outturn position can be predicted within a margin of +/- £250,000; - more detailed reporting of CIP performance; and

- more recently in 2014/15, more detailed analysis at BDU level.

In the Board meeting in July 2014, as Chair of the Audit Committee, my views were recorded that the current level of disclosure in the financial reporting was the most transparent it had been during my time in office.

The Audit Committee considered the question and agreed that it could take assurance from the safeguards and controls in place under the following headings.

Personnel

- The Trust is a values-based organisation, which incorporates values of openness and honesty. These values are reflected in the approach to recruitment and training of staff and the ongoing work in the Directorate on organisational development to promote the appropriate culture and values.
- The restructure undertaken in 2012 re-drafted all job descriptions and a 'skills escalator' to outline the requirements for each post.
- Senior level posts in finance are required to demonstrate a level of attainment and experience linked to a professional qualification. This is an important control in that retention of the qualification requires the individual to complete continuing professional development and maintain professional standards. The Directorate actively promotes staff members undertaking a professional qualification and provides financial support for staff in undertaking accredited study courses.
- The financial skills and experience required for roles responsible for the deployment of resources (that is, budget holders and governance, such as Audit Committee members, and reflected appropriately in job descriptions and compliance) is evidenced through the recruitment and appraisal processes.
- Leadership from Director downwards, focusses 'how' things are done as well as 'what' is done. This is reviewed through the appraisal process, including seeking customer feedback.

Process

- The Trust has a robust timetable for the production of reports and the content and standards for completion are understood and complied with by the finance team.
- The Trust maintains a budget hierarchy which details the scope of level of authority held by each budget holder. Transactions, such as payment of invoices and movement of budgets, require the authorisation of budget holders.
- The Finance Directorate operates a devolved management structure so that finance/business managers work within the BDU management teams and are professionally accountable to the Director of Finance.
- Monthly financial forecasts are discussed by management within directorates/BDUs and the forecast position is agreed with the relevant Director or Deputy.
- For a number of years, a detailed review of the financial position has been produced at month 6 for Trust Board. This considers trends and underlying drivers of the cost base and the impact on future years' plans.
- Financial assumptions in the annual and five-year plans are outlined in the Trust Board report following discussion at EMT. Additional workshop sessions are held to ensure that Trust Board members have the opportunity to query assumptions to ensure they are confident in approving the annual plan and Monitor submissions.

Governance

- Monthly financial reporting is reviewed at a number of levels; by Directorates/BDUs, by the Director of Finance, by the Executive

	Management Team and, finally, Trust Board. The review forms part of minuted meetings, which can demonstrate the audit trail of reporting issues, agreement of how to deal with issues and delivery of actions. ➢ The internal audit plan is scoped annually using a collaborative approach with senior management and the Audit Committee so that the content is focused on core processes which need annual assurance plus key areas identified where management has identified that further independent scrutiny would be beneficial in tackling areas of risk or enabling improvement in practice. ➢ Core financial processes and systems are audited annually by internal audit. The findings are reviewed by the Audit Committee, including ongoing monitoring of compliance with recommendations. ➢ Scrutiny of financial reporting in the annual report and accounts by External Audit. The Trust has received an unqualified opinion on its financial statements and, over the last three years, minimal issues have been raised by the auditors in their report to the Audit Committee at the end of the annual audit. ➢ Scrutiny of financial reporting and financial planning by the Regulator, Monitor. Since becoming a foundation trust, the Trust has retained a financial risk rating of >3 on the Monitor metrics. The level of confidence in the planning and reporting of financial performance is reflected in the following. - The Trust is on quarterly in year reporting. - The review of the Trust's plan has been by telephone conference and not required further submission. - The Trust received a risk rating of 3 following the submission of the acquisition case for PCT provider services. It was agreed that the Chair of the Committee could make a recommendation to Trust Board that assurance is in place and that the Audit Committee has sufficient information to make such a declaration to the full Board. It should be noted that both internal and external audit were asked to comment. Both agreed that Trust Board, both non-executive and executive directors, must have the right skills and expertise, particularly in relation to finance, the right information must be presented to the right committee at the right time, and financial reporting must be clear and transparent to allow understanding by all members of Trust Board. The accountable director must fully understand the figures and assumptions, and that the financial information presented is valid from a data quality point of view and the narrative alongside is valid, transparent and considered. Both were of the view that the systems and processes in place within the Trust are sufficient to provide Trust Board with the assurance it is seeking. The Committee also noted that the requirement by Monitor for all foundation trusts to undertake a governance review every three years would provide assurance on the arrangements in place within the organisation and the Chair of the Trust will re-look at the timing of this review with the Chief Executive.
Recommendation:	**Trust Board is asked to NOTE the Audit Committee's recommendation that the systems and processes in place within the Trust provide the assurance sought by Trust Board.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 21 October 2014
Agenda item 5.3

Title:	**Customer services report quarter 2 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. A recent KPMG review has indicated Trust policy is robust and in line with best practice in NHS complaints management. The Trust-wide Service User Experience Group (a sub group of the EISTAG) is working to develop a dashboard of KPIs and enhanced reporting of service user experience.
Executive summary:	A range of key performance indicators is being developed to evidence patient experience. Reporting on these KPIs will be used as a tool to change behaviours, influence improvement and 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. **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 2: • 321 issues were responded to; • 67 formal complaints were received and 153 compliments; • care and treatment, waiting times, delays and cancellations, staff attitude and communication were the most common themes; • 6 complainants asked the Parliamentary and Health Service Ombudsman to review their complaint; • over 190 public enquiries were responded to and just under 300 staff enquiries; • 43 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 2 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 JULY 2014 – 30 SEPTEMBER 2014 (QTR. 2)

TRUST WIDE

INTRODUCTION

This report covers all feedback received by the Trust's Customer Services Team - comments, compliments, concerns and complaints, which are managed in accordance with policy approved by 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.

The report includes:

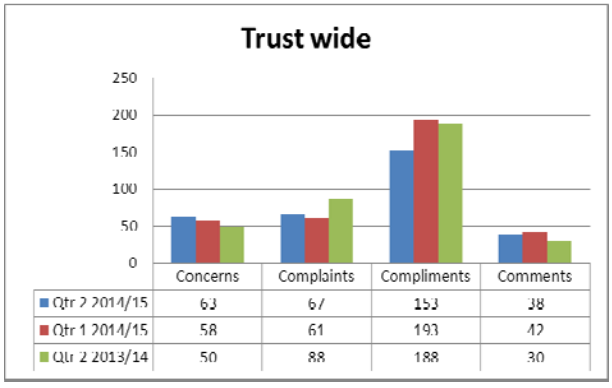
- the number of issues raised and the themes arising
- equality data
- external scrutiny and partnering
- Customer Service standards
- actions taken and changes made as a consequence of service user and carer feedback
- compliments received
- the number and type of requests processed under the Freedom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

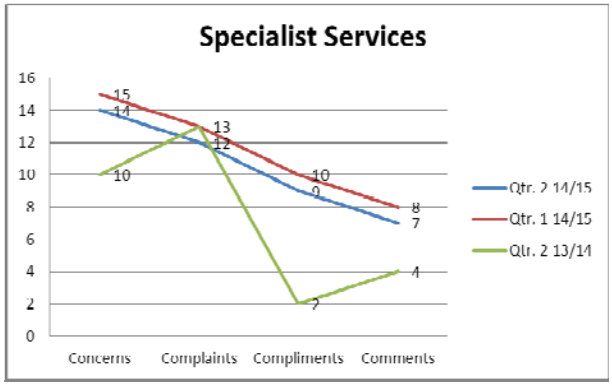
A more detailed report is shared with the Extended Executive Management Team which shows a breakdown of information at Business Delivery Unit level.

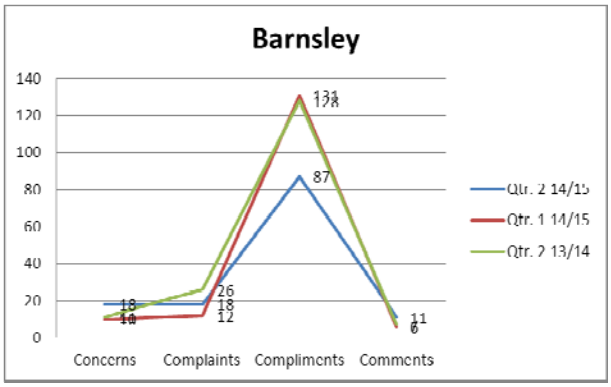
FEEDBACK RECEIVED

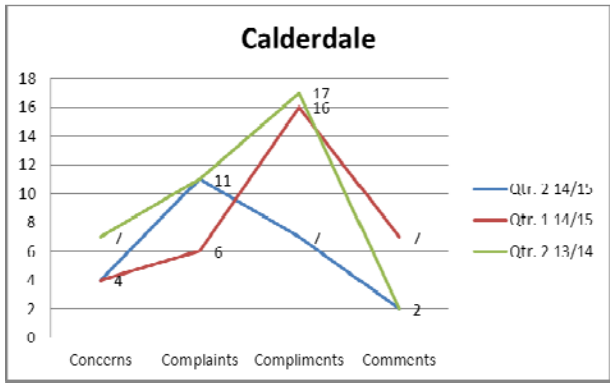
The tables below illustrate Customer Services activity in Qtr. 2. The customer services team responded to 321 issues; 67 formal complaints were received and 153 compliments. This compares to 354 issues, 61 formal complaints and 193 compliments in the previous quarter.

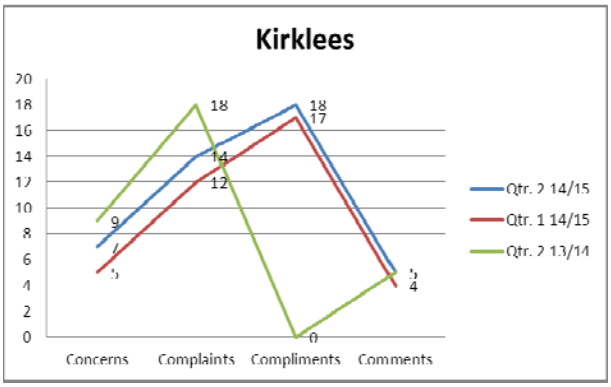
CUSTOMER SERVICES ACTIVITY QTR.2

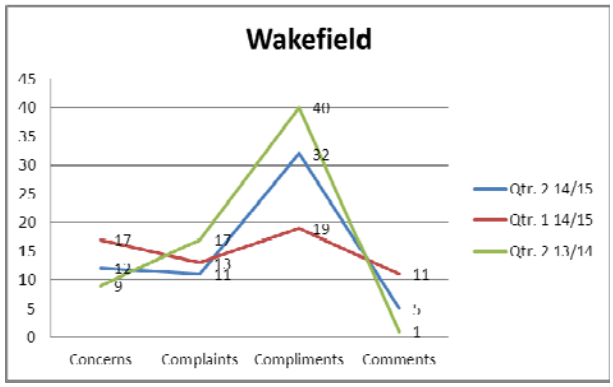


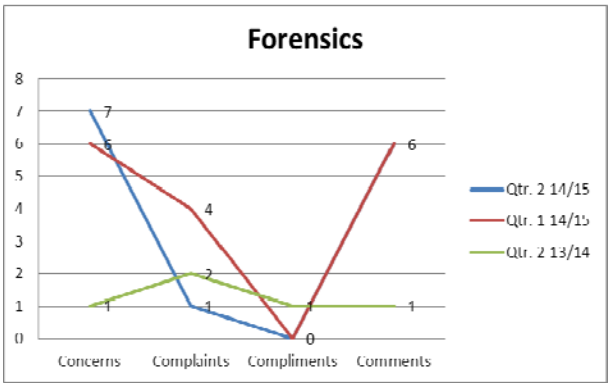


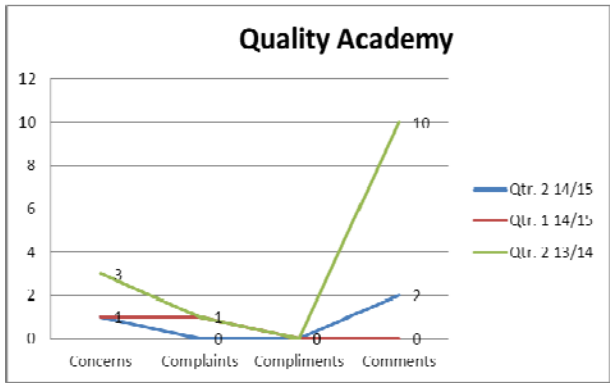












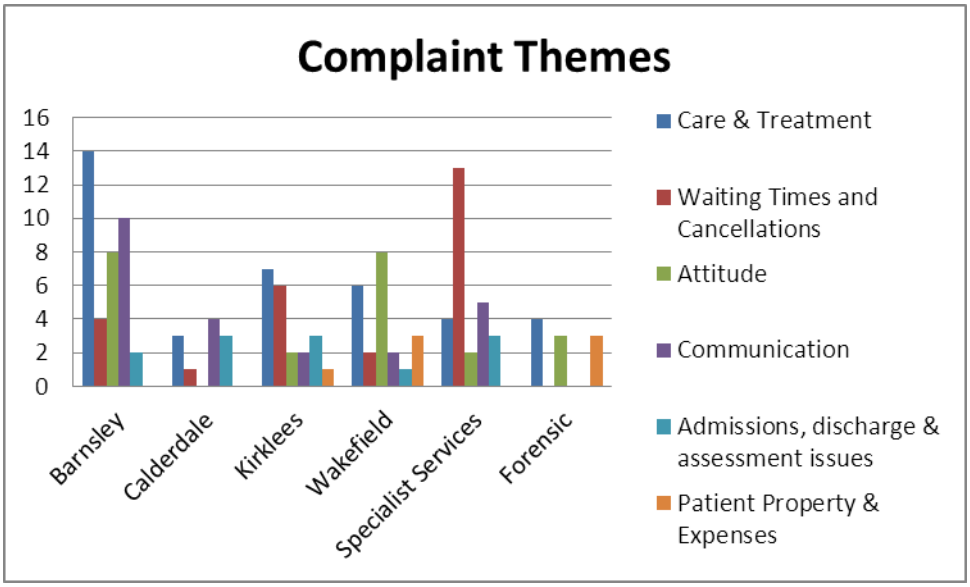
NUMBER OF ISSUES RAISED INFORMALLY

During Qtr. 2, Trust services responded to 63 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

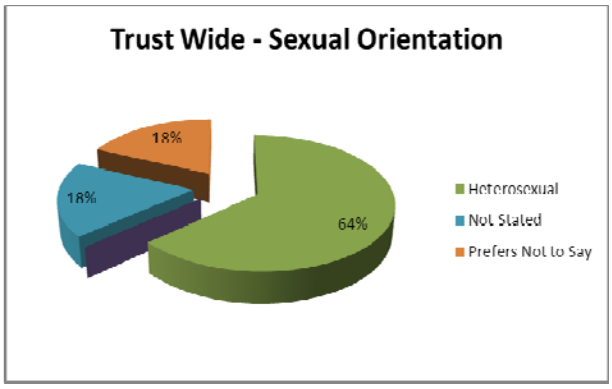
Consistent with past reporting, care and treatment was the most frequently raised negative issue (38). This was followed by waiting times, delays and cancellations (26), staff attitude (23), communication (23), admission, discharge and assessment issues (12), and patient property & expenses (7). Most complaints contained a number of themes.

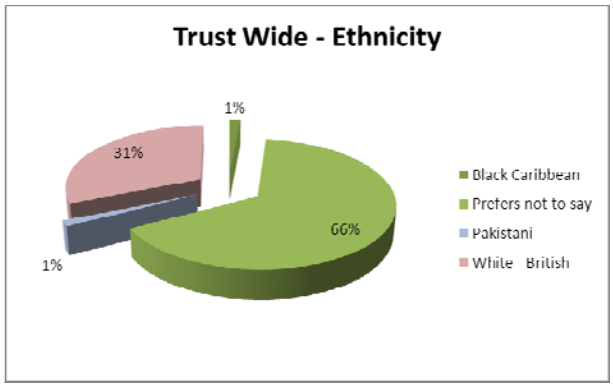
The Customer Services function connects to a weekly risk scan which brings together intelligence from the Patients Safety Support Team and the Legal Services Team to triangulate any issues of concern and assess the impact on service quality.

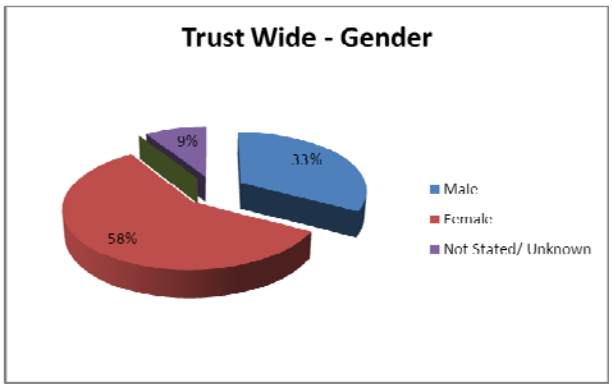


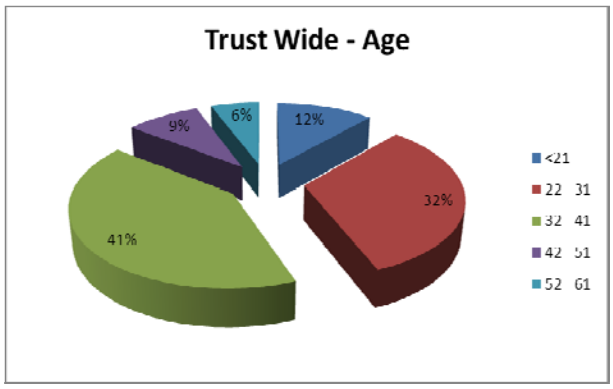
TRUST WIDE EQUALITY DATA

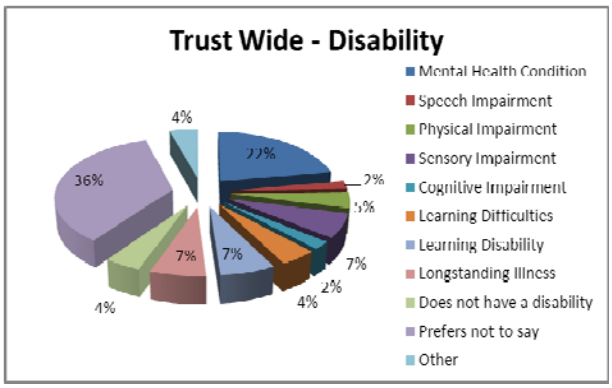
Equality data is captured, where possible, at the time a formal complaint is made. Where complaints are received by email or letter, an equality monitoring form is issued with a request to complete and return. The response rate for forms in Qtr. 2 was 42%. The charts that follow show, where information was provided, the breakdown in respect of gender, age, disability and ethnicity trust wide. The return rate of information is shown underneath the tables.











Although the team makes every effort to collect equality data through each contact point, some people prefer not to share this, and when asked indicate that it has no bearing on whether or not they provide feedback to the Trust or want to raise an issue. The large percentage in this category gives some cause for concern and we will be exploring this area further.

MP CONTACT

During Qtr. 2, there were 7 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: Barry Sheerman MP (1) Jason McCartney MP (1)
Enquiries related to transfer/continuity of care and follow up appointments in community services.

Specialist Services BDU: Jason McCartney MP (1) Ed Miliband MP (1)
Both enquiries related to access to CAMHS services.

Wakefield BDU – Mary Creagh MP (1)
Enquiry related to accessing crisis services and perceived lack of empathy from staff.

Barnsley BDU – Dan Jarvis MP (1)
Enquiry related to perceived lack of support from a community mental health team.

Trust Wide Corporate Services – Angela Smith MP (1)
Enquiry in relation to the availability of on-going speech and language, and the resources available to fund same.

MP's (in line with IG policy) are notified of the outcomes of the concerns raised. The Trust also makes proactive contact with MPs to keep them informed of news and initiatives on a monthly basis and offers specific briefing about relevant issues. In the period, the Chief Executive met with John Trickett to discuss CAMHS provision, and made an offer to Yvette Cooper to brief regarding the future of Castleford and Normanton District Hospital and continued investment by the Trust in the Eastern side of the Wakefield district.

PARLIAMENTARY HEALTH SERVICE OMBUDSMAN (PHSO)

During Qtr.2, 6 complainants asked the Parliamentary and Health Service Ombudsman to review their complaint (1 Specialist Services - Barnsley CAMHS), 1 Wakefield, 1 Calderdale, 1 Forensics and 2 Kirklees). 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.
During the quarter, the Trust received feedback that the Ombudsman is proceeding to investigation on 2 cases. The remaining cases are still subject to review; some of which date back a number of months.

MENTAL HEALTH ACT

2 complaints were made in Qtr. 2 with regards to service user detention under the Mental Health Act. Both individuals chose 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)

2 issues were referred to the Trust by the CQC in Qtr. 2.

Wakefield Older People's Inpatient Services – son complained about lack of care and treatment provided to his late father and about the attitude of staff. The issues are currently subject to investigation. Contact is being maintained with the complainant and with the CQC as the investigation progresses.

Specialist Services – Calderdale/Kirklees CAMHS – mother complained about the lack of care provided to her daughter – issues have been responded to through the NHS complaints procedure and resolved to the complainant's satisfaction. Full update has been provided to the CQC.

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.

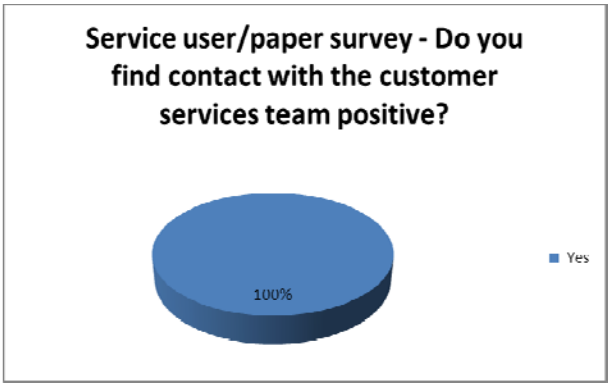
During Qtr. 2 additional detail regarding complaints was provided to BMBC Children's services, and the Trust participated in a national NHS benchmarking exercise.

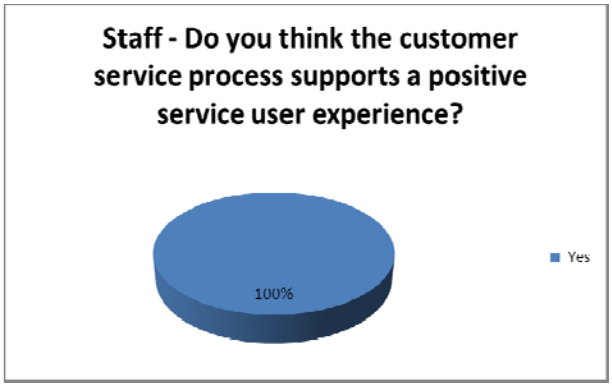
Issues spanning more than one organisation in Qtr.2	Formal Concern (Over 48 Hours) (COMPLAINT)	Informal Concern (Up to 48 Hours) (CONCERN)	Service Issue (COMMENT)	Total
Barnsley Hospital NHS Foundation Trust	1	0	1	2
Barnsley Metropolitan Borough Council	1	0	0	1
Care Quality Commission	0	0	2	2
NHS Bassetlaw CCG	0	0	1	1
NHS Calderdale CCG	0	0	1	1
NHS Greater Huddersfield CCG	1	0	0	1
Other Local Authority	0	1	0	1
Total	3	1	5	9

CONTACT WITH CUSTOMER SERVICES TEAM

The customer services team processed 193 general enquiries in Qtr. 2, in addition to '4 Cs' management. These included provision of information about Trust Services, signposting to Trust services, providing contact details for staff and information on how to access healthcare records. The team also responded to just under 300 telephone enquiries from staff, offering 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. Numbers responding to the request to give feedback are very low (6 and 7 respectively in the tables below) – but from those who do, the response is entirely positive.





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. A small number of complainants take up the offer to meet, but most say they are happy with the contact offered via Customer Services and don't wish to attend a separate meeting.

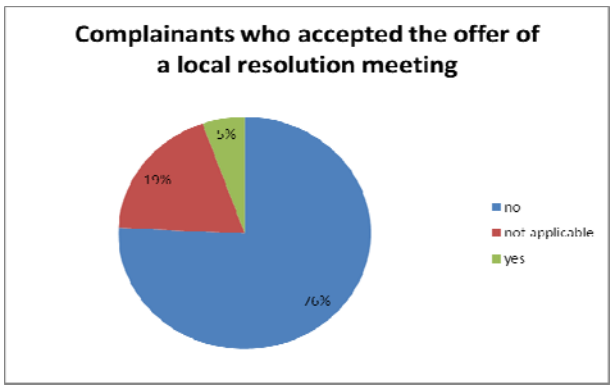
Feedback from staff who participate indicates that this improves overall understanding of how service users and their families perceive Trust services.

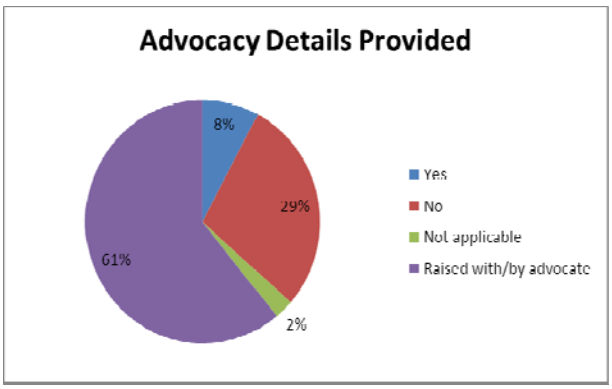
'*Customer Services was very thorough in dealing with my concerns; professional and listened well. My queries were handled very quickly. I was kept informed and got help to resolve my issues.'*
Service user

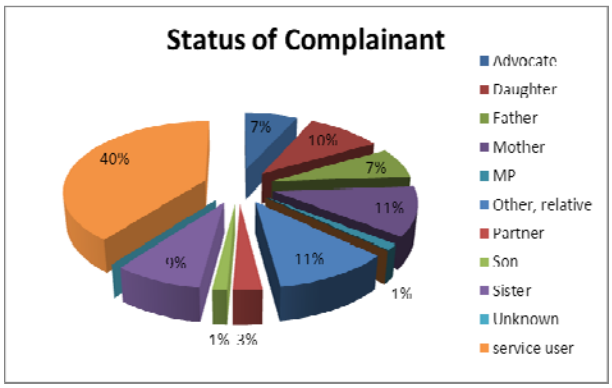
In relation to staff satisfaction (evaluated by questionnaire), 100% of respondents indicated they were happy with the support provided.

'The team is easily accessible for advice.'
'Always supported throughout the process and were at the 'end of the phone' whenever I needed them'
'The investigation toolkit is easy to follow and complete.'
Staff comments

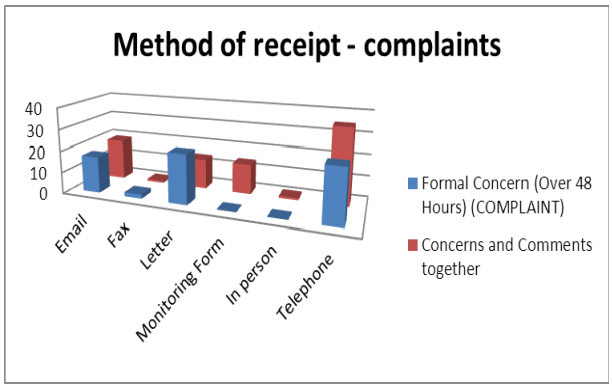
Complainants are also provided with contact details for independent advocacy services and are encouraged to use this support if helpful. A small number of service users are supported by an advocate.







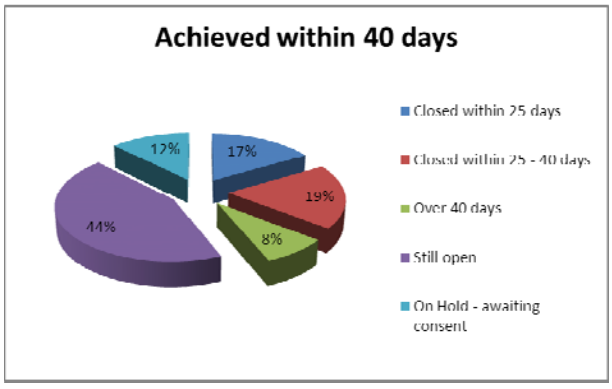
Complainants may wish to communicate in writing (by letter or completion of the Customer services feedback form), by ‘phone, email, text message, via the website or through face to face meetings. Ensuring that people have access and opportunities to feedback their views and experiences of care is essential 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. 2, 31% of cases took longer than the 40 day internal service standard. This was due to:

- Further issues added as the complaints investigation progressed
- Complaint put on hold at the complainant's request.
- Cases awaiting further information or clarification
- Capacity issues determined by responsible clinical
- Staff absence caused delay in obtaining witness statements
- Cases re-opened following Trust response.



52 formal complaints remain open, 38 of which were received in the quarter. 12 of these are awaiting consent to investigate. 13 complaints were initially raised in the previous quarter and remain open or have been re-opened as the complainant remains dissatisfied with the Trust's response.

COMPLIMENTS

During Qtr. 2, 153 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.2

Requests for assistance, guidance and information were dealt with promptly, efficiently, professionally and compassionately.

Wakefield - CMHT

We were very impressed with our choice appointment. The doctor was great, with a lovely attitude and great with children. She explained my son's diagnosis to him very well.

Barnsley - CAMHS

To all the staff on the ward, thank you for taking the time to care. You have done an excellent job looking after our mum.

Kirklees – Priestley Unit

Thank you to all of you for your help when I fell. You were all so kind. Thank you all.

Barnsley – District Nursing Service

To all staff on PICU - You have showed such compassion. Your endless patience is quite remarkable. Thanks for everything.

Wakefield - PICU

Thank you for all your listening skills, I'm feeling great, partly thanks to you and partly me for realising that the person for the last 4 years really wasn't me. It's been great to open up to somebody so nice, you've helped me so much, thanks.

Calderdale – Psychological Therapy 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.

All complainants are offered the opportunity to meet with Trust staff to discuss their concerns, and some take this up. 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

- IAPT staff ensure they explain the types of therapy and methods offered and discuss these with service users to minimise any confusion regarding the service offer.
- District nursing staff seek clarification of understanding regarding procedures and follow up on concerns as and when they arise.
- Further training and support relating to catheter procedures is to be offered in a district nursing team.

- Staff from the health visiting team have reviewed the issues around professionalism in relaying sensitive information to carers.

Calderdale & Kirklees BDUs

- A family's experience of receiving care has been shared with the crisis assessment team as a learning exercise, and the importance of appropriate and professional conduct when making contact with service users and families has been reiterated.
- Attention has been given to more accurate recording and onward communication of telephone messages in a Calderdale CMHT.
- Sample caseload screening is underway in the Insight team to ensure copies of care plan documentation are routinely provided to service users in line with Trust policy.
- Revised procedures are in place in a Kirklees CMHT to ensure consent is received in advance from service users where requests are made for students to attend home visits along with practitioners.
- The Kirklees Insight team will ensure the reason for appointment cancellations is always recorded.
- Outpatient services in Kirklees will attempt to contact service users when clinics are running late to make people aware of the delay and to offer the choice of re-scheduling.

Wakefield BDU

- 136 suite staff have been reminded about the value and importance of involving and listening to carers and family members during the assessment process.
- Wakefield memory clinic staff will ensure in future that the side effects of medication are always discussed with service users and with carers and that information leaflets are always provided.
- Housekeeping staff have reviewed the procedures for checking meals to ensure meals are provided as ordered.
- APT practitioners have reviewed the safeguarding process, clinical and management supervision in respect of same, and the need to maintain familiarity with multi-agency safeguarding procedures.
- Staff attitude and the need to remain polite and professional at all times have been discussed with reception staff in a Wakefield CMHT.

Specialist services BDU

The following improvements have been made in Calderdale and Kirklees CAMHS services in response to feedback; all of which support the recovery plan agreed with commissioners:

- Appointments affected by staff sickness are reviewed to ensure any impact on waiting time is clearly communicated to service users and family members.
- Team restructuring is underway to support new service models to improve access and transition.
- A clinical lead for eating disorders has been appointed to support a multidisciplinary approach to screening for eating disorders.
- Service protocols have been reviewed for allocation of cases relating to deliberate self-harm and follow up appointments.
- Additional administrative support has been put in place to support improved record keeping and a tracking system for referral data.
- Joint working with acute staff in accident and emergency departments and on paediatric wards is underway to promote positive working relationships, clarify out of hours protocols and improve service user experience.

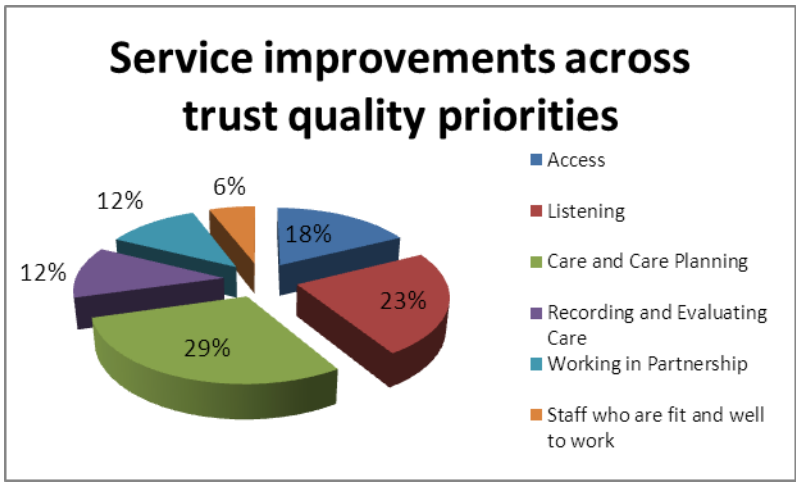
- The CAMHS service in Wakefield has reviewed its clinical record keeping and will ensure clear documentation of clinical decisions with the rationale to support same.

Forensic services BDU

- The importance of explaining restraint and seclusion procedures to service users has been reiterated to ward staff.

The forensic team are building on recent positive feedback on involvement, including the One Voice Group, the unit-wide Carer's Dialogue Group and recent ward based family events. A ward manager is leading work to raise awareness of the importance of recording positive feedback from service users, to share good practice and to have this acknowledged through Trust processes. The Customer Services monitoring form has been shared with all wards and staff are being encouraged to capture all feedback. Progress in this area will be monitored in subsequent quarterly reports.

Improvements made as a result of feedback as shown against Trust quality priorities:



EXAMPLE OF SERVICE USER AND CARER EXPERIENCE

Lynsey was referred to the Improving Access to Psychological Therapies (IAPT) team. She attended two face to face appointments with a therapist, but following these sessions, was only offered telephone support, with no explanation as to why the service offered to her had changed.

This complaint highlighted the issue that the IAPT process and likely progression was not always fully explained to service users, which resulted in confusion and a feeling of being moved on to a less helpful service. Team procedures were reviewed to ensure that the service offer, including the possibility of telephone based support, is always discussed at the outset to manage expectations.

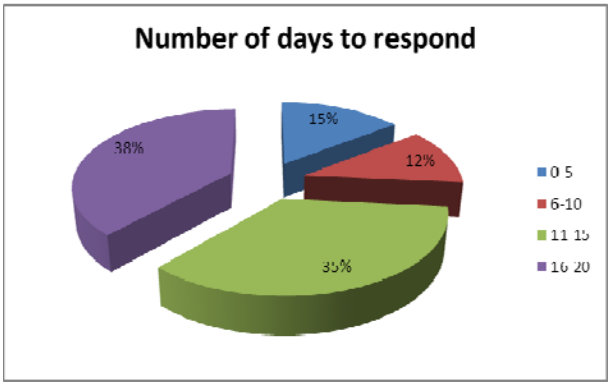
Alison raised concerns regarding the care and treatment her daughter, Kerry, had received from CAMHS following a second overdose of over the counter medication. Alison explained that it felt like there was no communication between staff teams.

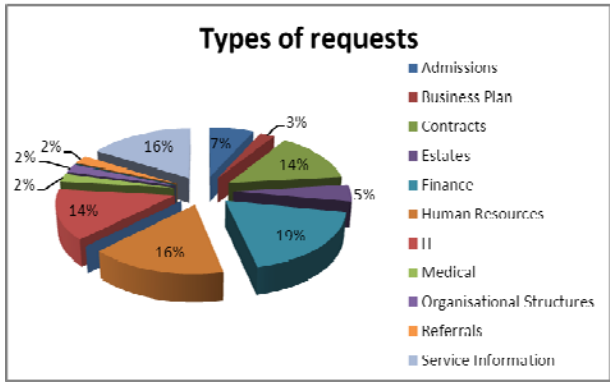
In response to the concerns raised, the CAMHS team reviewed the protocol for follow up appointments, and allocation of staff to cases relating to incidents of deliberate self-harm. The review has improved communication within the team and the changes implemented support improved case management.

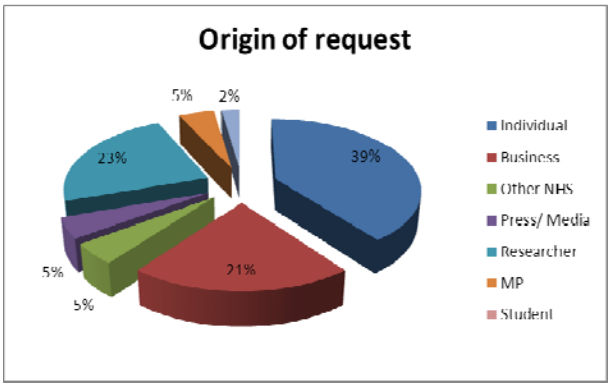
FREEDOM OF INFORMATION REQUESTS

43 requests to access information under the Freedom of Information Act were processed in Qtr. 2, a decrease on the previous quarter when 53 requests were processed. Many requests were detailed and complex in nature and required significant time to collate an appropriate response working with services and quality academy functions.

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







During Qtr. 2, there were no exemptions applied under the Act.

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.

During the quarter, feedback was received following a Members' Council review of Customer Services activity, that a breakdown of themes between inpatient and community services would provide helpful insight. Coding updates currently being applied to the Datixweb electronic recording system, to support service line reporting, will mean that this breakdown will be able to be provided in future reporting.

Work is underway to develop combined reporting of patient experience, customer services and equality information to maximise the opportunity for triangulation and to extrapolate themes and areas of both concern and best practice. This work is being progressed as part of the service user experience sub group of the Equality & Inclusion Trust Action Group.

In quarter 2, KPMG completed a review of patient experience and engagement, as part of the Trust's internal audit programme. In respect of Customer Services, the review identified good practice, including Trust policy being in line with national good practice in NHS complaints handling and a robust and comprehensive framework for escalation and reporting of complaints data to Trust Board, Extended EMT and to BDUs. The review also identified areas for development, including exploring further opportunities for supporting ward teams to learn lessons and implement change in response to feedback, and an action plan will be developed in response to this.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 21 October 2014
Agenda item 5.4(i)

Title:	**Equality Delivery System – update**
Paper prepared by:	Director of Corporate Development
Purpose:	The purpose of this paper is to provide an update of progress against the Equality Delivery System (EDS2) goals and the four prioritised objectives.
Vision/goals:	Equality and diversity considerations are intrinsic to improving the service user and carer experience and the workplace culture, supporting the delivery of the Trust's mission, underpinned by the Trust's values.
Any background papers/ previously considered by:	This paper supports the delivery of the Trust's Equality First Strategy and updates on the Equality Report 2013/14 presented to Trust Board in April 2014.
Executive summary:	The Trust is committed to promoting the equality and diversity agenda, aiming to provide services which promote recovery, challenge stigma, enable social inclusion and promote an inclusive and fair working environment for staff. The Trust's aim is to ensure that everyone that needs to can access the Trust's services and that it has a workforce that is free from discrimination and harassment. The Trust has adopted the NHS Equality Delivery System Framework (EDS2), which has recently been reviewed and simplified, to assess equality performance and to provide assurance that the Trust meets its public sector equality duties. The Trust has chosen, based on using the original version of the EDS and recent engagement activity, inclusion and involvement work, to focus on one objective from each of the four EDS goals: • better health care outcomes; • improved patient access and experience; • a representative and supported workforce; and • inclusive leadership. The purpose of this paper is to provide an update on progress in respect of the Equality Delivery System (EDS2) goals and the four prioritised objectives.
Recommendation:	**Trust Board is asked to RECEIVE this update**
Private session:	Not applicable

Equality Delivery System – update
Trust Board 21 October 2014

Background

The Trust is committed to promoting the equality and diversity agenda and we aim to provide services which promote recovery: challenge stigma, enable social inclusion and promote an inclusive and fair working environment for our staff. Our aim is to ensure that everyone who needs to, can access our services and that we have a workforce that is free from discrimination and harassment.

As a Trust, we have adopted the NHS Equality Delivery System Framework which has recently been reviewed and simplified and we are now working with EDS2, to assess our equality performance, ensuring we deliver better outcomes for patients and communities and better working environments for staff, which are personal, fair and diverse. The framework will also provide Board assurance that we are meeting the public sector equality duty, in partnership with our Commissioners, other external stakeholders and partners.

Performance against the EDS2 requirements is graded and compliance with the duties is measured, across the nine protected characteristics as set out in the Equality Act and an additional characteristic, namely "carers" to reflect the Trust's values.

Race	**Religion or Belief**	**Age**	**Pregnancy and Maternity**	**Marriage and Civil Partnership**
Gender	**Sexual Orientation**	**Carers ***	**Disability**	**Transgender**

At the heart of the EDS2 framework is a set of 18 outcomes grouped into four goals. These outcomes focus on the issues of most concern to patients, carers, communities, NHS staff and Boards. It is against these outcomes that performance is analysed and graded, as underdeveloped, developing, achieving or excelling and equality objectives and associated action determined. The four goals are:

- better health outcomes;
- improved patient access and experience;
- a representative and supported workforce; and
- inclusive leadership.

At the Trust Board meeting in April 2014, the Board approved, based on stakeholder grading's using the original EDS framework and recent engagement activity, inclusion and involvement work, to focus on one outcome from each of the above goals with an additional focus on one of the protected characteristics, being race.

Progress to date

The four prioritised objectives agreed by the board had been previously rated as developing, with a target of moving to achieving over the next 2 years and excelling, within 5 years, progress on this journey is set out below.

Goal 1- Better Health Outcomes: *Objective 1.3 - Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed.*

Rationale for choosing

- Key message from the "Transformation Events" of people not seeing the joins when interaction is undertaken between services or organisations.
- NHS Outcomes Framework Goal 4 "Ensuring people have a positive experience of care."
- NHS Constitution pledge: "The NHS also commits to make the transition as smooth as possible when you are referred between services, and to put you, your family and carers at the centre of decisions that affect you or them."
- CQC's key inspection questions: Are services effective? Are services responsive to people's needs?

How we are embedding this in the organisation

- RIO/IT Systems – work around improving the data collection of all the equality strands information is currently on-going, clinically led, which will be supported by a training package for staff.
- A forensic learning disabilities network has been set up to support partnership working. The network focusses on issues relating to the practice of working together with service users and their carer's.
- Barnsley Better Care Fund - the Barnsley Health and Wellbeing Strategy is designed from a whole systems perspective focused around integrated pathways and service re-design. This will ensure the health and care system is fit for purpose and sustainable, able to meet the needs of local people and deliver the best possible outcomes for the people of Barnsley. The project work in Barnsley has been cited as evidence of good practice in the recent report from the Winterbourne View Joint Investment Programme.
- Interpreting, Translation and Transcribing Policy is under review working alongside Procurement. The new policy will bring together all BDUs working practices across the Trust footprint. The review will also look at enhancing our partnership working arrangements for effectiveness and efficiency.

Goal 2 - Improved Patient Access and Experience: *Objective 2.2 - People are informed and supported to be as involved as they wish to be in decisions about their care.*

Rationale for choosing

- The CPA process – "No decisions about me without me…" aligns with National Policy,
- Links to Service User Information Project work progressing issues from "What Matters"

How we are embedding this in the organisation

- Trust wide review of CPA policy is currently being undertaken with a key focus on embedding the principles of "No decisions about me without me" ensuring people feel informed and supported and involved in their care.
- Calderdale Memory Service, recognised by the Royal College of Psychiatrists for the care they provide to people with memory problems and dementia and their families.
- CQUIN in the Forensics BDU focussed on Carers Engagement work is progressing, addressing capture and use of information.
- CQUIN - Carers Engagement work is progressing on Ward 18 led by the consultant following the "You said - We did" model.
- Forensic CAMHS shared their good practice and learning at the annual Faculty of Child and Adolescent Psychiatry conference, facilitating a workshop titled "How to take a good psychosexual history (without blushing)" as well as presenting a clinical case using role play to demonstrate what kind of questioning may be used in taking a history.

- Dementia Friends and Safe Places training has been commissioned and delivered to Arriva staff at Wakefield Bus Station to inform, support and build up awareness around people and health insight for drivers and other staff.
- The Trust was awarded the Customer Service Excellence accreditation last year, and this year we undertook and passed our annual review. The assessor talked to many different services from across the Trust to make sure we were still doing what we said we would and to explore where projects and initiatives had developed.
- In April 2014 the Trust was awarded the gold standard of the Rainbow Tick, based around the symbol of the Rainbow and what it represents to the Lesbian, Gay, Bisexual and Transgender community. By visibly showing the tick, we are saying that our Trust is a safe, inclusive and friendly place to be treated and to work for, for those in the LGBT community.
- Over 100 Service Users and Carers were involved in the Service User Information Project, the work of this project delivered 3 outcomes – supporting accessibility to services, with the production of 'we're here' guides for each building where service users visit - allowing people to read the most understandable third party information on common conditions that we see within the trust, information which has been selected as 'best in class' by our service users and carers - opening up conversations about general wellbeing in the form of a series of 15 booklets, on topics such as sleep, baby blues, low moods. The guides/booklets were co-produced with our service users, carers and staff and are available on the intranet for everyone to access.
- A project is now underway which will look at how the Trust currently provides support to the hard of hearing/deaf community and how we can improve.
- The Trust has devised a postcard questionnaire as well a long questionnaire which will capture equality Protected Characteristics information on the Friends + Family test. This has been acknowledged as a piece of good practice within the Equality and Diversity Regional network. The use of the questionnaire is due to go live October 2014.

Goal 3 A Representative and Supported Workforce: *Objective 3.1 - Fair NHS recruitment and selection processes lead to a more representative workforce at all levels.*

Rationale for choosing

- Delivery on the staff rights and pledges of the NHS Constitution.
- The NHS England Strategic Priority “creating an NHS workforce and leadership that is reflective of the communities we serve, and that are free from discrimination”

How we are embedding this in the organisation

- Values based appraisal rolled out across the organisation.
- Member of Project Innov8 supporting Trust strategic aims while increasing workforce diversity
- Bi-annual Wellbeing staff survey results showed positive findings in respect of work relationships, balanced workload, staff engagement, positive psychological well-being and commitment of organisation to employees, further work is required around employee perceptions regarding job security and change.
- Undertaking employee exit interviews and using insight to improve staff workplace experience.
- Clinical Apprenticeship scheme pilot (reflecting Francis and Cavendish and supporting the strategic theme of Recruitment in the NHS England Equality, Diversity and Inclusion in the Workplace Strategy 2013 – 2015) commenced August 2014 in Barnsley and Wakefield BDUs.
- Trans Awareness information was cascaded and shared through the Service Line Managers meeting from Community Development worker MESMAC - Wakefield. Two training events have been commissioned and delivered, with a very positive evaluation.

- Equality, Diversity and Inclusion training for face to face sessions with Trust staff is currently being refreshed by Professor Archibong of Bradford University and Director for Centre for Inclusion and Diversity. This will enhance the mandatory training we currently offer.
- Recruitment and Selection training was delivered to 50 people made up of Service Users, Carers and Members Council across the BDUs for interview panels across the trust to give Lived Experience insight.

Goal 4 Inclusive Leadership: *Objective 4.1 - Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations.*

Rationale for choosing

- Key leadership agenda, visibly supporting and advancing the equality agenda, through Board/Senior leadership team and direct reports, reflective of the communities we serve.
- CQC's key inspection question: Are services well led?

How we are embedding this in the organisation

- Members of our Trust Board and Calderdale and Huddersfield FT Board, forming an informal group to raise awareness about the NED role and role of Members' Council following publication of "Snowy White Peaks" report, to encourage future applicants from a BME background.
- Attendance at the Leadership Academy Chief Executive networking event for Y + H region to address regional/local action to follow the publication of "Snowy White Peaks".
- Research commissioned by Corporate Development Director around access into Trust Mental Health services for Black, Asian and Minority Ethnic, (BAME) service users and Non-BAME service users, to explore the perception that service users from BME communities access services late and as a consequence are more likely to be detained under the MH Act and have longer lengths of IP stays.

Trust Board 21 October 2014
Agenda item 5.4(ii)

Title:	**Quality Academy review and action plan**
Paper prepared by:	Chief Executive
Purpose:	The purpose of this paper is to provide an update on the Quality Academy review and proposed actions.
Vision/goals:	Clear leadership arrangements providing clarity around accountability and responsibility are intrinsic to improving the service user and carer experience and workplace culture, supporting the delivery of the Trust's mission, underpinned by the Trust's values.
Any background papers/ previously considered by:	Previous discussions at Trust Board
Executive summary:	An external review of the Quality Academy was commissioned by the Chief Executive to address the following questions. ➢ Is the Quality Academy fit for purpose? ➢ Does it have the right synergies and linkages within and across its separate corporate services? ➢ Is it effective and efficient and is the Trust spending too much on corporate services? Frontline, an independent company, was procured to undertake the review. The organisation undertook a wide-range of interviews with Quality Academy and BDU staff, and Trust Board, including: - the Deputy Chair/Senior Independent Director and Chair of the Audit Committee; - the Chief Executive; - Quality Academy Directors; - BDU Directors; - Quality Academy deputy directors and 'second in-line' managers; - BDU deputy directors. Frontline also undertook observation of Operational Requirement Group and Executive Management Team meetings and benchmarking with other mental health trusts, and conducted a review of current performance. The following key observations were made in the feedback report. ➢ Overall, people engaged positively, with enthusiasm, showed determination to improve services to patients and were optimistic about the future, but were open, honest and direct about where change is needed. ➢ There is tension between the need for decentralised autonomous action and the need for centralised direction and control. ➢ The current approach enables the Trust to achieve its critical success factors of compliance and accountability; however, the approach has a tendency to produce a culture that is characterised by silos, control and individual interests resulting in tension and lack of conversations about achieving improved quality and excellence. ➢ BDUs need to demonstrate the ability to deliver and be innovative, and the Quality Academy needs to manage the risk in delegating. ➢ A challenge is to turn data into information that gives knowledge to ask questions to join the dots to get insight to key areas. ➢ Insight of performance should lead to meaningful conversations on the

	basis of trust in the ability to both deliver and support. ➢ There is a need to recognise the challenge of which 'hat' is worn in conversations, negotiating the trade-offs for what is best at corporate level to transform services against the functional interest: - personal – individual contribution; - function – accountable for functional area; - corporate – team role within the Trust. Key actions have been agreed as follows. ➢ Develop capability both at BDU level and at deputy and direct report level in the Quality Academy. ➢ Focus on effective conversation to bring about change underpinned by robust processes that provide information to understand the business. ➢ Operational staff in the Quality Academy and BDUs need to build on work to develop conversations to understand both their perspectives. ➢ Quality Academy staff should be 'embedded' in BDUs as partners. ➢ Clear accountability for results is needed, which should come through new leadership and management structures. ➢ There is a need to be clearer about outcomes (not focusing on tasks) to ensure productive conversations. ➢ The Trust should develop a strategic reporting framework designed to make strategy 'everyone's job', joining the dots and letting everyone see the bigger picture. To support the development of an action plan, the Chief Executive is currently leading a process of 360° appraisal for all Directors, both Quality Academy and BDU. The findings will inform a stage 2 piece of work with Frontline focused on action planning. The work is essential to ensure corporate support is optimised to support frontline leadership and management in delivering and transforming services.
Recommendation:	**Trust Board is asked to RECEIVE this update**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 21 October 2014
Agenda item 6.1

Title:	**Members' Council evaluation**
Paper prepared by:	Chair
Purpose:	The purpose of this paper is to inform Trust Board of the outcome of the Members' Council evaluation session held on 17 September 2014.
Mission/values:	An effective and engaged Members' Council is a key element of the Trust's governance arrangements, which are essential for the Trust to remain legally constituted, financially viable and sustainable as a Foundation Trust and to continue to meet its obligations under its Constitution.
Any background papers/ previously considered by:	There are no background papers for this item.
Executive summary:	Since it was authorised as a Foundation Trust in May 2009, the Trust has held an annual evaluation/assessment event for the Members' Council, supported by the Chair and Deputy Chair of the Trust, and the Director of Corporate Development. These sessions have been externally facilitated to ensure independence and impartiality. In 2014, the Trust followed the approach adopted in previous years of an interactive and participative session. The focus of this year's session was to assess the contribution governors have made and the role they play, both collectively and individually. Governors were also asked to consider what they were most proud of, again individual and collectively. All governors came away with individual actions for the coming year in terms of their role and what they would like to do more of and less of. The session also asked governors to consider what constitutes a 'perfect' governor and to consider the Members' Council objectives for the coming year. The notes from the session are attached. In summary, governors do feel they are contributing effectively, at the right level; however, it was recognised that there is scope for development and support, not only from the Trust but also between governors. Participants were also asked to evaluate the session and a summary of this is included at the end of the paper. The comments will be used to inform the next session in 2015.
Recommendation:	**Trust Board is asked to NOTE the outcome of the Members' Council evaluation session.**
Private session:	Not applicable.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

A Members' Council Development Event
How can I personally and we collectively contribute to the Trust's future?
17 September 2014

Present:	Marios Adamou	Staff – medicine and pharmacy	Group 1
	Ian Black	Chair	Group 3
	Jackie Craven	Public – Wakefield	Group 3
	Andrew Crossley	Public – Barnsley	Group 1
	Adrian Deakin	Staff – Nursing	Group 3
	Michael Fenton	Public – Kirklees	Group 1
	Claire Girvan	Staff – allied health professionals	Group 2
	Nasim Hasnie	Public – Kirklees	Group 3
	John Haworth	Staff – non-clinical support staff	Group 2
	Andrew Hill	Public – Barnsley	Group 1
	Bob Mortimer	Public – Kirklees	Group 3
	Kevan Riggett	Public – Barnsley	Group 2
	Jeremy Smith	Public – Kirklees	Group 3
	Michael Smith	Public – Calderdale	Group 1
	Hazel Walker	Public – Wakefield	Group 3
	Peter Walker	Public – Wakefield	Group 2
	Tony Wilkinson	Public – Calderdale	Group 2
	Helen Wollaston	Deputy Chair	Group 2
	David Woodhead	Public – Kirklees	Group 2
In attendance:	Bernie Cherriman-Sykes	Board Secretary (author)	
	Ken Tooze	Facilitator	

1. Welcome and introductions

Ian Black welcomed everyone to the fifth Members' Council review/evaluation session. He hoped that everyone would enjoy and be challenged by the session, and feedback on the format and content was welcomed. He commented that the Trust may not be statutorily required to hold an event such as this; however, it does represent best practice for the Members' Council to review and evaluate its effectiveness and contribution to the Trust.

He also referred to the event last year and the personal actions he had taken away. One key action was to recognise the achievements of both the Trust and of staff individually. He highlighted a report from the Health Service Journal on the top NHS organisations to work for. Although not in the top ten, the Trust is ranked in the top 100 out of 334, which is a good achievement. The key thing that the top ten Trusts do is market themselves successfully and this is a key area for development this year for him as Chair. The Trust needs to do more of it. As Chair, he has also taken time to congratulate and thank staff for their achievements and recognition. Governors should also support and promote the Trust in their communities and he will give governors areas for celebration as often as possible. He ended by saying that one area that is not always given sufficient recognition is governors who give their time, contribution and support for no remuneration.

2. Thinking together

In support of the Chair's remarks, Ken Tooze added that it is good practice for all groups to pause and reflect on their personal and collective contribution to the success of an organisation and this session will provide an opportunity for the Members' Council to do this in a light, interactive and supportive way. Governors will be asked to reflect individually and collectively on their contribution during the session and will leave with a couple of things that they personally will take forward in the coming year.

The group undertook a brain teaser, which demonstrated that saying what you see is very important for governors and also the importance of team work.

3. How have I played it?

This session involved personal reflection of:

- what has been my contribution as a governor that I am most proud of over the last year? and
- thinking ahead to next year, what would I like to do more of, less of or stop doing, and what new actions would I like to take?

He reminded governors of their four distinct roles:

- practical duties (that is, statutory duties);
- offer advice to Trust Board about how the Trust can best serve its members;
- keep an eye on the Trust – is it sticking to the terms of its licence, for example, provides the services it said it would?
- advise on the plans the Trust will have, for example, new services.

Group 1 feedback

Proud of

- Involvement in the Quality Group – practical work on moving to community health.
- Involvement in PLACE visits.
- Encouraging getting to know NEDs more (speed dating at Members' Council in April 2014) – 1:1, governance, responsibility, holding to account.
- Deciding to put forward as a governor and being entrusted with this role/responsibility.
- Investment in CAMHS – recovery college involvement.
- Integrated health monitor pilot and set up.

More of

- Nominations Committee
- Make sure transformational change is financially sustainable
- Promote image of the Trust in Barnsley
- Training

Less of

- Committee – Co-ordination

Stop

- Remuneration Committee

New actions

- Positive contributions to awareness of what the Trust has to offer
- Contribute to the services disabled people can get
- Recognition of carers
- Structure and how Trust works
- Make sure transformational change is financially sustainable
- Promote image of the Trust in Barnsley

Group 2 feedback

Proud of

- Challenge – questions
- Listening events
- Promotion of governor role
- Selection of non-executive directors
- Quality Accounts group role
- 15 Steps – service improvement
- Service visits – 'mock CQC'

More of

- Engage NEDs
- Engage public
- Attend Trust Board
- Pass on information/partnership working
- Use pre-meeting time to ask questions of NEDs/Chair

Less of

Stop

- Keeping 'quiet'

New actions

- Positive public promotion
- Governors' poster and locality, etc.
- Link to a NED
- Act as an 'ambassador'
- Put the Trust on the agenda
- Ask for information between meetings

Group 3 feedback

Proud of

- Recovery College
- Unannounced visits
- Budgets and plans through Trust Board and Members' Council
- Having an active role in the Quality Accounts Group
- Reporting back from Ministers, local authorities and MPs
- Enabling someone at Enfield Down to have keys
- Monitoring and contributing to standards/quality through visiting centres/meetings

More of

- Promoting corporate image
- Reading papers
- More good news stories
- More specific discussions with service users
- Publicity with media, local authorities and public
- Help people get more comfortable care in hospital

Less of

- Wasting time
- Procrastination
- Less detail in governors' papers
- Less acceptance of what I am told
- Less napping in sessions
- Less abrupt interruptions
- Less distance to travel for patients/relatives

Stop

- Stop saying 'yes' to everything
- Stop being diverted from what I need to do
- Stop abbreviations/jargon
- Stop being gloomy
- Stop fearing coming to sessions
- Stop reacting to agreed actions/issues

New actions

- Concentration on dementia
- To attend day training session for governors
- CQC visit
- To promote safer practice
- Priority treatment for children
- To attend more meetings and unannounced visits
- To promote inclusivity right across the Trust

This section ended with governors identifying two actions they will personally work on (intention supported by practical action – how, who and timescales).

4. Contributing to the Trust

Ken Tooze explained that he has a fantasy for this session next year that there is a clear list of objectives governors can contribute to and governors can demonstrate their actions to meet these.

The Chair suggested the following objectives.

Objective
1. Fulfil and comply with statutory duties
2. Hold Non-Executive Directors to account
3. Contribute to the induction of new members
4. Use connections to promote the Trust
5. Provide support to improve the engagement and involvement of members
6. Contribute to the Trust's governance and assurance processes to improve quality of its services

Objective 1 is, of course, statutory, is well understood and is in the handout.

Group 1 considered objectives 2 and 3
Group 2 considered objectives 2 and 4
Group 3 considered objectives 5 and 6

Objective	How?
1. Fulfil and comply with statutory duties	
2. What should we do to hold Non-Executive Directors to account?	a) Have regular contact/meetings with NEDs and ask about their concerns, be a critical friend and how it will impact on services. b) Attend Trust Board/other meetings that the NEDs participate in and see them at work. Observe/attend Trust Board meetings. c) Governors need to be well-equipped on how services are delivered so need to participate in the opportunities available so they know what questions to ask. d) NED discussions at each Members' Council meeting. e) Obtain current information from NEDs on their activities. f) Let NEDs present reports at Members' Council and answer questions on their contributions/questioning performance.
3. Contribute to the induction of new members	a) Have one – structured information: - role/responsibility - Trust - Trust Board – who is who - Members' Council - how meetings run - adjustments b) Mentorship (register) c) Courses – FTN
4. Use connections to promote the Trust	a) Help the governors/Trust identify what it actually is/what it provides and how it informs its service users/public/ stakeholders/funders → building value (committee/group?) b) Find out for each governor who they know/connections, such as local councillor/local business/schools/ charities/church (stakeholder map?). Use this to set up approach for governors within each area to get 'message across'. c) Help governors get the message across by developing the message/brand. d) Information in GPs, LIFT centres, photos, information on the Trust. Connections through GPs.

Objective	How?
5. Provide support to improve the engagement and involvement of members	a) Via communications – ask all members how they would like to be kept informed, how often and what level of detail (multiple choice). Give ideas of what the options are. b) Improve publicity of public meetings/sessions (posters, mailshots, event awareness). c) Organise interactive sessions for staff and public members regarding workings of the Trust and, specifically, the Members' Council. d) Ensure that English is used rather than 'jargonese' in all communications and publications.
6. Contribute to the Trust's governance and assurance processes to improve quality of its services	a) Make sure GPs recommend patients with mental health problems to the mental health services for assessment and treatment. This includes children, youth and adults. b) Pills and medicine are not the full answers – counselling and jobs are a better pathway for the future. c) Case workers and carers should be enabled to continuously up-skill to provide quality services. d) Better communication – more listening and caring. e) Higher level of commitment both 'top down' and 'bottom up', working in synergy.

Additional objectives suggested

- Promote the role of the Members' Council to staff and ensure the views/feelings of staff are represented (however, not to be confused with the representative role of staff side).
- Gain intelligence and promote communication amongst governors.

5. The 'photo fit' of a 'perfect governor'

Could we describe to someone what a perfect/good governor looks like?

- Attributes
- Skills
- Knowledge
- Attitude/behaviours

Feedback (detailed feedback at appendix 1)

- Inquisitive
- Feet on the ground/typical
- Motivated and interested
- Empathy
- No stigma
- Good listener
- Commitment, particularly time
- Concise/straight to the point
- Be reflective
- Affinity

Each group made the point that the perfect governor does not exist as an individual but is only to be found in the collective performance of the Members' Council.

6. Evaluation of the session

What key messages will you take away from today?

- Lots of ideas, knowledge and skills to assist me in better contributing to the work of the Trust as a governor.
- I have similar views to others, strengths and limitations.
- The Trust is interested in how governors can have input and develop.

- Governors want more time with NEDs.
- The need to work and communicate with one another better.
- To engage myself in my role as part of daily life.
- CQC imperative.
- Being a governor is a serious and exciting business.
- New constitution next year.
- Need for better communication.
- Enhanced enthusiasm for the work and what I'm involved with at the Trust.
- Making new friends.
- Looking to the future as a governor – key two things I will get involved in over the next year.
- It's possible to be involved in a positive way and to help improve the services supplied by the Trust.
- We are stronger as a collective than as individuals.
- We are OK but can't be complacent.
- Be yourself and don't try to blend in.

What personal actions will you take away from today?
- Apply the learning to improve quality of services offered.
- To attend Trust Board and engage more with NEDs.
- Improve communication with NEDs.
- To read more regularly and ask questions when necessary.
- To engage more with NEDs and to find more intelligence as opposed to facts.
- Intention/action sheet.
- Find out about training courses.
- Improve publicity to involve public.
- Need for more personal involvement.
- Ensure that sustainability and transformation is kept in focus and on track.
- Knowing I can rely on other members for help.
- To promote the Trust to the local community.
- Promote ideas and views of staff group I represent and engage more with service users.
- Promote Trust.
- Don't be afraid to be yourself in sessions.

What would you like to do differently next year?
- Make more positive contribution to increase awareness of what the Trust has to offer in terms of services to the community.
- Action plan.
- Improve communication with NEDs.
- Hear from lead governor (Members' Council Co-ordination Group).
- More personal promotion of the Trust's vision and values.
- Good session – not much I would change.
- More regular attendance.
- Increase promoting the services within the Trust.
- More action; less passive.
- Engage with the electorate.
- Attend more unannounced visits.

Based on your experience today, do you have any suggestions on how we should review the Members' Council contribution in future?
- I believe the methodology used is quite interesting based on the current knowledge and skills of members and enables the future needs.
- Improve links with (between) governors.
- Trust should promote the partnership working it does with external organisations.
- Consider snapshot at each Members' Council meeting.

- Make it more interactive to gather more members' input and opinions.
- Have a personal record of events through the year.
- More experience in wards and core work.
- Self-evaluate and feedback each meeting, including Members' Council meetings.
- Get more feedback and encourage members to give more.
- Involve NEDs more individual contributions to the Members' Council so the governors are more aware of their responsibilities.
- Greater engagement with Trust members including staff sessions and public events.
- Keep doing the appraisals.

Interesting	**11**	Exciting	3
Challenging	**10**	Revealing	2
Fascinating	2	Entertaining	5
Boring		Confusing	
Difficult		Basic	
Easy		Clear	7
Realistic	3	Practical	6
Theoretical	2	Irrelevant	
Useful	9	New	3
Innovative	2	Complicated	
Comprehensive	1	Enjoyable	9
Valuable	8	Inspiring	6
Over-ambitious		Unfocused	1
Thought-provoking	**12**	Waste of time	
Stimulating	7	Fun	2
Exhausting		Nothing new	
Thorough	3	Changed my life	1
Rushed			

Appendix 1 – detailed feedback on the 'perfect governor'

Willingness to learn new information

Asking for support to fulfil role if needed

Being prepared

Have good concentration to be able to carry out the task at hand

Concentration on important issue – not be side-lined to other matters

Be prepared to a) be challenged and b) spend time reflecting on information

Be an attentive listener

Attend as many meetings as possible

Be able to ask questions

Know where/who to go to for information

Attitude – time commitment=true commitment

Hands on

Inquisitive

Honest

Challenging

Networking skill

Be prepared to put your views over to others

Thoughtful

Hard working

No stigma shown

Experience in hospital wards, casework, communities, carers, counselling

Knowledge of how the Trust or wards work

Be a good listener (loads of times!!!)

Enthusiasm

Empathy with people on wards

A good governor understands their role and is prepared

Good communicator - sticking to the point/concise

Be able to evaluate

Motivated/interested

Good citizenship – connections

Honest/genuine

'Ordinary'/feet on the ground/'typical'

Enthusiastic

Good communicator

Non-judgemental

Reflective

Persistence

Open mind

Observant

Knowledge of Trust direction

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 21 October 2014
Agenda item 6.2

Title:	**Changes to the Trust's Constitution – electronic voting and annual members' meeting quorum**
Paper prepared by:	Director of Corporate Development
Purpose:	Trust Board is required to approve changes to the Trust's Constitution.
Mission/values:	Robust governance arrangements are essential for the Trust to remain legally constituted, financially viable and sustainable as a Foundation Trust and to continue to meet its obligations under its Constitution.
Any background papers/ previously considered by:	None
Executive summary:	Background The Trust is required to have a Constitution in place that sets out how it is accountable to local people, who can become a member and what this means, the role of the Members' Council, how Trust Board and the Members' Council are structured and how Trust Board works with the Members' Council. The Constitution also contains a set of model rules that provide the basis for elections to the Members' Council. Electronic voting Trust Board will be aware that more and more organisations are using advances in technology to enable electronic voting in ballots and elections and, for some time now, work has been ongoing to allow for electronic voting in foundation trust elections. New rules were issued in August 2014 by the Foundation Trust Network following development and a pilot by Lancashire Teaching Hospitals NHS Foundation Trust. The Department of Health and Monitor have been fully involved throughout the process and have endorsed the rules; however, both are of the view that this is a matter for foundation trusts to take the lead. As a result, a revised set of model election rules has been issued, which will facilitate a move over time to the phasing out of paper-based systems, saving time and cost of elections, and may increase turnout. The Trust is proposing that it adopts the revised model rules to allow for electronic voting with a view to piloting for elections to staff vacancies in 2015 and extending this to public vacancies in 2016. It should be noted that adopting the revised model election rules does not commit the Trust to using such a system; the Trust will still be able to run its elections on a paper-based system whilst providing an option to change if it wishes to do so. Quorum for Annual Members' Meeting Paragraph 3.10 of annex 9 of the Trust's Constitution states that "Before a members' meeting can do business there must be a quorum present. Except where this constitution says otherwise a quorum is one Governor present

	from each of the Foundation Trust's constituencies." Trust Board will recall that approval was given to extend the Trust's public membership and, therefore, the requirement for an additional governor, to the rest of South and West Yorkshire. This would mean a quorum for the Annual Members' Meeting of one governor present from Barnsley, Calderdale, Kirklees, Wakefield and the rest of South and West Yorkshire (as well as one staff and one appointed governor). The Trust is proposing that this paragraph is slightly amended to read "Before a members' meeting can do business there must be a quorum present. A quorum is one Governor present from each of the Foundation Trust's public constituencies of Barnsley, Calderdale, Kirklees and Wakefield, and one staff and one appointed Governor."
Recommendation:	**Trust Board is asked to approve the changes as outlined above.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 21 October 2014
Agenda item 6.3

Title:	**Audit Committee assurance on staff register of interests**
Paper prepared by:	Director of Corporate Development
Purpose:	To inform Trust Board of the outcome of the discussion at the Audit Committee in relation to financial reporting
Mission/values:	Robust governance arrangements are essential for the Trust to remain legally constituted, financially viable and sustainable as a Foundation Trust. This item also demonstrates openness and transparency.
Any background papers/ previously considered by:	None
Executive summary:	Background As part of the work of the Trust's internal auditors in relation to counter fraud, KPMG undertook a risk assessment of the Trust's arrangements in respect of the Bribery Act 2010, which was presented to the Audit Committee in October 2013. One of the recommendations suggested that the Committee should expand its oversight role to encompass scrutinising the Trust's assurances around compliance with the Bribery Act by reviewing declarations of interest and assessing any interests that may be high risk in order to provide Trust Board with assurance that its relevant and high risk interests, relationships and business transactions are both compliant and subject to regular review. A paper was presented to the Committee in January of this year. The Committee agreed it was assured by, and satisfied with, the arrangements in place for declaration of interests by directors and governors. The risk assessment by KPMG suggested a number of development areas in relation to staff declarations of interest and the Trust's response. It was suggested that the staff register is reviewed at Board level for assurance with regard to risk and potential conflict, and the Committee supported the proposal that it should review the staff register on behalf of Trust Board on an annual basis to provide assurance. The Committee did not feel that any further assurance was required in relation to directors and governors. The matter was also raised as part of the audit by NHS Protect, who are keen to see progress in the number of declarations made from a counter fraud perspective and suggested that the Trust should seek 'nil' declarations from staff (as it does with Trust Board and the Members' Council). Audit Committee position At its meeting on 7 October 2014, the Committee noted the report presented and that a number of development areas will be refined to make the process more robust. This will include: - simplifying the process to enable staff to make declarations electronically, which will also make escalation and follow up easier; - consider whether a more detailed declaration is needed for some groups of staff, such as staff working in procurement; - ensure line managers are clear about their responsibilities when considering any declarations made by staff and that there are clear escalation processes in place; - ensure HR policies and processes are in place to provide guidance to staff and line managers; and

	- development of a formal RAG rated register with any red rated risks or those that present a concern reviewed by the Director of Finance and escalation agreed if necessary. The Committee noted that the Trust has the necessary measures in place to address any unacceptable conflicts of interest. <u>Recommendation</u> The recommendation made to the Audit Committee was that it could take assurance from the process in place that there are no declarations made that currently present a risk to the Trust. With the exception of five declarations, which will be taken up with the relevant Director, all declarations made were considered and approved by the member of staff's line manager with a clear rationale, where appropriate, for the approval.
Recommendation:	**Trust Board is asked to NOTE the Audit Committee's position.**
Private session:	Not applicable

Trust Board: 21 October 2014
Agenda item 7

Title:	**Implementing the Estates Strategy – major capital schemes update**
Paper prepared by:	Director of Human Resources and Workforce Development
Purpose:	This paper is designed to provide the Trust Board with an update on the progress of the major capital schemes in the 2014/15 capital programme.
Mission/values:	The Estates Strategy was developed to ensure that the Trust's properties and buildings are fit for purpose and support the delivery of services that enable people to live well in their communities.
Any background papers/ previously considered by:	The Trust's Estates Strategy was agreed by Trust Board in 2012. The business cases for Calderdale community hub and refurbishment of New Street (Barnsley central community hub) have been approved by EMT, scrutinised by the Estates Forum and agreed by Trust Board. The Estates Forum received an update on the capital plan on 6 October 2014.
Executive summary:	The Estates Strategy was designed to ensure that the Trust has a strategic direction for the effective management and development of the Trust's estate, which supports the delivery of agreed service plans and is aligned to the agreed financial plan. This paper is designed to provide Trust Board with an update on the delivery of the major capital schemes in the 2014/15 capital plan. **1. Calderdale Community Hub** Trust Board approved the business case for the development of the hub in June 2014. The Trust has now received planning permission and the Guaranteed Maximum Price (GMP) is being finalised with Interserve. The scheme is on schedule. **2. New Street (Barnsley central community hub)** Trust Board approved the business case in September 2014 and the GMP is being finalised. The impact of the recent decision by commissioners to tender Barnsley GUM/CASH services, which were planned to move to New Street, on the scheme is currently being assessed. The approved scheme is on schedule. **3. Wakefield Community Hub** A suitable central location, which meets the criteria for the Wakefield Hub, is proving difficult to find. A property that has recently come on the market is being assessed for its suitability. Problems in finding a suitable property have delayed the business case and the scheme is slightly behind plan. The Wakefield hub business case is now due for November 2014. **4. Trust-wide decant facility and Fieldhead master plan** The option appraisal for the Trust-wide decant facility identified at a very early stage that it needed to be sited at Fieldhead as this was the most central location. This resulted in the decant project becoming part of the Fieldhead master plan project. The preferred option for the decant is to relocate

	Newhaven and Ryburn behind the secure fence line leaving the old Newhaven as the decant Facility. This would mean a new build and would create a single reception and link corridors for the Bretton Centre, Ryburn and Newhaven giving greater security and operational efficiency. Whilst there are some revenue costs, which will be shared Trust-wide, it does represent additional costs for the Forensic BDU. As stated, this option does provide greater operational efficiency giving potential cost savings, which could offset the additional costs of the new build; however, this does require further financial modelling and 'stress testing'. The proposal is that the Trust seeks planning permission in the meantime for a new Newhaven and Ryburn as this would allow further time for the financial modelling and stress testing without causing a delay to the scheme. The business case for the Fieldhead master plan, including the decant facility, is planned for November 2014.
Recommendation:	**Trust Board is asked to NOTE the Estates Strategy update and NOTE the proposal to seek planning permission.**
Private session:	Not applicable

Trust Board 21 October 2014
Agenda item 8

Title:	**Trust Board self-certification – Monitor Quarter 2 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.
Executive summary:	Quarter 2 assessment Based on the evidence received by Trust Board through performance reports and compliance reports, the Trust is reporting a governance risk rating of **green** 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**. Self-certification Monitor authorises NHS foundation trusts on the basis that they are well-governed, financially robust, legally constituted and meet the required quality threshold. Monitor's Risk Assessment Framework is designed to: - show when there is a significant risk to the financial sustainability of a provider of key NHS services, which endangers the continuity of those services through the continuity of services risk rating; and/or - show where there is poor governance at an NHS Foundation Trust through the governance rating. Trust Board is required to provide board statements certifying ongoing compliance with its Licence and other legal requirements to enable Monitor to operate a compliance regime that combines the principles of self-regulation and limited information requirements. The statements are as follows. - For continuity of services, that the Trust will continue to maintain a risk rating of at least 3 over the next twelve months. - For governance, that the board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the Framework and a commitment to comply with all known targets going forward. - And that Trust Board can confirm there are no matters arising in the quarter requiring an exception report to Monitor, which have not already been reported. The Framework also uses an in-year quality governance metric, which is currently the same as that used for quarters 3 and 4 of 2013/14 and quarter 1 of 2014/15, 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 2 and the in-year governance declaration on behalf of the board will be made to confirm compliance with governance and performance targets.

Foundation Trust sector comparison

The following table shows overall performance by the 147 foundation trusts at the end of Q2 2014/15. Of these, 41 are mental health trusts.

All Foundation Trusts

		Governance rating			
		No evident concerns	Issues identified	Enforcement action	Total
Continuity	4	**64**	5	3	**72**
	3	34	7	4	**45**
	2	10	1	4	**15**
	1	0	7	8	**15**
	Total	**108**	**20**	**19**	**147**

Mental Health Trusts

		Governance rating			
		No evident concerns	Issues identified	Enforcement action	Total
Continuity	4	**28**	2	1	**31**
	3	8	0	1	**9**
	2	1	0	0	**1**
	1	0	0	0	**0**
	Total	**37**	**2**	**2**	**41**

The Trust remains in the upper quartile.

In September 2014, Monitor issued its Q1 performance report and the key financial headlines are:

- Q1 planned deficit £80 million; actual £167 million;
- 86 foundation trusts reported Q1 deficits (40 at Q4 2013/14);
- 80% of acute trusts reported a deficit;
- 61 trusts reported a surplus (£60 million, which is £29 million below plan); and
- CIP delivery is £223 million (£58 million less than planned).

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.**
Private session:	Not applicable

Trust Board self-certification - Monitor Quarter 2 return 2014/15
Trust Board 21 October 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 1.

Trust Board

The Trust informed Monitor in its Q1 exception report that Nisreen Booya, Medical Director, would be retiring from the Trust at the end of September 2014. Following a robust and challenging recruitment process, Dr Adrian Berry (previously Director of Forensic Services) was appointed as Medical Director from 1 October 2014. At its meeting on 23 September 2014, Trust Board approved the change to the Trust's Responsible Officer and this changed to Dr Berry from 1 October 2014. Monitor was informed by the Trust of the appointment and change on 26 September 2014.

Members' Council

The Members' Council is carrying the following vacancies.

Publicly elected, Kirklees – one seat following a resignation due to ill health.
Publicly elected, rest of South and West Yorkshire – this seat was not filled in the 2014 elections.
Staff elected, social care staff working in integrated teams – this seat was not filled in the 2014 elections.
Appointed, Kirklees Council – work is ongoing to ensure this seat is filled.
Appointed, staff side organisations – staff side will identify a replacement.

There was also one resignation for the appointed seat for Calderdale Council, which has subsequently been filled.

The Members' Council undertook its annual evaluation session on 17 September 2014. This was an externally facilitated event and focussed on governors' contribution, both personally and collectively, to the Trust and action in the coming year to support the Trust. A summary of the session was presented to Trust Board on 21 October 2014.

Care Quality Commission (CQC)

- The Trust has previously reported on the Care Quality Commission's Quality and Risk Profile for the Trust. The QRP has not been issued recently for a while as the CQC is replacing it with 'intelligent monitoring', which will be issued in draft form later in October.
- 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). All identified actions with one exception were 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 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 two CQC Mental Health Act visits in Q2 to Castle Lodge and Ryburn. Five MHA monitoring summary reports have been received for Chantry, Enfield Down, Thornhill (Bretton), Willow and Castle Lodge. The MHA monitoring visits were largely positive in terms of practice and implementation of actions identified from previous visits with an improvement in the recording of capacity assessment noted in most of the visits. Recurring issues related to the recording of consultation with the Second Opinion Appointed Doctor (SOAD) by the statutory consultees and the recording of S132 rights. Concern was raised at the lack of access to psychological therapies for in-patients at one visit.

Absent without Leave (AWOL)
There were no CQC reportable cases during quarter 2.

Eliminating Mixed Sex Accommodation (EMSA)
There have been no reported breaches in Q2. The Trust continues to monitor where service users are placed in an individual room on a corridor occupied by members of the opposite sex. There have been three reported incidents in Q2, which is a reduction from Q1. 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 Q2.

Infection prevention and control
In quarter 2, there have been two cases of Clostridium Difficile in Barnsley. The cumulative total for 2014/15 is two against a year-end position of eight. 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 2.

Safeguarding Children
- There were 50 reported incidents Trust-wide directly relating to issues of child protection in Q2. This represents a decrease on Q1 and reflects the reduction in the number of young people under 18 admitted to adult in-patient wards. All of the incidents were reviewed by the Named Nurses and were assessed to have been appropriately reported and managed.
- Barnsley Council children's services were inspected in June 2014 under the new OfSTED inspection framework. There was improvement noted but the overall finding was 'requires improvement', a step up from 'inadequate'.
- An inspection by OfSTED in Calderdale is widely anticipated in Q2 and preparation work is well under way as is close collaboration with the Council to ensure a smooth inspection period.

Safeguarding Vulnerable Service Users
No referrals have been made to the Disclosure and Barring Service this quarter and no red incidents reported through the Trust's reporting system, DATIX.

Serious Incidents
During the course of Q2 there have been 25 SIs reported to commissioners (fifteen in Barnsley which includes incidents related to pressure ulcers), one in Calderdale, five in Kirklees and four in Wakefield), decrease from Q1. 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 in Q1, which has an impact in Q2.

No 'Never Events' occurred in the Trust during this quarter.

There have been two CQC notifiable deaths in Q; (one in Kirklees (cause of death pneumonia) and one in Calderdale (cause of death acute myocardial infarction and chronic arterial disease). Both patients were under the care of older peoples services.

Customer Services
- The Trust received a total of 67 formal complaints in quarter 2. The breakdown across is as follows:
  - Barnsley – 18;
  - Calderdale – 11;
  - Kirklees – 14;
  - Wakefield – 11;
  - Specialist services – 12;
  - Forensic – 1.
- The majority of complaints related to adult services with the following themes being most evident:
  - care and treatment;
  - waiting times, appointments, attitude;
  - communications.

  Most complaints contain a number of themes.
- During quarter 2, six complainants asked the Parliamentary and Health Service Ombudsman to review their complaint (one Specialist Services (Barnsley CAMHS), one Wakefield, one Calderdale, one Forensics and 2 Kirklees). 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 did not feedback to the Trust in quarter 2 on any cases previously referred.

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

Third party reports
There was one internal audit reports with partial (formerly limited) assurance received by the Trust during the quarter in relation to patients' property. This was received by the Audit Committee at its meeting on 7 October 2014. The recommendations from the Trust's internal auditor focus on compliance of the Trust's policy with NHS Protect guidelines and

consistent implementation of the Trust's policy across all in-patient units. Management action has been agreed with internal audit with timescales for completion.

Children's and adolescents' mental health services (CAMHS)
The Trust has updated Monitor on the position with the Calderdale and Kirklees Tier 3 CAMHS, which transferred to the Trust on 1 April 2013. In view of the service and reputational risk, the Trust commissioned an independent review of the services, which took place at the end of August 2014. The reviewers fed back to Chief Executive, Medical Director, Director of Nursing and the District Director on 12 September 2014.

The recommendations support the areas of development identified locally and useful suggestions were made to enable the service to continue to improve. After discussion with the external reviewers, it was agreed to invite them to return in six months to undertake a further review and advise on any further action needed. Senior managers and clinicians are also intending to visit the service in Norfolk/Suffolk to learn from best practice in that organisation. The outcome of the review will also be shared with commissioners and Trust Board has asked that the review is shared with staff. An overarching recovery plan has been developed to address the recommendations, which will be reviewed by the Executive Management Team and by the Clinical Governance and Clinical Safety Committee on behalf of Trust Board.

On presentation of the report to Trust Board and the Committee, a number of actions taken by the Trust were highlighted as a demonstration of how the recovery plan is beginning to take effect. These included:

- the strengthening of leadership and management arrangements and the appointment of a clinical lead for CAMHS across the Trust;
- the secondment of the Deputy Director of specialist services for six months on a full-time basis to the service to deliver on transformation and the recovery plan;
- dedicated Quality Academy support, particularly around information management and technology, and HR;
- engagement and listening events for staff, led and facilitated by the Chief Executive; and
- improved engagement with families who use the services with the result that the clinical recovery team is starting to receive positive feedback from families.

Better Care Fund

Contracting/commissioning intentions
<u>Calderdale substance misuse service</u>
Commissioners in Calderdale tendered the substance misuse service (SMS) earlier this year. The Trust was unsuccessful at the pre-qualifying questionnaire stage and was not asked to submit a full bid. The Trust has discussed potential partnering arrangements with a supplier who was successful at the initial stage with a view to providing parts of the revised integrated service. The outcome of the bidding process was due on 10 October 2014 but has been delayed. There is a potential risk to the Trust, which is included in the Trust Board-level risk register, around TUPE arrangements for staff currently working in the service, which the Trust will work through with the successful bidder.

<u>Barnsley CASH/GUM services</u>
To be included following Trust Board.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 21 October 2014
Agenda item 9

Title:	**Assurance framework and organisational risk register Q2 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, and promotes good health within a system of effective controls and within the Government's 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 papers set out the systems and processes in place and the assurances derived. This report provides an update as at Quarter 2 covering the Assurance Framework and Organisational Risk Register. **Assurance framework 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 organisation's 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) is produced 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 report and accounts and, without this, the neither can be approved. The Assurance Framework informs the appropriate declarations made in the AGS, including any significant control issues in line with current guidance where appropriate. The AGS for 2013/14 was approved as part of 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 is reviewed by the Executive Management Team on a monthly basis, 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 quality; - the Care Packages and Pathways project for mental health; - impact on services as a result of continued local authority spending cuts and changes to the benefits system; - transformational service change programme; - changes to national funding arrangements; - bed pressures; - children's and adolescents' mental health services; - potential industrial action (new); and - substance misuse services in Calderdale (new). The Audit Committee has suggested that Trust Board considers inclusion of a risk in relation to the year 3 position set out in the Trust's five-year strategic plan and declaration of sustainability.
Recommendation:	**Trust Board is asked to:** ➢ **NOTE the assurances provided for Q2 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; and** ➢ **CONSIDER inclusion of an additional risk as suggested by the Audit Committee.**
Private session:	Not applicable

ASSURANCE FRAMEWORK 2014/15 Q2

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 to deliver the service offer and meet	▪ 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
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 share and possible de-commissioning of services.	▪ DDs ▪ DoCD	▪ C1, C2, C3, C6, C30	▪ A26, A29, A40, A39			

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 KPIs 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, DBS, 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
34.	Medical Leadership Programme in place with external facilitation.

Control (C...)	Key Control (systems/processes)
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 and EMT)
1.	Quarterly documented review of Directors objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	➢ CE summary letters to Directors following each quarterly review. ➢ Update reports to each Remuneration and Terms of Service Committee by the Chief Executive
2.	Production of Patient Experience quantitative and qualitative reports, triangulating themes, 'you said, we did' to Trust Board and Members' Council.	➢ Quarterly quality performance report to Trust Board ➢ Quarterly report on customer services to Trust Board ➢ Customer service annual report to Trust Board June 2014
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.	➢ Performance reports and HR performance reports to Trust Board and EMT (monthly) ➢ HR performance reports to R&TSC ➢ Appraisal records kept by line managers ➢ Values-based appraisal process now used for all staff following a review of the process and revision of policy and supporting documentation
4.	Transformation plans monitored and scrutinised through EMT ensuring co-ordination across directorates, identification of and mitigation of risks.	➢ Transformational service change reports to EMT (monthly) ➢ Report to Trust Board on progress against transformation plans July and September 2014 ➢ Quarterly investment appraisal report to Trust Board
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.	➢ Funding for BDU management of Innovation Fund approved by EMT for 2014/15 ➢ Quarterly Investment Appraisal Framework report to Trust Board, which includes investment in specific initiatives ➢ Transactional IT services Trust Board April 2014 ➢ Tier 4 CAMHS Trust Board April, June, July and September 2014 ➢ Newton Lodge service developments Trust Board April 2014 ➢ Calderdale hub Trust Board June 2014 ➢ Strategic outline case Trust Board June 2014 ➢ Technology Fund Trust Board July 2014 ➢ Barnsley hub Trust Board September 2014
6.	Performance management of estates schemes against resources through Estates TAG, deviations identified and remedial plans requested.	➢ Estates TAG minutes and papers ➢ Estates Forum minutes and papers through 2014/15 ➢ Estates Strategy update Trust Board April 2014 ➢ Calderdale hub Trust Board June 2014 ➢ Barnsley hub Trust Board September 2014 ➢ Fox View business case EMT July 2014 ➢ Savile Park View business case EMT July 2014
7.	Trust Board Strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives.	➢ Strategy session of Trust Board May 2014 ➢ Five-year strategic plan briefing for Trust Board June 2014
8.	Quarterly quality/integrated compliance reports to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	➢ Quarterly quality performance report to Trust Board ➢ Quarterly compliance reports to EMT to inform presentation to Trust Board
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.	➢ Monitor quarterly exception report return presented to Trust Board, including confirmation that Trust complies and continues to comply with the conditions of the Trust's licence
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.	➢ Assurance Framework and risk register presented to and reviewed by Trust Board on quarterly basis ➢ Risk register reviewed monthly by EMT

Assurance (A..)	Assurance on controls (planned outputs)	Board reports received (including sub-committees and EMT)
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.	➢ Clinical Governance and Clinical Safety Committee minutes ➢ Child and adolescent mental health services September 2014 (and Trust Board July and September 2014) ➢ Children's services April and June 2014 ➢ Hard Truths and Francis Report April and September 2014 (and Trust Board June and September 2014) ➢ Impact of cost improvement programme April, June and September 2014 ➢ Quality Improvement Plan April 2014 ➢ Patient Safety Strategy September 2014
12.	Annual Governance Statement reviewed and approved by Audit Committee and Trust Board and externally audited.	➢ Approval of annual report and accounts at Audit Committee May 2014 and Trust Board June 2014
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.	➢ Process in place to review compliance with Monitor targets on quarterly basis ➢ Progress reviewed monthly at EMT evidenced through EMT minutes ➢ Risk assessment of compliance to Trust Board April 2014
14.	Information Governance 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.	➢ Information Governance (included in IM&T TAG) papers and minutes ➢ Performance EMT meetings and papers ➢ Monthly performance reports ➢ Report to Clinical Governance and Clinical Safety Committee September 2014
15.	Monthly review and monitoring of performance reports through Delivery EMT deviations identified and remedial plans requested.	➢ Performance reports to EMT (which include 'hotspots' and areas for concern) ➢ Minutes from performance EMT meetings ➢ Transformational service change progress reports to EMT (monthly) ➢ Sickness absence included in performance report ➢ Risk assessment of target, CQUINs, etc. Trust Board April 2014 ➢ Detailed analysis in finance report to Trust Board on cost improvement programme (monthly from April to October 2014)
16.	Monthly review and monitoring of integrated and quality performance reports by Trust Board with exception reports requested around risk areas.	➢ Performance reports to Trust Board ➢ Minutes from Trust Board meetings ➢ Risk assessment of performance targets 2014/15 to Trust Board April 2014
17.	Annual report to Trust Board to risk assess changes in compliance requirements and achievement of performance targets.	➢ Risk assessment of performance targets 2014/15 to Trust Board April 2014
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	➢ Care Quality Commission registration certificates
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.	➢ Standing item on CG&CS Committee agenda to reflect rolling programme from 1 April 2014
22.	Remuneration Terms of Service Committee receive HR Performance Reports, monitor compliance against plans and receive assurance from reports around staff development, workforce resilience.	➢ Standing item on Committee agenda
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.	➢ Annual report and accounts ➢ Standing item on service line reporting ➢ Standing item on payment by results and currency development ➢ Standing item on procurement and review of procurement strategy ➢ Standing item on progress against counter fraud plan

Assurance (A..)	Assurance on controls (planned outputs)	Board reports received (including sub-committees and EMT)
		➢ Standing item on progress against internal audit plan ➢ Head of Internal Audit Opinion May 2014
24.	Independent CQC reports to Mental Health Act Committee providing assurance on compliance with Mental Health Act.	➢ Standing item at Mental Health Act Committee meetings
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.	The Trust was accredited against the IiP standard in 2009 and re-assessed in 2012, and is working towards achieving GOLD standard in 2014/15.
26.	Annual plan and budget, two-year operational plan and five-year strategic plan approved by Trust Board, externally scrutinised and challenged by Monitor.	➢ Monitor commentary on annual plan ➢ Annual plans, budgets and minor capital programme 2014/15 approved by Trust Board March 2014 ➢ Monitor two-year operational plan approved by Trust Board March 2014 with independent review by Deloitte (April 2014) and update against resulting action plan at each meeting ➢ Monitor five-year strategic plan approved by Trust Board June 2014 ➢ Monitor quarterly returns
27.	Health and Safety TAG monitor performance against plans deviations identified and remedial plans requested.	➢ Health and Safety TAG minutes
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.	➢ Quarterly quality performance report to Trust Board
30.	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and director leads to provide assurance against annual plan	➢ Audit Committee annual report to Trust Board 2013/14 April 2014 ➢ Review of other risk Committees' effectiveness and integration Audit Committee April 2014
31.	External and internal audit reports to Audit Committee setting out level of assurance received.	➢ Internal audit update reports to Audit Committee ➢ External audit update reports to Audit Committee ➢ Annual report and accounts to Audit Committee May 2014 ➢ Quality Accounts progress standing item on Clinical Governance and Clinical Safety Committee agenda ➢ Quality Accounts final report to Clinical Governance and Clinical Safety Committee May 2014
32.	External and internal audit reports performance managed through EMT.	➢ Internal audit follow up reports to EMT and consideration of internal audit reports with limited assurance throughout 2014/15 ➢ Quality Accounts external assurance Audit Committee May 2014 and Trust Board June 2014
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.	➢ Reports to Clinical Governance and Clinical Safety Committee ➢ Limited assurance reports considered by EMT ➢ Internal audit reports on financial management and reporting (including procurement follow up) (substantial), Monitor provider licence (substantial), Francis II (substantial), information governance toolkit (substantial), serious incidents (substantial), transformation, including service line management (moderate), data quality (moderate) and leadership development (moderate)
34.	Innovation fund allocation approved through EMT with guidance to ensure consistency of approach and alignment with strategic priorities and corporate objectives.	➢ Funding for BDU management of Innovation Fund approved by EMT for 2014/15
35.	Monitoring of organisational development plan through Chief Executive-led group,	➢ OD group led by CE established to review OD plan.

Assurance (A..)	Assurance on controls (planned outputs)	Board reports received (including sub-committees and EMT)
	deviations identified and remedial plans requested.	
36.	QIPP performance monitored through delivery EMT, deviations identified and remedial plans requested.	➢ Performance reports to EMT ➢ Delivery EMT minutes
37.	Sustainability action plans monitored through Sustainability TAG, deviations identified and remedial plans requested.	➢ Sustainability TAG minutes
38.	No longer applicable	
39.	Strategic overview of partnerships and growth in line with Trust vision and objectives provided through EMT and Trust Board.	➢ Stakeholder updates at strategy and risk EMT ➢ Stakeholder analysis and environmental scan Trust Board April and May 2014
40.	Market analysis reviewed through EMT, market assessment to Trust Board ensuring identification of opportunities and threats.	➢ Stakeholder analysis and environmental scan Trust Board April and May 2014
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	➢ Monitor five-year strategic plan, including Trust Board self-certification, approved by Trust Board June 2014 ➢ Approval by Trust Board of Monitor five-year strategic plan June 2014 ➢ Corporate Governance Statement approved by Trust Board June 2014 ➢ Self-certification on compliance with licence and level of resources Trust Board May 2014
42.	Rolling programme of staff, stakeholder and service user/carer engagement and consultation events	➢ Performance reports to Trust Board and EMT ➢ Rolling programme of engagement and listening events for staff
43.	Data quality Improvement plan monitored through EMT deviations identified and remedial plans requested.	➢
44.	Estates Forum monitors delivery against Estates Strategy.	➢ Estates forum minutes and papers outlining development of Estates Strategy
45.	Equality and Involvement Strategy into Action Group established monitoring delivery of equality, involvement and inclusion action plans, reporting into CG&CS Committee.	➢ Equality and Involvement Strategy into Action Group terms of reference and minutes
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.	➢ Incident Review Sub-Committee minutes and reports to Clinical Governance and Clinical Safety Committee ➢ Serious incidents quarterly reports to EMT, Clinical Governance and Clinical Safety Committee and Trust Board ➢ Annual SI report to Trust Board July 2014
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.	➢ Quarterly assurance from Trust Board Committees to Trust Board
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.	All detained but non-restricted patients have their renewal of section examined at a formal meeting with independent hospital managers who examine legality and appropriateness of detention. Also able to identify any concerns voiced by patients/advocates about care given. Feedback given to Mental Health Act Committee through standing item on the agenda (feedback from Hospital Managers' Forum).
51.	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.	➢ Medical Appraisers' Forum minutes ➢ Annual report to Trust Board June 2014 ➢ Appointment of Responsible Officer Trust Board September 2014
53.	Chief Executive-led Operational Requirement Group established to drive delivery	➢ ORG notes (weekly)

Assurance (A..)	Assurance on controls (planned outputs)	Board reports received (including sub-committees and EMT)
	of two-year operational plan.	
54.	Operational delivery plan to ensure IM&T Strategy is implemented within timescales and within resource envelope monitored through IM&T TAG, EMT and IM&T Forum	➢ IM&T TAG notes and EMT minutes ➢ IM&T Forum papers and minutes

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

ORGANISATIONAL LEVEL RISK REPORT

DATE: 21 October 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	➢ 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. Monthly system development board for RiO system. Agreed workplan and prioritisation.	15	Red	Yes		Trust Board October 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	➢ Re-launch of project January 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. ➢ Review by Director of Nursing, Medical Director and Director of Finance of implementation plan October 2014 with report to EMT 23.10.14	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 October 2014
275	Risk Assessment	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)				Continued reduction in Local authority funding and changes in benefits system will result in increased demand of health	➢ District integrated governance boards established to manage integrated working with good track record of cooperation. ➢ Maintenance of good	4 Major	4 Likely	16	Red	➢ 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.		BDU Directors	Included in two-year operational plan	EMT (monthly) and Trust Board (monthly) EMT review of 2015/16 contracts October/November 2014	12	Amber	Yes		Trust Board October 2014

							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.	➢ 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.					➢ Wakefield review of integrated services governance arrangements to be undertaken in Q3. ➢ EMT review of delivery risk in 2015/16 contract due to potential de-commissioning of services.									
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 transformation programme 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	➢ Ongoing engagement events programme on transformation programme. ➢ Business Case for RAID completed and being implemented Q4 2013/14. ➢ Director objectives linked to deliverables in the transformation programme. ➢ Mental health summit October 2014. ➢ Business case review and approval scheduled for completion Q3. ➢ Alternative non-recurrent substitutions for shortfall in transformation CIP (£500,000). ➢ Issues relating to Agenda for Change banding of key Project Management Office roles has delayed recruitment to level where there is a critical capacity issue.	£500,000	Workstream leads	Two-year operational plan	Monthly transformation and strategy and risk EMT meetings. Trust Board reports as appropriate. Business cases approved by Calderdale, Kirklees and Wakefield commissioners.	20	Red	Yes		Trust Board October 2014
522	Risk Assessment	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)				Risk that the Trust's financial viability will be affected as a result of changes to national funding arrangements (such as, CCG allocation and the Better Care Fund) coupled with emerging intensified local acute Trust pressures. Risk local re-tendering will increase the risk in the 2015/16 contracting round will increase the level of savings required to >5% to maintain financial viability and potential to fragment pathways and increase clinical risk.	➢ 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	➢ 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. ➢ Schemes being developed but costs unlikely to be released to commissioners in 2014/15. ➢ RAID scheme being implemented in Calderdale and Huddersfield ➢ Psychiatric Liaison scheme approved in Wakefield. ➢ Proactive involvement in negotiations regarding implementation of Better Care Fund in each of the localities.	£100,000	Deputy DCE lead & Directors	Two-year operational plan	Monthly at EMT	12	Amber	Yes		Trust Board October 2014
527	Risk Assessment	Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)				Bed occupancy is above that expected due to an increase in acuity and admissions is causing 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 BDUs with rest to follow. ➢ Linked to Acute Care Transformation Programme.	4 Major	4 Likely	16	Red	➢ 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. ➢ Trajectory monitored at EMT performance ➢ Internal audit undertaken on implementation of the bed management protocol. ➢ Action plan in place following review with ongoing monitoring.	`	BDU Director	Reviewed Protocol February 2014	Monthly at EMT	12	Amber	Yes		Trust Board October 2014
	Risk assessment	Corporate/ organisation level risk (corporate use only EMT)	Specialist services BDU	CAMHS			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	4 Likely	16	Red	➢ The implementation of the recovery plan 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 and reported. Action plan developed and implementation begun. ➢ Communication and briefings arranged for and with MPs. ➢ Round table meeting with local authorities and CCGs. ➢ Workshop in November 2014 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. Listening event held facilitated by the Chief Executive. ➢ Monthly reporting and review of action plan at EMT. ➢ Quality Academy staff continue to support recovery plan until all actions are implemented. ➢ Senior staff support identified and Chief		BDU Director		Monthly at EMT	12	Amber	Yes		Trust Board October 2014

													➢ Executive visit during August programme of service visits. ➢ 'Right first time' training for front-line staff planned.									
		Corporate/ organisation level risk (corporate use only EMT)	Trust-wide	HR	N/A	N/A	Possible industrial action in the NHS and wider public sector regarding the national pay award for 2014/15. Unions (except for BMA and Royal College of Nursing) are balloting for industrial action in October/November.	A group has been established reporting to the Health and Safety TAG, which includes emergency planning, involving HR, the emergency planning lead and BDU representatives. Contingency plans are being reviewed.	4 Major	4 Likely	16	Red	➢ Contingency plans under regular review. ➢ Discussions with Social Partnership Forum representatives regarding the extent and nature of industrial action to enable contingency planning.		BDU Directors /Director of HR	Not known	Health and Safety TAG to EMT/Trust Board EMT monthly/Trust Board monthly		Amber	Yes		Trust Board October 2014
677	Risk assessment	Corporate/ organisation level risk (corporate use only EMT)	Specialist services	Substance misuse services (Calderdale)			Risk that, as the Trust has been unsuccessful in the re-tender for substance misuse services in Calderdale where TUPE should apply for the staff group currently employed in the service on transfer to the new service, this will be contested by new provider, leaving the Trust with significant redundancy costs.	The Trust has sought legal advice regarding conditions of TUPE transfer. Commissioners accept that TUPE should apply and have included this in the tender document. Service continuity would be maintained by staff transfer.	4 major	3 possible	12	Amber/high (8-12)	➢ General Manager and Service Managers to enter into early negotiations with new provider, once known (likely to be mid-October) to negotiate and agree smooth transfer of service by February/March 2015. ➢ General Manager to continue to liaise with commissioners to maintain their support. ➢ HR to identify potential redundancy costs. ➢ Continued engagement with staff to provide assurance on service continuity, TUPE, staff rights and entitlement, commissioner intentions and timescales for transfer		Karen Taylor	March 2015		6	Yellow	Yes		Trust Board October 2014