With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board (business and risk – public session)
Tuesday 28 April 2015 at 13:00
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 31 March 2015

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

5. Audit Committee annual report to Trust Board 2014/15

6. Strategic overview of business and associated risks

7. Assurance framework and risk register

8. Quality performance reports month 12 2014/15

8.1 Quality performance report month 12 2014/15 (to follow)

8.2 Customer services/patient experience report quarter 4 2014/15

8.3 Exception reporting and action plans

(i) Child and adolescent mental health services
(ii) Risk assessment of performance and compliance targets 2015/16
(iii) Annual report on planned/unannounced visits
(iv) Standing orders, standing financial instructions and scheme of delegation

9. Strategies for approval

9.1 Patient Safety Strategy and Sign up to Safety
9.2 Leadership and Management Development Strategy

10. Annual Governance Statement 2014/15

11. Monitor quarterly return quarter 4 2014/15

12. Date and time of next meeting

The next meeting of Trust Board will be held on Tuesday 30 June 2015 in the Boardroom, Kendray, Doncaster Road, Barnsley.

Trust Board 28 April 2015
Agenda item 2

Title:	**Trust Board declaration of interests, including fit and proper persons declaration**
Paper prepared by:	Director of Corporate Development on behalf of the Chief Executive
Purpose:	To ensure the Trust continues to meet the NHS rules of Corporate Governance, the Combined Code on Corporate Governance, Monitor's Code of Governance and the Trust's own Constitution in relation to openness and transparency.
Mission/values:	The mission and values of the Trust reflect the need for the Trust to be open and act with probity. The Declaration of Interests and independence process and the fit and proper person declaration undertaken annually support this.
Any background papers/ previously considered by:	Declaration of interests policy approved by Trust Board March 2015.
Executive summary:	<u>Declaration of interests</u> The Trust's Constitution and the NHS rules on corporate governance, the Combined Code of Corporate Governance, and Monitor require Trust Board to receive and consider the details held for the Chair of the Trust and each Director, whether Non-Executive or Executive, in a Register of Interests. During the year, if any such Declaration should change, the Chair and Directors are required to notify the Company Secretary so that the Register can be amended and such amendments reported to Trust Board. Trust Board receives assurance that there is no conflict of interest in the administration of its business through the annual declaration exercise and the requirement for the Chair and Directors to consider and declare any interests at each meeting. As part of this process, Trust Board considers any potential risk or conflict of interests. If any should arise, they are recorded in the minutes of the meeting. There are no legal implications arising from the paper; however, the requirement for the Chair and Directors of the Trust to declare interests is part of the Trust's Constitution. <u>Non-Executive Director declaration of independence</u> Monitor's Code of Governance and guidance issued to Foundation Trusts in respect of annual reports requires the Trust to identify in its annual report all Non-Executive Directors it considers to be independent in character and judgement and whether there are any relationships or circumstances which are likely to affect, or could appear to affect, the Director's judgement. This Trust considers all its Non-Executive Directors to be independent and the Chair and all Non-Executive Directors have signed a declaration to this effect. <u>Fit and proper person requirement</u> There is a requirement for members of Boards of providers of NHS services

	to make a declaration against the fit and proper person requirement for directors set out in the new fundamental standard regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which came into force on 1 April 2015. Within the new regulations, the duty of candour and the fit and proper person requirements for Directors came into force earlier for NHS bodies on 1 October 2014. Although the requirement is in relation to new Director appointments, Trust Board took the decision to ask existing Directors to make a declaration as part of the annual declaration of interests exercise. All Directors have signed the declaration stating they meet the fit and proper person requirements. The Integrated Governance Manager is responsible for administering the process on behalf of the Chief Executive of the Trust and the Company Secretary. The declared interests of the Chair and Directors are reported in the annual report and the register of interests is published on the Trust's website.
Recommendation:	**Trust Board is asked to CONSIDER the attached summary, particularly in terms of any risk presented to the Trust as a result of a Director's declaration, and, subject to any comment, amendment or other action, to formally NOTE the details in the minutes of this meeting.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board – Declaration of Interests
28 April 2015

All members of Trust Board have signed a declaration against the fit and proper person requirement. All Non-Executive Directors have signed the declaration of independence as required by Monitor's Code of Governance, which requires the Trust to identify in its annual report those Non-Executive Directors it considers to be independent in character and judgement and whether there are any relationships or circumstances which are likely to affect, or could appear to affect, the Director's judgement.

The following declarations of interest were made by Directors.

Name	Declaration
CHAIR	
Ian Black	Non-Executive Director, Benenden Healthcare (mutual) Non-Executive Director, Seedrs (with small shareholding) Private shareholding in Lloyds Banking Group PLC (retired member of staff) Chair, Family Fund (UK charity) Chair, Keegan and Pennykidd (insurance brokers) Member, Advisory Group for the Point of Care Foundation's development of a report on health service leadership and management Member, Whiteknights, a charity delivering blood and organs on behalf of hospitals in West and North Yorkshire
NON-EXECUTIVE DIRECTORS	
Peter Aspinall	No interests declared
Laurence Campbell	Treasurer, Kirklees Citizens' Advice Bureau and Law Centre, includes NHS complaints advocacy for Kirklees Council
Julie Fox	Currently on secondment to the Youth Justice Board; however, this is not likely to conflict with the non-executive director role
Jonathan Jones	Member, Squire Patton Boggs (UK) LLP Member, Squire Patton Boggs (MENA) LLP Spouse, Company Secretary, Zenith Leasedrive Holdings Limited and its subsidiaries Spouse, shareholder, Zenith Leasedrive Holdings Limited
Helen Wollaston	Director, Equal to the Occasion Ltd. (consultancy) Director, WISE, a (Women in Science and Engineering), a social enterprise promoting women in science, technology and engineering
CHIEF EXECUTIVE	
Steven Michael	Member of Huddersfield University Business School Advisory Board Member, Leeds University Centre for Innovation in Health Management Member, Leeds University Centre for Innovation in Health Management International Fellowship Scheme Partner, NHS Interim Management and Support Trustee, Spectrum People NHS Confederation elected Chief Executive representative, Mental Health Network Board

Name	Declaration
	Health and Wellbeing Boards, Wakefield and Barnsley Involvement in Care Quality Commission mental health inspection arrangements
EXECUTIVE DIRECTORS	
Adrian Berry	No interests declared
Tim Breedon	No interests declared
Alan Davis	No interests declared
Alex Farrell	Spouse is General Practitioner partner, City View Practice, Leeds
COMPANY SECRETARY	
Dawn Stephenson	Voluntary Trustee for Kirklees Active Leisure
OTHER DIRECTORS	
Nette Carder	Director, Athena Leadership and Management Limited
Sean Rayner	Member, Independent Monitoring Board for HMP Wealstun Trustee, Barnsley Premier Leisure
Diane Smith	No interests declared
Karen Taylor	No interests declared

Minutes of Trust Board meeting held on 31 March 2015

Present:	Ian Black	Chair
	Peter Aspinall	Non-Executive Director
	Laurence Campbell	Non-Executive Director
	Julie Fox	Non-Executive Director
	Jonathan Jones	Non-Executive Director
	Helen Wollaston	Deputy Chair
	Steven Michael	Chief Executive
	Adrian Berry	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:	None	
In attendance:	Rob Adamson	Head of Finance
	Nette Carder	Interim District Service Director, CAMHS and Forensic Services (from item 7.2(i)
	Bronwyn Gill	Head of Communications and Customer Services
	Dawn Stephenson	Director of Corporate Development
	Bernie Cherriman-Sykes	Board Secretary (author)
Guests:	Jonathan Hayden	Otsuka Pharmaceuticals
	Bob Mortimer	Governor, publicly elected, Kirklees
	Jeremy Smith	Governor, publicly elected, Kirklees

TB/15/10 Welcome, introduction and apologies (agenda item 1)

The Chair (IB) welcomed everyone to the meeting. There were no apologies.

TB/15/11 Declaration of interests (agenda item 2a)

The following declaration was considered by Trust Board.

Name	Declaration
DIRECTORS	
Nette Carder	Director Athena Leadership and Management Ltd.

There were no comments or remarks made on the Declaration, therefore, **it was RESOLVED to formally NOTE the Declaration of Interest.** It was noted that the Chair had reviewed the declaration made and concluded that it did not present a risk to the Trust in terms of a conflict of interests. There were no other declarations made over and above those made in March 2014.

TB/15/12 Declaration of interests policy for Directors, including the fit and proper person requirement (agenda item 2b)

It was RESOLVED to APPROVE the revised declaration of interests policy for Directors of the Trust Board, including the fit and proper person requirement.

TB/15/13 Minutes of and matters arising from the Trust Board meeting held on 27 January 2015 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held on 27 January 2015 as a true and accurate record of the meeting. There were no matters arising.

TB/15/14 Assurance from Trust Board Committees (agenda item 4)

TB/15/14a Audit Committee 20 January 2015 (agenda item 4.1)

Laurence Campbell (LC) informed Trust Board that the Committee received a presentation from the Trust's external auditor, Deloitte, on what a 'good' Audit Committee looks like. A number of action points were identified and, as a result, some minor amendments will be made to the Committee terms of reference and brought back to Trust Board for approval.

TB/15/14b Clinical Governance and Clinical Safety Committee 3 February 2015 (agenda item 4.2)

Tim Breedon (TB) updated Trust Board on the development of a Patient Safety Strategy, which was scheduled for presentation at this meeting. To enable alignment with the 'Sign Up to Safety' national initiative, there has been a longer consultation period and the Strategy will now be presented to Trust Board at its April 2015 meeting.

TB/15/14c Mental Health Act Committee 24 February 2015 (agenda item 4.3)

Julie Fox (JF) raised the following.

- The Department of Health has published the revised Mental Health Act Code of Practice. This has implications for the Trust in terms of administration of the Act and for review and revision of Trust policies and procedures.
- The Committee received a report on an audit of Section 132 Patients' Rights in community services and questioned the different approach in Barnsley. As Chair of the Committee, JF has asked for the audit to be repeated in six months.
- With regard to Care Quality Commission (CQC) Mental Health Act visits, the Committee has agreed an expectation that issues raised should be resolved within a three-month period. The Committee will also expect an explanation from individual services where actions are not completed within this timescale.
- The Committee expressed its concern with the continued level of ethnicity recording.

TB/15/14d Remuneration and Terms of Service Committee 26 January and 10 February 2015 (agenda item 4.4)

From 26 January 2015 meeting, IB commented that this demonstrates the detailed scrutiny by the Committee to address Trust Board concerns in relation to sickness absence. He added that Peter Aspinall (PA) attended the meeting and he reiterated an invitation to Non-Executive Directors to attend other Committees if they are not a member and this should be arranged with the relevant committee chair in advance.

From the February 2015 meeting, IB asked Trust Board to note the update on Directors' performance in relation to the performance related pay scheme, which the Committee receives at each meeting.

Establishment of a Diversity and Inclusion Forum

Following a discussion with the Chief Executive (SM), Helen Wollaston (HW) asked Trust Board to consider the establishment of a short-life (anticipated as one year) Forum for diversity and inclusion along the lines of the two current Board-level Forums covering information management and technology, and estate. HW will Chair the initial meeting with a review of who assumes the Chair when new Non-Executive Directors are in post in the

context of a broader review of Committee membership. The aim is to ensure and provide assurance that diversity and inclusion are embedded in all aspects of Trust activity to support delivery and improvement of services. Dawn Stephenson (DS) commented that this will move diversity and inclusion from the compliance agenda and embed both in the culture of the organisation and delivery of services.

It was RESOLVED to APPROVE the establishment of a Diversity and Inclusion Forum.

TB/15/15 Chair and Chief Executive's remarks (agenda item 5)

SM began his remarks with feedback from the NHS Confederation Mental Health Network annual conference. The keynote speech was given by Simon Stevens, Chief Executive of NHS England. The issue of parity between physical and mental health services underpinned his list of nine priorities that mental health leaders could lead on over the coming year. This included:

- access standards;
- crisis care;
- child and adolescent mental health services;
- liaison psychiatry in emergency care;
- the physical health of people with severe and enduring mental health problems;
- getting the care models conversation 'right';
- commissioning models;
- capitalising on the technology enabled transformation of care; and
- the health and wellbeing of front-line staff.

He went on to comment on the following.

- The meeting with the Chief Constable of West Yorkshire Police and mental health trust Chief Executives in West Yorkshire came to a common agreement to develop a vision for crisis care linked to the Mental Health Crisis Concordat for trusts, the Police and the ambulance service. He would aim to replicate this in South Yorkshire.
- The strategic meeting of Trust Board on 3 March 2015 provided a framework to contextualise the Trust's strategy and how enabling strategies support the Trust's service strategy.
- The Trust is working closely with Locala on development of a tender for Care Closer to Home in Kirklees.

Alan Davis (AGD) confirmed that an application for outline planning permission for the Castleford, Normanton and District Hospital site has been submitted to Wakefield Council. An engagement event was held for local residents on 24 February 2015 and there was general support for development of the site and for the legacy of health services to remain. The future of Savile Park View House is subject to ongoing discussion with commissioners.

IB covered the following in his remarks.

- Out of 242 NHS provider organisations, he was pleased to announce that SM was in the top 50 leaders. This was a great acknowledgement for SM, and very much deserved, and for the Trust and its staff as a whole.
- Two new Non-Executive Directors will be appointed in April 2015 to replace PA and HW. Six excellent candidates have been shortlisted for interview on 27 April 2015.
- Following a tender process, Deloitte has been selected to undertake an independent review under the well-led framework, reporting to Trust Board and the Members' Council in July 2015. Deloitte will interview all Trust Board members. This is seen as a

developmental and challenging process from which the Trust will aim to develop and improve the arrangements it currently has in place.

- Heads of Terms have been agreed with Priory to provide a Tier 4 child and adolescent mental health service (CAMHS).
- Lastly, he informed Trust Board that he has put himself forward for the Board of NHS Providers.

TB/15/16 Corporate objectives 2015/16 (agenda item 6)

SM introduced this item and commented that approval will be followed by a process with Directors to develop meaningful objectives, which will support achievement of the Trust's strategy in 2015/16. The objectives will also link to the Board assurance framework.

LC suggested inclusion of an explanation of how the corporate objectives enable the Trust to meet external requirements, HW suggested inclusion of diversity, which should underpin the objectives, and JF suggested that the objectives should be more outcome-focussed. DS agreed to take these suggestions forward.

It was RESOLVED to APPROVE the strategic framework and underpinning delivery and organisational development objectives.

TB/15/17 Performance reports month 11 2014/15 (agenda item 7)

TB/15/17a Performance reports (agenda item 7.1)

TB highlighted two key areas.

- Data quality with assurance to Trust Board that plans are beginning to show improvement and
- mandatory training and the development of an approach to ensure a focus on key service areas. JF asked whether there is clarity on what constitutes mandatory training. AGD responded that there is a clear policy. What the Trust is now doing is to ensure training is prioritised in service areas, taking a risk-based approach. This will be monitored from Q1 in 2015/16.

Alex Farrell (AF) took Trust Board through the key points relating to the Trust's financial position. She confirmed that the Trust was on target to achieve its financial plan and highlighted the following.

- The re-valuation of assets and offset of impairment, which has improved the Trust's position.
- The healthy cash position.
- The underspend on capital. This will be a key area of focus in 2015/16 to ensure the Trust's estate is fit for purpose and meets service needs.

SM commented on the Trust's performance for service users on care programme approach supported into employment and settled accommodation. This will form a key part of the Trust's transformation of services for this to improve. This also demonstrates the need to improve relationships and links with employers and housing providers, linked to recovery work.

AF also confirmed the Trust achieved the 95% information governance training target on 30 March 2015.

TB/15/17b Exception reports and action plans – Child and adolescent mental health services recovery plan – progress report (agenda item 7.2(i))
TB introduced this item and reminded Trust Board of the context and background. Nette Carder (NC) went on to outline progress to address the recovery plan.

In response to a concern expressed by PA, SM responded that the Trust is sustaining a service under extreme pressure in its current form. The Trust is, therefore, continuing to maintain safety in delivery; however, this position is unsustainable in the long-term.

A business case has been submitted to commissioners for investment in crisis and intensive home-based treatment and Trust Board has set a deadline of the end of April 2015 for a response and/or decision. *[It should be noted that a further summit has been arranged for 8 May 2015 and the future position will be discussed and agreed at this meeting.]* Trust Board's position is that, if a decision is not made by then, this position is unsustainable.

IB commented that this reflects a national concern regarding investment in CAMHS and the position in Calderdale and Kirklees means it is a focus for this Trust. He reiterated that the Trust has invested £500,000 and commissioners £300,000 this financial year. SM responded that there has been significantly more investment in Wakefield for example than in Calderdale and Kirklees. Being able to identify what a 'good' service looks like provides a comparison for the service the Trust wants to be able to deliver and he was sure this position is replicated in other areas of the country.

TB commented that the Trust cannot continue to invest at the level it is doing over and above the contract value. AF added that the Trust is looking at the current run-rate and, therefore, how much delivery of the service would cost over and above the contract value. Given the trajectory for recruitment, the Trust could use additional development monies from commissioners to non-recurrently to meet the gap. This would provide commissioners with time to agree how to bridge the funding gap for investment in 2016/17.

JF asked if the additional funding was less than needed or none was forthcoming what the Trust's plan would be. AF responded that the Executive Management Team will come back to the April 2015 meeting with an outline of options. TB suggested one approach would be the establishment of a quality surveillance-type mechanism to provide a cross-system risk scan to enable the Trust to flag and escalate concerns. AF confirmed that the Executive Management Team will also check the notice required and that the current contract ends on 31 March 2016. SM reiterated the need to find a joint solution between partners before any escalation or the need for Trust Board to consider termination of the contract. It was agreed to receive a further update at April's meeting with an articulation of action the Trust is taking and planning to take in the short- and long-term.

Non-Executive Directors offered support in the process if required and this was noted.

It was RESOLVED to SUPPORT the position outlined and SUPPORT the request to commissioners for urgent resolution to the crisis and intensive home-based treatment position by the end of April 2015.

TB/15/17c Exception reports and action plans – Information Governance Toolkit 2014/15 (agenda item 7.2(ii))
It was RESOLVED to APPROVE the Trust's information governance submission.

TB/15/17d Exception reports and action plans – Eliminating mixed sex accommodation declaration of compliance (agenda item 7.2(iii))
It was RESOLVED to APPROVE the compliance declaration.

TB/15/17e Exception reports and action plans – Serious incidents report Q3 2014/15 (agenda item 7.2(iv))

TB commented that the end-of-year figures for 2014/15 are slightly higher but broadly similar to previous years. A full analysis will be undertaken to inform learning and will be reported to Trust Board in June 2015 with the presentation of the annual report. For 2015/16, reporting will be aligned for detailed scrutiny at the Clinical Governance and Clinical Safety Committee prior to Trust Board.

It was RESOLVED to NOTE the report.

TB/15/18 Approval of annual budget 2015/16 (agenda item 8a)

AF introduced this item and commented that the approval sought today provides a framework to enable the budget to be set for 2015/16. The final submission of the annual plan for 2015/16 to Monitor will be made by the deadline of 14 May 2015 and will be presented to Trust Board in April 2015. Following Trust Board approval of the budget, the Trust will submit its financial plan to Monitor by 7 April 2015.

AF continued that the Trust is predicting a bottom-line deficit of £734,000. This includes a reasonable review of the delivery of the cost improvement programme of £9.6 million (4.4%) and an additional £11 million of cost pressures, significantly above that anticipated, for investment in services split between £8.6 million recurrent spend and £4.2 million non-recurrent. The Trust remains in recurrent surplus at £3.5 million and is planning for a small surplus in 2016/17.

The external, independent review of the Trust's financial plan should provide assurance to Trust Board that savings are achievable. The paper presented also sets out areas of additional investment. The plan includes a capital plan of £16 million in 2015/16 and the Trust will continue to achieve a continuity of services risk rating of 4 (out of 4).

IB referred to the separate Trust Board session on 24 March 2015 and also the private session of Trust Board where more detailed consideration had been given.

It was RESOLVED to DELEGATE AUTHORITY to the Chair and Chief Executive to approve any changes to the plan in relation to changes in income for the submission to Monitor on 7 April 2015.

IB commented on the independent review by Deloitte, which demonstrated an improved level of BDU ownership, a robust quality impact assessment process and that the external review of risk was broadly similar to the Trust's own assessment.

He would like to see Trust Board focus on 'investment' in 2015/16 as well as scrutinising progress against the cost improvement programme. SM commented that the annual planning and budget setting process demonstrated the Trust's use of the financial freedoms and flexibilities afforded to foundation trusts to ensure it is relevant today, ready for tomorrow, and enables the Trust to undertake its transformation programme, making improvements to its services to benefit people who use its services.

It was unanimously RESOLVED to APPROVE the annual budget for 2015/16, including the capital plan, subject to the approval of the final submission of the annual plan to Monitor at April's meeting, and APPROVE the submission of the annual budget to Monitor on 7 April 2015 under the delegated authority outlined above.

TB/15/19 How the organisation runs – part 2 (agenda item 8b)

The outline of the how the organisation runs (second phase) was noted by Trust Board.

TB/15/20 Vision for volunteering, engagement and involvement (agenda item 9)

DS introduced this item. HW was supportive of the focussed approach and asked for additional assurance that volunteers would not replace staff or fill staff posts. This was given. JF commented that national accreditation would provide a good framework for the scheme and she asked that the Trust works to involve young people through universities and further education colleges, who are promoting volunteering to students.

DS responded to a number of questions from Trust Board.

- The intention is to launch the scheme from 1 May 2015 supported by communications and training. This will be through a celebration event for volunteers.
- The Trust will look at other measures of success, such as time and location, as well as the number of volunteers, which would be just one measure of success.
- The number of volunteers to be recruited (250) is an ambitious target; however, DS was confident that the Trust would move quickly to this figure through a focussed piece of work to recruit volunteers.
- Part of the planned work is to recognise staff who take on a voluntary role.

It was RESOLVED to NOTE the progress to date and SUPPORT the ongoing journey to recruit and support Trust volunteers to add value to the current service offer.

TB/15/21 Use of Trust seal (agenda item 10)

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

TB/15/22 Date and time of next meeting (agenda item 11)

The next meeting of Trust Board will be held on Tuesday 28 April 2015 in the small conference room, Learning and Development Centre, Fieldhead, Wakefield, WF1 3SP.

Signed …… Date ……

Trust Board 28 April 2015
Agenda item 5

Title:	**Audit Committee annual report to Trust Board 2014/15**
Paper prepared by:	Chair of Audit Committee
Purpose:	The purpose of this paper is to provide assurance to Trust Board that its Committees operate effectively and meet the requirements of the terms of reference.
Mission/values:	A strong and effective Board and Committee structure enables the Trust to achieve its vision and goals, and maintain a sustainable and viable organisation.
Any background papers/ previously considered by:	The Audit Committee received annual reports from Trust Board Committees as well as considering its own report at its meeting on 7 April 2015.
Executive summary:	The Audit Committee is required under its terms of reference to review other risk Committees' effectiveness and integration to provide assurance to Trust Board that: - risk is effectively managed and mitigated within the organisation; - Committees are fulfilling their terms of reference; and - integration between Committees avoids duplication. The Committee agreed to combine this process with the production of the Annual Governance Statement (AGS). Trust Board Committees are responsible for scrutiny and providing assurance to Trust Board on key issues within their terms of reference. Agendas are set to enable Trust Board to be assured that scrutiny processes are in place to allow the Trust's strategic objectives to be met, and to address and mitigate risk. As part of this process of assurance to Trust Board and as part of development of the AGS annually, Trust Board Committees are required to produce an annual report and an annual workplan, undertake an annual self-assessment, and review their terms of reference for relevance and appropriateness. The Audit Committee received the annual report from each Committee and its forward work programme at its meeting on 7 April 2015, supported by a short presentation from each Committee Chair and Lead Director to provide assurance to the Committee on the assurance each Committee has provided to Trust Board in terms of meeting its terms of reference, in identifying and mitigating risk, and in integrating with other Committees. A summary is contained in the Audit Committee annual report. There were no changes to the terms of reference for the Clinical Governance and Clinical Safety, Mental Health Act and Remuneration and Terms of Service Committees; however, in January 2015 at the request of the Audit Committee, it received a presentation from Deloitte on Audit Committee effectiveness and best practice. The Committee compared well against

	identified best practice and a number of actions were identified by the Company Secretary for further development. These have been agreed with the Chair of the Committee and these are included in the annual report. A number of actions relate to the terms of reference and these will be considered by the Committee at its meeting in July 2015. The individual Committee annual reports and work programmes have been approved by the relevant Committee and were presented to the Audit Committee. These are available for Trust Board if required. The Trust is required to report the significant audit risks identified by external audit in its annual report. It was suggested that this is done through the Audit Committee annual report to provide assurance to Trust Board that the risks have been reported and considered by the Committee. This has been done. Overall the review of the documents and presentation of the work of the Committees was sufficient to enable the Chair of the Audit Committee to support an assurance to Trust Board that the integrated governance arrangements in the Trust were operating effectively and that Committees: ➢ had met the requirements of the Terms of Reference; ➢ had followed a workplan aligned to the risks and objectives of the organisation, within the scope of its remit; and ➢ could demonstrate added value to the organisation.
Recommendation:	**Trust Board is asked to RECEIVE the annual report from the Audit Committee and to SUPPORT the view that the Committee can provide assurance that, in terms of the effectiveness and integration of risk Committees, risk is effectively managed and mitigated through assurance that:** - **Committees meet the requirements of their Terms of Reference;** - **Committee workplans are aligned to the risks and objectives of the organisation within the scope of their remit; and** - **Committees can demonstrate added value to the organisation.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Audit Committee Annual Report 2014/15
Presented to Trust Board 28 April 2015

1. Purpose of report

The purpose of the report is to provide a summary of the Committee's activities during the financial year 2014/15 in order to evidence its effectiveness and impact by demonstrating compliance with its Terms of Reference.

2. Background

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

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

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

The Committee is made up of Non-Executive Directors and members from April 2014 to March 2015 were Peter Aspinall (Chair to 31 December 2014), Laurence Campbell (from July 2014 and Chair from 1 January 2015), Bernard Fee (to May 2014) and Jonathan Jones.

3. Review of Committee activities

The Committee's activities during the year have been cross referenced to its Terms of Reference.

3.1 Internal Audit

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

	Progress
Consideration of the provision of the Internal	During 2015, the contracts for both internal and

	Progress
Audit service, the cost of the audit and any questions of resignation and dismissal.	external audit come to an end (KPMG (internal) 30 June 2015 and Deloitte (external) 30 September 2015). The Audit Committee considered the position at its meeting in October 2014 and was of the view that the Trust should not tender for both internal and external audit services at the same time. The Committee agreed, therefore, an extension to the contract for KPMG as the Trust's internal auditors for one year (to 30 June 2016).
Review and approval of the Internal Audit strategy, programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.	A draft Internal Audit Annual Plan for 2014/15 was presented to and agreed by the Audit Committee in April 2014. The plan provides a risk-based analysis of the Trust's operations, utilising the Trust Board assurance framework, reflecting the Trust's corporate objectives, priorities and areas identified for improvement. Progress against the plan is reviewed at every meeting and this includes reports on the Trust's progress against actions identified to address recommendations made by KPMG. Regular meetings are held with the Director of Finance to monitor progress against the work plan.
Consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources.	The Committee receives audit reports and audit findings in line with the audit plan. The recommendations are followed up to ensure actions are taken in line with the action plans agreed. To January 2015, 15 internal audit reports were presented to the Committee. Of these, there were: - no full assurance opinions; - eight substantial/significant assurance opinions; - six moderate assurance opinions; - one limited/partial assurance reports (patients' property); and - no 'no' assurance opinion. The audit of financial management, which provided a substantial assurance opinion, included a review/follow up of the recommendations from the procurement (non-pay purchasing) audit, which provided a no assurance opinion in October 2013. The follow up found that there had been timely and effective progress in relation to the actions agreed with the Trust, the interim arrangements where permanent solutions have not yet been implemented were effective and there was no indication of breaches in control. As part of this work, KPMG also evaluated the risk of financial loss for the period when control weaknesses were identified and found that there was no indication of financial loss. Management action has been agreed for all recommendations, these are reported to the Committee and, where appropriate, progressed by KPMG. In the main, there are no significant outstanding actions; however, the Committee has an ongoing concern regarding data quality within

	Progress
	the Trust and it has also asked the Executive Management Team to review the findings of the patients' property audit to ensure ownership and improvement.
	The Audit Committee reviewed and received the Head of Internal Audit Opinion as part of the final accounts process for 2013/14. This provided substantial assurance.
Ensure the Internal Audit function is adequately resourced and has appropriate standing in the organisation.	The ongoing adequacy of resources is assessed through review of the internal audit plan and monitoring rate of achievement. No significant issues have been raised in-year although some issues have been raised by the Director of Finance in relation to the planning of audit work by KPMG.
An annual review of the effectiveness of internal audit.	KPMG has identified a number of performance areas against which the Committee can assess its performance and the timing of this assessment will be agreed with the Chair of the Committee.

3.2 Counter Fraud

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

	Progress
Consideration of the provision of the Counter Fraud service, the cost of the audit and any questions of resignation and dismissal.	See 3.1 above. The Trust's contract for internal audit services with KPMG includes provision of counter fraud services.
Review and approval of the Counter Fraud strategy, programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.	KPMG presented a programme of work to the Committee in April 2014, which was approved. Progress against plan is reviewed at every meeting.
	The Committee received an annual report for 2013/14 in July 2014.
Consideration of the major findings of Counter Fraud (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources.	The Committee receives the Counter Fraud update report at each meeting to identify progress and any significant issues for action. The work of Counter Fraud is summarised in the annual report.
	KPMG undertook a proactive procurement review, reported to the Committee in July 2014, following guidance issued by NHS Protect that NHS organisations should review current arrangements around prevention and detection of procurement fraud. The review compared the current processes in place at the Trust with NHS Protect best practice in six areas relating to breaches of standing orders, standing financial instructions and EU public procurement directives, conflict of interest, bribes and kickbacks, false quotations and tenders, manipulating tender selection processes, and contract splitting. Six recommendations of medium priority were made and action agreed with the Trust.
An annual review of the effectiveness of Counter Fraud Services.	Based on the self-review toolkit, the Trust is rated as green for strategic governance, red for inform

	Progress and involve (the Trust was one of a number chosen by NHS Protect for a focussed counter fraud assessment focussing on the area of 'Inform and Involve' and the rating reflects the assessor's findings), amber for prevent and deter, and amber for holding to account. The recommendations from the assessor have been addressed and the focus for the Local Counter Fraud Specialist is to work with the Trust to continue to improve the quality assessment rating.

3.3 External Audit

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

	Progress
Consideration of the appointment and performance of the External Auditor, as far as Monitor's rules permit.	During 2015, the contracts for both internal and external audit come to an end (KPMG (internal) 30 June 2015 and Deloitte (external) 30 September 2015). The Audit Committee considered the position at its meeting in October 2014 and was of the view that the Trust should not tender for both internal and external audit services at the same time. As there is no further option in the original tender to re-appoint Deloitte, a tender process will be undertaken during 2015 for external audit services. The Committee considered and agreed the plan for the process at its meeting in January 2015. The Members' Council was informed of the decision at its meeting in January 2015 and the Members' Council will be involved in the tender process.
Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy.	The Audit Committee has received and approved the Annual Audit Plan (January 2015). Progress against plan is monitored at each meeting.
Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.	The Audit Plan and fee for Deloitte was approved as part of the re-appointment process during 2013. As part of the negotiation of the fee during this process, the Trust received a reduction in the fee level to reflect that there was no requirement for Deloitte to incur tending or marketing expenditure for retention of the Trust's contract. A formal plan and fee proposal was presented to and approved by the Committee in January 2015.
Review all External Audit reports, including agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.	The Audit Committee received and approved: ➢ the statement for those with responsibility for governance in relation to 2013/14 accounts; ➢ final reports and recommendations as scheduled in the annual plan.

The Trust's external auditor, Deloitte, was selected for a Quality Review of Audits by the Quality Assurance Directorate of the Institute of Chartered Accountants of England and Wales commissioned by Monitor. This was undertaken in August and September 2014 and

the outcome reported to the Audit Committee in October 2014. There were no findings of significance and only minor disclosure issues raised, which will be addressed in the 2014/15 annual report and accounts process. Monitor has confirmed there were no issues it wished to raise with the Trust on 24 November 2014. As required, this has been reported to the Members' Council.

The Committee was presented with the external audit plan in January 2015. Significant audit risks were outlined as follows.

- Recognition of NHS revenue – *fraudulent misstatement of revenue continues to be a presumed risk of misstatement.*
- Property valuations – *the valuation of the Trust's £96 million of property assets (as at 31 March 2014) is inherently judgemental.* This was identified as a continuing significant risk.
- Accounting for capital expenditure – *the Trust has begun a significant programme of investment in community hubs.* Deloitte specifically highlighted the Calderdale community hub development at Laura Mitchell House in Halifax.
- Management override of controls – *Deloitte will use computer-assisted audit techniques to support its work on the risk of management override.*

These were noted by the Committee and the Trust's annual report will specifically outline the management action to address these risks, explaining the mitigating action in place to address the risks or, where appropriate, an explanation as to why the Trust does not consider these to be risks, and explaining its tolerance of any residual risk.

4. Other Governance Duties

4.1 Standing Items for each Meeting

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

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

The Committee is also required to receive a report on any waiver of Standing Orders. Any waivers in relation to procurement are reported at each meeting through the procurement report and considered by the Committee. During 2014/15, there have been no other waivers of Standing Orders.

As part of its regular review of Treasury Management, the Committee reviewed the Treasury Management Strategy and Policy and recommended its approval to Trust Board in January 2015.

4.2 Ad-hoc and annual items

An internal audit of financial management was presented to the Committee in April 2014 and provided a substantial assurance audit opinion. This audit included a robust review of the Trust's implementation of the recommendations arising from the procurement (non-pay) purchasing audit and KPMG was able to provide a clean Head of Audit Opinion for 2014/15.

The Committee also:

- reviewed the external audit report on the production of Quality Accounts for 2013/14. (It should be noted that the scrutiny of the Quality Accounts themselves is a responsibility of the Clinical Governance and Clinical Safety Committee.);
- reviewed the process for the development of the Assurance Framework;
- considered the external agencies annual report for 2013/14 for assurance that the Trust acts on reports, etc. received; and
- received assurance on the outcome of the process in place to ensure staff make appropriate declarations of interest and supported the areas identified for development and improvement.

5. Annual items – financial reporting

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

- Received and approved annual report, annual accounts and Quality Accounts for 2013/14 and received and approved the annual accounts and annual report for Charitable Funds for 2013/14.
- Received the report from External Audit for those charged with governance, which outlines findings of external audit.
- Reviewed the Use of Resources Assessment for 2013/14.
- Reviewed and approved changes to the Trust's Accounting Policies.
- Reviewed the Procurement Strategy, priorities and progress against achievement of cost savings.
- At the request of Trust Board, received assurance on financial reporting.
- Received a briefing on the outcome of the quality review of audits by the Quality Assurance Directorate of the Institute of Chartered Accountants of England and Wales (see section 3.3 above).

6. Governance Assurance

6.1 Review of Audit Committee effectiveness

Each Committee has Terms of Reference and is required to produce an annual report outlining the achievements against objectives and compliance with Terms of Reference. The Committee reviewed a first draft of its own annual report, work programme and terms of reference at its meeting in January 2015. The work programme was approved.

In January 2015 at the request of the Committee, it received a presentation from Deloitte on Audit Committee effectiveness and best practice. The Committee compared well against identified best practice and a number of actions were identified by the Company Secretary for further development. These have been agreed with the Chair of the Committee as follows.

1. Consult Members' Council on Audit Committee terms of reference – to be discussed with the Chair of the Trust.

2. Receive a presentation from Director of Human Resources and Workforce Development on the Trust's arrangements for whistleblowing to provide assurance to the Committee and, as part of this, consider a confidential/anonymous telephone number to report concerns.
3. Presentation to Members' Council on Trust Board Committees. This will form part of the session for the Members' Council on holding Non-Executive Directors to account in October 2015.
4. Discuss with Chair (and then Members' Council Co-ordination Group) an effective way of reporting to governors any matters where action or improvement is needed.
5. Establish rolling log for Committees rather than meeting specific. This will be introduced from April 2015 for all Committees.
6. Develop Committee cover sheet for Trust papers. This will be introduced from April 2015 for all Committees.
7. Develop a key issues template for providing assurance to Trust Board. This will be introduced from June 2015.

There were also a number of minor points of best practice in relation to the Committee terms of reference as follows.

1. Stronger narrative around scrutiny of the effectiveness of control arrangements and arrangements for staff to confidentially raise concerns.
2. Statement on the responsibility to develop and implement a policy on the provision of non-audit services;
3. Clarifying the Committee's role and relationship with the Members' Council, as articulated in Monitor's Code of Governance; and
4. Specify that the Committee undertakes an annual review of its effectiveness (this is already included in the existing terms of reference).

The Chair of the Committee asked for a review of the existing terms with recognised best practice (Healthcare Financial Management Association Audit Committee Handbook and NHS Providers Foundations of Good Governance). The existing terms of reference were found to be fit for purpose against both and it was agreed to consider the points raised above during the coming year following wider discussion and consultation with the Chair of the Trust.

6.2 Audit Committee review of the effectiveness of Trust Board Committees

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

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

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

The Audit Committee reviewed Committee annual reports, annual work programmes and the outcome of self-assessments on 7 April 2015 for 2014/15. The purpose of the review is for the Audit Committee to provide assurance to Trust Board that:

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

The review was undertaken as part of formal Audit Committee business with Committee Chairs and key Committee members invited to present to provide assurance to the Audit Committee on the assurance each Committee has provided to Trust Board in terms of

meeting its terms of reference, in identifying and mitigating risk, and in integrating with other Committees.

Audit Committee

Chair – Laurence Campbell; Lead Director – Alex Farrell

The Committee met its Terms of Reference and developed a work plan to reflect the risks and objectives of the organisation. The actions arising out of the review of best practice will be taken forward during the coming year. In his role as Audit Committee Chair, Laurence Campbell has attended meetings of all Committees during the year. The suggestion that it would be worthwhile for other Non-Executive Directors to do the same was noted. The Committee has also begun a major piece of work to re-tender for external audit services and the extension of the contract for internal audit was noted.

Clinical Governance and Clinical Safety Committee

Chair – Helen Wollaston; Lead Director – Tim Breedon

The Committee met its Terms of Reference and continued to develop its work programme throughout the year to reflect the risks and objectives of the organisation. Scrutiny of progress to meet the recovery plan for child and adolescent mental health services is a standing item on the Committee's agenda and will remain so through 2015. Progress is slower than expected but the Committee is assured that action is in place and, in particular, by the appointment of an interim BDU Director for the service. Non-Executive Director links have been made with the interim Director.

The Committee's focus in the coming year will be on improvement and this is reflected by the ongoing scrutiny of the Trust's approach to the transformation of its services. Presentations on learning disability services, dementia and recovery have been received to date.

Mental Health Act Committee

Chair – Julie Fox; Lead Director – Tim Breedon

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

- As part of the ongoing review of monitoring information, information presented to the Committee has been enhanced and now includes reporting of trends.
- Legal updates are included as a standing item on the Committee's agenda, which the Committee members have found useful, and also links to Hospital Managers' reviews and Forum meetings.
- In a number of audits undertaken throughout the year, issues with recording were identified. Where the Committee does not feel it has received sufficient assurance, it has asked for a re-audit within six months.
- The Mental Health Act Code of Practice has been published by the Department of Health and the Committee will review the implications for the Trust and the Code's implementation.
- Training for new Non-Executive Director members of the Committee is an area that will be developed in 2015.

To facilitate closer links between the Audit and Mental Health Act Committees, it was suggested that sight of the Audit Committee's agenda would be helpful and this will be instigated.

Remuneration and Terms of Service Committee

Chair – Ian Black; Lead Director – Alan Davis

The Committee met its terms of reference and fulfilled its work programme for the year. The following was highlighted.

- The Committee undertakes a detailed review of areas of concern in relation to HR performance to provide assurance to Trust Board. This has included sickness absence, the staff wellbeing survey, recruitment and stability rates.
- The Committee also considers the Director structure informed by the Chief Executive, for example, the Medical Director and Director of Health Intelligence and Innovation.
- A number of redundancy business cases at senior level were considered and approved.
- Directors' performance related pay is a standing item on the Committee's agenda and links to Directors' quarterly reviews with the Chief Executive, which informs the Board assurance framework. The Committee receives the outcome of Director annual reviews and the Chief Executive's report on performance against corporate and individual objectives.

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

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

6.3 Internal audit of corporate governance arrangements

An internal audit of corporate governance arrangements was undertaken by KPMG in autumn 2014 and reported to the Committee in October 2014. The audit provided an audit opinion of significant assurance with minor improvement opportunities and enabled Trust Board to take assurance that the arrangements in place around Corporate Governance, and in particular the Trust's Corporate Governance self-certification and self-assessment against external standards, are generally sufficient.

Seven low risk recommendations were made although these were not vital to the achievement of the Trust's strategic aims and objectives. The Trust has also demonstrated that it has responded to the best practice recommendations made in the previous review in 2013 to enhance what was already a good position.

a. The Trust's corporate governance statement includes only brief narrative to say that Trust Board is made aware of guidance on good corporate governance from Monitor. The next statement could be enhanced if some recent examples were provided to support this statement. It was also suggested that the Audit Committee should ensure that it shares key headlines with the Board from Internal Audit's technical update paper, highlighting any recent Monitor publications
   The Trust will include more detailed narrative in the Corporate Governance Statement for 2015/16 supported by evidence. In terms of the Audit Committee alerting Trust Board to any Monitor reports relating to governance, Trust Board expects the Audit Committee to ensure that the Trust has noted and taken appropriate action arising from KPMG's technical updates (as well as those provided by external audit) and only raise any issues where it was apparent the Trust had not taken appropriate action.

b. It was suggested that more detail should be included in the Corporate Governance Statement to fully demonstrate the Trust's response to, for example, how risks to compliance are built into plans and day-to-day operations; the period that Trust Board finance and performance reports cover; and what arrangements are in place to ensure compliance with legal requirements.
   It was agreed this would be incorporated into the Statement for 2015/16.

c. The statement contains a few typographical errors and a small number of items which refer to things that have been arranged for dates in the past or are otherwise out-of-date when considered alongside other evidence provided. The Trust should, therefore, ensure that all evidence in the statement is updated and is reviewed prior to Trust Board so any typographical errors can be identified.
This was agreed and the Statement will be reviewed in more detail by the Director lead.

d. Trust officers are aware of the need to develop how the Members' Council canvasses opinion on the Trust's forward plan so Governors can provide their views to Trust Board. Evidence suggests a more ad-hoc approach is taken by each Governor. It was suggested, therefore, that Governors should consider how they might better canvass the views of Trust members and the public to feed their views back to the Trust.
The Trust will work with Governors to consider how they can canvass the views of members within both theirs and the Trust's resource envelope.

e. The annual report outlines how individual performance of the Trust Board members is assessed and there is evidence of a development session with an external facilitator, but it could be more explicit in relation to the reason why the Trust has adopted this particular method of performance evaluation.
The Trust will articulate its approach and rationale in a clearer way for the annual report 2014/15.

f. The Trust used consultants to provide advice on the remuneration of senior executives, but the remuneration section of the annual report does not disclose whether they have any other connection to the Trust. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the Trust. The terms of reference of the remuneration committee on the Trust's website should be updated to the latest version.
The point was noted and will be addressed for 2014/15. Up-to-date terms of reference for all Trust Board Committees are included on the Trust's website.

g. The review of Monitor's new Code of Governance was undertaken on an agreed sample basis. The Trust has already identified actions to be taken as part of its self-assessment, and it is important that these are followed up to ensure that current standards of corporate governance within the Trust are maintained and, where necessary, enhanced and evidenced.
This recommendation was noted. The Trust will ensure an action plan is developed in conjunction with the Chair of the Trust to ensure all actions are taken forward.

7. Review of Committee administrative arrangements

The Committee meets the minimum requirement for the number of meetings in the year and has been quorate at each meeting. The requirement to send papers out six clear days in advance of the meeting has been met throughout the year. There have been some instances where individual papers have, with agreement, been sent out after this requirement.

8. Self Assessment

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

- composition, establishment and duties;

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

From the feedback received the majority of areas were assessed as compliant. The key comments/findings were as follows. The responses will be considered by the Committee later in the year and any action agreed as a result.

Composition, establishment and duties

Does the Audit Committee have written terms of reference that adequately and realistically define the Committee's role in accordance with guidance?

Need to update for best practice with Members' Council links (see above).

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

Deloitte/KPMG sessions introduced in 2014.

Internal control and risk management

Has the Committee been briefed on its assurance responsibilities with regard to internal control and risk management, particularly in regard to the Statement on Internal Control, CQC Registration and Regulation, NHS LARMS and other areas of compliance, particularly that of clinical risk?

Care Quality Commission registration and regulation will be addressed in Clinical Governance and Clinical Safety Committee annual report and responsibility addressed in Audit Committee annual report.

Compliance with the law and regulations governing the NHS

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

Negative response and a response stating that "we have one".

To note

The Company Secretary role sits within the portfolio of the Director of Corporate Development. Trust Board considered this as part of its application for Foundation Trust status and during a review of its arrangements as a result of the transfer of services under Transforming Community Services.

Internal audit

Negative response but no comments made to the following.

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

Has the Committee determined the appropriate level of detail it wishes to receive from internal audit?

Does the Committee hold periodic private discussions with the Head of Internal Audit?

Does the Committee review the effectiveness of internal audit and the adequacy of staffing and resources within internal audit?

To note

This is considered as part of the annual planning process for internal audit in which the Committee is involved.

Are there any quality assurance procedures to confirm whether the work of the internal auditors is properly planned, completed, supervised and reviewed?

To note

Internal audit is subject to a number of key performance indicators, which are reported to the Committee at each meeting. There are also regular meetings between internal audit and the Director of Finance.

External audit

Negative response but no comments made to the following.

Does the Committee receive and monitor actions taken in respect of prior year's reviews?

Does the Committee hold periodic private discussions with the external auditor?

To note

The Committee meets at least once a year in private with the external auditor.

Does the Committee assess the performance of external audit?

To note

This is undertaken annually; however, as the Trust is undertaking a tender process for external audit services, it was agreed a review was not necessary in 2014/15.

Other issues

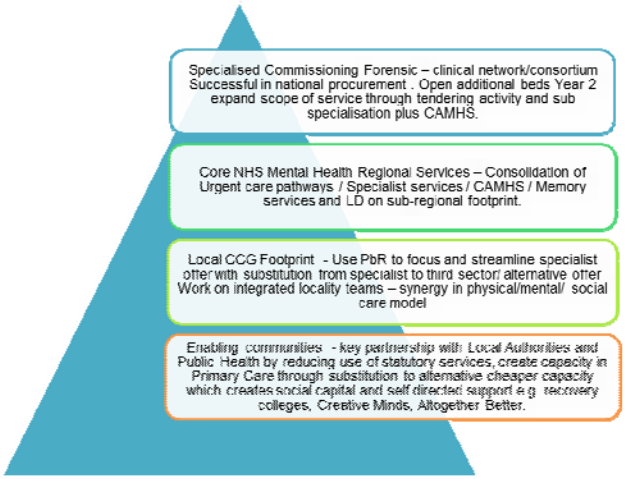
Has the Committee considered the costs that it incurs and are the costs appropriate to the perceived risks and benefits?

Negative response

9. Conclusion

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

Trust Board 28 April 2015
Agenda item 6

Title:	**Strategic overview of business and associated risks**
Paper prepared by:	Chief Executive
Purpose:	To support Trust Board in contextualising the major threats and opportunities for the Trust, including a review of PESTLE and SWOT analyses, and summary of connectivity with the Trust's Risk Register.
Mission/values:	Achievement of the Trust's mission relies on working in partnership with the Trust's service users and carers, staff and stakeholders.
Any background papers/ previously considered by:	Strategic Plan 2014 to 2019 and Annual Plan 2015/16
Executive Summary:	**1. Context** The Trust's Executive Management Team regularly scans the external environment and cross references this horizon scanning with the risks identified and managed as part of the Trust Risk Management Framework. In addition the Executive Management Team periodically reviews and refreshes a PESTLE analysis of external factors and a view of the Trust's strengths, opportunities, weaknesses and threats in response to those circumstances. To ensure the full Trust Board is able to contribute to this process of review and response, this paper summarises recent discussions related to these analyses. **2. SWOT/ PESTLE** The PESTLE analysis has been approached in the context of the Trust's Strategic Plan. The Plan stratifies services into four tiers, with each tier requiring distinct approaches and partnerships for sustainability. See below:  The PESTLE analysis is set out in full as an appendix to this report, and a summary is provided below; **2.1 Political** • Uncertainty of electoral outcome, and impact on health policy and key initiatives e.g. Vanguard, PMCF, BCF. • Gap between rhetoric regarding parity of esteem and actual investment and focus on acute sector of policy makers and politicians. • New organisational forms and extent of regional devolution – FYFV,

Dalton Review, Devo Manc etc.

2.2 Economic

- Impact of continued austerity post-election, especially local authorities in context of social care within local pathways
- Continued uncertainty regarding specialised commissioning, impacting on Forensic and CAMHS in particular
- Major prolonged CIP requirements of financially challenged NHS providers leading to sub-optimal approaches within local health economies

2.3 Socio-cultural

- Impact of demographic change on demand for services and also on workforce age profile
- Changing expectations of services. Public expect greater personalisation, higher standards of customer service and responsiveness, greater level of co-production. Policy makers and commissioners expect more self-care and emphasis on prevention
- All the above drive changed workforce requirements – new skills, new roles, new psychological contract at work

2.4 Technological

- Integration of services with individuals own personal technology. Including use of mobile technology Apps as part of self-directed support
- Increased use of communications technology for consultation – engagement of carers/ MDTs etc
- Interoperability including cross-organisational platforms for integrated working

2.5 Legal/ Regulatory

- Changing landscape of regulation and approaches from regulators – focus on quality, price and governance – especially integrated care
- Need to explore organisational form in response to 5YFV etc and changing expectations of services
- Mergers & Acquisitions regulation and guidance – Monitor, CMA, competition law – link to post-election political uncertainty

2.6 Environmental

- Change in travel patterns as part of new service models and technological change – e.g. more home based care but fewer trips back to base. More support staff using video conferencing
- Opportunities around renewable energy

3 Summary of SWOT Analysis

In the context of the above analysis of the external environment and the Trusts strategic plan, the following strengths, weaknesses, opportunities and threats are highlighted:

3.1 Strengths

- Compelling model for alternative capacity – Creative Minds, Recovery Colleges and Altogether Better is well aligned to 5YFV and self care/ asset based approaches
- Financial track record and cash position, relative to many others
- Integrated approach to quality improvement ensures quality drives

everything we do

3.2 Weaknesses

- Some elements of data quality undersell the true quality and contribution made by the Trust. This is required to maintain stakeholder confidence and therefore impacts on reputation and sustainability.
- Our marketing and customer relationship management approach is currently under-developed, but market conditions indicate this is increasingly required.
- Transition from current block funding arrangements to increasingly activity and outcome driven revenue models increases risk.

3.3 Opportunities

- The foundations of strong productive partnerships are in place and we have a track record of working collaboratively. This positions the Trust to operate effectively in the changing provider landscape.
- The use of operational leadership 'Trios' to maintain a balanced focus on clinical excellence, quality and use of resources, provides an opportunity for innovation and excellence.
- A full understanding and application of micro/ meso/ macro/ meta system approaches will support the transition of current transformation work into the delivery of practical benefits for service users, and a lasting culture of continuous improvement

3.4 Threats

- Marginalisation of the mental health agenda in political and policy arena; where focus primarily on the highly visible challenges to the viability of acute hospital model.
- Lack of agility to respond to changing priorities
- Impact of continued austerity on Local Authority funded services challenges flow through pathways, leading to additional unplanned pressures in Trust services.

4 Summary of Key Risks and Mitigation

The Trust's Risk Register contains 8 risks rated 15 or more out of 25. All are being actively managed by the Executive Management Team. Those risks and their mitigations are described below. There is a strong correlation with the factors identified in the PESTLE and SWOT.

Trust's financial viability affected as a result of national funding arrangements	• Contribute to national programmes developing payment methods to influence and gain early insight • Develop model scenarios, and maintain prudent planning approach. • Use of Service Line Reporting to understand potential impact at appropriate depth
Data quality and capture of clinical information on RiO	• Ongoing programme of RiO and SystmOne development, training and optimisation • Centrally resourced team working with BDUs to improve capability and performance in clinical data recording • Case load reviewers in BDUs - transitioning to business as usual approach through management supervision

	Mechanisms for contracting and pricing for mental health and community services	• Project plan in place with Memorandum of Understanding agreed with commissioners • Accountability arrangements in place for delivery of project • Regular review at EMT and Audit Committee • Key representation at national level of costing through CE and DoF through CPPP programme and Medical Director for specialist commissioning
	Transformation programme	• Regular review at EMT to ensure movement from design into implementation in all BDUs • Local implementation groups, plus continued central resourcing of support for transformation • Audit of programme implementation and of impact of CIPs
	Trust sustainability declaration made in five-year strategy plan	• Monitoring of changing external factors • Regular dialogue with external partners and regulators to contextualise Trust position • Dual focus in annual business plan on in-year operational delivery and actions required for longer range sustainability
	Reduction in local authority funding	• Maintenance of local dialogue to understand impact on Trust services • Marketing approach and exploration of partnerships and organisational forms to ensure continued access to LA commissioned contracts • Service line level business planning approach
	Bed occupancy	• Focus on all aspects of acute pathway, recognising connectivity • Specific focus on 'plan for every patient' and discharge planning from point of admission
	CAMHS Calderdale and Kirklees	• Additional investment to ensure quality. Co-ordinated support from all aspects of Trust Quality Academy. • Executive level leadership of dialogue with families, teams and commissioners
Recommendation:	**Trust Board is asked to consider the summary presented in this paper and contribute to further debate and refinement of the analysis of business and associated risks.**	
Private session:	Not applicable	

Trust Board 28 April 2015
Agenda item 7

Title:	**Assurance framework and organisational risk register Q4 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:	**Assurance framework 2014/15** The Board assurance framework provides Trust Board with a simple but comprehensive method for the effective and focused management of the principal risks to meeting the Trust's corporate 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 in place or that 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 outlines the internal control systems in place, which includes the Assurance Framework. The AGS forms an integral part of the annual report and accounts. The Assurance Framework supports the appropriate declarations made in the AGS, including any significant control issues in line with current guidance. 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, each lead Director has identified the principle high level risks to delivery of corporate objectives. For each of these, the Framework then sets out: - key controls and/or systems the Trust has in place to support the delivery of objectives; - assurance on controls where Trust Board will obtain assurance; - positive assurances received by Trust Board, its Committees or the Executive Management Team confirming that controls are in place to manage the identified risks and these are working effectively to enable objectives to be met; - gaps in control (if the assurance is found not to be effective or in place); - gaps in assurance (if the assurance does not specifically control the

	specified risks or no form of assurance has yet been received or identified), which are reflected on the risk register. The Chief Executive uses the Assurance Framework to support his quarterly review meetings with Directors to ensure Directors are delivering against agreed objectives and action plans are in place to address any areas of risk identified. For the Q4 report, an initial 'RAG' rating of the Assurance Framework has been undertaken to support the Chief Executive's discussions with Directors as part of their end-of-year appraisal. **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; - mechanisms for contracting and pricing for mental health and community services; - 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; - child and adolescent mental health services; and - Trust sustainability declaration The risk around industrial action has been removed as this is no longer a risk to the organisation. <u>Development for 2015/16</u> As discussed at the risk management training session in January 2015, the Director of Corporate Development is leading a review of the format of the assurance framework and risk register and how both are reported to Trust Board, based on best practice.
Recommendation:	**Trust Board is asked to:** ➢ **NOTE the assurances provided for Q3 of 2014/15;** ➢ **NOTE those areas where gaps in assurance have been identified, through the Trust wide risk register and are being addressed through specific action plans as appropriate led by the lead Director;** ➢ **NOTE the key risks for the organisation subject to any changes/additions arising from papers discussed at the Board meeting around performance, compliance and governance.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

ASSURANCE FRAMEWORK 2014/15 Q4

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
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, 695
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			ORR ref: 522, 463, 695
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			ORR ref: 522
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			
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			ORR ref: 275, 522
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 services 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 ➢ Transformation business cases present to EMT (acute and community mental health January 2015)
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 ➢ Bids and tenders report to EMT fortnightly ➢ Commercial strategy framework Trust Board January 2015 ➢ Transactional IT services Trust Board April 2014 ➢ Tier 4 CAMHS Trust Board April, June, July and September 2014, January and March 2015 ➢ 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 ➢ Telecommunications Trust Board January 2015
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 and December 2014, January and March 2015 ➢ 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 ➢ Fieldhead masterplan EMT December 2014 ➢ Future CNDH EMT January 2015
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 and November 2014 and February 2015 ➢ Five-year strategic plan briefing for Trust Board June 2014 ➢ Annual plan briefing for Trust Board March 2015
8.	Quarterly quality/integrated compliance reports to Trust Board providing	➢ Quarterly quality performance reports to Trust Board

Assurance (A..)	Assurance on controls (planned outputs)	Board reports received (including sub-committees and EMT)
	assurances on compliance with standards and identifying emerging issues and actions to be taken.	➢ Quarterly compliance reports to EMT to inform presentation to Trust Board ➢ Monthly scrutiny of 'hotspots' by EMT with mitigating action agreed
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
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 and November 2014, and February 2015 (and Trust Board July, September and December 2014, and January and March 2015) ➢ Children's services April and June 2014 ➢ Hard Truths and Francis Report April, September and November 2014 (and Trust Board June and September 2014) ➢ Impact of cost improvement programme April, June, September and November 2014, and February 2015 ➢ Review of implementation of changes to shift patterns in in-patient services April, June, September and November 2014, and February 2015 ➢ Quality Improvement Plan April 2014 ➢ Patient Safety Strategy September 2014 and February 2015 ➢ Tissue viability November 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 ➢ Report to Trust Board March 2015
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, such as gatekept admissions, early intervention in psychosis and child and adolescent mental health servcies) ➢ 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 December 2014) ➢ Scrutiny of financial position to inform mitigating action and detailed operational action through Operational Requirement Group
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

Assurance (A..)	Assurance on controls (planned outputs)	Board reports received (including sub-committees and EMT)
		➢ 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.	➢ Relevant guidance and publications taken to Clinical Governance and Clinical Safety Committee ➢ CQC Mental Health Act visit reports scrutinised at every meeting at Mental Health Act Committee (in relation to Trust implementation of Mental Health Act) and Clinical Governance and Clinical Safety Committee (in relation to clinical governance and safety, and quality of service issues)
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 ➢ Standing item on progress against internal audit plan ➢ Head of Internal Audit Opinion May 2014 ➢ External audit plan January 2015
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 ➢ CQC Mental Health Act visit reports scrutinised at every meeting at Mental Health Act Committee (in relation to Trust implementation of Mental Health Act) and Clinical Governance and Clinical Safety Committee (in relation to clinical governance and safety, and quality of service issues)
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 with assessment in 2015.
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 2015/16 approved by Trust Board March 2015 supported by detailed plan and budget briefing ➢ 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 ➢ Follow up review by Deloitte (December 2014) ➢ Monitor five-year strategic plan approved by Trust Board June 2014 ➢ Monitor annual plan approved by Trust Board March 2015 ➢ Review by Deloitte of financial plan 2015/16 received by Trust Board March 2015 ➢ Monitor quarterly returns ➢ Operational Requirement Group established by Chief Executive in April 2014

Assurance (A..)	Assurance on controls (planned outputs)	Board reports received (including sub-committees and EMT)
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), leadership development (moderate), patients' property (partial), statutory and mandatory training (significant), financial management and reporting (2014/15 audit) (significant), risk management and board assurance framework (significant) and payroll (significant)
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, deviations identified and remedial plans requested.	➢ OD group led by CE established to review OD plan.
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, May and November 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, May and November 2014, March 2015 (strategy meeting)
41.	Production of Corporate Governance Statement to support submission of Trust	➢ Monitor five-year strategic plan, including Trust Board self-certification, approved by

Assurance (A..)	Assurance on controls (planned outputs)	Board reports received (including sub-committees and EMT)
	plans, setting out evidence of compliance/assurance against the statements reviewed by Trust Board	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.	➢ Performance report monthly to EMT ➢ Compliance report produced quarterly ➢ Data Quality Steering Group in place chaired by Director of Nursing and reporting into EMT
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 ➢ Trust Board approval of Board-level short-life Forum, chaired by Non-Executive Director, to focus on equality, diversity and inclusion
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 (NB from November 2014 direct reporting to the Committee) ➢ Clinical Reference Group established with key issues brought into Clinical Governance and Clinical Safety Committee by Director of Nursing and Medical Director ➢ 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 of two-year operational plan.	➢ ORG notes (weekly)
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: 28 April 2015

	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			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			Data quality and capture of clinical information on RiO will be insufficient to meet future compliance and operational requirements to support service line reporting and the implementation of the mental health currency leading to reputational and financial risk in negotiation of contracts with commissioners.	➢ Data quality Strategy approved by Board Oct 2011. ➢ Annual report produced for Business and Risk Board to identify risks and actions required in order to comply with regulatory and contract requirements. ➢ Data quality framework is monitored by the Data Quality Steering group which is chaired by the Director of Nursing. ➢ Key issues in relation to data quality and clinical practice to support mental health currency implementation are included in the data quality action plan which is reviewed by the steering group. ➢ All BDUs have individual data quality action plan which is reviewed internally. ➢ Accountability for data quality is held jointly by Director of Nursing and Director of Finance. ➢ Responsibility for data quality is delivered by BDU directors, BDU nominated quality leads and clinical governance. ➢ Key metrics for Data quality are produced monthly in BDU and trust dashboards and reviewed by Performance EMT. ➢ Annual clinical audit programme is planned to reflect data quality priorities.	5 Catastrophic	4 Likely	20	Red/extreme /SUI risk (15-25)	➢ Progress against data quality action reviewed at Delivery EMT on ongoing basis. ➢ Communication via Team Brief and Extended EMT on key messages. ➢ Performance on Payment by Results metrics reviewed at EMT. Dedicated clinical resource in each BDU as part of PbR project team. ➢ RiO Optimisation – re-focused and linked to PBR roll out with engagement of clinical staff. ➢ Roll out plan reviewed by RiO development Board. ➢ Wider system development network established with clinicians and managers. First set of quick wins to be implemented Q3 2014 ➢ Data quality metrics included in monthly performance reports. ➢ EMT agreed additional resources in October 2014 to be managed by BDU to support clean-up of caseload to prepare for requirements of contracting in 2015/16 ➢ Link of clustering data to mental health transformation work in Mental Health Summit October 2014 to ensure mainstreamed into redesigned services. ➢ Develop implementation plan for RiO system upgrade to be achieved in 2015.	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 ➢ RiO system development Board. Monthly system development board for RiO system. Agreed work plan and prioritisation.	16	Red/extreme /SUI risk (15-25)	Yes		Trust Board April 2015
270			Corporate/ organisation level risk (corporate use only EMT)	Trust wide (Corporate support services)			The volatile commissioning climate and its impact on the nature of the system of classification and associated currency currently under review could increase the level of risk for mental health services if cost and pricing mechanisms are not fully understood at local, regional and national level.	➢ 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 CE and DoF through CPPP programme and by Medical Director for specialist services.	5 Catastrophic	4 Likely	20	Red/extreme /SUI risk (15-25)	➢ Re-launch of Project January 2013 with Director of 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 and 18.12.14. ➢ Mental health currency and service line reporting standing items on Audit Committee agenda. Has included presentation from BDU Directors on implementation within BDUs.	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	16	Red/extreme /SUI risk (15-25)	Yes		Trust Board April 2015

275			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 services - due to potential increase in demand for services and reduced capacity in integrated teams - which will create risk of a negative impact on the ability of integrated teams to meet performance targets.	➢ District integrated governance boards established to manage integrated working with good track record of cooperation. ➢ Maintenance of good operational links though BDU teams and leadership. ➢ Monthly review through Performance EMT of key indicators which would indicate if issues arose regarding delivery i.e. delayed transfers of care and service users in settled accommodation.	4 Major	4 Likely	16	Red/extreme /SUI risk (15-25)	➢ Continues to be monitored through BDU/commissioner forums. Some evidence in, for example, Kirklees where budgetary pressures have impacted 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/ high (8-12)	Yes		Trust Board April 2015
463			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/extreme /SUI risk (15-25)	➢ 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. Action agreed by EMT and business cases developed and approved January 2015. ➢ 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. ➢ Roll-out of mental health acute commissioning implementation starting January 2015.	£500,000	Work stream 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/extreme /SUI risk (15-25)	Yes		Trust Board April 2015
522			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) couples with emerging intensified local acute Trust pressures. Risk local re-tendering will increase the risk in the 2015/16 contracting round will increase 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/extreme /SUI risk (15-25)	➢ Trust proactive in involvement in system transformation programmes which are led by commissioners. ➢ Internal Trust 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/ high (8-12)	Yes		Trust Board April 2015
527			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/extreme /SUI risk (15-25)	➢ Actions in place to manage patient flow have had positive impact on numbers of bed days out of area and the level of cost incurred. ➢ Trajectory monitored at delivery EMT. ➢ 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/ high (8-12)	Yes		Trust Board April 2015
668			Corporate/ organisation level risk (corporate use only EMT)	Specialist Services	Child and Adolescent Mental Health Services (CAMHS)	Child and Adolescent Mental Health Services - Calderdale and Kirklees	Children potentially at serious risk due to lack of robust systems and processes to ensure safe clinical delivery. Reputation of the organisation if the concerns and issues are not addressed and the service governance aligned with the rest of the organisation.	Recovery plan to address the immediate concerns. Change Management plan to align delivery to the service specification. Trust wide CAMHs transformation programme to be developed.	4 Major	4 Likely	16	Red/extreme /SUI risk (15-25)	➢ Dedicated Team in place to deliver the recovery plan. This includes the appointment of interim support at Director-level. ➢ Monitoring of delivery of plans to be undertaken within specific time scales via EMT and BDU ➢ Recovery Plan developed as further concerns/issues have been raised. ➢ Ongoing scrutiny by Clinical Governance and Clinical Safety Committee and Trust Board.		Interim BDU Director	Timescale for completion 2015/16 and ongoing to ensure the actions in the recovery plan are implemented	EMT Clinical governance Board Meetings Specialist Services BDU meeting - monthly	12	Amber/ high (8-12)	Yes		Trust Board April 2015
695			Corporate/ organisation level risk (corporate use only EMT)	Trust wide			Ongoing requirement to reduce costs and meet commissioner QIPP will result in Trust becoming unsustainable clinically, operationally and financially by year 4 of the 5 year plan (2017-18)	Risk scenario modelled in 5 year plan submitted April 2014, which identified a tiered strategy to achieve sustainability which assumes consolidation of pathways and efficiencies in existing services; substitution of current service models for recovery based alternative service offers at lower cost; and strategic consolidation of key services to drive savings through	5	4	20	Red/extreme /SUI risk (15-25)	➢ Active stakeholder management to create opportunities for partnership and collaboration which are reflected in corporate objectives ➢ Development of preferred partners through Memorandum of understanding and joint tender bids ➢ Quarterly review of strategy by the Board every quarter ➢ Recruitment to key areas of expertise to enable 5		EMT	REVIEW OF PLAN submission to regulator march 2015	Monthly review EMT Transformation Board review Quarterly updates to Board	16	Red/extreme /SUI risk (15-25)			Trust Board April 2015

								critical mass.					year plan to be realised – Health intelligence, marketing and commercial skills Strategic planning and programme management.									

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Risk profile 28 April 2015

Consequence (impact/severity)	Likelihood (frequency)				
	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost certain (5)
Catastrophic (5)			= Trust's financial viability affected as a result of national funding arrangements (522)	= Data quality and capture of clinical information on RiO (267) = Mechanisms for contracting and pricing for mental health and community services (270) = Transformation programme (463) = Trust sustainability declaration made in five-year strategy plan (695)	
Major (4)				= Reduction in local authority funding (275) = Bed occupancy (527) = CAMHS Calderdale and Kirklees (668)	
Moderate (3)					
Minor (2)					
Negligible (1)					

= same risk assessment as last quarter
! new risk since last quarter
< decreased risk rating since last quarter
> increased risk rating since last quarter

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Quality Performance Report

Strategic Overview

March 2015

Table of Contents

Introduction

Dear Board Member/Reader

Welcome to the Trust's Integrated Performance Report: Strategic Overview for March 2015 information unless stated. The integrated performance strategic overview report is a key tool to provide assurance to the Board that the strategic objectives are being delivered and to direct the Board's attention to significant risks, issues and exceptions.

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

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

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

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

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

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 @ Q4 Month 12
				A	M	J	J	A	S	O	N	D	J	F	M	
Quality Priority 1: To continue to listen to our service users and carers and act on their feedback	% people (inpatient mental health - CKW) rating care as excellent or good	90%	Quarterly	91%			87%			85%			85%			
	% of people in CAMHs service rating care as excellent or good.	70%	Quarterly commencing Q3							73%			70%			
	% of people in Long Term Conditions who are extremely likely/likely to recommend the service to their Friends & Family	90%	Bi annually	97%						97%						
	Implementation of ? elements of Triangle of care across inpatient services	100%	Annual													
	Friends and Family Test: percentage of scores recommending our services as either likely or extremely likely:	80%	From Q3													
	ü Mental Health Services									94%			85%			
	ü Community services									98%			98%			
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%			78.70%			Awaiting Data			
	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%			83.90%			91.5%			
	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			99			Awaiting Data			
	CAMHs Barnsley: Patients seen within 5 weeks of initial referral	100%	Quarterly	14%			4%			Oct 10%/ Nov 26%			11.76%			
	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							7.80%			9.75%			
Quality priority 3: Continue to improve care, care planning & evaluation of care.	% people offered a copy of their care plan	85%	Monthly	82%	82%	82%	82%	82%	82%	82%	83%	83%				
	Mental Health currency development: Adherence to cluster reviews	90%	Monthly	73%	73%	73%	73%	72%	72%	71%	71%	71%	70%	69%	69%	
	Mental Health currency development: % of eligible cases assigned a cluster	100%	Monthly	95%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	95%	
	Increase the number of clinical audits that have actions implemented/ demonstrate outcomes	From Q3 5% increase Q$ further 5% increase	Quarterly				Benchmark 28%			40%						Awaiting Data
	Implementation of NICE clinical quality standard	Q1 Scope, Q2 Plan, Q3 Audit, Q4 implemen recommendations	Quarterly							Audit Completed						
	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 implemen recommendations	Quarterly													
	Mental health currency development: % mental health patients with a valid diagnosis code at discharge	99%	Monthly	91%	99%	82%	100%	100%	100%	100%	100%	100%	100%	95%		Awaiting Data
	% of people with ethnicity cases completed	99%	Monthly	-	-	-	94%	85%	95%	96%	95%	95%	95%	95%		Awaiting Data
	Implementation of actions in BDU data quality action plans	Evidence of activity against data quality action plan	Quarterly – Barnsley (CS)													Commination in progress with BDU's with regards to how they have been monitoring their DQ performance.
			Barnsley (MH)													
			Calderdale													
			Forensics													
			Kirklees													
			Wakefield													
Continue to improve transfers of care by working in partnership across the care pathway	Delayed transfers of Care (DTOC)	<=7.5	Monthly	3.3%	4.2%	4.5%	3.8%	3.7%	4.9%	4.2%	4.6%	4.9%	4.5%	3.2%	2.2%	
	Participation in and implementation of recommendations from of intermediate care pathways	Audit to remain on track	Quarterly													
	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	4.6	4.5	4.5	4.6	4.7	4.7	4.8	4.8	
	Development of a trust wide 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%			Awaiting feedback from national survey						
	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%			77.6%			Awaiting Data			
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							YTD 4			Awaiting Data			Awaiting Data
	Infection rates of MRSA bacteraemia	0	Quarterly	0			0			0	0	0	0	0	0	
	Infection rates of C Diff	<=8	Quarterly	0			2			0	0	0	0	0	0	
	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				59%			67%			66%			
	Reduction in the number of medication errors entered in the 'other' category. (5% reduction by end of Q4)						28%			29%			Awaiting Data			

Quality Headlines

CAMHS Summit

A Summit was held between Commissioners and Providers on 20th March 2015 to discuss the position in Calderdale & Kirklees CAMHS.

The Trust Board has received regular reports on progress for Calderdale & Kirklees CAMHS, most recently in January and March 2015.

The Trust has reiterated its commitment to improving data quality and sees this as a priority. It has confirmed to commissioners – and set this out in the Recovery Plan – that the data will improve incrementally, but that by the end of July 2015, these measures proposed will ensure that the data provided is much more robust.

Discussions have now been held with Commissioners regarding the establishment of jointly agreed quality surveillance mechanisms to ensure that concerns and risks are identified and examined jointly by Commissioners and the Trust. This is proposed to include both visits and more CAMHS-focussed compliance reporting.

The date for the next Summit has been set as 8th May 2015 and the Board will be updated following this meeting.

The Mental Health Crisis Care Concordat

In February 2014, 22 national bodies involved in health, policing, social care, housing, local government and the third sector came together and signed the Crisis Care Concordat

SWYPT is committed to working with partner agencies to make sure people always get the help they need when in crisis. Our partners in CCGs in Barnsley, Calderdale, Kirklees and Wakefield have responsibility to lead on the concordat and co-ordinate all agencies involved.

Since December 2014, the Trust and partner agencies have been signed up to the concordat and action plans are currently being developed in each area with input from SWYPT staff.

A number of crisis initiatives are already being led by SWYPT services including a pilot of street triage in Barnsley and a pilot education programme for police officers in Calderdale and Kirklees.

Department of Health Restrictive Physical Interventions Benchmarking

January 15 figures for the trust were much more in line with what was expected with use of restraint and seclusion significantly down from Aug 2014 return. MAV team leader did a retrospective review of the Aug figures and confirmed that it was an outlier month due to extreme clinical pressures across the system.

- January saw a large increase in numbers of formal patients and a decrease in informal patients
- Numbers of all restraints reduced from 169 to 112, with amount of prone staying pretty constant, dropping from 31 to 30.
- Use of seclusion which was a significant outlier in August, has dropped significantly 77 to 39 (which is around the average) – in addition 4 uses of ECA we identified.
- Pt on pt assaults dropped from 31 to 20, and pt on staff dropped from 88 to 55, again both significant reductions.
- Levels of self harm were exactly the same with again, 19 reported.

Always difficult to speculate with any great confidence about on mav figures due to their potential for spiking by a small number of people, but we can say that higher numbers of formal patients would suggest increased acuity within the system. Despite this, our use of RPI appears to have dropped across the board closer to the expected ranges we have experienced over the last few years. The amount of prone restraint used has remained constant.

Pilot education programme for police officers in Calderdale and Kirklees

Five training sessions provided to local police with approximately 30-40 police officers from North and South Kirklees at each. A service user was also involved. The sessions lasted approximately 3 hours and consisted of the following :-

. Acronyms were used for police to see how aware they are of services within mental health and their current understanding i.e. SPA, IHBT, CMHT, AMHP, MHLT.
. Clarification was given re each mental health service and advice given about when to use each one. Also explanations regarding limitations and resource implications.
. A short film was shown highlighting issues people with MH difficulties face.
. A scenario was used where a person was in their home threatening to end their life covering use of Breach of Peace/136/assessment at home/MHA Assessments. Discussions ensued regarding each way of dealing with the situation preferably least restrictive with an emphasis on closer liaison between Kirklees SPA and the police.
. General liaison between MH professionals and police.

Since the training, police officers are now spending full days with Kirklees SPA and with AMHP's which has proved very successful so far and forged closer links between SWYPT and the police. Local SPA noted an increase in calls from the police prior to and during attendance at incidents for advice and support to formulate a plan on how best to deal with a situation. Police liaison posts now in place, all of whom are existing practitioners

Serious incident framework and never events.

A new serious incident framework has been released at the end of March together with a updated never event guidance and list. The Trust is reviewing these document and discussing the implementation with Commissioners.
The definition of a never Event has been amended and the list of event has reduced. The new serious incident framework has removed grading of incidents and introduced a single timescale of 60 working days. Serious incidents have moved away from a definitive list of events/incidents that must be reported to a case by case review examine acts and omissions in care. The new framework is live from April 2015 but NHS England expect the change to take some time.

Street triage

This service is a pilot intervention funded by winter resilience money as part of the mental health concordat initiatives.
The service is managed by the Barnsley IHBTT and the aim of the service is to intervene earlier to conduct a mental health assessment and avoid section 136 referrals. The service started on 12th January 2015 and is due to end on 31st March 2015. It is a 7-days a week service operating from 1800 hours – 0200 hours each evening.
The service is delivered out of the IHBTT base in Barnsley and referrals seen in the police station. Staff are collected by police as needed. This is different to how it was originally envisaged with staff based at the police station. This didn't work as unable to get on with note writing and communicate effectively with colleagues. All assessments go on the clinical notes system and are entered as a referral.
Between 12th January and 2nd March 2015, 53 referrals were made to the street triage team.
. 34 of these related to self-harm of thoughts of self-harm
. 4 related to harm to others
. 14 of those people seen were not known to mental health services
. 5 had previous contact with the triage car.
. 6 were detained S136.
. 9 were taken to A&E for medical treatment, including 5 for assessment, although a total of 24 would have been taken to A&E without triage.
. 20 were left with family or friends.
. 13 were left at home on their own.
. None were informally admitted.
. 6 were arrested for an offence including 1 S136.
. During this time period, it is thought 13 x S136 detentions were avoided

It remains unclear what will happen after the 31st of March 2015.

Strategic Overview Dashboard

Business Strategic Performance Impact & Delivery

1	Section	KPI	Source	Target	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Q1	Q2	Q3	Q4	YTD	Year End Forecast Position
2	Monitor Compliance	Monitor Governance Risk Rating (FT)	M	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	*Green*	*Green*	Green	Green	Green	Green	*Green*	4
3		Monitor Finance Risk Rating (FT)	M	4	4	4	4	4	4	4	4	4	4	4	4		4	4	4		4	4
4	CQC	CQC Quality Regulations (compliance breach)	CQC	Green	2	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		Green	Green	Green	Green	*Green*	4
5	CQUIN	CQUIN Barnsley	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	*Amber/G*	Amber/G	Amber/G	*Amber/G*	*Amber/G*	Amber/G	3
6		CQUIN Calderdale	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	*Amber/G*	Amber/G	Amber/G	*Amber/G*	*Amber/G*	Amber/G	3
7		CQUIN Kirklees	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	*Amber/G*	Amber/G	Amber/G	*Amber/G*	*Amber/G*	Amber/G	3
8		CQUIN Wakefield	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	*Amber/G*	Amber/G	Amber/G	*Amber/G*	*Amber/G*	Amber/G	3
9		CQUIN Forensic	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	*Amber/G*	Amber/G	Amber/G	*Amber/G*	*Amber/G*	Amber/G	3
10	IAPT	IAPT Kirklees: % Who Moved to Recovery	C	52%	57.62%	51.67%	41.48%	54.10%	50.97%	49.21%	52.67%	52.14%	55.15%	61.24%	58.55%	54.17%	50.99%	51.34%	53.26%	58.10%	53.09%	4
11		IAPT Outcomes - Barnsley	C (FP)	90%	Not Avail	98.43%	97.42%	99.45%	97.39%	99.00%	99%	96.95%	*98.02%*	Not Avail	Not Avail		Not Avail	Not Avail	Not Avail	Not Avail	Not Avail	4
12		IAPT Outcomes - Calderdale	C (FP)	90%	97.00%	100%	96.00%	82.76%	91.67%	78.79%	90.91%	90.70%	100%	96.15%	88.89%		Not Avail	Not Avail	Not Avail		Not Avail	4
13		IAPT Outcomes - Kirklees	C (FP)	90%	100%	98.00%	95.81%	96.12%	98.65%	95.75%	99.32%	97.45%	97.24%	98.52%	98.84%		Not Avail	Not Avail	Not Avail		Not Avail	4
14	Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	C	8	0	0	0	1	1	0	0	0	0	0	0		0	2	0	0	2	4
15	C-Diff	C Diff avoidable cases	C	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0	4
16	PSA Outcomes	% SU on CPA in Employment		10%	7.60%	7.80%	6.60%	7.47%	7.36%	7.47%	7.36%	7.43%	7.47%	7.37%	7.54%	7.43%	6.60%	7.47%	7.47%	7.43%	7.26%	3
17		% SU on CPA in Settled Accommodation		60%	70.30%	72.20%	72.20%	71.28%	71.52%	70.66%	69.26%	69.11%	66.91%	65.37%	66.77%	66.08%	72.20%	70.66%	66.91%	66.08%	68.87%	4

Customer Focus

18	Section	KPI	Source	Target	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Q1	Q2	Q3	Q4	YTD	Year End Forecast Position
19	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)	11%7/64	14% 7/51	22% 10/45	15% 7/47	15% 2/44	15% 10/68	Not Avail	13% 23/180	15%24/160	8%29/15	Not Avail	4
20	MAV	Physical Violence - Against Patient by Patient	L	14-20	Within ER	Within ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Within ER	Above ER	Above ER	Not Avail	Not Avail	Not Avail		Not Avail	4
21		Physical Violence - Against Staff by Patient	L	50-64	Above ER	Above ER	Above ER	Within ER	Above ER	Within ER	Within ER	Above ER	Above ER	Within ER	Within ER	Above ER	Not Avail	Not Avail	Not Avail		Not Avail	4
22	FOI	% of Requests for Information Under the Act Processed in 20 Working Days	L	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100% (20)	100% (31)	100% (25)	100%	100%	100%	100%	100%	4
23	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%	73.00%	73.00%	75.00%	75.00%	75.00%	95.00%	83.00%	73.00%	75.00%	92.00%		4
24	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%	56.00%	56.00%	50.00%	50.00%	50.00%	50.00%	30.00%	56.00%	50.00%	50.00%		4
25		% of Quorate Council Meetings	L	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	4
26	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%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	4
27		% 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%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	40.00%	4
28	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%	80.00%	80.00%	50.00%	50.00%	50.00%		75.00%	80.00%	50.00%	50.00%		4
29		% of Service Users Requesting a Befriender Assessed Within 20 Working Days	L	80%	100%	100%	88.00%	88.00%	88.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%		88.00%	80.00%	80.00%	100.00%		4
30		% of Potential Volunteer Befriender Applications Processed in 20 Working Days	L	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%	100%	100%	100%	100%	4

Operational Effectiveness: Process Effectiveness

31	Section	KPI	Source	Target	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Q1	Q2	Q3	Q4	YTD	Year End Forecast Position
32	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%	98.16%	100%	99.36%	99.65%	100%	98.78%	99.10%	98.92%	99.33%	99.49%		4
33		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%	97.21%	99.46%	95.83%	97.35%	98.38%	98.75%	98.50%	97.31%	97.95%	98.25%		4
34		Delayed Transfers Of Care (DTOC) (Monitor)	M	7.50%	3.32%	4.18%	4.18%	3.82%	3.66%	4.97%	4.25%	4.68%	4.86%	4.49%	3.16%	2.20%	4.18%	4.97%	4.59%	3.20%	3.98%	4
35		% Admissions Gatekept by CRS Teams (Monitor)	M	95%	100%	100%	96.50%	100%	99.06%	95.06%	100%	100%	100%	98.53%	98.99%	100%	96.50%	95.06%	100%	100.00%	99.37%	4
36		% 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%	96.77%	96.90%	96.67%	98.10%	98.63%	96.57%	96.84%	95.36%	96.33%	97.82%	96.81%	4
37		% SU on CPA Having Formal Review Within 12 Months (Monitor)	M	95%	95.90%	94.00%	96.50%	94.02%	94.58%	98.06%	97.70%	91.98%	98.64%	96.70%	95.30%	98.59%	96.50%	98.06%	98.64%	98.59%	98.09%	4
38		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%	192.31%	189.4%	200.84%	141.03%	155.28%	177.82%	186.19%	179.49%	200.84%	177.82%	177.82%	4
39		Data completeness: comm services - Referral to treatment information	M	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	4
40		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%	94.00%	94.00%	100%	94.00%	94.00%	94.00%	94.00%	94.00%	4
41		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%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	4
42		Data completeness: Identifiers (mental health) (Monitor)	M	97%	99.40%	99.40%	99.40%	99.52%	99.56%	99.54%	99.68%	99.64%	99.58%	99.60%	99.65%	99.59%	99.40%	99.54%	99.58%	99.59%	99.53%	4
43		Data completeness: Outcomes for patients on CPA (Monitor)	M	50%	83.00%	84.70%	84.40%	84.77%	83.80%	83.20%	83.80%	81.64%	80.04%	72.45%	81.05%	80.27%	84.40%	83.20%	80.04%	80.27%	82.31%	4
44		Compliance with access to health care for people with a learning disability	M	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	4
45	Data Quality	% Inpatients (All Discharged Clients) with Valid Diagnosis Code	L	99%	90.80%	99.10%	81.70%	99.50%	100%	100%	100%	100%	100%	100%	99.53%	99.46%	81.71%	100%	100%	*99.46%*		4
46		% Valid NHS Number	C (FP)	99%	Not Avail	Not Avail	Not Avail	99.97%	99.93%	99.60%	99.91%	99.85%	99.65%	99.79%	99.86%	*99.88%*	Not Avail	99.60%	99.65%	*99.88%*		4
47		% Valid Ethnic Coding	C (FP)	90%	Not Avail	Not Avail	Not Avail	94.50%	94.84%	86.15%	95.58%	95.45%	95.32%	95.15%	95.07%	*95.11%*	Not Avail	86.15%	95.32%	95.11%		4
48	Mental Health PbR	% of eligible cases assigned a cluster	L	100%	95.30%	95.70%	95.90%	86.72%	95.99%	95.90%	96.06%	95.87%	95.81%	95.54%	95.66%	95.30%	95.90%	95.90%	95.81%	95.48%		3
49		% of eligible cases assigned a cluster within previous 12 months	L	100%	80.40%	80.20%	80.10%	73.72%	79.49%	79.10%	78.90%	78.50%	78.56%	77.20%	76.92%	75.80%	80.10%	79.10%	78.56%	76.64%		3

Strategic Overview Dashboard

Fit for the future Workplace

50	Section	KPI	Source	Target	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Q1	Q2	Q3	Q4	YTD	Year End Forecast Position
51	Sickness	Sickness Absence Rate (YTD)	L	4%	4.70%	4.70%	4.50%	4.60%	4.60%	4.50%	4.50%	4.6%	4.70%	4.70%	4.80%	4.80%	4.50%	4.50%	4.70%	4.80%	4.80%	1
52	Vacancy	Vacancy Rate	L	10%	2.50%	3.50%	4.60%	4.40%	4.50%	4.70%	3.70%	4.9%		5.40%	5.50%		4.60%	4.70%				4
53	Appraisal	Appraisal Rate Band 6 and above	L	95%	12.90%	29.00%	54.10%	58.90%	74.60%	88.50%	93.07%	95.00%	95.90%	96.20%	96.50%	96.45%	54.10%	88.50%	95.90%	96.45%	96.45%	4
54		Appraisal Rate Band 5 and below	L	95%	3.40%	8.20%	17.00%	23.80%	40.20%	78.30%	94.91%	94.20%	96.30%	96.90%	97.00%	97.07%	17.00%	78.30%	96.30%	97.07%	97.07%	4
55	Mandatory Training	Aggression Management	L	80%	56.00%	56.90%	56.60%	59.10%	61.20%	62.60%	64.37%	64.40%	67.30%	68.60%	70.90%	72.95%	56.60%	62.60%	67.30%	72.95%	72.95%	1
56		Equality, Diversity & Inclusion	L	80%	55.50%	58.60%	62.30%	64.80%	66.70%	70.20%	71.54%	73.60%	74.70%	77.00%	78.90%	81.43%	62.30%	70.20%	74.70%	81.43%	81.43%	4
57		Fire Safety	L	80%	74.39%	74.75%	76.74%	77.71%	80.50%	82.70%	84.04%	83.10%	84.30%	84.10%	85.00%	86.28%	76.74%	82.70%	84.30%	86.28%	86.28%	4
58		Infection, Prevention & Control & Hand Hygiene	L	80%	56.90%	59.40%	63.00%	64.80%	68.40%	71.30%	51.62%	75.30%	76.70%	58.00%	62.40%	80.90%	63.00%	71.30%	76.70%	80.90%	80.90%	4
59		Information Governance	M	95%	90.47%	89.31%	89.91%	89.68%	89.24%	89.80%	89.16%	87.10%	85.70%	77.10%	78.70%	96.04%	89.91%	89.80%	85.70%	96.04%	96.04%	4
60		Safeguarding Adults	L	80%	71.10%	72.30%	74.20%	75.50%	77.30%	78.60%	78.68%	79.00%	78.40%	83.80%	86.10%	82.19%	74.20%	78.60%	78.40%	82.19%	82.19%	4
61		Safeguarding Children	L	80%	64.50%	66.90%	69.70%	73.20%	75.00%	77.30%	78.42%	80.30%	81.50%	65.00%	67.40%	84.38%	69.70%	77.30%	81.50%	84.38%	84.38%	4
62		Food Safety	L	80%	40.80%	40.20%	41.80%	44.10%	45.30%	48.40%	51.62%	55.30%	57.70%	79.50%	81.00%	63.66%	41.80%	48.40%	57.70%	63.66%	63.66%	1
63		Moving & Handling	L	80%	23.80%	30.90%	36.10%	42.00%	47.50%	52.40%	56.44%	59.40%	62.00%	82.50%	83.40%	70.14%	36.10%	52.40%	62.00%	70.14%	70.14%	1

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 12 Performance	Annual Forecast	Trend from last month	Last 3 Months - Most recent			Assurance	
Trust Targets					11	10	9		
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 **REVISED** plan.			↓				4	-
5	Delivery of CIP			↑				4	-
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 Trust Financial Risk Rating is 4 against a plan level of 4. (A score of 4 is the highest possible).

2. The outturn position for 2014 / 2015 is a net surplus of £3.1m which is £0.5m ahead of plan.

3. At March 2015 the cash position is £32.62m which is £5.75m ahead of plan.

4. Capital spend to March 2015 is £6.13m which is £1.93m (24%) behind the revised Trust capital plan.

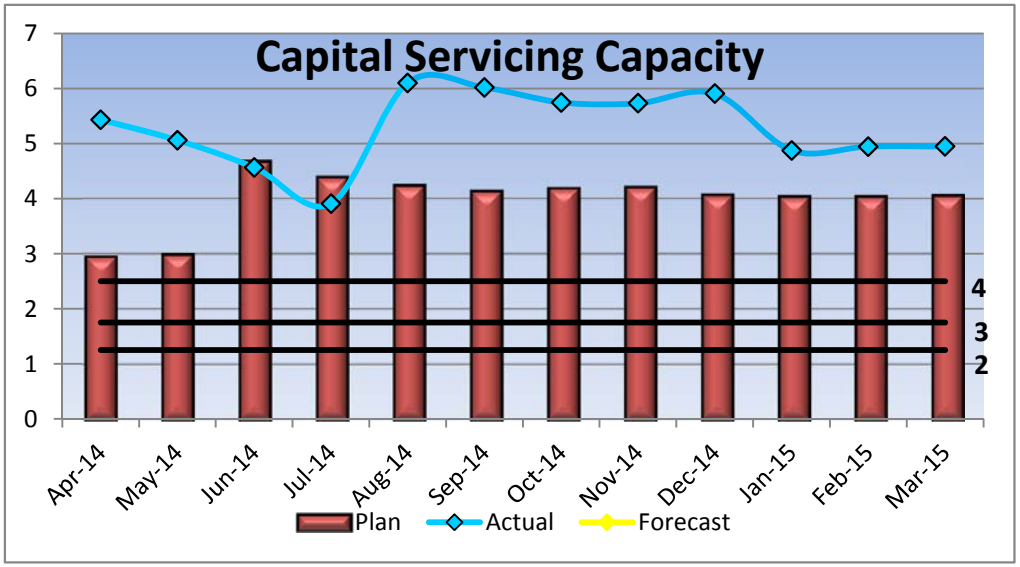
5. The Trust has delivered the 2014 / 2015 CIP programme in full. £2.8m (22%) was through substitution, of which £1.7m (14%) was non recurrent.

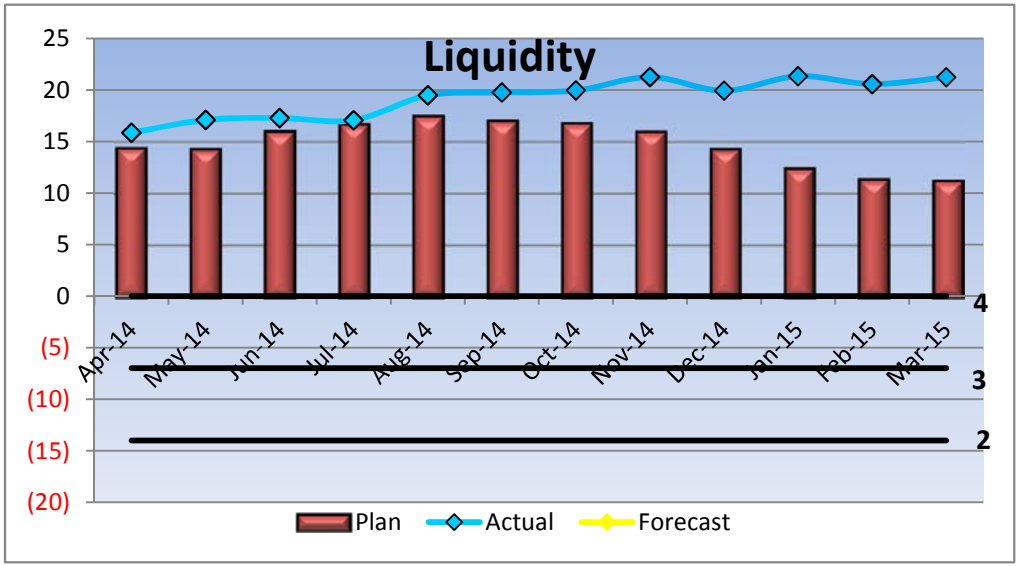
6. As at 31st March 2015 2015 (Month 12) 86% of NHS and 92% of non NHS invoices have achieved the 30 day payment target (95%).

Monitor Risk Rating

Continuity of Service Risk Rating 2014 / 2015				
	Actual Performance		Annual Plan March 2015	
Metric	Score	Rating	Score	Rating
Capital Servicing Capacity	4.9	4	4.1	4
Liquidity	21.2	4	11.3	4
Weighted Average		**4**		**4**

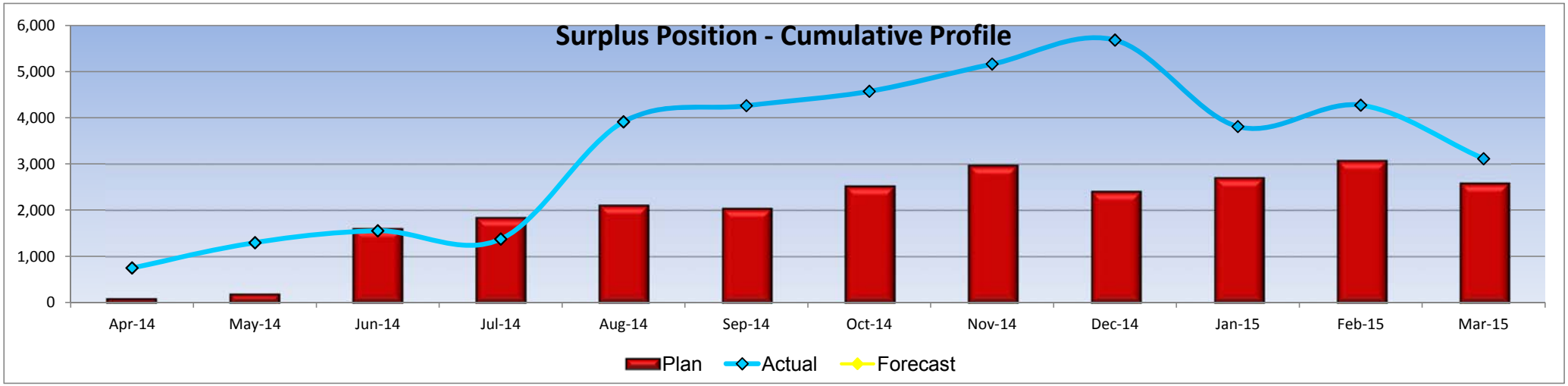
Overall the Trust maintains a Continuity of Service Risk Rating of 4 and maintains a material level of headroom before this position is at risk. This is shown in the graphs below.



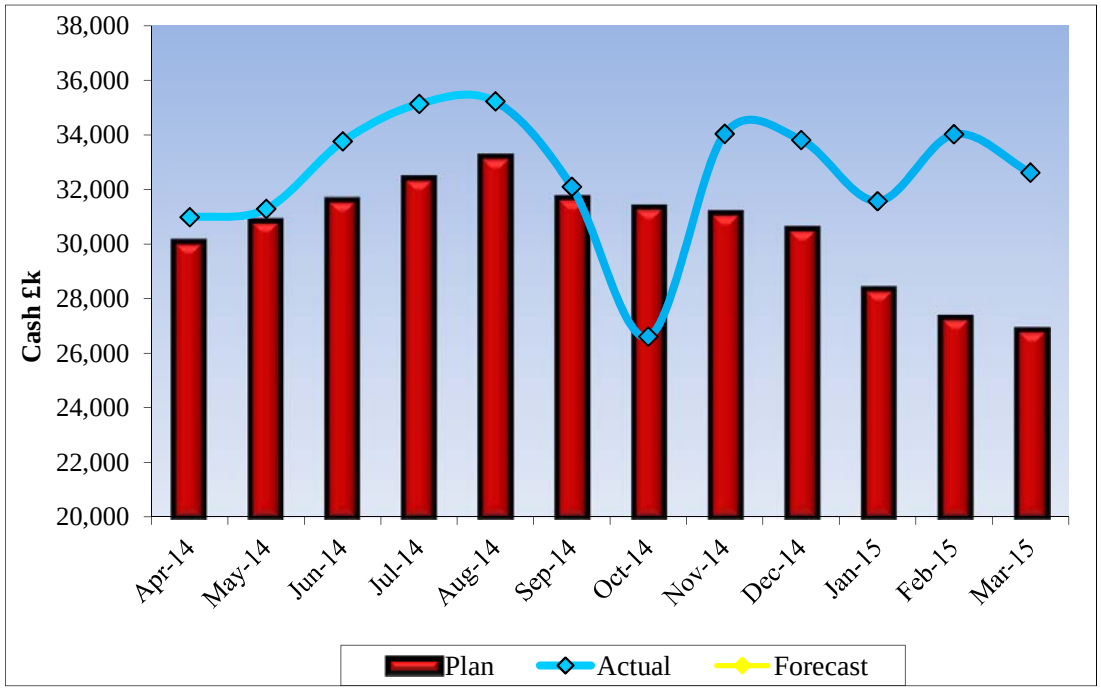


Income & Expenditure Position 2014 / 2015

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**
				(17,043)	(18,114)	(1,071)	Clinical Revenue	(217,710)	(217,632)	77	(217,710)	(217,632)	77
				(17,043)	**(18,114)**	**(1,071)**	**Total Clinical Revenue**	**(217,710)**	**(217,632)**	**77**	**(217,710)**	**(217,632)**	**77**
				(2,006)	(2,475)	(469)	Other Operating Revenue	(16,966)	(17,901)	(935)	(16,966)	(17,901)	(935)
				(19,050)	**(20,589)**	**(1,539)**	**Total Revenue**	**(234,676)**	**(235,534)**	**(858)**	**(234,676)**	**(235,534)**	**(858)**
4,577	4,380	(197)	4.3%	14,369	14,443	74	BDU Expenditure - Pay	175,771	171,437	(4,334)	175,771	171,437	(4,334)
				3,720	6,286	2,566	BDU Expenditure - Non Pay	46,764	50,919	4,154	46,764	50,919	4,155
				209	315	106	Provisions	1,903	2,493	590	1,903	2,493	590
4,577	**4,380**	**(197)**	**4.3%**	**18,297**	**21,044**	**2,746**	**Total Operating Expenses**	**224,439**	**224,849**	**410**	**224,439**	**224,849**	**410**
4,577	**4,380**	**(197)**	**4.3%**	**(752)**	**455**	**1,207**	**EBITDA**	**(10,237)**	**(10,685)**	**(448)**	**(10,237)**	**(10,685)**	**(448)**
				433	457	25	Depreciation	5,191	5,180	(11)	5,191	5,180	(11)
				264	273	9	PDC Paid	3,164	2,793	(371)	3,164	2,793	(371)
				0	(8)	(8)	Interest Received	0	(95)	(95)	0	(95)	(95)
				600	(16)	(616)	Revaluation of Assets	(700)	(305)	395	(700)	(305)	395
4,577	**4,380**	**(197)**	**4.3%**	**544**	**1,160**	**616**	**Surplus**	**(2,582)**	**(3,112)**	**(529)**	**(2,582)**	**(3,112)**	**(529)**



Cash Position Statement and Cash Flow Forecast 2014 / 2015



	Plan	Actual
	£k	£k
Opening Balance	33,114	33,114
Closing Balance	26,870	32,617

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

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

Overall the cash position for March 2015 is £32.62 m which is £5.75 m ahead of plan.

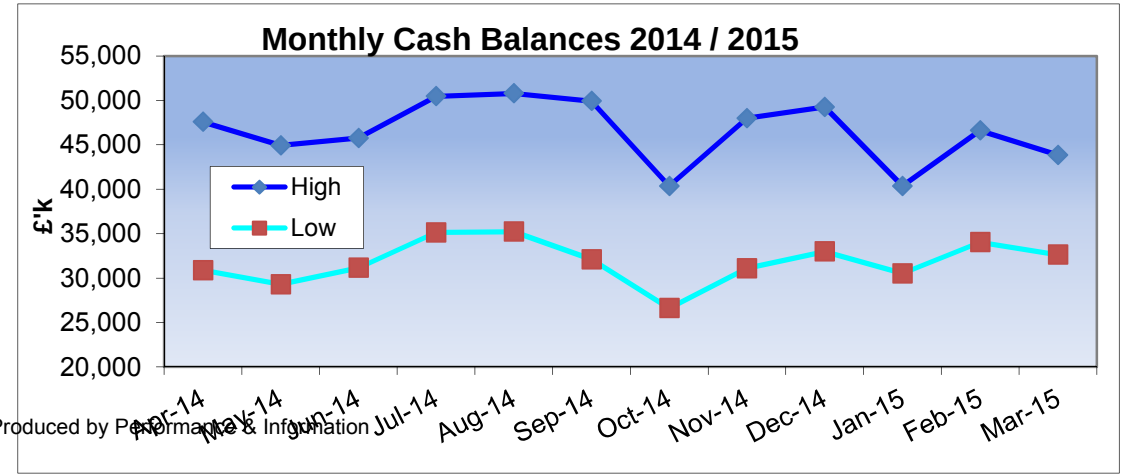
The Trust continue to complete a detailed reconciliation of cash and working capital balances. This highlights the main movements as:

Factors increasing the cash position

* Capital expenditure behind plan
* Accruals for outstanding invoices

Factors reducing the cash position

* Debtors are higher than planned. These continue to be chased.



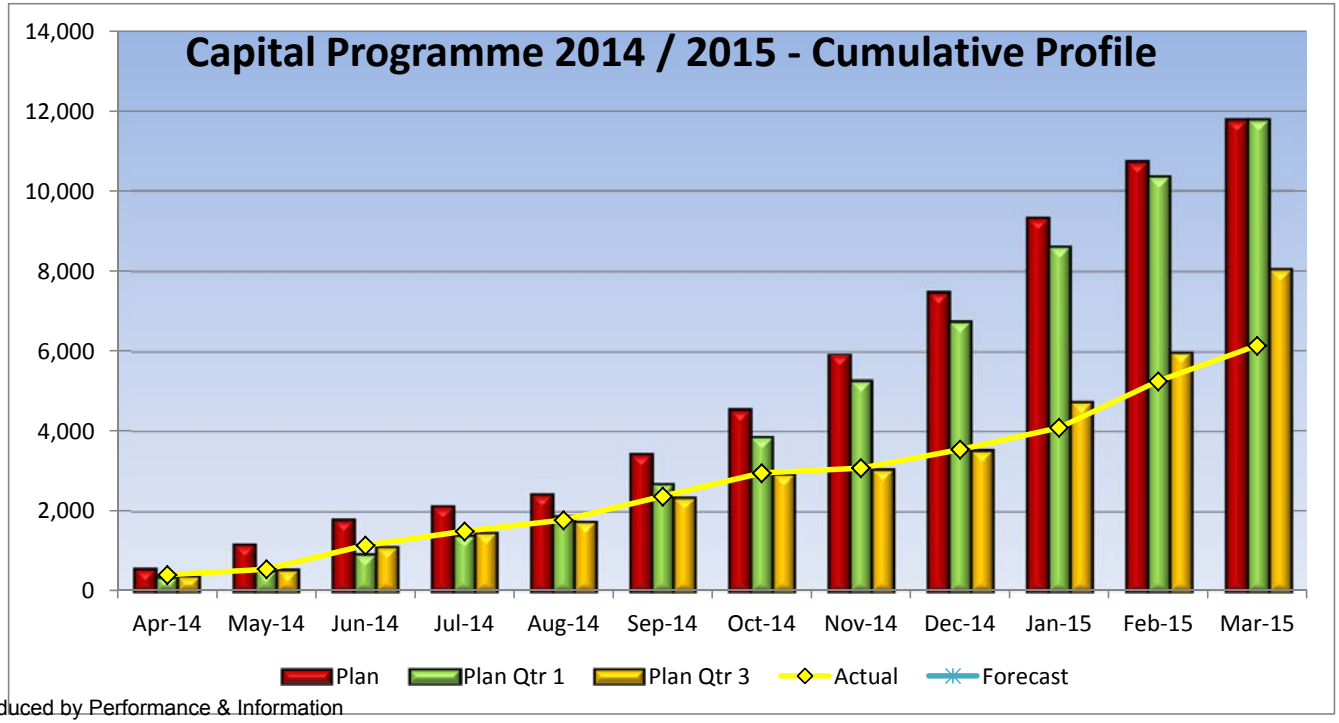
The graph to the left demonstrates the highest and lowest cash balances with each month. Maintaining an appropriate lowest balance is important to ensure that cash is available as required.

The highest balance is : £43.85m.
The lowest balance is : £32.62m.

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

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	2,805	2,805	2,792	(13)	2,792	(13)	*3, 4*
Total Minor Capital	**2,805**	**2,805**	**2,792**	**(13)**	**2,792**	**(13)**	
Major Capital Schemes							
Hub Development / Forensics	4,002	4,002	2,346	(1,656)	2,346	(1,656)	*6*
Fieldhead Hospital Development	808	808	780	(28)	780	(28)	*5*
IM&T	450	450	203	(247)	203	(247)	
Total Major Schemes	**5,260**	**5,260**	**3,329**	**(1,931)**	**3,329**	**(1,931)**	
VAT Refunds			9	9	9	9	
TOTALS	**8,065**	**8,065**	**6,131**	**(1,935)**	**6,131**	**(1,935)**	*1, 2*



Capital Expenditure 2014 / 2015

1. The original Capital Programme for 2014 / 2015 is £11.78m. As part of reporting to Monitor the plan for 2014 / 2015 has been revised to £8.07m.

2. Final expenditure for 2014 / 2015 is £6.13m which is a £1.94m under the revised plan (24%).

Notable projects in year include:

3. Minor Works improvement schemes were delivered in full and there were significant additions to the scheme list which were captured within the year which supported the Trusts ongoing Transformation and Improvement Programme.

4. The annual backlog programme was delivered in full

5. Fieldhead Infrastructure scheme completed during 2014 / 2015 resulting in the complete renewal of the water ring mains and the renewal of all the mains electrical cables which had all reached the end of their life. This scheme was designed to build in resilience for future projects.

6. Calderdale and Barnsley Hubs commenced in year with a completion date in 2015 / 2016. These schemes are both in line with the revised Estates Strategy and the Calderdale Hub in particular will generate savings whilst delivering a significantly higher standard accommodation in Halifax.

Better Payment Practice Code

NHS		
	Number	Value
	%	%
Year to February 2015	87.3%	88.9%
Year to March 2015	86.3%	88.4%

Non NHS		
	Number	Value
	%	%
Year to February 2015	92.2%	86.8%
Year to March 2015	92.4%	87.6%

Local Suppliers - 10 days		
	Number	Value
	%	%
Year to February 2015	82.8%	71.1%
Year to March 2015	82.7%	68.9%

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

The performance against target for NHS invoices is 86% of the total number of invoices that have been paid within 30 days and 88% by the value of invoices.

The performance against target for Non NHS invoices is 92% of the total number of invoices that have been paid within 30 days and 88% 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 83% of Local Supplier invoices by volume and 69% by the value of invoices within 10 days.

Mental Health Currency Development

The Trust has been a key member of the Care Packages and Pathway Project (CPPP) - a consortium of organisations in the Yorkshire & Humber and North East SHA areas who have been working together to develop National Currencies and Local Tariffs for Mental Health.

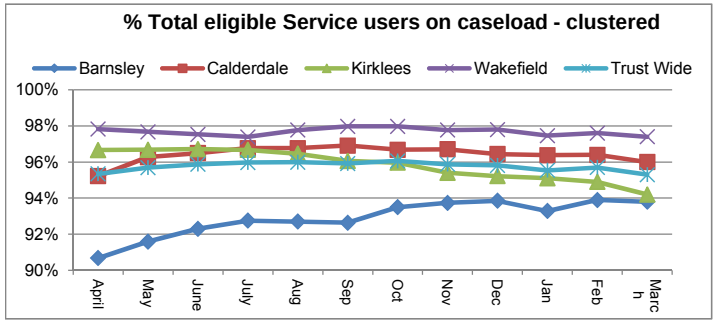
The currency for most mental health services for working age adults and older people has been defined as the 'clusters'. That means that service users have to be assessed and allocated to a cluster by their mental health provider, and that this assessment must be regularly reviewed in line with the timing and protocols. Clusters will form the basis of the contracting arrangements between commissioners and providers and this is due to take effect from April 2016. This will mean that for working age adults and older people that fall within the scope of the mental health currencies the activity value will be agreed based on the clusters, and a price will be agreed for each cluster review period. The cluster review period is the time between reassessments and their is some protocol behind this.

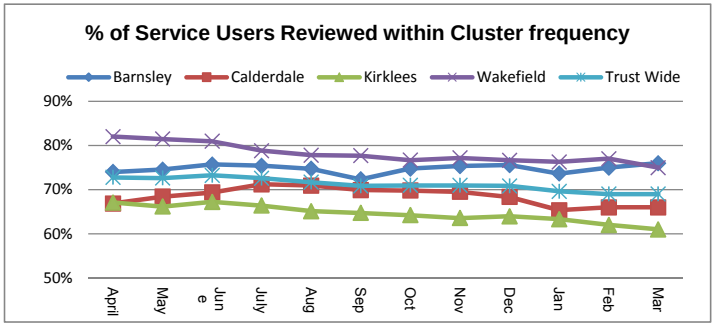
The scope of PbR is now being extended into other areas of Mental Health such as Learning Disabilities, Forensic, IAPT and Children and Adolescent Mental Health Services.

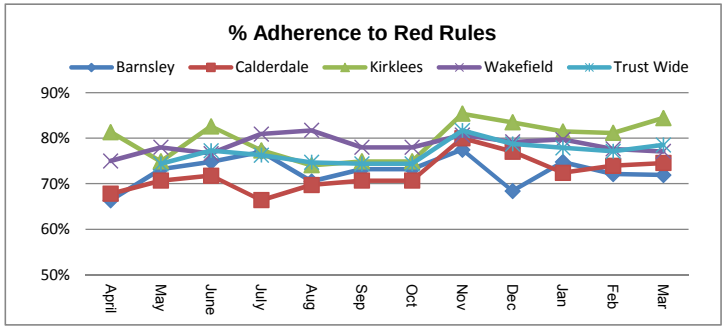
The Trust have been successful in agreeing a CQUIN related to MH Clustering in the two main commissioning contracts and this will assist greatly in the data quality preparatory work that needs to be undertaken in advance of April 2016. Some resource has been identified for a 6 month period. This work will commence in April 2015 and will report into the Transformation Board, the initial focus will be on Clients that have never been clustered, clients that are overdue a cluster and the review of specific cases to identify whether they have been allocated appropriately.

The CQUINs have 3 common elements:
Clustering of Initial Referral Assessments - 98% to be clustered within 8 weeks of 'eligible' initial referral assessments
Review of Service Users and Clusters - agreed % to be reviewed by March 2016.
Adherence to Red Rules (assurance that the cluster is accurate, complete and of high quality)

MH Currency Indicators - March 2015







IAPT & Forensic Secure Services and Clustering

The final Reference Cost Guidance for 2014/15 removed the requirement included in the draft guidance for IAPT and Forensics to reported by cluster. However, all IAPT clients entering treatment from 1st April 2015 must be clustered. The new Forensic Mental Health Clustering tool (MHCT) has been added to RiO with effect from 16th March to enable more robust reporting to be made for inclusion into the Forensic PbR Pilot submission. The datasets will have the facility to flow the data will flow from April 15.

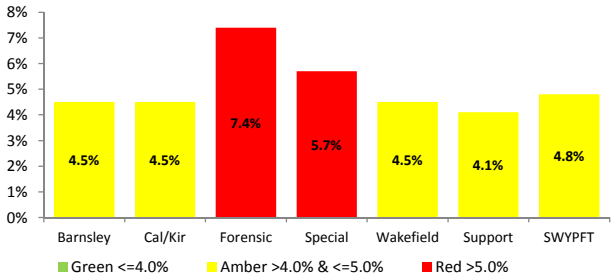
Learning Disabilities

The implementation of Clustering for Learning Disabilities service users, in relation to the CP&PP LD pilot, has been slower than anticipated, focus will be placed within the service to ensure this data begins to flow.

Workforce

Human Resources Performance Dashboard - March 2015

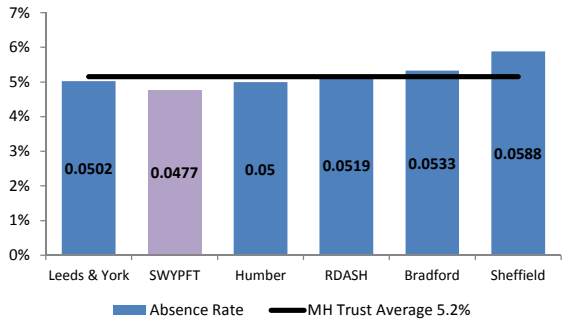
Sickness Absence



Current Absence Position - February 2014

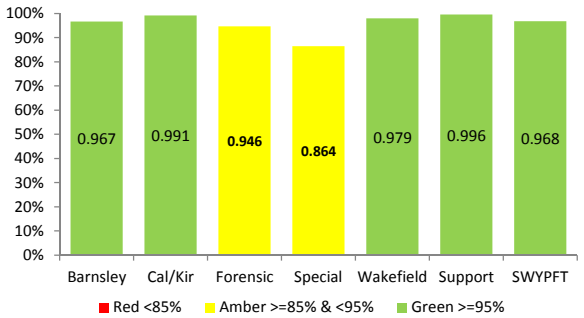
	Barn	Cal/Kir	Fore	Spec	Wake	Supp	SWYPFT
Rate	5.3%	5.0%	7.8%	6.2%	4.7%	3.7%	5.2%
Trend	↓	↓	↑	↑	↓	↓	↓

The Trust YTD absence levels in February 2015 (chart above) were above the 4% target at 4.8%



The above chart shows absence levels in MH/LD Trusts in our region to the end of Q3 2014/15. During this time the Trust's absence rate was 4.8% which is below the regional average of 5.2%.

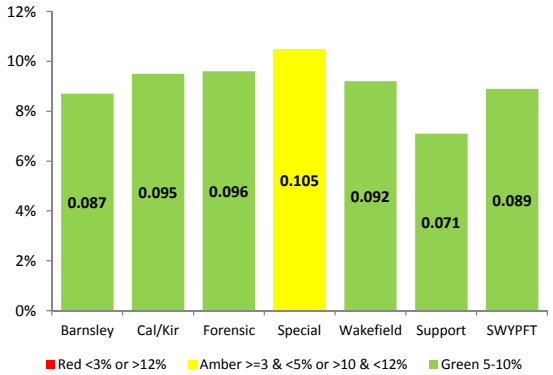
Appraisals



The above chart shows appraisals rates for all staff.

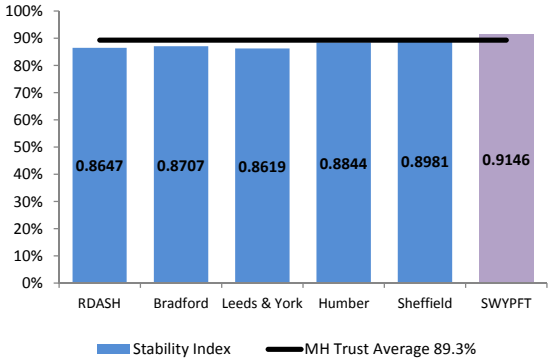
The Trust continues to stay above the 95% target as do 4 of the BDUs. Specialist Services and Forensic Services have maintained their position compared with last month. Figures will continue to be monitored closely.

Turnover and Stability Rate Benchmark



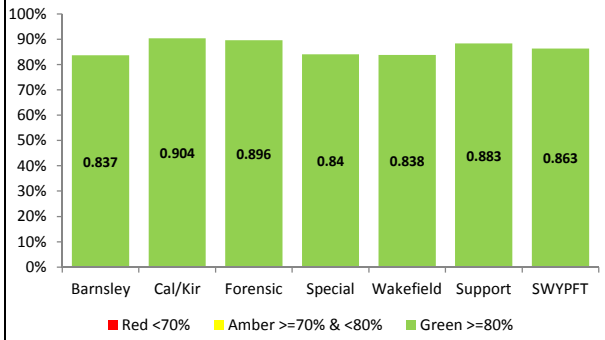
This chart shows Turnover levels up to the end of March 2015.

With the exception of Specialist Services, all BDUs and the Trust are well within the target range of 5%-10%.



This chart shows stability levels in MH Trusts in the region for the 12 months ending in Jan 2015. 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 continues to achieve its 80% target for fire lecture training. Specialist Services have also achieved the Trust target and now stand at 84%.

Workforce - Performance Wall

Trust Performance Wall

Month		Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Sickness (YTD)	<=4%	4.50%	4.50%	4.60%	4.70%	4.80%	4.80%
Sickness (Monthly)	<=4%	4.60%	4.80%	5.10%	5.30%	5.40%	5.00%
Appraisals (Band 6 and above)	>=95%	93.10%	95.00%	95.90%	96.20%	96.50%	96.50%
Appraisals (Band 5 and below)	>=95%	90.80%	94.20%	96.30%	96.90%	97.00%	97.10%
Aggression Management	>=80%	64.40%	64.40%	67.30%	68.60%	70.90%	72.90%
Equality and Diversity	>=80%	71.50%	73.60%	74.70%	77.00%	78.90%	81.40%
Fire Safety	>=80%	84.00%	83.10%	84.30%	84.10%	85.00%	86.30%
Food Safety	>=80%	51.60%	55.30%	57.70%	58.00%	62.40%	63.70%
Infection Control and Hand Hygiene	>=80%	73.90%	75.30%	76.70%	77.10%	78.70%	80.90%
Information Governance	>=95%	89.20%	87.10%	85.70%	83.80%	86.10%	96.00%
Moving and Handling	>=80%	56.40%	59.40%	62.00%	65.00%	67.40%	70.10%
Safeguarding Adults	>=80%	78.70%	79.00%	78.40%	79.50%	81.00%	82.20%
Safeguarding Children	>=80%	78.40%	80.30%	81.50%	82.50%	83.40%	84.40%
Bank Cost		£399k	£350k	£320k	£334k	£363k	£502k
Agency Cost		£366k	£388k	£358k	£269k	£383k	£517k
Overtime Cost		£8k	£12k	£11k	£12k	£14k	£11k
Additional Hours Cost		£72k	£77k	£76k	£70k	£89k	£93k
Sickness Cost (Monthly)		£477k	£525k	£539k	£585k	£581k	£481k
Vacancies (Non-Medical) (WTE)		343.36	368.7	371.42	381.86	408.27	404.26
Business Miles		305k	371k	308k	306k	314k	310k

Barnsley District

Month		Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Sickness (YTD)	<=4%	4.10%	4.20%	4.20%	4.30%	4.40%	4.40%
Sickness (Monthly)	<=4%	4.10%	4.40%	4.70%	5.10%	4.90%	5.00%
Appraisals (Band 6 and above)	>=95%	92.90%	96.30%	97.10%	96.90%	96.90%	96.70%
Appraisals (Band 5 and below)	>=95%	87.90%	92.80%	95.60%	96.50%	96.50%	96.80%
Aggression Management	>=80%	69.60%	70.30%	76.70%	74.20%	82.70%	83.70%
Equality and Diversity	>=80%	78.10%	79.20%	79.90%	81.40%	82.60%	83.80%
Fire Safety	>=80%	84.30%	82.50%	84.20%	82.80%	83.60%	83.70%
Food Safety	>=80%	58.40%	65.00%	66.20%	65.80%	69.90%	70.40%
Infection Control and Hand Hygiene	>=80%	77.50%	78.80%	81.30%	80.10%	81.30%	83.20%
Information Governance	>=95%	89.60%	89.70%	89.20%	84.10%	84.80%	93.20%
Moving and Handling	>=80%	61.70%	63.40%	65.80%	69.40%	70.80%	72.10%
Safeguarding Adults	>=80%	83.40%	83.10%	84.20%	83.80%	84.00%	85.40%
Safeguarding Children	>=80%	78.50%	80.10%	82.10%	82.70%	84.10%	84.50%
Bank Cost		£36k	£51k	£34k	£44k	£54k	£64k
Agency Cost		£95k	£151k	£134k	£12k	£109k	£181k
Overtime Cost		£3k	£6k	£4k	£3k	£5k	£6k
Additional Hours Cost		£35k	£34k	£37k	£33k	£46k	£48k
Sickness Cost (Monthly)		£155k	£170k	£180k	£197k	£181k	£158k
Vacancies (Non-Medical) (WTE)		105.6	106.2	118.0	119.5	119.5	122.4
Business Miles		130k	172k	131k	134k	138k	129k

Calderdale and Kirklees District

Month		Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Sickness (Monthly)	<=4%	4.80%	4.50%	4.20%	4.40%	4.90%	4.80%
Appraisals (Band 6 and above)	>=95%	98.80%	99.10%	99.70%	100%	100%	100%
Appraisals (Band 5 and below)	>=95%	96.20%	97.90%	98.90%	98.90%	98.70%	98.40%
Aggression Management	>=80%	64.00%	64.60%	67.00%	66.90%	67.80%	71.10%
Equality and Diversity	>=80%	71.70%	74.60%	75.90%	77.30%	80.40%	82.50%
Fire Safety	>=80%	85.80%	86.00%	86.50%	87.90%	88.00%	90.40%
Food Safety	>=80%	34.00%	38.30%	42.20%	42.40%	52.80%	54.50%
Infection Control and Hand Hygiene	>=80%	70.40%	73.20%	74.40%	76.80%	78.40%	80.60%
Information Governance	>=95%	93.40%	91.10%	86.60%	90.00%	92.30%	98.70%
Moving and Handling	>=80%	54.40%	60.30%	62.80%	65.20%	66.00%	67.40%
Safeguarding Adults	>=80%	79.70%	79.70%	75.10%	78.30%	80.20%	81.00%
Safeguarding Children	>=80%	73.30%	77.50%	79.00%	80.90%	81.70%	82.00%
Bank Cost		£108k	£75k	£73k	£89k	£105k	£120k
Agency Cost		£73k	£51k	£68k	£59k	£40k	£83k
Overtime Cost		£2k	£4k	£4k	£7k	£6k	£3k
Additional Hours Cost		£5k	£6k	£3k	£6k	£4k	£3k
Sickness Cost (Monthly)		£111k	£104k	£94k	£105k	£105k	£99k
Vacancies (Non-Medical) (WTE)		56.24	58.31	60.12	61	89.55	89.24
Business Miles		68k	70k	70k	59k	61k	63k

Forensic Services

Month		Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Sickness (YTD)	<=4%	6.80%	7.00%	7.10%	7.20%	7.30%	7.40%
Sickness (Monthly)	<=4%	6.20%	8.10%	8.00%	7.90%	8.40%	7.50%
Appraisals (Band 6 and above)	>=95%	92.30%	94.10%	96.20%	98.20%	98.10%	98.10%
Appraisals (Band 5 and below)	>=95%	83.00%	89.30%	92.70%	93.40%	94.10%	93.90%
Aggression Management	>=80%	70.80%	71.00%	71.90%	72.60%	74.70%	76.40%
Equality and Diversity	>=80%	71.10%	74.20%	74.70%	78.60%	84.00%	85.80%
Fire Safety	>=80%	88.00%	86.20%	86.70%	86.00%	88.50%	89.60%
Food Safety	>=80%	43.90%	47.60%	50.70%	50.30%	50.00%	51.00%
Infection Control and Hand Hygiene	>=80%	72.10%	73.00%	73.80%	77.10%	80.40%	83.20%
Information Governance	>=95%	87.70%	87.70%	88.50%	84.50%	95.70%	98.40%
Moving and Handling	>=80%	61.40%	63.20%	64.80%	68.40%	74.30%	76.60%
Safeguarding Adults	>=80%	70.30%	73.10%	73.10%	76.60%	83.90%	85.60%
Safeguarding Children	>=80%	75.40%	75.60%	76.50%	77.90%	79.40%	81.50%
Bank Cost		£104k	£101k	£95k	£92k	£83k	£137k
Agency Cost		£6k	£55k	£33k	£61k	£96k	£56k
Additional Hours Cost		£0k	£2k	£1k	£0k	£0k	£3k
Sickness Cost (Monthly)		£53k	£71k	£68k	£71k	£76k	£63k
Vacancies (Non-Medical) (WTE)		47.01	43.93	45.31	46.46	41.9	39.5
Business Miles		4k	5k	4k	4k	4k	7k

Workforce - Performance Wall cont…

Specialist Services

Month		Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Sickness (YTD)	<=4%	5.30%	5.40%	5.50%	5.50%	5.70%	5.70%
Sickness (Monthly)	<=4%	5.80%	5.70%	6.40%	5.80%	6.90%	6.00%
Appraisals (Band 6 and above)	>=95%	75.00%	78.90%	80.10%	82.20%	84.90%	84.70%
Appraisals (Band 5 and below)	>=95%	68.20%	77.30%	83.80%	86.80%	89.00%	88.80%
Aggression Management	>=80%	58.30%	56.10%	58.60%	66.30%	71.60%	74.30%
Equality and Diversity	>=80%	68.40%	68.90%	68.70%	73.40%	75.30%	82.50%
Fire Safety	>=80%	74.30%	75.70%	74.20%	76.10%	78.40%	84.00%
Food Safety	>=80%	76.60%	75.80%	79.00%	78.70%	79.30%	83.90%
Infection Control and Hand Hygiene	>=80%	65.70%	68.70%	68.60%	68.50%	72.70%	77.60%
Information Governance	>=95%	85.20%	83.30%	82.80%	79.40%	75.40%	94.80%
Moving and Handling	>=80%	49.10%	51.60%	55.50%	57.30%	60.90%	66.30%
Safeguarding Adults	>=80%	65.80%	66.70%	66.40%	70.00%	72.10%	75.10%
Safeguarding Children	>=80%	72.60%	75.20%	74.70%	76.30%	78.80%	83.40%
Bank Cost		£36k	£29k	£26k	£29k	£25k	£34k
Agency Cost		£120k	£113k	£96k	£114k	£69k	£152k
Overtime Cost		£3k	£1k	£2k	£1k	£2k	£2k
Additional Hours Cost		£4k	£4k	£6k	£5k	£7k	£6k
Sickness Cost (Monthly)		£49k	£66k	£70k	£69k	£84k	£62k
Vacancies (Non-Medical) (WTE)		36.83	41.96	35.92	37.5	36.48	33.44
Business Miles		30k	34k	32k	30k	31k	31k

Support Services

Month		Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Sickness (YTD)	<=4%	3.60%	3.70%	3.90%	4.10%	4.20%	4.20%
Sickness (Monthly)	<=4%	3.80%	4.30%	5.10%	5.40%	5.00%	3.60%
Appraisals (Band 6 and above)	>=95%	98.00%	98.00%	99.00%	100.00%	99.50%	99.50%
Appraisals (Band 5 and below)	>=95%	99.30%	98.90%	99.20%	99.40%	99.60%	99.60%
Aggression Management	>=80%	55.10%	47.70%	49.50%	51.90%	49.60%	49.20%
Equality and Diversity	>=80%	57.60%	61.00%	62.50%	65.00%	65.90%	68.60%
Fire Safety	>=80%	85.60%	83.40%	85.40%	85.10%	84.90%	88.30%
Food Safety	>=80%	95.60%	95.50%	95.40%	94.50%	96.20%	97.10%
Infection Control and Hand Hygiene	>=80%	74.10%	74.70%	74.80%	75.50%	74.90%	76.00%
Information Governance	>=95%	84.00%	78.50%	77.70%	77.70%	82.20%	97.10%
Moving and Handling	>=80%	51.30%	53.60%	57.40%	60.90%	65.00%	70.80%
Safeguarding Adults	>=80%	74.90%	75.00%	77.80%	77.90%	78.60%	81.70%
Safeguarding Children	>=80%	86.70%	87.10%	87.20%	87.70%	87.00%	88.20%
Bank Cost		£39k	£36k	£33k	£16k	£31k	£47k
Agency Cost		£29k	£-17k	£11k	£3k	£23k	£23k
Overtime Cost		£0k	£0k	£0k	£1k	£1k	£0k
Additional Hours Cost		£20k	£18k	£17k	£14k	£19k	£20k
Sickness Cost (Monthly)		£55k	£63k	£73k	£88k	£80k	£47k
Vacancies (Non-Medical) (WTE)		47.66	42.79	38.94	45.78	47.33	49.43
Business Miles		41k	45k	41k	37k	42k	45k

Wakefield District

Month		Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Sickness (YTD)	<=4%	4.30%	4.30%	4.40%	4.40%	4.50%	4.50%
Sickness (Monthly)	<=4%	4.80%	4.30%	4.90%	4.80%	4.80%	4.80%
Appraisals (Band 6 and above)	>=95%	96.10%	96.60%	97.70%	97.70%	97.70%	97.70%
Appraisals (Band 5 and below)	>=95%	94.90%	96.70%	98.50%	98.50%	98.10%	98.10%
Aggression Management	>=80%	71.60%	71.10%	74.00%	75.60%	75.60%	78.80%
Equality and Diversity	>=80%	74.60%	77.10%	80.10%	82.00%	83.20%	87.00%
Fire Safety	>=80%	82.40%	83.30%	85.20%	85.50%	87.40%	83.70%
Food Safety	>=80%	48.20%	49.50%	51.40%	53.40%	58.70%	59.50%
Infection Control and Hand Hygiene	>=80%	77.00%	75.90%	78.90%	77.10%	80.50%	82.30%
Information Governance	>=95%	91.80%	86.80%	85.70%	84.60%	87.20%	98.00%
Moving and Handling	>=80%	54.00%	57.50%	59.00%	60.40%	62.80%	65.80%
Safeguarding Adults	>=80%	84.30%	85.20%	81.30%	80.20%	81.60%	77.60%
Safeguarding Children	>=80%	81.70%	83.60%	84.50%	85.40%	85.10%	85.30%
Bank Cost		£76k	£58k	£58k	£64k	£65k	£100k
Agency Cost		£43k	£35k	£16k	£19k	£46k	£20k
Additional Hours Cost		£9k	£12k	£11k	£12k	£12k	£12k
Sickness Cost (Monthly)		£53k	£51k	£53k	£56k	£56k	£52k
Vacancies (Non-Medical) (WTE)		36.64	35.44	34.53	37.51	34.65	33.16
Business Miles		33k	44k	30k	41k	37k	34k

Publication Summary

This section of the report identifies up and coming items that are likely to impact on the Trust.

Monitor

Revised annual planning timetable 2015/16
Click here for link

NHS Employers

Agenda for Change pay charts and frequently asked questions
Click here for link

Department of Health

From 1 April 2015 the local authority responsible for mental health aftercare services, under section 117 of the Mental Health Act 1983 (the Act), will normally be the one where the person was ordinarily resident immediately before they were detained under the Act. This document has details about arrangements for referring disputes over ordinary residence in cases where one or more authority in dispute is in England and one or more is in Wales. These arrangements only apply where services are provided under section 117 of the Act.
Click here for link

2015/16 Choice Framework

This framework sets out patients' rights to choice in healthcare, where to find information to help choose, and how to complain if choice isn't offered. It is consistent with NHS England's recently published mental health choice guidance.
Click here for link

This section of the report identifies publications that may be of interest to the Trust and it's members.

A consultation on updating the NHS Constitution (Department of Health)
Diagnostics waiting times and activity data, January 2015 and Q3 2014-15 (NHS England)
Referral to Treatment waiting times statistics, January 2015 (NHS England)
NHS safety thermometer report - February 2014 to February 2015
End of life care: fifth report of session 2014-15 (house of Commons Health Select Committee)
Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing (Department of Health)
Access to hospital care: is the NHS on target? (Nuffield Trust)
Equal measures: equality information report for 2014 (CQC)
The Edge (NHS Improving Quality)
Independent Mental Health Advocacy (IMHA) (Social Care Institute for Excellence)
Celebrating good care, championing outstanding care (CQC)
Reference guide to the Mental Health Act 1983 (Department of Health)
Building the NHS of the Five Year Forward View: NHS England business plan 2015/16 (NHS England)
Delayed Transfers of Care: monthly situation reports, February 2015 (NHS England)
Friends and family test, February 2015 (NHS England)
Referral to treatment waiting times statistics, February 2015

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
QTD	Quarter to Date
RAG	Red, Amber, Green
RiO	Trusts Mental Health Clinical Information System
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 28 April 2015
Agenda item 8.2

Title:	**Customer services report – quarter 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 2014. The revised policy reflects CQC essential standards, the duty of candour and Trust action following KPMG audit. The audit provided assurance that Trust policy is robust and in line with best practice in NHS complaints management, and recommended only minor amendment to policy wording to reflect existing practice. Enhanced Customer Services reporting at BDU level is enabling increased scrutiny of issues and themes and action planning to ensure service improvement in response to feedback. The Trust-wide Patient Experience Group, is now re-constituted and work is being taken forward with a clinical lead as Chair, with a revised reporting and governance framework to enable more robust triangulation of service user experience data.
Executive summary:	Key performance indicators are 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 15/16. **Customer Services Report – quarter 4 2014/15** This report provides information on feedback received, the themes indicated, lessons learned and action taken in response to feedback. In quarter 3: • 369 issues were responded to; • 68 formal complaints were received and 206 compliments; • care and treatment, waiting times, delays and cancellations, communication, staff attitude, and admission, discharge, assessment and transfer issues were the most common themes; • 1 complainant asked the Parliamentary and Health Service Ombudsman to review their complaint; • over 165 public enquiries were responded to and over 320 staff enquiries; • 75 requests for information under the Freedom of Information Act were actioned.
Recommendation:	**Trust Board is asked to REVIEW and NOTE the feedback received through customer services in quarter 4 of financial year 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 JANUARY 2015 – 31 MARCH 2015

(QTR. 4 14/15)

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 policy is subject to annual review and was most recently reviewed by the Board in December 2014. It takes account of relevant regulation and best practice and emphasises the importance of using insight from service user experience to influence and improve services.

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 Trust and its 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

Each Business Delivery Unit (BDU) also receives a more detailed report showing a breakdown of issues at service line.

FEEDBACK RECEIVED

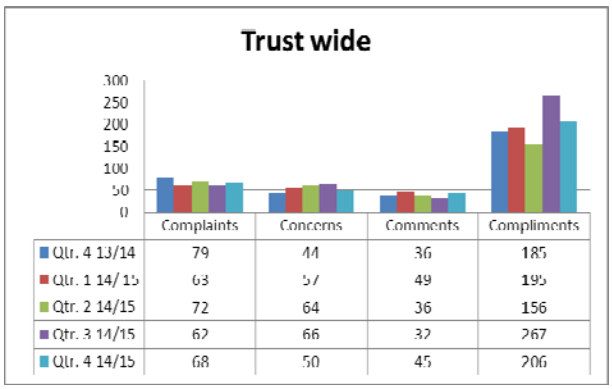
The tables below illustrate Customer Services activity in Qtr. 4. The Customer Services team responded to 369 issues; 68 formal complaints were received and 206 compliments. This compares to 426 issues, 57 formal complaints and 267 compliments in the previous quarter.

Complaint numbers show an increase on the previous quarter.

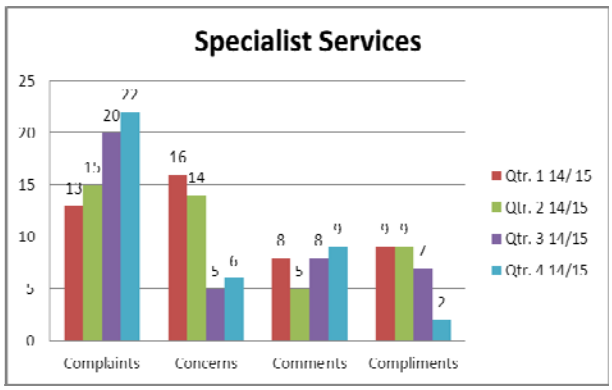
In Specialist Services, most of the complaints received related to CAMHS services, with Calderdale and Kirklees CAMHS having the most complaints (12), Barnsley CAMHS 6 and Wakefield 1. Access to services and waiting times (particularly the wait time from the initial 'Choice' appointment to treatment) were the most common issues raised in regards to CAMHS services.

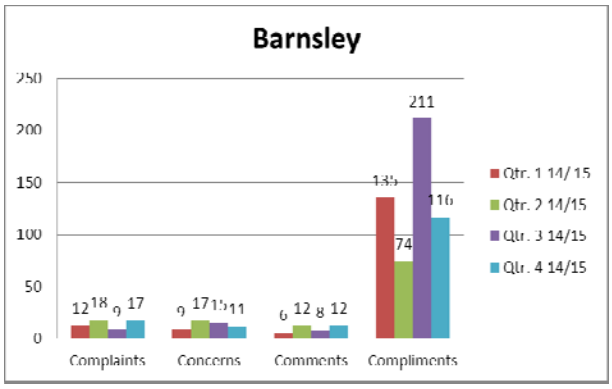
.

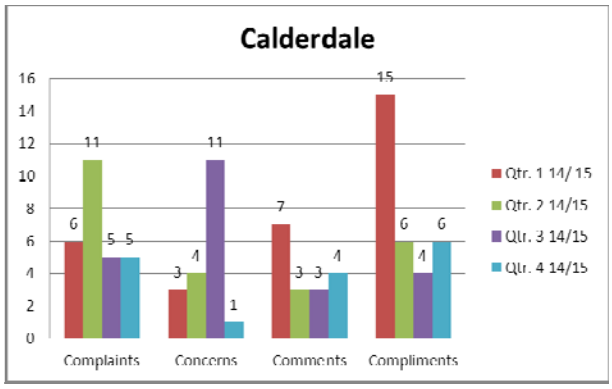
CUSTOMER SERVICES ACTIVITY QTR.4

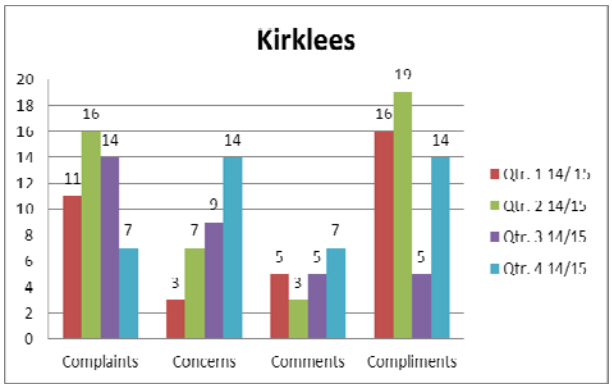


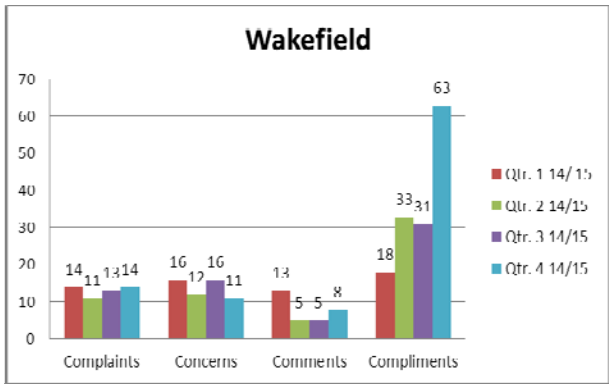
	Complaints	Concerns	Comments	Compliments
Qtr. 4 13/14	79	44	36	185
Qtr. 1 14/15	63	57	49	195
Qtr. 2 14/15	72	64	36	156
Qtr. 3 14/15	62	66	32	267
Qtr. 4 14/15	68	50	45	206

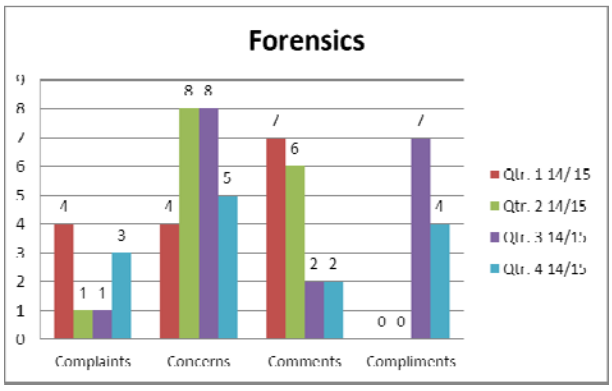


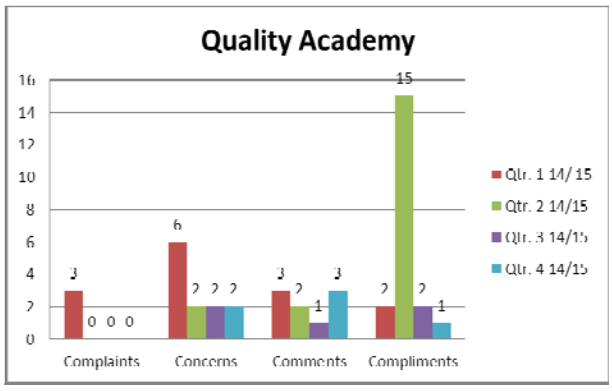












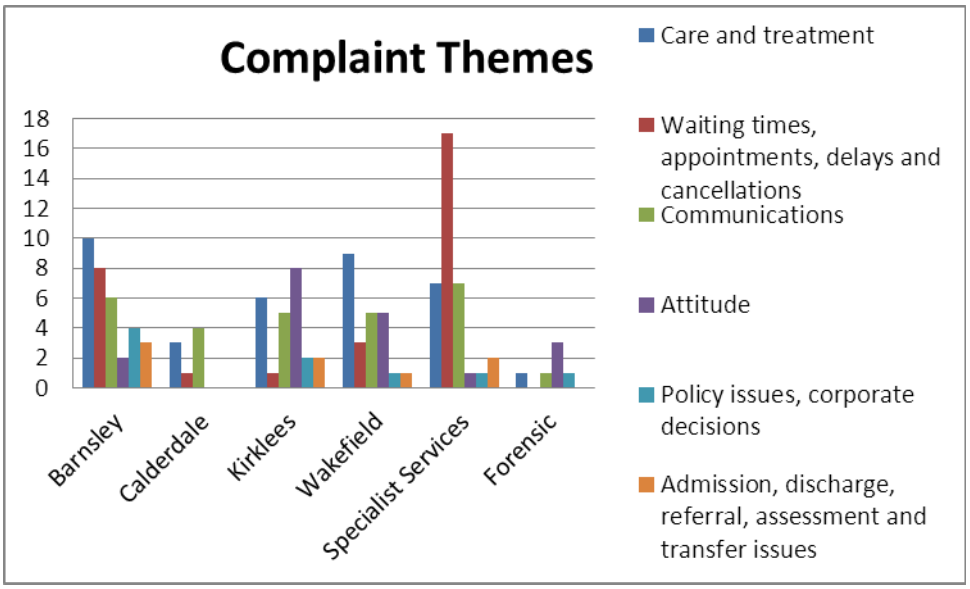
NUMBER OF ISSUES RAISED INFORMALLY

During Qtr. 4, Trust services responded to 50 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 (36). This was followed by waiting times, delays and cancellations (30), communications (28), staff attitude (19) and admission, discharge, referral, assessment and transfer issues (8). 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.

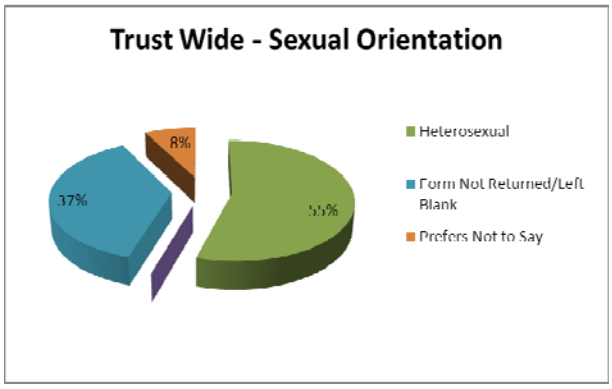


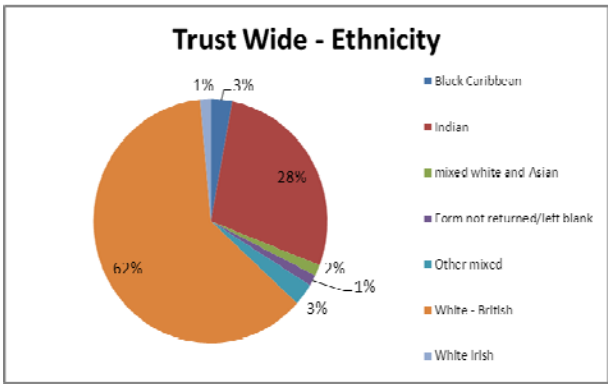
TRUST WIDE EQUALITY DATA

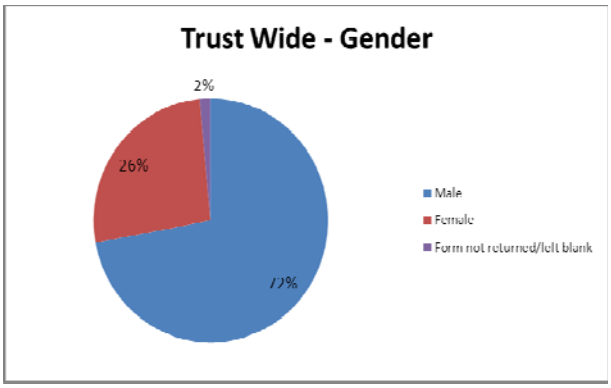
Equality data is captured, where possible, at the time a formal complaint is made. Where complaints are received by email or letter, an equality monitoring form is issued with a request to complete and return. Additional information is now also shared explaining why collection of this data is important to the Trust and that it is essential to ensure equality of access to Trust services.

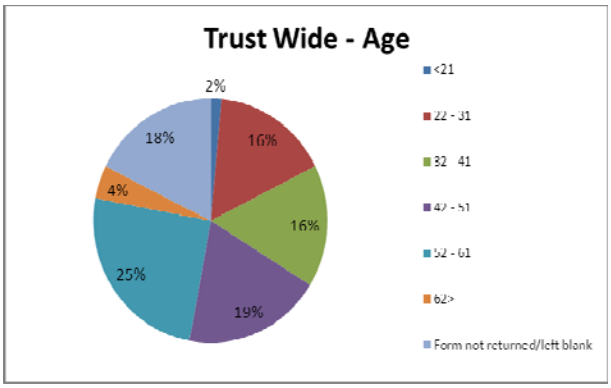
The Team is exploring best practice in data capture, internally with the Partnerships Team and externally with partner organisations and will incorporate any learning into routine processes.

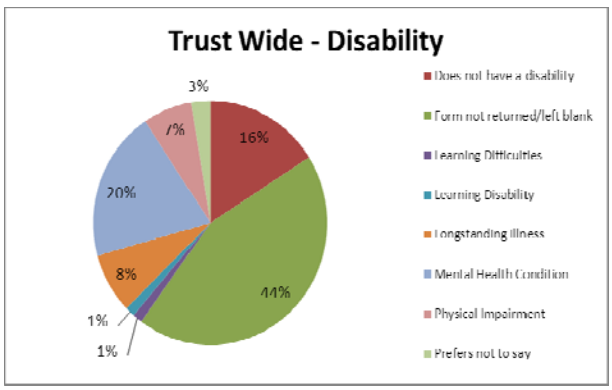
The charts that follow show, where information was provided, the breakdown in respect of gender, age, disability and ethnicity trust wide. The return rate of information is shown underneath the tables.











Age 56/68 ***Gender 67/68*** ***Disability 35/68*** ***Ethnicity 67/68*** ***Sexual Orientation 44/68***

The team makes every effort to collect equality data, but some people prefer not to share this and indicate that it has no bearing on whether or not they provide feedback to the Trust or want to raise an issue.

MP CONTACT

During Qtr. 4, 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.

Specialist Services BDU: Mike Wood (1) Jason McCartney (1)
Both enquiries related to access to CAMHS services.

Wakefield BDU – Mary Creagh MP (1)
Enquiry related to a constituent unhappy with the waiting time to see a specialist.

Calderdale BDU – Linda Riordan (1)
Enquiry related to level of care and support provided by APTS and waiting times.

Barnsley BDU – Dan Jarvis (3)
One enquiry was on behalf of a constituent regarding access to records, two related to changes in Trust service provision re CASH and SMS services.

The Trust makes proactive contact with MPs to keep them informed of news and initiatives on a monthly basis and offers specific briefing about relevant issues.

PARLIAMENTARY HEALTH SERVICE OMBUDSMAN (PHSO)

During Qtr.4, 1 complainant (Wakefield OPS Inpatient) asked the Parliamentary and Health Service Ombudsman to review their complaint. 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 from the Ombudsman regarding two cases which had been subject to review – 1 requiring no further action, and 1 requesting the Trust to resolve by means of apology and an action plan. Details as below:

Kirklees BDU (Acute inpatient WAA) recommendations made by means of an apology and an action plan covering discharge planning and risk assessment for day leave.

Calderdale BDU (Adult community services) Draft report shared with the Trust – no element of the complaint upheld.

The Trust is still waiting decisions on 3 cases, 1 Kirklees/Calderdale CAMHS (information provided to Ombudsman October 14,) 1 Forensic (February 15) 1 Kirklees – WAA community services (March 15)

MENTAL HEALTH ACT

2 complaints were made in Qtr. 4 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)

4 issues were referred to the Trust by the CQC in Qtr. 4:

- In 2 cases the CQC asked the Trust to review the complaint and respond direct to the individual.
- In one case (Barnsley MH Inpatients WAA) the CQC has indicted that Trust timeframes were not adhered to. Additional information has been provided to the CQC to counter this.
- An outcome is still awaited one complaint (Kirklees Rehabilitation & Recovery)

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.

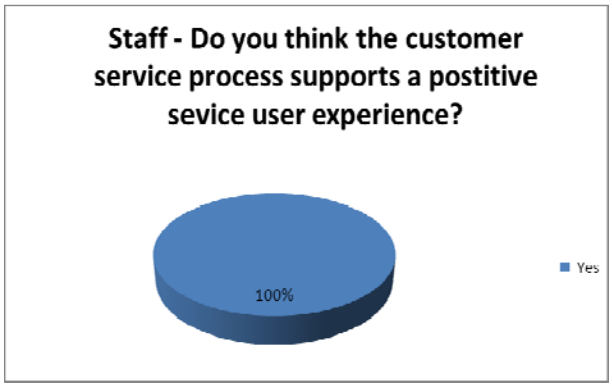
Issues spanning more than one organisation in Qtr.4	Formal Concern (Over 48 Hours) (COMPLAINT)	Informal Concern (Up to 48 Hours) (CONCERN)	Service Issue (COMMENT)	Total
Care Quality Commission	0	1	0	1
NHS Calderdale CCG	1	0	0	1
NHS North Kirklees CCG	0	0	1	1
NHS Wakefield CCG	1	0	0	1
Wakefield Metropolitan District Council	1	0	0	1
Total	3	1	1	5

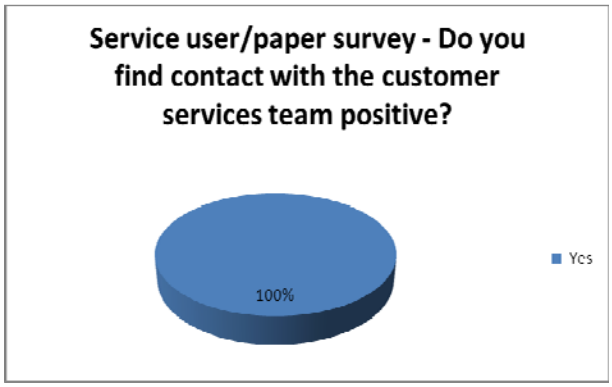
CONTACT WITH CUSTOMER SERVICES TEAM

The customer services team processed 165 general enquiries in Qtr. 4, 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 over 320 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 staff 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 is particularly encouraged 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, with those declining indicating they are satisfied with the contact offered via Customer Services.

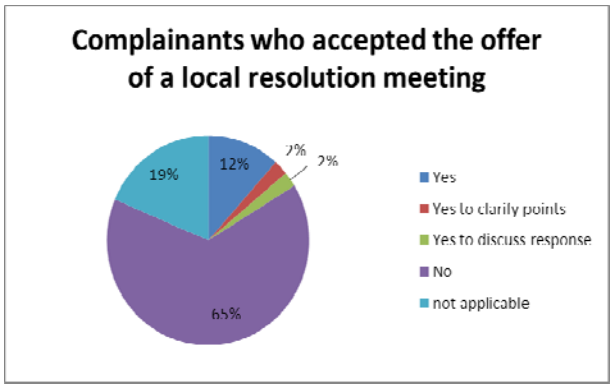
Feedback from staff who participated in meetings indicates that this improves overall understanding of how service users and their families perceive Trust services.

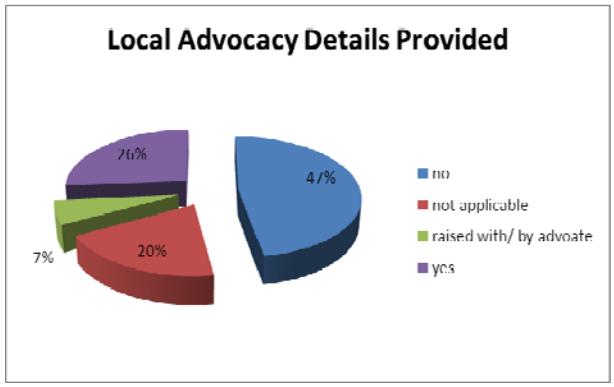
> *'I would like to thank you for your efforts on my and my parent's behalf. As a result of raising our concerns we felt our needs were listened to and we are now left with a viable plan of management, and a feeling of support which feels great! I wish to wholeheartedly thank all concerned.'*
>
> *Complainant*

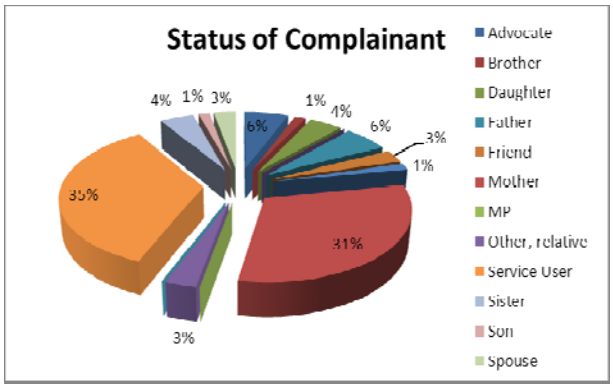
In relation to staff satisfaction (evaluated by questionnaire), 100% of respondents indicated they were happy with the support provided.

> *'The customer services team is absolutely tenacious, always helpful, and really committed to getting the best job done for our service users and carers - keeping us all on track and delivering results in a way that we can all learn from!'*
>
> *Staff member*

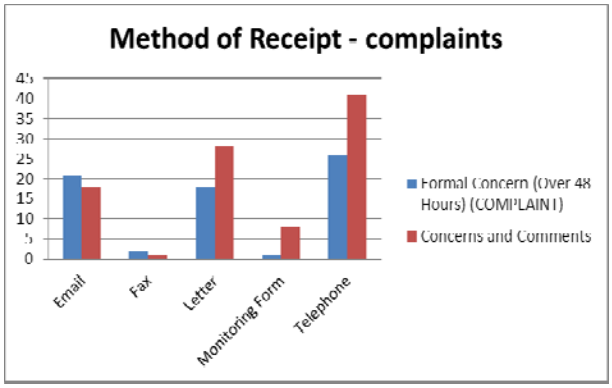
Complainants are also provided with contact details for independent advocacy services when their complaint is acknowledged and people are encouraged to use this support if helpful. A small number of service users are supported by an advocate.







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. This includes internally and externally generated surveys, real time data collected via tablets, friends and family test results and focussed engagement activity.



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 internal standard is for every complaint to be responded to within 25 days; or 40 days for more complex cases.

In Qtr.4, 44% of complaints were closed within 25 days, but 12% of cases (6) took longer than 40 days to investigate and offer a response, due to delay in investigation at BDU level (allocation of a lead investigator). General Managers are alerted in such cases.

6% of cases (3) could not progress to investigation. This related to issues raised by a third party where the individual in receipt of care and treatment refused to give consent for investigation.

28 formal complaints remained open at the end of the quarter (8 of which were received prior to Qtr. 4); 17 were awating consent and 11 awaiting allocation of a lead investigator at BDU level.

COMPLIMENTS

During Qtr. 4, 206 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.4

The care my mother received was excellent. Nothing was too much trouble for staff even though they were very busy. I cannot thank all the team enough on my mother's recovery and would not hesitate in recommending Mount Vernon.

Barnsley – Ward 4 MVH

May I take this opportunity to thank both the tele health service and the community matrons. They have my undying gratitude and admiration. When I fell ill on Christmas Day they were there for me without hesitation. I don't know where I would be without them.

Barnsley - Care Navigation & Community Matrons

We would like to thank you very much indeed for the excellent care and support you have given to mum over the past few weeks and the support you have given to us also!

Calderdale - Beechdale

We wish to thank you all from the bottom of our hearts for looking after our brother. He only ever had lovely things to say about everyone who helped him.

Kirklees - CMHT North

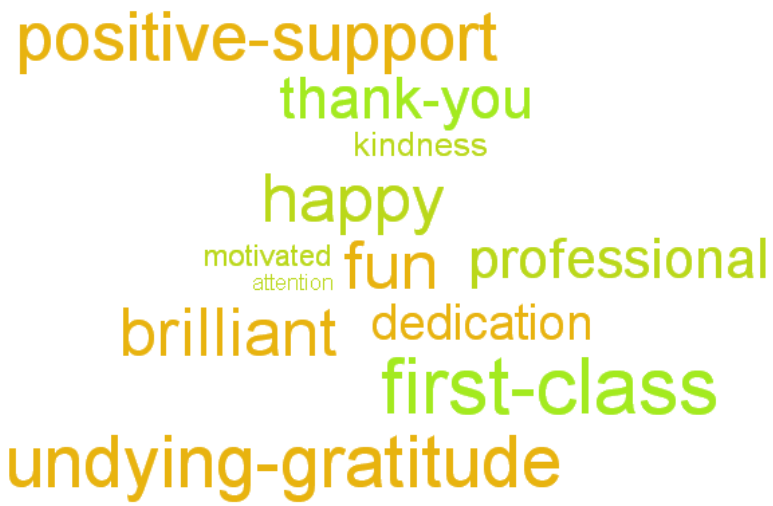
Thank you to staff for managing the recent admission in very difficult circumstances. The staff were magnificent in their response and made the gentleman as comfortable as possible and recognised when they needed to address his physical needs.

Wakefield – Trinity 2

It has been a great pleasure for us to express our sincere gratitude the OT's and all the other staff for motivating patients to do activities, access and cooking which involves 'Come Dine with me'. We hope that this process of building skills continues and inspires a positive path to recovery which of course are our main objectives in the future.

Forensic – Waterton Ward

Most frequently used words in compliments about Trust services:



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

Not all complaints require action plans to remedy issues, but all provide helpful feedback which is used in services to support service improvement. The responsibility to deliver on action plans is held within the BDUs and monitored through governance processes.

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.

The Customer Services monitoring form has been shared with all wards and staff are encouraged to capture all feedback at service level. Progress in capturing this additional information is being monitored.

Actions taken by BDUs in response to feedback include:

Barnsley BDU

- Staff have being reminded of the importance of involving and updating service users in regards to decisions made in respect of care and treatment ***(mental health services - CMHT WAA)***
- Information and contact details are to be provided for advice regarding self-management issues ***(long term conditions services)***
- the importance of updating and reviewing individual's records in a timely manner has been reiterated to staff ***(long term conditions services)***
- Review of the current process and systems to be undertaken to prevent future administrative errors ***(long term conditions services)***
- Improvements to administrative processes to ensure clients receive good customer service. ***(primary care and preventative services)***

Calderdale & Kirklees BDUs

- the importance of involving and listening to families and carers regarding aspects of care planning has been reiterated to staff members ***(inpatients OPS) & (acute services - inpatients WAA)***

- Staff have being reminded of the importance of being mindful of their surroundings when discussing sensitive information with patients and/or families and carers. ***(rehab and recovery services)***
- reception staff at a CMHT are to receive additional customer services training ***(community services WAA)***
- Improvements to administrative processes to ensure clients receive information in a timely manner ***(acute services - inpatients WAA)***
- Staff have being reminded of the importance of involving service users in regards to decisions made in respect of care and treatment ***(rehab and recovery services)***

Wakefield BDU

- Staff are to ensure that clear explanations are provided for recording specific information and information regarding access to records is available to patients ***(acute services WAA)***
- A review of current transfer pathways between PICU and acute inpatient wards to be undertaken and communication between staff and service users/carers has also been reviewed ***(acute services – inpatients WAA)***
- Staff are to ensure that carers/families viewpoints are incorporated within service user care plans ***(community services WAA)***
- Staff on an inpatient ward are to receive additional customer services training and additional supervision ***(inpatients – OPS)***
- Trust staff have been reminded to always ensure appropriate letter-headed stationary is used in responding to service user issues ***(OPS)***

Specialist services BDU

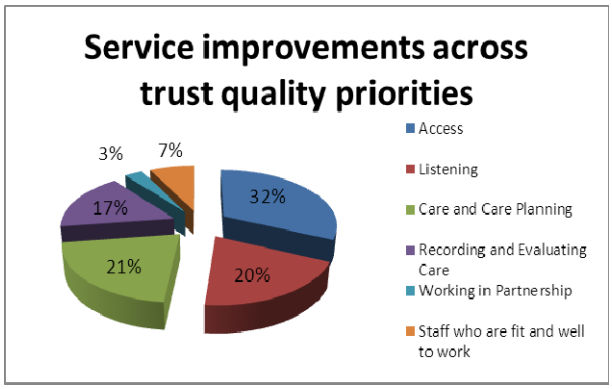
The following improvements have been made in ***Calderdale and Kirklees CAMHS*** services in response to feedback; all of which support the recovery plan agreed with commissioners:

- Staff have being reminded of the importance of involving and updating service users in regards to decisions made following assessment/appointments in respect of care and treatment and also to involve families and carers where possible.
- Additional processes have been implanted to ensure record keeping errors are kept to a minimum
- Staff have been reminded of the importance of returning calls in a timely manner
- The Trust is in the process of reviewing current IG processes, in relation to issues around consent and the releasing of healthcare records
- The Trust continues to work closely with commissioners in respect of the improving access and wait times for service users and exploring the need for a crisis services to meet emergency need.

The following improvements have been made in the ***Barnsley CAMHS*** service in response to feedback

- Staff to provide opportunities for parents/carers to feedback their views separately following clinical meetings.

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



EXAMPLES OF SERVICE USER AND CARER EXPERIENCE

Jamie raised concerns regarding lack of communication provided to his family around a CPA meeting. Jamie reported that the family was only provided with 1 week notice to prepare and attend. The family received little information regarding what a CPA meeting was and who would be in attendance.

Customer services met with Jamie and his family, and their experience was shared with the ward manager. A full review of the current system took place with action to ensure all paperwork/information is provided before and following a review in a timely manner. A full apology was provided to the family.

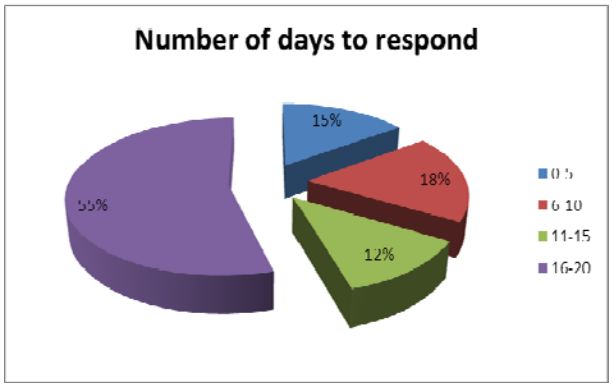
The parent of a child receiving support from the CAMHS service met with customer services to raise concerns regarding the lack of contact received from CAMHS, despite numerous attempts.

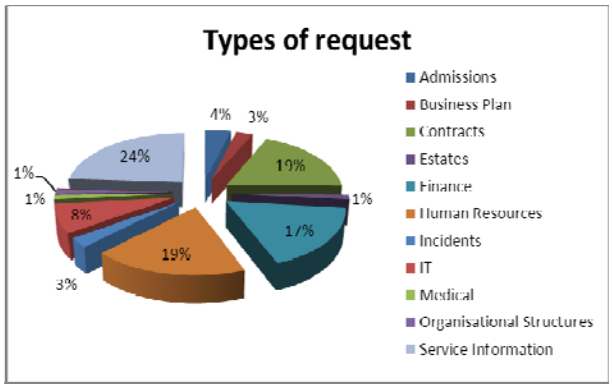
The general manager reviewed the process and a revised system has been implemented to ensure all correspondence/telephone contacts are recorded and responded to in a timely manner

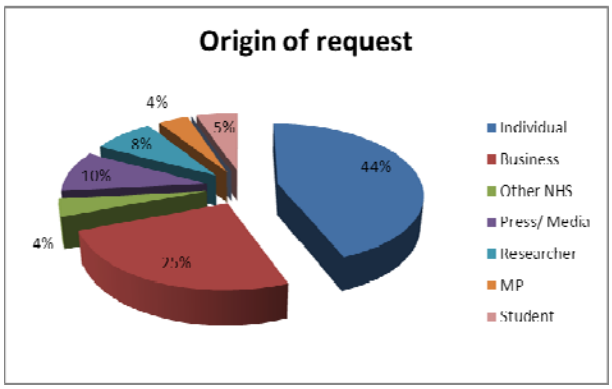
FREEDOM OF INFORMATION REQUESTS

75 requests to access information under the Freedom of Information Act were processed in Qtr. 4, an increase on the previous quarter when 57 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. 4, no exemptions were applied.

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 move to service line reporting and subsequent update of the Datixweb feedback module has enabled the introduction of revised reporting for BDUs. This will help services (in particular practice governance coaches) to review feedback and issues raised and ensure an appropriate service response. Some services have adopted a proactive approach, requesting additional detail regarding complaint themes and BDU efficiency in respect of investigation and action planning. Further work is on-going with BDUs regarding ownership of action plans and monitoring of delivery of same.

The Patient Experience Group, has met in its newly constituted form. This group is being taken forward with a clinical lead as Chair with a remit to work to a single reporting and governance framework to enable more robust triangulation of experience data.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 28 April 2015
Agenda item 8.3(i)

Title:	**Calderdale and Kirklees Child and Adolescent Mental Health Services (CAMHS) recovery plan – progress report**
Paper prepared by:	Director of Nursing, Medical Director and Interim Director of CAMHS
Purpose:	To provide an update on progress in the delivery of the recovery plan
Mission/values:	Improve and be outstanding in relation to the Recovery Plan Open, honest and transparent in terms of public reporting
Any background papers/ previously considered by:	Update reports previously provided to Trust Board, most recently 31 March 2015
Executive summary:	Following a successful tender bid, Calderdale and Kirklees CAMHS services transferred to the Trust in April 2013. As the work to transform services commenced, the scale of the challenge became clearer and a recovery plan was developed in February 2014. This plan is ambitious and has shown progress, but the Trust and Commissioners remain concerned that the Trust has not achieved the scale and pace of change that was planned and desired. This paper provides a progress update against the plan and action following the CAMHS Summit on the 20 March 2015 and the report to Trust Board on 31 March 2015. The Clinical Governance and Clinical Safety Committee also received an update at its meeting on 21 April 2015.
Recommendation:	**Trust Board is asked to NOTE the progress report**
Private session:	Not applicable

South West Yorkshire Partnership NHS
NHS Foundation Trust

Calderdale and Kirklees Child and Adolescent Mental Health Services (CAMHS)
Progress Report
Trust Board 28th April 2015

Introduction

Following a successful tender process, the Trust took over the provision of Tier 3 CAMHS in Calderdale & Kirklees in April 2013. Commissioners and the Trust are clear that the scale of the challenge to remodel and transform the service had been underestimated. As a result a recovery plan was instigated and the Trust has invested considerable additional corporate and management resources into the service, but concerns as to the sustainability of the service remain.

The Trust's CEO raised these concerns formally with Commissioners in January 2015 and a CAMHS Summit was held between Commissioners and Providers on 20th March 2015 to discuss the position.

The Trust Board has received regular reports on progress for Calderdale & Kirklees CAMHS, most recently in January and March 2015. This report updates the Board on progress.

CAMHS Summit

The Trust has now received the notes of the CAMHS Summit.

In order to redress the balance between emergency and planned work, a business case was submitted for a new Crisis Service. This request is being considered by Commissioners and we will provide a progress update at the Board.

The Trust has reiterated its commitment to improving data quality and sees this as a priority. It has confirmed to commissioners that the data will improve incrementally, and that by the end of July 2015, these measures proposed will ensure that the data is more robust.

Discussions have now been held with Commissioners regarding the establishment of jointly agreed quality surveillance mechanisms to ensure that concerns and risks are identified and examined jointly by Commissioners and the Trust. This is proposed to include both visits and more CAMHS-focussed compliance reporting.

The date for the next Summit has been set as 8th May 2015 and the Board will be updated following this meeting.

RECOVERY PLAN UPDATE

Management and leadership

It is clear that the skilled and experienced CAMHS General Manager has the confidence of staff in Calderdale & Kirklees and her presence at Broad Street Plaza, the CAMHS service base, has been very much welcomed. She is working closely with the Clinical Lead and Practice Governance Coach to ensure that the service has clear and visible leadership.

Demands on the service

Demands on the service continue to increase with emergency work dominating the workload resulting in the delays on planned work. The business case for a new Crisis Service will address this matter and the recruitment process is underway in anticipation of a successful outcome.

	January	February	March
Total No of Referrals	199	216	256
No of emergency referrals	36	65	70
No of emergency referrals out of hours	24	49	39

Clinical Pathways

At present emergency referrals (most often presenting in A&E) are usually seen within 4 hours, whilst parents and young people are usually given their first 'Choice' appointment within 6-8 weeks.

We have introduced a revised referral pathway in Calderdale which is being rolled out to schools and GPs in April. The pathway is the result of consultation with the Tier 2 provider and primary care partners and is specifically designed to reduce the number of inappropriate Tier 3 referrals by ensuring that professionals refer to the right service in the first instance.

The Recovery Team work, to address the pre-April 2014 generic waiting list will be concluded by the end of May 2015 when an assessment will have been offered to all the 149 young people who were waiting to be seen.

Data Quality

The lack of relevant and reliable data was identified as a key service risk in April 2013 and remains so. This is being addressed by the management team as a priority, with a drive on the use of RIO and cross-checking the use of RIO with manual records in the first instance. This is also being supported by training, mentoring and coaching for staff on the use of RIO.

Workforce

The position in relation to mandatory training is showing some small, but steady, improvement, particularly in Safeguarding Children and Information Governance, which

were identified as the key risk areas. The management team will continue to drive improvement in this area.

Staff sickness for the year to date (to the end of February 2015) is now 9.5%, which is an increase from the previous position of 8.6%. Management of long-term sickness absence is a priority, as this forms the majority of the sickness absence. There are plans in place for each individual to return to work.

The vast majority (over 80%) of staff appraisals - for all staff groups - are up to date.

Internal & External Governance Arrangements

Robust internal governance structures have been developed and were reported in detail to the March 2015 Trust Board.

The Director of Nursing and Interim District Director have met with the Director of Childrens Services of Kirklees to understand the safeguarding concerns in detail and will introduce revised escalation arrangements.

Progress continues to be monitored by the Trust's Clinical Governance and Clinical Safety Committee and the Trust's regulators are kept informed of the position.

Summary

Progress is being made with implementation of the recovery plan, but significant challenges remain.

The Director of Nursing, Clinical Governance and Safety, the Medical Director and interim BDU Director retain executive oversight and leadership of the service, working with Executive colleagues. The Chief Executive is providing direct support to this agenda.

The Trust remains committed to ensuring it provides a good Tier 3 service, as part of a whole system which supports the emotional health and wellbeing of children and young people in Calderdale and Kirklees.

16th April 2015
Tim Breedon, Director of Nursing, Clinical governance & Safety
Nette Carder, Interim Director of CAMHS.
Adrian Berry, Medical Director

Trust Board 28 April 2015
Agenda item 8.3(ii)

Title:	**Risk Assessment of Performance & Compliance Targets**
Paper prepared by:	Deputy Chief Executive/Director of Finance
Purpose:	The purpose of this report is to outline to Trust Board: • the main changes to performance and compliance requirements for 2015/16; • issues with expected level of attainment; • significant risk in terms of reputation and finance; • assurance on risk mitigation.
Mission/values:	The Annual review of compliance and contract arrangements supports the delivery of services which have the right quality and are efficient, making the best use of resources including technology and put the person in the centre.
Any background papers/ previously considered by:	Annual report April 2012, Risk Assessment Report 2013/14 and 2014/15. Monthly Performance Reporting.
Executive summary:	The report outlines the main changes to performance and compliance requirements for 2015/16. There is assessment of expected levels of attainment and risk in terms of finance and reputation with assurance given as to risk mitigation. The two areas considered are: • regulators and regulations; • contractual requirements. Identified risks in regard to regulatory compliance are as follows. • There are no major issues or risks identified for 2014/15 related to the Trusts compliance with Monitor licensing requirements. • SWYPFT has a positive financial risk rating of 4 for viability as a going concern and the annual plan is assessed to remain at level 4 with no risks identified; • SWYPFT has a green governance rating no risks to maintenance of this rating have been identified. • New inspection models for Mental Health and Community Services have been introduced from October 2014. Greater scrutiny, breadth and intensity of CQC regulatory inspections may attract further compliance and possibly enforcement actions. In mitigation the Trust is working through the various administrative and managerial challenges to ensure that staff understand and are aware of the CQC changes as well as revising our internal self-assessment processes to incorporate the new CQC standards and inspection approaches • Failure to perform against the national access and outcomes requirements impacting the trusts governance rating. In mitigation internal monitoring occurs at Board, EMT and BDU level. Significant changes to performance are not anticipated and the forecast remains green. Service Users with follow-up contact within 7 days of discharge is the target at most risk rated amber green but work is ongoing and action plans are in place to minimise the risk. • There are pressures arising from the increasing number, content and

	submission frequencies of national data sets and through the increasing role of the Information Centre as the central repository which will flow data to commissioners. This impacts on Impact on services with the requirement to collect additional data, creates reputational issues as interpretation and assumptions made by the HSCIC and or commissioners differ from internally generated analysis & reporting and potential reduction in data quality due to monthly submissions which reduce the time available for data checking/validation. Mitigation includes, BDU and clinical quality involvement in defining key operational practice standards so data input can be standardised and streamlined; pro-active management of data interpretation through our contracting meetings; review and prioritisation of specialist capacity to build data sets for submission. • The introduction of the legal rights for choice in mental health services in 2014/15 will be monitored through contract management processes with commissioners in 2015/16 which includes ensuring the application of choice within Single Points of Access. The Trust does have the required Choose and Book experience from using the system in relation to community services. Given the limited changes expected in patient flow the financial implication is expected to have minimal impact, but performance trends will be monitored. Identified risks in regard to contractual compliance are as follows. • Continued inclusion of national performance requirements through the standard NHS contract relating to 7-day follow up for service users on CPA and completion of MH minimum dataset items - ethnicity. These are rated amber/green and action plans are in place within each BDU. • Local performance targets are mainly a risk for the Barnsley BDU as the Barnsley commissioners use more financial penalty sanctions within their contracts. IAPT recovery and entry to treatment targets remain the greatest risk. • £3.8m of the available £4.7 CQUIN income has been assessed as the level of expected achievement. £2.6m is categorised at some level of risk falling within a RAG rating of amber/green, amber or amber/red. More detailed risk assessment identifies the most likely level of risk as £0.8m. The new national CQUIN for improving physical healthcare for Mental Health service users represents the biggest area of risk across all BDU's. For Wakefield, Calderdale and Kirklees Review of Service Users & Clusters, Quality of Care Plans and First Episode of Psychosis are also a risk. Outcomes Based Interventions for both the CAMHS service and Barnsley LD are the main risks for specialist services and Smoking Cessation the risk for Forensics. For Barnsley main risk areas are Dementia and Delirium and MH clustering (Adherence to Red Rules). • £5.7m of Trust contract income has been highlighted at a red risk rating where commissioners have confirmed commissioning intentions to disinvest or re-procure services through competitive tender at a future date. A process has been put in place to identify these contracts or service lines within contracts to support SWYPFT to be commercially prepared for services being placed out to tender. • Further action is required to develop and agree risk sharing arrangements across a number of QIPP schemes agreed with commissioners where co-dependencies with commissioners or other organisations are critical to deliverability. This is to ensure that where the ability to deliver is outside of SWYPFT's direct control or impacted by the actions of others risk is shared and mitigated jointly and does not default to removal from SWYPFT contracts. • The financial risk for Mental Health currency has been mitigated by

	remaining on block contracts and shadow arrangements with commissioners and underpinned by a Memorandum of Understanding which means that commissioners and providers will continue to work collaboratively in developing the currency model and understanding the baselines. • Service Line Reporting will continue to be embedded as a key financial management tool to improve financial decision making and support improved negotiation with commissioners in the future. All risks in achieving compliance will be included on the Risk Register with mitigating action plans in place. These will be monitored through BDUs and the Performance EMT.
Recommendation:	**Trust Board is asked to NOTE the content of the report, the assessment of risk and the actions planned to mitigate risk**
Private session:	Not applicable

Trust Board 28 April 2015
RISK ASSESSMENT:
2015-16 PERFORMANCE AND COMPLIANCE TARGETS

EXECUTIVE SUMMARY

1. PURPOSE OF REPORT

The purpose of this report is to:

- Outline the main changes to performance and compliance requirements for 2015-16
- Highlight any keys issues related to the level of attainment
- Identify any significant risk issues in terms of reputation and finance
- Provide assurance on risk mitigation

The two areas considered are:

- Regulators and regulations
- Contractual requirements

2. REGULATORS AND REGULATIONS

2.1 MONITOR

On 1 April 2013, the provider licence came into effect for all NHS foundation trusts. The licence replaced the terms of Authorisation as Monitor's primary tool for overseeing NHS Foundation Trusts, incorporating requirements covering governance and financial viability as well as other areas reflecting Monitor's expanded role within the health sector. There are no major issues or risks identified in relation to the Trust's continued compliance with its Licence. Trust Board makes a quarterly self-certification as part of the Trust's quarterly return to Monitor and annually receives a full assessment of compliance against the terms of the Trust's Licence. For 2015/16, this will include the new licensing condition in relation to integrated care.

2.1.1 Risk Assessment Framework

The Risk Assessment Framework, introduced in October 2013 as a replacement for the Compliance Framework, covers two parts related to Finance and Governance.

- **Continuity of Services Licence Condition 3 (Finance):**

Two ratios, liquidity and capital servicing capacity, are used to measure the ability of a provider to meet operational and financing cash demands to remain viable as a going concern. Quarterly reporting is made to Monitor and SWYPFT has a rating of 4 which signifies sufficient financial headroom and liquidity. The annual plan for 2015/16 is assessed at level 4 and no risks have been identified.

- **NHS Foundation Trust Licence Condition 4 (Governance)**

Monitor uses a governance rating, incorporating information across a number of areas, to describe their views of the governance of an NHS foundation trust.

Trust Board has taken the decision to undertake its first three yearly external governance review against Monitor's well-led framework for governance reviews. Deloitte has been appointed as

the independent reviewer and will report on the outcome of the review to Trust Board in July 2015. Monitor guidance does not clarify what level of impact the outcome of the review may have on a trust's governance risk rating.

The Trust continues to predict no significant impact on its current governance risk rating, which has been 'green' during 2014/15. Although, there is still some lack of clarity in regard to Monitor's interpretation of governance proxies, formal reporting is not required until late 2015/16, which provides time for the risk and impact to be fully assessed.

Performance against national access and outcomes requirements forms one strand of information used by Monitor in determining the overall governance rating for the Trust.

- **Performance against national access and outcomes requirements**

Monitor expects NHS foundation trusts to establish and effectively implement systems and processes to ensure that they can meet national standards for access to health care services and outcomes objectives. Monitor incorporates performance against a number of these standards in their assessment of the overall governance of a trust. Monitor will also assess the trusts' ability to meet certain requirements of the NHS Outcomes Framework.

Material or on-going underperformance against these access and outcomes requirements may reflect a governance concern and warrant consideration by Monitor for further investigation.

Monitor uses a limited set of national measures of access and outcome objectives as part of their assessment of governance at NHS foundation trusts. These cover acute, mental health, community and ambulance activities.

Trusts failing to meet at least four of these requirements at any given time, or failing the same requirement for at least three quarters, will trigger a governance concern, potentially leading to investigation and enforcement action.

Except where otherwise stated, any trust commissioned to provide services will be subject to the relevant governance indicators associated with those services. All indicators applicable to SWYPFT are subject to monitoring on a quarterly basis. Internal monitoring occurs on a monthly basis via the Strategic Overview report and individual BDU performance is monitored via the BDU Dashboards.

For 2015/16, the indicator set is a continuation of measures used throughout 2014/15 along with the addition of three new access indicators relating to Improving Access to Psychological Therapies (IAPT) and Early Intervention in Psychosis (EIP). These new measures require the Trust to commence reporting in Q3 for IAPT and Q4 for EIP with the aim that the standards are met by the end of Q4. No issues are identified to impact on the existing key performance indicators with the exception of 'meeting the commitment to serve new psychosis cases by early intervention teams'. The Executive commissioned an internal audit report to review data quality including the methodology and accuracy of reporting the EIP target as a result of the recommendations the process for recording and reporting has been improved from 1st April 2015. The indicator is not currently included in contracts or a mandatory indicator for performance monitoring by Monitor; it has been included in data submissions for completeness. Impact of improved process on data capture will be reviewed over first quarter of 2015/16.

The Trust are anticipating achievement of the new IAPT Access indicators and an initial analysis of the baseline data showed all IAPT services to be reporting above the threshold. The new standards require 75% to be treated within 6 weeks of referral and 95% to be treated within 18 weeks of referral.

The Early Intervention target requires people experiencing a first case of psychosis to be treated within a NICE approved care package within two weeks of referral. There is some element of risk associated with this indicator as currently the national guidance is still being defined by the Health and Social Care Services Information Centre (HSCIC) to confirm the definition of the 'NICE approved care package. SWYPFT will need to make a re-assessment and undertake a gap analysis and develop the formal plans for the service development and improvement schedule of contracts as per national guidance. This is planned for Q1, subject to release of the final guidance.

The forecast for achievement of the Monitor access and outcome requirements therefore remains at Green until Quarter 4 when the new access indicators comes into effect and this may then change the rating to Amber/Green subject to the final national guidance and definitions.

2.2 CHOICE IN MENTAL HEALTH SERVICES

In 2014/15 legal rights to choice in Mental Health services were introduced as part of the parity of esteem agenda covering both choice of mental health provider and choice of mental healthcare team. In December 2014 NHS England produced guidance and clinical scenarios on implementing choice to support consistent application of rights across the mental health sector. The requirements to adhere to offering choice are part of the contractual obligations placed on providers through the NHS standard contract and commissioners will monitor progress in implementation through contract management processes in 2015/16.

The legal right of choice must be offered at points where patients can make meaningful decisions about a provider and team from which to receive their care. This includes decisions in GP surgeries or in situations following GP referral where prior to receiving care assessment is required to determine appropriate treatment. This includes Single Points of Access where patients are reviewed either administratively or face to face by a healthcare professional and triaged to the most appropriate service.

Commissioners will monitor SWYPFT's compliance with the legal right of choice through contract monitoring in 2015/16 in line with NHS Standard Contract requirements. This includes the Provider publishing all relevant services on Choose and Book. The requirement on Providers to support implementation of choice is also part of Monitor's guidance on complying with licence conditions.

This is a key area for SWYPFT to address. Based on the previous experience of rolling out choice for physical health services nationally it is expected that the new legal right will be taken up gradually and not result in significant shifts of activity in the short term.

2.3 CQC

The CQC have published 'Fresh Start' documents in relation to the regulation and inspection of both mental health and community services and the new mental health and community models started to be rolled-out in October 2014.

As at April 2015 the Trust continues to carry 2 compliance actions (but no enforcement actions) in regard to CQC regulatory inspections under the current inspection regime. The Trust has formally notified the CQC of completion of the action plan in respect of these compliance actions from the Fieldhead inspection visit against outcomes 7 (safeguarding) and 10 (safety and suitability of premises). The return CQC inspection visit is still awaited. 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.

The new inspection framework includes the 5 key questions being asked of services: Are they safe?; Are they effective?; Are they caring?; Are they responsive?; Are they well-led?. Judgements will be made against a 4 point scale – Outstanding, good, requires improvement, inadequate. Ratings will not be limited to an aggregated whole but drilled down to department, specialty, care group and condition-specific level. The future frequency of inspection will relate to the judgement reached. The Trust has reviewed the Trust Visit Programme to reflect these changes.

Inspections will be more intensive, will include more specialised inspectors as part of inspection teams and make greater use of people's views and experiences of care. Visits will be made at weekends and nights and for the first time community teams will be subject to inspection with the same rigor as applied to hospital services. The CQC will consider how/whether lessons from other key reports such as Francis and Berwick are understood and applied. For mental health inspections there is a much stronger focus on the Mental Health Act, Mental Capacity Act and Deprivation of Liberty.
From 1st April 2015 if we have been awarded a rating from the CQC we are required to display them in each and every premise where regulated activity is delivered, in our main place of business and on our website. The CQC guideline also encourages Trusts to raise awareness of ratings when communicating with people who use our services, by letter, email or other means.

There is a risk that the greater scrutiny, breadth and intensity of CQC regulatory inspections may attract further compliance and possibly enforcement actions. In mitigation the Trust is working through the various administrative and managerial challenges to ensure that staff understand and are aware of the CQC changes as well as revising our internal self-assessment processes to incorporate the new CQC standards and inspection approaches.

2.4 MANDATORY DATA SETS

The Health and Social Care Information Centre (HSCIC) is increasingly becoming the main repository of health and social care data with the expectation that all information will flow to the Commissioning Support Units (CSUs) & regulators from the HSCIC rather than directly from Provider Organisations

The number, content & submission frequency of mandated data sets continues to increase. By late 2015/early 2016 the Trust is required to develop and submit additional data sets and comply with major changes to the newly released Mental Health & Learning Difficulties Data Set (MHLDDS) which is to be absorbed into a new comprehensive dataset including both CAMHS and CY-IAPT. The Trust is also required to develop and submit a further additional dataset for

the Children and Young People (CYPHS) non mental health services, however national delay in the publication of the Information Standard Notification (ISN) has prevented development by system supplier which will mean a significant in-house development will be required.

Key areas of risk include:

- National delay in publication of ISN is resulting in a significant amount of risk related to the development and reporting Children and Young People Dataset.
- Unknown release date, NHS England and HSCIC in discussions, could be anytime between October 2015 – January 2016
- Impact on services with the requirement to collect additional data
- Reputational issues as interpretation and assumptions made by the HSCIC and or the CSUs differ from internally generated analysis & reporting
- Inability of System supplier to provide a robust, fit-for-purpose extract from RiO.
- Inability of System supplier to provide a robust, fit-for-purpose extract from SystmOne.
- Potential reduction in data quality due to monthly submissions which reduce the time available for data checking/validation

Mitigation includes:

- BDU and clinical quality involvement in defining key operational practice standards so data input can be standardised and streamlined;
- Pro-active management of data interpretation through our contracting meetings;
- Review and prioritisation of specialist capacity to build data sets for submission.

3. CONTRACTUAL REQUIREMENTS

Contractual performance requirements are broadly split into two categories covering national and local requirements. These are set out within the Quality Schedule of the contracts.

3.1 NATIONAL PERFORMANCE REQUIREMENTS

There are a range of national performance and quality standards which continue from 2014/15 and attract financial penalties if not achieved or maintained. A number of these are only applicable to Barnsley BDU community services and relate to treatment within 18 weeks for consultant-led services, diagnostics within 6 weeks, and rates of MRSA, although these have been risk assessed as green.

Mixed sex accommodation breaches apply to all BDUs and can attract a penalty of £250 per day for every day of breach. Again this has been risk assessed as green.

Other indicators applicable to the Trust that incur a penalty for non-achievement of threshold relate to:

- Care Programme Approach (CPA): The percentage of Service Users under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care. This will apply to all BDU's and can attract a penalty of £200 per breach which falls below the threshold (95%). This has been risk assessed and some risk has been identified making the overall RAG rating Amber/Green – the risk attributed to this has reduced from 14/15.

- Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, the completion of IAPT Minimum Data Set outcome data and Mental Health Minimum Data Set ethnicity coding for all detained and informal Service Users. Trusts can attract a penalty of £10 per record, for every record that takes the breach below the threshold. These indicators have been risk assessed and no risk identified, RAG rating is therefore Green.

Risk RAG rating for each CCG can be seen in the table below:

National Performance Requirements	Penalty	Associated Risk - 2015/16				
		Barnsley CCG	Calderdale CCG	N Kirklees / Greater Huddersfield CCG	Wakefield CCG	Trust Wide Potential Penalty
Percentage of non-admitted Service Users starting treatment within a maximum of 18 weeks from Referral	£100 in respect of each excess breach above that threshold	Green	N/A	N/A	N/A	**Green**
Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	£150 in respect of each excess breach above that threshold	Green	N/A	N/A	N/A	**Green**
Percentage of Service Users waiting less than 6 weeks from Referral for a diagnostic test	£200 in respect of each excess breach above that threshold	Green	N/A	N/A	N/A	**Green**
Sleeping Accommodation Breach	£250 per day per Service User affected	Green	Green	Green	Green	**Green**
Care Programme Approach (CPA): The percentage of Service Users under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care	£200 in respect of each excess breach above that threshold	A/G Potential Annual Penalty £400	A/G Potential Penalty Forecast £1400	A/G Potential Annual Penalty £3000	A/G Potential Annual Penalty £800	**A/G Potential Annual Penalty £5600**
Zero tolerance MRSA	£10,000 in respect of each incidence in the relevant month	Green	Green	Green	Green	**Green**
Zero tolerance RTT waits over 52 weeks for incomplete pathways	£5,000 per Service User with an incomplete RTT pathway waiting over 52 weeks at the end of the relevant month	Green	N/A	N/A	N/A	**Green**
Publication of Formulary	Withholding of up to 1% of the Actual Monthly Value per month until publication	Green	Green	Green	Green	**Green**
Duty of candour	Recovery of the cost of the episode of care, or £10,000 if the cost of the episode of care is unknown or indeterminate	Green	Green	Green	Green	**Green**
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 in respect of each excess breach above that threshold	Green	Green	Green	Green	**Green**
Completion of Mental Health Minimum Data Set ethnicity coding for all detained and informal Service Users, as defined in Contract Technical Guidance	£10 in respect of each excess breach below that threshold	Green	Green	Green	Green	Green
Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users, as defined in Contract Technical Guidance	£10 in respect of each excess breach above that threshold	Green	Green	Green	N/A	**Green**
Total Potential Penalty		**A/G Potential Annual Penalty £400**	**A/G Potential Annual Penalty £1400**	**A/G Potential Annual Penalty £3000**	**A/G Potential Annual Penalty £800**	**A/G Potential Annual Penalty £5600**

3.2 LOCAL PERFORMANCE REQUIREMENTS

Local performance requirements are set for each service area and specified within the contractual documentation. These generally do not attract financial penalties but are subject to regular monitoring through formal contract performance review processes. Where performance is highlighted as an issue through appropriate processes and the Provider fails to address the performance the Commissioner has the contractual right to invoke the requirement for the Provider to produce a remedial action plan. If a formal contract performance notice is served these have to be declared within any bids the provider makes for new business under any tender opportunities.

In 2015/16, the number of KPI's with financial penalty for Barnsley CCG has reduced compared to 2014/15, however the final indicator set will be determined subject to quarter 4 CQUIN achievement. These have each been risk assessed and can be seen in the table below.

KPI's attracting Penalty 2015/16 Barnsley CCG	Threshold	Annual Penalty	Risk Rating
IAPT - Moving to Recovery	50%	160,000	A/R
IAPT - Receiving Psychological Therapies	15.00%	160,000	A/G
% of antimicrobial prescriptions with a specified review or stop date	90%	19,484	A/G
% of antimicrobial prescriptions with a specified indication	90%	19,484	A/G
Pressure Ulcer - zero heel ulcer	zero heel ulcers	900 per incidence	A/G
Number of Avoidable Pressure Ulcers	<26	16,000	G

Kirklees IAPT services are also subject to potential financial penalties for under-delivery against the moving to recovery target. The target threshold remains at 52% for 2015/16 and risk assessed as Green on the basis that the target has been delivered in 2014/15.

There are no other financial penalties related to KPI's with the Calderdale, Kirklees or Wakefield CCG's.

3.3 CQUINS

3.3.1 General

In line with the national planning guidance the value of the CQUIN scheme for 2015/16 remains up to 2.5% of annual contract value. However, for 2015/16 the emphasis on national indicators has increased with the ratio changing from an 80:20 local to national indicator split 14/15 to a 70:30 local: national components for 2015/16.

The total contract income associated with CQUIN schemes is £4.7m. £3m has been assessed as the level which will be achieved. £2.6m has been RAG rated within an amber/green, amber or amber/red category. Based on more detailed risk assessment the most likely risk has been assessed as £0.8m.

The CQUIN Schemes for 2015/16 contain a mix of nationally specified and local CQUIN goals. The total amount of CQUIN income related to national CQUIN goals is £1m

The total amount of CQUIN income related to local CQUIN goals is £3m

CQUIN schemes are agreed at contract level with some covering more than one BDU. The translation of how the CQUIN income relates to each BDU and associated risk is set out below.

3.3.2 CQUIN Income and Risk At BDU Level

Of the £4.7m total CQUIN income the amounts attributable to each of the BDUs is £0.8m Wakefield, £0.9m Kirklees, £0.4m Calderdale, £1,4m Barnsley, £0.7m Specialist Services and £0.6m Forensics Services.

All of the CQUIN schemes have been RAG rated and risk assessed. The risk has been presented at two levels firstly showing the amount included in RAG rating categories with some risk i.e. amber/green, amber and amber/red (at risk value) and secondly following more detailed risk assessment the most likely risk value.

BDU	Value RAG Rated Green	Value RAG Rated At Some Risk (amber/green, amber, amber/red)	Most Likely Risk Value Based On Risk Assessment	Expected Achievement Value	Total CQUIN Income
Wakefield	£0.1m	£0.6m	£0.2m	£0.6m	£0.79m
Kirklees	£0.2m	£0.7m	£0.2m	£0.6m	£0.88m
Calderdale	£0.1m	£0.3m	£0.1m	£0.3m	£0.39m
Barnsley	£1.1m	£0.3m	£0.1m	£1.3m	£1,42m
Specialist Services	£0.2m	£0.5m	£0.1m	£0.6m	£0.67m
Forensics	£0.3m	£0.2m	£0.1m	£0.4m	£0.58m
Total	**£2.0m**	**£2.6m**	**£0.8m**	**£3.8m**	**£4.73m**

- **Wakefield/Kirklees and Calderdale BDU's**

The Wakefield, Kirklees and Calderdale BDUs continue to have a single CQUIN scheme as part of the main contract with the relevant CCG's. In summary the CQUIN's scheme areas agreed are:

Local CQUINs	National CQUINs
1) MH Currency a) Clustering b) Review of SU's within Frequency c) Adherence to Red Rules d) PbR Data Set 2) Care Plans 3) Access – Early Intervention for Psychosis 4) Safety Thermometer 5) LD: Outcome Measures 6) CAMHS (Wakefield Only)	7) Improving Physical Healthcare a) Cardio Metabolic Assessment & Treatment b) GP Communication 8) Reduction in A&E MH Re-Attendances

All local schemes with the exception of the Safety Thermometer, LD Outcome Measures and CAMHS are new for 2015/16. The national physical healthcare CQUIN is a continuation from 2014/15, but reduction in A&E Mental Health re-attendances is new.

The key risk areas for all 3 BDUs include both of the National CQUINs; Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness and Improving Diagnosis and Re-Attendance Rates of Patients with Mental Health Needs.

The Improving Physical Healthcare CQUIN has 2 elements attached to it; a) Cardio Metabolic Assessment and Treatment for Patients with Psychosis (80% CQUIN value) and b) Communication with GPs (20% CQUIN value). The most likely risk has been calculated for the West as £142k and £35k respectively. This equates to £57k and £14k for Wakefield, £26k and £6k for Calderdale and £59k and £15k for Kirklees. The main concern is that SWYPFT will not meet the full 90% for inpatients and 80% for Early Intervention In Psychosis target at year end for Cardio Metabolic Assessment. A realistic achievement of between 70-79% has been placed on the second element (GP Communication) against the national target of 90%.

A 75% achievement has been attached to the second National CQUIN, Reduction in A&E MH re-attendances as although this CQUIN has been agreed in principle further work is required to agree the definitions and measurements.

Locally the areas of risk for part achievement are:

1) Review of Service Users & Clusters £82k across the 3 BDUs (£31k, £16k, £35k Wakefield, Calderdale, Kirklees).
2) Quality of Care Plans, £113k across the 3 BDUs (£42k, £22k,£49k Wakefield, Calderdale, Kirklees).
3) First Episode of Psychosis, £86k across the 3 BDUs (£33k, £16k, £37k Wakefield, Calderdale and Kirklees.

For all 3 CQUINs the in-year increase in targets across quarters has been factored into and reflected in the risk rating.

Performance and resulting payment continues to be awarded on achievement at individual BDU level. This will accurately reflect the income flows through individual contract values per commissioner and minimise the risk associated with non-achievement at trust level. There also remains improvement from 2014/15 in the partial payment rules to attract part payments per indicator spreading the risk and reducing the 'all or nothing' structure of schemes in former years.

- **Barnsley BDU**

The main CQUIN scheme applicable to the Barnsley BDU is with Barnsley CCG, including Rotherham, Doncaster and Sheffield CCG's as associates.

In summary the CQUIN's scheme areas agreed are:

Local CQUINs	National CQUINs
1) MH Currency a) Clustering b) Review of SU's within Frequency c) Adherence to Red Rules d) PbR Data Set	7) Improving Physical Healthcare a) Cardio Metabolic Assessment & Treatment b) GP Communication 8) Dementia & Delirium a) Find, Assess, Investigate, Refer & Inform

2) Care Navigation / Telehealth Care 3) Developing High Performing Teams	(FAIRI) b) Staff Training c) Supporting Carers

The key risk areas for the BDU includes both of the National CQUINs; Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness and Dementia & Delirium (further details of these CQUINs can be found under 3.3.3 National CQUINs).

Similar to the West contracts, the main concern in relation to the Improving Physical Healthcare CQUIN is that the Barnsley services will not meet the full 90% (IPs) and 80% (EIP) target at year end for Cardio Metabolic Assessment. 75% achievement has been placed on the first element of this CQUIN. 50% achievement has been placed on GP Communication. The value of the risk to this CQUIN is £48k

The Dementia & Delirium CQUIN risk relates to the first indicator of this CQUIN: Find, Assess, Refer and Inform (FAIRI). The main concern is that SWYPT will not achieve Q4 targets. The value of the risk to this CQUIN is £48k

Two out of the three local CQUIN's are RAG rated green, Care Navigation/Telehealth Care and Developing High Performing Teams. MH Clustering has been RAG rated amber/green, value of risk £86k.

There are a number of other smaller contracts relevant to the Barnsley BDU which have associated CQUIN income attached.

- **Specialist Services BDU (LD/CAMHS)**

There are 5 CQUIN indicators specifically relating to Specialist Services.

The total CQUIN income related to Specialist Services is £0.7m. This comprises of £0.6m for Learning Disability Services and £0.07m for CAMHs services.

In relation to Learning Disability Services the Wakefield, Kirklees and Calderdale CCG's have agreed to extend the 2014/15 Outcomes CQUIN with stretch. With targets being set realistically this CQUIN has been RAG rated green.

For Barnsley the CQUIN for Learning Disability Services is a stretch on the 2014/15 CQUIN, value £0.4m. With the targets being set based on 2014/15 outturn the CQUIN has been RAG rated as amber/green as there is potential risk of Q4 achievement (£86k).

In relation to CAMHS services, again the CQUIN for this year is only applicable to the Wakefield contract. The CAMHs contract with the Kirklees and Calderdale CCGs continues to be exclusive of CQUIN. For 2015/16 this CQUIN is focussed on a goal based outcome measure being completed within Community CAMHS, Primary Intervention and LD at first intervention, follow-up appointments and all subsequent intervention appointments. Achievement of this CQUIN has been rated Amber due to the level of increase in the target from 50% in Q2 to 90% in Q3 and 95% in Q4. The potential risk is £38k.

- **Forensics BDU**

For 2015/16 4 CQUINs have been attached to the Forensic Service. The National CQUIN for Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness continues in 2015/16. As has been identified within SWYPFT's other BDU's this CQUIN has been identified as a risk for achievement (£58k) and rated amber.

Locally, Collaborative Risk Assessments continue into 2015/16 and have been RAG rated green along with the Carer Involvement CQUIN. The remaining new CQUIN, Smoking Cessation, has been rated Amber due to the Service's concern of not reaching Q3 and Q4 targets. Potential CQUIN risk equates to £77k.

3.4 CONTRACT RISKS – Disinvestment/Re-procurement Risk

A process has been put in place and monitored routinely, in more detail through the investment appraisal reporting process, to identify known and potential risks to Trust contracts. There are two categories of risk:

- Red: which includes known risk to contracts or service lines within contracts where commissioners have already confirmed their intentions to disinvest or re-procure services through competitive tender;
- Amber: relating to contracts or service lines within contracts where final decisions have not been made or confirmed but where commissioners have strongly indicated the intention to dis-invest or re-procure or where services are under review to inform future procurement decisions

The initial risk assessment for 2015/16 identifies a potential of £27.21m contract income at risk within the next two years:

- £5.70m rated as red
- £21.51m rated as amber

3.5 QIPP TARGETS

A number of cash release QIPP targets have been agreed with Wakefield, Kirklees and Calderdale commissioners for 2015/16. Through contract negotiations the principle has been established that cash will not be released from contracts unless agreed schemes are in place between the parties and until the point in time that the cash release can be made, where the scheme is intended to release cash directly from SWYPFT contract. There are no QIPP requirements for Barnsley CCG.

The original two year 2014/15 and 2015/16 QIPP scheme agreement with Wakefield CCG totalled £1.75m which has now increased to £1.79m through the 2015-16 contract negotiations round. Schemes focus on reductions in out of area spend for acute placements, reducing spend on CCG held budgets for Learning Disability placements and continuing healthcare, reconfiguration of Older People's Services, Learning Disability Services and Adult Rehabilitation and Recovery Services.

The QIPP schemes agreed with Kirklees commissioners target £1m savings. The schemes planned aim to reduce spend on CCG held Out of Area budgets for management of specialist adult rehabilitation and recovery placements (£500k) and Learning Disability placements (£500k) supported through transformation plans.

The cash release QIPP targets for Calderdale CCG are £274k. The CCG has agreed to work with SWYPFT to agree and plan schemes by the end of Q1.

Further action is required to develop and agree risk sharing arrangements across a number of schemes where co-dependencies with commissioners or other organisations are critical to deliverability to ensure that where the ability to deliver is outside of SWYPFT's direct control or impacted by others risk is shared and mitigated jointly and does not default to removal from SWYPFT contracts.

3.6 MENTAL HEALTH CURRENCIES

The payment rules around mental health services published for 2015/16 remains unchanged as does the methodology for calculating prices.

To minimise any financial risk SWYPFT has agreed across the range of Mental Health commissioners to contract in shadow format for 2015/16, remaining on block contract arrangements. Contracts are underpinned by a Memorandum of Understanding to mitigate risk and covers arrangements for:

- management of data quality, and arrangements to cleanse caseload activity through the year;
- reflecting service improvement/transformation in the contract;
- for re-basing the contract through the year where this is appropriate;
- agreed work programmes and priorities between commissioners and providers to be developed through joint steering groups

A key driver remains data quality improvement and cleansing and ensuring activity is based on 'active' caseload only. Actual activity will be monitored against baseline and may be re-based in agreement with commissioners.

Regular reporting at Board, EMT and BDU level continues to promote performance monitoring to drive forward improvement. Links with the Data Quality Steering Group will also feed in to improve data quality and clinical record keeping.

3.7 SERVICE LINE REPORTING

Service Line Reporting has continued to be implemented during 14/15 as a tool to inform future decision making at service line level and decisions in managing financial risks. Service Line Reporting is essential in order to facilitate service redesign and efficiency and to inform BDUs future service offer and plans.

The introduction of the system will also facilitate better benchmarking and information to support service-redesign and the transformation agenda during 2015/16 supporting:

- Development of transformation baseline positions;
- Rebasing exercises/equalising contribution;
- National benchmarking;
- Informing negotiations with commissioners

4.0 CONCLUSION

The main conclusions in regard to regulatory and contractual compliance are:

- There are no major issues or risks identified for 2015/16 relating to the Trust's compliance with its License.
- SWYPFT has a positive financial risk rating of 4 for viability as a going concern and the annual plan is assessed to remain at level 4 with no risks identified;
- SWYPFT has a green governance rating and no risks to maintenance of this rating have been identified.
- The potential impact of the outcome of the independent governance review on the governance risk rating is not known.
- New inspection models for Mental Health and Community Services have been introduced from October 2014. Greater scrutiny, breadth and intensity of CQC regulatory inspections may attract further compliance and possibly enforcement actions. In mitigation the Trust is working through the various administrative and managerial challenges to ensure that staff understand and are aware of the CQC changes as well as revising our internal self-assessment processes to incorporate the new CQC standards and inspection approaches.
- Failure to perform against the national access and outcomes requirements impacting the trusts governance rating. In mitigation internal monitoring occurs at Board, EMT and BDU level. Significant changes to performance are not anticipated and the forecast remains green. Service Users with follow-up contact within 7 days of discharge and ethnicity recording of Mental health service users is the target at most risk rated amber green but work is ongoing and action plans are in place to minimise the risk.
- The introduction of the legal right to choice for mental health services will be monitored by commissioners in 2015/16 through contract management processes. This includes the application of choice within Single Points of Access. The Trust does have the required Choose and Book experience from using the system in relation to community services. Given the limited changes expected in patient flow the financial implication is expected to have minimal impact, but performance trends will be monitored.
- There are continuing pressures arising from the increasing number, content and submission frequencies of national data sets and through the increasing role of the Health and Social Care Information Centre (HSCIC) as the central repository which will flow data to commissioners. This impacts on services with the requirement to collect additional data, creates reputational issues as interpretation and assumptions made by the HSCIC and or commissioners differ from internally generated analysis & reporting and potential reduction in data quality due to monthly submissions which reduce the time available for data checking/validation. Mitigation includes, BDU and clinical quality involvement in defining key operational practice standards so data input can be standardised and streamlined; pro-active management of data interpretation through our contracting meetings; review and prioritisation of specialist capacity to build data sets for submission.
- Continued inclusion of national performance requirements through the standard NHS contract relating to 7-day follow up for service users on CPA and completion of MHLD minimum dataset items - ethnicity. These are rated amber/green and action plans are in place within each BDU.
- Local performance targets are mainly a risk for the Barnsley BDU as the Barnsley commissioners use more financial penalty sanctions within their contracts. IAPT recovery and entry to treatment targets remain the greatest risk.
- £3.8m of the available £4.7 CQUIN income has been assessed as the level of expected achievement. £2.6m is categorised at some level of risk falling within a RAG rating of amber/green, amber or amber/red. More detailed risk assessment identifies the most likely

level of risk as £0.8m. The new national CQUIN for improving physical healthcare for Mental Health service users represents the biggest area of risk across all BDU's. For Wakefield, Calderdale and Kirklees Review of Service Users & Clusters, Quality of Care Plans and First Episode of Psychosis are also a risk. Outcomes Based Interventions for both the CAMHS service and Barnsley LD are the main risks for specialist services and Smoking Cessation the risk for Forensics. For Barnsley main risk areas are Dementia and Delirium and MH clustering (Adherence to Red Rules).

- £5.7m of Trust contract income has been highlighted at a red risk rating where commissioners have confirmed commissioning intentions to disinvest or re-procure services through competitive tender at a future date. A process has been put in place to identify these contracts or service lines within contracts to support SWYPFT to be commercially prepared for services being placed out to tender.
- Further action is required to develop and agree risk sharing arrangements across a number of QIPP schemes agreed with commissioners where co-dependencies with commissioners or other organisations are critical to deliverability. This is to ensure that where the ability to deliver is outside of SWYPFT's direct control or impacted by the actions of others risk is shared and mitigated jointly and does not default to removal from SWYPFT contracts.
- The financial risk for Mental Health currency has been mitigated by remaining on block contracts and shadow arrangements with commissioners and underpinned by a Memorandum of Understanding which means that commissioners and providers will continue to work collaboratively in developing the currency model and understanding the baselines.
- Service Line Reporting will continue to be embedded as a key financial management tool to improve financial decision making and support improved negotiation with commissioners in the future.

5.0 RECOMMENDATION

The Board is asked to note the content of the report, the assessment of risk and the actions planned to mitigate risk.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 28 April 2015
Agenda item 8.3(iii)

Title:	**Trust visit programme annual report 2014/15**
Paper prepared by:	Director of Nursing, Clinical Governance and Safety
Purpose:	The purpose of this report is to outline to Trust Board: ✓ Findings from the 2014/15 Trust Visit Programme ✓ Recommendations for the 2015/16 Trust Visit Programme
Mission/values:	The Trust Visit Programme report supports the governance framework by enabling objective assessment of Trust services against both the CQC essential standards and the Trusts quality priorities. Undertaking these reviews gives teams the opportunity to reflect on the care and treatment they deliver, celebrate their achievements and make required improvements. In addition it aids the strategic team to further understand the difficulties teams face on a day to day basis, identify good practice and encourages learning from across the Trusts services.
Any background papers/ previously considered by:	A previous update paper on the Trust's Visit Programme 2013/14 has been submitted to the Board. Regular updates are provided to the Clinical Governance and Clinical Safety Committee.
Executive summary:	The report outlines the findings of the Trust visit programme for 2014/15 and provides detail with regards to the visit programme for 2015/16. The experience gained from the 2014/15 visits has reinforced the organisational value of conducting such a programme. Visit team findings have facilitated learning and provided teams with useful experience of an inspection process. Feedback reports are received and reviewed by Business Delivery Units with direction for action focused through BDU governance functions. Once again, lessons learned from the process have been used to inform changes to the next planned visit programme. For 2015/16, the Trust will continue to invite staff from external partners (for example, clinical commissioning groups and NHS England) to participate in visits when appropriate. Changes to the process for 2015/16 are as follows. ✓ Revision of prompt questions in line with the revised Care Quality Commission (CQC) Key Lines of Enquiry. ✓ Introduction of the CQC's judgement framework into the process. ✓ On-line questionnaires for staff prior to the visit to their team. This will allow for the visit team to explore areas of concern. ✓ Patient experience feedback will be included in the pre-inspection data packs. ✓ Anonymised reports will be shared on the intranet to encourage teams to learn for each other's good practice.
Recommendation:	**Trust Board are asked to NOTE the contents of the report and support the Trust visit plan for 2015/16.**
Private session:	Not applicable

Clinical Governance and Clinical Safety Committee
21 April 2015
TRUST VISIT PROGRAMME 2014/15 and 2015/16

1. 2014/15 PROGRAMME

The experience gained from the 2014/15 visits has reinforced the organisational value of conducting such a programme. Visit team findings have facilitated learning and provided teams with useful experience of an inspection process. Feedback reports are received and reviewed by Business Delivery Units with direction for action focused through BDU governance functions. Once again lessons learned from the process have been used to inform changes to the next planned visit programme.

Visit teams are made up of a Director/senior manager, clinician/specialist adviser, ward/team manager and governance lead. In the 2014/15, every attempt was made to have representation from each group in each visit team; however, in order for the visit to be viable, teams had to include a minimum of the governance lead and a clinician/specialist advisor and one other to form a minimum of three people at all times. In addition to the core members, there was an opportunity for Non-Executive Directors, members of the Trust's Talent Pool and additional specialist advisors to attend dependent on the nature and size of the team visited.

There were 49 visits arranged for the 2014/15 programme. Of these:

- 40 were allocated a Director/senior manager
- all 49 were allocated a clinician/specialist advisor, including medics, practice governance coaches, pharmacy staff, nurse consultants and senior nurses, and specialist advisors;
- 43 were allocated a ward/team manager;
- all 49 visits were co-ordinated by a governance lead.

Non-Executive Directors participated in eleven visits.

Commissioners (from Clinical Commissioning Groups on the West) joined two community team visits from which they were assured of the rigour of the governance process.

In 2014/15 the visit programme focused on assessment against both the CQC essential standards and the Trust's quality priorities. A total of 49 visits were made:

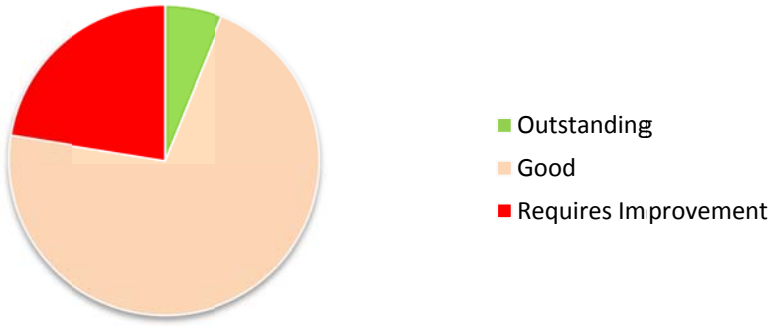
- 23 (47%) to community teams;
- 26 (53%) to bedded units.

Of these:

- three teams (6%) were given an overall rating of 'outstanding';
- 35 teams (71%) a rating of 'good'; and
- eleven teams (23%) a rating of 'requires improvement'.

None of the teams visited were given a rating of 'inadequate'.

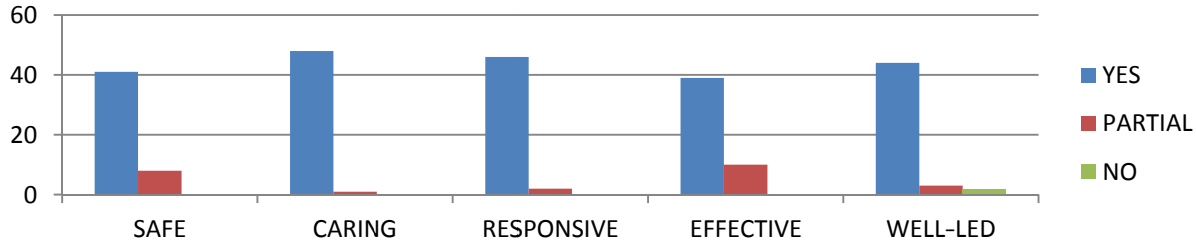
Figure 1: Overall Judgement



In regard to the 5 key CQC questions (safe, caring, effective, responsive, well-led):

- 41 teams (84%) were judged to provide safe care. For 8 teams (16%) there were some aspects related to safety questioned.
- 48 teams (98%) were judged to be caring. For 1 team (2%) there were some aspects related to caring questioned.
- 46 teams (96%) were judged as responsive. For 2 teams (4%) there were some aspects related to responsiveness questioned.
- 39 teams (80%) were judged to be effective. For 10 teams (20%) there were some aspects related to effectiveness questioned.
- The visit team concluded that well-led factors (both at team and organisational level) applied positively for 44 teams (90%). For 3 teams (6%) there were some aspects related to the well-led category that were questioned. For 2 teams (4%) a number of factors led to the visit team stating 'no' against the well-led category.

Figure 2: Judgements against the 5 key questions



There were a range of visit team responses covering areas of good practice and areas of concern (see Table 1 and Figures 3 & 4 below). In regard to good practice the largest number of comments for community teams fell within the 'Well-Led' category (31%). For bedded units a majority related to the 'Responsive' category (35%). The largest number of responses in relation to identified concerns for both community teams (41%) and bedded units (40%) fell in the 'Well-Led' category.

It is notable that the 'Caring' category attracted very few comments of concern for bedded units (3%) and none at all for community teams. In a post-Francis period this reflects very positively on the trust in terms of our ensuring that service users do not experience a lack of care, compassion or respect.

Table1 Comments	**GOOD PRACTICE Number of responses**					**CONCERNS Number of responses**				
	Safe	**Caring**	**Responsive**	**Effective**	**Well-led**	**Safe**	**Caring**	**Responsive**	**Effective**	**Well-led**
COMMUNITY	41 (18%)	18 (8%)	60 (26%)	39 (17%)	72 (31%)	44 (23%)	0	36 (19%)	32 (17%)	78 (41%)
BEDDED UNITS	71 (21%)	23 (7%)	119 (35%)	41 (12%)	84 (25%)	64 (23%)	8 (3%)	71 (26%)	20 (7%)	110 (40%)

Figure 3
Areas of Good Practice – Number of Visit Team Responses

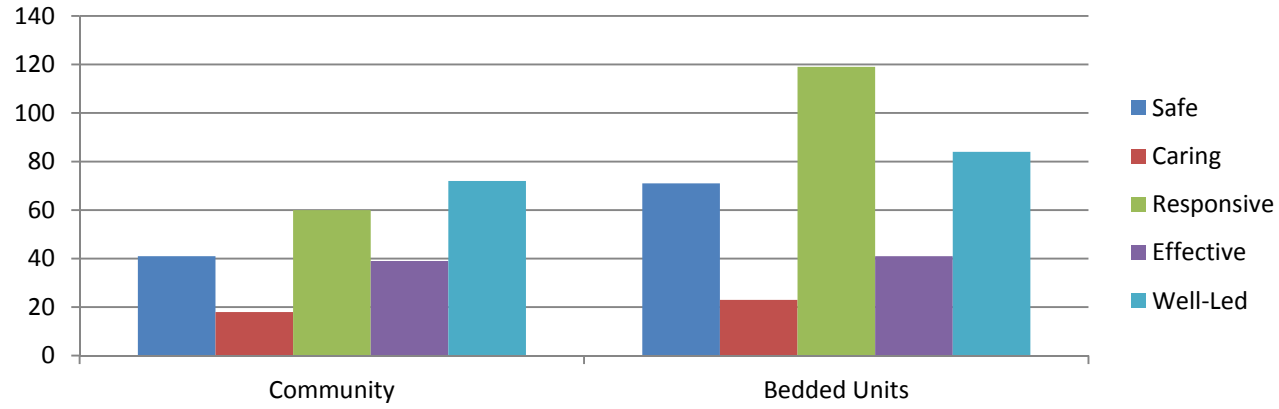
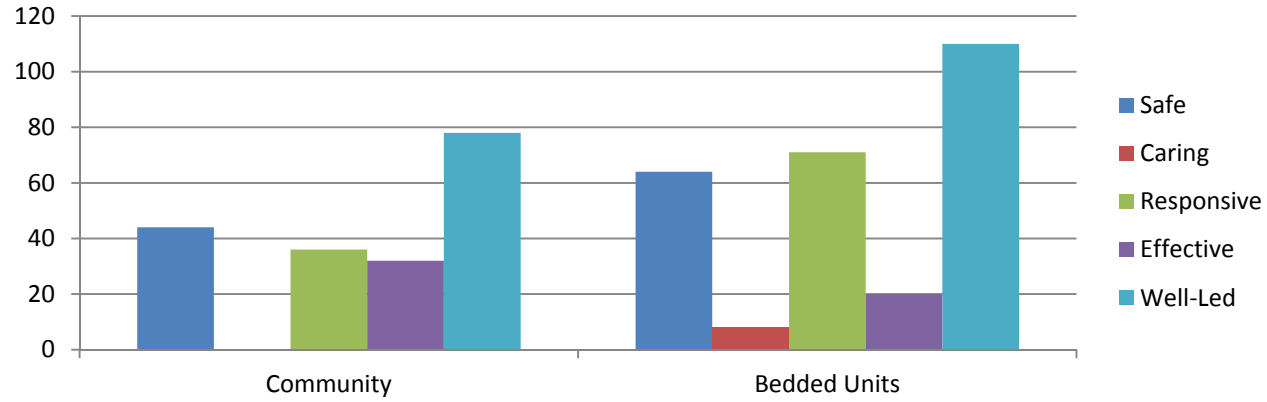


Figure 4
Areas of Concern – Number of Visit Team Responses



Some of the main areas of good practice and concerns specified by the visit teams are shown as table 2 below.

Variability between units is apparent in that the same categories of good practice for some teams are identified as concerns for other teams e.g. NICE awareness, understanding and application had both the largest number of positive findings and the largest number of negative findings across all bedded units. As an area for development BDUs might consider how to replicate the governance processes underpinning good practice in one unit across all teams.

Table 2: Main Areas of Good Practice and Concern

	GOOD PRACTICE		CONCERNS	
	COMMUNITY	**BEDDED UNITS**	**COMMUNITY**	**BEDDED UNITS**
SAFE	• Incident recording, reporting, review and learning • Safeguarding • Comprehensive/complete clinical records	• Incident recording, reporting, review and learning • Comprehensive/ complete clinical records • Understanding/application related to Mental Capacity, Deprivation of Liberty, the Mental Health Act and Duty of Candour	• Comprehensive/ complete clinical records • Incident recording, reporting, review and learning (including under-reporting of incidents) • Mixed/duplicate record systems (different electronic systems and mixes of electronic and	• Comprehensive/ complete clinical records • Incident recording, reporting, review and learning (including under-reporting of incidents) • Mixed/duplicate record systems.

	GOOD PRACTICE		CONCERNS	
	COMMUNITY	**BEDDED UNITS**	**COMMUNITY**	**BEDDED UNITS**
			paper records).	
CARING	• Dignity, respect and compassionate care • Care Plan	• Dignity, respect and compassionate care • Enabling Engagement.		• Dignity, respect and compassionate care.
RESPONSIVE	• Pathway transition, care coordination and care navigation • Service user involvement, engagement and feedback processes • Person centred care, care planning, choice and consent.	• Service user involvement, engagement and feedback processes • Range of activities and therapies offered • Person centred care, care planning, choice and consent.	• Service user involvement, engagement and feedback processes • Person centred care, care planning, choice and consent • Service user information.	• Pathway transition, care coordination and care navigation • Service user involvement, engagement and feedback processes • Range of activities and therapies offered
EFFECTIVE	• CQC Standards Self-Assessment • Clinical Audit • NICE	• NICE • Clinical Audit • Other Quality Improvement Processes	• Clinical Audit • NICE • Benchmarking, outcome measurement and performance monitoring.	• NICE • Clinical Audit • Benchmarking, outcome measurement and performance monitoring
WELL-LED	• Team meeting structures and processes • Supervision structures and processes • Appraisal completion.	• Training, development and induction • Team meeting structures and processes • Supervision structures and processes.	• Building, facilities and equipment • Supervision structures and processes • Training, development and induction.	• Building, facilities and equipment • Supervision structures and processes • Training, development and induction

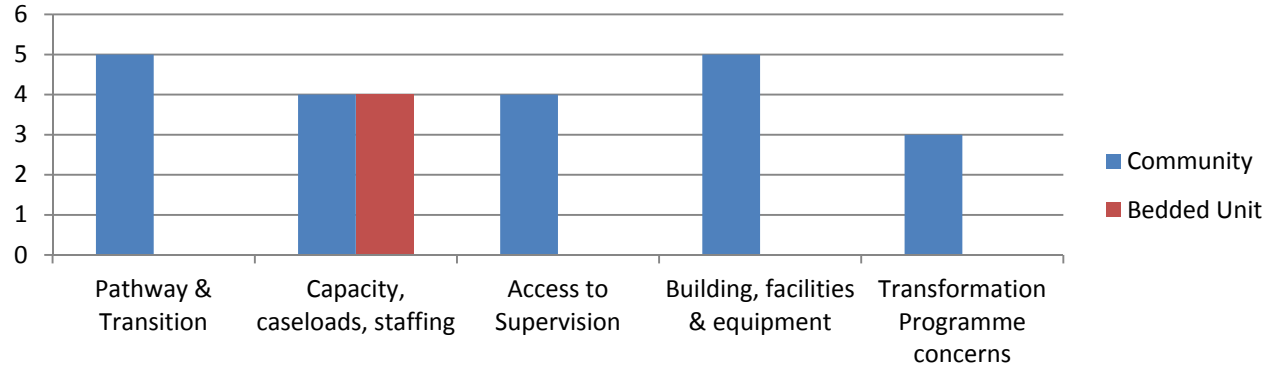
It is of interest that under areas of concern for both community teams and bedded units exactly the same three items in the same ranked order appears under the well-led category, these being concerns related to buildings, supervision and training.

Staff feedback

The main area of positive staff feedback for community teams was in respect of team culture and mutual support. For bedded units a majority of comments related to staff feeling that they offer compassionate and person centred care. The largest number of more negative staff comments in community teams related to pathway concerns and transition issues whereas in bedded units the comments were in regard to building, facilities and equipment concerns. The main areas of staff feedback are shown below as figures 4 and 5.

Figure 4: Positive Staff Feedback

Figure 5: Negative Staff Feedback



'best place I've ever worked'
'I am well supported by the team'
'one of the happiest teams I have been in',
'this team is a big asset for the trust'
'overall sense that we are all doing our best for our clients'
'We take a very person-centred approach'
'We always treat people as we would want to be treated and how they ask to be treated'
'Exemplary leader'
'The ward manager is really good'
'fantastic – best manager I have had – very approachable'
'I love it here … see people making progress'

'clinical note keeping is truly appalling .. want to bang heads together … lot of defensive practice'
'not fit for purpose'
'nursing office too small'
'layout of ward still too big'
'Need to do more on involving relatives'.

Service User & Carer feedback

The main area of positive service user feedback for both community teams and bedded units was being treated with compassion, dignity and respect. There were some negative aspects identified from community team service users related to services not being flexible enough to meet their needs. In bedded units visit teams specified the main negative service user experience factor to be that they did not have a copy of their care plan. However it should be noted that the feedback related to service users was overwhelmingly positive (90%) with very few negative responses especially in terms of statements made directly by the service users themselves. Main areas of service user feedback are shown below as figures 6 and 7.

Figure 6: Positive Service User Feedback

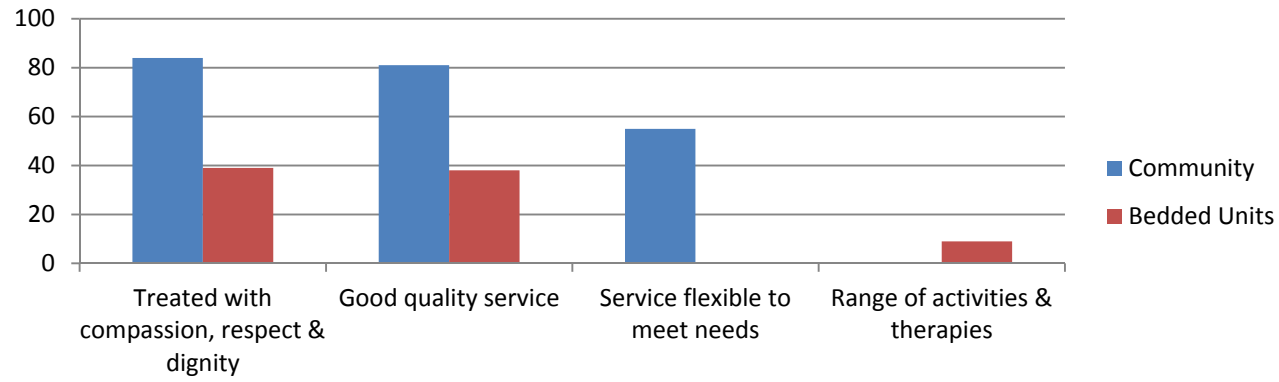
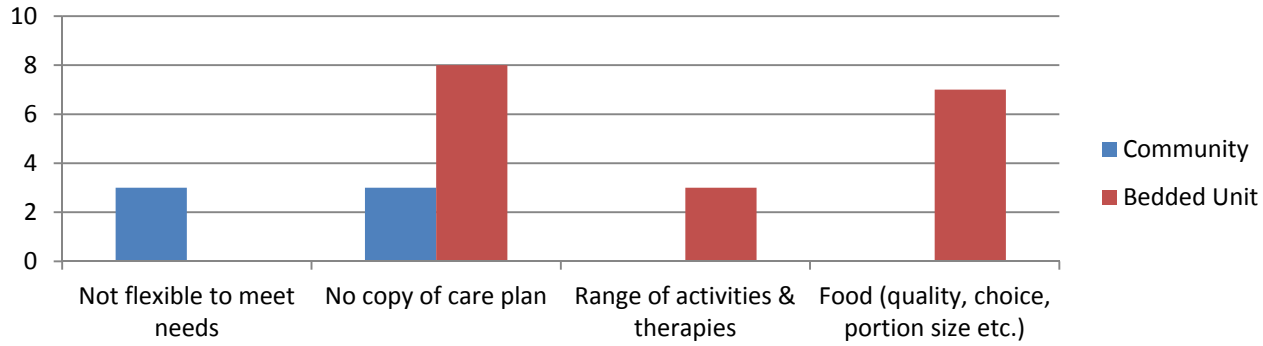


Figure 7: Negative Service User Feedback



'All 100% brilliant'
'doctors and staff have been amazing, I'm thankful for all the help I have been given'
'excellent service – totally non-judgemental not patronising. A positive experience all round'
'They created a network around me'.
'treated with respect from start to finish, was kept informed of process throughout, very pleased with service I received'
'care coordinator very supportive'
'Happy with care received'
'there is nothing I would choose to change'
'without exception all the staff are caring'
'Like my room, it has a shower in it, just for me, it's clean'
'very good with personal care'
'the service here is second to none, it's excellent and we can go away happy and content knowing that our daughter is safe and well looked after'

'the food's bland, not appealing'

Team/Ward Manager Comments

2014/15 was the first time that team and ward managers were asked to review the written feedback from visit teams and add their own commentary to this. (The visit team feedback was not altered; the team manager commentary was an additional section). It is pleasing to note that over half of the team/ward managers expressed very positive views about the visit in terms of it being a valuable learning experience.

Many team managers gave detailed responses to the points raised by the visit team which in themselves would constitute a plan of action. In some cases additional information was provided that the team manager believed addressed gaps in the visit team's awareness or provided an alternative explanation for some of the visit team findings. In some cases ideas were expressed as to how the visit team processes might be adapted and improved.

Some examples of team/ward manager commentary are shown below.

- *I will be meeting with all staff to look at each area of concern and develop an action plan to make the necessary improvements.*
- *The team found the CQC mock visit a useful experience and we have already started implementing some changes to our practice from the comments we received on the day of the visit from the visiting team.*
- *The inspection was a valuable learning experience and I welcome the objective overview of the service. The feedback received will be helpful to continue to improve and shape the service.*
- *Thank you to the inspection team for their comments and particularly for the thoughtful way in which they supported the client, partner and infant who formed part of this inspection.*
- *The visiting team were very thorough within their inspection, regarding their interviewing all available service users and staff members. The content of their questioning appeared very comprehensive and areas of improvement were felt to be 'fairly' highlighted. The amount of data /*

documentation viewed from our observation appeared limited. This was in part due to the inspector's lack of knowledge regarding the Rio system.

- *Thank you for the above report which has been shared with the Team and we agreed with the comments made and are using this as a learning opportunity and to bench mark against the CQC standards.*
- *Most of the concerns identified had been acknowledged by senior staff and we are trying to develop strategies to improve the area and address issues.*
- *The office door remains open so that the staff can hear if the office phone rings, however no confidential information is displayed and the notes cupboard is kept locked.*

Other Visit Team Comments

In some instances the visit teams added further comments which were often reflective and related to broader organisational controls such as: *The visiting team's overall impression was whilst the quality of care delivered is outstanding, the effectiveness is limited by issues outside the control of the immediate team. Some of these issues could be addressed by the Quality Academy providing more effective support to the frontline team. There may also be opportunities to release time for clinical care by providing better technology - e.g. tablets or smartphones to support clinical care and reduce the need for paper records.*

2015/16 PROGRAMME

The programme will consist of 37 visits to teams and units identified by the BDUs. The choice of teams has ranged from random selection, teams chosen because they have not been subject to any review process for some time, teams affected by transformation, teams believed to demonstrate good standards of practice and teams where some concerns have been raised. (In order not to conflict with the 2015/16 15 steps programme there are no visits scheduled in April 2015).

As a result of the experience gained in 2014/15 the visit team structure for the 2015/16 programme will be similar. Particular value was gained through the involvement of ward managers and team leaders including both the knowledge they brought to the process and the learning opportunities opened. Leaders were able to review ideas and consider how identified good practice might be replicated in their own working environment. The contribution and visibility of non-executive and executive directors via the visit programme has continued to be well-received and appreciated by the teams being visited. Together with senior managers the Directors bring an overview that is particularly helpful when considering how teams demonstrate organisational values. Visit teams in 2015/16 will therefore continue to be comprised from the following core members: Non-Executive Director, Executive Director, Senior Manager, Clinical Lead, Specialist Advisor, Practice Governance Coach, Ward Manager/Team Leader, Governance Lead/Coordinator. (An upper limit of 5 people per visit team unless special circumstances prevail).

The visit process itself will also not change significantly in 2015/16.

- Briefing sessions will be offered to those who participate as visit team members with explanatory material and relevant team information provided before each visit (such as numbers/types of complaints, incidents and mandatory training records).
- Information provided to the team being visited (pre-warning of the visit) will be given 24 hours before the visit for in-patient units and 1 week prior to the visit for community teams (to enable engagement of service users/carers and staff with the visit team and identification of documents/records for review).
- Visits will continue to be organised as half days (morning, afternoon or evenings). Although there are potential benefits from more intensive scrutiny over a longer period (matching more closely what might be expected on an actual CQC inspection) the time

demands on visit team members would make this logistically difficult with a resulting reduction in the number of teams visited.

- Visit team members will discuss care with service users and their carers, interview staff, observe practice, observe the clinical environment, review clinical and incident records as well as non-clinical records such as team meeting or service users group meeting notes.
- Verbal feedback will be provided at the end of the visit with written feedback sent to the ward/team manager to add comments prior to this being sent to the relevant BDU clinical/managerial trio and BDU Deputy Director/Director.
- BDU governance groups will be expected to ensure appropriate identification, monitoring and implementation of any required action.
- Anonymised versions of all the feedback forms will be accessible on the intranet to facilitate shared learning.

One main difference in 2015/16 is that visits will be based around specific questions developed from the Key Lines of Enquiry (KLOEs) used by the CQC when undertaking their comprehensive inspections. For each KLOE approximately 80 trust visit questions have been identified, some of which will more naturally be addressed via examination of care records, some by talking to service users and carers, some from observation and others from staff interviews. For each visit there will be a further selection down to what are felt to be the most pertinent 10-20 questions for the team/unit being visited (there will not be the time available to cover all 80 questions on a half day visit). However it is believed that the range of KLOEs explored for the Trust visits will be robust enough to enable visit teams to form a judgement against each of the 5 critical questions identified by the CQC.

A further difference in 2015/16 will be the way in which the judgement is reached against the 5 key areas (safe, effective, caring, responsive, well-led). The visit team will assess each of the 5 elements separately against the 4 point scale used by the CQC before reaching an overall judgement. To assist them visit teams will be provided with the CQC descriptions of *outstanding, good, requires improvement* and *inadequate* under each of the 5 areas. Visit teams will use the CQC framework shown as Table 3 below to assist their decision making as to the overall judgement. The team findings will be shown as indicated in Figure 8 on the feedback form. Should the visit team determine that a team's performance is *'inadequate'* (serious concerns) relevant BDU and organisational leads will be immediately apprised of the concerns in order that swift and effective remedial action is taken.

Table 3: CQC JUDGEMENTS

If one or more of the underlying ratings is inadequate then the aggregated rating is normally limited to requires improvement
If two or more of the underlying ratings is requires improvement then the aggregated rating is normally limited to requires improvement
If two or more of the underlying ratings is inadequate then the aggregated rating will normally be inadequate
At least two of the five ratings will need to be outstanding before a rating of outstanding can be awarded

Figure 8: VISIT TEAM FEEDBACK

5 KEY QUESTIONS		**INADEQUATE**	**REQUIRES IMPROVEMENT**	**GOOD**	**OUTSTANDING**
Is the unit/service **Safe?**	People are protected from abuse and avoidable harm				
Is the unit/service **Effective?**	People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence				
Is the unit/service	Staff involve and treat people				

5 KEY QUESTIONS		INADEQUATE	REQUIRES IMPROVEMENT	GOOD	OUTSTANDING
Caring?	with compassion, kindness, dignity and respect				
Is the unit/service **Responsive to people's needs?**	Services are organised so that they meet people's needs				
Is the unit/service **Well-led?**	The leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation and promotes an open and fair culture				

The overall impression of the unit is:			
Inadequate ☐	**Requires Improvement** ☐	**Good** ☐	**Outstanding** ☐

Trust Board 28 April 2015
Agenda item 8.3(iv)

Title:	**Review of Standing Orders, Standing Financial Instructions, and Scheme of Delegation**
Paper prepared by:	Deputy Chief Executive /Director of Finance
Purpose:	The purpose of this paper is to outline the process for the review of the Standing Orders (SO), Standing Financial Instructions (SFI) and the scheme of delegation.
Mission/values:	External evidence suggests that organisations with good governance save lives and have better outcomes. The SO, SFI and scheme of delegation are key elements of the Trust governance architecture and, therefore, support the overall mission and values.
Any background papers/ previously considered by:	This paper builds upon the presentations to Board of 'How the organisation runs' during 2015/16.
Executive summary:	The Standing Orders, Standing Financial Instructions and Scheme of Delegation are a key element of the governance framework of the organisation. Together they describe the processes by which the use of resources is managed and what controls are in place to ensure proper accountability and compliance with regulations, for example, procurement legislation. In addition, the scheme of delegation describes the framework for decision-making so, for example, what decisions are reserved for Trust Board, what the financial threshold is for investment decisions that can be made by the Chief Executive and what is reserved for Trust Board. In the past, the review of these documents has been a technical governance review which has been managed through the Audit Committee. With the exception of a small number of changes to address logistical and practical considerations, there has not been a major review of SFI, SO and scheme of delegation since the transfer of services through Transforming Community Services (TCS). Part of the reason for this is that the management structures for the organisation have been re-designed over the last four years and establishment of a robust scheme of delegation requires clarity, transparency and consistency around management structures . The development over the last year of the operational 'trios' and the deputy director posts in BDUs has enabled a much clearer definition of clinical leadership and operational management linked to delivering quality. The adoption of the micro/meso/macro methodology to describe how a complex organisation operates also provides an important context and framework for the consideration of the SO, SFIs and scheme of delegation. The review of the governance documents will, therefore, consider not just "what is permissible" but also "how we do it" consistent with the mission, values and principles outlined in 'how the organisation works'. The revised governance documents should provide the following. • Clarity on those things that require compliance and, therefore, are not

	negotiable, such as, compliance with tendering procedures and ensuring appropriate authorisation or escalation. • Alignment with the operational reality, that is, the way the business works so that creation of bureaucracy is avoided and the Trust has appropriate risk taking and accountability arrangements. • Creation of a framework for decision-making based on principles rather than rules to enable a service line management approach to devolve decision-making and accountability for use of resources to the front line and allow autonomy for the development of services to meet local needs through BDUs that are aligned with strategic intent and corporate accountability. This approach requires the exercise of judgement and, therefore, a pre-requisite is that staff who have delegated authority have the appropriate information, skills, knowledge and training to carry out what is being asked of them. • Enable clarity of roles and responsibilities between the Quality Academy and BDU senior managers and staff. The review will be carried out over the next six months and report back to Trust Board in October 2015. Key activities in the process will be: - quarterly time out with EMT and Deputy Directors to explore the schemes of delegation and ways of working; - alignment of the content with the Leadership and Management Strategy (May 2015) and the application of the micro/meso/macro model; - alignment with the design and completion of objectives for 2015/16; - alignment with investment appraisal framework; - alignment with the development of service line reporting; and - work programme through the Executive Management Team.
Recommendation:	**Trust Board is asked to raise any issues for clarification and APPROVE the approach and timetable for reviewing the standing orders, standing financial instructions and scheme of delegation.**
Private session:	Not applicable

Trust Board 28 April 2015
Agenda item 9.1

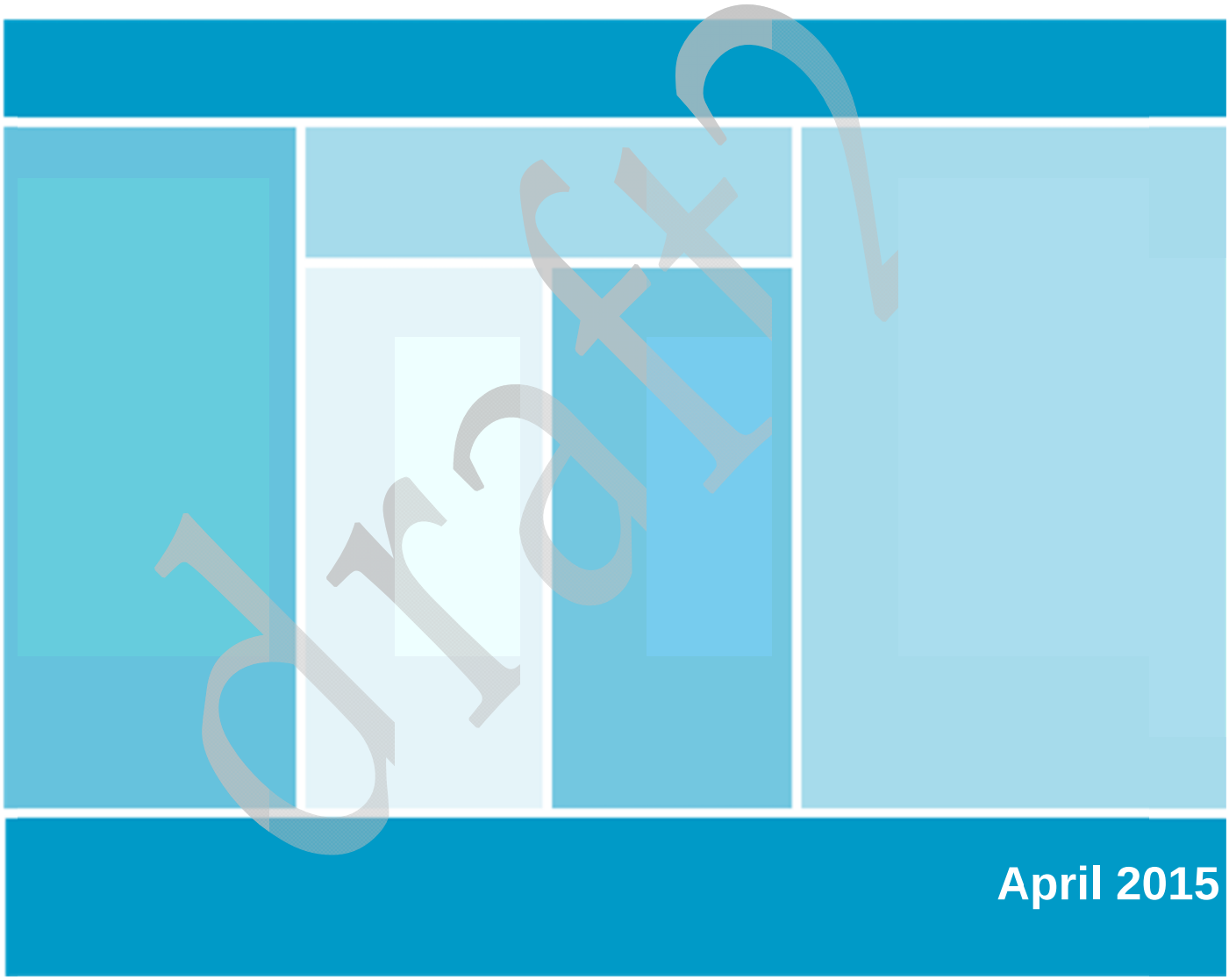
Title:	**Patient Safety Strategy and Sign up to Safety improvement plan**
Paper prepared by:	Director of Nursing, Clinical Governance and Safety
Purpose:	For Trust Board to approve the content of the Patient Safety Strategy, to note the Sign up to Safety Improvement Plan and to approve submission to national Sign up to Safety Campaign for review and feedback.
Mission/values:	Honest, open and transparent, person first and in the centre, and improve and be outstanding
Any background papers/ previously considered by:	The Trust has consulted on its Patient Safety Strategy following support for the outline strategy by Clinical Governance and Clinical Safety Committee. The responses to the consultation have been considered in the production of this final draft. The Sign up to safety improvement plan, which is a deliverable of the strategy, has been approved by the Executive Management Team and sent to the national lead for comment. This has received a very positive response.
Executive summary:	<u>Patient Safety Strategy</u> The Trust has developed the Patient Safety Strategy to build on existing robust governance processes. The strategy sets out the national context and current position in brief and in detail our goals to improving patient safety further and to re-focus the existing resources. The aims are to:- 1. Improve the safety culture throughout the organisation whilst supporting people in their recovery journey. 2. Reduce the frequency and severity of harm resulting from patient safety incidents. 3. Enhance the safety, effectiveness and positive experience of the services we provide. 4. Reduce the costs both personal and financial associated with patient safety incidents. The strategy links with other key pieces of work such as Sign up to Safety and suicide strategy. It includes the five key pledges the Trust has signed up to and the goals we will work with. The strategy will be supported by a three-year implementation plan and will be monitored through a new patient safety strategy group. The Clinical Governance and Clinical Safety Committee will receive annual reports on progress. The strategy is challenging but closely linked to the Trust vision, values and goals. There will be resource implication both in terms of staff being supported to do some things differently, for example, to develop skills in understanding the economics of harm and some invest to save to reduce the harm in care provided, for example, considering the use of universal precautions for pressure ulcers. These will be presented in business cases as these arise. <u>Sign up to Safety implementation plan</u> Sign up to Safety is a new national patient safety campaign which has the aim of strengthening patient safety in the NHS and making it the safest healthcare system in the world. The Trust has embraced this opportunity and signed up

	to the campaign. This document describes the background to the initiative and the steps we are taking to put it into action locally. This safety improvement plan will highlight key areas in which we will commit to reducing avoidable harm in accordance with our patient safety strategy and in collaboration with Yorkshire and Humber Academic Health Sciences Network and the newly formed Yorkshire Patient Safety Collaborative. We have identified five key areas where we want to significantly reduce avoidable harm. These are: 1. Falls 2. Medication omissions 3. Pressure ulcers 4. Prone restraint 5. Injuries following physical restraint The safety improvement plan will be monitored through the patient safety strategy group. Each key area has a lead to drive forward the improvement with the support of the Business delivery units and the quality academy teams supporting. The National Sign up to Safety campaign has offered to review the Trust's plan and feedback before it is formally submitted and placed on the Trust's website.
Recommendation:	**Trust Board is asked to:** - **APPROVE the Strategy;** - **NOTE the Trust's Sign up to Safety improvement plan; and** - **APPROVE submission of the plan for review and feedback**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Patient Safety Strategy 2015



Patient Safety Strategy 2015

"Culture will trump rules, standards and control strategies every single time, and achieving a vastly safer NHS will depend far more on major cultural change than on a new regulatory regime"

Professor Don Berwick

Introduction

The Trust is committed to providing high quality, safe, effective and accessible care, so that users of our services are fully enabled to reach their potential and live well in their communities.

Delivering services safely is our key priority. The Francis[1] and Berwick[2] reports have highlighted how avoidable harm has been, and remains, a significant problem in the provision of health care. This patient safety strategy sets out how we intend to keep patient safety at the forefront of care, ensuring that all of our staff embrace a positive patient safety culture, that we are proactive in preventing harm and that we are open and honest with patients and carers when harm has occurred.

We will ensure that improvements in patient safety are driven by strong leadership and supported by robust governance arrangements. We will maintain monitoring and reporting systems which accurately record incidents where harm has or could have occurred and ensure that patients and carers can readily report concerns about safety.

We will be open and transparent with patients and carers, the public, commissioners of our services and monitoring bodies where harm has occurred.

We will strive to learn lessons from incidents and, crucially, make changes to reduce the likelihood of recurrence. We will foster a culture where local services are encouraged to find solutions to problems relevant to their service, supported by leaders within the service. Where lessons learned are relevant across the whole Trust we will ensure that these are disseminated and result in changes to practice.

Personal and public safety need to be balanced with patient autonomy and choice. Avoiding all possible risks can be counterproductive, impeding recovery and diminishing hope. The Trust is committed to defensible positive risk taking in partnership with patients and their carers to enable them to safely live their lives to their full potential, still managing risks to reduce the likelihood of harm. This can lead to greater independence, choice, support and recovery, while fostering hope and avoiding restrictive practices and unnecessary interventions.

The Trust has embraced the national *Sign up to Safety*[3] initiative and will develop a specific safety improvement plan, to be implemented over 3 years. This plan will highlight key areas in which we

[1] Francis, R. (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: The Stationery office.
[2] Berwick, Don A promise to learn– a commitment **to** Act August 2013 DOH

[3] http://www.england.nhs.uk/signuptosafety/

will commit to reducing avoidable harm. Our progress against this plan and other measures of patient safety will be publicly available.

This strategy sets out in detail our goals towards improving patient safety. It will lead to a more detailed action plans as to how we will achieve these goals.

Aims of the Strategy

In response to the *Berwick Report* and '*Sign up to Safety'* but also consistent with the Trust mission and values, this strategy has been developed to:

1. Improve the safety culture throughout the organisation whilst supporting people in their recovery journey.
2. Reduce the frequency and severity of harm resulting from patient safety incidents.
3. Enhance the safety, effectiveness and positive experience of the services we provide.
4. Reduce the costs both personal and financial associated with patient safety incidents.

Current position

The Trust views patient safety as a key priority and has leadership and governance structures in place to ensure that this translates into safe clinical practice (Appendix 1). If we are to improve patient safety it is important that we first of all take stock of our current position.

The Board is ultimately accountable for ensuring that patients are cared for safely. Safe care also depends on effective leadership in clinical services supported by strong financial management, human resources, procurement and estates management.

A robust governance structure[4] is in place to monitor patient safety incidents, the Board ultimately receiving assurance on performance, risks and associated action plans through the Clinical Governance and Clinical Safety Committee. Internal reviews based on Care Quality Commission standards and expectations enable dialogue with individual teams about how they are performing. The Trust has existing and new work strands to support performance, for example Francis steering group, clinical audit and practice effectiveness group and NICE guidance steering group.

Individual service lines each have a clinical lead, service manager, and practice governance coach in place, providing a firm leadership base upon which services can build, to improve patient safety close to the point of delivery of care. Business delivery units each hold governance meetings at which patient safety related issues, incidents, trends and associated action plans are monitored. Practice governance coaches are integral to the sharing of lessons learned, whether from serious or more minor incidents, implementation of best practice and encouraging frontline clinical staff to keep patient safety uppermost in their minds.

The Trust has a well-established framework for reporting of incidents, both nationally and to commissioners locally. It is supported by a dedicated patient safety support team, led by an

[4] The Trust governance structure is appended to this document.

assistant director. The team works to meet statutory and contractual requirements in relation to incident management, providing reports to the Board, clinical commissioning groups and internally to committees, specialist advisers and business delivery units as needed.
Consultant psychiatrists have ready access to a dashboard in real time, highlighting the frequency and severity of incidents involving service users under their care, which can be interrogated in fine detail to help identify and address emerging patterns.

A range of specialist advisers lead on key areas involving the safe delivery of care, including child and adult safeguarding, tissue viability, management of violence and aggression, infection control, manual handling ,medical devices and medicines safety officers and health and safety.

There is a robust system of investigating incidents depending on severity, including a dedicated team of investigators to review serious incidents, utilising the clinical skills of consultant psychiatrists (and co-opted experts where necessary) to make an objective analysis of the care provided. Each investigation leads to a thorough report, highlighting good practice, any care and service delivery issues, underlying contributory factors and making corresponding recommendations to change practice where necessary. All serious incidents are followed by a learning event for the team involved, although it can often be a challenge to ensure that lessons learned reach frontline staff across the whole service. In order to streamline it further, the investigation process from initiation to approval of the incident report and action plan at board level is currently being reviewed.

We aim to recruit the right staff through value-based recruitment. Supervision and appraisal are integral to staff development and to identifying problems in practice. We strive for a just culture, where staff, patients and carers are treated fairly, with empathy and consideration when they have been involved in a patient safety incident or have raised a safety issue.

We are keen to support and implement new initiatives linked to patient safety and have joined the national *Sign up to Safety* campaign aimed at reducing harm to patients. We have links to the Yorkshire and Humber Academic Health Sciences Network and the newly formed Yorkshire Patient Safety Collaborative, both aiming to improve patient safety through best practice and innovation. The medicines safety and medical devices safety officers are established and are linked with local and national safety officer networks.

We believe that patients are experts in care, and the experience of those who use our services, their families and carers is constantly sought and evaluated by the Trust. We work hard to ensure that patients and carers have a voice through collaborative care planning, dialogue groups and collect feedback from users of our services via a variety of methods including the friends and family test and discharge surveys. Patients and carers have an additional route to raise their concerns through the complaints/compliments process.

We take seriously our obligation to be open with patients and their families when things go wrong. Under our duty of candour we share with the relevant person when there has been a notifiable safety incident that has caused moderate, severe harm or death or prolonged psychological harms (more than 28 days). Where a serious incident has taken place, the Trust makes contact with patients and their families to provide support, to explain how we will investigate the incident, to ask about concerns they may have relating to the care provided and to subsequently share with them the report through a supported reading.

The Trust has worked hard to ensure that the ethos, structures and processes described here work together to keep patient safety at the forefront of care. However, in accordance with our

philosophy of continual quality improvement, and in response to recent local and national initiatives, we intend to build on this foundation in setting out a new patient safety strategy, with our five safety pledges at its heart.

Five pledges

1. Put safety first

Our pledge: We will develop a trust-wide patient safety strategy with the primary aim of preventing harm and making safety a priority for all staff.

Culture

We will strive to develop and foster a culture where:

- Safety is at the forefront of care and is everybody's business.
- Staff feel confident and supported to report incidents and concerns about safety.
- Safety plays a key role in routine care.
- Concerns about performance are managed justly, with a 'fair blame' approach.
- We will actively seek to learn lessons where incidents have occurred, whether or not harm has occurred.
- The Trust is open with its staff, patients, carers and the public about levels of harm and publishes information about this on a public website.
- People understand that providing care which is safe can also promote recovery

Reducing Harm

We will:

- Develop a three-year patient safety improvement plan, targeting key areas to reduce avoidable harm, which will include local and national priorities.
- Engage with the local community, patients and staff to ensure that the focus of the improvement plan reflects what is important to the community the organisation serves.
- Make the plan public and regularly update progress made against it.
- Develop mechanisms for staff and service users to work together to devise safety plans which focus on keeping people well and safe

Staffing

We will:

- Ensure that staffing levels are sufficient to support clinical needs and manage risks.
- Develop systems to ensure staffing levels are managed effectively to respond in a timely way to changes in clinical need and acuity.
- Those who provide care for and on behalf of the Trust to service users including volunteers will be supported by clear procedures to safeguard from abuse.

Strategy/Policy

We will:

- Develop a suicide prevention strategy that will link with and complement strategies developed by local authorities and partner agencies.
- Maintain our commitment to improving patient safety by ensuring that relevant policies are in place and implemented.

Environment

We will:

- Ensure developments to new and existing infrastructure are safe and fit for purpose.
- Work to modify ward areas to proactively minimise the risk of in-patient suicides, falls and pressure ulcers. Also providing safe clean care, zero tolerance on avoidable HCAIs
- Ensure patients have appropriate assessments, interventions and equipment to minimise the risk of development of pressure ulcers in their own homes.

Compliance

We will:

- Comply with standards set by external bodies such as Care Quality Commission, Monitor and NHS England.
- Proactively respond as necessary to national initiatives or publications involving patient safety.

Leadership/organisational structure

We will:

- Have in place a management framework capable of leading on the delivery and review of the patient safety strategy outcomes.
- Ensure that leadership throughout the organisation is underpinned by a focus on patient safety.
- Ensure that individual business delivery units (BDUs) and service lines will drive an active patient safety culture and local developments in safety improvements, under the leadership of medical clinical leads, service managers and practice governance coaches. BDUs will be able to clearly demonstrate how they are addressing patient safety.
- Maintain Trust-wide Action Groups (TAGs) and ensure they consider those elements of patient safety relevant to their function.

2. Continually Learn

Our pledge: We will foster a culture of learning from patient safety incidents and demonstrate real changes in practice as a result of this learning.

Training

We will:

- Provide patient safety related training to staff relevant to their role.
- Discuss patient safety during staff appraisals.
- Ensure patient safety is an active part of managerial and clinical supervision.
- Facilitate timely advice and supervision for staff related to any safety concerns.

Learning

- The Trust commits to learning from incidents regardless of severity and will:

    - Have a robust system of reviewing incidents.
    - Conduct investigations according to the severity of the incident, leading to the identification of learning points, recommendations and appropriate action plans.
    - Look for trends/themes emerging across incidents.
    - Prepare an annual report which includes lessons learned from incidents.

We will:

- Support individual business delivery units to actively deliver learning to frontline staff.
- Implement changes to improve safety based on national guidance e.g. medicines alerts.
- Demonstrate how lessons learned have made a difference to practice.
- Learn from serious incidents and share lessons with individual patients and carers.
- Utilise the comprehensive incident reporting system (Datix) to its fullest, ensuring that real-time data is available to those who need it within the organisation to identify and address patient safety issues

3. Honesty

Our pledge: We will be open with patient and carers when harm has occurred, share lessons learned and communicate what we've done to stop it happening again.

Patients and carers

We will ensure:

- Patients and carers have an easy and accessible way to report any concerns about safety.
- Patients and carers are able to find out what the Trust is doing about safety.
- Data about how the Trust compares with other services locally and nationally is readily available to the public.
- Safety plans are co-produced with service users and conversations take place about risk and recovery

Communication

We will:

- Tell patients and carers when harm has occurred in accordance with the principles of *Being Open* and our *Duty of Candour*.
- Implement, monitor and evaluate the *Duty of Candour.*

- Communicate openly in reporting incidents nationally through the National Reporting and Learning System and to bodies which commission and monitor services locally.

4. Collaborate

Our pledge: We will maintain and develop our links with key stakeholders and establish links with patient safety networks locally and nationally.

Partnerships

We will:

- Consult with key stakeholders, including patients, carers, statutory agencies, independent and voluntary sectors when new strategies or initiatives related to patient safety are being developed.
- Actively engage with regional and national bodies e.g. Academic Health Sciences Networks and Patient Safety Collaboratives.
- Share this strategy with commissioners of our services and we will work actively with them to achieve our patient safety aims.

5. Support

Our pledge: Patients, carers and staff will be offered support which meets their individual needs after untoward incidents.

We will:

- Ensure that there is a robust system to support individuals and teams affected by serious incidents.
- Offer support to patients and carers affected or harmed by incidents.
- Support staff to take therapeutic positive risks when appropriate.
- Provide approaches e.g. Safewards to help people manage safety proactively and in line with best evidence

Implementation and Evaluation

The strategy sets out our ambitions to improve the quality of care we provide and to make a positive patient safety culture central to everything we do. We will use both qualitative and quantitative information, feedback from key stakeholders and narratives from patients, carers and staff to achieve this. We recognise that meeting our aims may involve a refocusing of resources and that staff must be supported and valued in doing so.

The Trust will implement, monitor and evaluate progress made against the patient safety strategy by:

1. Identifying a Trust Board lead for the implementation, monitoring and evaluation of the strategy.

2. Monitoring and evaluating the strategy through the patient safety team and identifying a strategy co-ordinator.

3. Forming a dedicated steering group to include key stakeholders that will regularly monitor progress and evaluate outcomes; reporting to the Clinical Governance and Clinical Safety Committee.

4. Develop a SMART implementation plan that highlights short, medium and long term goals.

5. Identifying and securing additional resources and specialist advice.

6. Evaluating progress in reducing harm associated with *Sign up to Safety* indicators.

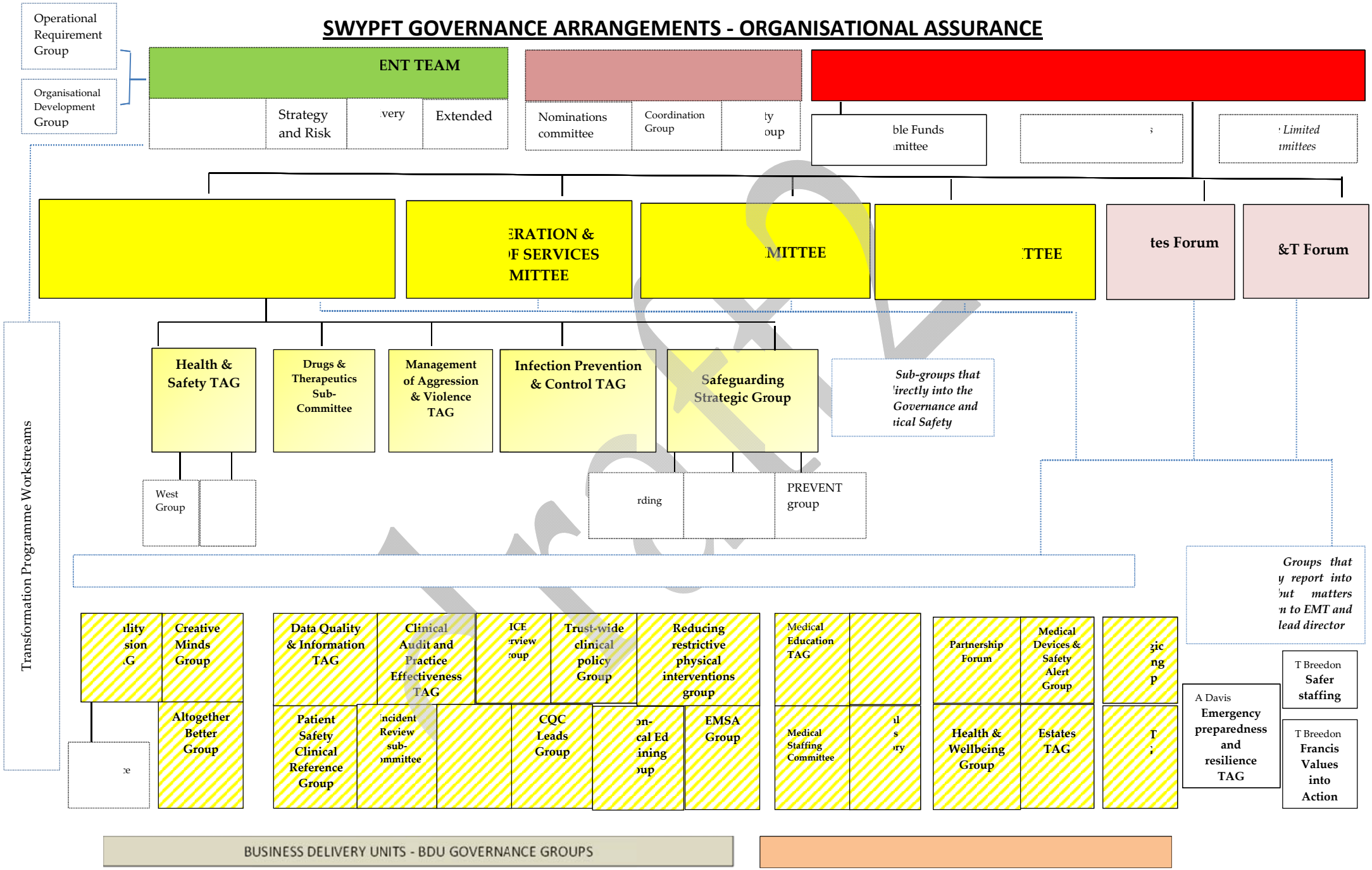
7. Measuring changes in the patient safety culture among staff and services.

8. Asking patients and carers about their experience and perception of safety.

9. Developing a system to measure the financial cost of untoward incidents and use this to evaluate progress made in reducing these costs.

10. Reviewing the nature and frequency of complaints.

SWYPFT GOVERNANCE ARRANGEMENTS - ORGANISATIONAL ASSURANCE



With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Sign up to safety

Safety improvement plan

March 2015

Sign up to SAFETY
LISTEN LEARN ACT

1. Introduction

Sign up to Safety is a new national patient safety campaign which has the aim of strengthening patient safety in the NHS and making it the safest healthcare system in the world. The Trust has embraced this opportunity and signed up to the campaign. This document describes the background to the initiative and the steps we are taking to put it into action locally.

2. Background

In 2014 the Secretary of State for Health set out the ambition of halving avoidable harm in the NHS over the next three years, and saving 6,000 lives as a result. This goal is supported by a campaign that aims to listen to patients, carers and staff, learn from what they say when things go wrong and take action to improve patients' safety, helping to ensure patients get harm free care every time, everywhere.

3. Campaign organisation and support

A national co-ordinating and support group has been established and the following national organisations have committed to system-wide support of Sign up to Safety:

- NHS England will provide expert clinical patient safety input to the development of improvement plans and framework for plan assessment. They will also play a key leadership role in the campaign and will ensure all their programmes of work described above are actively working to support the campaign.

- Monitor and the NHS Trust Development Authority will offer leadership and advice to trusts and foundation trusts who participate in Sign up to Safety and who will develop and own locally their improvement plans. They will also sign post to partner organisations for specific expertise where required.

- The NHS Litigation Authority which indemnifies NHS organisations against the cost of claims will review trusts' plans and if the plans are robust and will reduce claims, they will receive a financial incentive to support implementation of the plan. Any savings made in this way will be redirected into frontline care.

- The Care Quality Commission will support trusts signed up by reviewing their improvement plans for safety as part of its inspection programme. CQC will not offer a judgment on the plans themselves but consider them as a key source of evidence for trusts to demonstrate how they are meeting the expectations of the five domains of safety and quality.

- The Department of Health will provide Government-level support to the campaign and work with the Sign up to Safety partners to ensure that the policy framework does all it can to support the campaign and the development of a culture of safer care.

4. Involvement of South West Yorkshire Partnership NHS Foundation Trust

In joining the initiative the Trust makes a number of commitments:

- To set out the actions we will undertake in response to five Sign up to Safety pledges and agree to publish this on the organisation's website for staff, patients and the public to see.
- To turn proposed actions into a safety improvement plan which will show how the Trust intends to save lives and reduce harm for patients over the next 3 years.
- To identify specific patient safety improvement areas, taking into account national high priority issues and our own local needs.
- To engage with the local community, patients and staff to ensure that the focus of our improvement plan reflects what is important to the community the organisation serves.
- To make our plan public and regularly update progress made against it.

We have made five pledges:

1. *Put safety first*

We will develop a trust-wide patient safety strategy with the primary aim of preventing harm and making safety a priority for all staff.

2. Continually Learn

We will foster a culture of learning from patient safety incidents and demonstrate real changes in practice as a result of this learning.

3. Honesty

We will be open with service users and carers when harm has occurred, share lessons learned and communicate what we've done to stop it happening again.

4. Collaborate

We will maintain and develop our links with key stakeholders and establish links with patient safety networks locally and nationally.

5. Support

Service users, carers and staff will be offered support which meets their individual needs after untoward incidents.

6. Strategic perspective

This safety improvement plan will be delivered as part of SWYPT's new *Patient Safety Strategy*, which sets out in detail our goals towards improving patient safety and aims to:

1. Improve the safety culture throughout the organisation.
2. Reduce the frequency and severity of harm resulting from patient safety incidents.

3. Enhance the safety, effectiveness and positive experience of the services we provide.
4. Reduce the costs both personal and financial associated with patient safety incidents.

This safety improvement plan will highlight key areas in which we will commit to reducing avoidable harm in accordance with our strategy and in collaboration with Yorkshire and Humber Academic Health Sciences Network and the newly formed Yorkshire Patient Safety Collaborative.

7. Key areas for improvement and rational

We have identified five key areas where we want to significantly reduce avoidable harm. These are:

1. Falls
2. Medication omissions
3. Pressure ulcers
4. Prone restraint
5. Injuries following physical restraint

- **Falls**

Falls and related injuries are preventable. Across England and Wales, approximately 36,000 falls are reported from mental health units each year (NPSA 2010). A significant number of falls result in death, severe or moderate injury, at an estimated cost of £15 million per annum for immediate healthcare treatment alone (NPSA 2007). This is likely to be an underestimation of the overall financial burden from falls once the costs of rehabilitation and social care is taken into account, as up to 90% of older people who fracture their neck of femur never recover their previous level of mobility or independence.

In addition to these financial costs, there are other costs that are more difficult to quantify. The human cost of falling includes distress, pain, injury, loss of confidence and independence, as well as the anxiety caused to the person who falls, their relatives, carers, and healthcare staff.

Sign up to safety target set:-

To reduce frequency of falls by patients in an inpatient setting by 15% by 2018 while still undertaking positive risk.

Base figure 796 incidents (data 01.01.14 – 31.12.14)
15% reduction = 119

Target = 677 per year

Also reduce falls related injury moderate/severe and death by 10% by 2018
Base figure 17 incidents (data 01.01.14 – 31.12.14)
10% reduction = 2

Target = 15 per year

- **Medication omissions**

The NPSA issued a Rapid Response Report NPSA/2010/RRR009 in February 2010. Medicines are often omitted or delayed in hospital for a variety of reasons. For some critical medicines or conditions delays or omissions can cause serious harm or death.

Between September 2006 and June 2009, the NPSA received reports of 27 deaths, 68 severe harms and 21,383 other patient incidents relating to omitted or delayed medicines. Of the 95 most serious incidents, 31 involved anti-infectives (antibiotics and antifungals), and 23 involved anticoagulants.

Missed medicines can lead to:

- Treatment failure.
- Withdrawal or discontinuation symptoms
- Concordance issues.
- Disruption of therapeutic drug monitoring and misinterpretation of levels.
- Incomplete courses, return of symptoms.
- Side effects occurring on recommencement of treatment.
- Re-titration of dose being required which may prolong hospital stay or lead to need for re-admission.

Sign up to safety target set:-

To reduce unintended missed doses (i.e. doses omitted without clear documented clinical decision) by 25% (either not prescribed, dispensed or administered) by 2018. Baseline data needs to be collected.

- **Pressure ulcers**

Nearly 700,000 patients are affected by pressure ulcers each year. In relation to the National Reporting and Learning System a review of death and severe harm themes undertaken for 2011/2012 demonstrated that pressure ulcers were the largest proportion of patient safety incidents accounting for 19% of all reports. Hogan et al (2012) suggest that pressure ulcers are accountable for 2% of preventable deaths.

Pressure ulcers are often preventable and their prevention is included in domain 5 of the Department of Health's NHS outcomes framework 2014/15. NICE published their current guideline in April 2014 which rationalises the approaches used for the prevention and management of pressure ulcers. Its implementation will ensure practice is based on the best available evidence. It covers prevention and treatment and applies to all people in NHS care and in care funded by the NHS.

Sign up to safety target set:-

To reduce the frequency of incidence of new pressure ulcers attributable and avoidable to our care by 50% by 2018.

Base figure 159 (01.01.14 – 31.12.14 data)
Grade 2 = 112
Grade 3 = 38

Grade 4 = 9

Of the 159 incidents ------ are avoidable
To reduce avoidable incidents by 50%
Target _____

- **Prone restraint**

The Department of Health (DH) launched *Positive and proactive care: reducing the need for restrictive interventions* in April 2014. The guidance is aimed at promoting the development of therapeutic environments and minimising all forms of restrictive practices so they are only used as a last resort.

Mental Health Crisis Care: physical restraint in crisis published in June 2013 by Mind found evidence of significant variations in the use of restraint across the country. They raised concerns about the use of face down or 'prone' restraint and the numbers of restraint related injuries that were sustained.

Prone restraint can cause:

- Physical injury
- Psychological trauma
- Harm therapeutic relationships
- Prolong admission
- In extreme cases fatalities

- **Injuries following physical restraints**

The Department of Health (DH) launched *Positive and proactive care: reducing the need for restrictive interventions* in April 2014. It identified that there is considerable concern and controversy surrounding potential harm to individuals caused by restrictive interventions.
In some instances they have caused serious physical and psychological trauma, and even death. It goes on to say that all services where restrictive interventions may be used must have in place restrictive intervention reduction programmes which can reduce the incidence of violence and aggression and ensure that less detrimental alternatives to restrictive interventions are used. A reduction in the rate of injuries supports this approach.

Sign up to safety target set:-

To reduce incidents of restraint resulting in moderate/severe harm or death.

Baseline of all restraint incidents 1469 incidents (data 01.01.14 – 31.12.14)

15 severe /moderate harm
To reduce by 30 %
Target= 11/12

To reduce the number of prone restraint

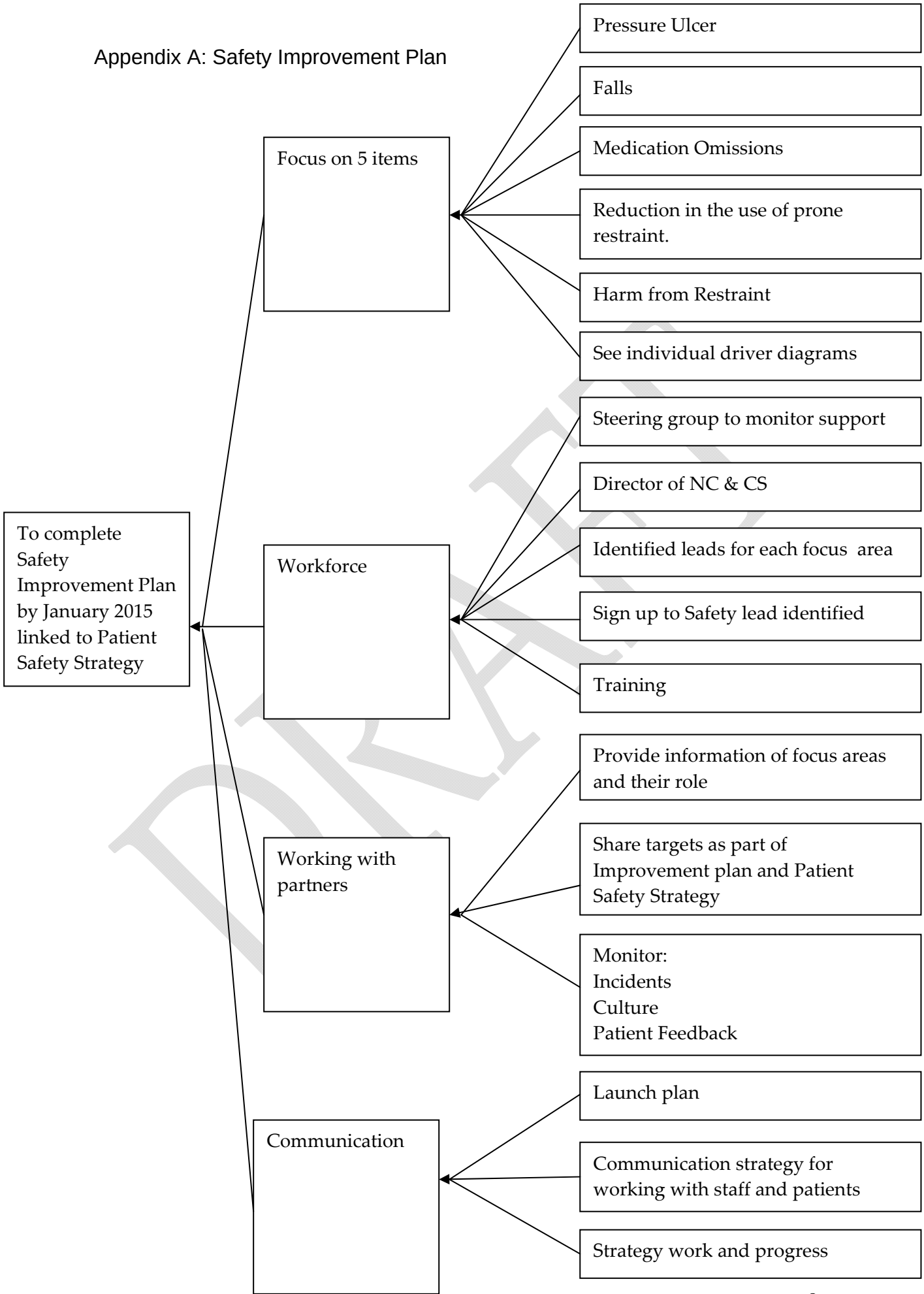
Baseline 365 incidents (data 01.01.14 – 31.12.14)

6 moderate harm – note this 6 is in the figure above.

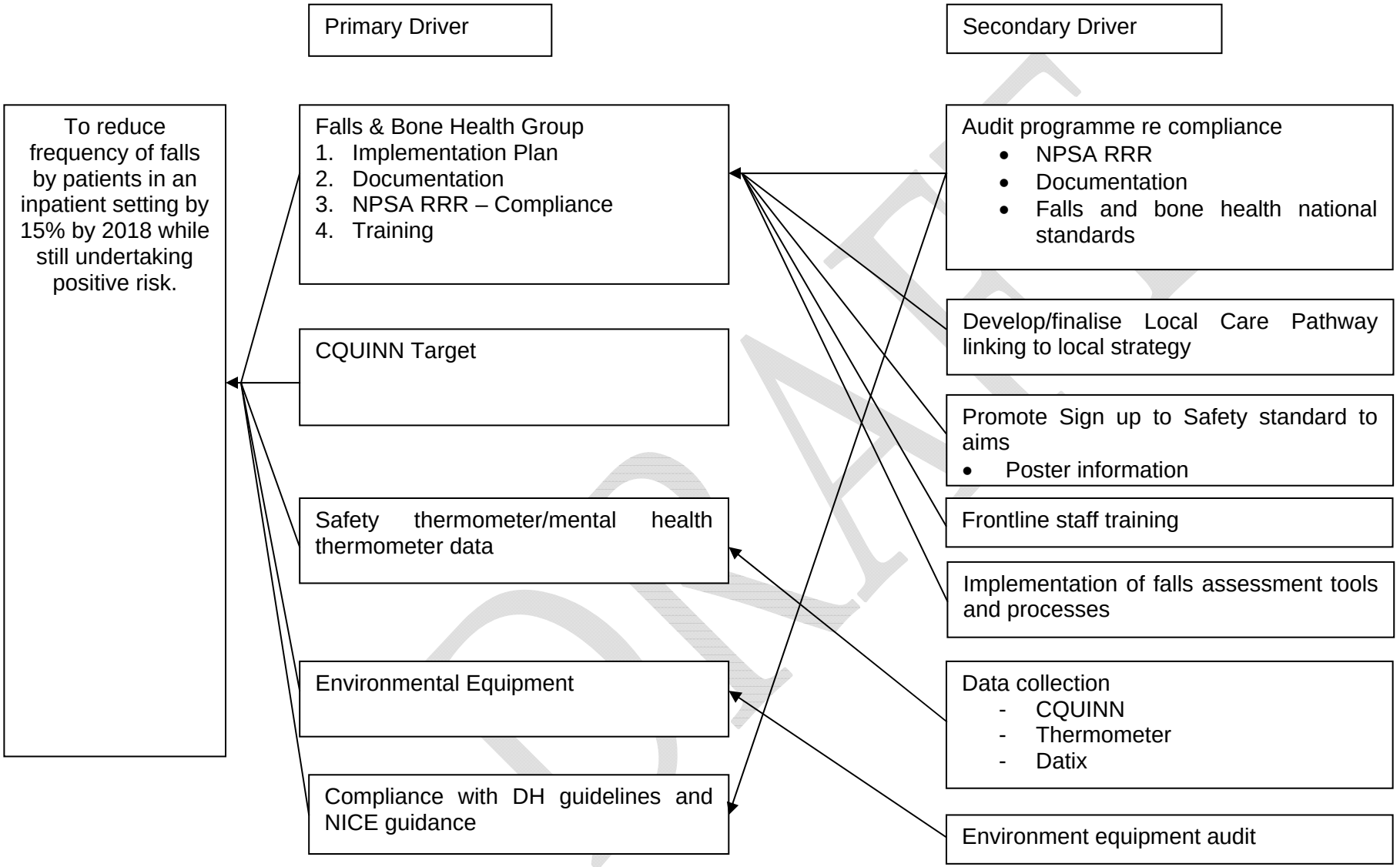
8. Implementation and monitoring

The safety improvement plan will be monitored through the patient safety strategy group. Each key area has a lead to drive forward the improvement with the support of the Business delivery units and the quality academy teams supporting.

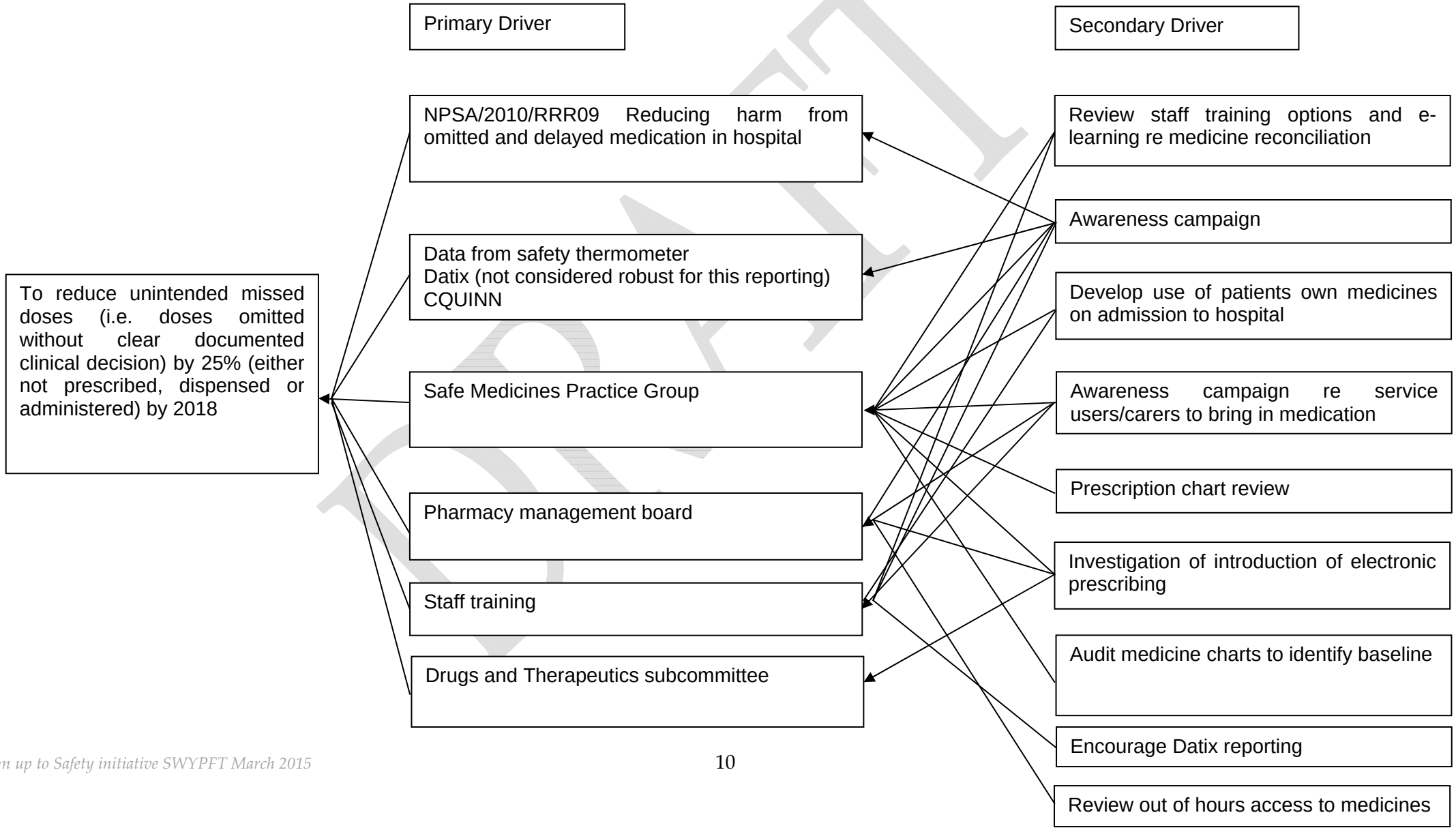
Appendix A: Safety Improvement Plan



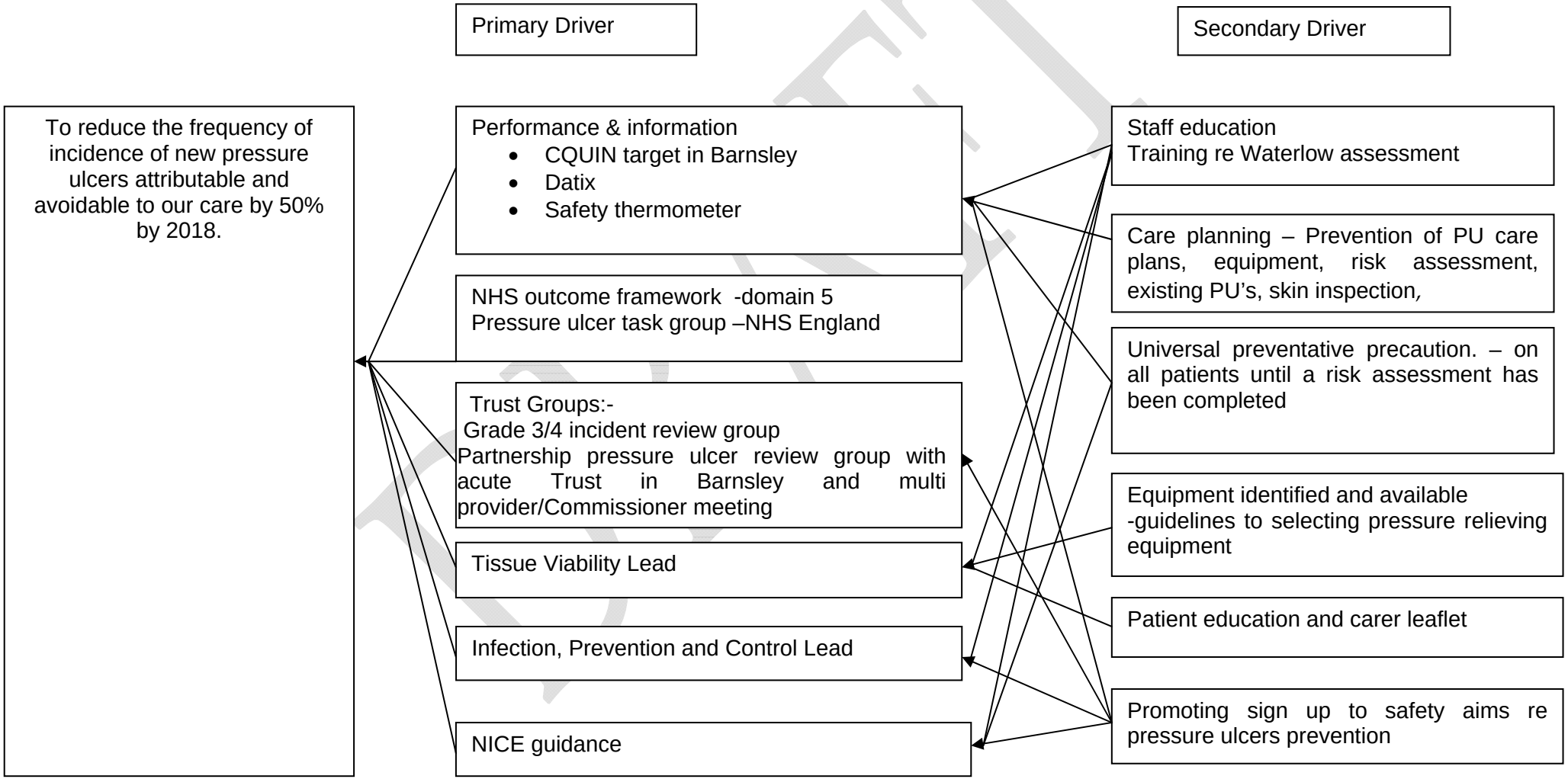
Appendix B: Falls Driver Diagram



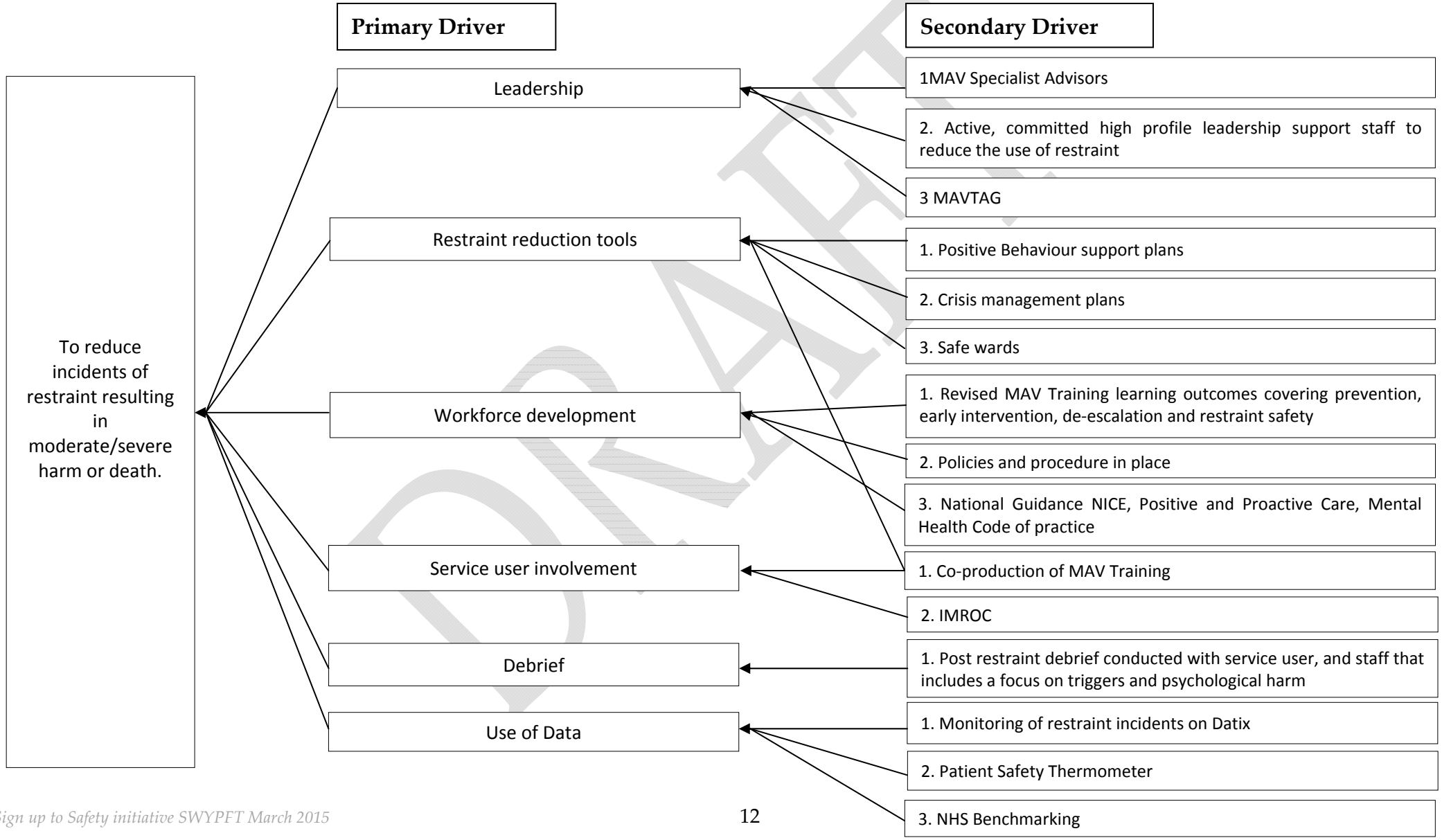
Appendix C: Medication Omissions Driver Diagram



Appendix D: Pressure Ulcers Driver Diagram



Appendix E: Restraint Driver Diagram



Trust Board: 28 April 2015
Agenda item 9.2

Title:	**Leadership and Management Development Strategy update**
Paper prepared by:	Director of Human Resources and Workforce Development
Purpose:	The paper is designed to provide Trust Board with an update on the strategic framework for leadership and management development to support the implementation of 'How the Organisation Runs'.
Mission/values:	A key element of the leadership and management development strategy is a valued based approach where leaders and managers are expected to model the values of the Trust.
Any background papers/ previously considered by:	The Leadership and Management Development Strategy underpins the Trust's implementation of 'How the Organisation Runs' part 2, which Trust Board received at its last meeting. The Remuneration and Terms of Service Committee has continued to review the development of leaders and managers as part of the new leadership and management arrangements detailed in 'How the Organisation Runs' part 1.
Executive summary:	Trust Board received a paper on and discussed the second phase of 'How the Organisation Runs' at its last meeting. The paper set out the Trust's ongoing organisational development approach to leadership and management across the organisation and builds on the learning from the partnership with the health community in Jönköping, Sweden. The Trust has invested a lot of time and resources in leadership and management development over the last twelve months to support the implementation of the first phase of 'How the Organisation Runs', examples of which include: ➢ Executive Management Team Development ▪ Frontline review and support to Quality Academy and BDUs ▪ Collective coaching model for EMT ➢ Deputy District Service Directors Development ▪ Collective and individual coaching support ➢ Trio (i.e. General Manager/Clinical Lead/Practice Governance Coach) Development at Service Line ▪ Development sessions and workshops for all Trios on roles and models for collective leadership ➢ Band 6/7 Development Programme ▪ Magnificent 7 programme with Huddersfield University ➢ Appointment of Head of Leadership and Management Development ▪ New post created to support the development and delivery of a strategic framework for leadership and management development The second phase of 'How the Organisation Runs' provides a greater understand of the system approach to leadership and management development in the Trust. It is vital to support this next phase of developing the Trust to ensure alignment of approach to leadership and management at all levels of the organisational system. The Leadership and Management Development Strategy is designed to provide a strategic framework which

	builds on the learning from the Swedish community and the activity detailed above to ensure we have the right leaders and managers to meet the challenges ahead. The Leadership and Management Development Strategy keys aims are to: ❖ develop the leadership and management capacity and capability to deliver safe, effective, caring and well led services; ❖ develop a valued based approach to leadership and management to support the Trust mission and values; ❖ ensure leaders and managers have the competencies to be successful in their role; ❖ actively support and encourage diverse leadership and management; ❖ support the development of talented leaders and managers and succession planning for key roles; ❖ develop a strong coaching and mentoring framework; ❖ exploit opportunities at regional and national level to support the development of leaders and managers within the Trust; and ❖ ensure effective engagement of the leadership and management community in the Trust's strategic goals and objectives. An important part of the Leadership and Management Development Strategy is recognition that effective leaders and managers require both the necessary competencies as well as demonstrating the values of the Trust. As part of the development process for the strategy, the Trust asked its internal auditor, KPMG, to provide support in the role as 'critical friend'. KPMG has completed the field work and the Trust is awaiting the report. The proposal is that the Leadership and Management Development Strategy will be part of the agenda for the strategic Board meeting in May 2015.
Recommendation:	**Trust Board is asked to NOTE the update and the proposal for Leadership and Management Development Strategy to be part of the agenda at May's meeting**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 28 April 2015
Agenda item 10

Title:	**Annual Governance Statement 2014/15**
Paper prepared by:	Chief Executive
Purpose:	The purpose of the paper is to seek Trust Board support for the Annual Governance Statement, which will be included in the annual report and accounts for 2014/15 and will be subject to independent audit by Deloitte as part of this process.
Mission/values:	A sound system of internal control supports the Trust's governance arrangements.
Any background papers/ previously considered by:	Guidance on completing the Annual Governance Statement is included in Monitor's Annual Reporting Manual and is based on Treasury requirements.
Executive summary:	All NHS organisations are required to have risk management, control and review processes in place, appropriate to their circumstances and business. All Foundation Trusts have to produce an Annual Governance Statement (AGS), which is included in the organisation's annual report and accounts and is externally audited, covering : - scope of responsibility; - the purpose of the system of internal control; - capacity to handle risk; - the risk and control framework; - review of economy, efficiency and effectiveness of the use of resources; - annual Quality Report; - review of effectiveness; - conclusion. Foundation Trusts are required to make disclosures or qualifications in the AGS about their risk management and review processes being in place for the full year, and gaps in assurance frameworks. The AGS must contain statements on compliance with and assessment against specified requirements and significant control issues for 2014/15. Organisations should ensure that they have evidence which they deem sufficient to demonstrate that they have implemented processes appropriate to their circumstances under each of the high level elements to support their AGS for 2014/15. The AGS has been produced in accordance with current guidance from Monitor. The Trust is required to include the narrative in blue in the Statement by Monitor as this follows HM Treasury guidance.
Recommendation:	**Trust Board is asked to approve the Annual Governance Statement for 2014/15.** Trust Board should note that the Statement may be subject to change following review by Deloitte as part of the audit of the Trust's annual report and accounts. As a consequence, **Trust Board is asked to delegate authority to the Audit Committee to approve a final version of the**

	Statement as part of its approval of the annual report and accounts on 22 May 2015, if necessary. The final version of the statement will be brought back to Trust Board in June 2015 as part of Trust Board's consideration of the annual report and accounts.
Private session:	Not applicable

Annual Governance Statement 2014/15

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of South West Yorkshire Partnership NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

My Annual Governance Statement reflects the challenges and changes facing the Trust over the past year. The complexity and diversity of the services the Trust provides and the geographical areas it covers presents a unique challenge, which is reflected in the Trust's approach to the management of risk.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of South West Yorkshire Partnership NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in South West Yorkshire Partnership NHS Foundation Trust for the year ended 31 March 2015 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust has robust arrangements and frameworks in place to ensure it has the capacity to handle and manage risk.

One of the Trust's continued strengths is the stability of its Board.

An experienced and long-standing Non-Executive Director came to the end of his term of office in May 2014. One of the key considerations for the Nominations Committee, which has devolved responsibility from the Members' Council to oversee and manage the process to appoint the Chair and Non-Executive Directors, is to ensure effective succession planning. As a result, the Committee supported the Chair's view that the recruitment process should focus on recruiting an individual who could replace the current Chair of the Audit Committee, who leaves office in 2015. The recruitment process was successful and supported by an external recruitment consultant to ensure transparency and independence. The Members' Council approved the appointment of a new Non-Executive Director who joined the Trust on 1 June 2014 and assumed the Chair of the Audit Committee on 1 January 2015. This has been a successful and smooth transition minimising any risk to the organisation.

The Members' Council also approved the re-appointment of one non-executive director for a further three-year term to continue to provide stability and strength within the Board.

The coming year may prove more challenging in terms of changes to Non-Executive Directors on the Board. The Board will lose twelve years of Non-Executive experience during 2015 and the Chair does not under-estimate the gap this may leave as the Trust enters another challenging year. A process has begun, through the Nominations Committee, to appoint two new Non-Executive Directors for approval by the Members' Council in April 2015.

Towards the end of the year, the Board approved the establishment of a non-executive director-led forum to focus on diversity and inclusion to address a potential area of risk. The two existing forums, focusing on estates, and information management and technology, have continued their work through the year. All three forums ensure the Trust's strategy is developed and implemented, and that risk is managed effectively.

During the year, the Trust's Medical Director indicated that she wished to retire. As Chief Executive, and in consultation with the Chair of the Trust, I initiated a recruitment process and handover, which was managed positively and effectively, resulting in the appointment of an experienced clinician and operational Director to take on the role. The new Medical Director's experience at Board level minimised any risk to the organisation at Executive Director level and demonstrates the Trust's ability to foster and utilise skills and experience at senior level.

During the year, the changes initiated in 2013 to the Director structure at operational level to ensure strong and effective strategic and operational management within each BDU whilst maintaining a strong local focus continued to develop. These were strengthened by the appointment of deputy directors to provide operational leadership and management, allowing BDU Directors to focus on building and managing strategic and partner relationships, and to lead the transformation agenda. Through 2014/15, this has been supported by arrangements at service line level to provide a framework where a clinical lead, general manager and practice governance coach work together and carry responsibility at ward, unit and department level to enact the service change required to achieve transformation.

Following an interim appointment at Director-level to cover service improvement, innovation and health intelligence, with the support of the Remuneration and Terms of Service Committee, I created a permanent post to provide a focus on health intelligence and innovation and, following a recruitment process, the interim appointment was made substantive.

Although I have adopted a prudent approach to Director-level appointments over the past year, in consultation with the Chair, the Trust is entering a difficult period to realise its plans for transformation and to deliver its service delivery and financial plans. In the coming year, the Trust Board structure will be reviewed to ensure it has the capacity, skills and experience in place within the parameters of its Constitution to support sustainability and ongoing fitness for purpose.

Trust Board continues to be ably supported by an involved and proactive Members' Council, which forms a key part of the Trust's governance arrangements. Since becoming a Foundation Trust in 2009, the Members' Council has gone from strength-to-strength in its ability to challenge and hold non-executive directors to account for the performance of Trust Board. The agendas for Members' Council meetings focus on its statutory duties, areas of risk for the Trust and on the Trust's future direction. The Trust continues to develop its approach to training and development to ensure governors have the skills and experience required to fulfil their duties in partnership with the Members' Council Co-ordination Group.

This year has seen the Trust lay the firm foundations for its ambitious transformational service change programme and associated structures to transform the way it delivers

services. The programme will ensure the Trust continues to deliver services that meet local need, offer best care and better outcomes, and provide value for money whilst ensuring we remain sustainable and viable. Implementation of this programme as well as maintaining delivery of high quality and safe services has, again, presented the Trust with its biggest challenge in 2014/15. Four workstreams provide the framework, covering mental health services, learning disability services, general community services and forensic services. Each has a Director sponsor and clinical lead and is supported by robust project management arrangements through the Project Management Office. Although the scale and pace has made it hard to effect and enact fundamental change during the year, the work to develop the framework holds the Trust in good stead to achieve the pace of transformational change needed during the coming year.

The strategic framework for the organisational development (based on "What really works: the 4+2 formula for sustained business success" (Nohria, Joyce and Robertson)) continues to support operational delivery. The model provides a framework for principal objectives to be agreed and set by the Board, underpinning the Board assurance framework and implementation objectives determined in line with key executive director accountabilities. These objectives are reviewed by me with individual directors on a quarterly basis. Any resulting amendments to the Assurance Framework are reported directly into the Trust Board including any changes to the organisational risk register.

In October 2014, I developed an articulation of 'How the Organisation Runs', which reiterated our mission and strategic objectives, and clarified the roles and responsibilities at every level to deliver continued success. This was followed by a second phase in March 2015, which sets out a clear and simple model to describe the systems we operate within and how they interact, enabling the organisation to run to best effect. The model is based on the work of Dartmouth Institute in the USA, most notably, Dr Gene Nelson, who, through our ongoing relationship with Jönköping County Council in Sweden, has provided the basis for this model.

The Trust works within a framework that devolves responsibility and accountability throughout the organisation by having robust service delivery arrangements. This year has seen further development and embedding of the BDU operational and governance arrangements, underpinned by service line management and currency development at service delivery level. Development work continues to progress, closely scrutinised by the Audit Committee.

BDUs are supported in their work by the Quality Academy, which provides co-ordinated support services linked to the accountabilities of executive directors. There are six key domains in the Quality Academy:

- financial management;
- information and performance management;
- people management;
- estates management;
- compliance, governance and public involvement; and
- health intelligence and innovation.

As 2014/15 saw the Trust enter a critical point in its development, I commissioned a review of the Quality Academy to ensure it is fit for purpose to support BDUs in the current challenging climate. The review made a number of sensible and constructive recommendations for the development of our approach and these will be taken forward where I believe they can make a difference.

The organisational development framework has allowed work to be tracked in terms of effectiveness and this has been developed further through regular review. From this Framework, a number of workstreams have been developed, launched and implemented to ensure the Trust has a workforce fit for the challenges in the future, such as the Talent Pool, the Magnificent 7 and a values-based recruitment, induction and appraisal programme.

The Trust continues to develop and create additional capacity in the community and different models of delivery and support for service users and carers through initiatives such as Creative Minds, joining the second phase of the Improving Recovery through Organisational Change (ImROC) initiative and developing recovery colleges across our districts, as well as continuing to host Altogether Better, a national initiative which supports development of community champions.

The training needs of staff in relation to risk management are assessed through a formal training needs analysis process and staff receive training appropriate to their authority and duties. The role of individual staff in managing risk is also supported by a framework of policies and procedures that promote learning from experience and sharing of good practice and is set out in the Risk Management Strategy, reviewed and approved by Trust Board on an annual basis. This is supported by risk management training for Trust Board, undertaken annually.

As Chief Executive, I have a duty of partnership to discharge, and therefore work collaboratively with other partner organisations. The Trust recognises that in the medium- and longer-term, services across the local health economy are unsustainable in their current form. Therefore, the Trust has to work in partnership with other organisations to ensure that services are provided in the most effective way and that the Trust remains sustainable and viable.

The Trust has sound and robust partnership arrangements with the four local authorities in Barnsley, Calderdale, Kirklees and Wakefield and the five clinical commissioning groups covering Barnsley, Calderdale, Greater Huddersfield, North Kirklees and Wakefield. Relationships have been fostered, developed and built on with commissioners. The Trust also has good working relationships with Local Area Teams at Director and senior management level. The relationship with the Secure Commissioning Group, covering the Trust's medium and low secure services, has again proved challenging during 2014/15 as national policy affects commissioning intentions locally. This has impacted on the Trust's forensic services, and maintenance of sound relationships locally is a critical factor in supporting the future success of these services.

All Executive Directors are fully engaged in relevant networks, including quality governance boards, nursing, medical, finance and human resources at local and regional level. Both the Chair and I attend national network meetings and I am the NHS Confederation elected Chief Executive representative on the Mental Health Network Board. I am also involved in the Care Quality Commission's new inspection process for mental health trusts, providing invaluable intelligence for the Trust.

As Chief Executive of the Trust, either I or nominated directors attend formal Overview and Scrutiny Committees in each of the local authority areas as requested and meet informally, on a regular basis, with the Chairs of each of the Committees to update on the Trust's strategic direction.

The risk and control framework

The Trust was awarded a Licence by Monitor on 1 April 2013 with no conditions. There are currently no risks to compliance with the Licence conditions that apply to the Trust, including

NHS Foundation Trust condition 4, which applies to Foundation Trusts only. An internal audit undertaken early in 2014, provided an opinion of substantial assurance on the arrangements that the Trust has in place for ensuring compliance with its Licence conditions, which supports assurance of the validity of the Corporate Governance Statement and is backed by a self-assessment at Board level of the arrangements the Trust has in place. This is supported by my Annual Governance Statement, risk management arrangements, and the Trust's annual plan. A review in early 2015/16 will include a risk assessment of the new licence condition in relation to integrated care.

Trust Board has the overall responsibility for probity (standards of public behaviour) within the Trust, and is accountable for monitoring the organisation against the agreed direction and ensuring corrective action is taken where necessary. Its attitude to risk is prudent and pragmatic, adopting a flexible approach to risk and determination of its response as the need arises. Trust Board acknowledges that the services provided by the Trust cannot be without risk and it ensures that, as far as is possible, this risk is minimised. The Trust does not seek to take unnecessary risks and will determine its approach and its appetite for risk to suit the circumstances at the time.

As Chief Executive, I remain accountable, but delegate executive responsibility to the Executive Directors of the Trust for the delivery of the organisational objectives, while ensuring there is a high standard of public accountability, probity and performance management. Central to this process of quality assurance has been the development of the Quality Academy. The personal objectives of each director have clear risk and assurance statements attached to them. The Assurance Framework reflects the strategic objectives assigned to the Executive Directors.

Agenda setting ensures that the Board can be confident that systems and processes are in place to enable individual, corporate and, where appropriate, team accountability for the delivery of high quality person-centred care. The cycle of Trust Board meetings continues to ensure that Trust Board devotes sufficient time to setting and reviewing strategy and monitoring key risks. Within each quarterly cycle, there will be one meeting with a forward-looking focus on centred on business risk and future performance, one meeting focusing on performance and one strategic development session. Trust Board meetings are held in public and the Chair encourages governors to attend each meeting.

Strategic risk is managed in line with the Trust's Risk Management Strategy, which was amended and approved by the Trust Board in January 2015 to ensure it remains fit for purpose. The strategy sets out specific responsibilities and accountabilities for the identification, evaluation, recording, reporting and mitigation of risk in accordance with the principle to reduce risk to as low a level as reasonably practical. The Trust's risk matrix sets out those risks which, under this principle, are tolerable from those which are unacceptable.

The Trust has an organisational risk register in place which outlines the key strategic risks for the organisation and action identified to mitigate these risks. This is reviewed on a monthly basis by the Executive Management Team (EMT) and quarterly by Trust Board, providing leadership for the risk management process. Risk registers are also developed at service delivery level within BDUs and within support directorates, again being subject to regular reviews in line with Trust's Risk Management Strategy and monitored monthly by EMT. This includes the opportunity to share concerns and good practice.

The Trust's main risks as set out in the organisational risk register are as follows.

1. 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. Mitigated by robust project management arrangements, engagement plans with commissioners and implementation plans reflected in contract monitoring agreed and in place, supported by the Data Quality Steering Group chaired by the Director of Nursing and BDU data quality improvement plans.

2. The volatile commissioning climate and its impact on the nature of the system of classification and associated currency currently under review could increase the level of risk for mental health services if cost and pricing mechanisms are not fully understood at local, regional and national level. Mitigated by established project management arrangements and formal working groups linked to commissioners in all areas, work on currency and benchmarking included in the mental health strand of the transformation programme to evidence benefits, and input and participation in Care Packages and Pathways programme nationally to share best practice, benchmark progress and support development.

3. Continued reduction in Local Authority funding and changes in benefits system will result in increased demand of health services due to a potential increase in demand for services and reduced capacity in integrated teams, which could create the risk of a negative impact on the ability of integrated teams to meet performance targets. Mitigated by dialogue with local authorities on solutions that maintain quality, participation in transformation programmes at system level to deliver improvements, creating opportunities to reduce reliance on the public sector through support for third sector providers, and development of the ImROC implementation plan in partnership with service users to promote recovery.

4. The planning and implementation of transformational service change through the transformation programme will increase clinical and reputational risk for delivery in-year through an imbalance of staff skills and capacity between the 'day job' and the 'change job'. Mitigated by additional resources and external consultancy recruited to support the transformation programme, and key deliverables reviewed and monitored by EMT.

5. The Trust's financial viability will be affected as a result of changes to national funding arrangements (such as clinical commissioning group allocation and the Better Care Fund) coupled with emerging intensified local acute Trust pressures. The risk of local re-tendering will increase the risk in the 2015/16 contracting round for the level of savings required to maintain financial viability with potential to fragment pathways and increase clinical risk. Mitigated through active engagement in system transformation programmes, engagement of expertise to ensure capacity is in place and robust EMT review of commissioner intentions and contract management.

6. Bed occupancy is above that expected due to an increase in acuity and admissions and is causing pressures across all bed-based mental health areas across the Trust. Mitigated through development and implementation of a revised Bed Management Protocol with robust monitoring across all BDUs and a clear escalation process and clinical leadership, and robust actions to manage patient flow.

7. The Trust has identified a lack of robust systems and processes to support safe practice within inherited children's and adolescents' mental health services, including timely access and responses, and appropriate clinical interventions, mitigated by development of a robust recovery plan based on best practice and compliance requirements with timescales in place for delivery and with strong commissioner involvement.

8. The ongoing requirement to reduce costs and meet commissioner QIPP will result in the Trust becoming unsustainable clinically, operationally and financially by year four of the

five-year plan. Mitigated by a tiered strategy to achieve sustainability, which assumes consolidation of pathways and efficiencies in existing services, substitution of current service models for recovery-based alternative service offers at lower cost, and strategic consolidation of key services to drive savings through critical mass.

The risks outlined above will continue into 2015/16 with mitigating action in place.

Innovation and learning in relation to risk management is critical. The Trust uses an e-based reporting system, DATIX, at Directorate and service line level, so that incidents can be input at source and data can be interrogated through ward, team and locality processes, thus encouraging local ownership and accountability for incident management. The Trust identifies and makes improvements as a result of incidents and near misses in order to ensure it learns lessons and closes the loop by improving safety for service users, staff and visitors. The Trust operates within a just, honest and open culture where staff are assured they will be treated fairly and with openness and honesty when they report adverse incidents or mistakes.

The Trust works closely with the National Patient Safety Agency (NPSA) patient safety manager and uses Root Cause Analysis (RCA) as a tool to undertake structured investigation into serious incidents with the aim of identifying the true cause of what happened, to identify the actions necessary to prevent recurrence and to ensure that the Trust takes every opportunity to learn and develop from an incident. The Trust has a number of Serious Incidents Investigators in place to provide capacity for, and independence in, undertaking investigations into serious incidents. The Trust also appointed Practice Governance Coaches to work within BDUs to learn lessons, implement best practice and address areas of weakness and development.

The Trust works hard to deliver the highest standards of healthcare to all its service users. The promotion of a culture of openness is a prerequisite to improving patient safety and the quality of healthcare systems. This communication is open, honest and occurs as soon as possible following a patient safety event. The Trust's duty of candour is taken extremely seriously and a robust approach is in place to ensure staff understand their role in relation to duty of candour, that they have the support required to comply with the duty and to raise concerns, that the duty of candour is met through meaningful and sensitive engagement with relevant people, and all staff understand the consequences of non-compliance.

The Clinical Governance and Clinical Safety Committee monitors the implementation of recommendations arising from external agencies, such as the Francis Report and the Government's response, and Winterbourne View, independent inquiries and external reviews until actions have been completed and closed. The Clinical Review Group, chaired by the Director of Nursing, provides an organisational overview of the incident review, action planning and learning processes to improve patient safety and provide assurance on the performance management of the serious incident review process, associated learning, and subsequent impact within the organisation.

The provision of mental health services carries a significant inherent risk, resulting, on occasion, in serious incidents, which require robust and well governed organisational controls. During 2014/15, there were 106 SIs across the Trust compared to 101 SIs in 2013/14. The underlying trend for SIs is stable. There were no 'Never Events' (as defined by the Department of Health) relating to serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

The independent review process in relation to three cases in Kirklees and a thematic analysis review to cover the learning outcomes from three previous Kirklees homicides that took place in 2007/08 is now complete. The report and action plan was published by NHS

England, commissioners and the Trust on 23 January 2015 and the action plan will be implemented and monitored by the Clinical Governance and Clinical Safety Committee and by commissioners their Quality Board.

The Trust works closely with public stakeholders to involve them in understanding and supporting the management of risks that impact upon them. Stakeholders are able to influence the Trust in a number of ways, including patient involvement groups, public involvement in the activities of our Trust, membership of the Trust and its Members' Council, and regular dialogue with MPs and other partners. The engagement events held by the Trust during 2014/15 to support its transformation programme have also provided an opportunity to involve service users, carers and stakeholders in the management of risk.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with through Trust policies, training and audit processes, ensuring equality impact assessments are undertaken and published for all new and revised policies and services. Any new or revised polices, strategies, service re-design and projects must undertake an Equality Impact Assessment before approval. This ensures that equality, diversity and human rights issues, and service user involvement are systematically considered and delivered on core Trust business. All commissioned services also have an Equality Impact Assessment. The Equality and Inclusion into Action Group ensures EIAs are fully mainstreamed into BDUs' performance framework.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

South West Yorkshire Partners NHS Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission. The Trust continues to assess its compliance with CQC registration requirements through an internal regulatory compliance review process and a regular programme of unannounced visits. The experience gained from visits in 2013/14 has reinforced the organisational value of conducting the programme. Visit team findings have facilitated learning and provided teams with useful experience of an inspection process. Feedback reports are received and reviewed by BDUs with direction for action focused through BDU governance functions. Lessons learned from the process have been used to inform changes to the next planned visit programme. In 2014/15 the visit programme focused on assessment against both the CQC essential standards and the Trust's quality priorities. The focus of unannounced visits in 2014/15 has been on areas of risk and to follow up findings of previous visits. The programme has visited a range of services, both community and in-patient.

The Trust assessed itself against the NHS Constitution and a report was presented to Trust Board in September 2014. This covered all areas of the Trust. The Trust meets all the rights and pledges with the exception of the pledge "The NHS commits to make the transition as smooth as possible when you are referred between services, and to include you in the relevant discussions". It meets this partly as the Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care;

however, there are occasions when the nature of an individual's illness makes this inappropriate.

The key elements of the Trust's quality governance arrangements are as follows.

- The Trust's approach to quality reinforces its commitment to quality care that is safe, person-centred, efficient and effective. The Quality Improvement Strategy outlines the responsibilities held by individuals, BDUs, the Executive Management Team and Trust Board, co-ordinated under the Quality Academy. The Clinical Governance and Clinical Safety Committee is the lead committee for quality governance.
- There are quarterly quality reports for Trust Board and the Executive Management Team as well as monthly compliance reporting against quality indicators within performance reports. Trust Board also receives a quarterly report on complaints.
- CQC regulation leads monitor performance against CQC regulations and the Trust undertakes regular self-assessments.
- External validation, accreditation, assessment and quality schemes support self-assessment (for example, accreditation of ECT, PICU and Memory Services; CQC Mental Health Act Visits, NHSLARMS status, national surveys (staff and service user), implementation of Essence of Care and Productive Ward, etc.)
- Trust Action Groups provide organisational overview and performance monitoring against key areas of governance such as SIs, Infection Prevention and Control, Information Governance, Management of Aggression and Violence, Drugs and Therapeutics and Practice Effectiveness.
- Measures are implemented and maintained to ensure practice and services are reviewed and improvements identified and delivered, such as the Trust's prioritised clinical audit and practice evaluation programme.

The Trust continues to build on its existing service user insight framework to enhance and increase understanding of the Trust's services, to demonstrate the quality of services and to show the actions taken in response to the feedback. A number of initiatives have been established to strengthen customer insight arrangements, including the following.

- Systematising the collection of service user and care feedback through kiosks and hand held tablets, with a consistent approach to action planning and communication of the response to feedback, including assessment against the Department of Health's Friends and Family Test.
- Review and implementation of the '15 Steps Challenge' in Barnsley involving service users and carers, and stakeholders, including staff.
- Production of 'How was it for you today' working with service users and staff toolkit to receive service user carer feedback of their experience in out-patient clinics.
- Series of engagement events for staff, service users and carers, and stakeholders on mission and values, and transformation programme.
- Quantitative and qualitative local and national surveys undertaken on a regular basis and actions taken.
- Principle of co-production being embedded throughout the Trust, such as co-production of training in Recovery Colleges.

This has resulted in an increase in the number of issues raised and in the number of compliments received, which is a positive development in the context of the encouragement the Trust gives to people to offer feedback in all its forms.

The Trust maintained its Customer Service Excellence award for all areas in 2014.

Review of economy, efficiency and effectiveness of the use of resources

The governance framework of the Trust is determined by Trust Board. It is described in the Trust's annual report and includes information on the terms of reference, membership and attendance at Trust Board and its Committees, including the Audit and Remuneration and Terms of Service Committees, and the Nominations Committee, which is a sub-group of the Members' Council. The Trust complies with Monitor's Code of Governance and further information is included in the Trust's annual report.

The Executive Management Team has a robust governance structure ensuring monitoring and control of the efficient and effective use of the Trust's resources. Financial monitoring, service performance, quality and workforce information is scrutinised at meetings of the Trust Board, Delivery EMT, BDU management teams and at various operational team meetings. The Trust is a member of the NHS Benchmarking Network and participates in a number of benchmarking exercises annually. This information is used alongside reference cost and other benchmarking metrics to review specific areas of service in an attempt to target future efficiency savings. Work has continued with BDUs to implement and utilise service line reporting. In 2014/15, work also continued to develop the Trust's health intelligence function to support development of existing and new services. Work also continues both internally and with partners on the quality, innovation, productivity and prevention (QIPP) agenda.

The Trust has a well-developed annual planning process which considers the resources required to deliver the organisation's service plans in support of the Trust's strategic objectives and quality priorities. These annual plans detail the workforce and financial resources required to deliver the service objectives and include the identification of cost savings. The achievement of the Trust's financial plan is dependent upon the delivery of these savings.

The Trust's financial plan for 2014/15 was externally and independently reviewed by the Trust's external auditors, Deloitte, and a number of recommendations made. The report and actions arising from it were presented to Trust Board and progress against these recommendations monitored at each meeting. To support implementation of the 2014/15 plan and to ensure robust operational management is in place to manage Trust resources and to meet the plan, as Chief Executive, I established an Operational Requirement Group attended by Executive and operational Directors and their Deputies. The Group meets weekly and is chaired by myself. The Group supports the assurance provided to EMT and to Trust Board that there is strong management control over the Trust's resources and that risk is managed and mitigated.

A robust process is undertaken to assess the impact on quality and risks associated with cost improvements both prior to inclusion in the annual plan and during the year to ensure circumstances have not changed. The process and its effectiveness are monitored by the Clinical Governance and Clinical Safety Committee. Quality Impact Assessments take an objective view of cost improvements developed by BDUs of the impact on the quality of services in relation to the Trust's seven quality priorities (access, listening to and involving service users, care and care planning, recording and evaluating care, working in partnership, ensuring staff are fit and well to care, and safeguarding). The Assessments are led by the Director of Nursing and the Medical Director with BDU Directors and senior BDU staff, particularly clinicians. This process and its outcome was also reviewed as part of the review by Deloitte.

In consultation with the Board, I asked Deloitte to review progress against the recommendations made for the 2014/15 plan and to review the financial plan for 2015/16. Deloitte found that, overall, the process had significantly improved. Development of the cost improvement programme showed a clear bottom/up approach with clear ownership within

and by BDUs. The risk assessment was thorough, was a good process, and was seen to be balanced. The depth and detail of the quality impact assessment and quality of challenge was commended and was seen to be rigorous, particularly compared with other organisations. The Quality Impact Assessment process was seen as a well-developed methodology for the Trust to understand the level of risk involved with each proposed cost saving.

In terms of the follow up to the 2014/15 review, the recommendations had been substantially implemented and completed or partially completed. Where only partially completed, this presented no material weaknesses. For the review of the 2015/16 plan, for the majority of schemes, Deloitte concurred with the Trust's assessment of risk to delivery in terms of outcome; however, by value of savings to be realised, Deloitte considers the risk to delivery to be higher.

During 2015, the arrangements for external and internal audit come to an end. In October 2014, the Audit Committee reviewed the Trust's current. For external audit, Deloitte was awarded a two-year extension to its contract from 1 October 2013. As this was all that was allowed for in the original tender, the Trust would be unable to negotiate a further extension with Deloitte and must re-tender for external audit services. The Committee was of the view that tendering for both internal and external audit services at the same time would present a risk to the organisation and agreed to an extension to the contract for KPMG as the Trust's internal auditors for one year and to re-tender for external audit services.

As part of the annual accounts review, the Trust's efficiency and effectiveness of its use of resources in delivering clinical services are assessed by its external auditors and the auditor's opinion is published with the accounts.

Information Governance

Information governance is a key compliance area for the Trust. Control measures are in place to ensure that risks to data security are identified, managed and controlled. The Trust has put an information risk management process in place led by the Trust SIRO (senior information risk owner). Information asset owners cover the Trust's main systems and record stores, along with information held at team level. An annual information risk assessment is undertaken. All Trust laptops and memory sticks are encrypted and person identifiable information is required to be only held on secure Trust servers. The Trust achieved the target of 95% of staff completing training on information governance by 31 March 2015 and messages on compliance with Trust policy have been backed up by regular items in the weekly staff news. Incidents and risks are reviewed by the Information Management and Technology Trust Action Group chaired by the Director lead for information governance, which informs policy changes and reminders to staff.

The Trust is required to report any information governance incidents scoring level 2 or above externally to the Information Commissioners Office (ICO). Three incidents have been reported as meeting the threshold for external reporting under the new reporting requirements. One of these involved a wrongly addressed Compulsory Treatment Order in Kirklees and this is currently being followed up by the Information Commissioner's Office.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust boards on the form

and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

The following steps have been put in place to assure Trust Board that the Quality Report presents a balanced view and that there are appropriate quality governance arrangements in place to ensure the quality and accuracy of performance information. Quality metrics are reviewed monthly by Trust Board and the Executive Management Team and form a key part of the performance reviews undertaken by Business Delivery Units as part of their governance structures. The Clinical Governance and Clinical Safety Committee has delegated authority from Trust Board to oversee the development of and approve the Quality Report.

Governance and leadership

There is clear corporate leadership of data quality through the Deputy Chief Executive/Director of Finance with data quality objectives linked to business objectives, supported by the Trust's data quality policy and evidenced through the Trust's Information Assurance Framework, Information Governance Toolkit action plans and updates. The commitment to, and responsibility for, data quality by all staff is clearly communicated through Trust induction, Information Management and Technology Strategy, Data Quality Policy and RiO training.

The Director of Nursing chairs the Trust's Data Quality Steering Group. The Group ensures there is a corporate framework for management and accountability of data quality, with a commitment to secure a culture of data quality throughout the organisation and that this is supported by appropriate polices or procedures to secure the quality of the data recorded and used for reporting. It is also tasked with the Trust has in place arrangements to ensure that staff have the knowledge, competencies and capacity for their roles in relation to data quality.

Role of policies and plans in ensuring quality of care provided

The Trust firmly believes that good clinical recording is part of good clinical practice and provision of quality care to service users. There is comprehensive guidance for staff on data quality, collection, recording, analysis and reporting which meets the requirements of national standards, translating corporate commitment into consistent practice, through the Data Quality Policy and associated information management and technology policies. There are performance and information procedures for all internal and external reporting. Mechanisms are in place to ensure compliance through the Information Management and Technology TAG and annual reports to the Audit and Clinical Governance and Clinical Safety Committees on data quality.

Systems and processes

There are systems and processes in place for the collection, recording, analysis and reporting of data which are accurate, valid, reliable, timely, relevant and complete through system documentation, guides, policies and training. Corporate security and recovery arrangements are in place with regular tests of business critical systems. These systems and processes are replicated Trust-wide.

People and skills

Roles and responsibilities in relation to data quality are clearly defined and documented, with data quality responsibilities referenced within the Trust's induction programme. There is a clear RiO training strategy with the provision of targeted training and support to ensure responsible staff have the necessary capacity and skills.

Data use and reporting
Data provision is reviewed regularly to ensure it is aligned to the internal and external needs of the Trust through Performance EMT and Trust Board, with KPIs set at both service and Board level. This includes identification of any issues in relation to data collection and reporting and focussed action to address such issues.

The Trust's external auditor, Deloitte, provides external assurance on the Quality Report and the findings are presented to the Audit Committee, Clinical Governance and Clinical Safety Committee, Trust Board and the Members' Council.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within South West Yorkshire Partnership NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by Trust Board, the Audit Committee and the Clinical Governance and Clinical Safety Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Assurance Framework provides me with evidence that the effectiveness of controls put in place to manage the risks to the organisation achieving its principal objectives have been reviewed. The Assurance Framework is approved by Trust Board on an annual basis and reviewed and updated on a quarterly basis throughout the past year. There were no significant gaps identified in the Assurance Framework.

Directors' appraisal is conducted by me as Chief Executive. Objectives are reviewed on a quarterly basis, prioritised in line with the performance-related pay structure agreed by the Remuneration and Terms of Service Committee. This has provided a strong discipline and focus for Director performance. Non-Executive Director appraisals are undertaken by the Chair of the Trust.

The Trust has developed a values-based appraisal system for staff, which was introduced across the Trust in 2013. The Trust set a target of all staff in bands 6 and above having an appraisal in the first quarter of the year and the remainder of staff by the end of the second quarter. Although this is a challenging, managers and staff work hard to achieve the target within operational capacity. The Trust has also introduced values-based recruitment and selection.

As a result of an inspection visit to the Fieldhead site by the Care Quality Commission, the Trust was issued with two compliance actions in July 2013. Locations visited were Trinity 2, Newton Lodge and Bretton. The CQC found that overall patients were receiving a good level of service; however, there were some concerns regarding the design and layout of some of the hospital's seclusion rooms and the general décor and environment of Hepworth ward (within Newton Lodge). The CQC also identified some concern regarding how some patients' seclusions had been reviewed and continued. A detailed action plan was submitted to address the compliance issues, which was fully completed in June 2014. The CQC has yet to return to the Trust to review the compliance actions.

All Committees of Trust Board are chaired by Non-Executive Directors to reflect the need for independence and objectivity, ensuring that effective governance and controls are in place. This structure ensures that the performance of the organisation is fully scrutinised. The Committee structure supports the necessary control mechanisms throughout the Trust. The Committees have met regularly throughout the year and their minutes and annual reports are received by the Board. Further information on Trust Board Committees is contained in the annual report and in the Trust's Risk Management Strategy.

The Audit Committee is charged with monitoring the effectiveness of internal control systems on behalf of the Board and has done so as part of its annual work programme and reported through its Annual Report to the Board. The Audit Committee is able to provide assurance to Trust Board that, in terms of the effectiveness and integration of risk Committees, risk is effectively managed and mitigated through assurance that Committees meet the requirements of their Terms of Reference, that Committee workplans are aligned to the risks and objectives of the organisation, which would be in the scope of their remit, and that Committees can demonstrate added value to the organisation.

The role of internal audit at the Trust is to provide an independent and objective opinion to me, my managers and Trust Board on the system of control. The opinion considers whether effective risk management, control and governance arrangements are in place in order to achieve the Trust's objectives. The work of internal audit is undertaken in compliance with the NHS Internal Audit Standards. The internal audit function within the Trust is provided by KPMG.

The work undertaken by internal audit is contained in an annual audit plan approved by the Audit Committee. Development of the work programme involves pre-discussion with the Executive Management Team and with the wider Extended Executive Management Team. It is based on an audit of core activity around areas such as financial management, corporate governance and Board assurance processes, and audit of other areas following assessment and evaluation of risks facing the Trust. This includes priority areas identified by the Executive Management Team focusing on risk and improvement areas. Internal audit provides the findings of its work to management, and action plans are agreed to address any identified weaknesses. Internal audit findings are also reported to the Audit Committee for consideration and further action if required. A follow up process is in place to ensure that agreed actions are implemented. Internal audit is required to identify any areas at the Audit Committee where it is felt that insufficient action is being taken to address risks and weaknesses.

From April 2014 to January 2015, twelve internal audit reports were presented to the Audit Committee. Significant assurance was received for three reports and significant assurance with minor improvement opportunities given in six areas. Three reports were given partial assurance in relation to patients' property, bed management and data quality.

Action plans are developed for all internal audit reports in response to the recommendations and the Audit Committee invites the lead Director for each limited or no assurance report to attend to provide assurance on actions taken to implement recommendations. For all partial and no assurance reports, a further audit is undertaken within six months.

Three reviews are ongoing at the end of the year and are due to report to the Audit Committee in July 2015.

The Head of Internal Audit's overall opinion for 2013/14 is one of substantial assurance.

The Trust is committed to a continual improvement in the quality of its data in order to support improvement of the service it offers to users of its services and to meet its business

needs. Regular reviews of the quality of the Trust's clinical data are undertaken by the Data Quality Steering Group and, where data quality standards are identified as a risk factor, these will be reported to the Trust's Senior Information Risk Owner (SIRO) for further investigation. Business Delivery Units and the Executive Management Team are also responsible for reviewing and assessing the quality of data and for ensuring mitigating action is in place to ensure any areas of weakness are addressed. Trust Board, through its Committees, also considers data quality from both an operational and analytical perspective. The principles supporting the Trust's approach to data quality are contained in its Data Quality Strategy and Policy.

As Chief Executive, I am supported by the Executive Management Team. The EMT supports me in co-ordination and prioritisation of activity in the Trust ensuring that the strategic direction, set by a unitary Trust Board, is delivered. It is jointly responsible for ensuring that agreed leadership and management arrangements are in place, supported by robust and clear governance and accountability processes. It ensures the organisation champions equality and that the Trust is 'diversity competent'.

Conclusion

I have reviewed the relevant evidence and assurances in respect of internal control. The Trust and its executive managers are alert to their accountabilities in respect of internal control. Throughout the year, the Trust has had processes in place to identify and manage risk.

With the exception of the internal control issues that I have outlined in this statement, which are not considered significant, my review confirms that the Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.

Over the past year, the Trust has undergone significant change; however, it is my view that the system of internal control has remained robust and enabled change and risk to be managed effectively.

……

Steven Michael
Chief Executive
22 May 2015

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 28 April 2015
Agenda item 11

Title:	**Trust Board self-certification – Monitor Quarter 4 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 4 assessment Based on the evidence received by Trust Board through performance reports and compliance reports, the Trust is reporting a governance risk rating of **green** 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 since quarter 3 of 2013/14, of executive team

turnover as this is seen as one of the potential indicators of quality governance concerns. The Trust is required to provide information on the total number of executive (voting) posts on the Board, the number of these posts that are vacant, the number of these posts that are filled on an interim basis, and the number of resignations and appointments from and to these posts in the quarter.

Subject to any changes required by Trust Board as a result of earlier board papers and the resultant discussion, the attached report will be submitted to Monitor in respect of Quarter 4 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

At the end of Q2 2014/15, Monitor issued a press release commenting on the following issues to come out of its analysis of Q2 returns.

- The sector reported a deficit of £321 million due to growth in operating costs continuing to exceed revenue. Under-performance on cost savings has also had an adverse effect.
- A forecast deficit of £375 million is projected at the year-end.
- 78 foundation trusts reported a deficit of which 60 were acute trusts.
- The combined deficit of these 78 trusts was £530 million, offset by 71 trusts making a surplus of £209 million.
- Trusts planned to deliver 3.3% CIPs by Q3 2014/15. The year-to-date savings delivered were 20.6% (£210 million) short of plan. Pay cost savings was the major contributor to this shortfall. This equated to achievement of £811 million, £210 million less than planned.
- Capital expenditure was £1,413 million against a plan of £1,941 million, 27% behind plan compared to 23% in the same quarter last year.
- 67 trusts triggered concerns under the risk assessment framework in Q3 (54 of these had also triggered concerns in previous quarters). 24 of these are subject to enforcement action by Monitor because of governance and performance concerns.

All Foundation Trusts

		Governance rating			
		No evident concerns	Issues identified	Enforcement action	Total
Continuity	4	**71**	2	2	**75**
	3	30	8	5	**43**
	2	7	3	5	**15**
	1	0	8	9	**17**
	Total	**108**	**21**	**21**	**150**

Mental Health Trusts

		Governance rating			
		No evident concerns	Issues identified	Enforcement action	Total
Continuity	4	**28**	0	1	**29**
	3	7	1	1	**9**
	2	2	1	0	**3**
	1	0	0	0	**0**
	Total	**37**	**2**	**2**	**41**

The Trust remains in the upper quartile of foundation trusts.

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 4 return 2014/15
Trust Board 28 April 2015

Compliance with the Trust's Licence
The Trust continues to comply with the conditions of its Licence.

As notified in Q3, there are two changes in Commissioner Requested Services relating to the Calderdale substance misuse service and Barnsley contraceptive and sexual health/genito-urinary medicine (CASH/GUM) (see below) as a result of commissioner tendering of services, which took effect on 1 April 2015.

Trust Board
As previously notified to Monitor, the Trust has two Non-Executive Directors whose terms of office come to an end in 2015 (Peter Aspinall on 30 April 2015 and Helen Wollaston on 31 July 2015). The recruitment process is now at the interview stage with formal interviews to be held on 27 April 2015 for both vacancies. The recruitment process will conclude with a recommendation to the Members' Council on 29 April 2015.

The Trust will continue the interim operational support at Director level to cover the child and adolescent mental health services and the forensic services portfolio until September 2015.

Members' Council
The election process for the Members' Council will conclude on 27 April 2015. Following the nominations process, the following seats have been filled.

- Kirklees (three vacant seats) – two seats filled
- Wakefield (two vacant seats) – one seat filled
- Staff
  Medicine and pharmacy
  Non-clinical support staff
  Nursing

An election for the staff Allied Health Professionals seat will conclude on 27 April 2015.

The following seats are vacant.

- Barnsley – one seat (due to resignation at end of April 2015)
- Rest of South and West Yorkshire – one seat vacant
- Staff nursing support
- Social care staff working in integrated teams

The Trust is also awaiting notification of representatives from Barnsley Hospital NHS Foundation Trust and Wakefield Council for appointed seats that become vacant on 1 May 2015.

The Members' Council will also receive a recommendation from the Nominations Committee in relation to the Lead Governor. The current Lead Governor has indicated that he wishes to end his term at the end of April 2015 to allow for a smooth transition and handover before his term of office as a governor ends in 2016.

Care Quality Commission (CQC)

- The 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) remain open. As previously reported the Trust has formally notified CQC of completion of the action plan. .
- The CQC continues to monitor the Trust in regard to admission of patients to wards when no beds are available.
- There were two CQC Mental Health Act visits in Q4 to Priestley (Newton Lodge) and Trinity 1 (Fieldhead, Wakefield).
- Within the quarter, four Mental Health Act monitoring summary reports were received relating to visits made to : Ward 18 (Priestley Unit, Dewsbury), Lyndhurst (Calderdale), Priestley ward (Newton Lodge) and Trinity 1 (Fieldhead, Wakefield). Most aspects of the monitoring visits were positive in terms of practice and implementation of actions identified from previous visits; however, recurring issues relate to:
  - the recording of Section 132 rights;
  - recording and practice relating to seclusion; and
  - poor understanding of the interface between the Mental Health and Mental Capacity Acts with a lack of recording of assessments of capacity.

  In addition concerns were raised regarding mental health staff access to physical health care records.

Absent without Leave (AWOL)

There were no CQC reportable cases during Q4.

Eliminating Mixed Sex Accommodation (EMSA)

There have been no reported breaches in Q4. The Trust continues to monitor where service users are placed in an individual room on a corridor occupied by members of the opposite sex. In Q4, there were four reported incidents (six in Q3). All incidents have been appropriately care-managed with required levels of observation and support implemented.

Infection prevention and control

In Q4, there have been no 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.

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 4.

Safeguarding Children

In Q4, there were 31 recorded incidents directly relating to issues of child protection. This represents an increase on Q3; however, 30 of these were graded as green. Increasingly, referrals to children social care are being reflected in Trust reporting which should be viewed positively. All of the incidents were reviewed by the Named Nurses and were assessed to have been appropriately reported and managed.

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 Q4 there have been 21 SIs reported to the Commissioners (three in Barnsley (general community), four in Barnsley (mental health), three in Calderdale, six in Kirklees, four in Wakefield and one in forensic services.
- SI investigations and reports are being completed within timeframes agreed with commissioners; however, there is continued pressure to complete reports within timescales.
- No 'Never Events' occurred in the Trust during this quarter.
- The independent review process in relation to three Kirklees cases (2010/9926, 2011/11370 and 2011/11502) and a thematic analysis report to cover the learning outcomes from three previous Kirklees homicides that took place in 2007/08 has been completed. The report and action plan was published by NHS England, commissioners and the Trust on 23 January 2015. The action plan is being implemented and monitored by the Clinical Governance and Clinical Safety Committee and by commissioners through the Quality Board.

Duty of Candour (Q3 figures)
The Trust aims to deliver the highest standards of healthcare to all its service users. The promotion of a culture of openness is a prerequisite to improving patient safety and the quality of healthcare systems. This communication is open, honest and occurs as soon as possible following a patient safety event. It should be noted that the severity of the incident as recorded on the Trust's Datix system is different from the National Patient Safety Agency definition of harm; therefore, this set of data is not comparable with other data.

- Total number of incidents meeting NPSA definition of moderate, severe harm or death = 31 (Q1 – 35, Q2 - 38)
- Number reported on STEIS as SIs = 28 (Q1 – 24, Q2 – 23)
- Other (all moderate) = 3 (Q1 – 11, Q2 – 15)

Customer Services
- The Trust received a total of 68 formal complaints in quarter 4. The breakdown is as follows:
  - Barnsley – 17;
  - Calderdale – 5;
  - Kirklees – 7;
  - Wakefield – 14;
  - Specialist services – 22;
  - Forensic – 3.
- In Specialist Services, most of the complaints received related to child and adolescent mental health services, with the Calderdale and Kirklees service having the most complaints (twelve), Barnsley CAMHS six and Wakefield one. Access to services and waiting times (particularly the wait time from the initial 'Choice' appointment to treatment) were the most common issues raised.
- Consistent with past reporting, care and treatment was the most frequently raised negative issue (36). This was followed by waiting times, delays and cancellations (30), communications (28), staff attitude (19) and admission, discharge, referral, assessment and transfer issues (eight). Most complaints contained a number of themes.
- During the quarter, one complainant (Wakefield older people's service inpatient) asked the Parliamentary and Health Service Ombudsman to review their complaint. 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 from the Ombudsman regarding two cases which had been subject to review. One required no further action and one required the Trust to resolve by means of apology and an action plan.

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

Third party reports
In quarter 3, the Trust received an internal audit report with partial (formerly limited) assurance in relation to information governance. Management action was agreed with internal audit with timescales for completion to ensure the Trust meets the required level for its submission of the Toolkit at the end of March 2015. The follow up review by internal audit provided an increased significant assurance rating.

Data quality narrative to be updated.

Children's and adolescents' mental health services (CAMHS)
Narrative to be updated following Trust Board.

Quarter 4 2014/15 financial monitoring
To come